STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laurie Buchanan,

Petitioner,

vs. NO: 11 WC 16599

Olin Corporation,

Respondent.

17IWCC0591

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice provided to all parties, the Commission, after considering the issues of benefit rates, causal relationship, temporary total disability benefits, medical expenses, maintenance versus PPD advancement and permanent disability and being advised of the facts and the law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Arbitrator's Decision- finding Petitioner failed to prove a causal relationship exists between the accidental injuries she sustained on April 18, 2011 and her current condition of ill-being as it relates to her cervical spine. Based on this finding, the Commission vacates the Arbitrator's award of medical expenses.

The medical records evidence although Petitioner complained of neck pain, she did not receive treatment for her cervical spine until almost four years after her April 18, 2011 accident, absent a cervical MRI performed on July 1, 2013 at her request. During this period, Petitioner treated for her low back condition with Dr. Gornet, who performed a laminotomy and foraminotomy at L5-S1 on the right side on November 30, 2011. Dr. Gornet

felt Petitioner reached maximum medical improvement on July 12, 2012, noting he agreed with the functional capacity evaluation which placed her at a sedentary level. Thereafter, on January 24, 2013, Petitioner reported her symptoms in her neck, shoulders and arms had worsened, and Dr. Gornet recommended a cervical MRI. On May 23, 2013, Petitioner reported having right-sided low back pain on the same side as her decompression which Dr. Gornet felt might be a recurrent disc herniation and recommended a lumbar MRI. Dr. Gornet noted, "I have again asked her to not move forward with any issues on her neck, as I believe this will be a prolonged fight with the employer insured, but certainly I think it is reasonable and all parties could agree that if she is having increasing symptoms in her low back to the right side, this would warrant further workup." On July 1, 2013, Petitioner reported to Dr. Gornet she underwent a cervical MRI under her own insurance. Dr. Gornet reviewed the MRI and recommended Petitioner try and live with her neck symptoms, and her pain was predominately in her low back, right buttock, and right leg. (The Commission notes neither the July 1, 2013 MRI report nor bill were offered into evidence). On October 28, 2013, Petitioner underwent a lumbar MRI which Dr. Gornet interpreted as evidencing a continued disc herniation- central right at L5-S1, which correlated with Petitioner's right buttock and leg pain. Dr. Gornet opined no further treatment was recommended; permanent restrictions of no lifting greater than 10 pounds, no repetitive bending or lifting; and placed Petitioner at maximum medical improvement. PX4, DepEx2.

On November 3, 2014, a year later, Dr. Gornet re-evaluated Petitioner who reported neck pain into both shoulders with some right scapular and arm pain. Dr. Gornet recommended an oral steroid and a cervical MRI. The Commission notes this was the commencement of Petitioner's treatment for her cervical complaints. Petitioner underwent a cervical MRI on November 21, 2014 which was compared to the July 1, 2013 MRI. The radiologist's impression was: 1) degenerative disc disease primarily involving the C3-4 through C6-7 disc levels with disc bulges and disc protrusions; there was multilevel central canal stenosis spanning from C3-4 through C6-7 levels; and 2) varying degrees of neural foraminal exit stenosis, most severely involving the bilateral C5-6 and C6-7 neural foramen. Petitioner underwent two epidural steroid injections on January 5 and 14, 2015 performed by Dr. Boutwell. On March 16, 2015, Dr. Gornet evaluated Petitioner for a final time noting further treatment might be necessary for her cervical complaints but ultimately releasing her on an "as needed" basis. PX4, DepEx2.

At his April 20, 2015 deposition, Dr. Gornet testified as of July 12, 2012, he placed Petitioner at maximum medical improvement for both her back and neck as further treatment was not indicated. PX4, p. 29. Dr. Gornet opined a causal relationship exists between Petitioner's cervical symptoms and the April 18, 2011 accident, based upon her complaints to him. PX4, p. 15.

Dr. Lange evaluated Petitioner at various times pursuant to §12 of the Act at Respondent's request. On June 21, 2011, Dr. Lange examined Petitioner and reviewed the medical records to date and noted Petitioner's complaints of low back pain and to a lesser degree discomfort in the neck and intrascapular area. Dr. Lange noted it was Dr. Gornet's plan to address Petitioner's neck as a secondary issue. On September 19, 2011, Dr. Lange examined

Petitioner and reviewed Dr. Gornet's records since his prior evaluation and again noted Dr. Gornet planned to address Petitioner's residual intrascapular discomfort in a secondary fashion. Dr. Lange opined addressing cervical/intrascapular complaints with more treatment, particularly invasive, was not indicated. On March 29, 2012, Dr. Lange evaluated Petitioner and opined 1) she reached maximum medical improvement, and 2) further diagnostic testing was not necessary nor indicated. RX5.

On October 22, 2013, Dr. Lange evaluated Petitioner for a final time noting primarily persistent low back complaints and some aching into the neck extending slight to the arm. Dr. Lange noted his prior evaluation approximately one and half years ago, at which time he opined Petitioner reached maximum medical improvement and was in no need of further treatment. Dr. Lange noted Petitioner continued to seek treatment with Dr. Gornet. Dr. Lange noted although Petitioner exhibited multiple signs of symptom magnification, she complained of both axial neck and low back pain. Dr. Lange opined Petitioner suffered from low back pain which was impossible to quantify objectively and re-iterated maximum medical improvement occurred approximately one and half years previously. Dr. Lange again opined regarding the cervical spine finding Petitioner suffered from multilevel degenerative changes and re-iterated further treatment was not indicated. PX11.

The Commission finds, based on 1) the nearly four-year gap in treatment, 2) Petitioner being declared at maximum medical improvement numerous times (July 12, 2012, March 29, 2012, October 22, 2013, and October 28, 2013 by both Dr. Gornet and Dr. Lange), and 3) Dr. Lange's opinion cervical treatment was not indicated, Petitioner failed to prove a causal relationship exists between the accidental injuries she sustained on April 18, 2011 and her current condition of ill-being as it relates to her cervical spine. The Commission vacates the medical expenses awarded of $11,931.02 as such expenses as outlined in PX9 relate to treatment for the cervical spine. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's September 6, 2016 decision is modified for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHERED ORDERED BY THE COMMISSION that the award of medical expenses contained in PX9 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing October 14, 2014, Respondent pay to Petitioner the sum of $723.41 per week for life under §8(f) of the Act for the reason that the injuries sustained caused the total permanent disability of Petitioner.

IT IS FURTHERED ORDERED BY THE COMMISSION that Respondent 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 under this order.

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IT IS FURTHER ORDERED BY THE COMMISION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes Respondent paid $132,381.75 in temporary total disability benefits and $32,450.00 in permanent total disability benefits following October 14, 2014 for a total credit of $164,831.75.

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 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 §8(g) of the Act.

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: SEP 27 2017
LEC/maw
o08/02/17
43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUCHANAN, LAURIE
Employee/Petitioner

Case# **11WC016599**

OLIN CORPORATION
Employer/Respondent

17IWCC0591

On 9/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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DOUG MENDENHALL
PO BOX 8248
ALTON, IL 62002

0299 KEEFE & DePAULI PC
ANDREW J KEEFE
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

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

Laurie Buchanan
Employee/Petitioner

v.

Olin Corporation
Employer/Respondent

Case # 11 WC 16599

Consolidated cases: N/A

17IWCC0591

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **8/25/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0591

FINDINGS

On **4/18/11**, 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 **$56,425.62**; the average weekly wage was **$1,085.11**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$132,381.75** for TTD, and maintenance, and **$32,450.00** for other benefits (PTD) paid following 10/14/14, for a total credit of **$164,831.75**.

ORDER

Respondent shall pay reasonable and necessary medical services of $11,931.02, as set forth in PX9, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner permanent and total disability benefits of **$723.41**/week for life, commencing **10/15/14**, as provided in Section 8(f) of the Act.

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

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

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

Signature of Arbitrator

8/13/16
Date

ICArbDec p. 2

SEP - 6 2016

FINDINGS OF FACT

Petitioner, 48 years of age, worked for Respondent as a quality group leader. Her job required walking, bending, stooping, measuring, auditing and reporting on production. She oversaw other employees' work. She occasionally was required to lift up to 30 pounds. On April 18, 2011she sustained an undisputed accident when she sat on a stool which broke, causing the chair to turn and flip her sideways onto a tub of bullets with a steel bar. She landed on tub and bar, and twisted her body. She felt excruciating pain and something popped in her lower back. Her right shoulder and neck also hurt.

Her supervisor sent her to the Respondent's medical department where she saw Dr. Sun. She was sent to the emergency room at Alton Memorial Hospital. She had a CT scan at the hospital and was discharged. The next morning she could hardly walk from pain in her right back side and neck. She contacted and saw her family physician, Dr. Crancer, who prescribed medication and ordered her off work.

Soon thereafter, on May 5, 2011, Petitioner saw Dr. Gornet. She reported a chief complaint of low back pain as well as neck pain. Dr. Gornet stated neck treatment would be put on hold. A lumbar MRI was ordered. Petitioner was prescribed prednisone and four weeks of physical therapy. (PX 4). Jerseyville Therapy records reflect a diagnosis of low back pain. Petitioner received therapy for the lumbar spine alone. (PX 3; RX 9).

Petitioner returned to Dr. Gornet on June 16, 2011. Dr. Gornet interpreted the MRI to reveal a central right sided disc herniation at L5-S1. He recommended three lumbar epidural steroid injections. Petitioner reported only temporary relief from the injections. Dr. Gornet recommended surgery. A second lumbar MRI was ordered prior to surgery. (PX 4).

Dr. David Lange evaluated Petitioner on June 21, 2011 at the request of Respondent. Dr. Lange documented low back pain as well as neck pain. The cervical pain did not radiate to her upper extremities. Dr. Lange documented that Petitioner weighed 298 pounds and was very obese. Dr. Lange believed the accident resulted in her low back pain. Dr. Lange agreed with Dr. Gornet's recommendation for lumbar injections. (RX 5). Dr. Lange generated an addendum report dated August 8, 2011 following review of additional records. He noted Petitioner had been diagnosed with a L5-S1 herniation in 2006, but still believed the accident triggered symptoms in her low back. (RX 5).

Dr. Lange re-examined Petitioner on September 19, 2011. He opined surgery would be reasonable, but Petitioner should anticipate ongoing lower extremity and low back complaints after surgery. He opined that prolonged rehab activities would not change her outcome because of her pre-existing psychological disease, obesity and multiple complaints. He stated there was no point in obtaining multiple diagnostic tests with respect to her cervical spine because axial pain does not respond to invasive treatment whether by injection or surgery. (RX 5).

On November 30, 2011, Petitioner underwent a laminotomy and foraminotomy at L5-S1. Following surgery, Petitioner reported that her leg pain was better with alleviation of pain below the knee. She continued to experience pain in her back. She reported having intermittent stabbing pain and pressure in her back. (PX 4).

Petitioner returned to Dr. Lange on March 29, 2012. Petitioner confirmed that the surgery was beneficial with regard to her radicular symptoms. Dr. Lange noted that Petitioner presented with a very flat affect and was resistant during physical examination. Dr. Lange opined Petitioner had reached maximum medical improvement with respect to her work related injury. He reiterated additional diagnostic testing would be pointless. Dr. Lange opined that Petitioner had significant psychological issues, but she could work at the sedentary demand level. (RX 5).

Petitioner continued to follow up with Dr. Gornet post operatively. When Petitioner returned three months following surgery Dr. Gornet testified "we had her involved with exercise conditioning, and she developed increasing low back pain, which would be fairly typical." (PX 4, p.10) A new MRI was recommended and ultimately performed on May 10, 2012.

Petitioner underwent an FCE on May 29, 2012. The study revealed that Petitioner provided a fair but guarded effort. The therapist concluded Petitioner could function at a sedentary physical demand level. (PX 5).

Petitioner returned to Dr. Gornet on July 12, 2012. Permanent restrictions were imposed. Dr. Gornet concluded that Petitioner was capable of work with a 10 pound restriction, no repetitive bending or stooping, and she should be also allowed to change positions, sit or stand as needed. (PX 4 p. 10; RX 4).

In September of 2012 Petitioner met with June Blaine at the request of Respondent. They discussed her background work, training and experience. Respondent then advised they were not able to provide a job within her restrictions.

Petitioner returned to Dr. Gornet on January 24, 2013. Petitioner reported having symptoms in her neck, shoulder and arms, but denied a new accident. Dr. Gornet recommended a cervical MRI scan.

In April of 2013 there was another meeting with June Blaine to look at the idea of training and computer skills. Petitioner knew a little typing because she had entered data on a system at Respondent's facility. She still does not know how to use the Internet or use a computer at home. She completed high school and had taken some community college courses after high school in the 1980s. She had done some keyboard typing to create keypunch cards. All of her work experience was working in factory or warehouse settings performing manual labor.

Under the direction of Ms. Blaine, a private training program was set up at CALC, in Alton, IL. The plan was to become trained to be an administrative assistant. She understood the training to involve light typing and computer programs and literacy. She started into the program in April of 2013 and it was to be concluded by October, 2014. There was a break in her training from February 22, 2014 to May 6, 2014 during which time she was hospitalized as a result of complications with stress and anxiety. She has had anxiety and depression problems since her early twenties. She has been treated with medication since that time. She was going through a change in medications when complications arose, giving rise to the need for hospitalization. She had been taking medication for these conditions while working for Respondent. Petitioners had a similar reaction to medication changes in 2010 which required her to miss approximately six weeks while working for Respondent. She felt she coped well with the anxiety over 11 years while working for Respondent.

Petitioner returned to Dr. Gornet on May 23, 2013 reporting the cervical MRI would not be authorized. Petitioner also reported recurrent low back pain and was concerned with a kidney issue. Dr. Gornet recommended Dr. Crancer work Petitioner up for the kidney issue. He also recommended that she undergo an updated lumbar MRI. (PX 4).

Petitioner met with Steve Dolan, a vocational counselor, at her attorney's request in May, 2013. She was at his office in Alton for almost 4 hours. She answered his questions concerning how she was doing and took a series of tests including reading, spelling and math. She tried hard on the tests. She thought she did fairly well but the result showed her reading was poor. He advised her to get counseling treatment for her anxiety and depression which she did at Wellspring in Jerseyville Illinois. The counseling she has received has helped and she has also gone through medication changes.

Mr. Dolan testified that he is a certified vocational rehabilitation counselor who performed a vocational assessment of the Petitioner on referral from her attorney. Over 20 years he served in various capacities with the Illinois Department of Rehabilitation Services including Administrator of Field Operations for the entire agency and finally, as Acting Deputy Director for the agency. He now maintains a private practice, consulting with the Social Security Administration and performing vocational assessments and counseling on a private referral basis. (PX 7)

He met with Petitioner on April 1, 2013 to assess her ability to work and if necessary, provide vocational rehabilitation services. He reviewed various records involving Petitioner including transcripts from Lewis and Clark Community College, school records, employment application from Olin, and medical records including those from Dr. Gornet and Dr. Lange. He interviewed the Petitioner gathering background information about employment history and function, day-to-day activities and function and then gave her a battery of tests, the Wide Range Achievement Test.

Her educational background reflected some community college course work after high school including a medical transcriptionist program. But this was not completed and she stated she had not done well at typing. Her data entry training was for operating a keypunch machine, a technology which is no longer used. She stated she was to begin a proprietary business training program the day following their meeting. Essentially she had worked at physical labor type jobs including various kinds of factory jobs since the middle 1990s. She had no specific vocational skills that would transfer to other types of work. Her last job with Olin required bending and stooping and lifting to inspect ammunition product. She and her team were supposed to find defective product and let the machine operator or supervisor know that something was wrong with the production process. She had a medical history that included anxiety and depression for which she had been on medication for some years. He recommended that she seek treatment at a local community counseling program to treat her current symptoms for that condition.

He reviewed medical records from Dr. Gornet and Dr. Lange. He also reviewed the functional capacity examination stating that she could lift only 10 pounds occasionally and 3 pounds frequently. It stated that she functions at the sedentary level and that her work was further eroded because she can't sit constantly. He felt this was consistent with restrictions from Dr. Gornet of no lifting over 10 pounds and no repetitive bending or lifting.

He testified that he went through her day-to-day activities with her. He stated she limited her driving. Her daughter and her husband did all the cooking and household cleaning including vacuuming, dishes, laundry and outside lawn work. Her daughter would do the grocery shopping and lifting and the Petitioner would ride an electric cart. Her sleep was reported as interrupted through the night. Typically she would be lying down for several hours during the day. She reported she no longer goes to activities such as movies or playing bingo because she cannot sit very long.

He noted on page 6 of his report that during the three hours and 45 minutes she was there she stood 11 times and during 20 minutes of the time she was lying on her left side on the carpet. He testified that he observed that he she could not sit very long. He felt that she was very credible during the interview process because her anxiety and depression prevented her from any deception.

On the Wide Range Achievement Test her scores were below average. He made a follow-up telephone call to her on May 2, 2013 to check on the training program at CALC. She reported she was having trouble with pain, spending time on a couch and had trouble focusing on the material.

Mr. Dolan concluded that she had no transferable skills for any new employment. With the restrictions from Dr. Gornet and Dr. Lange, there were jobs which hypothetically she might be able to perform. However she would need training. Based on her reading and math abilities shown in the testing, he felt she would have a difficult time with clerical training. Later reports from June Blaine dated December 13, 2013 showed Petitioner was only progressing slowly with her CALC training. It appeared she would not be able to obtain certification as an administrative assistant as hoped. It was his opinion that Petitioner will not be able to perform any employment for which a reasonably stable labor market exists. She would not be able to do that unless the pain could be brought under control and her anxiety and depression improved. Based on the pain condition alone, he did not feel that she could tolerate a regular work schedule because she has to lie down periodically. He noted the records from June Blaine showed some progress at the training but not what was expected from an average student. Further, his testing showed Petitioner was unlikely to be successful in clerical training and she had never done well in previous attempts in community college.

Petitioner proceeded with a cervical MRI under her own health insurance. Dr. Gornet reviewed the study on July 1, 2013 and recommended that Petitioner try and live with her neck symptoms. He noted that her predominant pain was low back and right leg at that time. No new restrictions were imposed. (PX 4).

Petitioner returned to Dr. Lange on October 22, 2013. Dr. Lange again stated no further diagnostic testing or treatment interventions were necessary. Petitioner informed Dr. Lange that she had enrolled in a CALC program, but from the very beginning she did not believe it was practical due to her learning deficiencies. Dr. Lange noted there was a difference between the vocational opinions of Ms. Blaine and Mr. Dolan as to whether Petitioner is fit for clerical work from an intelligence standpoint. He opined that Petitioner's medication might result in difficulties with keyboard speed and concentration. Dr. Lange could not objectively quantify the amount of low back pain Petitioner was reporting. Based on Petitioner's physical capabilities, Dr. Lange did not believe she was totally disabled for all occupations. Dr. Lange stated that while Petitioner may not be a candidate for a clerical position (based on Mr. Dolan's reported intellectual testing), he could certainly envision several occupations at the sedentary physical demand level. (PX 11).

On October 28, 2013, Dr. Gornet stated that Petitioner could work with permanent restrictions of no lifting greater than 10 pounds and no repetitive bending or lifting. Petitioner was again placed at maximum medical improvement. (PX 4). On October 29, 2013 Petitioner underwent the lumbar MRI that Dr. Gornet recommended May 23, 2013. (PX 4).

Petitioner did not progress well with the training at CALC. She was having physical issues with back, neck and shoulder pain. Her schedule was three days per week for four hours per day. There was a schedule set out for how she was to progress. She strained her neck while typing and had headaches. Sitting for a period of time caused her back to spasm. Her instructor allowed her to leave the room and walk around and sit at a couch on another level to prop up her leg. She took her book to study and try to read.

The beginning computer skills she learned without much trouble. However, learning the Word program and on to the intermediate level was a problem. She felt she had a reading comprehension problem because she would read things two or three times to try to retain it. It was a self-paced training program and she did not feel she could teach herself. The instructor Jim Applegate was very helpful. She would read and retain material for a short time but then later have to go back again and repeat study. Although she fell behind in her classes, she kept trying. She began to come in an extra day each week on Mondays to try to catch up. She also took books home. Her typing speed improved to about 12 words per minute. But she would have to stop typing due to neck pain. She stated she did not feel she could spend an hour at a time at a computer job. She could not sit that long due to pain in her neck and back. She does not feel she would be able to complete the training at CALC. She continuing to work at the program until October 14, 2014. At that time there was a meeting with Jim Blaine and Mr. Applegate. They told her that even though she tried she wasn't going to be able to complete the work in sufficient time and they needed to drop her from the program.

James Applegate testified that he was subpoenaed to appear for the hearing. He is employed by CALC Institute of Technology. It is an adult education trade school, teaching technology for office administration. It is a privately owned company. Mr. Applegate has been an instructor at CALC for five years. He has 20 years of experience in computer technology. He has taught a couple hundred students over the years in that role.

He identified documents involving Petitioner and her enrollment at CALC. Her records included admission documents, verbal tests skills, grade reports and monthly evaluation reports which are done for all students. He was also asked to fill out a form monthly and provide that to June Blaine who had referred Petitioner to the program. He also used it to go over the monthly evaluation with the student. He was the instructor for Petitioner.

The records reflect that she was in the program from April 2013 to October 2014. He observed her during the course of her training. She received an excellent grade on the basic computer skills course teaching her how to use a computer. She moved on to Microsoft Word. The training is self-paced. The student is given a course and he monitors the progress. He will assist and help them out with any questions. Petitioner was expected to complete each course program within a certain timeline. For instance, Word Basic was to have been completed by May 7, 2013. Word Intermediate should have been done by May 21, 2013 and Word Advanced by June 4, 2013. She did not complete the program. She was too have completed all the training by September 15, 2014. He observed that she was having difficulty from day one sitting at her desk for any long periods of time.

She would have to get up and walk around in sit in more comfortable areas and this continued throughout her time at CALC. They accommodated her because she was in rehabilitation. They would accommodate any student with the same request.

She completed the practical PC training but then her progress slowed significantly with Word. It was his observation that she was eager to be in school but she had difficulties. He discussed with her about being away from her desk and whether she was able to sit at the desk longer. His observation was that she was in pain and having difficulty. She definitely cooperated and that is reflected in the monthly evaluations. She did what he asked in terms of trying and doing paperwork. Eventually she completed all three segments of Word, Basic, Intermediate and Advanced. This took the entire time that she was there. This should have been done within about six weeks of starting the program. She did have a leave of absence and the administration received notes that she was to be away from school.

In his opinion there was not a potential for her to complete the program that was outlined for her. She could not make the progress. Mr. Applegate approached the director of the school and advised him that he did not see enough progress to continue. He felt that June Blaine should be contacted and advised that nothing more could be accomplished. There was a meeting with Petitioner's attorney and June Blaine in October of 2014. During this time Mr. Applegate felt that Petitioner was giving a full effort to complete the training. He believed the director spoke to Petitioner about terminating the program because she was not progressing as expected.

Petitioner completed 4 of 26 courses of the program planned for her. She also worked on keyboarding but she didn't complete the keyboarding program. She tried to certify as a Microsoft Office Specialist in Word. He advised the director that he did not feel they were doing Petitioner any good.

The witness was asked to compare Petitioner's progress up to December, 2013 to that of a student who was receiving Title IV government funding. Based on government standards for required progress to continue funding, Petitioner would have been discontinued from the program due to lack of adequate progress to that point. It was acknowledged that the private funding for Petitioner was not being cut off.

Petitioner testified that June Blaine never suggested that she undertake a job search. No one has offered to help her do a job search. If she was able to complete the CALC training they were going to help her find a job. She feels she could work at a job emotionally but not physically. She could not do any of the work she has done in the past. She wishes she could have her old job back. She had some back pain in 2006 but she was treated with therapy and continued to work for Respondent. She had no other injury before the accident of 2011.

Petitioner returned to Dr. Gornet on November 3, 2014 complaining of neck pain radiating into both shoulders and her right arm. Dr. Gornet described these symptoms as "part of her original work related injury." On January 5, 2015 and January 14, 2015, Petitioner underwent C5-6 epidural injections. (PX 6). Respondent has disputed payment of those bills. The bills purportedly remain outstanding. (PX 9). Petitioner last returned to Dr. Gornet on March 16, 2015. Dr. Gornet's review of the cervical MRI revealed multilevel problems involving pathology at C3-C7. He indicated the injections in January provided some relief and suggested steroid injections might be indicated on an intermittent basis. He further indicated she may require cervical disc replacement at some point, but he was content with managing her condition conservatively for the time being. (PX 4). Dr. Gornet testified that the additional cervical MRI and lumbar MRI would help to reassure that no

further surgery was needed and that Petitioner should be managed conservatively. The later treatment of her cervical spine was due to chronic symptoms attributable to the work accident because no other intervening accident broke the chain of connection.

Petitioner testified that she lives at home with her husband and grandson. She gets up in the morning and walks around but doesn't do a lot physically. Her husband does the cooking and the housework and cleaning. Her daughter died in May. Her husband takes care of the housework. At some point during the day she has to lie down for a while. She takes pain medication and then she is tired and drowsy and she has to alleviate the pain from her leg. She can stand for perhaps 15 to 30 minutes before having problems. Sitting is probably 15 minutes to a half hour depending on pain medication. She watches television and reads her Bible. She visits her mother and takes her grandson to a park next to her house where she can sit and stand on the porch and watch him. He is seven years old and in school. She can dress her upper body but her husband does her shoes and socks because she cannot bend that low. She drives to her mother's but does not drive a lot and relies on her sister. She stays in her home area usually driving only to local doctor appointments. She will shop at Walmart usually riding and electric cart.

It was noted on the record that during the course of her testimony Petitioner stood up and down several times.

Among other records admitted into evidence, Alton Memorial Hospital emergency room records for the date of accident show a prescription from Dr. Shaping Sun, Olin Corporation, prescribing a CT scan of the cervical spine. The parties stipulated that most of Petitioner's medical bills have been paid. Petitioner submitted bills for treatment of the cervical spine totaling $11,931.02 which were unpaid. Respondent disputed the bills as unnecessary and unrelated. The primary dispute between the parties is with regard to Petitioner's cervical spine condition.

CONSLUSIONS

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

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

The evidence indicates that Petitioner injured her back and neck when she fell from the broken chair at work on April 18, 2011. She was sent from Respondent's medical facility to the emergency room at Alton Memorial Hospital with a prescription from Respondent's physician, Dr. Sun, for a CT scan of the cervical spine. She complained to her family doctor of neck pain on her first visit, two days after the incident and she complained to Dr. Gornet of neck and shoulder pain on the first visit with him May 5, 2011. Respondent's examining physician, Dr. Lange saw Petitioner June 21, 2011 with complaints of discomfort in the neck and into the interscapular region. Nothing in Dr. Lange's records disputes the causal relationship between the fall and injury to Petitioner's cervical spine. The only medical opinion was from Dr. Gornet who testified that there was a causal relationship. The fact that she continued to complain of neck symptoms is reflected in the records admitted from physical therapy, Dr. Gornet, Dr. Lange and vocational assessment and training. Based upon the

foregoing and the record taken as a whole, the Arbitrator finds Petitioner's current cervical condition is causally related to the injury.

Dr. Gornet testified that he initially placed treatment of Petitioner's neck and shoulder "on hold" to concentrate on the low back condition. Petitioner continued to complain of neck symptoms as reflected in various records. Petitioner testified credibly that her neck pain and shoulder complaints never resolved and she continued to seek treatment. Eventually in 2013 and 2014 Dr. Gornet diagnosed herniations at C5 – 6 and C6 – 7. He recommended cervical epidural injections which were performed by Dr. Boutwell in January, 2015. Petitioner testified that the injections gave her some relief of the neck pain. Dr. Gornet testified that the treatment was necessary and reasonable. Although Petitioner had been placed at maximum medical improvement, treatment can be required if symptoms persist due to the work-related injury. Dr. Lange was not asked to render an opinion as to the reasonableness of the epidural steroid injections. The only opinion came from Dr. Gornet.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds the cervical treatment was reasonable and necessary and Respondent is ordered to pay $11,931.02 as listed in PX 9 pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for any bills paid.

Issue (K): What temporary benefits are in dispute?

Issue (N): Is Respondent due any credit?

The parties agree that as the date of hearing Petitioner had been paid $164,831.75. Petitioner received $132,381.75 for temporary total and maintenance benefits paid from April 20, 2011 through October 14, 2014 when her CALC program was discontinued. Thereafter Petitioner received $32,450.00 in permanent disability payments. Payments post-dating October 14, 2014 are deemed permanent total disability advancements.

Respondent shall be given a credit of $132,381.75 for TTD, and maintenance, and $32,450.00 for other benefits (PTD) paid following 10/14/14, for a total credit of $164,831.75.

Respondent is entitled to an 8(j) credit for any medical bills submitted and paid by the group insurance carrier.

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

Petitioner was released with permanent restrictions from Dr. Gornet of no lifting over 10 pounds, no repetitive lifting or pending. He testified that he also included a restriction of the need to alternate sitting and standing as needed. Although this was not included on the specific instruction sheet issued in July 2012, he testified that this was expected with any such sedentary release. His dictated note of May 10, 2012 reflected that restriction. Respondent's examining physician, Dr. Lange also stated that Petitioner could function at a sedentary level only.

Based on these physical restrictions Petitioner was evaluated by vocational counselor Stephen Dolan at the request of Petitioner's attorney and by June Blaine at Respondent's request. Petitioner was placed in a clerical training program but was unable to complete the program. Her instructor, James Applegate testified that she gave consistent effort but clearly had pain which restricted her ability to perform typing at a computer as

needed. He felt that she could not complete the program since she had only completed a word processing course during many months of study.

Stephen Dolan opined that Petitioner will not be able to perform any employment for which a reasonably stable labor market exists. She would not be able to do that unless the pain could be brought under control and her anxiety and depression improved. Based upon the pain condition alone, he did not feel that she could tolerate a regular work schedule because she has to lie down periodically. He observed her for hours and felt her pain complaint were credible.

Dr. Lange, Respondent's examiner, saw Petitioner October 22, 2013. He felt she had mechanical low back discomfort which was to be expected. He stated it would not be unusual to have axial low back pain with prolonged sitting. He said these symptoms are extremely common in post-discectomy patients with prolonged sitting.

This evidence confirms Petitioner's testimony about ongoing pain and limitations. Petitioner testified credibly and appeared to be uncomfortable during her testimony. June Blaine was not called to testify and no opinion was presented stating that Petitioner was capable of gainful employment. The only opinion came from Mr. Dolan who stated Petitioner was unable to perform any work for which a reasonably stable job market existed.

Pursuant to *ABB C-E Services v. Industrial Commission*, 316 Ill.App.3d 745, 737 N.E.2d 682, 250 Ill.Dec. 60 (2000), a claimant is not required to perform a job search to prove entitlement to an odd-lot permanent total disability. He may show that, by virtue of his present condition, age, training and experience, he is unfit to perform any but the most menial tasks for which no stable labor market exists. Petitioner has met that burden here.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Respondent shall pay Petitioner permanent and total disability benefits of $723.41/week for life, commencing 10/15/14, as provided in Section 8(f) 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 MADISON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Floyd "Joe" Sumpter,
Petitioner,

vs. No. 14 WC 32743

Hi-Way Motor Co., Inc.,
Respondent.

17IWCC0592

DECISION AND OPINION ON REVIEW

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

The Arbitrator's Decision is modified through the Commission's finding that Petitioner failed to prove that the condition of ill-being in his left hand – namely, carpal tunnel syndrome -- is causally connected to the accident of August 8, 2014, in which Petitioner suffered a traumatic injury to his right wrist. The Commission does not disturb the Arbitrator's determination of compensability with regard to Petitioner's right hand.

Petitioner, 49, had been employed as automobile detailer for about 10 weeks with Respondent as of August 8, 2014, On that day, Petitioner was using an electric buffer to polish a truck. While holding onto the spinning wheel of the buffer, the wheel hit a gas cap and jerked backwards to the right, causing Petitioner's right shoulder to be flung back and his wrist to be wrenched. He felt immediate, severe pain in his right wrist and was taken to the emergency room. (Tr. 12-15). He was taken off-work while he treated for this wrist sprain.

A month after the accident, on September 9, 2014, he was seen by Respondent's Section 12 examiner, hand surgeon Dr. R. Evan Crandall. To Dr. Crandall, Petitioner reported pain, swelling, numbness, a pins-and-needle sensation, and a sharp, knife-like pain to the dorsal aspect of his right hand. An EMG/NCV study of the right hand confirmed advanced, severe carpal tunnel syndrome, for which Dr. Crandall recommended carpal tunnel release surgery. (RX 2; RX 4).

Dr. Crandall returned Petitioner to work. (RX 2). Although Petitioner was returned without restrictions, Petitioner testified that he began to use his left hand predominantly at his job as a detailer, and it was not long (about a week or so) before he started noticing the same symptoms in his left hand. (Tr. 25). On January 7, 2015, Dr. Crandall performed a second Section 12 examination, after it became apparent that Petitioner would claim a work-related injury to the left hand as well as to the right hand. At that time, an EMG/NCV study of the left hand was done, and it revealed longstanding, severe carpal tunnel syndrome in that hand too. (RX 3; RX 4).

Petitioner does not deny that his bilateral carpal tunnel syndrome long preexisted his employment with Respondent. (Tr. 25-26). Instead, he alleges that he was asymptomatic in both hands until the traumatic accident of August 8, 2014 caused his carpal tunnel syndrome -- first in the right hand, and then in the left hand – to manifest. That is, he alleges that the electric buffer mishap that sprained his right wrist aggravated his preexisting right carpal tunnel syndrome and caused it to become symptomatic, after which his preexisting left carpal tunnel syndrome was aggravated and made symptomatic through the subsequent compensatory overuse of his left hand at work.

Regarding causation, Dr. Crandall testified that Petitioner's bilateral carpal tunnel syndrome was advanced and predated his employment with Respondent by 3 to 5 years or more. (RX 4 at pp. 18-19). Dr. Crandall explained that it took many years to develop the level of nerve demyelination as revealed in the EMG/NCV studies. (RX 2 at p. 32). Dr. Crandall's opinion was that the August 8, 2014 wrist sprain did not cause Petitioner's right carpal tunnel syndrome, and that the subsequent alleged overuse of his left hand did not cause the left carpal tunnel syndrome. (RX 4). The hand surgeon noted that patients with severe carpal tunnel syndrome usually have it in both hands, and he further opined that it would not have been possible for Petitioner not to have noticed symptoms prior to the asserted date of accident. (RX 2 at p. 3). Petitioner's independent medical examiner, orthopedic surgeon Dr. Corey Solman, testified regarding his opinion that the August 8, 2014 wrist injury had "aggravated a carpal tunnel syndrome and created a more symptomatic condition" in the right hand and that Petitioner's "compensatory work that he did with his left hand was probably enough to incite symptoms" in the left hand. (PX 1 at p. 21; PX 1 exhibit 1).

The Arbitrator found Petitioner to be a credible witness. In finding the current condition of ill-being in not just the right but also the left hand to be compensable, the Arbitrator favored the opinion of Dr. Solman and accordingly awarded prospective bilateral carpal tunnel release surgery. The Commission views the evidence differently and further finds the opinion of Dr. Crandall to be more persuasive, particularly in light of the severity of the findings and the likely duration of the preexisting condition at that level of severity.

17IWCC0592

For the reasons stated, the Commission finds that Petitioner has not proven that his left carpal tunnel syndrome was causally connected to the asserted work-related accident. Accordingly, the Arbitrator's award of medical expenses for treatment for the left hand, including prospective treatment to that hand, is vacated. The prospective care relative to the right hand as awarded is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 6, 2015, 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 only the reasonable and necessary medical expenses incurred for treatment to the right hand and wrist under § 8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of prospective medical care to the left hand is vacated. The prospective care relative to the right hand as awarded is affirmed.

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

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

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

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: SEP 27 2017

o-08/01/17
jdl/ac
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Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

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

SUMPTER, FLOYD JOE
Employee/Petitioner

Case# **14WC032743**

HI-WAY MOTOR CO INC
Employer/Respondent

17IWCC0592

On 5/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4888 LAW OFFICE OF KEITH SHORT PC
1801 N MAIN ST
EDWARDSVILLE, IL 62025

2542 BRYCE DOWNEY & LENKOV LLC
JESSICA M RIMKUS
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Floyd Joe Sumpter
Employee/Petitioner

v.

Hi-Way Motor Co., Inc.
Employer/Respondent

Case # 14 WC 32743

Consolidated cases: N/A

17IWCC0592

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **August 27, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **8/8/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$10,754.20**; the average weekly wage was **$203.35**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of **$1091.03** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,091.03**.

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 $12,980.99, as set forth in Petitioner's exhibits 6 – 10, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall also authorize and pay for prospective medical treatment as recommended by Dr. Solman, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Signature of Arbitrator

5/13/16
Date

ICArbDec19(b)

FINDINGS OF FACT

This claim was tried pursuant to section 19(b) of the Act. The Application for Adjustment of Claims was amended, without objection, to include bilateral carpal tunnel syndrome. The primary issues in dispute are causation between Petitioner's need for bilateral carpal tunnel syndrome surgery and his employment accident of 8/8/14.

The essential facts of the case are not in dispute. Prior to the accident Petitioner worked approximately 10 weeks for Respondent as an automobile detailer. His work included washing and waxing vehicles, buffing the exteriors; shampooing and cleaning the interiors and making needed body repairs to vehicles. He used a variety of hand tools including electric buffers, drills, hoses, hand towels, sponges, power washers and vacuums.

Prior to 8/8/14 Petitioner did not have any symptoms of CTS in either hand. He had never seen a doctor for CTS, nor had he expressed any complaints of numbness or tingling to any of his coworkers or employer. Prior to 8/8/14 he had never lost time from work due to complaints involving his hands.

Petitioner is not diabetic. He has no history of neck injury; no history of thyroid illness and no history of rheumatoid arthritis. Petitioner has no hobbies or other non-work activities which involve extensive use of the hands.

On 8/8/14 Petitioner was buffing a truck when the spinning wheel of the buffer caught the edge of a gas cap causing the buffer to twist violently in Petitioner's hands. The buffer operates at several thousand rotations per minute. Petitioner immediately felt a sharp pain in his right wrist. He was taken by his employer to the emergency room at Red Bud Regional Hospital. Physical exam and diagnostic studies revealed excessive swelling and numbness in the right hand. Petitioner was referred by the ER to Dr. David Walls.

Petitioner saw Dr. Walls on 8/11/14 and was diagnosed with tendonitis of the wrist and elbow pain. An MRI of the right wrist done on 9/9/14 revealed a cyst and degenerative changes but no acute tears.

On 10/30/14 Petitioner was seen by Dr. Walls who noted ongoing right wrist pain and likely CTS. A referral to Dr Prieb was attempted for surgical management of the CTS. Instead, on 9/9/14, Petitioner was seen by Dr. Richard Crandall, a plastic and hand surgeon at the request of Respondent.

Dr. Crandall diagnosed Petitioner as suffering a right wrist sprain and sent him for electrodiagnostic studies. Petitioner was sent to Dr. Daniel Phillips by Dr. Crandall for EMG/NVC study of the right wrist on 9/9/14. The study revealed "motor median neuropathy across the right carpal tunnel.

On 1/7/15 Dr. Phillips performed EMG/NVC studies of both wrists. The studies revealed bilateral CTS with the right more severe than left.

Dr. Crandall reviewed the studies and agreed that Petitioner had evidence of CTS and required surgery on the right wrist. Dr. Crandall testified that the degree of demyelation of the median nerves suggested the syndrome had been ongoing for several years and, as such, was not related to the acute accident of 8/8/14. (Resp. ex 4, pg 13). Dr. Crandall did acknowledge that the job of car detailer could cause CTS, though he did not believe it was the cause of Petitioner's CTS. *Id.*, at 20. Dr. Crandall also agreed the Petitioner did suffer a

work related right wrist sprain but did not believe that he was asymptomatic for CTS before the work injury. Despite there being no medical evidence of CTS and no history of complaints or lost time from work before 8/8/14, Dr. Crandall believed the CTS must have pre-dated the accident.

Dr. Corey Solman saw Petitioner on 11/7/14 at the request of his attorney. Dr. Solman agreed that Petitioner needed bilateral CTS surgery. He also noted the mechanism of injury; that the buffer placed Petitioner's arm in an abducted and externally rotated position at the level of the shoulder and "wrenched his wrist and elbow into a fully extended position." (Pet. ex 1, pg. 8). Dr. Soleman believed that the wrist MRI revealed a possible ligament tear. *Id.*, at 9. Films also revealed inflammation of the tendons suggestive of a recent trauma. *Id.*, at 10

Dr. Solman testified that the EMG findings were suggestive of long term demyelation of the right wrist and that physical exam findings were consistent with bilateral CTS. He felt that a left EMG would reveal CTS, which it did. Dr. Solman opined that Petitioner's injury of 8/8/14 aggravated and made symptomatic the CTS that existed in Petitioner's right hand and that Petitioner being returned to work by Dr. Crandall resulted in such an overload of the left wrist that his heretofore asymptomatic left CTS became symptomatic requiring surgery. *Id.*, at 20-21. As such, Dr. Solman related the need for surgery on both hands to the effects or consequences of the 8/8/14 accident. Dr. Solman testified that people can have severe CTS and remain totally asymptomatic and "don't really recognize their symptoms and if they have an injury or worsening of their condition with work-related activities sometimes they'll get worse...despite carpal tunnel syndrome being severe." *Id.*, at 26-27.

CONCLUSIONS

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

The Arbitrator found Petitioner to be a credible witness. Further, the Arbitrator found the testimony and opinions of Dr. Solman more persuasive than those of Dr. Crandall in this case.

The undisputed evidence presented shows Petitioner suffered a significant sprain of his right wrist on 8/8/14. There is no evidence to indicate he had symptoms of bilateral CTS before that date. There is no medical evidence of complaints of CTS and no EMG/NVCs before that date. Petitioner performed all of the essential functions of his employment without lost time, without complaints and without restrictions prior to 8/8/14. Petitioner's job is hand intensive; a fact with which Respondent IME, Dr. Crandall agreed.

Given the history of a traumatic hand injury on 8/8/14, the Arbitrator finds that there was an aggravation of the demyelination of the right median nerve. Surgery for CTS is done to address symptoms or loss of function. There is no evidence Petitioner had either symptoms of CTS or loss of function in the right hand prior to 8/8/14.

There is no dispute Petitioner requires surgery on the left wrist. The source of his complaints of numbness and tingling in the left hand are confirmed by EMG. It is noted that he did not express any complaints involving the left hand when seen by Dr. Crandall for treatment of the right hand. In fact, Dr. Crandall's exam notes indicate the Tinel's and Phalen's testing of the left hand were normal. This was despite the fact that Dr. Crandall believes the EMG showed long standing left CTS. Petitioner had advanced CTS on

diagnostic study, but did not have complaints or clinical findings of CTS in the office exam. It was only after he went back to work, in a job Dr. Crandall agreed was hand intensive, that he developed complaints of left CTS. The Arbitrator agrees with Dr. Solman's opinion, that the demands of doing a hand intensive job primarily with the non-dominant left hand was an aggravation of any underlying, dormant CTS.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that his current condition of ill-being is causally related to the accident of 8/8/14.

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

Issue (K): Is Petitioner entitled to any prospective medical care?

Both Dr. Solman and Dr. Crandall agree Petitioner is in need of surgical repair of his bilateral CTS. Based upon the findings with regard to issue F above and the record taken as a whole, the Arbitrator finds the medical expenses incurred up to the date of hearing were both reasonable and necessary. The Arbitrator further finds that Petitioner is entitled to any prospective medical care.

Respondent shall pay reasonable and necessary medical services of $12,980.99, as set forth in Petitioner's exhibits 6 – 10, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall also authorize and pay for prospective medical treatment as recommended by Dr. Solman, 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.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary Jones,
Petitioner,

vs. NO: 11 WC 40147

Brian Moreman,
d/b/a, Moreman's Home Improvement,
& Injured Worker's Benefit Fund.
Respondent.

17IWCC0593

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, Petitioner's permanent partial disability, medical expenses, benefit rates, notice and penalties, pursuant to Section 19(l) 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, other than as stated above, the Decision of the Arbitrator filed October 5, 2015 is hereby affirmed and adopted.

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

DATED: SEP 27 2017

Joshua D. Luskin

o-08/02/17
jdl-wj
68

Charles J. DeVriendt

17I CC0593

SPECIAL CONCURRING OPINION

I concur with the outcome as to the denial of benefits. I write separately as I believe Petitioner established he was a traveling employee, and the motor vehicle accident was a reasonable and foreseeable occurrence. As such Petitioner proved he sustained an accident which occurred during and arose out of his employment. While I believe Petitioner proved accident, I believe Petitioner failed to prove a causal relationship between his accident and his current condition of ill-being, and therefore, benefits are denied.

Petitioner eventually received treatment on September 30, 2011 at the emergency room despite declining the need to seek emergency treatment. PX1; T. 37-38. Petitioner's testimony regarding an immediate onset of pain following the motor vehicle accident is not credible given the contrary evidence of Mr. Brian Moreman and the contemporaneous photographic evidence corroborating Mr. Moreman's testimony. Mr. Moreman testified Petitioner denied being injured following the accident. T. 60. Petitioner declined medical treatment offered by ambulance personnel at the scene of the accident. T. 37-38. Mr. Moreman testified approximately one hour after the accident, Petitioner voluntarily repaired the bent fender of the van using a 2x6 board weighing 36 pounds which required lifting and prying. T. 63-64; 70. Such repairs took at least 15 minutes to complete (T. 65) and were documented photographically. RX4-RX7. Mr. Moreman testified Petitioner did not complain of pain or exhibit pain behaviors while making the repairs. T. 65; 73. Mr. Moreman further testified Petitioner helped him unhook the trailer from the van (T. 64) which was also documented photographically. RX8. Following the motor vehicle accident, Petitioner returned to work full duty and voiced no complaints of pain or injury. T. 79-80. Additionally, the testimonies of Ms. Lena Otis and Ms. Linda Englert belie Petitioner's testimony and complaints to his medical providers of ongoing pain and difficulties.

At best Petitioner suffered cervical/lumbar strains for which he received treatment at the emergency room. PX1. While at the emergency room, Petitioner underwent diagnostic testing for both the cervical and lumbar spine which indicated findings related to an old injury and chronic findings. PX2. Petitioner continued to treat due to his subjective complaints of pain, but given Petitioner's lack of credibility, such treatment is due to Petitioner's degenerative and long-standing conditions and not the motor vehicle accident, Dr. Santiago and Dr. Fletcher's opinions notwithstanding. Both physicians based their opinions on an inaccurate understanding of Petitioner's pain complaints and the onset of the same. (See *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC, ¶24- "Expert opinions must be supported by facts and are only as valid as the facts underlying them [internal quotations omitted].")

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JONES, GARY A
Employee/Petitioner

Case# 11WC040147

BRUCE MOREMAN D/B/A MOREMAN HOME IMPROVEMENT DANRUTHERFORD STATE TREASURER AND EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

17IWCC0593

On 10/5/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

1551 STOKES LAW OFFICES
JACOB R JACKSON
200 N GILBERT
DANVILLE, IL 61832

1937 TUGGLE SCHIRO & LICHTENBERGER
TODD D LICHTENBERGER
510 N VERMILION
DANVILLE, IL 61832

1368 ASSISTANT ATTORNEY GENERAL
CHRISTINA SMITH
500 S SECOND ST
SPRINGFIELD, IL 62706

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON

17IWCC0593

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Gary A. Jones
Employee/Petitioner

v.

Case # 11 WC 40147

Consolidated cases: n/a

Brian Moreman d/b/a Moreman's Home Improvement,
Dan Rutherford, State Treasurer and ex officio Custodian of the Injured Workers' Benefit Fund

Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on August 20, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On September 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 not sustain an accident that arose out of and in the course of employment.

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

In the year preceding the injury, Petitioner earned $n/a; the average weekly wage was $n/a.

On the date of accident, Petitioner was 45 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator

September 29, 2015
Date

OCT 5 – 2015

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 September 30, 2011. The Application alleged that Petitioner sustained injuries to the neck and back as a result of a "Car wreck" (Arbitrator's Exhibit 2). Respondent did not have workers' compensation insurance at the time of the accident and the Injured Workers' Benefit Fund was named as an additional party. Respondent disputed liability primarily on the basis of accident but also disputed that there was an employee/employer relationship. Petitioner also claimed entitlement to Section 19(l) penalties (Arbitrator's Exhibit 1).

Petitioner worked for Respondent doing various construction/remodeling work. Petitioner testified that Respondent had the right to fire him, designated where the work was performed and the number of hours Petitioner worked. Respondent was present at the job site and supervised the work performed by Petitioner. Petitioner brought some of his own tools such as hammers, knives, etc.; however, Respondent provided other tools such as air hammers, a generator, etc.

Petitioner stated that Respondent would give him a ride to the job site virtually every day because Petitioner did not have a car or drivers' license. Petitioner's girlfriend would drive him to a gas station and Respondent would pick him up there. At the end of the workday, Respondent would drive Petitioner back to the gas station where Petitioner would be picked up by his girlfriend.

On September 30, 2011, Petitioner had just completed working at a project in the East end of Danville and Petitioner was in a van that was owned by Respondent and being driven by one of Respondent's employees. Petitioner was sitting on a toolbox directly behind the driver of the vehicle. There was an automobile accident and Petitioner complained of neck and low back pain shortly thereafter.

On cross-examination, Petitioner agreed that the work at the job site was completed at 3:30 PM. Afterward, Petitioner consumed some beer that was provided by the homeowner.

Petitioner testified that he pled guilty to home repair fraud when he was operating his own construction business a number of years ago. He stated that the money in his business account was seized for past due child support and, for that reason, he had no money to complete some jobs he was working on. Petitioner pled to the charge, served some time and is still paying restitution.

Respondent, Brian Moreman, testified at trial and stated that he was the sole owner of the business. He had no knowledge that Petitioner was a convicted felon at the time he hired him, and, if he had been aware of that fact, he would not have hired.

Moreman stated that on the day of the accident the work at the job site was completed and Petitioner consumed some beer with the owner of the residence. Petitioner then asked Moreman for a ride to the gas station and Moreman agreed to give him a ride. He also stated that he did not always provide Petitioner with transportation to/from the gas station.

In regard to the accident, Moreman testified that when a Jeep attempted to pass the van it struck it. Subsequent to the accident, the van was drivable; however, a fender on the trailer that the van was hauling was bent in causing it to be in contact with one of the tires. Petitioner used a 2 x 6 piece of lumber to pry the fender away from the tire. Respondent tendered into evidence photographs of the Petitioner performing this task (Respondent's Exhibit 4 and 5). Moreman also stated that Petitioner did not complain of any pain after the accident.

Subsequent to the accident, Moreman drove the van and trailer to his residence where Petitioner performed some additional work on the trailer. Respondent tendered into evidence a photograph of Petitioner bending over at the waist performing some work on what appears to be the trailer hitch (Respondent's Exhibit 8).

Petitioner subsequently sought medical treatment and has been seen by numerous physicians, has had various diagnostic procedures performed, etc. No surgeries have either been performed or recommended. At trial, Petitioner claimed to be permanently and totally disabled.

Conclusions of Law

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

The Arbitrator concludes that there was an employee/employer relationship between Petitioner and Respondent on September 30, 2011.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding his being hired by Respondent, Brian Moreman, was unrebutted. Further, Moreman testified that he directed Petitioner where to work, determined Petitioner's working hours and supervised Petitioner's work.

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 September 30, 2011.

In support of this conclusion the Arbitrator notes the following:

Petitioner was not in the course and scope of his work duties when the accident occurred. Petitioner had completed his work day and was no longer performing any work tasks for Respondent. Petitioner's work for Respondent on that date ended at 3:30 PM and, afterward, he consumed some beer with the property owner.

Petitioner asked Respondent to provide a ride to the gas station so that his girlfriend could pick him up. It was at Petitioner's request that Respondent provided transportation to/from the worksite and Respondent did not require that Petitioner ride with Respondent.

Generally, injuries sustained while an employee is traveling to/from the workplace are not considered to arise out of and in the course of employment. Venture - Newberg - Perini v. Illinois Workers' Compensation Commission, 1 N.E.3d 535 (Ill. 2013).

An exception to the preceding rule is when the employee is a "traveling employee." Such employees are those whose duties require them to travel away from the employer's premises and they are treated differently than other employees when determining whether an injury arises out of and in the course of employment. The Courts have found injuries sustained by "traveling employees" to be compensable when (1) the employer instructs the employee to perform acts; (2) acts which the employee has a common-law or statutory duty to perform while performing duties for his employer; and (3) acts which the employee might be reasonably expected to perform incident to his assigned duties. Wright v. Industrial Commission, 338 N.E.2d 379 (Ill. 1975).

In the instant case, the facts clearly indicated that Petitioner was not a "traveling employee." Respondent was in the business of construction/remodeling. Accordingly, the worksite of the Respondent was wherever the location of the project might be. Petitioner's work day began when he arrived at the worksite. It was at Petitioner's request that Respondent provided transportation to/from the worksite and Respondent did not require that Petitioner ride with Respondent. Respondent was merely doing Petitioner a favor so that Petitioner could meet his girlfriend and get a ride home.

In regard to disputed issues (E), (F), (G), (J), (K), (L) and (M) 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)
) 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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Zielinski,

Petitioner,

vs. NO: 07 WC 29995

Cerami Construction,

Respondent.

17IWCC0594

DECISION AND OPINION ON REVIEW

A Section 19(h)/8(a) Petition having been filed by the Respondent herein, and notice given to all parties, the Commission, after considering Respondent's request for modification from a Section 8(d)(1) award to a Section 8(d)(2) award, and being advised of all facts and law, hereby denies Respondent's Petition for the reasons stated below:

FACTUAL BACKGROUND

On May 10, 2007 Petitioner was employed by Respondent as a Cement Mason. On said date he was carrying his tool bag up a two-story ladder. As he reached the top, he felt a pop in his shoulder. He looked down and saw that his right biceps had "come off and was flopping." Petitioner underwent conservative treatment, work conditioning, and ultimately arthroscopic surgery in 2008. However, in 2009 he complained of increased pain again, and was diagnosed with a torn rotator cuff.

By 2012, Petitioner had been permanently restricted from working as a Cement Mason. Medical professionals opined that his condition was livable as long as he avoided stressing his arm. Petitioner was limited to lifting up to fifty pounds. A vocational rehabilitation assessment found

17IWCC0594

Petitioner's post-accident earning capacity to be between $12-$15/hr. Petitioner, however, was unable to secure employment at this wage level.

In 2016, Respondent received notice from a Claims Examiner that Petitioner had been working as a Cement Mason. Respondent's 19(h)/8(a) Petition was presented for hearing before Commissioner Gore. At hearing, Mr. Michael Dynowski, the current VP of Elliott Construction Corporation testified that, in 2015, he held the position of Flat Work Supervisor, and hired Petitioner as a Cement Finisher for one day from Local Union Number 502. Petitioner was hired to pour a floor and the daily work log indicates that he worked eleven hours. Mr. Dynowski testified that pouring a floor requires the use of a ten-pound bull float to smooth concrete, but that he did not recall which arm Petitioner used to operate the float.

To operate a bull float, a Cement Finisher floats it across concrete until it gets to the desired distance, then twists the handle a quarter turn to cock it back towards him or herself, smoothing the concrete as it returns.

Mr. James Ornelas owns Ornelas Construction. He hired Petitioner for two days of work on October 29th and 30th of 2015. There was testimony that a Cement Finisher entailed several duties, some more intense than others. Petitioner worked sixteen hours on the 29th and one hour on the 30th as a Concrete Finisher. Mr. Ornelas was not on site on the days Petitioner worked, and thus did not know if Petitioner actually operated a bull float or simply used a rake the entire time. A garden rake would be used to make sure perforated plastic did not get covered up while concrete was being poured.

Mr. Michael Pirron owns DeGraf Concrete Construction. He hired Petitioner for two and-a-half days to pave cement. Petitioner was one of fifty employees paving cement, which entails numerous duties, including carrying a spray can around with water in it to mist the concrete so that it does not dry out before it has been properly smoothed. Mr. Pirron acknowledged that the person performing this duty could fill up the can at his or her discretion.

Petitioner testified that he is still incapable of lifting over fifty pounds and cannot climb ladders. The aforementioned four and-a-half days of work are the only days he has worked since the 2012 award was entered. When he worked for DeGraf Construction, Petitioner testified that the first day everyone was sent home due to a machine breaking down. The remainder of his time he spent spraying mist over concrete. He kept the five gallon spray can two-thirds full.

Petitioner testified that when he worked for Elliott construction he simply walked the bull float forward and back, he did not sling it out, twist and cock it back towards himself. This prevented any stress on his shoulder.

Petitioner testified that he only used the garden rake while working for Ornelas Construction.

17IWCC0594

Being older, Petitioner stated that he was allowed to choose the duties he wanted to perform while working for the above employers, because older workers usually performed the easier jobs.

Petitioner stated that he only worked these four and-a-half days because he lost his insurance due to unemployment. Being a diabetic, he had to pay out of pocket for medical expenses, and his blood work costs $1,300.00 every three months. In 2016 Petitioner's pension began, thus he no longer has a need to earn money via employment.

Petitioner's treating physician testified that the vast majority of his opinions regarding Petitioner were in reference to his general health. He acknowledged that in 2016 he indicated that Petitioner could lift over 50 pounds, but noted that this did not necessarily mean he could lift this weight with his right upper extremity. The treating physician also noted that he was unaware of the specific duties performed by a Cement Finisher, and he never specifically treated Petitioner's right shoulder, thus he was not qualified to opine whether or not Petitioner's shoulder had improved to the point he could perform as a Cement Finisher.

ORDER

The Commission finds that there is no objective evidence supporting Respondent's §19(h)/8(a) claim. Petitioner has not worked as a Cement Finisher subsequent to the September 4, 2012 arbitration Decision. He did not work at all in 2013 and 2014. He worked a total of four and-a-half days in 2015, but did not perform any duties that required him to lift over fifty pounds or use his right shoulder. Petitioner's treating physician clarified his medical records, stating that he was not qualified to render an opinion on Petitioner's ability to return to work with regards to his right shoulder, and only opined about Petitioner's ability to work with respect to his diabetic condition.

Petitioner's "return" to the workforce had nothing to do with any improvement in his condition, and everything to do with his need for funds to keep up with his health regimen. Four and-a-half days of work between 2013 and 2017 cannot realistically be categorized as a return to the workforce, and Petitioner's testimony makes it understandable why such a "return" was necessary.

Respondent cannot use the records of Petitioner's treating physician to prove that Petitioner is capable of returning to work, as the treating physician himself admitted he did not know for sure what the duties of a Cement finisher entailed, thus he could not say whether or not Petitioner was capable of performing the physical requirements necessary. He also stated that he examined Petitioner generally, and was in no position to render an opinion regarding the vocational functionality of his right shoulder.

17IWCC0594

Based on the totality of testimony and evidence, the Commission finds no sufficient evidence of a material change in Petitioner's condition, and therefore denies Respondent's Petition.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Section 19(h)/8(a) Petition be denied.

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

SEP 28 2017

DATED:
DLG/wde
O: 8/31/17 (Discussion)
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ZIELINSKI, JAMES
Employee/Petitioner

Case# **07WC029995**

CERAMI CONSTRUCTION
Employer/Respondent

17IWCC0594

On 9/4/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC
MITCHELL HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
EMILY C DAWKINS
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

17IWCC0594

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

James Zielinski
Employee/Petitioner

v.

Cerami Construction
Employer/Respondent

Case # 07 WC 029995

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 **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **July 25, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0594

FINDINGS

On **May 10, 2007**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$86,905.00**; the average weekly wage was **$1,671.25**.

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

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

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

Respondent shall be given a credit of **$243,862.03** for TTD, **$0** for TPD, **$0** for maintenance, and **$3,137.04** (advance against PPD) for other benefits, for a total credit of **$246,999.07**. Arb Exh 1.

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

ORDER

Respondent shall be given a credit of **$243,862.03** for TTD, **$0** for TPD, **$0** for maintenance, and **$3,137.04** for other benefits, for a total credit of **$246,999.07**.

Respondent shall pay Petitioner temporary total disability benefits of $1,114.17/week for 192.86 weeks, commencing May 11, 2007 through January 20, 2011, as provided in Section 8(b) of the Act and as more fully explained in the attached conclusions of law.

Respondent shall pay Petitioner permanent partial disability benefits of $785.75 per week from January 21, 2011 through May 31, 2012 and permanent partial disability benefits of $799.92 per week from June 1, 2012 forward and through the duration of his disability as provided in Section 8(d)1 of the Act and as more fully explained in the attached conclusions of law.

Respondent shall pay reasonable and necessary medical services of $1,638.40, as provided in Sections 8(a) and 8.2 of the Act and as more fully explained in the attached 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.

Molly E Mason
Signature of Arbitrator Molly Mason

September 4, 2012
Date

SEP -4 2012

James Zieliniski v. Cerami Construction
07 WC 29995

Arbitrator's Findings of Fact

Petitioner, who was sixty-one years old as of the hearing, testified he began working as a cement mason at age thirteen. T. 14. As of May of 2007, he worked as a cement mason for Respondent. He was a member of the Cement Masons' Union, Local 502. T. 14.

As a cement mason, Petitioner's duties included preparing the sub-base, framing, pouring concrete and smoothing the poured surface. T. 12. He used a variety of hand tools, including a 20-pound sledge hammer. His tool bag weighed about 30 or 35 pounds. T. 13. He had to lift not only his tool bag but also lumber and machines. During a pour, he would stand and walk in wet concrete for an extended period. He regularly climbed ladders and sometimes climbed scaffolding.

Petitioner testified he was required to work 8 ½ hours per day while employed by Respondent. Once the masons started to pour concrete, they had to continue working until the job was finished. Otherwise, "part of the structure [would] not bind to the other part." They would work through their half hour lunch. Per their union contract, they received double time for that half hour period. T. 15. Petitioner characterized that half hour of work as "mandatory." If he had refused to work through lunch, and had taken the allotted half hour, he would have been let go. T. 16.

Petitioner testified that the work week in his trade consisted of five days. He had to make himself available to work on each of those five days. Because he was required to work 8 ½ hours per day, his work week consisted of 42 ½ hours. T. 17-18.

Petitioner offered into evidence a document from Respondent entitled "employee time history." PX 8, p. 2. This document reflects that Petitioner worked a total of four days (April 5, 2007, May 1, 2007, May 2, 2007 and May 4, 2007) and thirty-five hours for Respondent during the year preceding his undisputed accident of May 10, 2007. The document also reflects total gross earnings of $1,451.60 (including .50 hours of double time on April 1, May 1 and May 2 and 1.50 hours of double time on May 4, 2007). Petitioner testified he was required to work 9 ½ hours on May 4, 2007 because cement was poured that day. T. 17.

Respondent did not object to the "employee time history." T. 80. Nor did Respondent offer any evidence contradicting Petitioner's wage-related testimony.

Petitioner testified that, on May 10, 2007, he arrived at the jobsite early, as was his custom, and learned he would have to carry his cooler and tool bag up a ladder by hand. T. 19. The ladder was almost two stories long. He came back down, put his tool bag over his right shoulder and headed back up. Just as he got to the top of the ladder, he "felt something pop" in his shoulder. T. 19. After climbing two other ladders, he looked at his right upper arm and

saw that his biceps had "come off and was flopping." T. 20. He reported the injury and went to the Emergency Room at Glenbrook Hospital. T. 20-21.

The Emergency Room triage note sets forth the following history: "Pt states was climbing ladder this AM when felt a painful pop in R biceps area." Dr. Wahl described Petitioner's right biceps tendon as "tense." He also noted deformity and laxness proximal to the tendon, "consistent with proximal rupture." He obtained X-rays [no X-ray report is in PX 4], applied a sling to the affected arm and instructed Petitioner to follow up with an orthopedic surgeon close to his home. PX 4.

Petitioner saw Dr. Rhode, an orthopedic surgeon, the following day, May 11, 2007. Petitioner completed a patient information form indicating that his primary care physician referred him to Dr. Rhode.

Dr. Rhode's note of May 11, 2007 reflects that Petitioner experienced an abrupt onset of right shoulder pain while climbing a ladder at work the previous day. Petitioner complained of a "bulging mass in the biceps area." He denied having previously injured his shoulder. On examination of Petitioner's right shoulder, Dr. Rhode noted a positive impingement sign, specifically with internal rotation, "representing the posterior (infraspinatus) rotator cuff." He also noted "evidence of biceps rupture with a bulbous biceps mass." He prescribed Feldene and Tylenol #4 and took Petitioner off work. PX 5.

Petitioner returned to Dr. Rhode on May 25, 2007 and again complained of right shoulder pain. Dr. Rhode's examination findings were unchanged. He refilled Petitioner's Tylenol #4 prescription, recommended a right shoulder MRI and indicated Petitioner would require a primary biceps repair. He took Petitioner off work. PX 5.

In an addendum dated June 27, 2007, Dr. Rhode noted that he talked with Petitioner "about the mechanism of injury," with Petitioner indicating he felt his arm give way while he was pulling on the rung of a ladder with his tool belt strapped to his back. Based on this description, Dr. Rhode opined that "the concentric load of pulling up on a ladder rung with the affected extremity could rupture a proximal biceps tendon." PX 5. The Arbitrator notes that causal connection is not in dispute. Arb Exh 1.

An adjuster authorized the recommended MRI and surgery via facsimile on July 13, 2007. Based on entries in several records (RX 2 and 3), it appears that Petitioner underwent the MRI on July 30, 2007. The report concerning this MRI is not in evidence.

Petitioner testified he subsequently came under the care of Dr. Ho, an orthopedic surgeon affiliated with the University of Chicago.

Petitioner first saw Dr. Ho on October 1, 2007. A handwritten note bearing that date reflects that Petitioner "had MRI" but "did not bring." Dr. Ho obtained a consistent history of the work accident and noted that Petitioner was continuing to work but having difficulty

swinging a sledge hammer overhead and reaching behind his back. On examination of Petitioner's right shoulder, Dr. Ho noted a full and painless range of motion and normal strength on Jobe's testing but a "classic Popeye muscle deformity of the right biceps tendon." He prescribed physical therapy and instructed Petitioner to return to him in six weeks. He indicated he "would like to review the MRI more so to study the rotator cuff than the bice{ps." PX 1.

Petitioner underwent an initial physical therapy evaluation at AthletiCo on October 3, 2007. The therapist recommended he undergo therapy two to three times a week for four to six weeks.

Petitioner returned to Dr. Ho on October 29, 2007 and indicated he had "noted increased right shoulder pain over the past week with physical therapy." On examination of the right shoulder, Dr. Ho again noted the "Popeye's deformity" of the biceps. He also noted positive Neer's, Hawkin's, Jobe's and Speed's tests. He reviewed the MRI and interpreted it as showing a partial thickness bursal tear of the supraspinatus with impingement and AC joint arthritis. He offered an injection but Petitioner declined, saying he wanted to try Feldene first. Dr. Ho updated Petitioner's therapy prescription to include a rotator cuff program. He instructed Petitioner to return to him as needed. PX 1.

Dr. Ho issued a correction on November 2, 2007 indicating there was an error in his October 1, 2007 note and that Petitioner had actually been off work since May 11, 2007. Dr. Ho indicated Petitioner should remain off work until his next office visit, scheduled for December 3, 2007.

On November 12, 2007, Petitioner's therapist issued a note indicating Petitioner was not making any progress, despite having attended fourteen sessions, and complained of constant pain. PX 1.

Petitioner returned to Dr. Ho on December 3, 2007 and reported no relief with either the therapy or the Feldene. Dr. Ho injected the subacromial bursa with Kenalog and instructed Petitioner to continue therapy and remain off work. PX 1.

At the next visit, on January 14, 2008, Petitioner reported "75% improvement" to Dr. Ho but expressed concern about being able to resume his cement finishing duties. Dr. Ho described this concern as "reasonable." He noted a full range of right shoulder motion and good strength on Jobe's testing. He prescribed work conditioning but indicated Petitioner might require surgery if his symptoms returned or worsened. PX 1.

At Respondent's request, Petitioner saw Dr. Tonino for a Section 12 examination on February 4, 2008. [The Arbitrator notes that RX 2 and RX 3 appear to be identical documents concerning this examination, although RX 2 is dated July 26, 2007 and RX 3 is dated February 4, 2008]. Dr. Tonino is chief of sports medicine at Loyola University Medical Center. He described Petitioner as right-handed. He indicated he reviewed various records, including a MRI report of

July 30, 2007 describing a paralabral cyst, a posterior labral tear and a biceps tendon "within normal limits." He noted that Dr. Ho had offered Petitioner an injection because he believed the MRI to show a partial-thickness rotator cuff tear.

Dr. Tonino noted complaints of right arm weakness and pain with overhead activities. On examination of Petitioner's right shoulder, Dr. Tonino noted external rotation to 30 degrees versus 60 on the left, internal rotation to L5, versus to T12 on the left, and weakness with both resisted palmar abduction and resisted external rotation.

Dr. Tonino, like Dr. Ho, believed Petitioner to have a partial-thickness rotator cuff tear. Based on Petitioner's lack of improvement with conservative care, he recommended an arthroscopy. He indicated Petitioner might also need a subacromial decompression and rotator cuff repair. He also indicated Petitioner would need to undergo therapy postoperatively. RX 2, 3.

On February 11, 2008, Petitioner called Dr. Ho and indicated he was experiencing increased pain with work conditioning and wanted to undergo surgery. Dr. Ho instructed Petitioner to discontinue work conditioning and return to him. Petitioner returned to Dr. Ho on February 20, 2008 and indicated his pain had been aggravated by work conditioning. Petitioner also told Dr. Ho that he had seen Dr. Tonino at the carrier's request and that the doctor had suggested surgery. On examination, Dr. Ho noted pain on Jobe's, Neer's and Hawkin's testing. He prescribed Vicodin, told Petitioner to continue his rotator cuff strengthening program, either on his own or in formal therapy, and scheduled Petitioner for a rotator cuff repair. PX 1.

On May 1, 2008, Dr. Ho performed arthroscopic surgery consisting of a rotator cuff repair and biceps tendon debridement. In his operative report, he noted a 50% partial-thickness tear of the supraspinatus and infraspinatus and a tear of the biceps tendon near the bicipital groove. He described the labrum as "frayed but intact." He also noted Grade 3 chondromalacia of the glenoid, a type 3 acromion and a prominent distal clavicle. Following the surgery, he instructed Petitioner to keep his right arm in a sling at all times and start passive range of motion exercises. Dr. Ho removed the sutures on May 12, 2008 and instructed Petitioner to begin weaning out of the sling and continue therapy. Petitioner returned to Dr. Ho on June 16, 2008 and reported only occasional twinges of right shoulder pain. Petitioner expressed a desire to "start formal therapy and ride his motorcycle." On examination, Dr. Ho noted a near full range of motion, active elevation of 175 degrees and 4/5 strength with Jobe's testing. He instructed Petitioner to begin a rotator cuff strengthening program in therapy. He cautioned Petitioner that, due to the nature of cement finishing, it might take up to six months for him to be able to resume working. He did not comment on motorcycle usage. PX 1.

A therapy note dated August 13, 2008 reflects that Petitioner reported "riding his bike since surgery" and denied having any pain while doing so. The therapist cautioned Petitioner against riding his bike "as frequently as he should [sic] due to muscle weakness and chance of re-injury," with Petitioner purportedly stating he was going to continue riding since it "was not his bike that was causing him pain." Petitioner complained of severe pain when raising his arm

and related this pain to exercises performed in therapy. The therapist described Petitioner as exhibiting both subjective and objective inconsistencies. At the end of her report, the therapist attributed Petitioner's pain to either "too much activity outside of therapy or from condition of shoulder joint." RX 6.

Petitioner returned to Dr. Ho on August 18, 2008 and described "an episode where he hyper-extended the shoulder in therapy." Petitioner indicated his shoulder had been sorer since this episode. On examination, Dr. Ho noted an essentially full range of motion and good strength. He renewed Petitioner's Vicodin ES prescription and instructed Petitioner to continue his strengthening program. He indicated Petitioner was not ready to return to work. PX 1.

On September 8, 2008, Petitioner went back to Dr. Ho and reported experiencing a sharp onset of pain while performing an "internal rotation move" during therapy three or four weeks earlier. Petitioner indicated he had taken four or five days off therapy. On examination, Dr. Ho noted a full range of motion in forward flexion, abduction and external rotation but pain with cross-over. He prescribed Naprosyn and additional therapy and instructed Petitioner to remain off work. PX 1.

A physical therapy note dated October 24, 2008 reflects that Petitioner reported having fallen and fractured his right ankle on October 18, 2008. Petitioner was wearing a cast and ambulating with crutches. Petitioner continued attending therapy thereafter through November 7, 2008, at which time he reported having increased pain and being unable to lift his right arm past 90 degrees. Therapy was placed on hold a week later. PX 3.

Petitioner testified that Respondent discontinued his temporary total disability benefits in October of 2008 because he allegedly missed an appointment to be re-examined by Dr. Tonino. Petitioner testified he did not receive notice of the re-examination because he was in the process of moving and had his mail held until the move was completed. It was not until he retrieved his mail that he learned of the appointment. T. 26. He saw Dr. Tonino in November of 2008, about two weeks after he retrieved his mail. Dr. Tonino did not release him to work. After the November 2008 re-examination, Respondent resumed paying him benefits. T. 27-28. Respondent did not offer into evidence any report from Dr. Tonino concerning a November 2008 re-examination.

Petitioner returned to Dr. Ho on November 10, 2008 and reported having seen Dr. Tonino. Petitioner told Dr. Ho that Dr. Tonino recommended an MR arthrogram. On examination, Dr. Ho noted pain with overhead activity with positive Neer's and Hawkin's signs as well as pain with cross over. Dr. Ho recommended an MR arthrogram "to evaluate for possible rotator cuff pathology versus labral pathology." He directed Petitioner to return to him following the MR arthrogram. PX 1.

Dr. Tonino re-examined Petitioner on February 23, 2009 and indicated Petitioner had not yet undergone the MR arthrogram that both he and Dr. Ho had recommended. Dr. Tonino indicated he had last examined Petitioner on November 3, 2008 and had recommended an MR

arthrogram on that date. When Dr. Tonino re-examined Petitioner on February 23, 2009, he noted elevation of 160 degrees on the right, compared with 180 on the left, external rotation to 45 degrees on the right, compared with 60 on the left, internal rotation to L3 on the right, compared with T12 on the left, and pain with both resisted palmar abduction and resisted external rotation. With respect to the intervening ankle injury, he stated: "I do not believe the fact that the patient was ambulating on crutches led to any further damage in the shoulder." He again recommended an MR arthrogram and found it likely that Petitioner would require more surgery based on the calcification shown on his X-rays. He found Petitioner capable of light duty with no lifting over 5 pounds, no overhead work and no repetitive use of the right arm. He characterized the treatment to date as reasonable and necessary and stressed that Petitioner "will not reach maximum medical improvement until he has had his MR arthrogram and determination has been made whether further surgery is indicated." RX 4.

On April 6, 2009, a NovaCare therapist issued a discharge summary explaining Petitioner's discharge from physical therapy as follows: "Progress has plateaued. Non-compliance. Stopped coming, hasn't been seen in 147 days, case is pending litigation." RX 7.

Petitioner finally underwent the recommended MR arthrogram on May 11, 2009. The radiologist noted a "recurrent complete tear of the supraspinatus tendon with underlying rotator cuff tendinopathy," degenerative changes of the posterior aspect of the bony glenoid, thinning of the long head of the biceps tendon over the superior surface of the humeral head, with a tear at this site suspected, and post-operative changes from the previous rotator cuff repair. PX 1.

On August 3, 2009, Petitioner complained of increased pain to Dr. Ho and indicated he was experiencing difficulty adducting his arm across his body. On examination, Dr. Ho noted minimal tenderness to palpation over the AC joint, a negative Jobe's test, "exquisite pain localized to the shoulder with resisted forward flexion" and internal rotation only to the upper lumbar/lower thoracic spine. Dr. Ho reviewed the arthrogram report and recommended a right rotator cuff repair. PX 1.

At Respondent's request, Dr. Tonino examined Petitioner again on July 29, 2010. Dr. Tonino noted that Dr. Ho had recommended a revision rotator cuff repair on August 3, 2009. Dr. Tonino also noted that Petitioner had not seen a physician since August 3, 2009 and continued to complain of right shoulder pain. Dr. Tonino found Petitioner to be a candidate for a right rotator cuff repair. He indicated Petitioner should undergo a functional capacity evaluation if he opted not to proceed with this surgery. He characterized the treatment to date as reasonable. He indicated he could not determine whether Petitioner would require permanent restrictions until after the functional capacity evaluation. RX 5.

Petitioner testified he declined to undergo additional surgery because he "went through a lot of pain" following the first surgery and no one could guarantee a good result. T. 28-29.

Petitioner testified he became employed on January 21, 2011. On that date, he started driving a cab taking problem students to school. He continued performing this work until late May 2011. He denied performing any other jobs in 2011. T. 30. His 2011 tax return reflects he derived a net profit of $8,577.00 in 2011. He has looked for work in 2012 but has not worked. He looked for jobs as a parts driver or tow truck driver. The parts driver job paid $8.00 per hour. He did not receive any calls asking him to interview for either of these jobs. T. 31.

Petitioner underwent a functional capacity evaluation at ATI on April 10, 2012. T. 32-33. The evaluator, James Lemley, described the evaluation as valid. He found Petitioner's physical capabilities consistent with a medium physical demand level, meaning Petitioner could occasionally lift 55 pounds. He noted that Petitioner's cement finisher job is typically considered a heavy physical demand level position by the Dictionary of Occupational Tables. He also noted he had not been given a job-specific description. He indicated Petitioner complained of pain with side to side arm movements "which are consistent with the movements he performs on the job." He recommended Petitioner follow up with his physician. PX 2.

On March 22, 2012, Susan Entenberg, a certified rehabilitation counsel, evaluated Petitioner at the request of Petitioner's counsel. Entenberg issued a report concerning her evaluation on May 29, 2012. Entenberg described Petitioner as "very pleasant and cooperative" throughout her evaluation. She noted that Petitioner's temporary total disability benefits were terminated on December 25, 2011 and that Petitioner denied any current source of income. She noted Dr. Ho's and Dr. Tonino's recommendation of a revision rotator cuff repair and indicated Petitioner did not want to undergo more surgery. She characterized Petitioner's previous cement mason job as heavy and noted a valid functional capacity evaluation placed Petitioner at medium duty.

Entenberg described Petitioner's most recent work experience as follows:

> "Mr. Zielinski did work as a cab driver during 2011 and indicated that his gross income was $8,577.00 for the year. He states he also worked in 2012 for Arctic Snow & Plow doing snow removal this past winter and earned around $600 for the winter season. He states he also attempted a finishing job recently. An 11' by 16" area was filled with concrete by truck and no finishing was done. He states he spent 45 minutes smoothing the concrete and was in severe pain the next morning from the repetitive activity."

PX 7, p. 3.

Entenberg found Petitioner to be an appropriate candidate for vocational rehabilitation. She found Petitioner's prognosis for job placement to be "fair," given his age, work history and

restrictions. She found Petitioner's present earnings capacity to be approximately $12.00 to $15.00 per hour. PX 7, p. 4.

Petitioner returned to Dr. Ho on May 14, 2012 and indicated his shoulder had not really changed since his last visit in 2009. Petitioner indicated that his shoulder was essentially pain free with rest. He also reported being able to ride his motorcycle. He told the doctor he did not want to undergo any additional surgery. Dr. Ho reviewed the functional capacity evaluation and the May 2009 MRI. He addressed Petitioner's work capacity as follows:

> "Based on his recent functional capacity evaluation and the findings of his post-operative MRI, I agree with the patient being permanently restricted from his prior job duties. If he were to be re-employed, it would have to be at the medium physical demand level unless the patient were willing to undergo a repeat repair of his rotator cuff."

PX 1.

At the request of his attorney, Petitioner saw Dr. Rubinstein for an evaluation on May 21, 2012. T. 33-34. PX 6. Dr. Rubinstein is associated with the Illinois Bone and Joint Institute. In his addendum of May 24, 2012, Dr. Rubinstein opined that Petitioner had a "re-tear of his rotator cuff following an initial workplace accident where he injured his rotator cuff, which was previously asymptomatic." Based on the valid functional capacity evaluation and Petitioner's description of his cement finisher duties, Dr. Rubinstein further opined that Petitioner was unable to resume his former trade. He found Petitioner capable of medium duty within the lifting-related abilities identified at the functional capacity evaluation. He also found Petitioner to be at maximum medical improvement, based on Petitioner's decision to forego further surgery. He suggested a home exercise program and either placement in an alternative job or early retirement. He concurred with Drs. Ho and Tonino concerning causation. PX 6.

On May 30, 2012, Entenberg issued a brief report indicating she reviewed Dr. Ho's report of May 14, 2012 and the report did not prompt her to change any of the opinions expressed in her report of May 29, 2012. PX 7, p. 5.

Petitioner testified he has been unable to find any jobs at the wage level, i.e., $12.00 to $15.00 per hour, identified by Entenberg. T. 32. Petitioner further testified that no doctor who has treated or examined him has indicated he can resume working as a cement mason. T. 34. Respondent's carrier has never offered him vocational rehabilitation or job search assistance. T. 34.

Petitioner testified that Local 502 cement masons currently work 42.5 hours per week. If he had been able to work as a union cement mason between January of 2011 and May of 2012 his base pay would have been $41.85 per hour. As of June 1, 2012, union cement masons began earning $42.35 per hour. T. 35-36.

Petitioner testified he is right-handed. T. 36. His current pain level varies depending on his activities and whether or not he inadvertently sleeps on his right side. His right arm "feels halfway decent" if he avoids all activities. Out of every ten days, he will have one day when he experiences no pain and two or three days when he feels slight pain. He takes Aleve when his pain increases. T. 36, 38. He continues to ride his motorcycle because, ironically, that activity "doesn't hurt at all." T. 37. If he rakes leaves or shovels snow, he will "feel it the next day." T. 37. He still does not want to undergo the second surgery that Dr. Ho offered. T. 37. Had the accident not occurred, he "absolutely" would have continued working as a cement mason. T. 37-38. Shortly before the hearing, his right arm unexpectedly flared up for five to seven days. The flare-up subsequently resolved. T. 38.

Under cross-examination, Petitioner testified he was subject to weather-related layoffs when he worked as a cement mason. The layoffs had no set pattern. He has poured cement in the rain and snow. If he was working on a high-rise, he would be sent home if the winds got high. T. 41. After looking at his 2011 tax return, Petitioner acknowledged his gross receipts totaled $18,312.00 in 2011. T. 44-45. Between January and May of 2011, he worked for R & E Taxi as a specialized cab driver, taking children to and from school. T. 48. During this time, he paid gas and lease expenses daily. The owner of R & E Taxi deducted these expenses from Petitioner's fares each day and paid Petitioner the remainder in cash. T. 52. Petitioner testified it was "too difficult" to estimate how much he received in cash each day because, if a student was suspended from school or failed to show up, he would receive no pay. T. 53. Petitioner denied receiving any tips during this period. T. 53. Petitioner quit this job in May of 2011, when the school year ended. T. 45, 49. In October or November of 2011, the owner of R & E Taxi asked if he would work as a conventional cab driver. Petitioner agreed but the job proved to be not worth his time. He was driving in a "very poor neighborhood." He received very few tips and earned very little. The cab ended up sitting in his driveway. T. 46-49, 54. During this period, the owner of R & E Taxi did not charge him a set lease each day. The lease could be as low as $5.00 on a day when Petitioner received few fares. T. 55. He drove a cab for about 31 weeks in 2011. During this period, he received $1,018.67 per week in temporary total disability benefits. T. 50. He never told anyone he was continuing to receive these benefits while working. He is diabetic and was "freaking out" because his insurance coverage was running out. T. 69. He also operated a snow plow for Arctic Snow Removal during the winter of 2011-2012 but earned only about $600 because the winter was so mild. The hourly rate of pay was about $23.75. T. 56.

Petitioner testified that his motorcycle is a Harley Davidson with a 1564 cc motor. The motor is 96 cubic inches in size. His motorcycle weighs 730 pounds "dry" and close to 900 pounds when it is full of gas and oil. He has to support the motorcycle with his legs while riding. His motorcycle is a "touring bike," meaning that the handlebars are about even with his elbows. When he rides, he holds his arms straight forward at about elbow level. T. 58. He rides as much as he can, weather permitting. T. 69. He received permission from Dr. Ho to resume riding his motorcycle about six weeks after his May 1, 2008 surgery. T. 59. Dr. Ho asked him if it was painful to ride and he said "no." The doctor then said, "go at it." T. 60.

Petitioner recalled a female physical therapist telling him he should not be riding. He told this therapist his doctor gave him permission and he was going to ride. T. 59. He denied being discharged from therapy due to non-compliance. T. 61-62. He discontinued therapy on Dr. Ho's orders. T. 62. He underwent no active care between August of 2009 and his functional capacity evaluation in 2012. T. 62-63. When he met with Susan Entenberg, he told her he can use a computer to check his E-mails, use Facebook and surf the Internet. T. 63. He has been on Facebook for about a year. He is starting to acquire basis computer skills. T. 64. He acquired an E-mail address in March of 2012. T. 64.

Petitioner testified that cement masonry can involve overhead work. When cement masons do "patching," they use their hands to hold a grinder above shoulder level. T. 65. He worked as a foreman for about two years. During 99% of that two-year period, he was a "working" foreman. He would perform the usual tasks of a cement mason during the day and complete his foreman tasks, i.e., paperwork, each night at home. T. 67. Three months ago, he registered with the Illinois Department of Employment to look for jobs. T. 67. He has also looked for work online. He has yet to find a posted job for which he is qualified. T. 68.

On redirect, Petitioner testified he obtained assistance preparing his 2011 tax return. T. 69-70. Before 2011, he had never filed a tax return based on self-employment. T. 70. As far as he knows, his 2011 tax return is accurate. T. 70. He made a "bad choice" in continuing to receive temporary total disability benefits while working. He made this choice because his diabetes medication costs about $1,000 per month and he was not going to have health insurance in 2011. He called the State but was unable to obtain any assistance. T. 71. It was not until 2012 that he started operating the snowplow. T. 72. He never injured his right arm while operating his motorcycle. T. 72-73. Since the work accident, he has aggravated his right arm during therapy and on those occasions when he slept "wrong." T. 72. He underwent a repeat MRI in May of 2009. In August of 2009, Dr. Ho offered him the option of additional surgery. Dr. Ho did not prescribe more therapy at that time. T. 74. He believes the therapy made him worse. T. 74. He has never held a job where he sat at a desk and operated a computer. T. 74-75. He is "self-taught" when it comes to computers. He never had to use a computer when he worked as a cement mason. T. 75.

Arbitrator's Credibility Assessment and Conclusions of Law

Was Petitioner credible?

In its proposed decision, Respondent describes Petitioner as "evasive" and "inconsistent," pointing to Petitioner's testimony concerning his work hours, motorcycle usage and therapy attendance.

The Arbitrator views this testimony in a different light. Petitioner testified in a detailed and convincing manner concerning the demands of his trade and consequent work schedule. Respondent did not offer any contradictory evidence. Petitioner never attempted to hide his motorcycle usage. On June 16, 2008, only six weeks after his surgery, Petitioner told Dr. Ho he

was "anxious to ride his motorcycle," with the doctor expressing no negative reaction. PX 1. Petitioner's initial therapist at NovaCare did react negatively but, even then, did not tell Petitioner to completely avoid riding. This therapist also noted inconsistencies in Petitioner's behavior. RX 6. However, Dr. Ho, who presumably reviewed the therapy notes, did not note any inconsistencies. Neither did Respondent's examiner, Dr. Tonino, who specifically referenced the NovaCare records in his reports. RX 4-5. A NovaCare discharge summary (RX 7) reflects that Petitioner was non-compliant and "stopped coming to therapy" in November of 2008 (RX 7) but the last NovaCare treatment note, dated November 7, 2008, reflects that a therapist instructed Petitioner to return to Dr. Ho for re-assessment because pain was limiting his progress. As discussed more fully below, Dr. Tonino had recommended an MR arthrogram only four days earlier, on November 3, 2008 [see Dr. Tonino's report of February 23, 2009 [RX 4] which reflects he last saw Petitioner on November 3, 2008], but this arthrogram was not performed until May of 2009. On this record, with Respondent having failed to offer Dr. Tonino's report of November 3, 2008 into evidence, the Arbitrator cannot find Petitioner to be "non-compliant."

This is not to suggest that Petitioner was 100% believable on all issues. Petitioner was not completely forthcoming with respect to his post-accident employment and continued to cash Respondent's temporary total disability checks while engaging in that employment, so as to be able to afford his expensive diabetes medication. T. 69.

What is Petitioner's average weekly wage?

Petitioner claimed an average weekly wage of $1,671.25 while Respondent claimed an average weekly wage of $1,528.00. Arb Exh 1.

Petitioner testified he was required to work through his half-hour lunch each day due to the demands of his trade. T. 16. Petitioner also testified he was required to work extra hours on May 4, 2007 because a cement pour took place that day. T. 17. Respondent did not offer any evidence contradicting this testimony. Petitioner offered into evidence an "employee time history." This document appears to have been generated by Respondent. PX 8. PX 8 reflects that Petitioner earned $38.20 per hour and worked four days for Respondent during the year prior to his undisputed May 10, 2007 accident. On three of those days, he earned 8 hours of regular pay and ½ hour of double time. On the fourth day, May 4, 2007, he earned 8 hours of regular pay and 1 ½ hours of double time. Respondent did not offer any other evidence concerning Petitioner's pre-accident hours or earnings.

Based on Petitioner's testimony, PX 8 and Arcelor Mittal Steel v. IWCC, 2011 Ill.App. LEXIS 1154, the Arbitrator includes the double time earnings reflected on PX 8, at straight time rate, in her calculation of Petitioner's average weekly wage. Based on Section 10 and Sylvester v. Industrial Commission, the Arbitrator arrives at an average weekly wage of $1,671.25 by dividing Petitioner's total earnings of $1,337.00 (with double time reduced to straight time) by 4 days, or .8. This average weekly wage gives rise to a temporary total disability rate of $1,114.17.

Is Petitioner entitled to temporary total disability benefits from October 10, 2008 through November 2, 2008?

Petitioner claims he was temporarily totally disabled from May 11, 2007 through January 20, 2011. Respondent takes issue only with the period running from October 10, 2008 through November 2, 2008. Arb Exh 1. Respondent claims Petitioner is not entitled to benefits during this period because he failed to appear for a Section 12 re-examination by Dr. Tonino. Petitioner testified he missed the re-examination because Respondent provided less advance notice than with the original examination and he had his mail held while he changed residence. T. 25-26. Petitioner further testified his benefits resumed after he submitted to the re-examination.

Section 12 provides, in relevant part, that if an employee "refuses to submit himself to examination or unnecessarily obstructs the same, his right to compensation payments shall be temporarily suspended until such examination shall have taken place and no compensation shall be payable under this Act for such period."

The Arbitrator finds no evidence in the record suggesting Petitioner either "refused to submit" to a re-examination or "unnecessarily obstructed" a re-examination. Petitioner's testimony about the short notice is unrebutted. Respondent did not offer into evidence the letter it sent to Petitioner requesting the re-examination. Nor did Respondent offer any evidence indicating it complied with Section 7110.70 of the Rules Governing Practice Before the Illinois Workers' Compensation Commission in suspending the payment of benefits on October 9, 2008. The Arbitrator finds credible Petitioner's testimony that he had his mail held while moving and attended the re-examination once he learned of the missed appointment. Dr. Ho's note of November 10, 2008 reflects Petitioner saw Dr. Tonino, with the doctor recommending an MR arthrogram. Dr. Ho concurred with Dr. Tonino's recommendation. PX 1. Dr. Tonino's report of February 23, 2009 reflects he last examined Petitioner on November 3, 2008, and recommended an MR arthrogram on that date. The Arbitrator finds it significant that Respondent failed to offer into evidence Dr. Tonino's report concerning his November 3, 2008 re-examination.

Based on the foregoing, and because Petitioner's condition was clearly unstable pending the MR arthrogram, which was not performed until May of 2009, the Arbitrator includes the disputed period, October 10, 2008 through November 2, 2008, in her award of temporary total disability benefits. Petitioner is entitled to temporary total disability benefits at the rate of $1,114.17 per week from May 11, 2007 through January 20, 2011, with Respondent receiving credit for the benefits it paid prior to arbitration, pursuant to the parties' stipulation. Arb Exh 1.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner offered into evidence the following unpaid medical bills:

Provider	Date of Service	Orig. Charges	Charges per F/S	TOTAL
ATI	4/10/12, FCE	$2,613.96	$1,024.02	$1,024.02
North Shore Univ.	5/10/07	$ 480.00	$ 346.80	$ 346.80
North Shore Univ. Physicians	5/10/07	$ 199.00	$ 199.00	$ 199.00
University of Chgo. (Dr. Ho)	5/15/12	$ 143.00	$ 68.58	$ 68.58
	TOTALS:	**$ 3,435.96**	**$1,638.40**	**$1,638.40**

PX 11. Respondent stipulated to causation (Arb Exh 1) and did not object to any of these medical expenses. T. 80. Respondent's examiner, Dr. Tonino, consistently described Petitioner's treatment as reasonable and necessary. RX 2-5. Accordingly, the Arbitrator awards Petitioner the foregoing outstanding fee schedule charges of $1,638.40.

Did Petitioner establish entitlement to wage differential benefits?

Petitioner seeks an award of wage differential benefits under Section 8(d)1 of the Act while Respondent seeks an award under 8(d)2. The Arbitrator finds that Petitioner qualifies for a wage differential award.

Section 8(d)1 of the Act provides, in relevant part:

> "If, after the accidental injury has been sustained, the employee as a result thereof becomes partially incapacitated from pursuing his usual and customary line of employment, he shall . . . receive compensation for the duration of his disability . . . equal to 66 2/3% of the difference between the average amount 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."

The record supports the conclusion that Petitioner became "partially incapacitated from pursuing his usual and customary line of employment" as a result of his work accident. Accident and causation are not in dispute. Arb Exh 1. Petitioner was diagnosed with a rotator cuff re-tear following his initial surgery. Petitioner elected not to undergo a second surgery. Dr. Ho agreed with this election, noting that Petitioner's condition was livable so long as he avoided stressing his arm. PX 1. The valid functional capacity evaluation of April 10, 2012 showed that Petitioner is limited to medium duty, with occasional lifting of 55 pounds, and that Petitioner is thus not capable of resuming his former trade. Dr. Ho reviewed the functional capacity evaluation on May 14, 2012 and agreed that Petitioner should be permanently

restricted from resuming work as a cement finisher. PX 1. Dr. Rubinstein, Petitioner's selected examiner, agreed. PX 6. Respondent did not offer any contrary opinion from its examiner, Dr. Tonino.

Respondent maintains that, despite his partial incapacity, Petitioner is not entitled to wage differential benefits because he failed to conduct an appropriate job search. Petitioner correctly points out that "there is no affirmative requirement under Section 8(d)1 that [he] even conduct a job search." Rather, he need only demonstrate an impairment of earnings. Gallianetti v. Industrial Commission, 315 Ill.App.3d 721, 731 (2000). Petitioner also correctly points out that Respondent failed to provide vocational rehabilitation. Respondent also failed to prepare a written assessment in accordance with Section 7110.10(a) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission. Ill. Admin. Code Tit. 50, Sec. 7110.10 (2004). In Ameritech Services, Inc. v. IWCC, 389 Ill.App.3d at 191, 207 (1st Dist. 2009), the Appellate Court held that such assessments must be prepared and periodically updated even when it appears that vocational rehabilitation is unnecessary.

In the instant case, only Petitioner offered any evidence concerning his employability. On direct examination, Petitioner testified he derived taxable income of $8,577.00 in 2011 from driving a cab (in two different capacities) for R & E Taxi. Petitioner indicated his first stint with R & E, during which he drove individual students to and from school, lasted only until May of 2011, when the school year ended, and his second stint, as a conventional cab driver, was unsuccessful due to a lack of customers in the economically depressed neighborhood to which he was assigned. Petitioner denied working in 2012. T. 31. Under cross-examination, however, Petitioner acknowledged earning $600.00, at the rate of $23.75 per hour, from driving a snow plow in 2012. T. 56. Petitioner offered into evidence a report from Susan Entenberg, a certified vocational rehabilitation counselor. Entenberg found Petitioner's present earning capacity to be approximately $12.00 to $15.00 per hour based on his work history and restrictions. PX 7.

Petitioner requests that the Arbitrator use the figure at the lowest end of Entenberg's range, i.e., $12.00 per hour, in calculating his wage differential benefits. The Arbitrator instead uses the figure at the highest end of the range, i.e., $15.00 per hour. Based on Petitioner's employment-related testimony, lengthy work history (albeit in one trade) and supervisory experience, the Arbitrator finds this figure to be a more realistic estimate of Petitioner's earning capacity.

PX 9, the wage scale for members of Petitioner's union, Local 502, shows that Petitioner would have earned $41.85 per hour in the full performance of his cement finisher journeyman duties from January 21, 2011 through May 31, 2012 and $42.35 per hour beginning June 1, 2012. The Arbitrator relies on PX 8 and Petitioner's credible testimony in finding a 42.5-hour work week.

From January 21, 2011 through May 31, 2012, the Arbitrator awards Petitioner wage differential benefits of $785.75 per week. The Arbitrator arrives at $785.75 by multiplying

$41.85 per hour by 42.5 hours, arriving at $1,778.63, subtracting $600.00 per week ($15.00 per hour multiplied by 40 hours), arriving at $1,178.63, and multiplying $1,178.63 by 2/3.

From June 1, 2012 forward, and for the duration of his disability, the Arbitrator awards Petitioner wage differential benefits of $799.92 per week. The Arbitrator arrives at $799.92 by multiplying $42.35 per hour by 42.5 hours, arriving at $1,799.88, subtracting $600.00 per week, arriving at $1,199.88, and multiplying $1,199.88 by 2/3.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DUDLEY WILLIAMS,

Petitioner,

vs. NO: 12 WC 26805

THE AMERICAN COAL COMPANY,

17IWCC0595

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease, causation, and permenancy and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner established that he has an occupational disease arising out of and in the course of his employment on September 11, 2011, and established a causal connection between that disease and his current condition of ill-being. The Commission further finds that Petitioner established "disablement", as that term is used in the Act, and that he is entitled to permanent partial disability benefits of $695.78 per week for a further period of 50 weeks as provided in §8(d)2 of the Act, because the injuries sustained caused 10% loss of use of the person as a whole.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner started his mining career in 1972. (T.20) He testified that he worked for Respondent for 22 years, though worked in the mines for an additional 18 years for other coal companies, the entire time below ground. (T.16) Petitioner initially worked as a belt shoveler and then as a shuttle car operator. (T.20-21) He next moved to the continuous miner. (T.22) In 1989, Petitioner took a job with Kerr-McGee, which became American Coal. He worked maintenance, and at the end for the last few years, he took a foreman's job. (T. 27-28) He was a foreman on the long wall face.

(T.28) Petitioner testified that he signed a resignation from his employment at American Coal on 1/27/12. (T.36) Petitioner didn't work anywhere after he left the mine. (T.20) Petitioner testified that during his coal mining career he was regularly exposed to coal dust, as well as silica dust, roof bolting glue fumes, and diesel fumes. (T.17) Petitioner's last date of work in the mine was September 11, 2011. (T.17) Petitioner smoked from age 18 until he was about 25 and quit and ha not smoked since that time. He smoked maybe half a pack a day. (T.32-33)

2. Petitioner testified that he started noticing problems with his breathing about ten years before he left the mines. (T.29) Petitioner testified that his breathing problems have progressively worsened over time. (T.31-32)

3. On March 20, 2012, Petitioner underwent a chest X-ray. Dr. Smith, a certified B reader, interpreted this X-ray on May 15, 2012. (Px2) Dr. Alexander, a certified B reader, interpreted this X-ray on January 30, 2013. (Px3) Dr. Smith's impression stated: "simple coal-worker's pneumoconiosis with small opacities, primary p, secondary s, mid to lower zones bilaterally, profusion 1/0." Dr. Alexander noted that "[t]he film quality is 1. The lung volumes are normal. Small round opacities are present bilaterally, consistent with pneumoconiosis, category p/p, 1/0.... Impression: Coal Worker's Pneumoconiosis, category p/p, 1/0."

4. Petitioner filed an Application for Adjustment of Claim on August 6, 2012, claiming shortness of breath and exercise intolerance due to "[i]nhalation of coal mine dust including but not limited to coal dust, rock dust, fumes & vapors for a period in excess of 39 years." (Ax2) Petitioner claimed a last exposure date of September 11, 2011.

5. Petitioner saw Dr. Paul on December 3, 2012, at which time he underwent an evaluation and pulmonary function test. (Px1) Dr. Paul noted that Petitioner complained of "shortness of breath for 5-6 years when he walks about 1 mile and has shortness of breath when he goes up about 3 flights of stairs." Dr. Paul diagnosed Petitioner as having simple coal workers' pneumoconiosis (CWP) and mild chronic obstructive pulmonary disease. Dr. Paul testified that Petitioner "has a clinically significant pulmonary impairment in the form of pulmonary symptoms and physical exam of the chest caused by coal dust. The radiographic evidence was consistent with radiographically apparent pulmonary impairment." (Px1 p. 17) Based on Dr. Paul's diagnoses and description of Petitioner's impairment, he didn't believe Petitioner would be able to work as a coal miner again and that Petitioner's condition was permanent. (Px1 p. 18-19)

6. Dr. Meyer, a certified B reader retained by Respondent, reviewed films regarding Petitioner. (Rx1) In his report, Dr. Meyer noted "the lungs are clear. There are no fine irregular, fine nodular, or large opacities. Atherosclerotic calcification is seen in the thoracic aorta. The cardiac silhouette, bones and soft tissue are unremarkable." It was his impression that there was no radiographic finding of CWP. (Rx1)

7. On August 15, 2013, Dr. Selby, Respondent's Section 12 examiner, evaluated Petitioner. (Rx2) In his report, Dr. Selby noted that Petitioner has shortness of breath as well as some scarring on his chest. Dr. Selby disagreed with Dr. Paul's "impression" of Petitioner having simple CWP and mild COPD. (Rx2)

8. At his evidence deposition on August 11, 2015, Dr. Selby opined that Petitioner does not suffer from "any respiratory or pulmonary abnormality as a result of coal mine dust inhalation or coal mine employment." (Rx2, p.23) Dr. Selby also opined that Petitioner does not suffer from CWP. (Rx2, p.23) On cross-examination, Dr. Selby acknowledged that it's possible to have CWP that is determined at biopsy or autopsy, that may not have been appreciated by radiographic study. (Rx2, p.59) Dr. Selby also acknowledged that it's possible to have a chest x-ray or radiographic study read as being negative and that does not rule out that the possibility that the person could still have CWP on pathologic review. (Rx2, p.60)

9. The Arbitrator found that Petitioner failed to prove that he has an occupational disease arising out of and in the course of his employment by Respondent. The Arbitrator relied on the opinions of Dr. Meyer, Dr. Selby and the independent NIOSH B-readers. In the Commission's view, the weight of the evidence supports the conclusion that Petitioner has CWP and that this condition stems from his occupational exposure to coal, rock dust and fumes in Respondent's mines. Accordingly, the Commission reverses the Arbitrator's Decision and finds that Petitioner proved exposure to an occupational disease arising out of and in the course of his employment with Respondent.

In reversing the Arbitrator's Decision, the Commission relies primarily on the findings and opinions of Dr. Paul and x-ray interpretations of Dr. Smith and Dr. Alexander. Dr. Paul found that Petitioner suffers from CWP. The Commission also relies on these doctors' findings of radiographic evidence of CWP. The Commission takes note of Dr. Paul's opinion that Petitioner should avoid additional exposure to coal and rock dust due to his prior lengthy exposure.

Next, the Commission considers the issue of whether Petitioner has proved "disablement" as that term is defined in the Act. Under Illinois law, a claimant does not have to have clinical impairment to establish disablement. He need only show that he cannot resume his former occupation. 820 ILCS 31/1(e). Based on Dr. Alexander's and Dr. Smith's 1/0 ILO rating and Dr. Paul's opinion, the Commission finds that Petitioner proved disablement from an occupational disease.

Under the particular facts of this case, the Commission elects to award permanency equivalent to 10% loss of use of the person as a whole under §8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator entered on February 11, 2016, is reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.78 per week for a further period of 50 weeks as provided in §8(d)2 of the Act, because the injuries sustained caused 10% loss of use of the person as a whole.

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

17IWCC0595

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $35,000. 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: SEP 29 2017

Charles J. DeVriendt

Joshua D. Luskin

CDJ/dmm
O: 8/1/17
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DISSENT

I respectfully dissent. I would affirm and adopt the well-founded and well-reasoned decision of Arbitrator Lindsay. As Arbitrator Lindsay did, I would afford greater weight to the opinions of Dr. Selby and Dr. Meyer both of whom are certified B Readers whereas Dr. Paul is not. Further, the diagnostic x-rays performed while Petitioner was in Respondent's employ (05/22/02; 12/19/06; 06/18/11) fail to evidence pneumoconiosis.
Accordingly, I dissent.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, DUDLEY
Employee/Petitioner

Case# **12WC026805**

THE AMERICAN COAL COMPANY
Employer/Respondent

17IWCC0595

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

If the Commission reviews this award, interest of 0.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

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

17IWCC0595

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DUDLEY WILLIAMS
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # 12WC 026805

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 **Herrin**, on **December 9, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0595

FINDINGS

On **September 11, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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's earnings were **$86,730.80** and the average weekly wage was **$1,667.90.**

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

Petitioner claims no medical or temporary total disability 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.**

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

ORDER

Petitioner failed to prove he sustained an occupational disease arising out of and in the course of his employment. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Signature of Arbitrator

2/8/16
Date

FEB 11 2016

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator Finds:

Medical records from Primary Care Group were admitted into evidence. The first record was a radiology report of Dr. James O. Alexander for a chest x-ray taken of Petitioner on October 3, 1996. Dr. Alexander interpreted the film as revealing pulmonary hyperinflation. (Respondent's Exhibit No. 5, p. 63). Petitioner was seen on March 4, 2005, with complaint of cold for seven to eight days. His review of systems respiratory revealed no cough, dyspnea or sputum production. Physical examination of the chest revealed normal breath sounds. The assessment was acute respiratory infection. (Respondent's Exhibit No. 5, pp. 59-60). Petitioner was seen on April 18, 2005, complaining of cough which had been present for two weeks. Same was productive of mucoid sputum which was indicated to be scanty. Physical examination of the chest revealed expiratory and inspiratory wheezes in both lung fields. The assessment was acute bronchitis. (Respondent's Exhibit No. 5, pp. 57-58).

In May of 2006 Petitioner was seen by Dr. Jones at Primary Care Group for a complaint of ongoing back pain for three weeks. Petitioner reported that he had been having back problems for a long time but he was now working in "lower coal" than his used to. (Respondent's Exhibit 5)

Petitioner was seen on October 31, 2006, with cold complaints. He related runny nose, cough and headache. Review of systems respiratory revealed cough, difficulty breathing and sputum production. Assessment was acute upper respiratory infection and rhinitis. (Respondent's Exhibit No. 5, p. 54). Petitioner was seen again on November 22, 2006, with complaint of cough. The cough was productive of mucoid sputum. Review of systems respiratory revealed cough with difficulty breathing and sputum production. Petitioner was diagnosed with acute bronchitis. (Respondent's Exhibit No. 5, pp. 52-53).

In June of 2008 Petitioner returned to Primary Care Group with complaints of sciatica, foot numbness, bilateral leg pain and weakness. At his July 15, 2008 visit with Dr. David Lange, Petitioner described chronic low back pain and a sensation of feeling like he was losing strength in his legs over the last few months. He had begun wearing an ankle brace in his rubber boots and fallen a time or two. Petitioner was trying to be cautious with his body mechanics and lifting at work. (Respondent's Exhibit 2, dep. ex. 3, pp. 9-10. See also Respondent's Exhibit 5)

Petitioner was seen on October 13, 2009, complaining of cough and cold for one week duration. He related runny nose, cough and chest congestion. Review of systems respiratory revealed cough, difficulty breathing and sputum production. The assessment was acute bronchitis. (Respondent's Exhibit No. 5, p. 33). On December 28, 2009, he reported cough with congestion and sore throat for a few days. Petitioner related waking up at night and feeling like he had something in his throat and that it was difficult for him to breathe or swallow. Petitioner's cough was characterized by productive mucoid sputum. The amount of sputum was stated to be scanty. Review of systems respiratory revealed cough but no difficulty breathing. Assessment was acute bronchitis. (Respondent's Exhibit No. 5, pp. 31-32). He was diagnosed with acute bronchitis again on February 25, 2010. (Respondent's Exhibit No. 5, p. 27).

Petitioner was seen on June 23, 2011, relating pain in his left arm. It was charted that Petitioner had fallen into a swimming pool with about a foot of water in it on June 11, 2011. (Respondent's Exhibit No. 5, p. 26). He returned on August 19, 2011, saying that his muscle in his left arm looked like it had fallen. On that date the assessment was ruptured triceps tendon. Petitioner was referred for orthopedic consult. (Respondent's Exhibit No. 5, p. 24).

Medical records of the Orthopedic Institute of Southern Illinois were admitted into evidence. In a handwritten history, presumably completed by Petitioner on August 24, 2011, he listed his chief complaint as weakness in triceps of the left arm. (Respondent's Exhibit No. 4, pp. 31-33). He indicated that the date of onset was June 6, 2011, following a fall at home. He denied shortness of breath or coughing. He had left triceps weakness and deformity. He thought he would get better following the fall but failed to do so. The assessment was left elbow triceps tear. (Respondent's Exhibit No. 4, pp. 26-27).

Petitioner was seen at Primary Care Group on September 12, 2011. He reported that he was scheduled for surgery the following day to reattach the large triceps muscle. On that date review of systems respiratory revealed no difficulty breathing or coughing. (Respondent's Exhibit No. 5, pp. 19-20).

On September 13, 2011, Petitioner underwent a left elbow open primary repair of his triceps tendon rupture. (Respondent's Exhibit No. 4, pp. 13-14). When seen on January 9, 2012, in follow-up, Petitioner still had some weakness but was making improvement. The doctor thought he was progressing well from his surgery. Petitioner was advised to continue with protective body mechanics, home exercises and medications. He was to follow up in three to four months. This was the last visit that Petitioner had with Orthopedic Institute of Southern Illinois. (Respondent's Exhibit No. 4, p. 5).

On May 15, 2012, and at the request of counsel for Petitioner, Dr. Henry K. Smith, board certified radiologist and B-reader, interpreted chest x-ray of March 20, 2012, as positive for pneumoconiosis, profusion 1/0 with P/S opacities in the middle and lower lung zones bilaterally. (Petitioner's Exhibit No. 2).

Petitioner signed his Application for Adjustment of Claim herein on July 19, 2012. (AX 2)

Petitioner saw Dr. Glennon Paul on December 3, 2012, at the request of his counsel. (Petitioner's Exhibit No. 1, Plaintiff's Deposition Exhibit No. 2).

On January 30, 2013, at the request of Petitioner's attorney, Dr. Michael Alexander, board certified radiologist and B-reader, interpreted the chest x-ray of March 20, 2012, as positive for pneumoconiosis, profusion 1/0 with P/P opacities in all lung zones. (Petitioner's Exhibit No. 3).

On April 19, 2013, at the request for counsel for Respondent, Dr. Cristopher A. Meyer reviewed chest x-rays for Petitioner dated June 8, 2011, and March 20, 2012. He noted the films were of quality 2 but neither showed coal workers' pneumoconiosis. (Respondent's Exhibit No. 1)

On August 15, 2013, and at the request of Respondent, Petitioner was examined by Dr. Jeff Selby. (Respondent's Exhibit No. 3, dep. ex. 3) Dr. Selby reviewed Petitioner's earlier medical records as well as two chest x-rays dated June 8, 2011 and March 20, 2012. He disagreed with Dr. Paul's impression that Petitioner had CWP and mild COPD. In particular he noted Dr. Paul's description of "maculopapular lesions" as sounding more like a skin rash than chest x-ray B-readings or even non B-readings. He felt it was not standard nomenclature when radiologists and pulmonologists read chest x-rays. He noted that multiple chest x-rays read by the most credible B-readers had found no evidence of CWP in Petitioner through the time of his exam. A high resolution CT scan of Petitioner's chest demonstrated incompatability for Petitioner to have CWP. Dr. Selby also noted that Petitioner lacked any obstruction by his FEV1/FVC and thus, there was no chronic obstructive pulmonary disease. Petitioner's diffusion capacity was in the normal range when tested by Dr. Selby. Dr. Selby read both the 2011 and 2012 chest x-rays as negative for CWP and he noted their quality as "2." Dr. Selby further authored an addendum recording that he telephoned Petitioner to advise him that a nodule was seen on the CT scan and that it had a very high probability of being benign due to calcium deposits. Petitioner replied that he would be seeing someone at the VA Center in several months and would get a follow-up CT scan.

On August 16, 2013 Dr. Meyer was deposed. Dr. Meyer has been board certified in radiology since 1992. (Respondent's Exhibit No. 1, p. 7). Dr. Meyer has been a B-reader since 1999. (Respondent's Exhibit No. 1, p. 19). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot who was on the original committee that developed the training course which was called the B-reader Program. (Respondent's Exhibit No. 1, pp. 19-21). Dr. Meyer has recently been asked to have a more active academic role with the B-reader course. (Respondent's Exhibit No. 1, p. 32). Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion radiologists have a better sense of what the variation of normal is. (Respondent's Exhibit No. 1, pp. 34-35).

Dr. Meyer testified that he reviewed chest x-rays for Petitioner dated June 8, 2011 and March 20, 2012. He felt both films were quality 2. The 2011 examination was improperly positioned and there was a scapula overlap. The 2012 examination had poor contrast. Dr. Meyer found both films to be interpretable for pneumoconiosis. (Respondent's Exhibit No. 1, p. 40). Dr. Meyer testified that there were no findings of coal workers' pneumoconiosis on these chest x-rays. (Respondent's Exhibit No. 1, pp. 40-41).

Dr. Meyer testified that the B-reader looks at the films of the lung to decide whether there are any small nodular opacities or linear opacities and based on the size or appearance of the small opacities, they are given a letter score. (Respondent's Exhibit No. 1, p. 22). Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. (Respondent's Exhibit No. 1, pp. 28-29). The distribution of opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. (Respondent's Exhibit No. 1, pp. 22-23). The last component of the interpretation is the extent of the lung involvement or the so-called profusion. (Respondent's Exhibit No. 1, p. 23). Dr. Meyer testified that the profusion defines the density of the small opacities in the lung. (Respondent's Exhibit No. 1, p. 30).

Dr. Meyer testified that simple pneumoconiosis typically will not progress once exposure ceases. Dr. Meyer saw no evidence of bulla or hyperinflation on the chest x-rays that he reviewed. (Respondent's Exhibit No. 1, p. 87). Dr. Meyer testified that the study by Laney and Petsonk he was questioned about was not done to address the early disease process. The abstract which was first published alluded to findings for individuals in the early disease process where fewer than all lung zones were involved. With regard to early disease it found an upper zone predominance involving round opacities. (Respondent's Exhibit No. 1, p. 88).

Medical records of the VA Medical Center were admitted into evidence. Petitioner's first visit was on August 21, 2013. On that date he was complaining of a dry skin lesion on the right forearm. He denied any problems with shortness of breath He had a history of heart murmur, irregular heartbeat, hiatal hernia and chronic seasonal allergies. Review of his respiratory system revealed no shortness of breath, cough or phlegm. Examination of the lungs showed bilateral breath sounds clear and equal with no crackles or rhonchi. (Respondent's Exhibit No. 6, pp. 68-72).

Petitioner was seen at Primary Care Group on September 16, 2013, complaining of shortness of breath and reported that he had worked in the coal mines for a long time. He gave an onset of his symptoms "years ago" and he described same as worsening. His symptoms were exacerbated by walking, exercise and allergenic exposure. Petitioner denied cough. His oxygen saturation was 96% on room air. Physical examination of the chest revealed no adventitious sounds. The doctor's assessment was probable pneumoconiosis. (Respondent's Exhibit No. 5, pp. 8-9).

Petitioner was seen again at the VA Medical Center on February 21, 2014. A review of Petitioner's respiratory system showed no shortness of breath, cough or phlegm. Physical examination of the lungs showed bilateral breath sounds clear and equal with no crackles or rhonchi. (Respondent's Exhibit No. 6, pp. 55-58). Petitioner was seen on August 26, 2014, for a cardiology consult. He had a history of a murmur and episodes of lightheadedness. It was noted that he had been working construction during the summer and had no exertional complaints. He had no recent change in exercise tolerance. (Respondent's Exhibit No. 6, p. 32).

The VA Medical Center telephoned Petitioner on August 22, 2014 regarding an appointment. Petitioner advised that he had been very busy with mine work under his home. (RX 6)

Petitioner was seen at the VA Medical Center on August 26, 2014 for his heart murmur, hypertension, and cholesterol. Petitioner denied any shortness of breath. He reported being very active and climbing stairs without any issues. He further reported that if he had to, he could run a short distance. Petitioner said he had been performing lots of physical labor working on his house after the recent sinking of one end of his house. (RX 6)

Petitioner returned to Primary Care Group on January 20, 2015, to discuss a CT scan performed on August 15, 2013, which revealed a lung mass in the right upper lobe. He had not followed up regarding the mass after August 2013. At this visit review of systems respiratory was marked as negative. Physical examination of the chest and lungs showed normal and symmetrical movements, no use of accessory muscles in breathing and no adventitious sounds. (Respondent's Exhibit No. 5, pp. 3-4).

Petitioner returned to Primary Care Group on May 14, 2015, for an initial Medicare preventive exam. His review of his respiratory system did not reveal any difficulty breathing. He had no adventitious sounds on examination of the chest. He had no diagnoses of a pulmonary or respiratory nature. (Respondent's Exhibit No. 5, pp. 1-2).

The deposition of Dr. Glennon Paul was taken on June 8, 2015. Dr. Paul is board certified in allergy, immunology and asthma. (Petitioner's Exhibit No. 1, p. 9). Dr. Paul testified that when he did his fellowship in 1970 to 1972, there were not any pulmonary fellowships developed. (Petitioner's Exhibit No. 1, p. 10). Dr. Paul testified that he reads 100 chest x-rays a week and interprets the same number of pulmonary function tests. (Petitioner's Exhibit No. 1, pp. 7-8). Dr. Paul is not board certified in pulmonary medicine. (Petitioner's Exhibit No. 1, p. 48). Dr. Paul is the chief medical officer of the Central Illinois Allergy and Respiratory Service.

Dr. Paul testified that on physical exam, Petitioner had two plus wheezes on forced expiration only. This is one of the physical findings one would see in someone who has obstructive airways disease. (Petitioner's Exhibit No. 1, p. 12). Dr. Paul noted a minimal obstruction on pulmonary function testing and decreased carbon monoxide diffusing capacity. He related the diffusing capacity reduction to either emphysema or coal workers' pneumoconiosis. Dr. Paul testified that he diagnosed Petitioner with COPD which would encompass emphysema. (Petitioner's Exhibit No. 1, pp. 12-13). Dr. Paul did not find restrictive lung disease in Petitioner. (Petitioner's Exhibit No. 1, p. 14).

Based on all the data that he had, Dr. Paul concluded that Petitioner has coal workers' pneumoconiosis caused by coal dust. He also had emphysema and COPD caused by the coal dust environment. Dr. Paul's diagnosis of coal workers' pneumoconiosis was based, at least in part, on his reading of the chest x-ray. (Petitioner's Exhibit No. 1, pp. 14-15). Dr. Paul testified that a negative chest x-ray reading for pneumoconiosis could not rule out the existence of coal workers' pneumoconiosis. He testified that it might be found on biopsy or autopsy. (Petitioner's Exhibit No. 1, p. 15).

Dr. Paul testified that in light of his diagnoses of pneumoconiosis, COPD, emphysema and reduced diffusing capacity, Petitioner could have no further exposure to the environment of a coal mine without endangering his health. (Petitioner's Exhibit No. 1, p. 16). Dr. Paul testified that Petitioner had clinically, radiographically, and physiologically significant pulmonary impairment which was caused by his exposure to coal dust. (Petitioner's Exhibit 1, pp. 17 & 18) In order to have coal worker's pneumoconiosis you must have, in addition to coal mine dust deposited in your lungs, a tissue reaction. That tissue reaction can be called scarring or fibrosis. That scarring of coal worker's pneumoconiosis cannot perform the function of normal healthy lung tissue. (Id.,

pp. 19, 20) Dr. Paul testified that by definition if one has coal workers' pneumoconiosis, he has an impairment of the function of the lung at the site of the scarring whether it can be measured by spirometry or not. (Petitioner's Exhibit No. 1, p. 20).

Dr. Paul testified that by definition if you have coal worker's pneumoconiosis, you necessarily have some impairment in the function of the lung at the site of the scarring whether it can be measured by spirometry or not. (Id., p 20) Dr. Paul testified that a person can have radiographically significant coal worker's pneumoconiosis and not have shortness of breath. He can also have normal pulmonary function studies, normal blood gases, and normal physical examination and still have radiographically significant coal worker's pneumoconiosis. (Id. p 24) Coal worker's pneumoconiosis is considered a progressive disease that can be life threatening. (Id., p 24) Coal worker's pneumoconiosis has no cure. (Id. p 24) If a coal worker has coal worker's pneumoconiosis and ends his exposure in the coalmine, it can still progress. (Id., pp. 24 & 25) There is no way to stop the progression of coal worker's pneumoconiosis. (Id., p 25) Dr. Paul listed other exposures in the coalmine other than coal dust that can injure the lungs. These include silica, diesel fumes, fumes from other petroleum products, smoke and fumes from high sulfur coal fires, smoke and fumes from electrical cable fires, fumes from the glues used in the roof bolting process, and welding fumes. (Id., p 26)

While Dr. Paul has done evaluations for the coal companies over the years, he also acknowledged that he has seen hundreds of individuals at the request of Petitioner's counsel over a period of years. In the past he has seen as many as 50 individuals a year for Petitioner's counsel. (Petitioner's Exhibit No. 1, pp. 40-41). Petitioner related to Dr. Paul shortness of breath with exertion. He testified that there are causes for shortness of breath other than lung disease. Petitioner was not taking any breathing medications and did not provide to Dr. Paul a past history of having taken breathing medications. (Petitioner's Exhibit No. 1, p. 43). Dr. Paul reviewed no treatment records. Petitioner did not relate to Dr. Paul any cough or sputum. Petitioner did not tell Dr. Paul he retired at the time he did due to a breathing problem. Dr. Paul did not know why Petitioner left mining when he did. (Petitioner's Exhibit No. 1, pp. 43-44). Dr. Paul testified that simple coal workers' pneumoconiosis typically does not have symptoms. More likely than not, the disease will not progress once the exposure ceases. Dr. Paul had no pathologic evidence of pneumoconiosis in Petitioner. (Petitioner's Exhibit No. 1, pp. 44-45).

Dr. Paul did not know the date of the chest x-ray that he reviewed. He testified that the opacity type present was "coal". He indicated that there was a greater lower lung involvement in Petitioner's film. (Petitioner's Exhibit No. 1, p. 45). Dr. Paul did not give the film a profusion rating. (Petitioner's Exhibit No. 1, p. 46). Dr. Paul has not taken the B-reading course or the exam to be certified as a B-reader. (Petitioner's Exhibit No. 1,

p. 47). Dr. Paul testified that in the B-reader course they do not teach one to tell if a person has coal workers' pneumoconiosis or not. He testified, "They just kind of tell you how to count spots." (Petitioner's Exhibit No. 1, pp. 46-47). With regard to the diffusion capacity testing performed on Petitioner, Dr. Paul did not know the inhalation time for the tracer gas. He did not know what the hold time was for the tracer gas. (Petitioner's Exhibit No. 1, p. 47). He did not know the expiration time or the inspiration volume for the tracer gas. (Petitioner's Exhibit No. 1, p. 48).

The deposition of Dr. Jeff Selby was taken on August 11, 2015. Dr. Selby is board certified in internal medicine and pulmonology. He has been a B-reader since 1985. (Respondent's Exhibit No. 2, p. 3). Dr. Selby has a general pulmonology practice that entails both inpatient and outpatient. He does all manner of consultation work as far as chest, lungs or breathing disorders. His practice also encompasses occupational lung disease including individuals with coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, pp. 4-5). Dr. Selby testified that the board certification of pulmonary disease was first recognized in 1941. (Respondent's Exhibit No. 2, p. 25).

Petitioner reported to Dr. Selby that his last day of work in the mines was in September 2011. On his last day he worked a regular day as maintenance foreman. He had no shortness of breath or respiratory complaints that day. Petitioner reported to Dr. Selby that after the mines he went to college for welding and hydraulics and had done a lot of welding since leaving the mines. Petitioner's chief complaint was "I want my breath back." (Respondent's Exhibit No. 2, p. 9). Petitioner stated that he had not had "good air" for five years. He could walk about one mile at his own pace, which was slow. He noticed his shortness of breath usually with exertion. He also noticed it when walking the dog at about the quarter mile mark. He reported that he could make it up one flight of stairs. He had a rare cough but produced no sputum. (Respondent's Exhibit No. 2, pp. 9-10). Petitioner reported to Dr. Selby that he injured his elbow in July 2011, when he fell at home putting in a pool liner. He waited on surgery until September 2011, when he decided to retire. (Respondent's Exhibit No. 2, p. 10). Petitioner reported that he started smoking at age 18 and stopped at age 25. He smoked less than one pack a day. (Respondent's Exhibit No. 2, p. 11).

Dr. Selby conducted a physical examination. Petitioner was breathing easily at rest. His pulse oximetry was 98% on room air. His BMI was 29.1, placing him in the overweight category. His chest exam showed clear lung sounds. (Respondent's Exhibit No. 2, p. 12).

Dr. Selby ordered a chest x-ray and performed a B-reading on same. Dr. Selby found the film to be quality 3 due to overexposure. He found no parenchymal or pleural abnormalities consistent with pneumoconiosis. The chest x-ray was completely negative.

(Respondent's Exhibit No. 2, pp. 12-13). Dr. Selby also reviewed outside films dated June 8, 2011, and March 20, 2012. Dr. Selby found no parenchymal or pleural abnormalities consistent with pneumoconiosis on these outside films. (Respondent's Exhibit No. 2, Deposition Exhibit No. 3). A high resolution CT of the chest was completed on August 15, 2013, and read by Dr. Anthony Perkins, a board certified radiologist. Dr. Perkins found no evidence of coal workers' pneumoconiosis. There were several scattered three to four millimeter non-calcified nodules in the chest. There was a 5x8 millimeter somewhat spiculated-appearing nodule in the right upper lobe abutting the major fissure. There appeared to be some central punctate calcification although there was no additional evidence of granulomatous change in the chest. There was also a four millimeter non-calcified nodule which abutted the major fissure. Dr. Selby also read the CT of the chest and found no evidence of coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, pp. 13-14).

A complete pulmonary function study was conducted by Dr. Selby. The interpretation was normal spirometry without change post bronchodilator, normal lung volumes and normal diffusion capacity. (Respondent's Exhibit No. 2, p. 14). Petitioner also underwent an exercise test. The test was stopped due to him completing all seven stages of Naughton. Petitioner stated he felt slightly short of breath. His arterial blood gases drawn at rest and at peak exercise were normal. (Respondent's Exhibit No. 2, pp. 14-15). With regard to his EKG findings, he had a sinus arrhythmia which was not anything serious. The possibility of a left atrial enlargement was noted on his EKG which could indicate certain strains on the chambers of his heart. Dr. Selby testified that often times an enlarged atrium will lead to atrial fibrillation which can cause a significant shortness of breath in some individuals. Petitioner did not have a past history of that and was not taking any medication related to same. (Respondent's Exhibit No. 2, pp. 15-16).

Dr. Selby testified that for a proper B-reading, one needs to use the standard issue films for NIOSH in a side by a side comparison for most accuracy. Dr. Selby testified that the date of the film, the opacity type, the lung zone involvement as well as the profusion are noted. (Respondent's Exhibit No. 2, pp. 16-17). Dr. Selby testified that in the B-reading course it takes about two days of constant reading of x-rays, listening to leaders in the field that are assigned the role of teaching how to perfoerm a B-reading and then the testing to prove whether or not one really understands how to read the x-ray properly. He testified that it is more than just counting spots. (Respondent's Exhibit No. 2, p. 17).

Dr. Selby testified that Petitioner had a diffusion capacity of 85%. For a valid diffusion capacity test, the subject has to be properly coached. The inhalation has to be 85% of the best forced vital capacity in a two-second inhalation, a breath hold from nine to eleven seconds and then a smooth exhalation. Dr. Selby testified that if the testing is not performed in that fashion, then the validity of the test is called into question.

(Respondent's Exhibit No. 2, p. 18). Dr. Selby testified that if scarring of the lungs due to dust exposure results in a reduction in an individual's diffusion capacity that is permanent. He would not expect it to disappear with time. (Respondent's Exhibit No. 2, p. 19).

Dr. Selby testified that if the Guides to the Evaluation of Permanent Impairment, Pulmonary System Sixth Edition is applied to the results he obtained from spirometry on Petitioner, as well as a diffusion capacity being at 85%, he would fall in a Class zero. Dr. Selby testified that Petitioner had no evidence of either an obstruction or a restriction. (Respondent's Exhibit No. 2, pp. 21-22). Dr. Selby concluded that Petitioner did not suffer from any respiratory or pulmonary abnormality as a result of coal mine dust inhalation or coal mine employment. Dr. Selby noted that Petitioner's obesity contributed to his shortness of breath. He also testified that Petitioner had clinical sleep apnea which may lead to pulmonary hypertension which can cause shortness of breath. The shortness of breath Petitioner experienced was not associated with any objective evidence connected to a respiratory mechanism. He was able to complete all seven stages of a Naughton exercise test, indicating normal cardiopulmonary function. Dr. Selby noted that the scarring seen on Petitioner's chest x-ray was likely due to histoplasmosis which is extremely common in the Ohio Valley and has no clinical significance regarding gas exchange. (Respondent's Exhibit No. 2, pp. 22-23).

Dr. Selby also reviewed treatment records from 1996 to 2012. In those records he never saw a diagnosis of COPD or emphysema. He testified that there was no record of pathologic evidence of coal workers' pneumoconiosis in Petitioner. (Respondent's Exhibit No. 2, p. 24). Dr. Selby testified that when he looked at Petitioner's treatment records, there were episodes of bronchitis, but it was not a daily issue. He testified that when Petitioner had episodes of bronchitis, no doubt he did produce sputum but those were episodes not the normal. (Respondent's Exhibit No. 2, pp. 50-51).

Dr. Selby testified that for a person to have coal workers' pneumoconiosis, in addition to having coal mine dust in the lungs, a tissue reaction is required. This tissue reaction is called scarring or fibrosis. Dr. Selby testified that by definition if a person has pneumoconiosis, he would necessarily have impairment in the function of his lung at the very site of this scarring whether that impairment could be measured by spirometry or not. (Respondent's Exhibit No. 2, pp. 25-26).

Dr. Selby testified that removal from any further exposure to coal dust is the only treatment for coal workers' pneumoconiosis. He testified that if a person continues his exposure after he has pneumoconiosis, it is a chronic, slowly progressive disease. (Respondent's Exhibit No. 2, p. 30). Dr. Selby testified that if a coal miner leaves the coal mine environment with category 1 pneumoconiosis and does not have any more exposure, in the vast majority of cases pneumoconiosis does not progress. (Respondent's Exhibit

No. 2, p. 31). Dr. Selby testified that if an individual had category 1 radiographic coal workers' pneumoconiosis, he probably would not be having abnormal pulmonary function tests or blood gases or physical examination of the chest or even symptoms. (Respondent's Exhibit No. 2, pp. 32-33).

Dr. Selby disagreed with the literature cited in the Federal Register of December 2000, concerning the incidence of obstructive lung disease for coal mine dust inhalation. He testified that the global literature was being applied to a specific region of our country, and it was never intended for that. Dr. Selby testified that his experiences were from the tristate region where he sees nothing near the degree of obstruction purely from coal mine exposure as what is purported to occur in the literature from the international studies. (Respondent's Exhibit No. 2, pp. 35-37). Dr. Selby testified that in the course of treating hundreds or thousands of coal miners over the last 25 years, it is rare that someone has chronic obstructive pulmonary disease purely from coal mining. (Respondent's Exhibit No. 2, p. 37).

Petitioner was seen at the VA Medical Center on October 15, 2015, for a routine cardiac consultation. Petitioner's pulmonary system showed no evidence of dyspnea, cough, or wheezing. Physical examination of Petitioner's lungs showed that they were clear bilaterally. It was noted that Petitioner was physically active with landscaping activities around his home and had no cardiovascular complaints. He reported that he had shortness of breath on exertion but stated he had no change in his shortness of breath over the past several years. (Respondent's Exhibit No. 6, pp. 2-10).

Petitioner's case proceeded to arbitration on December 9, 2015. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that he lives in Galatia, Illinois. He was 65 years old at the time of arbitration. Petitioner graduated from high school and went to maintenance school at Rend Lake College for approximately six months. He completed the program in welding and hydraulics. Petitioner served in the U.S. Marine Corp from 1968 through 1970 as a rifleman and machine gunner. He was on active duty in Vietnam. Petitioner worked almost 40 years in the coal mine with all of those years being underground. He testified that in addition to coal dust, he was regularly exposed to and breathed silica dust, roof bolting glue fumes and diesel fumes.

Petitioner's last day working in the coal mine for Respondent was September 11, 2011. He was 61 years of age on that date and his job classification was that of maintenance foreman. He testified that he was exposed to coal dust on that day. Petitioner testified that September 11, 2011 was his last day working in the coal mine because he had injured his arm in a fall at home and it needed to be surgically repaired. Petitioner had surgery on

September 13, 2011. He retired on January 27, 2012. Petitioner further testified that after he got his arm fixed, he decided not to go back to work because he thought he was losing his edge. He testified that his health was starting to dwindle and it was time for him to get out. He testified that he wanted out of the dust and away from the hazards. According to Petitioner, part of his health concerns was related to his breathing.

Petitioner started his coal mining career on March 1, 1972, at Old Ben 21. He worked there as a belt shoveler for about six months. Petitioner then became a shuttle car operator which is the vehicle that takes the coal from a continuous miner at the face and dumps it on the belts. After a year as shuttle car operator, he moved to being a continuous miner operator which involves cutting the coal from the face of the mine. After about six months on the continuous miner, Petitioner took a job in maintenance. He was responsible for repairing machines and equipment in the mines. After that he went to work on the longwall. The longwall has a wheel on each end. There is a five foot drum on each end of the shear. It is 50 feet long and there is a conveyor that runs the entire length of the 1,200 to 1,400 foot face. The shear knocks the coal off the face and it falls onto the conveyor which takes it to the belt which then runs it out of the coal mine. He worked on the longwall for approximately nine years at Old Ben and then took a job with Kerr McGee which became Respondent. At Respondent he worked in maintenance and in the last few years took a maintenance foreman position out by the longwall.

Petitioner testified that he first noticed breathing problems at least ten years before he left coal mining. He noticed shortness of breath. He testified that the longwall is very demanding, physically heavy work. It mandates that one be in fairly good shape. Petitioner testified that from the time he first noticed breathing problems until he left the mine, they got worse. He testified that his breathing problems have gotten worse since leaving the mine. He really notices the breathing problems when it is hot. Petitioner testified that he could climb three or four flights of stairs before having to stop and rest. Petitioner does not take any breathing medication. Petitioner testified that he stays active at home, but his breathing problems limit his level of exertion. Petitioner testified that he has talked to his treating doctor, Dr. Jones, and the physician at the VA, Dr. Patel, about his breathing difficulties. Petitioner testified that he started smoking cigarettes about age 18 and quit at about age 25. Petitioner testified that he smoked about a half pack a day. Petitioner takes medication for high blood pressure and cholesterol.

Petitioner testified that he had surgery in September 2011 to repair the ruptured triceps tendon in his left arm. Following the surgery he went through physical therapy and rehabilitation. Petitioner signed a resignation from employment at Respondent on January 27, 2012. He could not recall if he had been released to return to work regarding his arm at that time. Petitioner testified that he has never worked in a construction business. He testified that the entry in the chart in the VA Medical Center in August 2014

regarding him working construction may have referred to some work he was doing on a building at his home. Petitioner testified that he likes hot rods and he piddles around on his cars.

The Arbitrator concludes:

1. Petitioner has failed to prove by a preponderance of the evidence that he sustained an occupational disease arising out of and in the course of his employment. In so concluding the Arbitrator finds the B-readings by Drs. Meyer and Selby as well as the independent NIOSH B-readers to be more persuasive. In particular the Arbitrator finds the testimony of Dr. Meyer insightful, informative and persuasive. His background and experience in radiology, B-reading and coal workers' pneumoconiosis were impressive and beyond that of Petitioner's physician, Dr. Paul. He explained how difficult it is to determine who is "right" when two B-readers reach different conclusions noting that it is important to make sure that individual reading the films has ample experience in reading them. (Respondent's Exhibit No. 1, pp. 47-48). Dr. Meyer has that experience. Dr. Paul, in contrast, is not a B-reader. While Dr. Paul has purportedly performed many evaluations for coal companies over the years, his extensive number of examinations at the request of Petitioner's counsel in recent years suggests a troubling bias. Furthermore, the doctor made significant concessions regarding his lack of knowledge of specifics regarding Petitioner that undermine the persuasiveness and strength of his opinions.

   The Arbitrator is further troubled by Petitioner's credibility as it may impact his motivation herein. While Petitioner insinuated that one of the reasons he left the mine in September of 2011 was breathing difficulties, the Arbitrator finds little objective corroboration for that testimony. While he testified that he felt his health was dwindling when he left, nothing in the medical records from that time period suggests breathing concerns. He had injured his left arm and needed surgery but he also had a chronic low back condition that was bothering his legs and feet significantly. Furthermore, medical records subsequent to his retirement and, separate and apart from the examinations he was attending as part of his claim herein, indicate he was a physically active man post-retirement with no issues stemming from shortness of breath. With the exception of an isolated visit to his primary care doctor in September of 2013 Petitioner's other medical records (the VA Medical Center records from 2013 and 2014) indicate an active gentleman with no exertional problems. Petitioner indicated he was doing construction, working on his house, could easily climb stairs, and could run if he needed to. The Arbitrator gives more weight to these medical entries

than Petitioner's arbitration testimony as the latter may have been motivated to support his claim.

2. Petitioner has failed to prove by a preponderance of the evidence that his current condition of ill-being is causally connected to his employment.

3. Petitioner has failed to prove by a preponderance of the evidence that he suffered a timely disablement under Section 1(f) of the Occupational Diseases Act.

4. Petitioner's claim for compensation is denied and no benefits are awarded.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gertrude Birkhead,
Petitioner,

17IWCC0596

vs.

NO: 15 WC 21233

Northrop Grumman Systems Corp.,
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, permanent disability, causal connection, evidentiary ruling and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 6, 2016, is hereby affirmed and adopted.

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

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

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

SEP 29 2017

DATED:
o8/31/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0596

BIRKHEAD, GERTRUDE
Employee/Petitioner

Case# **15WC021233**

NORTHROP GRUMMAN SYSTEMS CORP
Employer/Respondent

On 9/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

1315 DWORKIN AND MACIARIELLO
GERALD CONNOR
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

0507 RUSIN & MACIOROWSKI LTD
KISA P STHANKIYA
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

17IWCC0596

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Gertrude Birkhead
Employee/Petitioner

Case # 15 WC 21233

v.

Consolidated cases: D/N/A

Northrop Grumman Systems Corp.
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 7/18/16. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☐ What temporary benefits are in dispute? [Petitioner waived TTD and Respondent waived credit for short-term disability payments. Arb Exh 1.]

L. ☒ What is the nature and extent of the injury?

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☒ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On 5-27-15, Respondent was operating under and subject to the provisions of the Act.

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

Petitioner claims an accident of May 27, 2015. Respondent stipulated the accident occurred in the course of Petitioner's employment. For the reasons set forth in the attached decision, the Arbitrator finds Petitioner lacked credibility and failed to establish that the accident arose out of her employment. The Arbitrator views the issues of medical expenses and permanency as moot and makes no findings as to those issues. Compensation is denied.

Timely notice of this accident was given to Respondent.

In the year preceding the injury, Petitioner earned $114,972.00; the average weekly wage was $2,211.00.

On the date of accident, Petitioner was 68 years of age, married, with 0 children under 18.

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 $87,916.41 under Section 8(j) of the Act, as stipulated by the parties. Arb Exh 1.

ORDER

The Arbitrator, having found that Petitioner failed to establish her accident arose out of her employment, awards no benefits in this case. The Arbitrator declines to award Respondent credit for a $600 "no show" fee charged by Dr. Vinci, Respondent's Section 12 examiner.

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

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

Molly C Mason

Signature of arbitrator

Date 9/2/16

SEP - 6 2016

Gertrude Birkhead v. Northrop Grumman
15 WC 21233

17IWCC0596

Summary of Disputed Issues

Petitioner claims she injured her right ankle when she slipped on some kind of liquid and fell while exiting a bathroom stall at Respondent's facility on May 27, 2015. She seeks an award of medical expenses and permanency. Respondent concedes the accident occurred in the course of Petitioner's employment but maintains it did not arise out of the employment. Respondent seeks credit for a $600 "no show" fee charged by its Section 12 examiner.

Arbitrator's Findings of Fact

Petitioner testified she worked as a subcontract administrative purchaser for Respondent as of May 27, 2015, the date of her accident. On that date, she was working inside Respondent's facility, which she described as huge. She testified the facility is secure and not open to the public. Employees have to present badges to gain admittance.

Petitioner testified there are about twenty bathrooms inside Respondent's facility. She used the bathroom that was closest to her work station. On average, she used this bathroom three to five times per workday. The bathroom was large. It was equipped with about six to eight stalls and six to ten sinks. The floor of the bathroom was not normally wet.

Petitioner testified she typically worked between 6:30 and 4:00 each day. At about 9:30 on May 27, 2015, she slipped while exiting one of the stalls inside the bathroom. She testified she slipped because there was some kind of liquid on the floor. There were no signs inside the bathroom indicating the floor was wet.

Petitioner testified she fell after she slipped, hitting the stanchion inside the stall. She was in tremendous pain and could see that her right foot was 180 degrees "off angle." Paramedics arrived at the scene, applied a boot to her foot and transported her to the Emergency Room at Northwest Community Hospital. She was subsequently admitted to the hospital and underwent surgery on her right ankle the following day.

The paramedic run sheet is not in evidence.

The Emergency Room records from Northwest Community Hospital reflect that Petitioner arrived via ambulance at about 9:57 AM, having been given Fentanyl by paramedics while en route. The records also reflect that Petitioner's blood pressure was "90s/30s" on arrival. The history describes the accident as a "slip and fall in bathroom at work with deformity to right ankle." Petitioner acknowledged having been on a liquid fast for two days but denied passing out or losing consciousness. PX 1, p. 2. The examining physician described Petitioner's right ankle as "grossly deformed." He applied a splint to the ankle, ordered several X-rays and CT scans, along with pain medication and other studies, and later admitted

Petitioner to the hospital. Right ankle X-rays demonstrated a severely comminuted bimalleolar fracture/dislocation with comminuted fractures of the distal tibia and fibula.

Later the same morning, a physician's assistant recorded the following history:

> "Gertrude Birkhead is a 68 y.o. female who was admitted after sustaining an unwitnessed fall while at work this AM. She states that she had been in the bathroom due to abdominal cramping/pain but denies diarrhea or constipation. Over the last two days she has been partaking in the isogenics diet and has been fasting/performing a cleanse which involved consuming only vitamins and liquids x 48h. She denies feeling lightheaded or having palpitations prior to falling. She states she simply tripped. Denies LOC and hitting her head. She complains only of pain in her R ankle which is clearly disfigured.
>
> She received Fentanyl in the field for her ankle fracture and subsequently became hypotensive in the ED. FAST exam is currently negative."

PX 1, p. 14. The physician's assistant assessed Petitioner as having a right ankle fracture as well as "hypotension s/p fall." She indicated she suspected the latter was "related to dehydration from her recent fasting over the last 48h."

Petitioner saw Dr. Benuck, an orthopedic surgeon, on May 28, 2015. Dr. Benuck interpreted the post-reduction right ankle X-rays taken in the Emergency Room as showing a "reduced ankle with still some displacement of the mortise." He recommended an open reduction and internal fixation. He performed this surgery later the same day, inserting a locking plate and screws into Petitioner's ankle.

Petitioner was discharged from the hospital on May 30, 2015. She testified she was not able to move on her own at this point since she was in a cast and unable to bear any weight on her affected foot/ankle. The hospital contacted rehabilitation facilities and identified Alden Terrace as the facility closest to Petitioner's home. Petitioner testified she spent about two weeks at Alden Terrace. PX 8. She identified PX 7 as the bill she received from Alden Terrace. She testified she paid this bill.

Petitioner testified she followed up with Dr. Benuck thereafter and underwent physical therapy at his direction. On August 21, 2015, Dr. Benuck directed her to discontinue the CAM boot and transition to a cane and continue therapy. PX 2. On September 4, 2015, Petitioner complained to Dr. Benuck of persistent right ankle and foot pain as well as right knee pain that had started one week earlier, when she resumed full weight bearing. The doctor obtained right knee X-rays and injected Lidocaine into the knee. He prescribed six weeks of knee therapy and directed Petitioner to follow up with him as needed. On November 13, 2015, Dr. Benuck described Petitioner's right ankle as doing well but noted gastrocnemius weakness. He prescribed additional therapy and directed Petitioner to return to him in six months. He

obtained right ankle X-rays, which showed intact hardware and no widening of the mortise. PX 2. The Accelerated Rehabilitation physical therapy records (PX 3) reflect Petitioner was discharged from therapy on February 5, 2016, but was still complaining of pain and stiffness with rainy weather and when negotiating stairs and hills. The therapist recommended she continue home exercises.

Petitioner testified she was off work from May 27, 2015 until September 2, 2015. Dr. Benuck's chart includes a statement from the doctor dated July 8, 2016 reflecting Petitioner was unable to work during the aforementioned period due to her right ankle fracture. PX 2.

Petitioner testified she is currently 69 years old. She attended college for two years. She previously relied on good health to earn a living. Since the accident, she has experienced pain with every step she takes.

Under cross-examination, Petitioner testified her job duties included purchasing sub-assemblies, such as PC boards with components. Her job was sedentary in nature. She worked at a desk.

Petitioner acknowledged that, during the two days before the accident, she adhered to an "isogenics cleanse" diet, consisting of five protein shakes and several snack bars per day. She did not recall telling hospital personnel she was on this diet.

Petitioner acknowledged having hypertension and Type 2 diabetes before the accident. She testified these conditions were controlled by medication. After the accident, hospital personnel diagnosed her with dehydration and hypotension. It is her belief the hypotension was secondary to pain medication administered by the paramedics. She had a bad reaction to this medication.

Petitioner acknowledged that the bathroom where she fell was cleaned multiple times per day. She also acknowledged there was no defect in the bathroom floor. There is "no question" in her mind that she slipped on some kind of liquid but she does not know what kind of liquid was present. It could have been coffee, since co-workers were known to bring coffee cups inside the bathroom. It also could have been juice or a bodily fluid. She did not notice anything unusual when she entered the stall. The stall was not tiny. She entered on the right side of the stall and was exiting on the left side when she slipped.

Petitioner acknowledged she did not look at her clothes after she fell. She was in too much pain to do this.

Petitioner acknowledged providing a statement to Josh Ruedin, an insurance adjuster, on June 2, 2015. She was aware the statement was recorded. She gave permission for the recording. She did not, however, receive a copy of the statement.

The Arbitrator admitted the transcript of Petitioner's June 2, 2015 recorded statement (RX 1) into evidence over Petitioner's objection. The first page of the transcript reflects that Ruedin advised Petitioner the statement was being recorded and secured her permission for the recording. In the course of the statement, Petitioner indicated she began working for Respondent in 1968. She denied any prior workers' compensation claims against Respondent. RX 1, p. 3. She denied any history of other significant injuries. She acknowledged a history of arthritis, diabetes, hypertension, thyroid removal and gall bladder removal. RX 1, pp. 4-5. She described her job as sedentary and clerical in nature. RX 1, p. 8.

The following exchange occurred in connection with the claimed accident:

"Q: Could you tell me where you were when you were injured?

A: In the bathroom.

Q: OK. Thank you. All right. Um, so now in as much detail as you can provide, can you kind of explain to me what you were doing and how you were injured?

A: I was in the bathroom stall. I opened the door to exit the bathroom stall and one minute I was standing and the next second I was on the floor. So I just, I don't know. It went, it happened so fast I don't know. I don't know if there was water on the floor. I don't know what caused the, the slippage.

Q: OK. Um, all right. So you said you, you slipped, uh, so, uh, did, you didn't trip over anything?

A: No.

Q: OK. Um, and you're unsure if there was water or anything else on the floor?

A: Yeah, do not know.

Q: All right. OK. Um, OK. All right. Uh, and so, uh, just to make sure that I understand correctly and have it documented correctly, um, so you're really not sure what happened to, to cause you to fall, um, you know that you didn't trip on anything, you just know that you were standing, uh, then you fell. That correct?

A: I just slipped, yes. I did not lose consciousness. I didn't faint. I, just normal."

RX 1, pp. 8-9.

Petitioner testified she took voluntary retirement in November 2015, at which point she was 68 years old. She worked for Respondent for 47 years.

Petitioner testified she last saw Dr. Benuck in May 2016. [No records concerning this visit are in evidence.]

Petitioner testified she was not aware that Respondent scheduled an appointment for her to be examined by Dr. Vinci on June 1, 2016. She did not attend this appointment. Had she known of the appointment, she could have attended it, since she is not currently working.

Petitioner testified she resides with her husband. She denied that Northwest Community Hospital recommended she be discharged to home health care. She paid the rehabilitation facility, Alden Terrace, herself because her group carrier, Blue Cross/Blue Shield, refused to pay the bill. Blue Cross/Blue Shield took the position that her policy did not cover care at a rehabilitation facility because she did not require intravenous feedings.

Petitioner denied falling when she slipped in Respondent's hallway. She managed to catch herself on that occasion. She denied having a history of falling at the workplace.

On redirect, Petitioner reiterated she is unsure of the kind of liquid she slipped on. Other Respondent employees use the bathroom where her accident occurred.

Under re-cross, Petitioner reiterated she is unsure whether the liquid was coffee. At the time of the accident, a co-worker was in the bathroom but was in a stall that was several stalls away from her. No one was in her immediate vicinity.

Freddie Celletti testified on behalf of Respondent. Celletti testified he works for Respondent as a physical security specialist. He held the same job in May 2015. If an accident occurred at Respondent's facility, it fell to him or one of his co-workers to examine the accident scene. He was one of the first people to respond to Petitioner's accident. After he learned of the accident, he and a Securitas officer (employed by an outside contractor) went to the bathroom and encountered Petitioner, lying on the floor. Petitioner's feet were sticking outside of a stall. Petitioner's head was on the left side of the stall. Another female was inside the stall where Petitioner was lying. He looked for a hazard such as liquid or a wire but saw nothing. He observed no defects in the floor, no wires, no leaks and no broken fixtures. He exited the bathroom, leaving the Securitas officer and two women behind, so that he could meet the paramedics, who were due to arrive. After the paramedics took Petitioner away, he went back inside the bathroom. No one had entered the bathroom in the interim. He did not recall whether the bathroom door was closed. During his second visit, he again observed no liquid on the floor and no defects such as cracked floor tile.

Celletti testified that the bathrooms inside Respondent's facility are cleaned several times each day.

Celletti identified RX 2 and RX 3 as copies of photographs he took of the bathroom where the accident occurred. He initially testified he did not take these photographs on the day of the accident. The stall where he encountered Petitioner can be seen on the left side of the photograph marked as RX 2. RX 3 is a photograph of this stall. The photograph accurately depicts the condition of the stall after the accident. It shows no leakage and no defects.

Celletti identified RX 4 as an E-mail he sent to Shirley Pawlisz concerning his examination. In this E-mail, Celletti indicated he "did not notice any liquid or skid mark on the floor" when he responded to the women's restroom where Petitioner was lying, having fallen inside a stall. Celletti also indicated he returned to the restroom "for a second look" after Petitioner left with the paramedics and "still noticed no indication of a slip or cause for a slip in the stall."

Celletti testified that, apart from examining the scene, obtaining photographs and sending the E-mail, he was not involved in the investigation of Petitioner's accident. He also did not perform any work on the bathroom. His department does not perform that kind of function.

Under cross-examination, Celletti indicated he cannot recall when he took the two photographs. He does not know the name of the woman who was inside the stall with Petitioner after the accident. Other individuals at Respondent investigated Petitioner's accident. Shirley, who works in the nurse's office at Respondent, headed up the investigation. He was not inside the bathroom before Petitioner fell and did not witness the fall.

On redirect, Celletti distinguished between his role as a first responder and the role of an investigator. He saw no stains on the bathroom floor during either of his two visits.

Respondent also offered into evidence accident-related reports authored by Nicole Heine, R.N., BSN, and Shirley Pawlisz. Both of these reports are dated May 28, 2015. RX 5.

Arbitrator's Credibility Assessment

Petitioner's very lengthy tenure with Respondent weighs in her favor, credibility-wise, but her testimony concerning the cause of her fall is at odds with the recorded statement she provided to an adjuster. Petitioner testified there is "no question" in her mind she slipped on some kind of liquid but, when she talked with the adjuster, only six days after the accident, she admitted she did not know what caused her to slip. The adjuster specifically asked her whether there was water or some other liquid on the bathroom floor. She said she did not know. RX 1.

Freddie Celletti's testimony concerning the two inspections he conducted on the day of the accident was detailed and credible.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident arising out of her employment on May 27, 2015?

There is no dispute that Petitioner's accident occurred in the course of her employment. The issue is whether the accident arose out of the employment. Based on the foregoing credibility assessment, the other relevant evidence and controlling case law (First Cash Financial Services v. Industrial Commission, 367 Ill.App.3d 102 (1st Dist. 2006), the Arbitrator finds that Petitioner failed to meet her burden of proof on this issue. One Emergency Room history reflects that Petitioner slipped in a bathroom at work but the history contains no mention of Petitioner slipping on liquid. Another history describes Petitioner as tripping rather than slipping. The Emergency Room physician found it likely that Petitioner fell due to dehydration resulting from her restricted diet. When Petitioner provided a recorded statement, six days after the accident, she indicated she slipped but admitted she did not know what caused her to slip. She clearly stated she did not know whether there was water or anything else on the floor. At no point in time did Petitioner claim any other possible cause of her accident, such as a defect in the tile. At the hearing, she conceded that the bathroom is cleaned several times per day. Respondent's witness, Freddie Celletti, who twice inspected the bathroom shortly after the accident, credibly testified he saw no liquid on the floor of the stall where Petitioner fell. He also testified he saw no other potential slipping/tripping hazard.

The Arbitrator concludes there is no credible evidence showing that Petitioner slipped due to water or any other liquid on the floor of the employee bathroom. Although the bathroom was in a facility that was not open to the public, there is no credible evidence which would prompt the Arbitrator to conclude that Petitioner's use of the bathroom subjected her to an increased risk of injury.

Having found that Petitioner failed to prove her accident arose out of her employment, the Arbitrator declines to award benefits. Compensation is denied. The Arbitrator clarifies that the accident/incident reports offered by Respondent (RX 5) played no role in her assessment of Petitioner's credibility and denial of benefits.

Is Respondent entitled to a credit for its examiner's claimed $600 "no show" fee?

Respondent claims Petitioner failed to appear for a Section 12 examination with Dr. Vinci and that it is thus entitled to credit for a $600 "no show" fee charged by the doctor. RX 8. The Arbitrator declines to award Respondent credit for this fee. Section 12 of the Act does not contain any provision requiring a claimant who fails an examination to pay such a fee. The only sanction afforded by Section 12 is temporary suspension of compensation benefits until the examination occurs. No other section of the Act contemplates the kind of credit Respondent seeks. Furthermore, Respondent failed to establish it paid Dr. Vinci's fee and the Arbitrator has made no award against which a credit could lie. Also see Antonio Lee v. University of Illinois, 13 IWCC 692, a unanimous decision in which the Commission (Basurto, Gore and Latz) upheld the

Arbitrator's denial of an employer's claim for credit for a Section 12 examination cancellation fee against a permanency award.

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

Catalina Hernandez,
Petitioner,

17IWCC0597

vs.

NO: 15 WC 15279

Legendary Baking,
Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $15,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

SEP 29 2017

DATED:
o8/31/17
DLS/rm
046

David L. Gore

Stephen J. Mathis

17IWCC0597

DISSENT

I respectfully dissent from the Decision of the majority. Petitioner was injured on January 14, 2015 when a rack struck her while she was working at a bakery. On July 14, 2015, Dr. Aribindi performed right shoulder arthroscopy with repair of labral tear, synovectomy, subacromial decompression, and debridement of tendonosis of the bursal surface of the rotator cuff for labral tear, synovitis, and tendonosis. On November 11, 2015, Dr. Aribindi noted that Petitioner continued to progress well. She noted that Petitioner's pain and motion continued to improve and had good motion of the shoulder. She had some limitation of reaching behind her back. Dr. Aribindi encouraged her to continue her home exercise program for increased range of motion and strength, and released her to work at full duty as of November 16, 2015. On December 9, 2015, Petitioner reported occasional discomfort in her shoulder but she had good motion and strength and Dr. Aribindi released her from treatment.

At Arbitration, Petitioner testified she still worked for Respondent. In her day-to-day work activities, she felt a lot of pain in her right shoulder. Her right hand and right side are weaker. She cannot sleep on her right side. She has pain while pushing/pulling, has trouble driving, and cannot clasp her bra because she cannot "push [her] hand all the way back." She was not currently taking prescription pain medication and had not since her return to work. She took two over-the-counter pain medications a day. She had no doctor appointments after Dr. Aribindi released her from treatment and she lost no time at work after she returned.

Dr. Philips performed a medical examination at Respondent's request pursuant to Section 12 of the Act. He opined that Petitioner's shoulder condition was caused by her work accident. He performed an impairment rating under the AMA Guides. He concluded that Petitioner suffered 3% impairment of the right arm, or 2% impairment of the person-as-a-whole. After considering the statutory factors in determining permanent partial disability awards, the Arbitrator awarded Petitioner 55 weeks of permanent partial disability benefits representing loss of 11% of the person-as-a-whole. The majority affirmed and adopted the Decision of the Arbitrator.

In looking at the statutory factors, Dr. Philips rated Petitioner's impairment at 2% of the person-as-a-whole, according to the AMA Guides. Petitioner was able to return to her previous work, which required significant physical activity. She had not established any loss of earning potential. Her current complaints were relatively minor and her medical records indicate she progressed well after surgery and had good strength and good motion. On her last visit, she noted only occasional discomfort in her shoulder. She had an anticipated work-life of 15 years. In analyzing all these factors, as well as the record in its entirety, I would have found Petitioner established permanent partial disability of 7.5% of the person-as-a-whole, and would have modified the award accordingly. For the reasons stated above, I respectfully dissent from the Decision of the Majority.

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

17IWCC0597

HERNANDEZ, CATALINA
Employee/Petitioner

Case# **15WC015279**

LEGENDARY BAKING
Employer/Respondent

On 8/29/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1836 RAYMOND M SIMARD PC
221 N LASALLE ST
SUITE 1410
CHICAGO, IL 60601

2542 BRYCE DOWNEY & LENKOV LLC
KEVIN S BOROZAN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

17IWCC0597

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
***CORRECTED* ARBITRATION DECISION**

Catalina Hernandez
Employee/Petitioner
v.
Legendary Baking
Employer/Respondent

Case # **15** WC **15279**

An *Application for Adjustment 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 IL**, on **May 26, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On **January 14, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$17,946.24**; the average weekly wage was **$330.00**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **3** 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 **$14,495.34** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

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

ORDER

*Respondent shall pay reasonable and necessary medical services of **$473.07** to ATI Physical Therapy, as provided in § 8(a) and §8.2 of the Act.*

*Respondent shall pay Petitioner temporary total disability benefits of **$300.00/week** for **40 & 6/7** weeks, commencing February 2, 2015 through November 15, 2015, as provided in § 8(b) of the Act.*

Respondent shall be given a credit of $14,495.34 for temporary total disability payments that have been paid. Respondent shall have a credit of $965.34 toward permanent partial disability

*Respondent shall pay Petitioner permanent partial disability benefits of **$330.00/week** for **55** weeks, because the injuries caused a permanent partial loss of use of the person-a- a-whole of Petitioner to the extent of **11%** thereof, as provided in §8(d)2 of the Act.*

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

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

Signature of Arbitrator

August 29, 2016
Date

ICArbDec p. 2

AUG 29 2016

Catalina Hernandez v. Legendary Baking
15 WC 15279

INTRODUCTION

Disputed issues included: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; **K:** What temporary benefits are in dispute? TTD; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for reasonable and necessary medical services?; ***L:*** What is the nature and extent of the injury?

The parties stipulated that Petitioner is entitled to Total Temporary Disability from February 2, 2015 through November 15, 2015 and that Respondent paid TTD from November 16, 2015 through December 6, 2015, for which Respondent claims a credit of $965.34.

FINDINGS OF FACTS

On January 14, 2015 Petitioner Catalina Hernandez was a 39 year old packer at Respondent's bakery. Petitioner's job duties consisted of placing pies into boxes by taking them off a waist-level shelf and also from a conveyor belt (RX #2). On that date Petitioner testified that she was moving a rack laden with bags of fruit filling when the rack tilted toward her. She tried to stop the rack from falling on her with her hands. She felt immediate pain in her right shoulder and hand.

Respondent sent Petitioner to Advocate Occupational Medical Center for initial care on January 19, 2015. Dr. Mark Veldman recorded complaints of pain which extended from the right hand to the right shoulder. He noted swelling over the dorsum of the hand. The right shoulder examination showed a positive Yergason's test. Dr. Veldman prescribed applying ice to the right wrist, a wrist brace, occupational therapy; and ibuprofen (PX #1). Dr. Veldman restricted Petitioner to 5 pounds without pushing or pulling and ordered occupational therapy.

At the follow-up exam of February 3, 2015 Petitioner's primary complaint was with her right shoulder. Nurse Practioner Colleen Cardinal found a positive impingement sign and a decreased range of motion. Petitioner was waiting start occupational therapy. She reported working beyond her restrictions. NP Cardinal diagnosed right shoulder strain/impingement and right upper extremity radiculitis. A Medrol Dosepak and Flexeril were prescribed and Petitioner was put on 2 pound restrictions with no overhead duties. When Petitioner failed to show improvement at follow-up examination on March 19, 2015 an MRI was ordered. Petitioner was put on 2 pound restrictions with no overhead duties.

The MRI performed on April 9, 2015 showed a partial thickness tear of the supraspinatus tendon and bursal surface fraying in the supraspinatus through the

infraspinatus tendons. Dr. Veldman reviewed the MRI on April 14, 2015. He noted that Petitioner was not improving with therapy and referred her to Dr. Ram Aribindi who is an upper extremity specialist at Southland Orthopedics (PX #1).

Dr. Aribindi examined Petitioner on April 22, 2015. Petitioner had a decreased range of motion on flexion and abduction and a positive Hawkins sign (PX #2). Dr. Aribindi injected the right shoulder and ordered 4 weeks of physical therapy. Petitioner still had complaints after conservative care. On May 20, 2015 Dr. Aribindi recommended surgery for the right shoulder.

Petitioner received therapy for ATI Physical Therapy (PX #3) April 24 through June 11, 2015. Registration notes show referrals for both Dr. Veldman and Dr. Aribindi.

Dr. Aribindi performed arthroscopic surgery on July 14, 2015, consisting of a repair of a posterior superior labral tear with a suture anchor, a subacromial decompression with acromioplasty and a debridement of the bursal surface of the rotator cuff, and a synovectomy. On July 24, 2015, Dr. Aribindi examined Petitioner and referred her to physical therapy. Petitioner attended 43 physical therapy sessions at ATI from August 3, 2015 to November 5, 2015 (PX #3).

Petitioner had a routine follow-up on October 19, 2015. Dr. Aribindi examined Petitioner in follow up on November 11, 2015. He found 170° of active flexion, 160° to 170° of active abduction, 45° of external rotation and internal rotation to T-12. Dr. Aribindi gave Petitioner a note to return to work without restrictions on November 16, 2015 (PX #2). Petitioner saw Dr. Aribindi for the last time on December 9, 2015 at which time Petitioner demonstrated a full range of active motion of the right shoulder. Dr. Aribindi gave Petitioner a home exercise program for her right shoulder and neck and released her to regular work without restrictions. Petitioner testified that she has not had any medical attention to her right shoulder since December 9, 2015.

Petitioner claimed a balance of $473.07 remaining on the bill of ATI Physical Therapy (PX #4). Respondent did not dispute responsibility for the bill and that the bills had been submitted for payment pursuant to the fee schedule or negotiated amount.

Petitioner testified that she continues to work for Respondent. She has "lot of pain" in her right shoulder and she does not have the same strength as before the accident. Her right shoulder hurts when she has to push things. Petitioner testified that she can't sleep on her right side and she cannot put her right hand behind her when getting dressed.

Orthopedic surgeon Dr. Craig Phillips performed a §12 examination of Petitioner's right shoulder on December 29, 2015(RX #2). Dr. Phillips found active flexion of 170° with pain and 130° of active abduction with pain. Petitioner had full range of passive motion. The provocative tests, Neer, Jobe, Speed, Yergason, and O'Brien, were all negative. Dr. Phillips noted that Petitioner's range of motion appeared limited due to some degree of pain and seemed less than when she last saw Dr. Aribindi.

Dr. Phillips diagnosed a posterior superior labral tear as well as a rotator cuff injury. He opined that these injuries were causally related to petitioners work accident on January 14, 2015. He found that Petitioner's subjective complaints were consistent with the objective findings. He further opined that Petitioner had received all appropriate and necessary medical care. Finally, Dr. Phillips opined that Petitioner was at MMI and could return to work without restrictions.

Dr. Phillips provided an AMA rating based only on the labral repair because her pathology "relates primarily to the labral tear". Dr. Phillips concluded that Petitioner had a 3% upper extremity impairment, which correlates with a 2% whole body impairment rating.

CONCLUSIONS OF LAW

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

This issue was not genuinely disputed. The chain of events connecting petitioner's objective injury to the work accident was sufficient circumstantial evidence to prove causation. Moreover, Dr. Phillips, Respondent's §12 examiner, opined that there was a causal connection between the accident and Petitioner's torn right labrum. He also opined that the degenerative tendinopathy in Petitioner's right shoulder became symptomatic and required surgery as a result of the accident.

The Arbitrator finds that Petitioner's current condition of ill-being regarding her right shoulder is causally related to the January14, 2015 work-related injury.

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

Petitioner claimed an unpaid balance of $473.07 for services rendered at ATI Physical Therapy. Respondent has accepted responsibility for the bill, stipulating that the bill would be resolved with ATI per the fee schedule or a lesser negotiated amount.

The Arbitrator finds that Respondent is liable, pursuant to § 8(a) and §8.2 of the Act, for payment of the outstanding balance of $437.07 of ATI Physical Therapy.

K: What temporary benefits are in dispute? TTD

The parties stipulated that Petitioner was temporarily totally disabled from February 2, 2015 through November 10, 2015. The disputed period of TTD is the five days from November 11, 2015 through November 15, 2015. Dr. Aribindi examined Petitioner on November 11, 2015 and stated that she could return to work without restrictions (PX #2). He also gave Petitioner on that date a document labeled "Doctor's Report of Work Status and Restrictions". The document states "[R]eturn to work without restrictions, starting November 16, 2015".

The Arbitrator views the Work Status form given to Petitioner on November 11, 2015 as clarification of the undated return to work stated in the chart note for that date.

The Arbitrator finds that Petitioner was temporarily totally disabled from February 2, 2015 through November 15, 2015, a period of 40 & 6/7 weeks.

L: What is the nature and extent of the injury?

The Arbitrator evaluated Petitioner's permanent partial disability is accord with §8.1b(b):

(i) Respondent submitted in evidence the AMA impairment rating of 2% of whole body as determined by Respondent's expert, Dr. Craig Phillips. The Arbitrator notes that Dr. Phillips examined Petitioner only one time, and then on retained for Respondent. The Arbitrator that Dr. Phillips' retainer by one of the parties in this matter may have engendered a bias in the subjective component of Dr. Phillips' assessments. The Arbitrator gives this factor moderate weight.

(ii) Petitioner worked as a packer at the time of her accident. She has since returned to that job. The Arbitrator gives this factor greater weight.

(iii) Petitioner was 39 years old at the time of the accident. She had a statistical life expectancy of approximately 45 years and a worklife expectancy of 13 years. Petitioner still has occasional complaints with her work. It is likely those complaints will extend beyond her worklife. The Arbitrator therefore gives greater weight to this factor.

(iv) There was no evidence that Petitioner's earning capacity was affected by her injury. The Arbitrator gives no weight to this factor.

(v) Evidence of Petitioner's disability was corroborated by the treating medical records. Petitioner's testimony regarding her current condition was credible. The Arbitrator notes that Petitioner's subjective complaints of were consistent with the objective nature of her injury, the surgery, and the physical nature of her job. Further, Dr. Phillips' found that the subjective complaints were concordant with the objective findings. The Arbitrator therefore gives great weight to this factor.

Based on the above factors, the nature of the surgery performed and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 11% loss of use of the person-as-a-whole pursuant to §8(d)2 of the Act, 55 weeks at PPD rate of $330.00/week.

Steven J. Fruth, Arbitrator

July 22, 2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stephen Hayward,
Petitioner,

17IWCC0598

vs.

NO: 14 WC 14308

Eastern Illinois University,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 10, 2017, is hereby affirmed and adopted.

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

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

DATED: SEP 29 2017
o8/31/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAYWARD, STEPHEN
Employee/Petitioner

Case# **14WC014308**

17IWCC0598

EASTERN ILLINOIS UNIVERSITY
Employer/Respondent

On 3/10/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1727 LAW OFFICE OF MARK N LEE LTD
KEVIN MORRISON
1101 S SECOND ST
SPRINGFIELD, IL 62704

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

1368 ASSISTANT ATTORNEY GENERAL
CHRISTINA SMITH
500 S SECOND ST
SPRINGFIELD, IL 62706

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

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

MAR 10 2017

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

17IWCC0598

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
NATURE AND EXTENT ONLY

Stephen Hayward
Employee/Petitioner

v.

Eastern Illinois University
Employer/Respondent

Case # 14 WC 014308

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **January 19, 2017**. By stipulation, the parties agree:

On the date of accident, **7/25/2013**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**40,924.52**, and the average weekly wage was $**1,354.70**.

At the time of injury, Petitioner was **53** years of age, ***married*** with **1** dependent children.

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

Respondent shall be given a credit of $**108,639.48** for TTD, $**0** for TPD, $**49,287.88** for maintenance, and $**0** for other benefits, for a total credit of $**157,927.36**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner permanent and total disability benefits of $903.58/week for life, commencing 1/19/2017, 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.

Respondent shall pay reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act and per the stipulation of the parties, subject to any credit pursuant to Section 8(j).

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

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

D. Dyan McCarty

2/20/2017

Signature of Arbitrator

Date

MAR 10 2017

Statement of Fact

Petitioner testified he is 56 year old roofer out of Local 92 with a high school education. Since 2000, Petitioner worked for Respondent as a roofer. Prior to working for Respondent, Petitioner worked as a roofer with King Lar and had been a union roofer since 1985. Prior to 1985 Petitioner did odd jobs and factory work.

Petitioner's job as a roofer concentrated on commercial work with flat roofs and big buildings. Petitioner described his job as heavy in nature with constant lifting and bending over. Petitioner testified his job required him to cut roofs off and tear the flashing and insulation out and then replace said roofing and insulation. Petitioner would lift pieces of rubber that weighed 45-50 pounds apiece and install flashing. Petitioner described his job as seasonal and would be laid off depending on the weather, especially in the winter.

On July 25, 2013, Petitioner was working for Respondent and described that he was working on flashing that day and lifting it up into a wheelbarrow and he felt his left shoulder pop and crunch. Petitioner testified that the flashing weighed 50 to 60 pounds. Petitioner reported his injury to his foreman and waited for a week before treating with a doctor on a Monday. He was then sent to Bonutti Clinic.

The first date of treatment from Bonutti Clinic, with a Dr. Lee, reflects that Petitioner was seen on September 18, 2013, and reported an injury date of July 25, 2013. The history notes that Petitioner was lifting flashing and weight when he heard a crunch in his left shoulder. The plan at that time was to order an MRI and the physical findings of the exam suggested a full tear of the rotator cuff.

An MRI was conducted on November 11, 2013, that showed a full thickness tear at the insertion of the greater tuberosity of portions of the supraspinatus infraspinatus tendons.

Petitioner saw a Dr. Lewis for an independent medical examination for the first time on December 19, 2013. Dr. Lewis reviewed the medical to date and surgical recommendation. Dr. Lewis agreed with the Dr. Lee's surgical recommendation and related it, causally to Petitioner's reported July 25, 2013 work incident. Dr. Lewis agreed that Petitioner was eligible for light duty restrictions.

On January 23, 2014, Petitioner underwent an operation on his left shoulder. The findings of the operation were consistent with a left shoulder rotator cuff tear including superior labral tear. Petitioner did a series of check-ups with his physician and started physical therapy from February 2, 2014, through May 16, 2014, with some signs of improvement to his shoulder. On the May 16, 2014, check-up Petitioner was still complaining about weakness and pain. The plan at that time was to obtain another MRI of his shoulder due his lack of progress in shoulder elevation strength. A second MRI was completed on June 17, 2014 with findings of an anterior superior labral tear and full thickness perforation through the supraspinatus tendon.

On July 23, 2014, Petitioner was seen again after starting work hardening but was having complaints of lack of progress. Petitioner was given an injection and advised to restart work hardening. On August 22, 2014, Petitioner was seen again and recommended to use a JAS Brace to address his rotational stiffness and if that failed, a scope capsular release and manipulation would be considered.

On December 2, 2014, Petitioner underwent a second independent medical exam with Dr. Lewis. Again, Dr. Lewis attributed Petitioner's current complaints and work restrictions to his work injury and certified the operation ordered by Dr. Lee. Dr. Lewis anticipated a full duty release after the second procedure.

Petitioner was fitted for a JAS Brace and used it until January 1, 2015. At this time Dr. Lee considered a second attempt at surgery and scheduled Petitioner for a follow up attempt. On April 7, 2015, Petitioner underwent a second surgery. Dr. Lee preformed an arthrosocopy of the left shoulder with lysis of adhesions subacromial and capsular release anteroinferior capsule.

On May 18, 2015, Petitioner followed up with Dr. Lee. He reported some progress but had continued complaints of pain in the anterior shoulder/upper chest region.

On June 16, 2015, Petitioner sought a second opinion from a Dr. Gurtler and reported his injury and gave a medical and injury history to Dr. Gurtler. At that time Dr. Gurtler ordered a third MRI and advised Petitioner follow up after the MRI.

On June 24, 2015, Petitioner was reported to Dr. Lee he was still making progress but it was slow and Dr. Lee reported, at that time, it would be difficult to predict if and when Petitioner would be able to perform his regular duty.

On July 14, 2015, Petitioner underwent a third MRI which showed a small recurrent rotator cuff tear. On July 28, 2015, Petitioner was seen, again, by Dr. Gurtler who recommended that no further treatment will be of assistance to Petitioner. An off work slip was entered from that state of treatment on noted that Petitioner would have a 5-10 pound weight limit and a note that Petitioner would never be able to return to work as a roofer.

On November 9, 2015 Petitioner underwent a final independent medical exam with a Dr. Lewis. Dr. Lewis again reviewed the entire file, including the recommendations from Dr. Gurtler. Dr. Lewis found no nonorganic findings during his examination. He again related Petitioner's current complaints to his original injury and found all treatment to date to be reasonable and necessary. Dr. Lewis agreed with Dr. Gurtler's assessment that further left shoulder treatment would not result in significant improvement in Petitioner's condition. He then concluded that Petitioner would not be able to return to his previous occupation as a roofer, without specific restrictions.

Petitioner testified that he was terminated from Respondent's employment on September 18, 2015, due to a reduction of work force. Petitioner then had an initial vocational assessment on October 26, 2015, with a Dave Patsavas. The report was entered into evidence by both Petitioner and Respondent.

A rehabilitation plan was also entered into evidence that included suggestions of job searches, leads and possible retraining programs available to Petitioner.

The first vocational report was entered into evidence and dated February 29, 2016, covering the February 1st 2016, and February 25, 2016 meetings. Eleven reports in total were entered into evidence by both parties with the most recent report dated December 31, 2016, which covered the December 19, 2016 meeting.

Petitioner testified he fully complied with all the efforts and suggestions of his vocational rehabilitation counselor. He also completed training courses at Lakeland community college. Petitioner testified he did 10 to 15 job searches a week and he did them both in person and on-line. Petitioner completed job searches all the way up to the day before trial and reported he was still looking until yesterday. Petitioner then verified the job search logs he completed. Said logs reflect that Petitioner did a job search from February 2016 until January 18, 2017. The reports appear fully filled out and completed. During his search Petitioner only completed one formal interview at County Materials but that they could not use him once they found out about his restrictions. Petitioner received a few phone calls but no one offered him a job throughout his job search. Petitioner also indicated he was willing to continue to do a job search if so asked.

Petitioner testified on cross that he got an A and a B in his Lakeland community college courses. He verified he had stopped taking courses because no one told him to continue but he would be willing to continue if it was asked of him.

Respondent then called Dave Patsavas, the vocational counselor, as Respondent's only witness. Mr. Patsavas testified he has been a certified rehabilitation counselor since 1982. His work is ninety percent related to workers' compensation working for both plaintiff's and defense.

Mr. Patsavas testified that he sought jobs for Petitioner within the 5 to 10 pound work restrictions per the treating physician's recommendation. Mr. Patsavas testified this put Petitioner in the sedentary category of physical demands. Based upon Petitioner's work history, work restrictions, skill level, and age, Petitioner had five percent of the job market available to him.

Mr. Patsavas confirmed he worked with Petitioner from September 28th, 2016 until present. During which time either Mr. Patsavas or Mrs. Mueller would meet with the Petitioner. Mr. Patsavas testified the initial plan for Petitioner included vocational testing. On the vocational testing Petitioner did average to above average considering his age and education. Based upon Petitioner's score, Mr. Patsavas knew Petitioner would need additional computer skills and

possible CAD program training. Petitioner then took a compass test which Mr. Patasavas described as more academic then the previous tests recommended. Petitioner's score on this test were significantly below average which indicated Petitioner would have to take preliminary courses before he would be eligible for the credit courses.

After taking two preliminary courses, it was Mr. Patsavas opinion that Petitioner struggled in class and needed more one on one attention and took twice as long on assignments as other students. After reviewing Petitioner's progress, Mr. Patsavas testified that he thought further retraining would not be worthwhile. He said that based upon the Petitioner's difficulties in the class room, he would be 60 years old by the time he would complete his educational program. Based upon Petitioner's slow performance and his age, Mr. Patsavas did not think further courses would be worthwhile.

Mr. Patsavas then looked into security programs but no training courses were available locally. But due to a lack of available jobs in the security field in Petitioner's area it would likely not be worthwhile to recommend security job training either.

Using a geographical area of 50 miles Mr. Patsavas had Petitioner conduct a job search. Petitioner's activities were then monitored. When asked about Petitioner's job search and his compliance, Mr. Patsavas answered in the following way;

Q: How would you describe Mr. Hayward's compliance in the slightly less than a year or year you have known him?

A: Well, we outlined a rehabilitation plan with specific goals, recommendation both for Mr. Hayward and ourselves. Mr. Hayward was fully compliant with all aspects. So – probably one of the more motivated clients we have had as far as documenting, looking for work, doing due diligence." (Trans. Pg. 59)

Concerning if further vocational efforts should be taken Mr. Patasavas said the following;

Q: As we sit here today, do you believe it would be worthwhile, -- basically if Mr. Hayward were continuing to do what he is doing now, is it –basically worthwhile to continue the vocational efforts for Mr. Hayward given his geographical area, his age, his transferable skills?

A: In that equation I would put the physical restrictions I think that's one of the major aspects that would limit him. So including the physical aspect I don't see anything changing. I don't see any jobs popping up being available for Mr. Hayward.

Q: Would it be fair to assess that at this stage given the year job search, the training he has attempted and his good effort that there is no stable job market at this stage for Mr. Hayward in his geographical area?

A: Correct (Trans. Pg. 62-63)

Mr. Patsavas also did not think further training programs would be cost effective in this claim.

Conclusions

The Arbitrator finds that Petitioner successfully established his work related injury made him eligible to an odd-lot permanently totally disabled. The Arbitrator bases this finding upon the following;

Petitioner suffered a major injury to his left shoulder that made him unable to return to his customary trade as a commercial roofer. Petitioner's injury was not disputed at the time of trial. Respondent's own medical expert agreed that Petitioner's injury to his left shoulder precluded him from returning to work as a roofer. Further, after his release Petitioner was terminated by his employer for a reduction in work force and was unable to return to work with Respondent.

Soon after his release, Petitioner began formal vocational rehabilitation with a Dave Patsavas, who was referred by Petitioner's attorney, but presumably approved by Respondent to conduct formal vocational rehabilitation on Respondent's behalf. Petitioner's job log appeared to document an extensive attempt by Petitioner to find new employment. This conclusion is supported by the testimony of Dave Patsavas who testified that Petitioner gave full effort and was in fact one of his more diligent clients and appeared both motivated and willing to find new employment.

Petitioner even attempted retraining at the local community college. Even though Petitioner was given good grades in two introductory classes, it was the opinion of the vocational counselor that he struggled in class and is unable to continue to harder classes. Based upon the testimony of Mr. Patsavas, it appeared that the Petitioner diligently worked at completing the retraining efforts in spite of struggles and completed both courses. However, Mr. Patsavas eventually concluded that to continue in the retraining effort of the Petitioner would not be cost effective due to Petitioner's limitations in the classroom and his advanced age.

In the end, it was the testimony of the vocational counselor that swayed the opinion of the Arbitrator. Mr. Patsavas essentially concluded that there was no stable job market for the Petitioner due to his age, physical limitations, and transferrable skills. He came to this conclusion after reviewing a year of Petitioner's diligent job search. Petitioner also gave a good faith effort with his retraining program at Lake Land Community College. The Petitioner's testimony on the stand, and the evidence presented at trial showed that he was both eager and willing to find employment but due to his injuries he had lost the ability to find gainful employment.

There are three ways in which a petitioner can prove entitlement to permanent and total disability on an odd-lot basis. See Federal Marine Terminals, Inc. v. The Industrial Commission, 371 Ill. App. 3d 1117 (2007) The Petitioner has proven entitlement under two of the three ways. He has shown a diligent but unsuccessful job search and he has shown that because of age, training,

education, experience and condition, he is incapable of performing services except those for which there is no reasonable stable market.

Respondent argues that he voluntarily quit taking college classes and therefore has failed to complete his vocational training necessary to become employable. While it is true that he did voluntarily stop his classes, Mr. Patsavas, the only vocational expert to provide an opinion on the matter, testified credibly that it was unlikely that the Petitioner could successfully complete his class work within a reasonable time. Thus, the Arbitrator finds that as of the date of arbitration, the Petitioner no longer met the established requirements for vocational rehabilitation.

Therefore, the Arbitrator awards the Petitioner a permanent total disability award.

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

Tameka McClellon,
Petitioner,

17IWCC0599

vs.

NO: 14 WC 5249

Illinois Department of Transportation
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 6, 2016, is hereby affirmed and adopted.

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

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

SEP 29 2017

DATED:
o8/31/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0599

McCLELLON, TAMEKA
Employee/Petitioner

Case# 14WC005249

ILLINOIS DEPT OF TRANSPORTATION
Employer/Respondent

On 9/6/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

0412 RIDGE & DOWNES
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5661 ASSISTANT ATTORNEY GENERAL
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1430 CMS BUREAU OF RISK MANAGEMENT
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SPRINGFIELD, IL 62794-9208

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

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

SEP 6 - 2016

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

17IWCC0599

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

Tameka McClellon,
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # **14** WC **5249**

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 **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **4/27/16, 7/26/16 and 8/25/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **1/7/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$51,000.00**; the average weekly wage was **$989.77**.

On the date of accident, Petitioner was **34** years of age, ***single*** with **3** dependent child.

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

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

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

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

ORDER

The Respondent shall pay and/or hold harmless any medical bills paid by Medicaid for dates of service 1/7/14, 1/9/14, 1/24/14, 4/5/14, and 4/8/14 for reasonable and necessary medical services provided to the Petitioner, and subject to the medical fee schedule of Section 8.2 of the Act.

Petitioner is not entitled to temporary total disability.

Petitioner's request for permanent partial disability 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.

David A. Kane
Signature of Arbitrator

September 1, 2016
Date

17IWCC0599

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tameka McClellon,
Employee/Petitioner,

Case # 14 WC 5249

v.

Chicago – Arbitrator David Kane

Illinois Department of Transportation,
Employer/Respondent.

RESPONDENT'S PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. FINDINGS OF FACT

Tameka McClellon (the "Petitioner) seeks relief from the Respondent-Employer, the Illinois Department of Transportation (the "Respondent"), for the Petitioner's alleged work-related accident on January 7, 2014, pursuant to the Illinois Workers' Compensation Act (the "Act"). On April 27, 2016 and May 26, 2016, a hearing on the disputed issues was held before Arbitrator David Kane in Chicago, Illinois. The disputed issues are: causation, medical bills, TTD, and nature and extent.

The Petitioner testified that on January 7, 2014, the date of the alleged work-related accident, she was 34 years old and single with three dependent children.

Petitioner testified that she began working for IDOT on January 2, 2014. She was hired as a seasonal employee to plow snow and maintain the expressways. On January 7, 2014, Petitioner was a passenger in a

truck that pulled over to the side of the road. While they were parked, a taxi driver lost control of his vehicle and the taxi started spinning. While spinning, the taxi crashed into the rear of Petitioner's truck. Petitioner testified that her right shoulder hit the hand rail.

Petitioner testified that she did not immediately feel pain from the accident. An ambulance reported to the scene and the passengers in the taxi were taken to the hospital. Petitioner did not feel that she needed the ambulance as she did not feel any pain. Petitioner returned to her work site.

Later that day, Petitioner reported to Mercy Works on Ashland. [Pet. Ex. 1]. She was diagnosed with a contusion to her left temple and right shoulder, strain and sprain to her neck, post traumatic headaches, and contusion to her shoulder and upper arm. [Pet. Ex. 1].

Petitioner returned to Mercy Works on January 9, 2014. [Pet. Ex. 1]. An MRI was ordered. [Pet. Ex. 1]. She was released to work full duty. [Pet. Ex. 1].

Petitioner underwent an MRI right shoulder without contrast on April 5, 2014. [Pet. Ex. 4]. The impression was moderate supra and infraspinatus tendinopathy; mild selective atrophy of the anterior supraspinatus muscle belly; no large partial thickness or discrete full thickness rotator cuff tear. [Pet. Ex. 4].

Petitioner also underwent an MRI cervical spine without contrast. [Pet. Ex. 4]. This revealed mild upper cervical degenerative disc changes. [Pet. Ex. 4]. It was negative for central canal or neural foraminal stenosis. [Pet. Ex. 4]. The MRI also revealed a left thyroid lobe nodule. [Pet. Ex. 4].

Petitioner returned to Mercy Works on April 8, 2014. [Pet. Ex. 1]. Dr. Homer Diadula called Mercy MRI to learn why the patient did not have the

MRI when it was scheduled. [Pet. Ex. 1]. Mercy MRI did not know why, just that she didn't go the 3 times it was scheduled. [Pet. Ex. 1]. A physical exam revealed no headaches, dizziness, blurred vision, hearing loss, nor equilibrium problems. [Pet. Ex. 1]. Petitioner had full range of motion and was non-tender to both the cervical spine and right shoulder. [Pet. Ex. 1]. Her headaches had resolved. [Pet. Ex. 1]. She was released to work full duty and discharged. [Pet. Ex. 1]. She was instructed to follow-up with her primary care physician due to an unrelated left thyroid module. [Pet. Ex. 1].

Petitioner testified that she always had pain and diminished range of motion. On cross-examination, Petitioner specifically stated that on this appointment, April 8, 2014, she had diminished range of motion in her right shoulder. This is contradictory to what is contained in the medical records.

Petitioner's temporary assignment with IDOT ended at the end of April. Petitioner worked full duty until the last date of her assignment. She did not miss any work from IDOT due to this injury.

Petitioner sought no treatment between April 8, 2014 and May 5, 2014. On May 5, 2014, Petitioner presented to Mercy Hospital. [Pet. Ex. 2]. She stated that she was experiencing pain to her right shoulder that started 1.5 weeks ago without trauma or incident. [Pet. Ex. 2]. Petitioner testified that her pain began due to mopping. A physical exam revealed full range of motion. [Pet. Ex. 2]. She was diagnosed with tendinitis. [Pet. Ex. 2]. She was prescribed Motrin and Norco and instructed to follow-up with her primary care physician. [Pet. Ex. 2].

On June 12, 2014, Petitioner returned to Mercy. [Pet. Ex. 2]. She was diagnosed with rotator cuff tendinitis. [Pet. Ex. 2]. She was instructed to follow-up with an orthopedic doctor, specifically Dr. Maday at Midland Orthopedics, and to begin physical therapy. [Pet. Ex. 2].

On July 2, 2014, Petitioner did not show up for her PT evaluation.

On July 8, 2014, Petitioner returned to Dr. Hadigal. [Pet. Ex. 2]. This visit was a follow-up for her thyroid nodule. [Pet. Ex. 2]. They also discussed her right shoulder and Petitioner was once again instructed to being physical therapy. [Pet. Ex. 2]. She was taken off work to provide rest. [Pet. Ex. 2].

On September 29, 2014 Petitioner returned to Mercy. [Pet. Ex. 2]. She had not seen the physical therapist. [Pet. Ex. 2].

On November 24, 2014, Petitioner returned to Dr. Hadigal. [Pet. Ex. 2]. Petitioner did not see the therapist. [Pet. Ex. 2]. Her social history lists employment as a leasing agent. [Pet. Ex. 2]. She wanted a form filled out for desk work. [Pet. Ex. 2]. Petitioner testified that the doctor filled out the form for desk work and she did not ask for it. She also denied that she was employed or in school to be a leasing agent at this time.

On March 9, 2015, Petitioner returned to Dr. Hadigal. [Pet. Ex. 2]. She states that she saw the physical therapist but stopped because it was too aggressive. [Pet. Ex. 2]. No physical therapy records were admitted into evidence.

Petitioner testified that she attended 2-3 physical therapy appointments. She could not remember even the month that she underwent physical therapy. No physical therapy records were admitted into evidence and therefore the Arbitrator does not find that Petitioner underwent physical therapy.

Petitioner testified that she had difficulty working after the accident due to her right should pain. She testified that she was disciplined twice due to her poor performance after her injury.

Ms. Gallagher: At work, did you get evaluations during your time-

A: I did. I did.

Q: Can you tell me about those.

A: Yeah. So my evaluations didn't go well, of course, because after the accident, I couldn't perform as I did the first week of work. I couldn't lift the cylinders like I had done before. I couldn't steer properly.

I didn't do the job good anymore after the accident because of the pain that I felt in my shoulder.

Q: So your testimony is that you got an evaluation for poor performance, is that correct?

A: That's correct.

(Transcript pp 35-36).

Georgina Syas testified on behalf of the Respondent. Ms. Syas is the Personnel Manager at the Illinois Department of Transportation. Ms. Syas testified that on February 7, 2014 Petitioner was issued a written reprimand due to an altercation of January 14, 2014. [Resp. Ex. 1]. On January 14, 2014, Petitioner confronted and accused two co-workers of looking through her phone. [Resp. Ex. 1]. A verbal exchange ensued. [Resp. Ex. 1].

Petitioner was issued another written reprimand on January 30, 2014. [Resp. Ex. 2]. On January 26, 2014, she failed to report to work. [Resp. Ex. 2].

Those two written reprimands were the only evaluations that Petitioner received.

CONCLUSIONS OF LAW

With regard to issue "F", whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner's current condition of ill-being is not causally related to her work-related accident. Petitioner reported to Mercy Works after the accident and was released to full duty work. She prolonged getting an MRI and missed three scheduled appointments. Finally on April 5, 2014 she underwent an MRI. When she returned for the results, Mercy Works released her to full duty. She had no complaints or symptoms on April 8, 2014. She had full range of motion, was non-tender to both the cervical spine and right shoulder. Her headaches had resolved. She was discharged and released to full duty work.

Petitioner's next appointment was one month later when she relayed neck pain for the past 1.5 weeks. Petitioner testified that this pain started when she was mopping the floor 1.5 weeks earlier.

The Arbitrator finds that Petitioner reached MMI on April 8, 2014. She was discharged and released to full duty work. She had no pain and full range of motion. She only returned to the doctor after suffering an intervening accident. The Arbitrator finds that Petitioner's current condition is not related to her work-related accident because her symptoms completely resolved and only started up again after an injury while mopping. The Arbitrator also notes that Petitioner does not have an opinion from her doctor that her condition is related to her work-related motor vehicle accident.

With regard to issue "J", whether the medical services provided to Petitioner were reasonable and necessary, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner reached MMI on April 8, 2014 when she was discharged from care. The Respondent shall pay medical bills incurred up to that date. The bills after April 8, 2014 are related to Petitioner's intervening accident and not to her work-related accident.

With regard to issue "K", what temporary benefits are in dispute, the Arbitrator finds as follows:

Petitioner has not proven to be entitled to temporary total disability. Petitioner worked full duty for three months after her work-related accident. It was only after her mopping injury and after being discharged from IDOT that she was taken off work. The Arbitrator finds it suspicious that Petitioner was taken off work only after her assignment with IDOT ended and she would not have been earning her regular paycheck.

Petitioner's testimony and the medical records are also inconsistent. Petitioner's medical records as early as November 2014 state that she was working or studying as a leasing agent and requested a form filled out for desk work. This would indicate the Petitioner was working during the time she is claiming TTD. However, Petitioner stated that she did not request a light duty release. Additionally, she testified that she was not working as a leasing agent and does not know why the medical records would reflect that. The Arbitrator notes the inconsistencies in Petitioner's testimony and finds her not credible.

Additionally, Petitioner did not seek the recommended treatment during this time. She was repeatedly referred to an orthopedic doctor and

physical therapist. She repeatedly ignored these recommendations and did not seek treatment. The Arbitrator cannot award TTD for a period when Petitioner was not following the doctor's recommendations. Petitioner claims 31 and 5/7 weeks of TTD during which time was not treating for her right shoulder. TTD is not awarded.

With regard to issue "L", what is the nature and extent of the injury, the Arbitrator finds as follows:

Under Section 8.1(b), factors to consider include a physician's impairment rating report, the employee's occupation, age, future earning capacity, and evidence of disability and the corroborating medical records.

a. The reported level of impairment. No physician's impairment rating report was offered into evidence.

b. The occupation of the injured employee. Petitioner was employed as a driver. She was released to full duty work. She is currently not working in this capacity because her position with the Respondent was temporary.

c. The age of the employee at the time of injury. Petitioner was 34 years old at the time of the accident.

d. The employee's future earning capacity. Petitioner was released to full duty work. There was no evidence presented of diminished future earning capacity. Petitioner incorrectly relies on the fact that

she was not invited back to work for IDOT the following season. Petitioner testified that she was disciplined for poor performance because of issues with her shoulder following the injury. However, the records are clear that she was disciplined for a verbal altercation with co-workers and for an unexcused absence. This would explain why she was not invited back the following season. The Arbitrator once again notes the inconsistencies in Petitioner's testimony and finds her not credible.

e. Evidence of disability corroborated by medical records. The arbitrator finds that Petitioner's testimony is not corroborated by the medical records. Petitioner was released to full duty the day of the accident and continued to work full duty for three months. She did not undergo physical therapy nor see an orthopedic doctor. In fact, she had no treatment other than pain medications. On April 8, 2014, her symptoms had completely resolved and she was discharged. Petitioner testified that she had diminished range of motion and pain at this appointment. This is not supported by the medical records. The Arbitrator finds Petitioner's recollection unreliable. Petitioner's current complaints of pain are out of proportion to the evidence contained in her medical records. It is

clear from the medical records that Petitioner has made a full recovery and suffers no residual symptoms from her work-related accident.

The Arbitrator finds that the parties waived their rights to an AMA impairment rating. Based upon the other factors, the Petitioner has not proven permanent partial disability.

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

David Arcega,

Petitioner,

vs. NO: 13 WC 18774

S4 Industries,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 18, 2016, is hereby affirmed and adopted.

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

17IWCC0600

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.

SEP 29 2017

DATED:
o8/31/17
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

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

17IWCC0600

ARCEGA, DAVID
Employee/Petitioner

Case# **13WC018774**

S4 INDUSTRIES INC
Employer/Respondent

On 11/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1067 ANKIN LAW OFFICE LLC
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CHICAGO, IL 60602

2837 LAW OFFICES JOSEPH MARCINIAK
BRENT W HALBLEIB
TWO N LASALLE ST SUITE 2510
CHICAGO, IL 60602

17IWCC0600

STATE OF ILLINOIS)
)SS.
COUNTY OF DUPAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

David Arcega
Employee/Petitioner

v.

S4 Industries, Inc
Employer/Respondent

Case # **13** WC **18774**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Jessica Hegarty, Arbitrator of the Commission, in the city of **Wheaton (Elgin)**, on **9/23/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **4/27/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $ **NA**; the average weekly wage was **$480.00**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of **$7,680.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$7,680.00**.

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

ORDER

- Respondent shall pay Petitioner temporary total disability benefits of $330.00/week for 170 4/7 weeks, commencing 6/13/13 through 9/23/13, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner's outstanding medical bills (see Petitioner's Exhibit 2) as provided in Sections 8(a) and 8.2 of the Act including:

- $28,052.65 (RX Development)
- $22,734.46 (Athletico)
- $20,034.50 (Confirmative Management Services)
- $10,466.61 (Instant Care Equipment Leasing)
- $1,551.00 (Orthopedic Specialists of the North Shore)
- $1,473.63 (Infinite Strategic Innovations)
- $1,210.00 (Advanced Foot and Ankle Center for Illinois)
- $1,138.62 (Elmwood Park Same Day Surgery)

- Respondent is liable for Petitioner's prospective medical care in the form of a repeat left knee arthroscopy recommended by Dr. Ronald Silver, along with all associated reasonable and necessary post-operative care.

- Respondent shall be given a credit for medical benefits that have been paid pursuant to the Fee Schedule, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

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

Jason C. Wright

Signature of Arbitrator

11/9/16
Date

ICArbDec19(b)

NOV 28 2016

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

DAVID ARCEGA, Petitioner,	)	
v.	)	**13 WC 18774**
S4 INDUSTRIES, INC., Respondent.	)	

BACKGROUND

Petitioner was involved in an undisputed accident on 4/27/13. Treatment from the time of the accident through an initial left knee arthroscopic procedure was approved by Respondent's carrier. The primary issue in dispute concerns Petitioner's entitlement to a prospective second arthroscopic procedure recommended by his treating surgeon.

FINDINGS OF FACT

Petitioner testified that on 4/27/13 he was working for Respondent as a materials handler when he was injured in a work related accident in which some metal poles struck both of his knees. Petitioner testified he felt something "crack" and began massaging his knees. He then called his wife and went home.

On 4/29/13, Petitioner presented at Immediate Care Plus where a cortisone injection was administered. (PX 3 & 4).

The Petitioner testified that he returned to work, but was being harassed by "Martin", an employee for the Respondent. The Petitioner testified he left his left his job because he couldn't take the constant knee pain or the harassment by Martin.

The Petitioner then sought the consult of Dr. Joel Anderson who noted a similar history of accident, took the Petitioner off of work and referred him to Dr. Ronald Silver. (*Id.*)

On 6/22/13, Petitioner presented to Dr. Silver at Advanced Foot and Ankle Centers of Illinois with complaints of severe knee pain. (PX 7). Dr. Silver noted a significant antalgic gait with inability to bear full weight on his left leg due to his knee pain. (Id.). Petitioner was fitted with orthotics, kept off work, instructed to obtain a left knee MRI and begin a course of physical therapy. (Id.).

On 7/1/13, an MRI of Petitioner's left knee noted a medial meniscal tear involving, primarily, the posterior horn. After reviewing the scans, Dr. Silver recommended left knee surgery. (Id.).

The surgery was later authorized and on 11/26/13 Dr. Silver performed a partial medial meniscectomy, partial lateral meniscectomy and debridement of tricompartmental synovitis. Dr. Silver testified that while the MRI only noted a medial meniscal tear, during the course of

surgery, he found a lateral meniscal tear. He further testified the meniscal tears he observed were acutely traumatic rather than degenerative. Dr. Silver also noted an articular cartilage fracture, which he repaired. (PX 1, 7, 9, & 10).

Following his left knee procedure, the Petitioner began a course of physical therapy on 12/9/13 which he continued until 2/14/14 when Respondent's carrier discontinued such benefits. (PX 6). Dr. Silver testified that after the initial arthroscopy, Petitioner made progress in the course of physical therapy and had advanced to sedentary work restrictions with occasional walking and standing by the time such benefits were terminated.

On 5/12/14, Petitioner was examined pursuant to Respondent's Section 12 request by Dr. Bryan Neal who agreed that Petitioner's medical care and treatment had been reasonable and necessary to date but felt that Petitioner was at Maximum Medical Improvement and could return to full duty work pursuant to his exam findings. (PX4).

The Petitioner testified that he received TTD benefits from 11/26/13 through 5/13/14.

Petitioner continued treatment for his left knee pain with Dr. Silver who, on 9/16/14, prescribed a new MRI pursuant to Petitioner's persistent complaints of pain. Dr. Silver testified he recommended the updated scans due to his concerns that further meniscal tearing had occurred.

On 9/26/14, the updated MRI indicated tears in the medical and lateral meniscus. Dr. Silver testified that the medial and lateral meniscal tears [present on the prior MRI] now extended into different areas of Petitioner's meniscus.

On 10/21/14, Dr. Silver reviewed the new films and prescribed a repeat left knee arthroscopy.

The Petitioner underwent a 2nd Independent Medical Evaluation on 2/16/15 with Dr. Bryan Neal who interviewed, examined and reviewed Petitioner's records. Dr. Neal diagnosed Petitioner with "residual subjective left knee pain, status post previous left knee arthroscopy, continued pain, unexplainable and nonphysiologic" to any intra-articular joint pathology. (PX5)

Dr. Neal did not recommend surgery "at this point in time" recommending instead, "discussion" concerning a left knee corticosteroid injection. Dr. Neal further opined that Petitioner's purported need for left knee surgery was not causally related to the April 27, 2013 work accident. In explaining the basis of this opinion, Dr. Neal stated that because the previous partial meniscal irregularities were debrided, such meniscal conditions would therefore have been eliminated and no longer present. He stated *if* Petitioner does have meniscal tearing, that condition developed after Petitioner's surgery and is secondary to injuries not related to his employment. Dr. Neal states that the repeat MRI further substantiates that the Petitioner "may have" had trauma at a point in time "significantly after his previous work injury" *(PX5)*

The Petitioner testified he currently experiences a great deal of left knee pain. He continues to wears his knee brace and take medication for pain. He further testified that he had not been involved in any intervening accidents involving his left knee following the 11/26/13 arthroscopy.

CONCLUSIONS OF LAW

The Arbitrator incorporates the above factual findings into the following conclusions of law.

WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE WORK RELATED INJURY

As stated above, the primary issue in this case is whether Petitioner's need for a second arthroscopic procedure is causally related to the undisputed work accident of 4/27/13. (Arb. 1) Based on the evidence contained in the record, the Arbitrator finds that Petitioner has sustained his burden of proof with respect to this issue.

Petitioner suffered tears to his medial and lateral meniscus as a consequence of the 4/27/13 work accident, for which, a partial medial meniscectomy, partial lateral meniscectomy and debridement of tricompartmental synovitis was performed. Intra-operatively, Dr. Silver observed such tears were acutely traumatic rather than degenerative.

Following surgery, Petitioner participated in physical therapy but later developed persistent pain in his left knee . Dr. Silver then ordered an updated MRI which confirmed further tearing of the same menisci that were injured in his work accident. Dr. Silver opined that such tearing had occurred due to the weakened nature of the residual meniscus and residual meniscal rim. Consequently, the doctor recommended a second arthroscopic procedure, the necessity for which, in his opinion, was causally related to the original work accident as there was no evidence of any intervening accidents.

Dr. Neal, pursuant to his 2nd IME exam, opined that *if* there was persistent meniscal tearing present, such tearing would have been due to "other trauma" or accidents.

The Arbitrator notes no evidence of any intervening accident is contained in the record to support Dr. Neal's assertion.

With respect to Petitioner's first surgery, Dr. Neal was of the opinion that because the partial meniscal irregularities were debrided, such conditions were therefore, eliminated and no longer present. He further stated that *if* Petitioner does have meniscal tearing, that condition developed after Petitioner's surgery and is secondary to injuries not related to his employment. The doctor claimed the repeat MRI substantiates his opinion that Petitioner "may have" had trauma at a point in time "significantly after his previous work injury" *(PX5)*.

The Arbitrator notes Dr. Neal's testimony that he only reviewed the updated MRI report and not the actual scans.

Petitioner presented at the hearing as straight forward and honest. His testimony regarding his left knee history, complaints and treatment are consistent with the medical chronology outlined in Dr. Silver's medical records and corroborated by diagnostic evidence in the form of two left knee MRI's performed on 7/1/13 & 9/26/14. Petitioner's testimony that he had no left knee injuries or medical treatment prior to his work injury and no intervening accidents between the left knee surgery and the hearing date was unrebutted.

The Arbitrator notes that Petitioner's physical therapy benefits were terminated approximately nine weeks after his surgery and before his treating surgeon released him to full duty work.

Based on the totality of evidence contained in the record, the Arbitrator finds that Petitioner's current left knee condition is causally related to his 4/27/13 work accident. In so finding, the Arbitrator adopts Dr. Silver's opinions which were substantiated by his treating medical records as well as the diagnostic testing.

MEDICAL BILLS & SERVICES

The Arbitrator finds the medical services provided to the Petitioner were reasonable and necessary and that the Respondent has not paid all appropriate charges. Respondent is ordered to satisfy Petitioner's outstanding medical bills as reflected in Petitioner's Exhibit 2.

PROSPECTIVE MEDICAL CARE

Pursuant to Dr. Silver's testimony , coupled with the above findings regarding causation, the Arbitrator finds Petitioner is entitled to prospective medical care in the form of a repeat left knee arthroscopy recommended by Dr. Silver, along with all associated reasonable and necessary post-operative care.

TEMPORARY BENEFITS

The Arbitrator finds Petitioner is entitled to TTD benefits from June 13, 2013 to September 23, 2016. The Petitioner's medical records establish that the Petitioner has been medically unable to work or has been issued light duty work restrictions that have not been accommodated by the Respondent since his accident on April 27, 2013. Respondent has paid TTD from November 26, 2013 to May 13, 2014. Accordingly, the Petitioner is awarded TTD benefits from June 13, 2013 through September 23, 2016 payable at a rate of $330.00 per week.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSE LOERA,

Petitioner,

vs. NO: 16 WC 24528

CENTRALIA CORRECTIONAL CENTER,

Respondent.

17IWCC0601

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 and prospective medical care, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner is a Correctional Officer for Respondent. He has been employed by Respondent for 17 years. During his lunch break on July 7, 2016 he was exercising in the inmate exercise room. While doing skull crushers he felt a shift in his elbow. An hour later he began to notice pain.

2. After undergoing treatment, Petitioner eventually underwent triceps surgery on his right side. After surgery Petitioner was off work from July 10, 2016 through August

24, 2016. At the time of trial, he was performing light duty work behind a desk, and was still unable to put weight on his right triceps.

3. Petitioner works 7.5 hour shifts at work with a thirty-minute lunch break. He is not permitted to leave the premises at lunch. There are only four areas employees are allowed to go to during lunch. These areas include the dining room, the break room, the workout area and the outdoor smoking area.

4. The workout room is designated for inmates, but facility staff uses it consistently as well.

5. Petitioner testified that he exercises because he feels he owes it to himself, his family and his employer to stay in the kind of shape that allows him to go home in one piece every night.

6. Major Ted McAbee testified and corroborated Petitioner's testimony, noting that the State of Illinois allowed employees to use inmate workout areas. Mr. McAbee also believes that a physically fit Officer benefits the State of Illinois.

The Commission views the evidence slightly different than does the Arbitrator, and thus reverses the Arbitrator's finding of accident. Petitioner analogizes the case at bar to Eagle Discount Supermarket v. Indus. Comm'n, 82 Ill.2d 331, 338, 412 N.E.2d 492, 496 (1980). In Eagle Discount, the claimant was injured on his lunch break when he tripped in the parking lot while playing frisbee. The night Manager unlocked the door to allow the claimant and other employees outside, and turned on the parking lot lights so they could see. In finding for the claimant, the Supreme Court held that the personal comfort doctrine was applicable, highlighting that the recreational activity was accepted, regular and normal, and that the injury occurred during an authorized lunch break. The Supreme Court also held that, when analyzing injuries occurring during a lunch break, the most important factor is the location of the occurrence. If the injury occurs on employer premises, it bolsters the claimants personal comfort argument. The Arbitrator found this argument persuasive, adding that there was no evidence Petitioner was exercising in an unreasonable manner, that Respondent acquiesced to the activity, and that a Correctional Officer being stronger and in better shape is a clear benefit to Respondent and furthers Respondent's best interests. Accordingly, the Arbitrator found accident.

Respondent points out that, subsequent to Eagle Discount, the Illinois legislature enacted a portion of Section 11 of the Act, which states that injuries incurred while participating in voluntary recreation programs, including but not limited to athletic events, do not arise out of and in the course of employment. 820 ILCS 305/11. Despite Petitioner's assertion that the aforementioned portion of Section 11 of the Act is only intended to apply to situations involving recreational programs such as employer sports teams and employer picnics (and not lunch break

17IWCC0601

activity), the Commission relies on the above-mentioned portion of Section 11 of the Act to deny Petitioner's claim.

The Commission hereby reverses the ruling of the Arbitrator and vacates all awards granted to Petitioner.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner has failed to meet his burden of proof on the issue of accident.

IT IS FURTHER ORDERED BY THE COMMISSION that all awards granted to Petitioner in relation to his accident claim are hereby vacated.

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: SEP 29 2017
O: 8/3/17
DLG/wde
45

Stephen Mathis

Deborah L. Simpson

Dissent

I respectfully dissent from the majority decision and would affirm the Arbitrator's well reasoned decision in its entirety.

David L. Gore

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

LOERA, JOSE
Employee/Petitioner

Case# **16WC024528**

STATE OF ILLINOIS/CENTRALIA CORR CENTER
Employer/Respondent

17IWCC0601

On 2/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0969 RICH RICH & COOKSEY PC
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0558 ASSISTANT ATTORNEY GENERAL
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1350 CENTRAL MANAGEMENT SYSTEMS
BUREAU OF RISK MANAGEMENT
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SPRINGFIELD, IL 62794-9208

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

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

FEB 14 2017

DONALD A. RARRIA, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0601

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

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

JOSE LOERA
Employee/Petitioner

v.

STATE OF ILLINOIS / CENTRALIA CORR. CENTER
Employer/Respondent

Case # **16** WC **24528**

Consolidated cases: _____

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

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **July 7, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$64,848.00**; the average weekly wage was **$1,247.08**.

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

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

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

Respondent is entitled to a credit for **ALL PREVIOUSLY PAID** medical expenses under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner has proven that he sustained accidental injury arising out of and in the course of his employment on July 7, 2016, and that his right triceps injury is causally related to this accident.

Respondent shall pay Petitioner temporary total disability benefits of **$831.39 per week** for **6-4/7 weeks**, commencing **July 10, 2016 through August 24, 2016**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **July 10, 2016 through September 7, 2016**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services that are indicated in the bills contained in Petitioner's Exhibit 1, subject to the Medical Fee Schedule, as provided in § 8(a) and § 8.2 of the Act.

The awarded medical expenses shall be paid by Respondent directly to the providers and, per the stipulation of the parties, and shall be subject to the Medical Fee Schedule or PPO agreement, whichever is less.

Respondent shall authorize the physical therapy recommended by Dr. Mall on August 22, 2016.

Respondent shall be given a credit for any and all medical benefits that have been previously paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

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

Signature of Arbitrator

February 7, 2017
Date

ICArbDec19(b)

FEB 14 2017

STATEMENT OF FACTS

The Petitioner is a 42-year-old Correctional Officer at Respondent's Centralia Correctional Center. He testified that he was injured on 7/7/16, when, while lifting weights on his lunch break he tore his right tricep. The parties have indicated on the record that there is no dispute that the tricep tear occurred during this activity, and that the dispute in the case centers around whether the Petitioner sustained accidental injuries arising out of and in the course of his employment on 7/7/16. Petitioner testified that he had no trouble with his tricep before this incident and required no prior treatment or diagnostic studies.

Petitioner testified that he works an 8 hour shift where he is paid for 7.5 hours and has an unpaid half hour lunch period. He and Respondent supervisor Major McAbee both testified that correctional officers are not permitted to leave the premises during their shift, but can utilize four different areas during their lunch period: a break room area, a lunchroom area, the gym/workout area or a smoking area. The Petitioner testified that other officers and management staff use the same exercise equipment. This was confirmed by Major McAbee. The exercise equipment is paid for via an inmate fund which is funded from a portion of inmate commissary purchases. The inmates do not actually own the equipment.

With regard to lifting weights, the Petitioner testified that he has been doing this for many years. He further testified that he felt he owed it to his employer, his family and himself to stay in shape so he could "come home in once piece" and perform his job duties.

Petitioner initially sought treatment on 7/7/16 with his family physician, Dr. Rahman, who diagnosed a tricep injury and referred him for an MRI, which confirmed a distal triceps tendon tear, and then to an orthopedic surgeon. (Px3; Px4).

Petitioner sought treatment with orthopedic surgeon Dr. Mall on 7/11/16. Dr. Mall reviewed the MRI and examined Petitioner, diagnosing a "somewhat unusual" right tricep tear that was torn both off of the bone as well as some of the musculotendinous junction. Dr. Mall recommended and performed a prompt right elbow triceps repair on 7/14/16, noting this repair would be difficult due to the tear pattern and would be performed on

an open basis. (Px5). The operative report indicated a complicated triceps repair involving multiple aspects of the tendon with an intermediary intact segment with allograft augmentation. (Px6). Petitioner returned to Dr. Mall on 7/22/16 and reported significant improvement. Dr. Mall prescribed an elbow brace and recommended progressive rehabilitation. He referred Petitioner for physical therapy on 8/22/16 with instructions to begin active range of motion graduating to isokinetic strengthening eight weeks later. Petitioner was scheduled to return in five weeks and released to light duty work. (Px5).

CONCLUSIONS OF LAW

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

The Arbitrator notes that the facts of this case made it a difficult one to decide, as it involves the interaction of Section 11 of the Act, and the "personal comfort doctrine."

To obtain compensation under the Act, an injury must "arise out of" and "in the course of" employment. 820 ILCS 305/1(d). "The phrase "arising out of the employment" refers to the requisite causal connection between the employment and the injury; that is, the injury must have had its origins in some risk incidental to the employment. The phrase 'in the course of employment' refers to the time, place and circumstances of the injury." *Eagle Discount Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 338, 412 N.E.2d 492, 496 (1980). With regard to injuries sustained during activities performed during a claimant's lunch period, Courts have held that the "personal comfort doctrine" may apply. Acts of "personal comfort," including engaging in sports activities, may be "incidental to employment" and satisfy the "arising out of" requirement. So long as an employee does not engage in the sports activities in an unexpected manner and expose him or herself to an unreasonable risk, the resultant injury will be deemed to have occurred within the course of employment. Notwithstanding the latter, the employer may still be held liable where it has knowledge of or has acquiesced to the practice or custom. *Id.* at 496-497.

However, subsequent to the decision in *Eagle Discount Supermarket*, the Illinois legislature enacted a specific portion of Section 11 of the Act, which states as follows:

> "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 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." 820 ILCS 305/11.

While Section 11 of the Act provides that injuries sustained during voluntary recreation do not arise out of and in the course of employment, the law holds, " . . . [T]he mere fact that a recreational activity is involved does not necessarily trigger the analysis employed in the recreational activities cases." *Eagle Discount Supermarket* at 496.

In *Eagle Discount*, the claimant was on lunch break, without pay, when he tripped and was injured on the employer's parking lot while playing Frisbee. Although the employees were not restricted to the employer's premises, claimant and his fellow employees worked the night shift when the store was closed and had to request that the night manager unlock the door before they could leave the building. The manager would also

turn on the parking lot lights so that the employees would have light in which to play. The employer argued that the claimant's injuries were non-compensable for four (4) reasons: (1) The claimant's "parking lot" injury is noncompensable since there was no showing that there existed a hazard other than that to which the general public would be exposed; (2) the injury is a noncompensable "recreational" injury since there was no evidence of employer organization, sponsorship, coercion to participate and benefits derived; (3) the injury, which was sustained during an unpaid and unrestricted lunch break, was not sustained in an activity sufficiently related to the employment; (4) the "personal comfort" doctrine precludes recovery since there was no showing that the employment created an increased risk of injury. *Eagle Disc. Supermarket v. Indus. Comm'n*, 82 Ill. 2d 331, 336, 412 N.E.2d 492, 495 (1980).

The Supreme Court determined that the personal comfort doctrine was applicable in the case, and gave significant weight to two specific factors: (1) the recreational activity was an accepted, regular and normal one; and (2) the injury occurred on the premises during an authorized lunch break. The Supreme Court stated, "In the lunch hour cases, the most critical factor in determining whether the accident arose out of and in the course of employment is the location of the occurrence. Thus, where the employee sustains and injury during the lunch break and is still on the employer's premises, the act of procuring lunch has been held to be reasonably incidental to the employment . . . Other acts during a break time in the employment besides the act of eating have also been held to be acts of personal comfort." *Id.* at 496-97. Consequently, Court held that the Commission properly found that the claimant's injuries arose out of and in the course of his employment with Respondent, as the activity of playing Frisbee was during an authorized lunch break on the employer's premises, the claimant did not expose himself to an unnecessary or unreasonable risk, and the employer acquiesced to the activity. *Id.*

The Arbitrator believes that this case resembles *Eagle Discount Supermarket*, and that the personal comfort doctrine is applicable here. In Petitioner's case, the relevant factors are undisputed. The injury occurred on Respondent's premises, and the employer, by the testimony of Respondent's own witness, acquiesced to the activity with regard to various Respondent employees. Thus, the evidence shows that this was a common activity for a number of correctional officers. There was no evidence presented that there was anything unreasonable about the manner in which Petitioner engaged in lifting weights. Furthermore, Petitioner was not permitted to leave Respondent's premises during the lunch period. While this activity may or may not be one that would typically be considered a personal comfort, such as eating or using the restroom, the Arbitrator notes that in the specific job of a correctional officer, being strong and in good shape would clearly be in such an employee's best interests in terms of having the duty of keeping order among an inmate population. Additionally, the Supreme Court found that an activity, playing Frisbee, which does not specifically appear to promote the duties of a stock worker was determined to constitute a personal comfort. Here, again, the activity of weightlifting appears to the Arbitrator to more directly positively impact the duties of a correctional officer. The Arbitrator thus finds that Petitioner's accidental injuries arose out of and in the course of his employment with Respondent while engaged in an act of personal comfort during an authorized lunch break.

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 parties agreed on the record that the issue of causation was derivative of the dispute regarding accident. As accident has been found in favor of the Petitioner, the Arbitrator finds that the Petitioner's right triceps injury is causally related to the 7/7/16 accident. Regardless of the agreement of the parties, the Arbitrator notes that the evidence in the record clearly supports this finding.

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

The Petitioner has submitted a number of medical expenses that were alleged to be causally related to the Petitioner's 7/7/16 accident as Petitioner's Exhibit 1. The Arbitrator notes that the parties stipulated that additional medical bills that were not available at the time of the hearing be submitted into evidence at a later date as part of Px1, so long as Respondent had an opportunity to review same, and to object. As Respondent indicated no objection to the additional expenses being admitted, the Arbitrator did so and they were added to Px1.

Based on the Arbitrator's findings with regard to accident and causation, the Arbitrator further finds that the Petitioner is awarded the causally related medical expenses contained in Px1. As was stipulated by the parties, the Respondent is entitled to credit for any of the awarded expenses that have been previously paid, so long as the Respondent holds the Petitioner harmless from any provider efforts to collect for same. The parties also stipulated that the awarded expenses were to be paid by Respondent directly to the providers, either per the fee schedule or separate PPO agreement, whichever is less.

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

The only recommendation by Dr. Mall for treatment that was current as of the 9/7/16 hearing date was physical therapy. The Arbitrator awards the recommended physical therapy, and Respondent shall authorize same.

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

The Respondent has stipulated that the only issue in dispute with regard to temporary total disability is liability for same, and that there was no dispute as to the applicable period being claimed by the Petitioner. As the Respondent has been found liable for same, Respondent shall pay the Petitioner TTD benefits from 7/10/16 to 8/24/16.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

HILARIO GARCIA,

Petitioner,

vs. NO: 11 WC 6287

BRETFORD MANUFACTURING,

Respondent,

17IWCC0602

DECISION AND OPINION ON REVIEW

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

As to temporary total disability, accident and causation were not disputed. Petitioner reached maximum medical improvement, albeit with restrictions, as of November 7, 2012, contingent on a release from his urologist. Petitioner was cleared by his urologist on November 13, 2012. Petitioner was temporarily laid off beginning November 7, 2012, but called back to work on November 20, 2012. Respondent accommodated Petitioner and paid TTD during other periods of layoff prior to Petitioner reaching maximum medical improvement on November 7, 2012. The parties stipulated to TTD, during periods of layoff, prior to November 6, 2012. In addition to the periods of time stipulated to by the parties, the Commission awards TTD from November 7, 2012 through November 19, 2012, but reverses the Arbitrator's award of TTD between January 28, 2013 and March 21, 2013, as Petitioner was at maximum medical improvement and able to return to work as of November 13, 2012. The reduction in force impacting Petitioner between January 28, 2013, and March 21, 2013, was no different than subsequent periods wherein Petitioner was laid off.

We affirm the Arbitrator's award of medical expenses of $1,115.00 related to La Clinica. We further affirm the Arbitrator's denial of $3,143.10 to G&U for a service date of August 15,

17IWCC0602

2011, as those expenses are unrelated to Petitioner's work related injury. Petitioner was at maximum medical improvement with permanent restrictions as of November 13, 2012. The Arbitrator denied $34,670.92 in billing from Advanced Ambulatory Care on the basis that Petitioner testified he did not recall treating with them and the bills were vague as to treater. However, the dates of billing clearly coincide with dates of treatment by Dr. Jain and the Chicago Pain and Orthopedic Institute. These bills should be awarded in accordance with the fee schedule. The bills are for treatment dates of March 15, 2011 through November 7, 2011.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $429.20 per week for a period of 83 2/7 weeks, from February 19, 2011, through September 25, 2011, November 22, 2011 through November 6, 2012, and November 7, 2012 through November 19, 2012, 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 $386.28 per week for a period of 162.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 32.5% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $35,785.92 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 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: SEP 29 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/dmm
O: 8/30/17
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GARCIA, HILARIO
Employee/Petitioner

Case# **11WC006287**

BRETFORD MANUFACTURING
Employer/Respondent

17IWCC0602

On 2/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.41% 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:

5006 THE ROMAKER LAW FIRM
PATRICK SEROWKA
211 W WACKER DR SUITE 1450
CHICAGO, IL 60606

1109 GAROFALO SCHREIBER HART ETAL
JAMES R CLUNE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

H. Garcia v. Bretford Mfg., 11 WC 6287

17IWCC0602

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

Hilario Garcia
Employee/Petitioner
v.
Bretford Manufacturing
Employer/Respondent

Case # 11 WC 06287

An *Application for Adjustment 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 **June 2 and 13, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 **1/21/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$33,477.94**; the average weekly wage was **$643.80**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$39,135.16** for TTD, **$0** for TPD, **$0** for maintenance, and **$6,844.80** for other benefits, for a total credit of **$45,979.96**.

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 $1,115.00 as is specified below, as provided in §§8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $429.20/week for 90-4/7 weeks, as is specified below, as provided in §8(b) of the Act. Petitioner's claim for maintenance benefits is denied.

Respondent shall pay Petitioner permanent partial disability benefits of $386.28/week for 162.5 weeks, as is provided in §8(d)2 of the Act, because the injuries sustained caused the 32.5% loss of use of the person as a whole.

Petitioner's claim for penalties and attorney's fees is denied.

Respondent shall pay Petitioner the compensation benefits that have accrued from 1/21/2011 through 6/13/2014 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

February 18, 2016
Date

ICArbDec p. 2

FEB 18 2016

Findings of Fact

Petitioner testified via an interpreter (Spanish/English).

Petitioner was employed by Respondent as a machine operator, making cabinetry in its Franklin Park facility. He worked for Respondent since 1989. He first worked for Respondent at its Schiller Park facility and transferred to Franklin Park in 2009. The two facilities have different unions, so Petitioner's plant seniority was determined by the date of his transfer from Franklin Park to Schiller Park (February 16, 2009). Petitioner was 54 years old on the date of accident.

Petitioner's job duties as a machine operator included putting materials in a mold, setting up the welder, and taking a 35 pound cabinet out of the mold and placing it on a skid. He would stand all day at this job. He would make about 38 cabinets a day. The goal was to make 40 cabinets per day. If Petitioner was not making production, Respondent would call it to his attention. Respondent manufactures products for Apple, furniture for schools and whiteboards with computer attachments.

Petitioner denied any serious low back injury prior to January 21, 2011.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on January 21, 2011. He was removing a formed, molded cabinet when "I felt a lesion in the foot and ... in my back." He felt a snap and pain in his back, left hip and left foot.

Petitioner was sent to Advanced Occupational Medical Center in Schiller Park. He was directed to the Center by somebody from Respondent's safety department. Thereafter, he was returned to work with a limitation of 15 pounds lifting and limitations on bending, squatting, pushing, and pulling. (PetEx. 6)

Petitioner returned to work in a modified capacity, using a press machine and bending sheets of metal. Petitioner was allowed to sit and stand as he needed. Petitioner also worked on a metal cutting machine. He could take breaks as needed.

Petitioner continued to treat with Advanced Occupational through February of 2011. Petitioner was laid off on February 19, 2011.

Petitioner then began treating with Dr. Jain at Chicago Pain Orthopedics. Dr. Jain authorized Petitioner to remain off work and to go to physical therapy. Dr. Jain referred Petitioner to La Clinica for physical therapy. (PetExs. 2&4)

Dr. Jain provided two injections to Petitioner's lower back; one on March 15, 2011 and the other on April 26, 2011. The injections helped very little. Petitioner testified that anything Dr. Jain did for him would only help for a few days and then the pain would return. Petitioner described a procedure where Dr. Jain "burned his nerves" (RFA ?). He stated that this did not help at all. However, the later surgery by Dr. Lorenz did help reduce the pain.

The Parties stipulated that Petitioner was temporarily and totally disabled from February 19, 2011 through September 25, 2011. On or about September 25, 2011, Petitioner was contacted by

Christina Innocente to return to work. He did so and performed the same work that he was performing prior to his layoff, to wit: the folding machine and the cutting machine. Petitioner confirmed that he could sit or stand while performing these jobs and he could ask to take a break when he felt he needed to.

Petitioner testified that he would program the metal cutting machine. The cutting machine would take about 5 to 6 seconds to cut a piece and during that time Petitioner would either sit or stand as he needed. Petitioner worked these jobs until November 21, 2011 per the stipulation of the Parties. On November 22, 2011, Petitioner was again laid off.

On December 15, 2011, Dr. Jain referred Petitioner to Dr. Mark Lorenz at Hinsdale Orthopedics. Dr. Lorenz restricted Petitioner from work entirely and recommended back surgery. (PetEx. 3)

The Parties stipulated that Petitioner was again temporarily and totally disabled from November 22, 2011 through November 6, 2012. The total agreed lost time is 81-1/7 weeks. (ArbEx. 2)

On June 15, 2012, Petitioner underwent back surgery by Dr. Lorenz, Dr. Fronzak and T. Lindley Pittman, MS, PA-C. The opperation was described as encompassing 12 procedures, but basically consisted of an L4-5 laminotomy, foraminotomy,nerve root decompression and discectomy with posterolateral fusion, instrumentation, transforaminal interbody fusion, iliac crest bone graft and allograft bone stem cells and DBM putty. Petitioner was hospitalized through June 19, 2012. (PetEx. 1)

Petitioner received physical therapy at ATI in July, August, and September 2012. At the end of that time Petitioner underwent a functional capacity test, which suggested light/medium restrictions. (PetEx. 8)

Ultimately, Dr. Lorenz released Petitioner to return to work with permanent restrictions of no lifting more than 30 pounds, as of November 7, 2012, pending urological clearance. Dr. Lorenz charted that Petitioner was at MMI and was to return, PRN as of November 7, 2012. Urological clearance was given November 13, 2012. Petitioner was seen by Pittman, PA-C, on December 26, 2012, with complaints of an inability to stand more than 1 hour at work. He was able to tolerate working otherwise. Petitioner was given additional work restrictions of standing for 1 hour and then a 5 minute sitting break and a referral to Dr. Bardfield for pain management. Petitioner was seen by Dr. Bardfield on January 11, 2013 and a recommendation for a caudal ESI was made, along with prescription medication. Petitioner was seen by Dr. Lorenz on April 22, 2013. He had continued complaints of an aching back, which Dr. Lorenz thought were addressed by the work restrictions that had been given. Petitioner was at MMI from Dr. Lornenz's treatment standpoint. A referral to a neurologist was made (apparently for other medical issues). Petitioner was last seen by Dr. Lorenz on December 19, 2013. His condition was unchanged and he was on layoff, allegedly because of his work restrictions. Petitioner was again released, PRN. (PetEx. 5)

After the release from Dr. Lorenz of November 7, 2012, Petitioner was called back to work on November 20, 2012. Petitioner testified that he was working on the metal cutting machine, on a metal folding machine, and on other machines doing different things. He described putting pieces in a "robot". He described that the "robot" would weld the pieces and this would take the approximately 45 minutes. During the time that this operation was conducted Petitioner would sit and watch the machine. He would also, occasionally, when he finished with the robot, go to the folding machine

during the same shift. Petitioner testified that job assignments were made in the morning before work began. Once he completed his first job, he was to transition to another machine. Petitioner advised that he could sit down as needed or take breaks as needed. Petitioner noted that other workers did not sit or stand as he did.

Petitioner worked in this capacity until January 27, 2013. At that time he was laid off. He was told that his medical insurance would end at midnight. This was similar to what had happened in previous layoffs. Petitioner did not receive any workers' compensation benefits between January 28, 2013 and March 21, 2013, presumably his layoff time. Petitioner was called to return to work on or about March 27, 2013. At that time he met with a supervisor. He returned to the same jobs, bending metal sheets and putting pieces into the "robot" machine. The work conditions remained as before.

Petitioner was laid off again on November 15, 2013. The process was the same. He was called back to work on January 13, 2014. He was not paid workers' compensation benefits during his layoff. When he went back to work, he performed the same work as he had in the recent past, including the metal cutting machine, the metal folding machine, and the "robot" machine.

Petitioner was laid off again on March 27, 2014. This lasted until May 4, 2014. Petitioner did not receive workers' compensation benefits during this time.

Respondent disputes the obligation to pay temporary total disability benefits during Petitioner's layoffs after the time when Petitioner had reached maximum medical improvement, or had plateaued, or had permanent restrictions.

When Petitioner returned to work on May 5, 2014, he was told that he would be making less money per hour. He was also told he would be going into a different department, making electrical extension cords for computers. He did not ask why he was not returned to his normal jobs. At times, this transfer would also have him work using a blowtorch or putting wires into small cables. Some of these jobs were jobs that were performed in a seated position. There were other people working in these jobs as well. Two weeks prior to trial, Petitioner was returned to his customary jobs in the fabrication department, operating machines.

Petitioner testified that when he has completed a job assignment on a particular machine, he is generally referred to another machine that is ready for manufacturing parts. There are also times when he finishes with a machine and a machine setup person sets up that same machine for another job. He does not recall any time since 1989 that he has worked on a machine that has broken down and he has had to wait for the machine to be repaired. Petitioner confirmed that he has a chair at his machine, which allows him to both sit and stand while engaged in machine operation. It is clear that the duties Petitioner described are not fast-paced and do involve some "down time" while the machines he operates cycle or generate parts. Petitioner confirmed that some of the machines which he operates are better operated from a seated position. These include the metal folding machine and the roll former machine.

Petitioner testified that during the times that he was laid off, he searched for alternative work. He claims that his job searches took him to the facilities listed on Petitioner's Exhibit Number 12. He claims to have been seeking warehouse jobs, machine operator positions, and maintenance technician jobs. Petitioner claims that a few of the potential employers called him back to discuss job

opportunities, but when he informed them that he had restrictions they said they would call him back and never did.

Petitioner describes his condition as causing him to have an inability to walk fast, difficulty bending over, unavailability to work overtime, and an inability to play sports. He claims not to be able to find alternative employment.

On cross-examination, Petitioner was questioned about Petitioner's Exhibit 12, regarding his attempts to seek other employment. Some documents in Exhibit 12 were handwritten and others were computer-generated. Petitioner conceded that the computer-generated documents were prepared or otherwise generated by his daughter. The handwritten documents were prepared or generated by him. Although he claimed that he was contacted by a number of potential employers, he does not remember whom those might have been. He never asked for their names. He did not remember the dates that he discussed potential employment or offers. He has no knowledge of how many other candidates were vying for the same positions. Some of the jobs were management jobs, yet Petitioner had no management experience. One of the jobs was a business in need of a foreman, but Petitioner had no experience as a foreman. One of the jobs was for the position of building engineer or head janitor. Petitioner had no experience in either position. Petitioner conceded he had no experience supervising other workers.

Petitioner described a visit to a mattress company located at 47th and Kedzie. He stated that he was met at the door by an individual from the company and he was told they were not hiring any new personnel.

Petitioner was questioned regarding a TIG welder position. He conceded that he did not know what a TIG welder was, but that he does know how to weld. He advised that when a piece does not come out right from the "robot" he repairs it by welding. He puts on a mask to accomplish that task. His statements and his description of the task of putting on a mask confirmed that he was describing welding and not soldering.

Petitioner conceded that, from the lists in Petitioner's Exhibit 12, only four or five people called him. He stated that they all spoke English to him and he did not understand them very well. He asked if he could have a position with the restrictions that were imposed on him and they said that they would call back. However, he explained, they did not call back. Petitioner specifically emphasized to the callers that he had a 30-pound lifting restriction. Petitioner conceded that he had no knowledge of whether any of the jobs he sought involved lifting less or more than 30 pounds. Petitioner conceded that he had no job description regarding any of the positions for which he filled out applications.

Petitioner was questioned regarding his other work experience. He had cut grass at golf courses on riding lawn mowers. He worked for a time at a belt factory. He confirmed that belts weigh less than the weight restriction imposed on him. He described his experience at Bretford on the roll forming machine. He advised that during the operation of the machine he would hold a tool to solder or weld parts into position; so-called spot-welding.

Petitioner testified that in January of 1995 he took a test regarding forklift operation. He received a certificate that he passed the test. Petitioner testified that there were times when he was at the Schiller Park facility that there were layoffs before his injury, but that he was not involved in the layoff because he had a higher level of seniority than those who were.

Petitioner testified that when he was laid off in 2011, from February through September 2011, other people were laid off as well. He received temporary total disability benefits during this time. He agreed the same thing happened between November 2011 and November 2012. Other workers were on lay-off between January 2013 and March 2013, as well as November 2013 through January 2014, and March 2014 through May 2014. Petitioner did not receive TTD or maintenance benefits during these time periods.

Gabino "Carl" Barajaz testified on behalf of Respondent. Mr. Barajaz is a lead supervisor for the Respondent. As such, he takes on the responsibilities of productivity, efficiency, quality, and safety for the shift to which he is assigned. He also has responsibility for direction or guidance to be given to his counterpart on the next shift. Barajaz was present as Respondent's representative during the testimony of Petitioner.

Barajaz described the three primary machines now operated by Petitioner. Each of these machines provides necessary parts for Respondent's manufacturing process, including materials for the Apple Corporation, furniture for schools, and whiteboards with computer attachments. Barajaz confirmed that if Petitioner was not operating machines and making the parts described, some other worker would have to perform this work. Mr. Barajaz further confirmed that the work at Respondent is affected by the economy and the needs of school districts. When customer orders do not come in, the business is slow, and they have to lay people off. Layoffs are determined by plant union seniority. This is determined by the collective bargaining agreement in place at the Franklin Park facility.

When Petitioner returned from his last layoff, he was assigned to a different position than his normal machine operation. This is because of a collective bargaining requirement that all permanent employees must be returned to work from layoffs first before temporary workers can be hired to do what amounts to, essentially, semi-skilled work. After two weeks, Petitioner was returned to his regular machine operator job.

Mr. Barajaz confirmed that each machine operator has a quota associated with the machine they are operating. Barajaz testified that he has not had any reason to talk to Petitioner about not meeting his goals.

Mr. Barajaz confirmed the nature of Petitioner's work restrictions. Barajaz also confirmed that Petitioner's restrictions would have been accommodated whether he sustained a work injury or a personal injury. Barajaz further confirmed that the nature of the products that Respondent produces are conducive to accommodating restrictions because the regular job involves working with very light weights, the heaviest ranging between 15 and 45 pounds and the lightest being mere ounces. Barajaz confirmed that Petitioner generally worked on parts that weighed between 2 pounds and 10 pounds.

In the Franklin Park facility, the larger manufactured items are in pieces. No worker is picking up more than 30 pounds at a time. Once a larger product is assembled, it is taken off the line by a fork truck.

Mr. Barajaz testified that if somebody is not meeting their quota the issue is dealt with right away and, certainly, on a day-to-day basis. Petitioner testified that he has not been told that he is not meeting his quotas. Barajaz also confirmed that Petitioner is meeting his quotas, performing his regular job,

running machines, and, although he has restrictions, Petitioner's job falls within his restrictions. The only difference is that now Petitioner can choose to sit if he wants to take breaks, when he wants to take breaks, and hourly breaks were not part of Petitioner's normal job, although periodic machine downtime was.

Mr. Barajaz testified that layoffs are determined by seniority. He further confirmed that when Petitioner was laid off, other people were laid off as well. He confirmed that Petitioner is experienced in, operating a robotic machine. He further confirmed the other manufacturing companies use robotic machines.

Bill Churchwell, Respondent's EHS (environmental, health and safety) Manager, testified on behalf of Respondent. Among other responsibilities, Mr. Churchwell occasionally sees and adds to or corrects personnel records. He is also responsible for OSHA compliance. Accommodations under the ADA also fall within his responsibilities.

Churchwell confirmed Petitioner's hourly rate of pay in January 2010 as being $13.86. By March 6, 2010, it increased to $14.26. It stayed that way up to the date of Petitioner's accident. Churchwell confirmed that the hourly wage of a machine operator is established by the collective bargaining agreement. The Union is the Manufacturing, Production, and Service Workers Union, Local 24. Between January 2010 and January 2011 Petitioner worked overtime. Approximately 70% to 75% of that overtime was mandatory.

Churchwell confirmed that the collective bargaining agreement determines who gets laid off when there is a layoff. It is based on seniority. Petitioner's seniority was established on the date he transferred from Schiller Park and arrived at Franklin Park. The employees from Schiller Park that chose not to transfer to Franklin Park received severance pay. The employees that chose to transfer to Franklin Park retained their jobs. When Petitioner transferred to Franklin Park, he joined a different union. As a result, his union seniority date was established at the time of his transfer, that being February 16, 2009.

Mr. Churchwell advised that individuals that are laid off from Franklin Park have the benefit of their jobs waiting for them when they are called back. They do not have to reapply for their positions. They are offered COBRA to retain their medical benefits. When they return to their jobs at Franklin Park medical benefits are covered by the facility. The returning employees do not have to go through an interview process to resume their jobs, as would a new employee. They do not have to go through a pre-employment physical, as would a new employee. When employees are laid off from Franklin Park, they frequently apply for unemployment compensation. For example, Petitioner did so when he was assigned to the Schiller Park facility in 1990. (PetEx. 9)

During the time that Petitioner was convalescing from February 19, 2011 through September 25, 2011 and there was a layoff at Respondent, 21 employees with more seniority than Petitioner were laid off at the same time. During the layoff from November 2011 into 2012, 25 employees with more seniority were also laid off. Between January 28, 2013 and March 21, 2013, 20 employees with greater seniority than Petitioner were laid off. Between November 15, 2013 and January 12, 2014, 15 employees with greater seniority than Petitioner were also laid off. Between March 27, 2014 and May 4, 2014, 20 employees with greater seniority than Petitioner were also laid off. The layoffs were not unique to Petitioner, but were common to the general employee population at Respondent. Certain employees are exempt from layoffs. Set-up men, lead men, and the union steward are all exempt, as

they have "super seniority". On each occasion that Petitioner has been laid off, he has eventually been called back to work. Obviously, the CBA controls.

Churchwell confirmed the testimony of Mr. Barajaz. Respondent will attempt to accommodate a medical restriction whether it is work related or personal. Churchwell described a so-called "sit-stand" chair, which is essentially a slanted seat and about the height of a stool making it easier for a machine operator to transition from sitting to standing and back again. Petitioner has such a device available to him.

Mr. Churchwell returned to testify on June 13, 2014 regarding seniority and layoff issues. In particular, he was asked questions regarding the relationship between Respondent and an employee by the name of Guillermo Villanueva, and the respective seniority relationships between Villanueva, Petitioner, and Respondent. Petitioner had testified on rebuttal that Villanueva had the same seniority as Petitioner and was not laid off at times when Petitioner was.

Mr. Churchwell was asked to assume that testimony outside of his hearing was adduced at the first hearing indicating that there were times when Petitioner was laid off while Mr. Villanueva was not. Churchwell explained that both of these employees arrived at the Franklin Park facility on February 16, 2009, having transferred from Schiller Park and, therefore, both had the same plant seniority date. They had different hiring dates, however, in that Villanueva was hired 11 or 12 years before Petitioner at Schiller Park. The significance of this is that the hiring date is the tiebreaker when there is an identical union seniority date. In other words, if there is identical union seniority, the next tie-breaking marker is company seniority. That is why Villanueva has greater seniority than Petitioner and was not laid off at times that Petitioner was.

There are also times when individuals with greater seniority than Villanueva are laid-off while Villanueva is not. This is because Respondent moved a particular manufacturing process from Schiller Park to Franklin Park at the time that Petitioner and Villanueva transferred to Franklin Park. This is the roll forming machine that makes a particular type of metal leg for a cart. Only two workers are trained to set up and operate the roll forming machine. They are Petitioner and Villanueva. As a result, in the event of layoff, at least one of them must be kept on duty while others, even with greater seniority, might be laid off.

Petitioner presented the testimony of Kari Stafseth, MA, CRC. She believed that Petitioner was a non-competitive candidate for a job as a machine operator. His current job tasks are not indicative of recognized sectors in the labor market for machine operators. Petitioner does not have transferable skills, given his educational and vocational background. He has lost access to his usual and customary occupation, given the restrictions that he has as a result of his injury. He is prospectively employable in an entry level unskilled position where he could speak Spanish. He would benefit from vocational rehabilitation. (PetEx. 15)

Petitioner's Personnel File and wage documents were submitted as Petitioner's Exhibit Number 9. The claimed medical bills were submitted as Petitioner's Exhibit Number 11. Respondent submitted bill payment information as Respondent's Exhibits Numbers 2, 3, and 4. Petitioner's Penalty Petition and supporting documentation were submitted as Petitioner's Exhibits Numbers 13 and 14. Respondent's Response was submitted as Respondent's Exhibit Number 1. Subsequent to trial, the

Parties stipulated that Respondent had paid $39,135.16 in TTD benefits and $6,844.80 in other benefits for a total compensation paid credit of $45,979.96.

Conclusions of Law

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

F.
Is Petitioner's current condition of ill-being causally related to the injury of January 21, 2011?

Petitioner's current condition of ill-being regarding his low back (status post L4-L5 fusion by Dr. Lorenz as described above, with resulting loss of function and subjective complaints) is causally related to the injury, based upon Petitioner's testimony and the medical records.

G.
What were Petitioner's earnings?

Petitioner claimed an Average Weekly Wage of $713.00. Respondent alleged an AWW of $567.87. Petitioner's Exhibit Number 9 contains wage information for Petitioner. Churchwell testified that the Petitioner's hourly rate of pay in January 2010 was $13.86 per hour and the rate increased to $14.26 per hour as of March 6, 2010. The rate remained $14.26 per hour through the date of accident. Mr. Churchwell also confirmed that at least 70% of all overtime worked by Petitioner was mandatory.

Wage records within Petitioner's Exhibit 9 reveal that Petitioner's gross earnings between January 11, 2010 and January 10, 2011 were $33,477.94 resulting in an Average Weekly Wage of $643.80. The Temporary Total Disability rate is $429.20, and the Permanent Partial Disability rate is $386.28.

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

Petitioner's Exhibit 11 lists claimed medical bill balances totaling $38,929.62. The billing providers are Accredited Ambulatory Care (balance of $34,670.92 following billing of $107,146.18, payments of $51,277.70, and adjustments / write offs of $21,197.56), G&U Orthopedic (balance of $3,143.70 after payments and adjustments / write offs), and La Clinica (a balance of $1,115.00 following billing of $35,255.00, payments of $30,396.38, and adjustments / write offs of $3,743.62). Respondent submitted Exhibits 2, 3, and 4 regarding partial payments made to these providers.

Respondent agreed to the admission of the bills, but did not agree that the charges were reasonable, or that the services were necessary or related to the accidental injuries. Nevertheless, the report of Dr. An, Petitioner's Exhibit Number 10, an independent medical examination conducted on June 21, 2011 at the request of Respondent, confirmed that, through that date, the medical care provided to Petitioner was reasonable and necessary.

Petitioner, on cross-examination, denied receiving treatment at Accredited Ambulatory Care. This entity's medical billing does not identify the actual service provider (doctor, nurse, therapist, or technician). Based upon Petitioner's testimony and the bill from this provider submitted in Petitioner's Exhibit 11, Petitioner's claim for the remaining bill from Accredited Ambulatory Care is denied.

Regarding the claimed bill from G&U Orthopedic, the unpaid balance of $3,143.10 is for services rendered to Petitioner on August 15, 2011, which appears to be for "Cervical/Upper Extremity Supplies-Spine & Scapula Stabilizer". (PetEx. 5) This bill is not awarded because it is for treatment involving the cervical spine/upper extremity and, therefore, is not related to the lumbar injury that Petitioner suffered while working for Respondent.

Regarding the claimed bill from La Clinica, the same is awarded, in the amount of $1,115.00, based upon the report of Dr. An and Petitioner's Exhibit Numbers 4 and 11.

This award is made pursuant to §§8(a) and 8.2 of the Act and Respondent is entitled to a credit for all bills paid.

K.
What temporary benefits are in dispute?

The Parties stipulated that Petitioner was entitled to TTD from February 19, 2011 through September 25, 2011 and from November 22, 2011 through November 6, 2012 (81-1/7 weeks. The Parties, subsequent to the hearings in this case, also jointly stipulated that Respondent paid, and Petitioner received, temporary total disability benefits in the amount of $39,135.16, and $6,844.80 in other compensation benefits. Respondent is entitled to a credit for a total of $45,979.96 in compensation payments. The Arbitrator notes that TTD benefits were paid at the rate of $378.58/week.

Petitioner requests an award of maintenance benefits during the times when he was laid off from work from November 7, 2012 through November 19, 2012, January 28, 2013 through March 21, 2013, November 15, 2013 through January 12, 2014, and March 27, 2014 through May 4, 2014. Respondent denies that Petitioner is entitled to such benefits and claims that temporary lay-offs do not entitle Petitioner to maintenance benefits in this case.

Petitioner arguably reached MMI on November 7, 2012, per Dr. Lorenz. The Arbitrator finds that Petitioner's condition did not stabilize and, therefore, he did not reach MMI until the April 22, 2013 visit with Dr. Lorenz. Petitioner was released back to work with restrictions as of the November 7, 2012 visit, but he still had to be cleared by a urologist. Thereafter, Petitioner was referred to Dr. Bardfield for pain management and saw Dr. Lorenz in follow-up on April 22, 2013. At that visit, Dr. Lorenz documents that Petitioner had overall improved post surgery and was being released again at MMI (True MMI?), PRN. Basically, Dr. Lorenz could offer Petitioner no further treatment options. The Arbitrator finds that April 22, 2013 is the date of MMI for the purpose of awarding temporary total disability benefits.

The Arbitrator notes that Petitioner was not in a vocational rehabilitation program during the claimed lay off periods. The Arbitrator also notes that on each occasion Petitioner returned to work after lay off to his regular job, except for a two-week, temporary stint in packaging. Unlike terminated

employees, individuals laid off from Respondent, including Petitioner, do not have to reapply for work, do not have to go through an interview process, and do not have to take a pre-employment physical when they are called back. The pattern of lay-offs and reinstatements at Respondent confirms that the lay-offs are temporary and not a true termination of the employees' employment.

Petitioner is not entitled to any maintenance benefits for the times that he was on layoff status after he reached MMI. Petitioner's alleged job search was not a bona fide or acceptable self-directed job search as contemplated by case law under the vocational rehabilitation provisions of the Act. Hunter Corp. v Industrial Commission, 86 Ill.2d 489 (1981). In the instant case, Petitioner appears to have contacted a number of employers through a computer job site (done by his daughter?) and otherwise. However, Petitioner failed to meet his burden of establishing that all or any of the potential employers had positions within Petitioner's restrictions, or that Petitioner had the training, education, or transferrable skills for the positions sought, or that the jobs were not already filled, or that Petitioner did not receive job offers because of his physical limitations. Petitioner spoke with four, or perhaps five, of the potential employers and immediately voiced his restrictions without inquiring about the nature or requirements of the jobs. Petitioner had no knowledge of whether he was a viable job candidate or whether others were competing for the same position.

Petitioner was asked on cross-examination about his transferrable skills. It is clear that he can operate a computerized brake press and a robotic welder. He also received training for, and was certified, as a forklift operator. The restrictions limiting his standing and sitting to one-hour intervals, and his 30-pound lifting restriction would not appear to prevent him from working at such positions.

Stafseth's opinions are not persuasive in this case, as is further explained below.

Petitioner is obviously a skilled laborer and Respondent obviously appreciates the value of a trained, loyal and talented employee. Respondent will accept employees back that have restrictions, either from a personal medical condition or due to a work related injury. The soundness of this business practice is obvious (the costs to hire and train new employees, including quality issues in its product far outweighs the minor loss in production associated with re-employing skilled workers that have limitations placed upon them by their physicians). Employers should be encouraged to facilitate their employee's productive return to work, as Respondent has done in this case.

Accordingly, Respondent shall pay Petitioner TTD benefits, in the amount of $429.20/week for 90-4/7 weeks, beginning February 19, 2011 through September 25, 2011, November 22, 2011 through November 19, 2012 and January 28, 2013 through March 21, 2013. See: Interstate Scaffolding, Inc. v. Workers' Compensation Comm'n, 236 Ill.2d 132 (2010)

L.
What is the nature and extent of the injuries?

Petitioner maintains that he is permanently and totally disabled under the odd-lot theory, arguing that despite his current job with Respondent, his physical restrictions prevent him from being employed in any other job or capacity. Petitioner argues that other than Respondent, there is no stable market for his skills, experience, and education, as limited by his physical restrictions. Respondent argues that the Petitioner is currently employed, rendering Petitioner's argument moot, and that Petitioner is

employable, given his ability to set up and operate the types of machines on which he currently works at Respondent, that he has the ability to operate forklifts, and he is experienced in welding, as well as having experience in other areas.

Petitioner submitted the testimony of Kari Stafseth, a certified rehabilitation counselor, in support of Petitioner's argument for an award of odd-lot permanent total disability. Stafseth testified to her knowledge of the physical activities and functions of a machine operator. Such workers must stand or walk at least two-thirds of the time, that their physical capabilities or requirements vary, and that they must be able to lift up to 50 pounds. Stafseth relied upon the Petitioner's statements to her that, as part of his job, he had to carry cabinets weighing up to 50 pounds. Stafseth confirmed her knowledge of Petitioner's physical restrictions. She concluded that Petitioner's need for hourly breaks, his inability to lift at least 50 pounds, and his presumed inability to twist at the waist, bend, squat, and stoop prevented him from obtaining machine operator positions in the labor market. (PetEx. 15 at pp. 15 - 16) Stafseth disputed that there was a need for the type of work that Petitioner was performing when he returned to his machine operation duties with Respondent after his convalescence. (PetEx. 15, pp. 18 – 20)

In considering Petitioner's past vocational experiences and transferable skills, Stafseth did discuss Petitioner's ability to operate a forklift, but not his welding skills. She did not consider forklift jobs for Petitioner. (PetEx. 15, pg. 61) In fact, she did not attempt to seek any jobs for Petitioner, who has returned to a productive job, for a good wage, at a company that he has worked for many years.

Ms. Stafseth did not discuss the Petitioner's ability to set up the computerized brake press, operate the robotic welder, or operate the roll forming machine. She did reference his ability to cut metal and solder, but did not pursue any soldering jobs for the Petitioner. (PetEx. 15, pp. 61-62)

Ms. Stafseth concluded that Petitioner did not have any transferable skills. (PetEx. 15, pp. 23 - 24) Thereafter, Stafseth testified that Petitioner's advanced age, his lack of English as a primary language, and his limited education rendered him unemployable. The issue of Petitioner's education was later discussed and Stafseth revealed that Petitioner had a high school degree and two semesters of college work in electrical technology. Ms. Stafseth did not recall the extent to which she explored work options for Petitioner involving his electrical training. (PetEx. 15, pp. 56 – 59)

Ms. Stafseth testified on cross-examination that if currently Petitioner had a job that "is a viable and stable job that fits within his realm of knowledge .... and physical capabilities" then there is no reason why Petitioner should look for another job. (PetEx. 15, pp. 41-42) When asked whether she possessed any information that would cause her to conclude that Petitioner could not retain his current position with Respondent until he reached age 65, Stafseth advised that she was not aware of Petitioner's current position at Respondent. (PetEx. 15, pp. 42-46, 52-53) Stafseth further confirmed that she had no knowledge of the machine operations at Respondent because she had not visited Respondent's plant. In fact, Stafseth testified that she had had experience in visiting only one manufacturing facility in the entire Chicago metropolitan area and had no knowledge of how many manufacturing facilities actually existed in Chicago.

Stafseth agreed that federal ADAAA laws would give employers an incentive to accommodate workers with physical restrictions or with an advanced age. She agreed that while she presumed that a requirement that Petitioner be able to sit and stand while working was an impediment to his return to work, she never interviewed potential employers about such a limitation. (PetEx. 15, pp. 53-54)

Ms. Stafseth was questioned about Petitioner's job search. She did not know the names of the companies he contacted, did not know if Petitioner had any interviews, and did not know the reason or reasons why Petitioner did not get the jobs he sought. She was aware that Petitioner did not put his physical restrictions on the computer job search applications he submitted and so it was reasonable to conclude that Petitioner did not miss out on the jobs because he had restrictions. (PX 15, pg. 64) Stafseth also agreed that 20 to 25 jobs involving the types of skills and experience that Petitioner had per month became available to him. (PetEx. 15, pp. 64 – 71)

The Arbitrator does not find the testimony of Ms. Stafseth persuasive. The Arbitrator concludes that the job searches conducted by Petitioner did not meet the level of a meaningful job search. The conclusions of Ms. Stafseth are based upon insufficient facts and a rejection of Petitioner's valuable skills, experience, and education, along with an employer that appears motivated to maintain a skilled, talented and capable manufacturing labor force. Further, the fact that 20 to 25 jobs became available on average each month, which jobs were appropriate for the skills, experience, and education of Petitioner, and which jobs could not be ruled out because it was unknown as to whether the jobs exceeded Petitioner's restrictions, cause the Arbitrator to conclude that Petitioner has not met his burden of proving that there is no stable labor market for him.

The testimony from both Petitioner and Carl Barajaz confirms that Petitioner is working successfully within his restrictions for Respondent as a machine operator. The testimony reveals that the petitioner has not been warned, either orally or in writing, that he is not meeting his production quotas or goals as a machine operator operating the computerized brake press, also called the metal folding machine, the roll forming machine, and the robotic welding machine.

The Arbitrator's believes that Petitioner presently has a job compatible with his skills, experience, education, and restrictions, which with minimal accommodation, is a regular, valuable and viable job at Respondent. This is a job needed to be performed for Respondent's manufacturing process.

The Arbitrator concludes that Petitioner has not met his burden of proving he suffered disability under §§ 8(f) or 8(d)1 of the Act. He has not suffered a loss of earnings. Respondent has worked with him to facilitate his return to work as a machine operator, earning a good wage and helping Respondent to provide quality products to its customers.

Employers should be encouraged to maintain employment for employees that are able to return to work after an injury, albeit with some limitations on their ability to fully perform their job. A PTD award in this case would discourage employers from allowing employees to return to productive work. In the present case, Petitioner would probably have difficulty in finding a machine operator job at a less enlightened employer that was not familiar with Petitioner's skills and experience and this factor is considered in determining the PPD award set forth below.

Considering the entire Record, including the testimony of Petitioner, Stafseth and Respondent's witnesses and the medical records, the Arbitrator finds that Petitioner has suffered the 32.5% loss of use of a person as a whole, in accordance with §8(d)2 of the Act, as a result of the injuries sustained.

M.
Should penalties or fees be imposed on Respondent?

The Arbitrator concludes that Respondent has acted in good faith regarding the disputed issues in this case, that reasonable parties could differ regarding the compensability of certain aspects of this case, and that Petitioner has failed to meet his burden of proving that penalties and attorney's fees are warranted. Consequently, Petitioner's claim for penalties and attorney's fees is denied.

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 up	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GARY WALLISER,

Petitioner,

vs.

NO: 12 WC 2451

17IWCC0603

WASTE MANAGEMENT EAST,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below but attaches the Decision for the Findings of Fact, which is made a part hereof with the modifications noted.

Petitioner was a garbage truck driver who sustained left shoulder and low back injuries on December 20, 2011, while putting a sleeper sofa into the back of the truck. He had left shoulder surgery on March 2, 2012, but was eventually released at maximum medical improvement with no restrictions to the shoulder. On September 14, 2012, Petitioner underwent lumbar surgery, including L3-L5 fusion, with Dr. Kennedy. He was eventually released on February 27, 2013 with permanent restrictions of 20-pounds lifting, only occasional bending/ twisting/stooping, and only being able to sit/stand for one hour at a time. Petitioner has continued, however, for pain management with Dr. Gunapooti, including injections and medication.

There is no dispute about Petitioner's restrictions and he is clearly not "medically" permanently and totally disabled. Petitioner argues that he is an "odd-lot" permanent total based on his showing: 1) a diligent but unsuccessful job search and 2) that he is not regularly employable in a well-known branch of the labor market due to his age, skills, training, and work history. Respondent argues that Kelly Burger, the vocational counselor at GENEX, opined that Petitioner is capable of finding an entry level, minimum wage job.

Petitioner testified that he previously worked at a gas station, Dairy Queen, and a nightclub for a while but most of his jobs since high school have been driving semi-trailer trucks. After his release by Dr. Kennedy, he started his vocational rehabilitation with GENEX in May 2013. He worked with a few different counselors over the years but primarily with Ms. Burger up through the date of the hearing.

Petitioner has no high school diploma and his transcripts indicate that he failed out of school in

the 10th grade. Even with the assistance of Ms. Burger and taking GED classes, he has failed multiple attempts at passing the test. Ms. Burger testified that:

- Petitioner complied with her recommendations and goals at each vocational meeting.
- He has made a valid and notable effort to try and pass the GED test.
- He has made valid efforts to date to find a position in the workforce.
- She has no criticism of his effort.
- Petitioner has not secured a position in the workforce to date.
- Petitioner provided copies of his job search logs and she followed up on some of the businesses he listed to confirm that he did, in fact, apply for those positions.
- Petitioner's job search logs reflect a valid and full effort.

Despite his lack of success thus far, Ms. Burger still believed that he could find an entry level, minimum wage position making between $8 and $12 per hour. On cross-examination, Ms. Burger admitted that, in general, six months to a year and a half is adequate to find out what the labor market will sustain for an individual. The Commission notes that Petitioner has been receiving vocational counseling with GENEX for over three years, since May 2013. Ms. Burger testified that 80 to 90% of employers require a high school diploma or GED and that this would be a "big barrier" to Petitioner finding a job. She admitted that it is not surprising that he is having a difficult time passing the GED considering his educational background and transcripts. She testified that Petitioner had been going to GED classes but was told to stop attending the class because he had used up his allowed amount of time. Now, he only has access to online training and practice tests. She agreed that Petitioner's effort was commendable. Petitioner almost passed the GED test at one point but then the test was made harder with a new format and he has never passed.

Despite Petitioner's lack of a GED, she encouraged him to apply to those jobs anyway and indicate that he is "trying" to obtain his GED so employers would see that he is at least trying to work on it. She admitted that she did not currently know of a job that was available for Petitioner but stated, "it is not impossible in my eyes" and that just because she hasn't found him a job so far doesn't mean that there isn't one out there. Ms. Burger estimated that Petitioner's job search included close to 1,000 companies but she wouldn't be surprised if it was 2,000. She agreed that this is a "pretty good sample" and, out of those, he's not employable.

We find that Petitioner is a compliant and motivated client who gave full, valid effort for more than three years with the assistance of multiple vocational counselors at GENEX; yet, still, has been unsuccessful in finding a job. Ms. Burger, despite all the evidence to the contrary, basically opines that it is possible (Px25 at 32) that Petitioner could find a job due to his "potential" (Id. at 33). We find that this opinion is completely speculative and contradicted by the actual evidence. Petitioner is required to show a "diligent but unsuccessful job search," which he has done. He is not required to engage in a universally exhaustive job search that excludes every possible employer that might, possibly, offer employment to him at some undetermined point in the future.

Respondent argues that Petitioner failed to meet his burden of proof because he did not have his own vocational counselor testify that he was unemployable. However, the parties agreed that GENEX would provide the vocational rehabilitation services and we find that Ms. Burger's testimony made it unnecessary for Petitioner to need another opinion. There is no evidence that Petitioner was uncooperative or unmotivated. Ms. Burger testified that Petitioner gave full, valid effort for over three years. We find that Ms. Burger's opinion is based more on hope and a desire to not give up on Petitioner than a rational analysis of the situation.

In addition to Ms. Burger's completely speculative opinion, the Arbitrator's primary basis for denying the odd-lot permanent total award seems to be her "suspicion" that Petitioner did not really

apply for more than 2,000 jobs because some of them are duplicated, since he applied online and also in person at some of them. Although Petitioner's job search logs are not very detailed, they do list the date, name, position, and how they were contacted. We note that this was not a self-directed job search, which could require a more careful review of those logs. Instead, Petitioner worked closely with Ms. Burger who commended him on a valid job search and she, in fact, had contacted some of the employers to confirm that Petitioner actually applied for the positions he listed. In addition, Petitioner's multiple contacts with the same employers via different methods could be viewed as diligence in trying to "get in the door." Although not specifically about this issue, Ms. Burger testified that they were trying different avenues to get around the fact that Petitioner did not have a GED and he was having great difficulty passing the exam. Regardless, whether it was 2,000 job search contacts or 1,000, and whether some of them were contacted in more than one way, the point is that Ms. Burger testified that it was a valid job search and Petitioner was unable to secure employment within his restrictions.

Based on all of the above, we find that Petitioner has proven that he is entitled to a permanent total disability award under the "odd-lot" theory by showing a diligent and unsuccessful job search for three years, even with the assistance of a vocational counselor. The parties stipulated that Petitioner's average weekly wage was $933.33 in the year preceding his injury. This results in a permanent total disability benefit of $622.22 per week, as provided in §8(f) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay the petitioner the sum of $622.22 per week for life, commencing December 21, 2016, as provided in §8(f) of the Act, because the injury caused the permanent and total disability of the Petitioner.

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 §8(g) of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 29 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 8/30/17
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WALLISER, GARY
Employee/Petitioner

Case# **12WC002451**

WASTE MANAGEMENT EAST
Employer/Respondent

17IWCC0603

On 4/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.91% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1580 BECKER SCHROADER & CHAPMAN PC
TODD J SCHROADER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

1109 GAROFALO SCHREIBER HART ETAL
CRAIG M SCARPELLI
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

17IWCC0603

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
NATURE AND EXTENT ONLY

Gary Walliser
Employee/Petitioner

v.

Waste Management East
Employer/Respondent

Case # 12 WC 2451

Consolidated cases: N/A

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **December 21, 2016**. By stipulation, the parties agree:

On the date of accident, **December 20, 2011**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner's earnings were $48,533.16 and the average weekly wage was **$933.33**.

At the time of injury, Petitioner was **47** years of age, ***married,*** with **0** dependent children.

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

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

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

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits, commencing December 21, 2016, of $408.89/week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

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

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

Signature of Arbitrator

4/3/17
Date

APR 5 - 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Gary Walliser
Employee/Petitioner

Case # 12 WC 2451

v.

Consolidated cases: N/A

Waste Management East
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is currently age 52. He testified that back in December of 2011, he had an accident while putting a sofa sleeper into a trash truck and that he injured his left shoulder and low back. He testified that he underwent surgery in March of 2012 with Dr. Dusek, and that after that he had additional surgery on his low back with Dr. Kennedy. He testified that he continues to undergo treatment with his pain management physician.

Petitioner testified that he was given permanent restrictions by Dr. Kennedy. He testified that he then began performing a job search. He testified that he did not complete high school and that as part of his vocational rehabilitation, he attempted to pass the GED but was not successful. He testified that he took the GED several times but did not receive a passing grade at any point. He testified that he received tutoring and did his best to try to pass, but that the format for the GED had changed and was now more difficult to pass.

Petitioner testified that his work history includes having worked at a gas station, at Dairy Queen and at a nightclub as well as driving trucks. He testified that he was a driver of a trash truck at the time of the accident and that he had been able to perform those duties up until the accident occurred. He testified that since the accident, he has not been able to work and has not had a job. He testified that in addition to receiving help in taking the GED, his vocational counselor also assisted in trying to find a job for him. He testified that he worked with multiple vocational counselors, the most recent of which was Kelly Burger. He testified that he continues to work with her, but has not been successful in finding a job with her. He testified that he has given his best effort.

Petitioner testified that he has applied for more than 2,000 jobs and continues to perform his job search to date, but that he has not been successful. He testified that in his job searches, it has been a problem that he does not have a GED. He testified that some of the employers have stated that he needed a high school diploma.

Petitioner testified that his current restrictions do not allow for him to drive a truck. He testified that he was not able to return to work with Respondent. He testified that he attempted to return, but they sent him a termination letter in 2014. He testified that after receiving the letter, he started his job search and has been searching for almost three years both with and without the help of vocational counselors. He testified that during his job search, he has tried to apply for a lot of different types of work including customer service, dispatching and security jobs.

On cross examination, Petitioner testified that he was released from care by Dr. Kennedy in January of 2014 and that as to the left shoulder, he was released by Dr. Dusek in August of 2012. He testified that Dr. Dusek released him for the left shoulder with no restrictions, and that his permanent restrictions only applied to his lower back.

The medical records of Concentra Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner was seen on December 23, 2011, at which time it was noted that on December 20, 2011, he had to lift a heavy sleeper-sofa into his refuse truck and that as he did so, he felt a pain in his left shoulder and lower back. It was noted that the pain had persisted and even worsened, and that the shoulder hurt when lifting or raising the arm. It was noted that his back was worsened by bending over or lifting, and that there was no radiation of pain into the extremities. It was noted that x-rays of the lumbar spine noted no fracture and that degenerative changes were present; x-rays of the left shoulder were interpreted as negative. The assessment was that of (1) left shoulder strain, moderate; (2) lumbar strain, moderate. Petitioner was given medications and instructed to begin physical therapy. Petitioner was also placed under work restrictions. (PX1).

The records of Concentra Medical Center reflect that Petitioner was seen on December 28, 2011 for a recheck, at which time it was noted that he felt the pattern of his symptoms was about the same as the last visit for the left shoulder and lower back. The assessment was noted to be that of (1) left shoulder strain, moderate; (2) lumbosacral strain, moderate. At the time of the January 4, 2012 visit, Petitioner noted that his pain was still about the same. The assessment was noted to be that of (1) left shoulder strain, moderate; (2) lumbosacral strain, moderate. At the time of the January 11, 2012 visit, it was noted that Petitioner felt the pattern of symptoms was stable and it was noted that he had been working within the duty restrictions. The assessment was noted to be that of (1) shoulder strain, left; (2) lumbar strain. At the time of the January 27, 2912 visit with Dr. Khariton, it was noted that Dr. Dusek had recommended shoulder surgery and that Petitioner was being seen for his low back complaints. The assessment was noted to be that of (1) low back pain, left lower extremity pain and paresthesia per patient's complaints; (2) history of work-related injury on December 20, 2011, with no significant improvement of symptoms. Petitioner was referred for an MRI of the lumbar spine to rule out discogenic cause of his pain versus nerve root compression. (PX1).

The records of Concentra Medical Center reflect that Petitioner was seen on February 8, 2012, at which time it was noted that he noted no significant change in regard to his low back pain and left lower extremity pain. The impression was noted to be that of (1) low back pain, left lower extremity and paresthesia per patient's complaints; (2) degenerative disease of lumbar spine with neuroforaminal narrowing particularly at L5-S1 level. At the time of the February 22, 2012 visit, it was noted that Petitioner reported no significant changes in regard to his low back pain and left lower extremity pain. The impression was noted to be that of (1) low back pain, left lower extremity and paresthesia; (2) degenerative disease of lumbar spine as per MRI of lumbar spine from February 1, 2012. At the time of the March 28, 2012 visit, it was noted that Petitioner noted that he had had an epidural steroid injection about one week ago and that he stated it did not change his symptoms in regard to low back pain. The impression was noted to be that of (1) low back pain, left lower extremity and paresthesia per patient's complaints; (2) history of work-related injury on December 20, 2011 with no significant improvement with conservative treatment. Petitioner was referred to an orthopedic spine specialist at that time. (PX1).

The medical records of Dr. Dennis Dusek were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Petitioner was seen on January 19, 2012, at which time it was noted that he stated that his left shoulder had been asymptomatic until December 20th, at which time he was in the process of picking up a couch and love seat and felt something happen to his left shoulder. It was noted that Dr. Dusek was concerned that Petitioner may have a rotator cuff tear and was recommended to undergo an MRI. A letter directed to "To Whom It May Concern" dated January 27, 2012 was included within the records, which noted that Petitioner's MRI showed a full thickness tear of the anterior supraspinatus

tendon and that there was no sign of a SLAP tear. It was noted that Petitioner was recommended to undergo arthroscopic rotator cuff repair. (PX2).

The records of Dr. Dusek reflect that Petitioner was seen by Dr. Kumar on February 28, 2012, at which time it was noted that he was being seen regarding his lower back and left-sided lower extremity radicular symptoms at the request of Dr. Khariton for an epidural injection. The assessment was noted to be that of (1) most likely left-sided L5 radiculitis; (2) lumbar strain; (3) multilevel lumbar degenerative disease, worse at L5-S1 with discogenic bulge and severe left foraminal stenosis. At the time of the March 12, 2012 visit with Dr. Dusek, it was noted that Petitioner had undergone left shoulder arthroscopic double row rotator cuff repair with subacromial decompression and shaving of the biceps tendon 10 days ago. At the time of the April 13, 2012 visit, it was noted that Petitioner was coming along nicely in physical therapy and that he stated that he was 50-60% less painful than before surgery already. At the time of the May 11, 2012 visit, it was noted that Petitioner seemed to be improving very nicely and no longer woke up from sleep at night and had quite a bit less pain during the day. (PX2).

The records of Dr. Dusek reflect that Petitioner was seen on June 7, 2012, at which time it was noted that he was beginning to feel very good pain relief and his physical therapy report was very encouraging with essentially full active motion and minimal pain. At the time of the July 5, 2012 visit, it was noted that Petitioner was showing full overhead motion to the shoulder and noted minimal pain. The assessment was noted to be that of partial rotator cuff tear. At the time of the August 2, 2012 visit, it was noted that Petitioner had done extraordinarily well and showed excellent progress in physical therapy to the point where he had essentially full strength and essentially full motion. It was noted that Petitioner had no complaints referable to the shoulder, but was still under the care of Dr. Kennedy for his back. It was noted that Petitioner would reach maximum medical improvement as of August 6, 2012 and he was released to full duty with respect to his shoulder on that date. (PX2).

The medical records of Dr. David Kennedy were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on May 1, 2012, at which time it was noted that on December 20, 2011 he was picking up a couch and attempting to place it into a truck when he had pain in the lower lumbar area and left shoulder. The diagnostic impression was noted to be that of sciatica secondary to a disc herniation as noted on the MRI, and that the abnormality correlated with Petitioner's pain complaints. At the time of the June 19, 2012 visit, it was noted that Petitioner had not had any improvement with treatment thus far including injections. After a lumbar myelogram was performed on June 25, 2012, it was noted that there was a disc herniation at L4-5 and that there was also stenosis noted at L3-4. Petitioner was recommended to undergo lumbar decompression and fusion. (PX3).

The records of Dr. Kennedy reflect that Petitioner was seen on September 14, 2012 for an elective decompression and fusion in conjunction with Dr. Robson. The impression was noted to be that of spinal stenosis L3-4 with severe foraminal encroachment and disc space collapse at L4-5, and it was noted that Petitioner was admitted for elective lumbar decompression and fusion at L3-4 and L4-5. The Operative Report dated September 14, 2012 noted pre- and post-operative diagnoses of (1) herniated nucleus pulposus at L4-5; (2) spinal stenosis at L3-4, and the procedure performed included (1) L3-4 laminectomy; (2) L4-5 laminectomy and facetectomy with disk removal; (3) pedicle screw fixation and fusion, L3 to L5; (4) posterolateral fusion, L3 to L5. (PX3).

The records of Dr. Kennedy reflect that Petitioner was seen on October 22, 2012, at which time it was noted that he reported constant low back pain radiating down his left leg that was keeping him awake during the night. It was noted that Petitioner was to continue wearing the bone growth stimulator and was strongly advised to quit smoking as much as possible. At the time of the December 4, 2012 visit, it was noted that Petitioner continued to have lower lumbar pain with radiating pain into the left leg and left flank. At the time of the January 18, 2013 visit, it was noted that Petitioner had been going to physical therapy three times per week which aggravated his pain even more. At the time of the February 27, 2013

visit, it was noted that Petitioner was still having pain. It was noted that the recent myelogram showed that Petitioner was solidly fused, and that the FCE reflected the fact that he was not able to work in his normal job capacity. Petitioner was recommended to not lift more than 20 pounds nor do more than occasional bending, twisting or stooping and should not sit or stand for more than an hour at a time without an opportunity to change positions. Petitioner was instructed to return as needed and was recommended to undergo an evaluation by a pain management specialist for further treatment, if necessary. Petitioner was thereafter seen on January 30, 2014, at which time it was noted that he had undergone a series of injections by Dr. Gunapooti which did not help. (PX3).

The medical records of Injury Specialists were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner was seen on May 23, 2012, at which time it was noted that he was referred by Dr. Kennedy with a history of low back pain down the left lower extremity. The impression was noted to be that of (1) lumbar radiculopathy; (2) lumbar spondylosis without myelopathy; (3) back pain; (4) sacroiliitis. Petitioner was recommended to change medications and undergo a selective nerve root block/"transformational" facet injection left L5-S1. The first injection was performed on May 23, 2012, the second was performed on May 31, 2012 and the third was performed on June 7, 2012. (PX4).

The medical records of Dr. Mahendra Gunapooti were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner was seen on May 24, 2013 for an initial medical exam. It was noted that Petitioner was seen for evaluation of chronic low back pain with radiation to the hips to leg to calf, as well as intermittent numbness and tingling. It was noted that Petitioner appeared to have chronic left lumbar radiculitis and history of spinal surgery with fusion and possible post-laminectomy syndrome. At the time of the August 30, 2013 visit, Petitioner was seen for a medication refill. At the time of the September 12, 2013 visit, Petitioner underwent a lumbar transforaminal epidural. At the time of the September 26, 2013 visit, Petitioner underwent a lumbar transforaminal epidural. At the time of the October 17, 2013 visit, Petitioner underwent a lumbar transforaminal epidural. (PX5).

The records of Dr. Gunapooti reflect that Petitioner was seen on November 15, 2013, at which time it was noted that he was seen for a medication refill. Petitioner was advised to follow-up with a spine surgeon, and it was noted that he appeared to have chronic lumbar radiculitis, lumbar degenerative disc disease and spondylosis and a history of lumbar spine surgery, possible post-laminectomy syndrome. Petitioner was advised about a multimodal approach to controlling his pain with a combination of lumbar spinal blocks, oral medications and as needed basis of physical therapy. (PX5).

The records of Dr. Gunapooti reflect that Petitioner was seen on December 13, 2013 at which time it was noted that he was not able to see Dr. Santiago and was requesting to see another spine surgeon. Petitioner was given a referral to Dr. Bailey. At the time of the January 10, 2014 visit, it was noted that Petitioner had an appointment with Dr. Kennedy in a few weeks. At the time of the February 6, 2014 visit, Petitioner underwent a lumbar transforaminal epidural and was advised to undergo an MRI of the lumbar spine. At the time of the March 6, 2014 visit, Petitioner was given a medication refill and underwent a lumbar transforaminal epidural. (PX5).

The records of Dr. Gunapooti reflect that Petitioner was seen on October 10, 2014, at which time it was noted that he was being seen for a medication refill. At the time of the November 21, 2014 visit, Petitioner was seen for a medication refill. At the time of the December 11, 2014 visit, Petitioner underwent a lumbar transforaminal epidural. At the time of the January 15, 2015 visit, Petitioner underwent a lumbar transforaminal epidural. At the time of the February 19, 2015 visit, Petitioner underwent a lumbar transforaminal epidural. (PX5).

The records of Dr. Gunapooti reflect that Petitioner was seen on March 30, 2015, at which time it was noted that he was still dealing with workers' compensation. At the time of the April 24, 2015 visit, Petitioner was seen for a medication refill. At the time of the May 22, 2015 visit, Petitioner was seen for

a medication refill. At the time of the June 19, 2015 visit, Petitioner was seen for a medication refill. At the time of the July 17, 2015 visit, Petitioner was seen for a medication refill. At the time of the August 14, 2015 visit, Petitioner was seen for a medication refill. At the time of the September 11, 2015 visit, Petitioner was seen for a medication refill. At the time of the October 9, 2015 visit, Petitioner was seen for a medication refill. At the time of the November 6, 2015 visit, Petitioner was seen for a medication refill. At the time of the December 11, 2015 visit, Petitioner was seen for a medication refill. (PX5).

The records of Dr. Gunapooti reflect that Petitioner was seen on January 22, 2016 for a medication refill. At the time of the February 19, 2016 visit, Petitioner was seen for a medication refill. At the time of the April 1, 2016 visit, Petitioner was seen for a medication refill. At the time of the April 29, 2016 visit, Petitioner was seen for a medication refill. It was noted that Petitioner reported seeing his primary care physician, Dr. Mahey, as well as a nephrologist, Dr. Singh, and reported there was improvement in his kidney function. At the time of the May 27, 2016 visit, Petitioner was seen for a medication refill. At the time of the June 24, 2016 visit, Petitioner was seen for a medication refill. At the time of the August 5, 2016 visit, Petitioner was seen for a medication refill. At the time of the September 2, 2016 visit, Petitioner was seen for a medication refill. At the time of the September 30, 2016 visit, Petitioner was seen for a medication refill. (PX5).

The records of Dr. Gunapooti reflect that Petitioner was seen on November 4, 2016 for a medication refill. At the time of the December 2, 2016 visit, Petitioner was seen for a medication refill. It was noted that Petitioner complained of chronic moderate low back pain with radiation to the hips, to the legs and to the feet, increasing with activity, standing, walking and weather changes, as well as intermittent associated numbness and tingling and with activity. (PX5).

Various x-rays reports of the lumbar spine were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. Petitioner underwent x-rays of the lumbar spine on December 23, 2011 which were interpreted as revealing spondylosis, and he also underwent x-rays of the left shoulder on the same date which were interpreted as revealing no acute osseous abnormality. Petitioner underwent x-rays of the lumbar spine on June 25, 2012, which were interpreted as revealing degenerative changes most severe L4 through S1. Petitioner also underwent x-rays of the lumbar spine on October 22, 2012, which were interpreted as revealing (1) internal disc derangement; (2) postoperative instrumentation and fusion L3-L5. Petitioner underwent additional x-rays of the lumbar spine on November 29, 2012, which were interpreted as revealing post laminectomy changes with transpedicular screws seen extending from L3-L5 with narrowing of the disc spaces between L4-L5 and L5-S1. The x-rays of the lumbar spine performed on January 31, 2013 were interpreted as revealing post-surgical changes. (PX6).

Various x-rays reports of the left shoulder were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. Petitioner underwent x-rays of the left shoulder and axillary lateral views of both shoulders on January 19, 2012, which were interpreted as revealing no evidence of osseous pathology in the left shoulder and two anchors from what appeared to be a superior labral repair of the right shoulder. On March 12, 2012, x-rays of the left shoulder were performed and were interpreted as revealing anchors in excellent position on the greater tuberosity, a type 1 acromion after the subacromial decompression and no fracture, dislocation or other bony abnormality. (PX7).

Various CT reports of the lumbar spine were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Petitioner underwent a CT myelogram of the lumbar spine on June 25, 202, which was interpreted as revealing (1) spinal canal stenosis L3-L4 and L4-L5; (2) left subarticular disc protrusion which contains a few locules of air L4-L5, resulting in narrowing of the left lateral recess; (3) bilateral foraminal narrowing, severe at L4-L5 on the right and L5-S1 on the left; (4) scoliosis. Petitioner also underwent a CT myelogram of the lumbar spine on January 31, 2013, which was interpreted as revealing (1) prominent degenerative disc disease as described L3 through S1; (2) post-surgical changes consistent with posterior instrumentation L3 to L5; solid fusion not yet present posteriorly; (3) foraminal

narrowing as described due to marginal vertebral body osteophyte overgrowth most prominent at L5-S1 especially on the left but also noted at L4-L5; (4) incidental atherosclerosis of the aorta and its branches. (PX8).

Various lumbar myelogram reports were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. Petitioner underwent lumbar myelography on June 25, 2012, which was interpreted as revealing (1) spinal canal stenosis L3-L4 and L4-L5; stenosis appears more prominent at L3-L4; (2) degenerative disc space narrowing most severe at L4 through S1; (3) scoliosis. Petitioner also underwent lumbar myelography on January 31, 2013, which was interpreted as revealing (1) marked disc space narrowing with end plate sclerosis and osteophytes note at L3 through S1; (2) bilateral posterior pedicle screws L3 through L5 connected by bilateral vertical rods; (3) no canal stenosis observed at this time. (PX9).

The Interpretive Report for an MRI of the left shoulder dated January 25, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The study was interpreted as revealing (1) full-thickness anterior insertional tear of the supraspinatus, measuring 19 mm AP diameter with retraction of the torn free end by approximately 12 mm; there is tendinopathy and delamination to the intact posterior supraspinatus rim, extending into the upper infraspinatus; (2) AC joint arthropathy and 7 mm undersurface spurring resulting in supraspinatus outlet stenosis and supraspinatus myotendinous junction impingement. (PX10).

The Interpretive Report for an MRI of the left sacroiliac joint dated February 1, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The study was interpreted as revealing sacroiliac joints negative for asymmetry or widening; no sacral fracture or pelvic hematoma seen. (PX11).

The Interpretive Report for an MRI of the lumbar spine dated February 1, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The study was interpreted as revealing (1) moderate to severe degenerative changes of the mid and lower lumbar spine as discussed; (2) focal moderate to severe left neuroforaminal stenosis at the L5-S1 level secondary to combination of moderate left sided lateralizing disc bulge and facet hypertrophy; (3) moderate central canal stenosis at the L3-5 levels; (4) no fracture seen. (PX12).

The Interpretive Report for an MRI of the left shoulder dated February 11, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The study was interpreted as revealing (1) there has been interval fusion from the L3 to L5 levels via posterior approach; (2) mild left convex scoliosis; (3) 8 mm retrolisthesis of L5 on S1; (4) 2 mm retrolisthesis of T12 on L1; (5) degenerative disc disease and spondylosis of the lumbar spine as noted; (6) at T120L1 on sagittal imaging, there is a minimal posterior disc bulge; (7) at L1-2 there is a posterior disc bulge; (8) at L2-3 facet hypertrophy and left neural foraminal disc bulge result in mild left neuro foraminal stenosis; (9) at L3-4 and at L4-5 facet hypertrophy and a disc bulge result in bilateral neural foraminal stenosis as noted; (10) at L5-S1 facet hypertrophy, a disc bulge and endplate spurring result in bilateral neural foraminal stenosis as noted. (PX13).

Various injection reports were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. Petitioner underwent a selective left L5 transforaminal epidural injection under fluoroscopy on February 28, 2012 and transforaminal epidural injections on May 31, 2012 and June 7, 2012. (PX14).

The Operative Report dated March 2, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 15. Petitioner underwent a left shoulder arthroscopic rotator cuff repair using double-row technique with subacromial decompression and shaving of biceps tendon on March 2, 2012 by Dr. Dusek. The pre-operative diagnosis was noted to be that of left shoulder rotator cuff tear and the post-

operative diagnoses were noted to be that of left shoulder rotator cuff tear plus partial biceps fraying. (PX15).

The Operative Report dated September 14, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 16. Petitioner underwent L3-4 laminectomy, L4-5 laminectomy and facetectomy with disk removal, pedicle screw fixation and fusion, L3-L5 and posterolateral fusion, L3-L5 on September 14, 2012. The pre-operative and post-operative diagnoses were noted to be that of (1) herniated nucleus pulposus at L4-5; (2) spinal stenosis at L3-4. (PX16).

The Functional Capacity Evaluation dated February 12, 2013 was entered into evidence at the time of arbitration as Petitioner's Exhibit 17. It was noted that the DOT placed Petitioner's occupation as a Garbage Collector in the very heavy strength category, and that he did not meet these strength requirements and may not return to work as a Garbage Collector. It was noted that Petitioner was capable of a position in the Medium strength category, and that his maximum lifting capacity was 40 pounds and that his maximum carrying capacity was 25 pounds. It was noted that in order for Petitioner to successfully return to work in the medium strength category, the following job factor restrictions must be met: no standing for more than 12 minutes continuously; no sitting for more than 23 minutes continuously; no walking for more than 0.2 miles continuously; no balancing activities that require crouching. (PX17).

Various physical therapy records from Fitness Designs were entered into evidence at the time of arbitration as Petitioner's Exhibit 18.

The transcript of the deposition of Dr. David Kennedy was entered into evidence at the time of arbitration as Petitioner's Exhibit 19. Dr. Kennedy testified that he is a physician specializing in neurosurgery and that he took a history from Petitioner at the time of the May 1, 2012 visit. He testified that the history provided by Petitioner matched up with the history he reviewed in the Concentra Medical Center records. He testified that the MRI dated March 1, 2012 demonstrated a disc herniation with significant foraminal encroachment at L5-S1 on the left side, as well as at least moderate stenosis noted at L3-4 and L4-5. He testified that he thought that Petitioner had sciatica secondary to the disc herniation noted on the MRI, for which he recommended additional conservative measures including pain management. He testified that he believed that Petitioner's symptoms were the result of the work injury of December 20, 2011. (PX19).

Dr. Kennedy testified that when he next saw him on June 19, 2012, Petitioner had had some injections and had not had any improvement so he was set up for a lumbar myelogram. He testified that the lumbar myelogram noted a disc herniation at L4-5 on the left that corresponded to the MRI level, and there was also stenosis at L3-4 from a combination of disc bulging and some facet degenerative changes. He testified that he then recommended surgery to include nerve root decompression and fusion at L3-4 and L4-5. He testified that surgery was performed on September 14, 2012 with Dr. Robson. (PX19).

Dr. Kennedy testified that what was visualized in the surgery was related back to the accident that Petitioner told him of in his initial visit, and that all of the medical bills were related to the procedure and the care and treatment of Petitioner. He testified that the medical bills were related to the accident that took place on December 20, 2011, and that all of the time off work was also related to the accident as well. (PX19).

On cross examination, Dr. Kennedy testified that the accident history that he obtained he obtained directly from Petitioner when he was first seen on May 1, 2012. He agreed that Petitioner provided a similar history to Concentra Medical Center. (PX19).

Petitioner's GED Information was entered into evidence at the time of arbitration as Petitioner's Exhibit 20. Petitioner took the test on December 4, 2013, July 28, 2014 and September 23, 2014 but did not qualify for an Illinois High School Equivalency Certificate. (PX20).

The Job Searches performed by Petitioner were entered into evidence at the time of arbitration as Petitioner's Exhibit 21. The records reflect that Petitioner applied for a number of positions during the timeframe of March 2, 2013 through June 20, 2016. (PX21).

Additional Job Searches performed by Petitioner were entered into evidence at the time of arbitration as Petitioner's Exhibit 22. The records reflect that Petitioner applied for a number of positions during the timeframe of June 29, 2016 through December 12, 2016. (PX22).

Various reports from Genex were entered into evidence at the time of arbitration as Petitioner's Exhibit 23. A Labor Market Survey was performed on July 5, 2013 by Brenda Latham. The records reflect that Petitioner's work history was summarized in the following DOT titles: Garbage Collector; Garbage Collector Driver; Truck Driver, Heavy; and Salvage Worker, non-ferrous metal. Appropriate vocational alternatives identified for Petitioner were noted to include Assembler; Telephone Solicitor (any industry); Dispatcher, Motor Vehicle; Security Guard, Unarmed; Escort Vehicle Driver; Customer Service Clerk and Cashier-Checker. It was noted that of the 10 employers listed in the Labor Market Survey 6-10 provided salary information with advertised job openings or it was requested through telephone contact. Salary information obtained included: Telemarketing – Inside Sales ($11.00-$11.50 per hour); Call Center, Customer Service Positions ($10.00 per hour); Inside Sales, Automotive Repair Tools ($14.50 per hour plus commissions); Unarmed Security Guards ($7.75-$11.00 per hour). It was noted that it was anticipated that Petitioner would be able to secure employment within the $7.75 (Missouri Minimum Wage) per hour starting salary range to a high starting salary range of $16.37 per hour, and that salary information provided by employers identified current advertised job openings in the $7.75-$14.50 starting salary range. (PX23).

A Rehabilitation Plan signed on July 15, 2015 with an Addendum dated June 5, 2015 was included within the records. The Job goals were noted to include Dispatcher; Cashier; Delivery Driver; Telephone Solicitor; Inspector; Security Guard; Customer Service Representative and other jobs within his restrictions not listed. (PX23).

Additional reports from Genex were entered into evidence at the time of arbitration as Petitioner's Exhibit 24.

The transcript of the deposition of Kelly Burger was entered into evidence at the time of arbitration as Petitioner's Exhibit 25. Ms. Burger testified that she is a vocational case manager for Genex Services and is a certified rehabilitation counselor. She testified that she was retained by agreement of both of the parties to perform vocational services for Petitioner. (PX25).

Ms. Burger testified that she met with Petitioner personally to establish a vocational rehabilitation plan, and that a plan was formalized which was agreed to by both parties. She testified that after establishing the agreed plan, she then began providing vocational assistance to Petitioner. She testified that Petitioner complied with her recommendations and goals at each vocational meeting, and that he made a valid effort to try and pass the equivalency exam for a high school diploma. She testified that he had made valid efforts to find a position in the workforce and did not have any criticism of his effort. (PX25).

Ms. Burger testified that she believed that Petitioner was employable, but that he had some barriers like passing the GED and a time gap in employment. She testified that she felt that he remained a good candidate for vocational rehabilitation. She testified that realistically she believed that Petitioner

would likely need to have an entry level position because of his restrictions and not being able to do what his past work history was as a truck driver, and that he would likely earn $8-12 per hour depending on the job. She testified that her only concern was that if he did not pass the GED, it would continue to make it hard for him. (PX25).

Ms. Burger testified that she felt that Petitioner's job search logs reflected a valid and full effort by Petitioner to apply for and follow up on the positions that he listed within the logs. She testified that she did not have any cause to disagree with the opinions and results of the July 5, 2013 labor market survey prepared by Brenda Latham. (PX25).

On cross examination when asked what would be the time period that she would say was adequate to figure out what the labor market would sustain for an individual, Ms. Burger responded that in general it would be six months to a year and a half depending on the person's background and skills but also the economy. She agreed that if someone was off work too long, it made it harder to place them. She agreed that Petitioner had a significant barrier concerning his education. She agreed that she reviewed his high school transcript and that she found it to be disturbing. She agreed that given the GED and Petitioner's grades, it was not surprising that he was having a tough time passing the GED. (PX25).

On cross examination, Ms. Burger agreed that there were a lot of employers that required a GED or high school equivalent. She testified that she believed that 80-90% of employers required a high school diploma or GED. She agreed that the changes that occurred with the GED test did not help Petitioner, that he was close to passing with the old test and that once they shifted to the new test it became a lot harder for him to even get close to passing. She agreed that none of Petitioner's job searching on his own lead to a job nor did their combined efforts lead to a job. (PX25).

On cross examination, Ms. Burger agreed that the earlier labor market survey did not incorporate the idea that Petitioner could not pass the GED. She agreed that the labor market survey was not up-to-date. She testified that she believed that there were various jobs available in the $8-12 per hour range including a delivery driver, sales, telemarketer and dispatcher. She testified that she thought the biggest barriers that she usually saw were a lack of computer skills and criminal backgrounds. She agreed that Petitioner did not have a criminal background. She testified that Petitioner did fairly well on the computer and that he was capable of doing basic computer work. She agreed that when Petitioner started he was terrible, and that now he was functional with a computer. (PX25).

On redirect examination, Ms. Burger testified that in her experience, a change in the administration could also cause a change in the job market. She testified that she hoped that there was potential for that to improve Petitioner's potential of finding a job over the next year. She agreed that it was fair to say that Petitioner's most likely prospect of finding a job would be something that would earn him the minimum wage in either Illinois or Missouri. (PX25).

The Madison Public School Transcript was entered into evidence at the time of arbitration as Petitioner's Exhibit 26.

The October 10, 2012 Section 12 Report of Dr. Brett Taylor was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The report noted that Dr. Taylor opined that Petitioner had severe end-stage lumbar degenerative disc disease combined with congenital stenosis, and that it most notably affected his L3-4, 4-5 and L5-S1 levels. It was noted that Petitioner's work exposure of December 20, 2011 was not the prevailing factor causing his spinal condition, that Petitioner's need for lumbar surgery was based on preexisting degenerative disc disease and that the work event at most aggravated the preexisting lumbar degenerative disc disease. It was noted that Petitioner's need to maintain out of work was due to his post-surgical state and that his fusion L3-5 had not yet healed. It was noted that Petitioner's persistent use of nicotine greatly increased his risk of a complication in the form of

a nonunion, and that the use of a bone stimulator and strict cessation of nicotine might provide a solid fusion. It was noted that Petitioner carried a guarded prognosis for return to a high level of function, if there was a successful osseous union. (RX1).

The December 2, 2014 Report and Rating of Dr. Robert Bernardi was entered into evidence at the time of arbitration as Respondent's Exhibit 2. It was noted that Petitioner reported that since the surgery, he was pretty much the same. It was noted that Petitioner was assigned permanent restrictions and discharged by Dr. Kennedy, and that since then he had been seeing Dr. Gunapooti, a pain management physician, who had been prescribing medications and also performed additional injections. It was noted that Dr. Bernardi did not note any Waddell's signs on physical examination, and that there was nothing to suggest that Petitioner did not give a full effort during his February 12, 2013 FCE. (RX2).

The Dr. Bernardi report reflects that he opined that Petitioner had untreated foraminal stenosis in his low back that was responsible for his ongoing complaints. It was noted that Dr. Bernardi opined that it was extraordinarily unlikely that additional non-operative intervention had anything to offer Petitioner and that to try and address his problem, he most likely needed additional surgery and that to address his symptoms he would need a left L5 foraminotomy and his L3-5 fusion would need to be extended to L5-S1. It was noted that Petitioner had already undergone an L3-L5 fusion which increased his risk of developing a pseudoarthrosis at L5-S1 following a revision procedure, and that Petitioner continued to smoke which represented a significant risk factor for the development of a failed/delayed fusion. (RX2).

The Dr. Bernardi report reflects that if Petitioner was interested in additional treatment, he could not currently determine the degree of impairment he had sustained as a result of his work accident. It was noted that if Petitioner did not wish to pursue additional treatment, Dr. Bernardi opined that Petitioner had a 17% whole person impairment related to his December 20, 2011 work injury. (RX2).

The July 5, 2013 Labor Market Survey from Brenda Latham was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The Rehabilitation Plan dated July 15, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The September 21, 2016 Vocational Report of K. Burger was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The November 22, 2016 Vocational Report of K. Burger was entered into evidence at the time of arbitration as Respondent's Exhibit 6.

CONCLUSIONS OF LAW

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, the Arbitrator notes that "To receive an award under section 8(d)(1), an injured worker must prove (1) that he or she is partially incapacitated from pursuing his or her usual and customary line of employment and (2) that he or she has suffered an impairment in the wages he or she earns or is able to earn." *Cassens Transport Co. v. Industrial Comm'n*, 218 Ill.2d 519, 844 N.E.2d 414 (Ill. 2006). The Arbitrator finds that both of these elements have been met by the evidence in this case.

In her deposition, Ms. Burger testified that realistically she believed that Petitioner would likely need to have an entry level position because of his restrictions and not being able to do what his past work history was as a truck driver, and that he would likely earn $8-12 per hour depending on the job. (PX25). She testified that she did not have any cause to disagree with the opinions and results of the July 5, 2013 labor market survey prepared by Brenda Latham. (PX25). While the Arbitrator concedes that Ms. Burger testified that she felt that Petitioner's job search logs reflected a valid and full effort to apply for and follow up on the positions that he listed within the logs, the Arbitrator also notes that there were multiple entries throughout the logs demonstrating that Petitioner made arguably duplicative entries reflecting not

only an attempt to visit a prospective employer in person, but also the completion of the online application. (PX21; PX22). As such, the Arbitrator is suspicious of Petitioner's assertion that he applied for more than 2,000 jobs.

That said, placing significant reliance upon Ms. Burger's opinions that Petitioner is employable and would likely earn $8-12 per hour depending on the job, the Arbitrator finds that Petitioner is entitled to 2/3rds of $613.33 ($933.33 - $320.00), or $408.89/week, until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Paul Kent,

Petitioner,

vs. NO: 14 WC 11948

17IWCC0604

Dave Black Trucking Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both parties herein and proper notice given, the Commission, after considering the issues of temporary disability, causal connection, medical expenses, maintenance benefits, permanent disability, penalties and fees, and evidentiary issues, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 1, 2016 is hereby affirmed and adopted.

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

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

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: SEP 29 2017

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

SJM/sj
o-9/7/2017
44

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KENT, PAUL
Employee/Petitioner

Case# **14WC011948**

DAVE BLACK TRUCKING INC
Employer/Respondent

17IWCC0604

On 12/1/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.61% 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:

0564 WILLIAMS & SWEE LTD
JEAN A SWEE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

4476 JAMES KELLY LAW FIRM
BRETT D KOLDITZ
4801 N PROSPECT RD
PEORIA HTS, IL 61616

17IWCC0604

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Paul Kent
Employee/Petitioner

v.

Dave Black Trucking Inc.
Employer/Respondent

Case # **14** WC **11948**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Ottawa**, on **10-31-16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3-21-14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$35,764.62**; the average weekly wage was **$729.89**.

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

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

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

Respondent shall be given a credit of **$24,409.69** for TTD, **$0** for TPD, **$0** for maintenance, and **$42,866.05** for medical benefits paid under Section 8(a) of the Act.

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 $486.59/week for 77 5/7 weeks, commencing 3-22-14 through 9-16-15, as provided in Section 8(b) of the Act. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner maintenance benefits of $486.59/week for 58 5/7 weeks, commencing 9-17-15 through 10-31-16, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical expenses for services rendered to Petitioner by Dr. Becker on 4-16-15 and 9-16-15; to St. Margaret's Hospital for the FCE performed on 7-2-15; and to St. Margaret's Hospital for the physical therapy sessions from 2-11-15 through 3-16-15, 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 $437.93/week for 150 weeks, because the injuries sustained caused the 30% 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.

Carolyn M. Doherty

Signature of Arbitrator

11/29/16

Date

DEC 1 - 2016

Petitioner, a 63 year old flatbed truck driver, testified that he was employed by Dave Black Trucking, Inc. and that he drove long distance flatbed trucks for Respondent for approximately 6 years prior to his undisputed work accident (TR 11, 12). Petitioner testified that on 3-21-14, he drove Respondent's flatbed truck to John Deere in Moline, Illinois. Petitioner said that while he was in Moline, a John Deere employee was trying to load a grader onto his flatbed truck and that he climbed onto the flatbed to guide him. Petitioner said that the flatbed trailer jerked and he fell approximately 5 feet off the truck and landed on his right hip and right arm on concrete. Petitioner experienced immediate right hip pain (TR 12-14, 31).

Petitioner was taken by ambulance to Unity Point Health. The admitting doctor took a history that Petitioner fell approximately 5 foot off the back of a flatbed trailer truck landing hard on his right hip (PX 4). Petitioner underwent an x-ray of his right hip on 3-21-14 which revealed an intertrochanteric fracture of the right proximal femur (PX 5). Petitioner underwent surgery with Dr. Mendel, an orthopedic surgeon, on 3-22-14. Dr. Mendel performed a right sided intramedullary nailing for intertrochanteric fracture, right hip. During the surgery, Dr. Mendel used an 11 intramedullary nail which he impacted into place (PX 6).

Petitioner was discharged from the hospital on 3-23-14 (PX 13). Petitioner testified that his wife drove him from the quad cities to their home in Tonica, Illinois. Petitioner said that when he was released, he used a walker for ambulation (TR 14, 15).

Petitioner treated with Dr. Mendel on 3-31-14 and 5-15-14. Petitioner continued to use a walker through this time and complained to Dr. Mendel of right hip pain while using a walker on 5/15/14. TR 15. Dr. Mendel prescribed physical therapy which was done at St. Margaret's Hospital, a hospital near Petitioner's home town. TR. 15.

Petitioner transferred his care to Dr. Meier, an orthopedic surgeon at Illinois Valley Orthopedics in Peru, Illinois, on 8-6-14. Petitioner said that he transferred care because it was too far to drive back and forth between the quad cities and his home (TR 15, 16). On that date, Dr. Meier took a history that Petitioner had right sided hip pain and anterior thigh pain since 3-21-14 when he fell approximately 5 foot onto a concrete floor landing on his right hip. Dr. Meier stated that Petitioner experienced sharp pain that comes and goes, aggravated with weight-bearing. Dr. Meier stated that Petitioner can walk about one block comfortably, that he has pain getting in and out of a bathtub or a vehicle, and that his activities of daily living were limited due to his pain (contained in PX 14, p. 21). Dr. Meier ordered an x-ray which showed moderate bilateral hip osteoarthritis with a healed intertrochanteric fracture of the right hip and intramedullary short locking nail in place. Dr. Meier diagnosed Petitioner with right hip osteoarthritis status right intertrochanteric hip fracture. Dr. Meier stated that Petitioner's symptoms appeared to be due to both his hip arthritis and some mechanical irritation from the implant (PX 14, p. 20).

On 8-14-14, Dr. Meier performed a right hip injection under fluoroscopy (PX 14, p. 17). On 8-27-14, x-rays showed a healed fracture but Dr. Meier recommended that Petitioner undergo surgery to remove the Gamma nail in an attempt to give some pain relief. Dr. Meier stated that Petitioner will eventually need a total hip arthroplasty in the future if this failed to give him adequate relief of his pain (PX 14, p.p. 15, 16). Dr. Meier performed surgery on Petitioner on 10-16-14 consisting of a removal of the intramedullary interlocking nail, right femur (PX 7).

On 10-29-14, Dr. Meier's records indicate that Petitioner was having a fair amount of discomfort in his hip and that he used a walker and cane to ambulate (PX 14, p. 9). Petitioner further reported that his pain was

improving. The records indicate that Petitioner walked with a slight limp and had good hip motion with minimal discomfort. Dr. Meier recommended increased activity as tolerated and follow up. On 11-26-14, Dr. Meier's records indicate that Petitioner walked with a start up limp and that he was not using ambulatory aides. He noted slight limited hip motion with pain. The diagnosis was continued right hip pain probably secondary to an aggravation of his osteoarthritis (PX 14, p. 6). On 11-30-14, Dr. Meier's records indicate that Petitioner continued to have symptoms in his hip with pain in the groin and the lateral aspect of his hip. The note indicates that removal of the Gamma nail did not give Petitioner much in the way of relief and that one of his biggest complaints is start up pain after he has been sitting for a long period of time (PX 14, p. 5). A right hip injection was recommended. On 12-4-14, Dr. Meier performed another injection under fluoroscopy on Petitioner's right hip.

On 1-7-15, Dr. Meier stated that Petitioner had improved pain after the Gamma nail was removed, but he still had pain in his groin and lateral hip and that he had known hip osteoarthritis. Dr. Meier stated that the cortisone injection on 12-4-14 did not give any relief of pain. Petitioner's biggest complaint was pain with sitting for long periods of time and start up pain. Dr. Meier diagnosed Petitioner with right hip arthritis and recommended therapy at St. Margaret's Hospital 3 times per week for 4 weeks. (PX 14, p.p. 1, 2). The records of 1/7/15 indicate that Petitioner was given a note to return to work light duty with restrictions. PX 14, p. 2. The records further indicate a post operative plan for "post op hip arthroplasty care" which stated, "the patient's weight bearing status is now full weight bearing. Routine x-rays to be obtained at the next visit... the patient is progressing as expected. I reassured the patient and family that they are within normal limits for their circumstances. The patient has done quite well and is pleased with the outcome. The patient has had a good recovery with no restrictions in range of motion or pain. The patient should continue with physical therapy or a home exercise program. Should the condition worsen or return, patient is instructed to call the office for further evaluation." PX 14, p. 2. Dr. Meier's records also indicate that Petitioner's work restrictions included no climbing, jumping, or tarping, no carrying or lifting more than 20 lbs and no long distance walking or sitting for more than 30 minutes. PX 18. The records further indicate a follow up scheduled for 2/11/15. PX 18.

On 2-11-15, Dr. Meier noted that Petitioner was "... following up for hip pain on the right hip joint. Has known osteoarthritis. He was seen on January 7, 2015, at which time he was treated with PT RX and he was prescribed Naprosyn... the patient is now here for a recheck. He is currently off work. He reports about 50% improvement in pain since starting PT. He tells me that he is definitely improving with physical therapy. He does not feel he could return to work yet because of continued weakness and pain in his hip." PX 8, p. 1. Under the diagnosis of "post-op hardware removal" the plan was to continue PT 3 times per week for 4 weeks. Under additional notes, Dr. Meier stated, "He is not yet able to RTW. I discussed with him our treatment options. I think we need to continue physical therapy in an attempt to help him regain full strength. He does have mild OA of the hp, and previous injections of the hip under fluro have given him no relief of his pain. There is no surgical indication at the time for the treatment of his hip OA. He will continue with Naprosyn as ordered.... My plan is to have him go to PT for one more month. If he is still unable to RTW after one more month of PT, I will order an FCE." With regard to the presented for a re-check prescribed no work for Petitioner (PX 8). Under the diagnosis of degenerative joint disease hip Dr. Meier noted that he "...advised the patient that most patients with hip DJD can achieve some measure of pain relief from nonsurgical options like lifestyle modification, exercise and physical therapy, and use of supportive devices. The importance of maintaining an ideal body weight to reduce stress on the hip joint was emphasized." Petitioner was to follow up in 4 weeks. PX 8, p. 2. Petitioner was taken off work until his next scheduled appointment. PX 20.

Petitioner testified that he saw Dr. Kevin Walsh at Respondent's request. Petitioner said that Dr. Walsh spent approximately 5 to 10 minutes with him (TR 19, 20). Dr. Walsh generated a 2-15-15 report addressed to Respondent's attorney at James Kelly Law Firm. On physical examination, Dr. Walsh noted that Petitioner had

a slight limp with ambulation. Dr. Walsh opined that Petitioner's diagnosis was post intertrochanteric hip fracture status post open reduction with internal fixation and status post removal of hardware. Dr. Walsh stated that Petitioner had returned to pre-injury status and was at maximum medical improvement. Dr. Walsh opined that Petitioner had moderate osteoarthritis of his right hip, but that the osteoarthritis was not caused by the injury described and was not aggravated or accelerated by the injury. Dr. Walsh opined that Petitioner would not require hip replacement as a result of the accident. Dr. Walsh opined that Petitioner could return to work without restriction because he had a healed fracture with no evidence of a complicating process. Dr. Walsh stated that, according to the AMA Guide to the Evaluation of Permanent Impairment, 6th Edition, Petitioner would be a Class 0 with no significant objective abnormalities and that he therefore had a 0% impairment rating. Dr. Walsh acknowledged that if Petitioner did have a mild motion deficit or a malalignment as a result of the hip fracture, he would qualify for an impairment rating, however there was no evidence in the medical records that he had mild motion deficits or a malalignment (RX 1).

Petitioner underwent physical therapy from 2-11-15 through 3-16-15. While attending PT, Petitioner returned to Dr. Meier on 3/11/15 for follow up on his complaints of right hip pain. Physical therapy was noted to partially alleviate his symptoms along with Naproxen and pain relievers. PX 20. X-rays of the right hip revealed a healed fracture. Dr. Meier noted that Petitioner localized his pan "to the lower back and buttocks on the right side. We believe his hip pain is due to lumbar spine pathology. We will work up his pain with an MRI of his lumbar spine." PX 20.

On 3-16-15, the therapist, Timothy Collins, stated that Petitioner continued to have pain along his lateral hip rated 2-3/10, that he feels weak with functional activities, and that he is unable to walk without a limp (contained in PX 20). Petitioner was discharged from PT having demonstrated decreased pain over his course of therapy and improved hip abduction to 4/5. Petitioner continued to have difficulty with a single leg stance and unchanged hip range of motion and strength for hip flexion. PX 20. Petitioner was discharged as being independent with his home exercise program. On 3-27-15, Respondent's insurance company, CCMSI, wrote to Dr. Meier and stated that, based on their IME with Dr. Kevin Walsh dated 2-9-15, no further treatment was authorized (contained in PX 20).

Dr. Meier ordered an MRI of Petitioner's lumbar spine on 3-16-15 which the radiologist, Dr. Coventry, stated showed "the most significantly encroached neural foramen is L5-S1 with a large asymmetric disc bulge and mild facet spurring contributing to the narrowing at that site (PX 9,20). On 3-18-15, Dr. Meier stated that Petitioner was to remain off work until his next scheduled appointment with Dr. Becker at the IVCH Pain Clinic on 3-23-15, to which Petitioner was referred. (PX 18,20).

On 3-25-15, Petitioner treated with Dr. Eugene Becker, a pain management specialist. Dr. Becker noted that Petitioner was referred for evaluation and treatment of pain in his low back. He stated that Petitioner's pain started after he was involved in a work related injury when he broke his leg and had surgery with hardware placement. Dr. Becker stated that Petitioner was complaining of pain in his lower lumbar spine on the right side with some radiation in the right leg on occasion. Petitioner denied weakness or numbness in the leg. Dr. Becker noted that since Petitioner's leg surgery, the length of his right leg is different and his gait has been affected. Dr. Becker reviewed the MRI and diagnosed disc degeneration most significantly at L5-S1 and L4-5 with multiple level facet degeneration. He diagnosed herniated disc, DJD and spondylosis. He recommended an epidural steroid injection, that Petitioner continue with home exercises, and that he remain off work (contained in PX 15 and contained in Dr. Becker's deposition of 12-29-15, p.p. 9, 10). On 3-31-15, Dr. Becker performed a lumbar epidural steroid injection at L5-S1. On 4-16-15, Dr. Becker stated that Petitioner's epidural steroid injection helped with the back pain, but Petitioner continued to have ongoing pain in the lateral side of his right leg where he had surgery. On exam, Dr. Becker found significant muscle tenderness over the surgical

site with muscle atrophy. Dr. Becker noted that Petitioner was not able to ambulate well. He advised Petitioner that his symptoms could improve if he continued with exercise. Dr. Becker stated that most of Petitioner's pain was related to his right leg and previous injury. Dr. Becker ordered Tramadol, Zanaflex and told Petitioner to return in 6-8 weeks. Dr. Becker testified that he ordered an FCE. (PX 1, p.p. 11-13).

Petitioner underwent a functional capacity evaluation on 7-2-15 at St. Margaret's Center for Physical Rehab. The therapist noted that Petitioner was on site for 3 hours on 1 day. The therapist stated that the preponderance of the evidence indicated that the worker participated fully in the testing and that the performance criteria profile was consistent with an acceptable effort. The therapist stated that Petitioner demonstrated impairment and that the data represented his true status. The therapist stated that Petitioner should be able to function in the medium work demand level abilities and the light demand level for endurance. The therapist stated that the main limiting factors for returning to work are subjective reports of achiness/pain in the right hip with activity performance, decreased right hip range of motion, decreased functional strength in the right lower extremity, inability to perform longer duration and higher frequency and intensity activities, and fear of further injury due to his job duties in relationship to his physical abilities. The therapist noted that Petitioner was only able to tolerate three hours of activities which was not even half of a full work day. (PX 3, p. 2). The therapist stated that within a reasonable degree of medical certainty, Petitioner could function on a limited basis as follows:

1. Material Handling: occasional box to waist 38 #, waist to shoulder 33 #, overhead 23 #, 2 hand carry 28 #, push force 41 #, pull force 52 #. Frequent: waist high 13 #, shoulder high 33 #, 2 hand carry 14 #.
2. Non-Material Handling: Occasional standing, walking, bending, squatting, shoulder high reaching, stair climbing and kneeling. Frequent: sitting and waist-high reaching. Constant: grip and fine motor. Avoid: Ladder climbing, crawling, increased repetition, longer duration, and higher intensity activity, and all constant activity (PX 3, p. 3). On exam, the therapist stated that Petitioner's strength was significantly weaker in the right lower extremity as compared to the left, except ankle dorsiflexion. The therapist noted that Petitioner limped and that his right leg was ¾" shorter than his left (PX 3, p. 4).

In summary, the therapist noted, "He is not currently working, he has increased pain in the right hip with increased exertion, he is able to perform some activity, but will have increased pain with and following performance, he was willing to perform all requested activity during the testing, he tests into the medium work demand level for lifting but would not be able to meet the time requirements for medium duty work, he requested stopping the test after 3 hours." PX 3.

At Respondent's request, Petitioner was examined by Dr. Marc Soriano on 7-28-15. In a 7-28-15 report, Dr. Soriano stated that Petitioner denied any low back pain, but he had intermittent pain in his right groin and pain in the right hip "when he exerts himself." On physical exam, Dr. Soriano stated that Petitioner's range of motion in his back was limited in flexion, extension, and lateral bending due to mechanical limitations. Palpitation to the right hip produced pain. Dr. Soriano opined that Petitioner sustained a fracture of his right hip as a result of his work accident. Dr. Soriano stated that it appeared that Petitioner complained of pain in the area of his right lateral buttock and over his hip and that the physician misinterpreted it to mean that he was having low back pain. Dr. Soriano opined that Petitioner did not need further treatment to his lumbar spine and that Petitioner's previous treatment to his lumbar spine was not necessary or causally related to the 3-21-14 accident. Dr. Soriano opined that Petitioner sustained no permanent disability as it related to his back under the AMA Guide Evaluation of Impairment, 6th Edition since he had no complaints of back pain (RX 3).

On 9-16-15, Dr. Becker saw Petitioner again noting that the lumbar epidural injection provided good low back pain relief. He notes, "Since that time, the patient states that his pain has been adequately controlled, however, since his leg surgeries, he still has pain around this site of the surgery and pain around the incisions. He currently does not take any medication for pain. Pain bothers him from time to time. However, he is able to manage it. I previously prescribed patient with pain medications. The patient states the is trying to be active and he does not have a formal exercise program." Medications for "pain around the hip" was discussed but Petitioner indicated he would like to "postpone" taking any pain medications. Petitioner was to follow up in the pain clinic PRN. PX 15.

In a separate note dated 9/16/15, Dr. Becker stated that he reviewed the FCE. Dr. Becker stated that, after reviewing the patient's functional capacity evaluation he did not think Petitioner would be able to return to his previous or usual job. Dr. Becker noted that the Petitioner met the criteria for medium work, however was not able to last longer than 3 hours which is not half of a full day of work. Dr. Becker stated that restrictions and Petitioner's ability for further employment should be based on the evaluation (PX 12,15).

Petitioner testified that prior to his 3-21-14 accident, he had never treated for his right hip, right leg, or lower back (TR 20). Petitioner testified that before 3-21-14, he was able to perform all of his job duties as a long distance flatbed truck driver and that he did not experience any discomfort. Petitioner said that his job as a flatbed truck driver included climbing, chaining, strapping, and tarping. Petitioner said that prior to 3-21-14, he lifted tarps that weighed over 100 pounds and that it could take 2 to 3 hours to tarp the loads down. Petitioner said that when he tarped, he would climb up and down off the flatbed truck multiple times. Petitioner said that the chains that he used to strap the loads down weighed approximately 20 pounds (TR 22-24).

Petitioner said that since his accident on 3-21-14, he has continued to have right hip and leg pain and that his right leg is weaker than his left. Petitioner said that he experiences increased discomfort walking any distance and that he wears a prescribed lift in his shoe because his right leg is shorter than his left (TR 46). Petitioner said that his right leg causes him discomfort if he sits for more than a few hours (TR 26). Petitioner said that his right hip and leg pain intensifies in the afternoon and that he sits in his recliner to elevate his feet to help alleviate the pain. Petitioner said that he used to actively do repairs around his house, however he no longer does that since the accident. Petitioner said that since the accident, he no longer does any climbing (TR 26-28).

Petitioner said that after Dr. Becker placed him on restrictions on 9-16-15, he asked Respondent for work within the restrictions, but was not offered a job (TR 19, 30). Petitioner testified that, at his attorney's suggestion, he applied for and received Social Security disability benefits (TR 24).

Petitioner said that he had worked as an over the road truck driver since 1986. As part of his job duties, he has always climbed, tarped and used chains. Petitioner said that he obtained a CDL in 1986. Petitioner said that his CDL expired after his work accident on 3-21-14. Petitioner said that he tried to renew the CDL after the work accident, but he could not because he was under doctor's care. Petitioner said that his CDL was still expired at the time of arbitration (TR 25).

Petitioner said that before his 3-21-14 accident, he underwent a physical every year and a stress test every two years to keep his CDL license. Petitioner testified that he had passed his physical and stress test consistently before his work accident. Petitioner stated that he had a heart attack in 2000 and that he underwent a stint procedure. Petitioner said that he treated with Dr. Lome, a cardiologist, for the heart attack and that Dr. Lome had not placed him on any restrictions for his heart condition (TR 21). Petitioner's testimony is consistent with Dr. Lome's records. On 4-26-11, Dr. Lome's record indicates that Petitioner could walk essentially unlimited, including stairs, without problems. Dr. Lome stated that Petitioner's leg strength was good and his energy level

was good (PX 17, p. 8). On 11-20-13, Dr. Lome's record states that Petitioner had a treadmill echocardiogram which he passed. (PX 17, p.p. 16-19).

Petitioner testified that he did not have any group insurance benefits available through his employment with Respondent. Petitioner said that his wife's insurance carrier paid for some of his medical bills (TR 28, 29).

On cross examination, Petitioner testified that he had never driven a truck without handling freight and that he has not applied for such a job since his release in that those jobs are very difficult to obtain. (TR 41-42). Petitioner said that his CDL expired before Dr. Becker released him and that IDOT would not let him complete a physical (TR 41-43).

On cross, Petitioner said that his daily activities include going to his garage where he has a T.V. Petitioner said that he takes his dog with him and that he throws the ball for the dog (TR 45). Petitioner said that he uses his riding mower to mow the grass on his acre of lawn. Petitioner said that he mows part of it, gets off the mower for a while, and gets back on to mow (TR 37, 38). On cross, Petitioner said that he could probably do sedentary work if he could sit down for more than three hours per day. (TR 39, 40).

Petitioner's counsel sent a series of letters to Respondent and Respondent's attorney beginning 1-14-15 requesting ongoing temporary total disability benefits or work within Petitioner's restrictions, including letters from 1-14-15, 3-16-15, 4-16-15, 6-12-15, 10-28-15, 1-5-16, and 1-29-16 (PX 21).

Petitioner's counsel filed a Petition for Penalties on June 23, 2016. In the petition, Petitioner's counsel noted that Dr. Becker placed Petitioner on permanent restrictions on 9-16-15. The petition for penalties includes a vocational assessment by Mr. Gustafson, a vocational rehabilitation counselor dated 4-20-16 (PX 22).

On 6-20-16, Dr. James L. Williams from Chesterfield, Missouri wrote a records review report to Respondent's attorney. Dr. Williams reviewed records, including a 4-1-08 stress echo, Dr. Lome's records, orthopedic records, FCE, and Respondent's Section 12 reports. Dr. Williams did not evaluate or examine Petitioner. Dr. Williams concluded that the 7-2-15 FCE did not represent a valid or reliable indication of Petitioner's work abilities as they related to his 3-21-14 accident. Dr. Williams opined that multiple factors contributed to the 7-2-15 FCE findings, but that the 3-21-14 accident was not a significant factor. Dr. Williams stated that Petitioner's pre-existing cardiovascular disease, relative deconditioning, age, pre-existing OA of the hip, and his motivation/tolerance all contribute to the results as documented in the FCE. Dr. Williams concluded that Petitioner did not require work restrictions for his work accident (RX 4).

Dr. Walsh generated a second supplemental report of 3-13-16 at Respondent's request. Dr. Walsh did not re-examine Petitioner. Dr. Walsh reviewed additional medical records and concluded that Petitioner did not require work restrictions as a result of his healed hip fracture. Dr. Walsh maintained that Petitioner had suffered no permanent disability as a result of his work accident (RX 2).

Dr. Kevin Walsh testified by deposition taken 4-11-16. Dr. Walsh testified that he was a practicing orthopedic surgeon and that he evaluated Petitioner on 2-9-15 (RX 5, p.p. 4, 5). Dr. Walsh testified that he generated a second report on 3-13-16 after he reviewed a functional capacity evaluation and updated records (RX 5, p.p. 8, 9). Dr. Walsh opined that the functional capacity evaluation is limited by Petitioner's age and subjective limitations. Dr. Walsh testified that the functional capacity examination did not change his opinion that Petitioner could return to full duty work following the healing of his hip fracture and that none of Petitioner's continued symptoms are related to his work injury. (RX 5, p.p. 10, 11). On cross, Dr. Walsh agreed that the functional capacity evaluation showed that Petitioner gave an acceptable effort and that the report indicated that

Petitioner could function at a medium work demand level and light demand level for endurance (RX 5, p. 12). On cross, Dr. Walsh testified that Petitioner was not deconditioned from being off work post-accident for 2 years, he opined that Petitioner was deconditioned from his heart disease. Upon further questioning, Dr. Walsh testified that if Petitioner was not engaging in physical activity, he could become deconditioned (RX 5, p.p. 13, 14). He further opined that Petitioner's fall from the truck did not aggravate his hip arthritis "because he actually broke his femur. The forces were absorbed by the fracture, not the articular surface of the femoral head... I think the hip took less of an impact because the bone broke. Most of the force was transferred in breaking the bone, not destroying the cartilage. ..." RX 5, p. 15.

Dr. Marc Soriano testified by deposition on 11-23-15. Dr. Soriano testified that he was a neurosurgeon and that he evaluated Petitioner at Respondent's request (RX 6, p.p. 4-6). Dr. Soriano opined that Petitioner never "... had any back pain. What he had was a soft tissue contusion possibly of the right buttock or the hip as a result of the accident, but he never, according to Petitioner himself... really had any back pain." RX 6. P. 17. Dr. Soriano opined that Petitioner did not require work restrictions or limitations from his 3-21-14 accident as it related to his back pain and that the back pain was not causally related to the work accident (RX 6, p.p. 17, 18,32). On cross, Dr. Soriano testified that it is possible that limping could aggravate a low back condition under certain circumstances. RX 6, p. 29. On cross, Dr. Soriano testified that symptoms from a low back disc injury could manifest as symptoms in the buttocks, leg, foot, and groin (RX 6, p.30).

Dr. James Williams testified by deposition on 9-22-16. Dr. Williams testified that he was board certified in physical medicine and rehabilitation and electrodiagnostic medicine. Dr. Williams testified that he reviewed medical records and rendered a report dated 6-20-16 (RX 7, p.p. 4-6). Dr. Williams evaluated the validity of FCE results and opined that the functional capacity evaluation did not represent a valid or reliable indication of Petitioner's work abilities as it relates to his 3-21-14 work accident because of Petitioner's pre-existing cardiovascular disease, age, pre-existing osteoarthritis of the hip, deconditioning, as well as a problem of motivation intolerance (RX 7, p. 9). Dr. Williams testified that the physical therapist stopped the FCE and made the conclusions based on Petitioner's request that the testing stop as opposed to an objective measure such as heart rate changes (RX 7, p. 10). Dr. Williams opined that Petitioner could return to his work as a truck driver which Dr. Williams determined was at medium duty work level. (RX 7, p.p. 13-15). On cross, Dr. Williams acknowledged that Petitioner likely had some limitations related to osteoarthritis of his hip (RX 7, p. 16). On cross, Dr. Williams stated that the functional capacity evaluation did state that Petitioner had continued pain and weakness in the hip (RX 7, p. 20).

Dr. Eugene Becker testified by deposition taken 12-29-15. Dr. Becker testified that he was an anesthesiologist and board certified pain physician (PX 1, p. 4). Dr. Becker testified that he first treated Petitioner on 3-25-15 and that the most notable finding he observed was Petitioner's antalgic gait (PX 1, p.p. 6, 9, 10). Dr. Becker testified that he reviewed Petitioner's MRI and performed an epidural injection for Petitioner's back pain. Dr. Becker testified that the back pain resolved with the injection; however, Petitioner continued with some pain in his right leg and pain around the surgical incision where the hardware had been placed (PX 1, p.p. 10, 11). Dr. Becker testified that Petitioner had significant atrophy in his right leg near the surgical incision and that there was not much muscle around the incision site. Dr. Becker stated that his treatment on 4-16-15 was related to Petitioner's hip fracture, not low back and that it was causally related to Petitioner's work accident (PX 1, p.p. 13, 14).

Dr. Becker testified that he ordered a functional capacity evaluation because he had determined that Petitioner had received "everything that could be done" and that he achieved MMI. PX 1, p. 14-15. Dr. Becker reviewed the FCE performed 7-9-15. When asked what permanent restrictions he imposed on Petitioner, Dr. Becker testified that he would "follow what the physical therapist recommended." He also noted that Petitioner was

"not able to go for longer than three hours. which is not half of his full day of work." Px 1, p. 20. He noted that Petitioner could work at the medium work demand with endurance at the light level and that he thought Petitioner could not work more than 3 hours according to the report. PX 1, p. 21. He noted that the therapist noted that Petitioner's right leg was ¾ inch shorter than his left and that this was significant in terms of the way Petitioner walked. Dr. Becker testified that the therapist concluded that Petitioner had participated fully in the testing (PX 1, p. 16). Dr. Becker agreed with the material handling measurements contained in the functional capacity evaluation (PX 1, p.p. 18-21). Dr. Becker opined that Petitioner's diagnosis stemming from the work accident was "... a leg fracture. But in terms of pain management patient ended up with a chronic pain related to the fracture." (PX 1, p.p. 21, 22).

On cross, Dr. Becker testified that Dr. Meier referred Petitioner to manage his hip and back pain (PX 1, p.p. 25-27, 29). On cross, Dr. Becker stated that he thought Petitioner's back pain was causally related to his 3-21-14 accident because of the initial fall and primarily from his abnormal gait (PX 1, p.p. 32, 33). On cross, Dr. Becker stated that Petitioner underrated his pain level. PX 1, p. 49-50. Dr. Becker further testified that Dr. Meier thought part of Petitioner's pain in his hip was from the hardware and some was from a degenerative hip condition. PX 1, p. 45-46. He testified that he would defer to Dr. Meier's opinion and the orthopedic diagnostic therapeutic work up results on whether Petitioner's hip condition was degenerative. PX 1, p. 46. Dr. Becker stated that Petitioner had a lot of pain, loss of strength, and appeared to be in a lot of discomfort when he treated him; however, Petitioner consistently reported low levels of pain and did not take medication (PX 1, p.p. 49, 50). Dr. Becker stated that Petitioner is a person who is "stoic" (PX 1, p. 50). Dr. Becker stated that during examinations, Petitioner could not really do anything (PX 1, p. 51). Dr. Becker testified that an orthopedic surgeon would be more qualified to review the results of the FCE than a pain management doctor as it relates to Petitioner's hip injury. PX 1, p. 62. On cross, Dr. Becker stated that Petitioner had not been physically active since his accident and this could contribute to Petitioner being limited to light physical demand level (PX 1, p.p. 63, 65-66). On re-direct, Dr. Becker stated that Petitioner's back problem improved quickly with treatment and was not a major problem (PX 1, p.p. 75, 76).

Dennis Gustafson, a vocational rehabilitation counselor, testified by deposition taken 6-28-16. Mr. Gustafson testified that he is a certified rehabilitation counselor and that he evaluated Petitioner on 4-20-16 (PX 2, p.p. 4-6). Mr. Gustafson stated that a tractor trailer truck driver position is medium in terms of physical demand requirements. Mr. Gustafson testified that the FCE testing that Petitioner underwent showed Petitioner lifting weights at less than medium level. Mr. Gustafson said that the FCE showed that Petitioner was only able to be on his feet up to 1/3 of the working day and that Petitioner's restrictions were more consistent with sedentary work, or a job that involves primarily sitting. When discussing sedentary work levels, Mr. Gustafson also testified, "the other relevant factor was that they stopped the functional capacity evaluation after three hours. And then tried to project from that that in fact it was based on his ability – what they said was based on his ability to perform an eight-hour day's employment. That becomes somewhat suspect. So what becomes questionable her is does he have the endurance to in fact work more than three hours a day. That's' what the FCE points to and that it would require a job primarily sitting. Then Dr. Becker was of the opinion, based on his review of that, he stated I don't think he could work more than three hours." PX 2, p. 9-10. Mr. Gustafson opined that Petitioner did not meet the physical requirements of truck driving. Mr. Gustafson opined that Petitioner would not be able to meet the standing and walking requirements of truck driving and that the actual weights that Petitioner was able to lift in the FCE was below the weight required for truck driving. PX 1, p. 10-11.

Mr. Gustafson opined that assuming Petitioner could work more than 3 hours per day Petitioner may qualify for sedentary work, however he has no transferrable skills and he lacks computer skills necessary (PX 2, p.p. 10, 11). Mr. Gustafson opined that Petitioner's chances of finding a job and being successfully employed are quite

poor (PX 2, p.p. 11, 12). On cross, Mr. Gustafson testified that a truck driver could drive up to 10 to 12 hours at a time before mandatory rest time. Mr. Gustafson testified that sitting in a tractor trailer truck driving is not a sedentary job as it requires moving the upper extremities and pushing in the clutch (PX 2, p.p. 28, 29). On re-direct, Mr. Gustafson testified that the likelihood of Petitioner being able to secure an entry level job was poor because there is too much competition for the jobs and the employers often seek people with prior work experience. Mr. Gustafson said that Petitioner does not have a track record of people skills, that he had always done manual work, and his age works against him (PX 2, p.p. 38, 39).

CONCLUSIONS OF LAW

The foregoing Findings of Fact are incorporated into the following Conclusions of Law.

F. Is Petitioner's Current Condition of Ill-Being Causally Related to the Injury?

The Arbitrator finds that Petitioner's condition of ill-being, including an intertrochanteric fracture of the right proximal femur requiring surgery for a right sided intramedullary nailing on 3-22-14, removal of the nail by Dr. Meier on 10-29-14 and continued current right hip pain, is causally related to Petitioner's work accident. The Arbitrator notes that all doctors, including Respondent's doctors, agree to the causal relationship for the hip fracture and subsequent surgeries. With regard to a finding of causal connection for the continued right hip pain, the Arbitrator relies on Dr. Meier's records and the unbroken chain of events in specifically finding that Petitioner's work accident aggravated his right hip osteoarthritis. The Arbitrator notes that Petitioner's complaints of right hip and leg pain were consistent and continuous following both surgeries. Petitioner received conservative care for these complaints up through his last visit with Dr. Becker, a pain specialist, on 9/16/15 at which time Dr. Becker discharged Petitioner at MMI and with permanent restrictions based on the July 2015 FCE.

The Arbitrator finds that Petitioner's low back treatment, consisting primarily of the MRI and the epidural injection, is not causally related to the work accident on 3-21-14. The Arbitrator finds that Petitioner's low back condition improved after the injection and is not a contributing factor to Petitioner's current condition and is not a contributing factor to the need for the restrictions per Dr. Becker and the functional capacity evaluation. The Arbitrator's finding of no causal connection for the low back complaints is based on Petitioner's own testimony regarding his lack of low back problems and on the testimony of every physician, including Dr. Becker.

J. Were the Medical Services that were Provided to Petitioner Reasonable and Necessary? Has Respondent Paid All Appropriate Charges for all Reasonable and Necessary Medical Services?

Having found that the low back is not causally related to the work accident, the Arbitrator finds that Petitioner's lumbar MRI at Illinois Valley Community Hospital on 3-16-15, Dr. Becker's treatment on 3-25-15 and the lumbar epidural on 3-31-15, is denied.

The Arbitrator finds that, in addition to the medical bills the parties stipulated that Respondent paid ($42,866.05), ARB EX 1, Respondent is ordered to pay for Dr. Becker's treatment on 4-16-15 and 9-16-15, the functional capacity evaluation of 7-2-15, and the physical therapy that Dr. Meier ordered from 2-11-15 through 3-16-15 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credits for amounts paid.

The Arbitrator finds that Respondent is not entitled to 8(j) credit any bills paid by a group carrier as Respondent did not provide Petitioner with group medical benefits.

K. What Temporary Benefits Are In Dispute?

In the request for hearing, Respondent stipulated that Petitioner was entitled to temporary total disability benefits from 3-22-14 through 2-8-15. Respondent denied benefits after 2-9-15 based on Dr. Walsh's exam. ARB EX 1.

The Arbitrator finds that Petitioner was still undergoing physical therapy for his right hip and leg from 2-11-15 through 3-16-15 and that Dr. Meier did not release Petitioner from treatment. Rather, Petitioner was referred for additional treatment of his pain complaints, albeit for ultimately determined unrelated low back condition. The Arbitrator finds that Petitioner was still under treatment for his pain complaints as of 3/16/15 when Dr. Meier referred Petitioner for additional diagnostic testing of these complaints. The Arbitrator notes that on 3-16-15, the therapist stated that Petitioner continued to have pain in his right hip, he was weak with functional activities, and that he was unable to walk without a limp (PX 20). The Arbitrator relies on the objective findings from the FCE on 7-2-15 and Dr. Becker's subsequent opinions and records which reflect that Petitioner had ongoing right leg weakness, loss of range of motion, loss of strength, and atrophy, and finds that Petitioner's condition had not stabilized until Dr. Becker found him at MMI and released him to return to work with permanent restrictions on 9-16-15.

The Arbitrator therefore finds that Petitioner was further temporarily totally disabled from 3-22-14 through 9-16-15.

What Maintenance Benefits Are In Dispute?

Petitioner alleges that he is entitled to maintenance benefits from 9-17-15 through the date of arbitration on 10-31-16. The Arbitrator finds that Petitioner is entitled to the requested maintenance benefits.

Petitioner was found to have permanent restrictions per the FCE and as assessed by Dr. Becker. The Arbitrator notes the confusion surrounding Petitioner's ability to work more than 3 hours per day and his light duty endurance level as is presented in the FCE and questioned by Mr. Gustafson. Nevertheless, the Arbitrator notes that Petitioner's remaining physical disabilities were clearly tested and documented in the FCE which was deemed valid by the physical therapist. The Arbitrator places greater weight on the FCE as written and as interpreted by the vocational counselor Mr. Gustafson than on the opinions of Respondent's witness, Dr. Williams. Although Petitioner was deemed able to work at the medium level his abilities were not sufficient for Petitioner to return to the type of flat bed truck driving he did for Respondent.

Petitioner provided Respondent with the permanent restrictions and was not accommodated. Thereafter, Petitioner's counsel requested TTD and/or maintenance benefits and vocational rehab on numerous occasions through 1-29-16. (PX 21). Petitioner's counsel set the case for hearing for maintenance and TTD on previous occasions in 2016 (PX 23, 24). Petitioner proceeded to his own vocational counselor and provided Respondent with Mr. Gustafson's 4-20-16 vocational report which indicated severe limitations on Petitioner's employability. The Arbitrator finds Petitioner's own vocational effort and attempts to initiate vocational assistance, which went unanswered by Respondent, sufficient to justify the payment of maintenance during this period. The Arbitrator therefore finds that Petitioner is entitled to maintenance benefits from 9-17-15 through the date of arbitration on 10-31-16.

L. What is the Nature and Extent of the Injury?

The Arbitrator initially notes that the record reflects that Petitioner waived his right to collect a wage differential under Section 8(d)(1) at the start of hearing.

The Arbitrator finds that, as a result of the 3-21-14 accident, Petitioner sustained a right intertrochanteric fracture of the right proximal femur requiring a right-sided intramedullary nailing for the intertrochanteric fracture on 3-22-14 and subsequent removal of the intramedullary nail on 10-16-14. The Arbitrator finds that as a result of the accident on 3-21-14, Petitioner has aggravated the osteoarthritis of his right hip, that he has right leg weakness and atrophy around the surgical site, and that he has permanent restrictions which prevent him from returning to work as a flatbed truck driver. The Arbitrator finds that Petitioner's permanent restrictions include no climbing, no walking or standing more than 1/3 of the day, and lifting restrictions consistent with the functional capacity evaluation and Dr. Becker's opinion. The Arbitrator notes that Petitioner's work as a flatbed truck driver included climbing up to 2 to 3 hours at a time and lifting tarps over 100 pounds.

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

(i) The reported level of impairment pursuant to Subsection (a) under the AMA Guides to the Evaluation of Permanent Impairment;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of the injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by the medical records.

With regard to Subsection (i) of 8.1b(i), the Arbitrator notes that the record contains an impairment rating of 0% of a leg as determined by Dr. Walsh as it relates to Petitioner's causally related right leg and hip pursuant to the most current edition of the American Medical Association's Guide to the Evaluation of Permanent Impairment. The Arbitrator notes that on cross examination, Dr. Walsh acknowledged that if Petitioner had a mild motion deficit or malalignment as a result of the hip fracture, he would qualify for an impairment rating, however in his opinion there was no evidence in the medical records that he had mild motion deficits or a malalignment (RX 1). The Arbitrator notes that the functional capacity evaluation reflects that Petitioner had decreased right hip range of motion and decreased functional strength. The Arbitrator notes that Dr. Becker found visible atrophy in the right hip upon examination. The Arbitrator notes the discrepancies between Dr. Walsh's examination and the examinations of Dr. Becker and the therapist in the FCE. The Arbitrator gives greater weight to this factor.

With regard to subsection (ii) of 8.1(b), the Occupation of the Employee, the Arbitrator notes that the record reveals that Petitioner was employed as a flatbed truck driver at the time of the accident and that he was not able to return to work in his prior capacity as a result of the right leg fracture, surgeries and aggravation of the right hip osteoarthritis. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of 8.1(b), the Arbitrator notes that Petitioner was 63 years old at the time of the accident. The Arbitrator gives lesser weight to this factor.

With regard to subsection (iv) of 8.1(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner is unable to return to his job as a flatbed truck driver, or a commercial truck driver, and therefore gives greater weight to this factor. This finding is supported by the testimony of Dennis Gustafson, Petitioner's vocational

expert, who opined that based on the FCE. Dr. Becker's restrictions per the FCE, and his evaluation of Petitioner, Petitioner was precluded from returning to his previous employment as a truck driver.

With regard to subsection (v) of 8.1(b), Evidence of Disability Corroborated by the medical records, the Arbitrator notes that Petitioner has evidence of disability as corroborated by the medical records including an altered gait, loss of leg strength, atrophy, and chronic right hip pain. The Arbitrator therefore gives greater weight to this factor.

Based on a consideration of these factors, the Arbitrator finds that Petitioner has sustained a loss of his occupation as a result of this accident and awards permanency of 30% man as a whole under Section 8 (d)(2) of the Act.

M. Should Penalties or Fees be Imposed Upon Respondent?

The Arbitrator finds that Respondent's failure to pay TTD and maintenance benefits after 2-9-15 is not unreasonable and/or vexatious under the terms of the Workers' Compensation Act as Respondent relied on its Section 12 exams. The Arbitrator therefore denies penalties.

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

Mario Moya,

Petitioner,

vs. NO: 15 WC 07807

Town of Cicero Department of Public Works,

17IWCC0605

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 22, 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.

17IWCC0605

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

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

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

DATED: SEP 29 2017

Stephen J. Mathis

SJM/sj
o-9/21/2017
44

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

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

MOYA, MARIO
Employee/Petitioner

Case# **15WC007807**

15WC030570

TOWN OF CICERO DEPT OF PUBLIC WORKS
Employer/Respondent

17IWCC0605

On 3/22/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0311 KOSIN LAW OFFICE LTD
DAVID X KOSIN
134 N LASALLE ST SUITE 1340
CHICAGO, IL 60602

4217 DEL GALDO LAW GROUP
TIMOTHY WOERNER
1441 S HARLEM AVE
BERWYN, IL 60402

17IWCC0605

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)

Mario Moya
Employee/Petitioner

v.

Town of Cicero, Department of Public Works
Employer/Respondent

Case # **15** WC **007807**

Consolidated cases: **15 WC 030570**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **February 10, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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. X Other – is the case ripe for a permanency determination?

FINDINGS

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 right knee condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $**34,000.00**; the average weekly wage was $**653.85**.

On the date of accident, Petitioner was **70** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner reasonable and necessary medical services of $111.00, as provided in Sections 8(a) and 8.2 of the Act. PX 6.

Respondent shall pay Petitioner temporary total disability benefits of $435.90 /week for 26 5/7 weeks, commencing March 13, 2015 through September 15, 2015, as provided in Section 8(b) of the Act.

Petitioner is entitled to prospective care in the form of right total knee replacement surgery, as recommended by his surgeon, Dr. Durkin, and Respondent's examiner, Dr. Lewis. Respondent shall authorize and pay for said surgery.

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

3/22/17
Date

ICArbDec19(b)

MAR 22 2017

Mario Moya v. Town of Cicero, Department of Public Works
15 WC 7807 and 15 WC 30570 (consolidated)

Summary of Disputed Issues in Both Cases

In 15 WC 7807, the parties agree Petitioner sustained an accident while working for Respondent on October 7, 2013. They also agree Petitioner provided Respondent with timely notice of the accident. The disputed issues include causal connection, one unpaid medical bill from Hinsdale Orthopaedics and whether the case is ripe for a permanency determination (with Petitioner seeking prospective care in the form of a right total knee replacement and Respondent arguing that the Arbitrator should address permanency, based on its causation defense). Arb Exh 1.

In 15 WC 30570, Petitioner claims he injured his back and right knee on February 27, 2015. The disputed issues include accident, notice, causal connection and whether the case is ripe for a permanency determination. Arb Exh 2.

Arbitrator's Findings of Fact Relative to Both Cases

Petitioner testified he is able to speak some English. He opted to testify through a Spanish-speaking interpreter.

Petitioner testified he was born on May 25, 1943. He is now 73 years old. T. 21.

Petitioner denied having any right knee problems before his October 7, 2013 accident. He had, however, experienced low back problems for about eleven years before that accident. T. 23. Since approximately 2007, he has been subject to a 10-pound lifting restriction due to those problems. It is his personal physician, Dr. Garcia, who imposed this restriction. He is still subject to the restriction. T. 25-26. Under cross-examination, Petitioner clarified that his back pain dated back to approximately 2005, at which point he worked at Respondent's precinct office. He reported a back injury to Respondent in about 2005. After he reported this injury, Respondent's human resources director sent him to UIC, where he underwent some examinations. T. 138-140.

Petitioner testified that, in 2010, he changed jobs and began working in Respondent's public works department. T. 27. Petitioner further testified that, after the job change, Respondent continued to accommodate his 10-pound lifting restriction. He was assigned to a cleaning job that involved using a device known as a "picker" to pick up lightweight refuse, essentially paper, outside various buildings. He worked with a partner who drove a pick-up truck and transported him to these buildings. T. 26-28.

Petitioner testified he was still performing the same cleaner job as of his October 7, 2013 accident. As of that accident, his shift started at 7 AM and ended at 3 PM. He started off his workday picking up garbage outside Respondent's public works building. At approximately

9 AM, he was inside this building, headed to a bathroom inside the cafeteria, when he tripped over the edge of a thick plastic mat that is shown in photographs marked as PX 1-A, 1-B and 1-C. T. 30-34. The mat was under a water fountain. He started falling forward. As he went down, he first tried to grab the water fountain with his left hand and then tried to use his right hand to break his fall. He landed on his right knee, with that knee striking the concrete floor. He testified he felt sharp pain in his right knee and was unable to get up on his own. T. 37. He called Maria, a secretary, and she came to his aid. T. 35-36. He then met with another co-worker, Dayanara, who completed a report (PX 2) concerning the accident. Petitioner testified he signed this report but did not fill it out. T. 37-38. The account of the accident set forth in the report is consistent with Petitioner's testimony. The report lists the following "affected body parts": right hand, left arm and right knee. PX 2.

Petitioner testified he underwent care at U.S. Health Works on the day of the accident. He testified that Respondent directed him to this facility. [Respondent provided written authorization for the visit. RX 2.] Petitioner testified his right knee and back felt "very bad" at this point. T. 39. A U.S. Health Works "new patient WC worksheet" dated October 7, 2013 describes Petitioner as a laborer whose job involves various activities, including lifting up to 10 pounds. This document also describes Petitioner as 5 feet, 2 inches tall. It sets forth a consistent account of Petitioner's fall, specifically stating that Petitioner tripped on a carpet and fell forward, striking his right knee "on ground." It reflects complaints relative to the right knee, right hand and left elbow. The examining physician, Dr. Khanna, noted that Petitioner denied any prior right knee or hand injury. He described Petitioner's gait as antalgic. He noted right knee swelling, right lateral joint line tenderness, a restricted range of right knee motion and a positive McMurray test on the right. He also noted a right hand contusion and a left elbow abrasion. He obtained right knee and right wrist X-rays, which were negative for fracture. He prescribed Nabumetone and ice applications. He released Petitioner to "sitting work only." PX 4. T. 39-40.

Petitioner testified that Respondent provided him with seated work consisting of counting brushes that are used in street sweepers. T. 40-41.

Petitioner returned to U.S. Health Works on October 14, 2013 (T. 41) and again saw Dr. Khanna. The doctor's right knee examination findings were essentially unchanged. He assessed Petitioner as having a lateral meniscus tear. He refilled the Nabumetone and prescribed a right knee MRI. He again released Petitioner to "sitting work only." He discharged Petitioner from care relative to the right hand. PX 4.

Petitioner underwent the right knee MRI on October 15, 2013. T. 42. The interpreting radiologist noted a "complex tear of the anterior and posterior horns as well as the body of the lateral meniscus, moderate to high grade chondromalacia of the lateral tibiofemoral compartment, extensive soft tissue edema and moderate effusion, a large popliteal cyst, likely ruptured, and osteoarthritis." He described the chondromalacia as "moderate to high-grade." PX 5.

On October 17, 2013, Dr. Khanna reviewed the MRI results with Petitioner. He aspirated bloody fluid from the right knee and injected the knee with cortisone. T. 42. He again released Petitioner to seated work. He noted that, if Petitioner's pain decreased, he would recommend physical therapy but, if not, he would "consider surgery." PX 4. RX 5.

Petitioner testified the injection provided relief only for a "very little time." T. 43. After his October 17th visit to U.S. Health Works, Respondent again provided him with seated work. T. 43.

On October 24, 2013, Dr. Khanna noted that Petitioner reported doing sitting work only and feeling "a little better after the injection." T. 43. He described Petitioner's gait as abnormal and indicated Petitioner complained of pain behind the right knee. He assessed Petitioner as having lateral and meniscal tears along with patellofemoral syndrome. He prescribed continued Nabumetone and ice applications along with physical therapy. He again released Petitioner to seated work. PX 4.

Petitioner underwent an initial physical therapy evaluation at U.S. Health Works on October 28, 2013. The evaluating therapist recorded a consistent history of the work accident and noted that Petitioner's job involved walking and "lifting up to 10 lbs." She also noted a history of lumbar disc problems. She indicated Petitioner reported right knee buckling and locking. On examination, she noted loss of motion in the right knee, limited straight leg raising on the left due to low back pain, straight leg raising to 40 degrees on the right, IT band tightness and tenderness and weakness in the right knee and both hips. She described Petitioner's balance and gait as poor. PX 4. RX 5.

Petitioner continued attending therapy thereafter. PX 4. RX 5.

On November 7, 2013, Dr. Khanna noted that Petitioner reported experiencing pain when putting weight on his right leg. His assessment was unchanged. He prescribed additional therapy and again released Petitioner to sitting work only. PX 4. RX 5.

The last U.S. Health Works therapy note is dated November 15, 2013. On that date, the therapist noted that Petitioner was still experiencing right knee pain, especially with walking. She noted that Petitioner's strength had improved but that he was "limited by pain symptoms in R knee." PX 4. RX 5.

On November 19, 2013, Dr. Khanna noted that Petitioner reported improvement secondary to therapy but was "not at 100%." T. 44. He noted positive McMurray's testing along with other right knee abnormalities on re-examination. He released Petitioner to "regular work" and directed him to return to the clinic on December 3, 2013. PX 4.

Petitioner testified that, after his November 19th visit to U.S. Health Works, Respondent put him back on the restricted cleaning job he had been performing prior to and as of the October 7, 2013 accident. He resumed working with a partner who drove him to various

buildings, where he used a "picker" to pick up garbage. T. 47. The only thing that changed was that his partner now drove a van rather than a pick-up truck. Petitioner testified the van was higher than the pick-up truck, in terms of the distance he had to step up when entering the passenger side. He estimated this distance to be between 1 ½ and 2 feet. T. 52-54. It was difficult for him to maneuver to get his body and right knee inside the van. He had to ask his partner for help with this. T. 49-50.

Petitioner testified he recalled resuming his regular cleaning job sometime in November. He could not remember the exact date. T. 47-48. [He went on to agree with U.S. Health Works records that purportedly indicated he resumed working on December 3rd but those records seem to suggest otherwise – see below.]

Petitioner returned to Dr. Khanna on December 3, 2013, as directed. The doctor noted Petitioner was "tolerating regular work" but still experiencing "soreness with walking in the morning [and] getting out of truck." The doctor described Petitioner's gait as normal and squat testing as mildly positive. On right knee examination, he again noted a reduced range of motion, lateral joint line tenderness and positive McMurray's testing. He released Petitioner to "regular work" and discharged Petitioner from care. PX 4.

Petitioner testified his right knee was still swollen when he last saw Dr. Khanna on December 3, 2013. He denied experiencing any right knee swelling before the October 7, 2013 accident. T. 49.

Petitioner testified he continued performing his cleaning job throughout 2014 and into the first part of 2015. During this time, he was still experiencing right knee pain and difficulty walking. He had difficulty using his right leg to support the weight of his body. T. 56.

Petitioner testified his job duties "suddenly" changed in late February 2015. He was taken off the cleaning job and assigned to garbage truck duty. His new job required him to walk behind the garbage truck and collect garbage for about eight to ten blocks (round-trip). The temperature was below zero and there was snow on the ground. He had to extract garbage cans from piles of snow that lined the sides of the alley. He explained that plows had come down the alleys, piling the snow off to the sides. After he pulled a can out of the snow, he had to drag it over to the truck and hook it up to the truck so that the contents could be dumped. T. 61-62. The cans had wheels but the wheels tended to freeze due to the ice and snow. T. 69-70.

Petitioner estimated the weight of an empty garbage can to be about ten pounds. T. 63. He testified the cans that contained garbage varied in weight but exceeded 20 to 30 pounds. The cans contained "house garbage" along with accumulated snow. T. 67.

Petitioner testified he was not able to lift the garbage cans. A co-worker, whose name he cannot recall, helped him with the lifting. T. 70.

Petitioner testified he lasted at the garbage truck assignment for only two days. T. 67. The second day was a Friday. T. 71. As of that day, he was experiencing pain and swelling in his right knee along with back pain that radiated down both of his legs. His back pain worsened over the course of the two days. T. 71-72.

Petitioner testified that, after work on that Friday, he spoke with Tony Tufano, a Respondent supervisor inside the public works building. The conversation took place at about 3 PM. There were other people in their general vicinity but only he and Tufano participated in the conversation. T. 73. Petitioner testified he complained to Tufano about being assigned to the garbage truck. Specifically, he asked Tufano why he had been given full duty when he was "still under light duty." T. 75. He also told Tufano about the problems he was having with his knee and back. T. 75.

Petitioner testified his back did not improve over the weekend. On the following Monday, March 2, 2015, he was not scheduled to work because it was Pulaski Day. T. 77-78. He went to his personal physician, Dr. Garcia, and secured an updated work status note. [Dr. Garcia's March 2, 2015 note states: "Pt wants disability note regarding LBP." The doctor issued a disability certificate imposing restrictions of no lifting over 10 pounds and no bending secondary to LBP – neuropathy." RX 8. Petitioner testified he took this disability certificate to U.S. Health Works, where he saw a physician. He told this physician he had been mistakenly sent back to full duty and was experiencing back and knee problems as a result. T. 79. The physician gave him a note to take back to work. Petitioner testified that PX 7 is not a true and accurate copy of the note the doctor gave him. The note he received was different from PX 7 in that the boxes next to lifting and bending restrictions were not checked. T. 82-84. [PX 7, a U.S. Health Works "fitness for duty form" dated March 2, 2015 contains check marks by "lifting over 10 lbs." and bending. It also contains a check mark next to the word "other," with a handwritten entry of "low back pain" appearing thereafter.]

The records from U.S. Health Works contain another form dated March 2, 2015, entitled "return to work evaluation worksheet." Dr. Peoples' signature appears at the bottom of both this form and PX 7. This form describes Petitioner's job as "garbage pick up" with lifting, pushing and pulling up to 10 pounds, among other requirements. The form attributes Petitioner's "recent absence from work" to back pain/disc disease. It reflects that Petitioner was seeing Dr. Garcia for this problem and was still under care. It lists February 27, 2015 as the "last day worked." Dr. Peoples noted that Petitioner complained of pain with walking, bending and stooping and was experiencing "left leg radiculopathy." He released Petitioner to work with no lifting over 10 pounds and no bending. PX 7.

Petitioner testified he went to Respondent's public works office after seeing the physician at U.S. Health Works and presented the note he received from the physician to Dayanara. Dayanara took the note from him. T. 82.

Petitioner testified that, when he presented to work the following day, Tuesday, March 3, 2015, he attended a meeting held inside the office of the public works Commissioner, Sam

Jelic. T. 84-85. In addition to Jelic, Derek Dominick and Tony Tufano participated in the meeting. After the meeting, Petitioner was sent to the cafeteria. During the following three days, he sat in the cafeteria for eight hours each day. He was not given any work to do and was not allowed to talk on the phone or listen to music. T. 85-86. He was still experiencing right knee pain and swelling during this period. After that three-day period, he was assigned to counting street sweeper brushes. T. 85.

On March 10, 2015, Petitioner saw Dr. Durkin, a physician associated with Hinsdale Orthopaedics. Dr. Durkin noted that Petitioner chiefly complained of right knee pain dating back to a fall in a hallway at work on October 7, 2013. He also noted that Petitioner "is a laborer in public works and has been on light duty restrictions which have been suspended as of 2 weeks ago." He indicated that Petitioner wanted to be evaluated in order to have his work status addressed. He indicated Petitioner rated his right knee pain at 8/10 when walking. He also noted a complaint of pain with range of motion of the right hip. On right knee examination, he noted a trace effusion, trace soft tissue swelling, active extension of -3 degrees, active flexion to 125 degrees, good quadriceps tone, no tenderness over the medial compartment, tenderness over the lateral compartment and negative varus/valgus stress testing.

Dr. Durkin obtained X-rays of the right knee and right hip/pelvis. He described the right knee X-rays as showing moderate osteoarthritis in the lateral compartment, mild arthritis in the medial compartment, no fracture or dislocation and good alignment of the patella. He described the right hip X-rays as showing some osteoarthritis in the joint and no fracture or dislocation. He injected the right knee with steroids, prescribed an unloader knee brace and indicated Petitioner could "return to sedentary work." He indicated he would consider recommending replacement surgery if Petitioner did not respond to conservative measures.

Dr. Durkin addressed causation as follows:

> "Patient reports no knee pain prior to his initial fall (10/7/13) and this likely exacerbated and increased the rate of osteoarthritis in his right knee."

PX 5.

Petitioner testified he resumed his brush counting sedentary job after seeing Dr. Durkin on March 10, 2015. On March 12, 2015, he was called into an office, where he again met with Jelic, Dominick and Tufano. He testified these individuals presented him with a group of documents regarding early retirement. He identified PX 3 as the documents he received. [The first page of PX 3 is a cover letter dated March 12, 2015 (also marked as RX 6) indicating that Respondent's human resources department had received information from public works indicating Petitioner had been given a 10-pound lifting restriction by his doctor "as a result of a non-duty-related medical condition," that Respondent had no assignments within this restriction and was not obligated to create such an assignment if the condition was non-work-

related, that Petitioner was being placed on an unpaid administrative leave, pending receipt of a release to unrestricted duty, and that Petitioner could consider Respondent's "voluntary separation incentive plan."] He testified he told the men he remained undecided but would think about taking early retirement. T. 89.

Petitioner testified he did not resume performing the brush counting job after the March 12, 2015 meeting. T. 97. He went home after the meeting. T. 104.

Petitioner returned to Dr. Durkin on April 9, 2015. The doctor noted that Petitioner viewed the unloader brace as helpful but reported obtaining only a couple of days of pain relief following the March 10, 2015 knee injection. On right knee re-examination, the doctor noted no effusion, mild soft tissue swelling and good quadriceps tone. He reviewed images of the October 13, 2015 right knee MRI, which Petitioner had brought with him. He indicated he advised Petitioner that this MRI showed both arthritis and a complex lateral meniscus tear but, that in his view, Petitioner's current symptoms stemmed from the arthritis rather than the tear and that a meniscectomy would thus not be helpful. He stated that the MRI showed it was "unlikely that the injury caused the osteoarthritis" but that "the injury likely exacerbated the osteoarthritis and caused pain." He recommended, and administered, a gel-one injection and recommended that Petitioner rest and apply ice to the knee for three to five days. He released Petitioner to sedentary work. PX 5.

Petitioner testified the gel-one injection provided "50%" relief "for a short period of time." T. 105.

Petitioner saw Dr. Durkin again on May 8, 2015, with the doctor noting 50% improvement since the injection. He advised Petitioner the injection would continue to provide benefit for another five months or longer. He addressed work capacity as follows:

> "Patient is not capable of doing full duty of a garbage man. Patient can work with restrictions of no climbing ladders, minimal walking, no lifting more than 10 lbs. and standing as tolerated."

He described these restrictions as permanent and found Petitioner to be at maximum medical improvement but went on to state that Petitioner could undergo more injections and "is candidate for surgery." PX 5.

Petitioner next saw Dr. Durkin on July 7, 2015. On that date, Petitioner complained of variable right knee pain and swelling, as well as waking at night due to pain and difficulty walking, sitting and using stairs. Petitioner indicated the unloader brace was helping slightly.

On right knee re-examination, Dr. Durkin noted active extension of 0 degrees, active flexion of 125 degrees, trace effusion, good quadriceps tone, tenderness over the medial and lateral compartments, as well as the medial and lateral joint lines, and positive lateral and

medial McMurray's testing. He recommended that Petitioner undergo another right knee MRI to determine whether an arthroscopy could help, prior to giving consideration to a total knee replacement. He released Petitioner to sedentary duty with no lifting over 5-10 pounds, no climbing ladders, minimal walking and standing as tolerated. PX 5.

Petitioner underwent the repeat right knee MRI on August 21, 2015. The radiologist indicated he compared the images with those of the previous MRI of October 18, 2013. He indicated the degree of chondromalacia had "worsened since the previous examination." He also noted "complex but predominantly horizontal tearing of the lateral meniscus with partial extrusion of the body segment" along with a moderate joint effusion and moderate-sized Baker's cyst. PX 5.

Petitioner testified that Respondent did not offer him any light duty position between the March 12, 2015 meeting and September 15, 2015. On September 15, 2015, he received a letter from Respondent offering him such a position. T. 108-109. [RX 7, a September 14, 2015 letter from Sam Jelic of Respondent to Petitioner references Dr. Durkin's restrictions of May 8, 2015 and directs Petitioner to appear immediately to "get [his] current job assignment."] After he received this letter, he immediately presented to Respondent and was again given the job of counting street sweeper brushes while sitting. He is still performing this job. T. 109.

On September 22, 2015, Dr. Durkin discussed the results of the repeat MRI with Petitioner and explained to him that "a knee scope will not help." He recommended a total knee replacement and continued the previous work restrictions. PX 5. T. 109-110.

On October 9, 2015, an employee or representative of Hinsdale Orthopaedics noted that Petitioner "has decided to proceed with the" knee replacement surgery. PX 5.

At Respondent's request, Petitioner saw Dr. Lewis of the Illinois Bone & Joint Institute for purposes of a Section 12 examination on December 15, 2015. Dr. Lewis issued a report concerning this examination on December 30, 2015. Durkin Dep Exh 3. The report sets forth an account of Petitioner's October 7, 2013 work fall and subsequent care. According to this account, Petitioner "tripped and fell inside a building on a carpet." The doctor noted that Petitioner complained of persistent right knee pain which had recently worsened. The doctor indicated Petitioner reported using a knee brace but not deriving much benefit from it.

Dr. Lewis described Petitioner as "an alert, very pleasant male who is 5' 2" tall and weighs 150 pounds." He noted a functional range of motion in Petitioner's lumbar spine, hips, knees and ankles. On right knee examination, he noted marked medial joint line tenderness, no effusion or ligamentous instability and full extension with further flexion to 120 degrees on the right versus 125 on the left. He obtained right knee X-rays and interpreted the films as showing marked narrowing of the lateral compartment with loss of joint space, "compatible with severe degenerative arthritis."

Dr. Lewis indicated he reviewed records from U.S. Health Works and Dr. Durkin along with nine physical therapy notes.

Referencing the results of the right knee MRI performed a week after the accident, Dr. Lewis addressed causation as follows:

> "Even though Mr. Moya denied pain referable to his right knee prior to his alleged injury, in my experience a fall on his knee on a carpet would not be a sufficient causative event to accelerate degenerative arthritis in his right knee. Therefore, in my opinion, the pre-existing degenerative arthritis of his lateral compartment is the cause for his current condition."

Dr. Lewis found objective evidence, i.e., X-rays showing severe degenerative joint disease, to support Petitioner's complaints. He did not believe an MRI or right knee arthroscopy to be necessary. He did find a right total knee replacement to be necessary, based on Petitioner's complaints and the arthritis demonstrated on X-ray. He described Petitioner as a "reliable historian." He anticipated that Petitioner would reach maximum medical improvement within four to six months of knee replacement surgery. He found Petitioner capable of modified light duty but indicated the need for this restriction did not stem from the October 7, 2013 work fall. Lewis Dep Exhibit 2.

On February 8, 2016, Dr. Durkin issued a report to Petitioner's counsel. In this report, the doctor addressed causation and treatment needs. He indicated that, while Petitioner had degenerative arthritis and meniscal tearing in his right knee before the October 7, 2013 work fall, based on the MRI, the fall likely worsened the tearing and caused the arthritis to become symptomatic. He further stated that a fall such as the one Petitioner described "could very easily take a knee with [de]generative joint disease and accelerate and exacerbate that condition to the point where a knee replacement would be necessary." PX 5.

Petitioner returned to Dr. Durkiin on March 8, 2016. The doctor noted complaints of 8-10/10 right knee pain and right knee swelling. On right knee examination, he noted active extension of 0 degrees, active flexion of 110 degrees, a mild effusion and tenderness over the lateral joint line and lateral compartment. He prescribed Tramadol for pain and again recommended knee replacement surgery. He released Petitioner to sedentary work with no lifting over 5-10 pounds, no climbing ladders, minimal walking and standing as tolerated. He told Petitioner he could follow up as needed "or when approved for surgery."

There is no indication Dr. Durkin examined Petitioner's back on March 8, 2016 but he did refer Petitioner to his partner, Dr. Zindrick, for back pain. PX 5.

Dr. Durkin testified by way of evidence deposition on March 10, 2016. PX 8. Dr. Durkin testified he obtained board certification in orthopedic surgery in 1994. PX 8 at 6. Durkin Dep

Exh 1. He has been affiliated with Hinsdale Orthopaedics for 13 ½ years. PX 8 at 5. He devotes about 40% of his practice to treatment of knee conditions. He has treated thousands of people with knee osteoarthritis or knee trauma. PX 8 at 5.

Dr. Durkin testified he first saw Petitioner on March 10, 2015. On that date, Petitioner complained of 8/10 right knee pain which he related to a work fall occurring on October 7, 2013. PX 8 at 8-9. On examination, he noted that the right knee was 3 degrees short of full extension, meaning Petitioner could not straighten his leg all the way. PX 8 at 9. Flexion was to 125 degrees. Most people can bend their knees to 135 or 140 degrees. PX 8 at 9. Dr. Durkin testified he also noted a little bit of fluid in the knee and lateral joint line tenderness. PX 8 at 10. He obtained right knee X-rays, which showed moderate osteoarthritis. He did not have access to any previous MRIs on March 10, 2015. PX 8 at 10. He diagnosed right knee osteoarthritis on that date. He administered a cortisone injection and provided Petitioner with an unloader brace to take pressure off the more severely arthritic, meaning the lateral, side of the knee. PX 8 at 11. He found Petitioner capable of sedentary duty. PX 8 at 12.

Dr. Durkin testified he next saw Petitioner on April 9, 2015. Petitioner was still experiencing right knee pain and swelling on that date. He reported that the brace was helping but that the injection helped only for a couple of days. PX 8 at 13. Dr. Durkin testified he reviewed the MRIs, which Petitioner had brought with him. PX 8 at 13. He interpreted the MRI of October 15, 2013 as showing complex tears in the anterior and posterior horns as well as the body of the lateral meniscus, moderate to high grade chondromalacia in the lateral tibiofemoral compartment, extensive soft tissue swelling, moderate effusion and a large popliteal cyst, which appeared to have ruptured. PX 8 at 14. On this date, he diagnosed aggravated osteoarthritis and a lateral meniscus tear. PX 8 at 14-15. In his opinion, Petitioner's work fall exacerbated the lateral meniscus tearing. PX 8 at 15. Petitioner likely had some tearing prior to the work fall, based on the degree of osteoarthritis he had, but the fall would have increased that tearing. PX 8 at 16. The osteoarthritis pre-dated the fall. The fall caused the effusion and soft tissue swelling, based on the history Petitioner provided of striking his knee against a hard surface when he fell. PX 8 at 17. The popliteal cyst was likely pre-existing and is unrelated to the fall. PX 8 at 18. He is not recommending that Petitioner undergo an arthroscopy because that procedure would likely increase the degree of load on the cartilage and worsen the osteoarthritis. PX 8 at 19.

Dr. Durkin testified that Petitioner has not voiced left knee complaints. He finds this significant, in terms of causation, because osteoarthritis is typically bilateral. PX 8 at 20, 33.

Dr. Durkin testified he administered a "gel one" shot in April 2015. This type of shot typically helps for a limited period of six months to one year. PX 8 at 21. He continued Petitioner on sedentary duty in April 2015. PX 8 at 21. He broached the subject of knee replacement surgery with Petitioner. A total knee replacement surgery would be the best way to treat Petitioner's osteoarthritis, in his opinion. PX 8 at 22.

Dr. Durkin testified that, at the next visit, on May 8, 2015, Petitioner reported about 50% improvement secondary to the "gel one" shot. He imposed restrictions of no climbing ladders, minimal walking, no lifting more than 10 pounds and standing as tolerated. PX 8 at 23. He described these restrictions as permanent. He found Petitioner to be at maximum medical improvement barring a knee replacement. He felt Petitioner would not get better without this surgery. PX 8 at 23.

Dr. Durkin testified he next saw Petitioner on July 7, 2015. On that date, Petitioner indicated he was no longer experiencing any benefit from the "gel one" injection. On examination, he noted positive McMurray's testing, which is pretty common in a patient with meniscal tearing and some arthritis. PX 8 at 24-25. He recommended a repeat MRI to see why Petitioner was experiencing more medial pain and to see whether an arthroscopy could help. PX 8 at 25. He continued the previous restrictions except he reduced the lifting to 5 to 10 pounds. PX 8 at 26.

Dr. Durkin testified Petitioner seemed to be worse at the next visit on September 22, 2015. Petitioner was having difficulty using stairs and getting out of vehicles. Dr. Durkin testified he interpreted the repeat MRI as showing complex horizontal tearing in the lateral meniscus and worsening of the cartilage damage. PX 8 at 27. It was his understanding that Petitioner had been performing full duty and had no right knee complaints before the work fall. PX 8 at 30.

Dr. Durkin testified he is still prescribing a total knee replacement. Pending that surgery, Petitioner requires restrictions of primarily sedentary work with no kneeling, minimal walking and no climbing/ladder usage. PX 8 at 35.

Under cross-examination, Dr. Durkin testified he did not see Petitioner on February 10, 2015. PX 8 at 36. He has some independent recollection of Petitioner. PX 8 at 36. In terms of his note taking, he would typically memorialize anything he felt was important. PX 8 at 37. On March 10, 2015, Petitioner made no mention of a back injury. On subsequent visits, Petitioner did not complain of back pain. It was not until the Tuesday before the deposition that he noted a complaint of back pain and referred Petitioner to a doctor for back treatment. PX 8 at 38. The X-rays and MRI performed shortly after the work fall showed arthritis and arthritis does not develop overnight. While it is common for arthritis to be in both knees, it is also common for patients to have arthritis in only one knee joint. PX 8 at 39. He understands that Petitioner tripped over a rubber mat and landed on linoleum. PX 8 at 39. If Petitioner in fact struck his knee against a carpeted surface when he fell, that would not prompt him to change his causation opinion. It is more the fact that Petitioner fell and had an immediate onset of pain after he fell that supports that opinion. No one ever falls in a clean, one-directional manner. Twisting is almost always involved. PX 8 at 40. The effects of cortisone shots vary, patient to patient. PX 8 at 41. The effects of the initial shot often last longer than subsequent shots. PX 8 at 42. As of March 10, the initial visit, he did not have any MRI images. Those images could have caused him to change his causation opinion. PX 8 at 43. He later ordered a repeat MRI because Petitioner's pain changed a little, location-wise. PX 8 at 44.

Dr. Durkin testified he disagrees with some of the statements made by Dr. Lewis. For example, he disagrees with Dr. Lewis's statement that Petitioner landed on a carpeted surface. In his view, all it takes is a little twisting of the knee, regardless of the surface the patient lands on, for underlying tearing to be aggravated. PX 8 at 52. No fall is completely straight. There is always some rotation. PX 8 at 53. It is more that Petitioner fell than what he landed on. PX 8 at 54. He also disagrees with Dr. Lewis's causation analysis. He agrees with Dr. Lewis that Petitioner is a reliable historian. PX 8 at 55. He is not aware of Petitioner having changed jobs at any point between the work fall and his first visit in March 2015. PX 8 at 57.

On redirect, Dr. Durkin testified that the absence of back complaints has no effect on his knee-related opinions. PX 8 at 58. Cortisone shots might afford pain relief but they do not stop the progression of meniscal loss or arthritis. PX 8 at 59. He believes a total knee replacement would allow Petitioner to get back to full duty, at least as far as the knee is concerned. PX 8 at 59-60. He is recommending sedentary duty while Dr. Lewis referred to light duty. PX 8 at 60.

Under re-cross, Dr. Durkin testified he did not ask Petitioner about any rotation of his knee as he fell. PX 8 at 61.

On further redirect, Dr. Durkin testified that no patient is able to tell a doctor exactly how he fell. Even a video of a fall does not clearly show exact rotation in three different planes. PX 8 at 62. A knee has six degrees of freedom when it moves and a video would not show that, either. PX 8 at 63.

Under re-cross, Dr. Durkin testified he would not change his opinions even if he assumed Petitioner performed full duty for a year and a half before he saw him. It was the fall that seemed to set off Petitioner's pain and it was reasonable for Petitioner to be able to work through that pain. PX 8 at 64.

Dr. Lewis, Respondent's Section 12 examiner, testified by way of evidence deposition on May 23, 2016. RX 10. Dr. Lewis testified he has practiced medicine in Illinois for more than forty years. He is board certified in orthopedic surgery and independent medical examination. RX 10 at 5. Lewis Dep Exh 1.

Dr. Lewis testified he examined Petitioner on December 15, 2015. Petitioner provided a history of his October 7, 2013 work fall on that date. Petitioner indicated he landed on his right knee on a carpeted surface. RX 10 at 8. Petitioner also indicated his job at that time did not require any heavy lifting. RX 10 at 9.

Dr. Lewis testified that, on examination, Petitioner exhibited a "slight limitation of motion of his right knee." RX 10 at 11. The records he reviewed and X-rays he obtained in his office showed that Petitioner had severe degenerative arthritis in that knee. RX 10 at 11. This arthritis would explain the severe pain Petitioner complained of. RX 10 at 12. He felt that Petitioner's complaints were genuine. He viewed Petitioner as a "credible honest person." RX

10 at 14. He would characterize Petitioner's arthritis as "end-stage," meaning it was "very likely that he would need to have treatment in the near future." RX 10 at 14. He saw no evidence of an acute injury that would have accelerated a pre-existing degenerative condition. In his report, he opined that striking one's knee against a carpeted surface would not be a sufficient causative event to accelerate arthritis. RX 10 at 18. Moreover, the severity of Petitioner's arthritis was evidenced by the radiographic studies he underwent within a week of his fall. RX 10 at 18.

Dr. Lewis opined that Petitioner has a permanent disability, i.e., severe degenerative arthritis of his right knee. He finds it "perfectly appropriate" for Petitioner's treating surgeon, Dr. Durkin, to have recommended a total knee replacement. RX 10 at 20. He does not see any reason, however, for Petitioner to undergo a repeat MRI. RX 10 at 20-21. He views Dr. Durkin as "being honest and reasonable" in his causation opinion but he does not agree with that opinion. It is "purely speculative" for Dr. Durkin to opine that Petitioner has meniscal pathology and that the fall worsened an underlying meniscal tear. RX 10 at 22.

Dr. Lewis testified he has seen many, many knee MRIs of patients who have severe degenerative arthritis. It is common for those MRIs to show complex meniscal tears. Those tears are degenerative, not acute. He "respects" Dr. Durkin's opinion that Petitioner's MRI showed acute tearing but disagrees with that opinion. RX 10 at 24.

Under cross-examination, Dr. Lewis testified he assumes he examined Petitioner at the request of the employer. He devotes 10% of his practice to conducting examinations. RX 10 at 28. Over the last two years, however, that percentage may have risen to 15%. RX 10 at 28-29. At the "absolute maximum," the percentage would be 20%. RX 10 at 29. The vast majority of the examinations he performs are for employers. RX 10 at 30. He is an employee rather than a partner of Illinois Bone and Joint and cannot estimate the charges associated with his examination and report. RX 10 at 30. He is able to independently recall Petitioner. Petitioner was a "very sincere gentleman." RX 10 at 32. He cannot recall, however, whether he utilized an interpreter. RX 10 at 33. He "may have made a few handwritten notes" concerning the history Petitioner provided but he does not normally retain such notes. If the notes were scanned into a file, they could be procured from Illinois Bone & Joint's IME department. RX 10 at 34. He has no independent recollection of Petitioner telling him he landed on a carpet. RX 10 at 34. Given the degree of pain Petitioner is experiencing, he would likely benefit from knee replacement surgery, on the right side only, at some point. RX 10 at 35. He reviewed the actual MRI images. RX 10 at 36. He saw no records indicating that Petitioner had problems with his right knee before the October 7, 2013 accident. RX 10 at 37-38. The records he reviewed suggest Petitioner resumed unrestricted duty in December 2013 but he does not know exactly what kind of work Petitioner performed after that time. RX 10 at 38-39. Petitioner told him he picked up garbage outside. He assumes this involved walking, bending and stooping. RX 10 at 39. He is not sure why Dr. Durkin ordered a repeat MRI in 2015. Before the deposition, no one asked him to formulate any opinions concerning Dr. Durkin's reports. RX 10 at 40-41. If Petitioner had been experiencing severe knee pain during the interval between December 2013 and March 2015, he would not have been able to work and would have been seeing a physician

regularly. RX 10 at 42. An acute injury could have consisted of a fracture or ligament rupture but Petitioner's post-accident MRI did not show any acute injury. RX 10 at 43-44. Theoretically, an acute injury could have also included further injury to the lateral meniscus. RX 10 at 44. He does not view Dr. Durkin as out on a limb. He just disagrees with the doctor's conclusions. RX 10 at 44-45. The fact that he disagrees does not mean Dr. Durkin is wrong. RX 10 at 45.

Dr. Peoples testified by way of evidence deposition on January 19, 2017. Dr. Peoples testified he has worked as a physician for IPC Health/Team Health for almost a year. He previously worked as a physician for U.S. Health. RX 11 at 9. He worked for U.S. Health as of March 2 and 3, 2015. RX 11 at 10. He specializes in internal medicine. RX 11 at 12.

Dr. Peoples testified he recalls Petitioner's name but would need to see his records to remember more. After reviewing Peoples Dep Exh 2, he testified he recalled seeing Petitioner on March 2, 2015. He examined Petitioner on that date and completed U.S. Health forms indicating Petitioner could return to work. RX 11 at 19. On one of the forms, he checked boxes indicating that a pathological condition, namely low back pain, prevented Petitioner from bending or lifting more than 10 pounds. He signed this form. RX 11 at 22-23. On March 3, 2015, he issued a revised version of the form indicating that his examination revealed a "non-occupational pathological condition to be followed by the personal physician" and that Petitioner could be assigned to "any work consistent with skills and training." RX 11 at 28.

Dr. Peoples testified he issued the revised form on March 3, 2015 after conversing with a Respondent employee. He does not recall exactly who he spoke with. RX 11 at 29-30. The person he spoke with asked him to issue a revised form. As of March 2, 2015, he did not have all of Petitioner's records. The only information he received on that date was the history Petitioner gave him. RX 11 at 33-34. He understands that Petitioner had previously been off work due to knee and hand injuries resulting from a work fall. RX 11 at 36. He did not treat Petitioner for these injuries. RX 11 at 36-37.

Under cross-examination, Dr. Peoples testified he worked for U.S. Health for less than a year. RX 11 at 37. Most of the patients seen at that facility have work-related injuries or have been referred. RX 11 at 37-38. U.S. Health protocols were kept in a binder at the office. He has no copies of those documents. RX 11 at 39. If a patient came in who wanted to return to work, U.S. Health did not have to seek advance authorization from the patient's employer to deal with that. RX 11 at 39. He is not board certified in any specialty. RX 11 at 40. He saw Petitioner on only one occasion. RX 11 at 41. The only outside record he reviewed was what Petitioner produced to him on that occasion. RX 11 at 41-42. He cannot recall the details of the examination. The history that Petitioner provided would not have been recorded word for word in any document. RX 11 at 42. Nowhere in his original or revised note did he document what, if anything, brought about Petitioner's symptoms. RX 11 at 43. Petitioner did not tell him what caused his low back pain. Petitioner completed a form answering "yes" to a question asking whether he had sustained a work injury. He did not ask Petitioner about this injury. RX 11 at 47. When he completed the revised form, he left the restrictions in place. RX 11 at 47. When Petitioner came to see him on March 2, 2015, a patient-physician relationship was

established. He never obtained Petitioner's authorization to discuss his medical condition with his employer. RX 11 at 48-49. When he spoke with an employer representative, before issuing the revised form, something the representative told him caused him to go back to review Petitioner's records. RX 11 at 51. Those previous records, from October 2013, contained no mention of a back injury. RX 11 at 51. He never asked Petitioner whether an intervening event occurred at some time after October 2013. RX 11 at 52. He revised the form so as to describe Petitioner's condition as non-occupational based solely on his review of the October 2013 records. RX 11 at 52-53. Petitioner said his job involved picking up garbage. RX 11 at 53-54.

Petitioner testified he wants to proceed with the recommended knee replacement surgery. T. 110. He last saw Dr. Durkin on March 8, 2016, at which time the doctor again prescribed this surgery and restricted him to sedentary work. T. 110. If the surgery is awarded, he will undergo it. T. 111-112.

Petitioner testified he continues to experience significant right knee pain. This pain affects his ability to walk. He does not have similar pain in his left knee. T. 111.

Under cross-examination, Petitioner reiterated he orally reported his October 2013 work fall and signed a report concerning that fall. T. 115-116. Respondent accommodated his restrictions after that fall. He was not required to continue to perform full duty. T. 116-118. Respondent authorized him to undergo care at U.S. Health Works after he fell. T. 118. A doctor at U.S. Health Works released him to work in December 2013 but did not tell him the nature of the work he was being released to. T. 121. The doctor also discharged him from care. T. 125. After being discharged from care, he did not return to U.S. Health Works until March 2, 2015. It was always his knee that prompted him to go to U.S. Health Works, although he recalls once complaining about his back at that facility. T. 126-127. If the record dated March 2, 2015 does not indicate he complained of knee pain, he would agree with the record. T. 131. He did not complete any accident report concerning his back. T. 131. No one associated with Respondent authorized him to undergo back-related care at U.S. Health Works. T. 132-133. In March 2015, Respondent sent him a letter indicating it did not have a light duty assignment for him. RX 6 is an accurate copy of this letter. T. 135-136. The subject line of this letter does not mention early retirement. The first sentence of the letter discusses a non-duty-related medical condition. T. 136. He first experienced back pain in approximately 2005 or 2006, at which point he worked for Respondent's administration in the precinct office. His boss at that time was Respondent's interim president, Romero Gonzalez. T. 139. He first reported a back injury to Respondent in approximately 2005, at which point the director of human resources sent him to U.S. Health Works. He did not ask for light duty when he went to U.S. Health Works on March 2, 2015. T. 148. He did not see a doctor for his right knee between December 2013 and March 2, 2015. He complained of back pain to doctors at Garcia Medical Center on several dates in 2014. T. 149. He underwent a low back MRI in 2007. T. 149. He reported an accident to Respondent in June 2010 but that accident involved his chest. The report concerning this accident (RX 9) mentions both chest and back pain but does not specifically mention low back pain. T. 150. He does not know how to complete an accident report but he knows how to sign off on one. If he signs such a report, he is responsible for its contents. T. 151. He does not

recall whether he signed a report concerning his back in March 2015. T. 151. He did not complain of back pain to Dr. Durkin. T. 151-152. RX 7 is not the letter he received from Respondent in September 2015. The letter he received at that time was personally delivered to him by a police officer. T. 152. He never responded to RX 7 because he never saw it. T. 152-153. The knee injection he received in October 2013 helped for only a very short time. T. 153. He does not know how often trash is collected by Respondent employees because he only worked behind a garbage truck for two days. T. 154. He had to drag the garbage cans about 20 feet. A snowplow went down the alleys before the garbage truck went down them. T. 155.

Under additional cross-examination, Petitioner reiterated he was subject to a 10-pound lifting restriction when he began working in Respondent's public works department in 2010. It was the rodent control department, where he used to work, that put him on that restriction, based on his doctors' notes. He provided Respondent's human resources department with those notes. T. 156. In 2010, he worked in rodent control, not the mayor's office. The notes he turned in were from both his own physician, Dr. Garcia, and Respondent's physician, Dr. "Chana" [sic]. T. 157-158. He did not retain copies of these notes. He turned in these notes when he was asked to do so. He does not know the exact dates he turned them in. T. 158. [At this point in the hearing, one of Respondent's attorneys asked Petitioner to roll up his pant legs. The Arbitrator viewed both of Petitioner's knees and did not appreciate any marked difference in their size.] Once a garbage can is moved into position, behind the truck, the truck mechanically lifts the can and dumps its contents. The can is then mechanically lowered to the ground. The can ends up in the same position it was lifted from. T. 163. He was over 65 years of age during the two days he worked behind a garbage truck. Respondent did not provide him with any back belt. T. 164. Tony Tufano arrived at work at 6 AM and left at 2 PM. If he is told that Tufano's stated shift ran from 2 AM to 10 AM, he cannot dispute that. T. 165-166. On March 2, 2015, he went to Dr. Garcia's office before heading over to U.S. Health Works. T. 166. He did not ask Dr. Garcia for a disability note on March 2, 2015. He simply asked for a note concerning his condition so he could present that note to Respondent. T. 167-168.

On redirect, Petitioner testified he received documents in addition to the letter marked as RX 6 at the March 2015 meeting. T. 169. In September 2015, he returned to work the day after he received the light duty offer letter from Respondent. T. 170. He had to get a garbage can into the proper position in order for the can to be mechanically lifted and dumped. T. 170. Tony Tufano was "always" at the public works building. T. 171.

Under re-cross, Petitioner testified that Tony Tufano's regular shift was in the morning. He reiterated that Tufano was "always" at the public works building but admitted he does not know whether Tufano worked around the clock since he had his own work to do outside of the building. T. 172.

Derek Dominick testified on behalf of Respondent. Dominick testified he has held the position of supervisor of Respondent's public works department for almost four years. He held this position in October 2013. T. 178. He sets the schedule for the trucks used by the sixty employees who work during the first shift. He also handles attendance records and other

issues. T. 179. He is one of Petitioner's supervisors. T. 179. Due to his scheduling responsibilities, he is kept apprised of the recovery status of any employees who report injuries. Depending on the situation, Respondent has the ability to send employees to a clinic for medical care. For example, Respondent would send employees for injury-related care, pre-employment physicals and drug testing. T. 179-180. Once an employee reports a work injury and completes an accident report in the office, he is given a form authorizing him to go to a clinic. Respondent's policy is that an accident report must be completed before the start of the day following the accident. T. 181. RX 1 is an accurate copy of the report concerning Petitioner's accident of October 7, 2013. T. 182. The report serves several purposes. It notifies Respondent of the body part(s) involved in the accident and allows Respondent to monitor the employee's condition. T. 183. RX 2 is an accurate copy of a form dated October 7, 2013 authorizing Petitioner to undergo care at U.S. Health Works. T. 184. Once Petitioner began undergoing care at U.S. Health Works, the clinic kept Respondent apprised of his condition and work status. T. 185-186. After December 2013, he did not see any reports from U.S. Health Works concerning Petitioner's knee condition. T. 186. Petitioner resumed full duty in December 2013. He was not subject to restrictions at that time. Petitioner is now on light duty "doing sweeper brushes." T. 186. Petitioner was not on light duty at any time between December 2013 and March 2015. T. 187.

Dominick testified that Respondent employees were off work on March 2, 2015 due to the holiday. T. 187. On or about that date, he received a report from Petitioner or U.S. Health Works regarding a back injury being claimed by Petitioner. T. 187. He is not sure whether he spoke with Petitioner at that time. Petitioner saw Dr. Peoples on March 2, 2015, based on RX 5. U.S. Health Works provided Dr. Peoples' March 2, 2015 slip to him. The slip indicates Petitioner complained of low back pain but, at that time, he did not have any report indicating Petitioner had sustained a back injury. T. 189. Upon receipt of the slip, he "contacted Dr. Peoples to find out who allowed him to see [Petitioner]." Petitioner "went to the clinic without [Respondent] having any idea of what his injury was." Respondent "wasn't sure if it was work-related, non-work-related." Thus, he had to contact Dr. Peoples to find out whether Respondent could let Petitioner work. He did not ask Dr. Peoples to change his report. Dr. Peoples subsequently issued a "revised" report indicating that Petitioner had a non-occupational condition that was to be followed by his personal physician. He did not ask the doctor to issue this revised document. T. 191. [The parties then stipulated that it is Respondent's policy that no light duty has to be offered to an employee unless that employee has established a work-related injury. T. 195.] As of March 3, 2015, he drew a conclusion, based on Dr. Peoples' revised form, as to whether Petitioner sustained a work injury on February 27, 2015. The revised form described Petitioner's condition as non-occupational. It also indicated Petitioner could be assigned to any work consistent with his skills and training. T. 204. He did not schedule Petitioner for light duty in March 2015. After March 3, 2015, he scheduled Petitioner for light duty on September 14, 2015, via a letter bearing that date. The letter is signed by Sam Jelic, Respondent's public works commissioner. T. 205. RX 7. Once Petitioner presented to work, after receiving the letter, he was given the job of assembling and counting street sweeper brushes. T. 206. That job is a light duty assignment, unlike Petitioner's previous pick-up and garbage truck assignments. T. 207. Petitioner has never complained to him of back pain. T. 207.

On further direct examination, Dominick testified that Respondent did not plow alleys as of the period during which Petitioner worked behind a garbage truck. T. 209-210. He is familiar with the van Petitioner described. The van is actually lower to the ground than the pick-up truck. T. 211. Some of Respondent's employees are Hispanic. An employee claiming an injury is required to complete a report. T. 214.

Under cross-examination, Dominick testified he schedules a variety of trucks used by the employees who work morning shifts. He goes out into the areas where the trucks are used. He drives a Respondent-owned pick-up truck. T. 218. It is his position that a Respondent employee claiming an injury has to see a doctor of Respondent's selection before he can see a doctor of his own choice. T. 218. He does not know whether the Workers' Compensation Act states this. T. 221. Sam Jelic is still Respondent's Commissioner of public works. T. 221. The first form he received from Dr. Peoples is page 7 of RX 5. That form, unlike the subsequent revised form, did not describe Petitioner's condition as non-occupational. He contacted Dr. Peoples after receiving the first form. He did not obtain authorization from Petitioner before he made this contact. T. 226. He spoke directly with Dr. Peoples but did not provide him with additional information. Based on the conversation he had with Dr. Peoples, the doctor issued a revised form. T. 227. He had full access to Petitioner at this point, and could have called Petitioner into his office to question him, but never did this. T. 228. He has not read Dr. Peoples' deposition. T. 228. He did not speak with anyone other than Dr. Peoples before he received the revised form. T. 229. He does not know what additional information Dr. Peoples relied on in making the revisions. T. 230. If he had not received the revised form, he would not have agreed Petitioner's condition was work-related. T. 232. Nine days after Dr. Peoples issued the revised form, Respondent tendered the letter marked as RX 3 to Petitioner. T. 234. He does not know what job Petitioner performed before April 2013 because he himself did not begin working in the public works department until April 2013. He believes Petitioner was already working out of the pick-up truck as of April 2013. He does not know how it was that Petitioner was assigned to that job. T. 236-237. Workers who have that job are often assigned to Cermak Road. He did not physically observe Petitioner performing this job between 2013 and February 2015. T. 237-238.

Arbitrator's Credibility Assessment Relative to Both Cases

Petitioner came across as a hard-working, honest individual. The Arbitrator agrees with the assessment of Dr. Lewis, Respondent's examiner, i.e., that Petitioner is a "very sincere gentleman."

The Arbitrator finds credible Petitioner's testimony that he was subject to various back-related restrictions for years before his undisputed October 7, 2013 accident and that Respondent was accommodating those restrictions. Petitioner's testimony on this point is fully supported by the October 7, 2013 records from U.S. Health Works, Respondent's selected medical provider. Those records describe Petitioner's "regular" job as subject to various restrictions, including a 10-pound lifting restriction. In this context, the term "regular job"

clearly refers to the duties Petitioner commonly performed, rather than to unrestricted duty. The Arbitrator also notes that Respondent's witness, public works supervisor Derek Dominick, did not contradict Petitioner's account of the paper collection work he performed after being transferred to public works in 2010. Respondent also offered no evidence to contradict Petitioner's testimony that the need for restrictions stemmed from a work-related back condition he reported to Respondent in approximately 2005. Petitioner credibly testified that the restrictions were imposed by a Respondent-selected physician, Dr. "Cana" [Dr. Khanna of U.S. Health Works] as well as his own physician, Dr. Garcia. Dominick's testimony that Respondent did not technically classify Petitioner's paper collection job as light duty does not mean the job requirements did not meet Petitioner's restrictions.

Also credible was Petitioner's denial of any right knee problems before the October 7, 2013 accident. Respondent's examiner, Dr. Lewis, admitted he saw no records alluding to any such problems.

Also credible was Petitioner's testimony that his right knee was still symptomatic as of December 3, 2013, the date Dr. Khanna of U.S. Health Works discharged him from care, and remained so thereafter. Dr. Khanna did not describe Petitioner's right knee as asymptomatic on December 3, 2013. In fact, he noted positive McMurray's testing on that date. He released Petitioner to his "regular" job, which had originally been accurately described as a restricted job. [The Arbitrator notes that Dr. Khanna had previously described Petitioner as potentially needing knee surgery.] Respondent's witness did not take issue with Petitioner's testimony that he resumed paper collection, using a hand-held device known as a "picker," after being discharged by Dr. Khanna. He readily conceded he did not know how it was that Petitioner had originally been assigned to this job in 2010, since he was not assigned to public works at that time. He only disagreed with Petitioner's description of the height of the van he worked out of after December 3, 2013.

In the Arbitrator's view, Petitioner was able to continue working after December 3, 2013, despite ongoing right knee symptoms, for two reasons: 1) he was motivated to work; and 2) his longstanding back-related restrictions were essentially being accommodated. That ability ended when Respondent abruptly assigned Petitioner to a new job behind a garbage truck in late February 2015. Petitioner's testimony concerning the requirements of this job and the weather conditions that existed at that time was detailed and believable. Dominick contradicted this testimony only to the extent of stating that Respondent did not perform snow plowing and could not have created the piles of snow that inhibited Petitioner's efforts. This testimony does not eliminate the possibility that private snowplows or other vehicles created the piles.

Also credible was Petitioner's testimony that, on the Friday before March 2, 2015, (i.e., February 27, 2015), after working behind the garbage truck for two days, he orally notified Tony Tufano, who was then Commissioner of public works, that his new duties, which violated his longstanding restrictions, were causing back and right knee problems.

Did Petitioner sustain an accident arising out of and in the course of his employment on February 27, 2015?

The Arbitrator finds that Petitioner sustained a work accident on February 27, 2015 in the sense he was not physically able to continue performing his newly assigned garbage truck collection duties after that date. While it is true there is no evidence Petitioner fell or sustained another type of specific trauma on either February 26 or 27, 2015, the word "accidental," as used in the Act is a "comprehensive term almost without boundaries in meaning," Peoria County Belwood Nursing Home v. Industrial Commission, 138 Ill.App.3d 880 (3rd Dist. 1985). It can, for example, refer to the point in time at which a worker's physical structure gives way under the stress of labor. The Arbitrator concludes that the garbage truck duties, which Petitioner performed for two days in severe weather conditions, aggravated Petitioner's underlying back and right knee conditions of ill-being, prompting him to notify Tony Tufano of those conditions on February 27, 2015 and seek care and work capacity clarification on March 2, 2015. The Arbitrator clarifies, however, that she views the lower back aggravation as temporary. See further below.

Did Petitioner provide Respondent with timely notice of his claimed February 27, 2015 work accident?

The Arbitrator finds that Petitioner provided Respondent with timely and sufficient oral notice of his claimed February 27, 2015 work accident. In so finding, the Arbitrator relies in part on Petitioner's credible testimony concerning his conversation with Tony Tufano on the Friday before March 2, 2015, the U.S. Public Health Works records of March 2, 2015 and Dr. Peoples' deposition testimony. The Arbitrator recognizes, however, that, based on the representation of Respondent's counsel, Respondent had no way to rebut Petitioner's testimony, since Tufano is deceased. The Arbitrator thus clarifies that she also relies on the following significant admission of Respondent's witness, Derek Dominick, made on direct examination:

> Q: On or about [March 2, 2015], did you get a report from – either directly from [Petitioner] or from U.S. Health regarding a claimed injury –
>
> A: Yes, I did.
>
> Q: --to [Petitioner's] back?
>
> A: Yes, I did."

- This exchange completely deflated Respondent's notice defense. That Dominick conceived of the written information he received from Dr. Peoples of U.S. Health Works on March 2, 2015 as a report of a work injury fully explains the action he took next, i.e., the call he placed to the doctor. Dominick conceded he did not receive authorization from Petitioner to make this call.

Dr. Peoples made a similar concession. He admitted he discussed Petitioner's medical condition with a representative of Respondent (presumably Dominick) despite having formed a doctor-patient relationship with Petitioner the previous day. The ensuing conversation was a clear violation of the Petrillo doctrine, which has been held to apply to workers' compensation claims. Hydraulics, Inc. v. Industrial Commission, 329 Ill.App. 3rd 166 (2nd Dist. 2002).

Did Petitioner establish a causal connection between his accidents and his claimed current conditions of ill-being?

The Arbitrator initially addresses causation vis-à-vis the first case, 15 WC 7807. The Arbitrator finds that Petitioner established a causal connection between the undisputed accident of October 7, 2013 and his current right knee condition of ill-being. The Arbitrator further finds that this accident contributed to the need for the right total knee replacement that Drs. Durkin and Lewis have recommended. In so finding, the Arbitrator relies in part on the unilateral nature of Petitioner's knee complaints. The records in evidence contain no hint of any left knee problems. Respondent's examiner, Dr. Lewis, did not note any left knee abnormalities. The Arbitrator also relies on Dr. Khanna's positive examination findings of December 3, 2013. The Arbitrator also relies on Petitioner's credible testimony that his right knee symptoms persisted after he resumed his "picker" garbage collection job in December 2013. The Arbitrator further relies on the causation opinions voiced by Dr. Durkin. The Arbitrator finds Dr. Durkin's causation opinions more persuasive than those voiced by Dr. Lewis, Respondent's examiner. Dr. Durkin saw Petitioner on several occasions while Dr. Lewis saw him once. At the point at which Dr. Lewis issued his examination report, he mistakenly believed Petitioner struck his knee against a carpeted surface. He attached great significance to this, at that time. It was only later, at his deposition, that he asserted it did not really matter whether Petitioner landed on a hard or soft surface. He found Petitioner to have "end stage" degenerative arthritis in his right knee, and very likely to require treatment in the near future, as of the work fall, but Petitioner was successfully performing a garbage "picker" job for Respondent at that point and was not seeking out any right knee care. Dr. Lewis also exhibited bias. Under cross-examination, he initially testified he devotes only 10% of his practice to conducting examinations. He quickly revised that estimate upward to 20%. He conceded the vast majority of the examinations he performs are for employers. He did not have a clear understanding of the "picker" job Petitioner performed between December 2013 and late February 2015. He incorrectly assumed this job required bending and stooping. RX 10 at 39. While he indicated he disagreed with Dr. Durkin's causation opinion, he emphasized that this disagreement did not mean Dr. Durkin was "wrong." RX 10 at 45. He took no issue with the treatment rendered to date and conceded Petitioner requires a right knee replacement.

Overall, the Arbitrator found Dr. Durkin to be better informed, more consistent and more persuasive than Dr. Lewis.

In the second case, 15 WC 30570, the Arbitrator finds that the accident of February 27, 2015, i.e., the vigorous activities Petitioner performed in snowy conditions on that date, further aggravated Petitioner's right knee and prompted him to resume care. The Arbitrator views this

accident as contributing to the need for the right total knee replacement surgery Drs. Durkin and Lewis have recommended. The Arbitrator recognizes that Dr. Durkin's records do not mention any February 27, 2015 accident. The Arbitrator does not find this surprising since Petitioner did not sustain a fall or other specific trauma on February 27, 2015. As noted previously, an employee need not show any external violence to his body in order to prove an accidental injury. Zion-Benton Township High School District 126 v. Industrial Commission, 242 Ill.App.3d 109 (2nd Dist. 1993). That Petitioner did not complete or sign a written report, as he did following the October 7, 2013 accident, is understandable, in the absence of a specific event.

The Arbitrator further finds that the accident of February 27, 2015 aggravated Petitioner's longstanding lower back condition but only temporarily. The Arbitrator views this condition as returning to baseline following the accident. Dr. Durkin's initial records contain no mention of back pain. It was not until shortly before his deposition, in March 2016, that Dr. Durkin mentioned any back condition. Dr. Durkin did not render any causation opinion concerning Petitioner's back. The Arbitrator finds that Petitioner did not establish a causal connection between the February 27, 2015 accident and his claimed current low back condition of ill-being.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from March 13, 2015 (the day after he met with Tufano, et al.) through September 15, 2015 (the day he received a written offer of accommodated duty), a period of 26 5/7 weeks. Respondent disputes this claim based on its accident and causation defenses.

The Arbitrator has previously found that Petitioner established an accident of February 27, 2015. The Arbitrator has also found a causal relationship between each of Petitioner's accidents and his current right knee condition of ill-being. The Arbitrator finds that condition to be unstable as of March 10, 2015, the date on which Petitioner resumed right knee care with Dr. Durkin. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010). On that date, the doctor recommended treatment and imposed sedentary duty. He continued to recommend care and work restrictions at subsequent visits. There is no dispute that, following the meeting of March 12, 2015, Respondent did not provide restricted duty to Petitioner until September 16, 2015. The Arbitrator awards temporary total disability benefits from March 13, 2015 through September 15, 2015.

Is Petitioner entitled to reasonable and necessary medical expenses?

In 15 WC 7807, Petitioner claims one outstanding bill, in the amount of $111.00, relating to his last visit to Dr. Durkin on March 8, 2016. PX 6. Respondent's examiner did not take issue with any aspect of Dr. Durkin's care. He agreed with Dr. Durkin's surgical recommendation. The Arbitrator awards this bill, subject to the fee schedule.

Is Petitioner entitled to prospective care in the form of a right total knee replacement?

The Arbitrator has previously found that Petitioner established a causal connection between his two work accidents and his current right knee condition of ill-being. The Arbitrator has also found that Petitioner established causation, via an aggravation theory, as to the need for a right total knee replacement, as recommended by Drs. Durkin and Lewis. The Arbitrator awards Petitioner prospective care in the form of this surgery.

Is either case ripe for a permanency determination?

Based on the foregoing findings and award of prospective right knee surgery, the Arbitrator does not view either of Petitioner's cases as ripe for a permanency determination, as requested by Respondent.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mario Moya,

Petitioner,

vs. NO: 15WC 30570

Town of Cicero Department of Public Works,

17IWCC0606

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 22, 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.

17IWCC0606

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

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

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

DATED: SEP 29 2017

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

SJM/sj
o-9/21/2017
44

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MOYA, MARIO
Employee/Petitioner

Case# **15WC030570**

15WC007807

TOWN OF CICERO DEPT OF PUBLIC WORKS
Employer/Respondent

17IWCC0606

On 3/22/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0311 KOSIN LAW OFFICE LTD
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CHICAGO, IL 60602

4217 DEL GALDO LAW GROUP
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BERWYN, IL 60402

17IWCC0606

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

Mario Moya
Employee/Petitioner

v.

Town of Cicero - Department of Public Works
Employer/Respondent

Case # **15** WC **30570**

Consolidated cases: **15 WC 07807**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **February 10, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 27, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

For the reasons set forth in the attached decision, the Arbitrator finds that the accident of February 27, 2015 was a cause of Petitioner's current right knee condition and contributed to the need for the total knee replacement surgery recommended by Drs. Durkin and Lewis. The Arbitrator further finds that the accident temporarily aggravated an underlying pre-existing lower back condition which returned to baseline.

In the year preceding the injury, Petitioner earned **$34,000.00**; the average weekly wage was **$653.85**.

On the date of accident, Petitioner was **71** 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

Respondent shall pay Petitioner temporary total disability benefits of $435.90/week for 26-5/7 weeks, commencing March 13, 2015 through September 15, 2015, as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for prospective care in the form of the right total knee replacement recommended by Drs. Durkin and Lewis.

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

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

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

Molly C Mason

Signature of Arbitrator

3/22/17
Date

MAR 22 2017

Mario Moya v. Town of Cicero, Department of Public Works
15 WC 7807 and 15 WC 30570 (consolidated)

Summary of Disputed Issues in Both Cases

In 15 WC 7807, the parties agree Petitioner sustained an accident while working for Respondent on October 7, 2013. They also agree Petitioner provided Respondent with timely notice of the accident. The disputed issues include causal connection, one unpaid medical bill from Hinsdale Orthopaedics and whether the case is ripe for a permanency determination (with Petitioner seeking prospective care in the form of a right total knee replacement and Respondent arguing that the Arbitrator should address permanency, based on its causation defense). Arb Exh 1.

In 15 WC 30570, Petitioner claims he injured his back and right knee on February 27, 2015. The disputed issues include accident, notice, causal connection and whether the case is ripe for a permanency determination. Arb Exh 2.

Arbitrator's Findings of Fact Relative to Both Cases

Petitioner testified he is able to speak some English. He opted to testify through a Spanish-speaking interpreter.

Petitioner testified he was born on May 25, 1943. He is now 73 years old. T. 21.

Petitioner denied having any right knee problems before his October 7, 2013 accident. He had, however, experienced low back problems for about eleven years before that accident. T. 23. Since approximately 2007, he has been subject to a 10-pound lifting restriction due to those problems. It is his personal physician, Dr. Garcia, who imposed this restriction. He is still subject to the restriction. T. 25-26. Under cross-examination, Petitioner clarified that his back pain dated back to approximately 2005, at which point he worked at Respondent's precinct office. He reported a back injury to Respondent in about 2005. After he reported this injury, Respondent's human resources director sent him to UIC, where he underwent some examinations. T. 138-140.

Petitioner testified that, in 2010, he changed jobs and began working in Respondent's public works department. T. 27. Petitioner further testified that, after the job change, Respondent continued to accommodate his 10-pound lifting restriction. He was assigned to a cleaning job that involved using a device known as a "picker" to pick up lightweight refuse, essentially paper, outside various buildings. He worked with a partner who drove a pick-up truck and transported him to these buildings. T. 26-28.

Petitioner testified he was still performing the same cleaner job as of his October 7, 2013 accident. As of that accident, his shift started at 7 AM and ended at 3 PM. He started off his workday picking up garbage outside Respondent's public works building. At approximately

9 AM, he was inside this building, headed to a bathroom inside the cafeteria, when he tripped over the edge of a thick plastic mat that is shown in photographs marked as PX 1-A, 1-B and 1-C. T. 30-34. The mat was under a water fountain. He started falling forward. As he went down, he first tried to grab the water fountain with his left hand and then tried to use his right hand to break his fall. He landed on his right knee, with that knee striking the concrete floor. He testified he felt sharp pain in his right knee and was unable to get up on his own. T. 37. He called Maria, a secretary, and she came to his aid. T. 35-36. He then met with another co-worker, Dayanara, who completed a report (PX 2) concerning the accident. Petitioner testified he signed this report but did not fill it out. T. 37-38. The account of the accident set forth in the report is consistent with Petitioner's testimony. The report lists the following "affected body parts": right hand, left arm and right knee. PX 2.

Petitioner testified he underwent care at U.S. Health Works on the day of the accident. He testified that Respondent directed him to this facility. [Respondent provided written authorization for the visit. RX 2.] Petitioner testified his right knee and back felt "very bad" at this point. T. 39. A U.S. Health Works "new patient WC worksheet" dated October 7, 2013 describes Petitioner as a laborer whose job involves various activities, including lifting up to 10 pounds. This document also describes Petitioner as 5 feet, 2 inches tall. It sets forth a consistent account of Petitioner's fall, specifically stating that Petitioner tripped on a carpet and fell forward, striking his right knee "on ground." It reflects complaints relative to the right knee, right hand and left elbow. The examining physician, Dr. Khanna, noted that Petitioner denied any prior right knee or hand injury. He described Petitioner's gait as antalgic. He noted right knee swelling, right lateral joint line tenderness, a restricted range of right knee motion and a positive McMurray test on the right. He also noted a right hand contusion and a left elbow abrasion. He obtained right knee and right wrist X-rays, which were negative for fracture. He prescribed Nabumetone and ice applications. He released Petitioner to "sitting work only." PX 4. T. 39-40.

Petitioner testified that Respondent provided him with seated work consisting of counting brushes that are used in street sweepers. T. 40-41.

Petitioner returned to U.S. Health Works on October 14, 2013 (T. 41) and again saw Dr. Khanna. The doctor's right knee examination findings were essentially unchanged. He assessed Petitioner as having a lateral meniscus tear. He refilled the Nabumetone and prescribed a right knee MRI. He again released Petitioner to "sitting work only." He discharged Petitioner from care relative to the right hand. PX 4.

Petitioner underwent the right knee MRI on October 15, 2013. T. 42. The interpreting radiologist noted a "complex tear of the anterior and posterior horns as well as the body of the lateral meniscus, moderate to high grade chondromalacia of the lateral tibiofemoral compartment, extensive soft tissue edema and moderate effusion, a large popliteal cyst, likely ruptured, and osteoarthritis." He described the chondromalacia as "moderate to high-grade." PX 5.

On October 17, 2013, Dr. Khanna reviewed the MRI results with Petitioner. He aspirated bloody fluid from the right knee and injected the knee with cortisone. T. 42. He again released Petitioner to seated work. He noted that, if Petitioner's pain decreased, he would recommend physical therapy but, if not, he would "consider surgery." PX 4. RX 5.

Petitioner testified the injection provided relief only for a "very little time." T. 43. After his October 17th visit to U.S. Health Works, Respondent again provided him with seated work. T. 43.

On October 24, 2013, Dr. Khanna noted that Petitioner reported doing sitting work only and feeling "a little better after the injection." T. 43. He described Petitioner's gait as abnormal and indicated Petitioner complained of pain behind the right knee. He assessed Petitioner as having lateral and meniscal tears along with patellofemoral syndrome. He prescribed continued Nabumetone and ice applications along with physical therapy. He again released Petitioner to seated work. PX 4.

Petitioner underwent an initial physical therapy evaluation at U.S. Health Works on October 28, 2013. The evaluating therapist recorded a consistent history of the work accident and noted that Petitioner's job involved walking and "lifting up to 10 lbs." She also noted a history of lumbar disc problems. She indicated Petitioner reported right knee buckling and locking. On examination, she noted loss of motion in the right knee, limited straight leg raising on the left due to low back pain, straight leg raising to 40 degrees on the right, IT band tightness and tenderness and weakness in the right knee and both hips. She described Petitioner's balance and gait as poor. PX 4. RX 5.

Petitioner continued attending therapy thereafter. PX 4. RX 5.

On November 7, 2013, Dr. Khanna noted that Petitioner reported experiencing pain when putting weight on his right leg. His assessment was unchanged. He prescribed additional therapy and again released Petitioner to sitting work only. PX 4. RX 5.

The last U.S. Health Works therapy note is dated November 15, 2013. On that date, the therapist noted that Petitioner was still experiencing right knee pain, especially with walking. She noted that Petitioner's strength had improved but that he was "limited by pain symptoms in R knee." PX 4. RX 5.

On November 19, 2013, Dr. Khanna noted that Petitioner reported improvement secondary to therapy but was "not at 100%." T. 44. He noted positive McMurray's testing along with other right knee abnormalities on re-examination. He released Petitioner to "regular work" and directed him to return to the clinic on December 3, 2013. PX 4.

Petitioner testified that, after his November 19th visit to U.S. Health Works, Respondent put him back on the restricted cleaning job he had been performing prior to and as of the October 7, 2013 accident. He resumed working with a partner who drove him to various

buildings, where he used a "picker" to pick up garbage. T. 47. The only thing that changed was that his partner now drove a van rather than a pick-up truck. Petitioner testified the van was higher than the pick-up truck, in terms of the distance he had to step up when entering the passenger side. He estimated this distance to be between 1 ½ and 2 feet. T. 52-54. It was difficult for him to maneuver to get his body and right knee inside the van. He had to ask his partner for help with this. T. 49-50.

Petitioner testified he recalled resuming his regular cleaning job sometime in November. He could not remember the exact date. T. 47-48. [He went on to agree with U.S. Health Works records that purportedly indicated he resumed working on December 3rd but those records seem to suggest otherwise – see below.]

Petitioner returned to Dr. Khanna on December 3, 2013, as directed. The doctor noted Petitioner was "tolerating regular work" but still experiencing "soreness with walking in the morning [and] getting out of truck." The doctor described Petitioner's gait as normal and squat testing as mildly positive. On right knee examination, he again noted a reduced range of motion, lateral joint line tenderness and positive McMurray's testing. He released Petitioner to "regular work" and discharged Petitioner from care. PX 4.

Petitioner testified his right knee was still swollen when he last saw Dr. Khanna on December 3, 2013. He denied experiencing any right knee swelling before the October 7, 2013 accident. T. 49.

Petitioner testified he continued performing his cleaning job throughout 2014 and into the first part of 2015. During this time, he was still experiencing right knee pain and difficulty walking. He had difficulty using his right leg to support the weight of his body. T. 56.

Petitioner testified his job duties "suddenly" changed in late February 2015. He was taken off the cleaning job and assigned to garbage truck duty. His new job required him to walk behind the garbage truck and collect garbage for about eight to ten blocks (round-trip). The temperature was below zero and there was snow on the ground. He had to extract garbage cans from piles of snow that lined the sides of the alley. He explained that plows had come down the alleys, piling the snow off to the sides. After he pulled a can out of the snow, he had to drag it over to the truck and hook it up to the truck so that the contents could be dumped. T. 61-62. The cans had wheels but the wheels tended to freeze due to the ice and snow. T. 69-70.

Petitioner estimated the weight of an empty garbage can to be about ten pounds. T. 63. He testified the cans that contained garbage varied in weight but exceeded 20 to 30 pounds. The cans contained "house garbage" along with accumulated snow. T. 67.

Petitioner testified he was not able to lift the garbage cans. A co-worker, whose name he cannot recall, helped him with the lifting. T. 70.

Petitioner testified he lasted at the garbage truck assignment for only two days. T. 67. The second day was a Friday. T. 71. As of that day, he was experiencing pain and swelling in his right knee along with back pain that radiated down both of his legs. His back pain worsened over the course of the two days. T. 71-72.

Petitioner testified that, after work on that Friday, he spoke with Tony Tufano, a Respondent supervisor inside the public works building. The conversation took place at about 3 PM. There were other people in their general vicinity but only he and Tufano participated in the conversation. T. 73. Petitioner testified he complained to Tufano about being assigned to the garbage truck. Specifically, he asked Tufano why he had been given full duty when he was "still under light duty." T. 75. He also told Tufano about the problems he was having with his knee and back. T. 75.

Petitioner testified his back did not improve over the weekend. On the following Monday, March 2, 2015, he was not scheduled to work because it was Pulaski Day. T. 77-78. He went to his personal physician, Dr. Garcia, and secured an updated work status note. [Dr. Garcia's March 2, 2015 note states: "Pt wants disability note regarding LBP." The doctor issued a disability certificate imposing restrictions of no lifting over 10 pounds and no bending secondary to LBP – neuropathy." RX 8. Petitioner testified he took this disability certificate to U.S. Health Works, where he saw a physician. He told this physician he had been mistakenly sent back to full duty and was experiencing back and knee problems as a result. T. 79. The physician gave him a note to take back to work. Petitioner testified that PX 7 is not a true and accurate copy of the note the doctor gave him. The note he received was different from PX 7 in that the boxes next to lifting and bending restrictions were not checked. T. 82-84. [PX 7, a U.S. Health Works "fitness for duty form" dated March 2, 2015 contains check marks by "lifting over 10 lbs." and bending. It also contains a check mark next to the word "other," with a handwritten entry of "low back pain" appearing thereafter.]

The records from U.S. Health Works contain another form dated March 2, 2015, entitled "return to work evaluation worksheet." Dr. Peoples' signature appears at the bottom of both this form and PX 7. This form describes Petitioner's job as "garbage pick up" with lifting, pushing and pulling up to 10 pounds, among other requirements. The form attributes Petitioner's "recent absence from work" to back pain/disc disease. It reflects that Petitioner was seeing Dr. Garcia for this problem and was still under care. It lists February 27, 2015 as the "last day worked." Dr. Peoples noted that Petitioner complained of pain with walking, bending and stooping and was experiencing "left leg radiculopathy." He released Petitioner to work with no lifting over 10 pounds and no bending. PX 7.

Petitioner testified he went to Respondent's public works office after seeing the physician at U.S. Health Works and presented the note he received from the physician to Dayanara. Dayanara took the note from him. T. 82.

Petitioner testified that, when he presented to work the following day, Tuesday, March 3, 2015, he attended a meeting held inside the office of the public works Commissioner, Sam

Jelic. T. 84-85. In addition to Jelic, Derek Dominick and Tony Tufano participated in the meeting. After the meeting, Petitioner was sent to the cafeteria. During the following three days, he sat in the cafeteria for eight hours each day. He was not given any work to do and was not allowed to talk on the phone or listen to music. T. 85-86. He was still experiencing right knee pain and swelling during this period. After that three-day period, he was assigned to counting street sweeper brushes. T. 85.

On March 10, 2015, Petitioner saw Dr. Durkin, a physician associated with Hinsdale Orthopaedics. Dr. Durkin noted that Petitioner chiefly complained of right knee pain dating back to a fall in a hallway at work on October 7, 2013. He also noted that Petitioner "is a laborer in public works and has been on light duty restrictions which have been suspended as of 2 weeks ago." He indicated that Petitioner wanted to be evaluated in order to have his work status addressed. He indicated Petitioner rated his right knee pain at 8/10 when walking. He also noted a complaint of pain with range of motion of the right hip. On right knee examination, he noted a trace effusion, trace soft tissue swelling, active extension of -3 degrees, active flexion to 125 degrees, good quadriceps tone, no tenderness over the medial compartment, tenderness over the lateral compartment and negative varus/valgus stress testing.

Dr. Durkin obtained X-rays of the right knee and right hip/pelvis. He described the right knee X-rays as showing moderate osteoarthritis in the lateral compartment, mild arthritis in the medial compartment, no fracture or dislocation and good alignment of the patella. He described the right hip X-rays as showing some osteoarthritis in the joint and no fracture or dislocation. He injected the right knee with steroids, prescribed an unloader knee brace and indicated Petitioner could "return to sedentary work." He indicated he would consider recommending replacement surgery if Petitioner did not respond to conservative measures.

Dr. Durkin addressed causation as follows:

> "Patient reports no knee pain prior to his initial fall (10/7/13) and this likely exacerbated and increased the rate of osteoarthritis in his right knee."

PX 5.

Petitioner testified he resumed his brush counting sedentary job after seeing Dr. Durkin on March 10, 2015. On March 12, 2015, he was called into an office, where he again met with Jelic, Dominick and Tufano. He testified these individuals presented him with a group of documents regarding early retirement. He identified PX 3 as the documents he received. [The first page of PX 3 is a cover letter dated March 12, 2015 (also marked as RX 6) indicating that Respondent's human resources department had received information from public works indicating Petitioner had been given a 10-pound lifting restriction by his doctor "as a result of a non-duty-related medical condition," that Respondent had no assignments within this restriction and was not obligated to create such an assignment if the condition was non-work-

related, that Petitioner was being placed on an unpaid administrative leave, pending receipt of a release to unrestricted duty, and that Petitioner could consider Respondent's "voluntary separation incentive plan."] He testified he told the men he remained undecided but would think about taking early retirement. T. 89.

Petitioner testified he did not resume performing the brush counting job after the March 12, 2015 meeting. T. 97. He went home after the meeting. T. 104.

Petitioner returned to Dr. Durkin on April 9, 2015. The doctor noted that Petitioner viewed the unloader brace as helpful but reported obtaining only a couple of days of pain relief following the March 10, 2015 knee injection. On right knee re-examination, the doctor noted no effusion, mild soft tissue swelling and good quadriceps tone. He reviewed images of the October 13, 2015 right knee MRI, which Petitioner had brought with him. He indicated he advised Petitioner that this MRI showed both arthritis and a complex lateral meniscus tear but, that in his view, Petitioner's current symptoms stemmed from the arthritis rather than the tear and that a meniscectomy would thus not be helpful. He stated that the MRI showed it was "unlikely that the injury caused the osteoarthritis" but that "the injury likely exacerbated the osteoarthritis and caused pain." He recommended, and administered, a gel-one injection and recommended that Petitioner rest and apply ice to the knee for three to five days. He released Petitioner to sedentary work. PX 5.

Petitioner testified the gel-one injection provided "50%" relief "for a short period of time." T. 105.

Petitioner saw Dr. Durkin again on May 8, 2015, with the doctor noting 50% improvement since the injection. He advised Petitioner the injection would continue to provide benefit for another five months or longer. He addressed work capacity as follows:

> "Patient is not capable of doing full duty of a garbage man. Patient can work with restrictions of no climbing ladders, minimal walking, no lifting more than 10 lbs. and standing as tolerated."

He described these restrictions as permanent and found Petitioner to be at maximum medical improvement but went on to state that Petitioner could undergo more injections and "is candidate for surgery." PX 5.

Petitioner next saw Dr. Durkin on July 7, 2015. On that date, Petitioner complained of variable right knee pain and swelling, as well as waking at night due to pain and difficulty walking, sitting and using stairs. Petitioner indicated the unloader brace was helping slightly.

On right knee re-examination, Dr. Durkin noted active extension of 0 degrees, active flexion of 125 degrees, trace effusion, good quadriceps tone, tenderness over the medial and lateral compartments, as well as the medial and lateral joint lines, and positive lateral and

medial McMurray's testing. He recommended that Petitioner undergo another right knee MRI to determine whether an arthroscopy could help, prior to giving consideration to a total knee replacement. He released Petitioner to sedentary duty with no lifting over 5-10 pounds, no climbing ladders, minimal walking and standing as tolerated. PX 5.

Petitioner underwent the repeat right knee MRI on August 21, 2015. The radiologist indicated he compared the images with those of the previous MRI of October 18, 2013. He indicated the degree of chondromalacia had "worsened since the previous examination." He also noted "complex but predominantly horizontal tearing of the lateral meniscus with partial extrusion of the body segment" along with a moderate joint effusion and moderate-sized Baker's cyst. PX 5.

Petitioner testified that Respondent did not offer him any light duty position between the March 12, 2015 meeting and September 15, 2015. On September 15, 2015, he received a letter from Respondent offering him such a position. T. 108-109. [RX 7, a September 14, 2015 letter from Sam Jelic of Respondent to Petitioner references Dr. Durkin's restrictions of May 8, 2015 and directs Petitioner to appear immediately to "get [his] current job assignment."] After he received this letter, he immediately presented to Respondent and was again given the job of counting street sweeper brushes while sitting. He is still performing this job. T. 109.

On September 22, 2015, Dr. Durkin discussed the results of the repeat MRI with Petitioner and explained to him that "a knee scope will not help." He recommended a total knee replacement and continued the previous work restrictions. PX 5. T. 109-110.

On October 9, 2015, an employee or representative of Hinsdale Orthopaedics noted that Petitioner "has decided to proceed with the" knee replacement surgery. PX 5.

At Respondent's request, Petitioner saw Dr. Lewis of the Illinois Bone & Joint Institute for purposes of a Section 12 examination on December 15, 2015. Dr. Lewis issued a report concerning this examination on December 30, 2015. Durkin Dep Exh 3. The report sets forth an account of Petitioner's October 7, 2013 work fall and subsequent care. According to this account, Petitioner "tripped and fell inside a building on a carpet." The doctor noted that Petitioner complained of persistent right knee pain which had recently worsened. The doctor indicated Petitioner reported using a knee brace but not deriving much benefit from it.

Dr. Lewis described Petitioner as "an alert, very pleasant male who is 5' 2" tall and weighs 150 pounds." He noted a functional range of motion in Petitioner's lumbar spine, hips, knees and ankles. On right knee examination, he noted marked medial joint line tenderness, no effusion or ligamentous instability and full extension with further flexion to 120 degrees on the right versus 125 on the left. He obtained right knee X-rays and interpreted the films as showing marked narrowing of the lateral compartment with loss of joint space, "compatible with severe degenerative arthritis."

Dr. Lewis indicated he reviewed records from U.S. Health Works and Dr. Durkin along with nine physical therapy notes.

Referencing the results of the right knee MRI performed a week after the accident, Dr. Lewis addressed causation as follows:

> "Even though Mr. Moya denied pain referable to his right knee prior to his alleged injury, in my experience a fall on his knee on a carpet would not be a sufficient causative event to accelerate degenerative arthritis in his right knee. Therefore, in my opinion, the pre-existing degenerative arthritis of his lateral compartment is the cause for his current condition."

Dr. Lewis found objective evidence, i.e., X-rays showing severe degenerative joint disease, to support Petitioner's complaints. He did not believe an MRI or right knee arthroscopy to be necessary. He did find a right total knee replacement to be necessary, based on Petitioner's complaints and the arthritis demonstrated on X-ray. He described Petitioner as a "reliable historian." He anticipated that Petitioner would reach maximum medical improvement within four to six months of knee replacement surgery. He found Petitioner capable of modified light duty but indicated the need for this restriction did not stem from the October 7, 2013 work fall. Lewis Dep Exhibit 2.

On February 8, 2016, Dr. Durkin issued a report to Petitioner's counsel. In this report, the doctor addressed causation and treatment needs. He indicated that, while Petitioner had degenerative arthritis and meniscal tearing in his right knee before the October 7, 2013 work fall, based on the MRI, the fall likely worsened the tearing and caused the arthritis to become symptomatic. He further stated that a fall such as the one Petitioner described "could very easily take a knee with [de]generative joint disease and accelerate and exacerbate that condition to the point where a knee replacement would be necessary." PX 5.

Petitioner returned to Dr. Durkiin on March 8, 2016. The doctor noted complaints of 8-10/10 right knee pain and right knee swelling. On right knee examination, he noted active extension of 0 degrees, active flexion of 110 degrees, a mild effusion and tenderness over the lateral joint line and lateral compartment. He prescribed Tramadol for pain and again recommended knee replacement surgery. He released Petitioner to sedentary work with no lifting over 5-10 pounds, no climbing ladders, minimal walking and standing as tolerated. He told Petitioner he could follow up as needed "or when approved for surgery."

There is no indication Dr. Durkin examined Petitioner's back on March 8, 2016 but he did refer Petitioner to his partner, Dr. Zindrick, for back pain. PX 5.

Dr. Durkin testified by way of evidence deposition on March 10, 2016. PX 8. Dr. Durkin testified he obtained board certification in orthopedic surgery in 1994. PX 8 at 6. Durkin Dep

Exh 1. He has been affiliated with Hinsdale Orthopaedics for 13 ½ years. PX 8 at 5. He devotes about 40% of his practice to treatment of knee conditions. He has treated thousands of people with knee osteoarthritis or knee trauma. PX 8 at 5.

Dr. Durkin testified he first saw Petitioner on March 10, 2015. On that date, Petitioner complained of 8/10 right knee pain which he related to a work fall occurring on October 7, 2013. PX 8 at 8-9. On examination, he noted that the right knee was 3 degrees short of full extension, meaning Petitioner could not straighten his leg all the way. PX 8 at 9. Flexion was to 125 degrees. Most people can bend their knees to 135 or 140 degrees. PX 8 at 9. Dr. Durkin testified he also noted a little bit of fluid in the knee and lateral joint line tenderness. PX 8 at 10. He obtained right knee X-rays, which showed moderate osteoarthritis. He did not have access to any previous MRIs on March 10, 2015. PX 8 at 10. He diagnosed right knee osteoarthritis on that date. He administered a cortisone injection and provided Petitioner with an unloader brace to take pressure off the more severely arthritic, meaning the lateral, side of the knee. PX 8 at 11. He found Petitioner capable of sedentary duty. PX 8 at 12.

Dr. Durkin testified he next saw Petitioner on April 9, 2015. Petitioner was still experiencing right knee pain and swelling on that date. He reported that the brace was helping but that the injection helped only for a couple of days. PX 8 at 13. Dr. Durkin testified he reviewed the MRIs, which Petitioner had brought with him. PX 8 at 13. He interpreted the MRI of October 15, 2013 as showing complex tears in the anterior and posterior horns as well as the body of the lateral meniscus, moderate to high grade chondromalacia in the lateral tibiofemoral compartment, extensive soft tissue swelling, moderate effusion and a large popliteal cyst, which appeared to have ruptured. PX 8 at 14. On this date, he diagnosed aggravated osteoarthritis and a lateral meniscus tear. PX 8 at 14-15. In his opinion, Petitioner's work fall exacerbated the lateral meniscus tearing. PX 8 at 15. Petitioner likely had some tearing prior to the work fall, based on the degree of osteoarthritis he had, but the fall would have increased that tearing. PX 8 at 16. The osteoarthritis pre-dated the fall. The fall caused the effusion and soft tissue swelling, based on the history Petitioner provided of striking his knee against a hard surface when he fell. PX 8 at 17. The popliteal cyst was likely pre-existing and is unrelated to the fall. PX 8 at 18. He is not recommending that Petitioner undergo an arthroscopy because that procedure would likely increase the degree of load on the cartilage and worsen the osteoarthritis. PX 8 at 19.

Dr. Durkin testified that Petitioner has not voiced left knee complaints. He finds this significant, in terms of causation, because osteoarthritis is typically bilateral. PX 8 at 20, 33.

Dr. Durkin testified he administered a "gel one" shot in April 2015. This type of shot typically helps for a limited period of six months to one year. PX 8 at 21. He continued Petitioner on sedentary duty in April 2015. PX 8 at 21. He broached the subject of knee replacement surgery with Petitioner. A total knee replacement surgery would be the best way to treat Petitioner's osteoarthritis, in his opinion. PX 8 at 22.

Dr. Durkin testified that, at the next visit, on May 8, 2015, Petitioner reported about 50% improvement secondary to the "gel one" shot. He imposed restrictions of no climbing ladders, minimal walking, no lifting more than 10 pounds and standing as tolerated. PX 8 at 23. He described these restrictions as permanent. He found Petitioner to be at maximum medical improvement barring a knee replacement. He felt Petitioner would not get better without this surgery. PX 8 at 23.

Dr. Durkin testified he next saw Petitioner on July 7, 2015. On that date, Petitioner indicated he was no longer experiencing any benefit from the "gel one" injection. On examination, he noted positive McMurray's testing, which is pretty common in a patient with meniscal tearing and some arthritis. PX 8 at 24-25. He recommended a repeat MRI to see why Petitioner was experiencing more medial pain and to see whether an arthroscopy could help. PX 8 at 25. He continued the previous restrictions except he reduced the lifting to 5 to 10 pounds. PX 8 at 26.

Dr. Durkin testified Petitioner seemed to be worse at the next visit on September 22, 2015. Petitioner was having difficulty using stairs and getting out of vehicles. Dr. Durkin testified he interpreted the repeat MRI as showing complex horizontal tearing in the lateral meniscus and worsening of the cartilage damage. PX 8 at 27. It was his understanding that Petitioner had been performing full duty and had no right knee complaints before the work fall. PX 8 at 30.

Dr. Durkin testified he is still prescribing a total knee replacement. Pending that surgery, Petitioner requires restrictions of primarily sedentary work with no kneeling, minimal walking and no climbing/ladder usage. PX 8 at 35.

Under cross-examination, Dr. Durkin testified he did not see Petitioner on February 10, 2015. PX 8 at 36. He has some independent recollection of Petitioner. PX 8 at 36. In terms of his note taking, he would typically memorialize anything he felt was important. PX 8 at 37. On March 10, 2015, Petitioner made no mention of a back injury. On subsequent visits, Petitioner did not complain of back pain. It was not until the Tuesday before the deposition that he noted a complaint of back pain and referred Petitioner to a doctor for back treatment. PX 8 at 38. The X-rays and MRI performed shortly after the work fall showed arthritis and arthritis does not develop overnight. While it is common for arthritis to be in both knees, it is also common for patients to have arthritis in only one knee joint. PX 8 at 39. He understands that Petitioner tripped over a rubber mat and landed on linoleum. PX 8 at 39. If Petitioner in fact struck his knee against a carpeted surface when he fell, that would not prompt him to change his causation opinion. It is more the fact that Petitioner fell and had an immediate onset of pain after he fell that supports that opinion. No one ever falls in a clean, one-directional manner. Twisting is almost always involved. PX 8 at 40. The effects of cortisone shots vary, patient to patient. PX 8 at 41. The effects of the initial shot often last longer than subsequent shots. PX 8 at 42. As of March 10, the initial visit, he did not have any MRI images. Those images could have caused him to change his causation opinion. PX 8 at 43. He later ordered a repeat MRI because Petitioner's pain changed a little, location-wise. PX 8 at 44.

Dr. Durkin testified he disagrees with some of the statements made by Dr. Lewis. For example, he disagrees with Dr. Lewis's statement that Petitioner landed on a carpeted surface. In his view, all it takes is a little twisting of the knee, regardless of the surface the patient lands on, for underlying tearing to be aggravated. PX 8 at 52. No fall is completely straight. There is always some rotation. PX 8 at 53. It is more that Petitioner fell than what he landed on. PX 8 at 54. He also disagrees with Dr. Lewis's causation analysis. He agrees with Dr. Lewis that Petitioner is a reliable historian. PX 8 at 55. He is not aware of Petitioner having changed jobs at any point between the work fall and his first visit in March 2015. PX 8 at 57.

On redirect, Dr. Durkin testified that the absence of back complaints has no effect on his knee-related opinions. PX 8 at 58. Cortisone shots might afford pain relief but they do not stop the progression of meniscal loss or arthritis. PX 8 at 59. He believes a total knee replacement would allow Petitioner to get back to full duty, at least as far as the knee is concerned. PX 8 at 59-60. He is recommending sedentary duty while Dr. Lewis referred to light duty. PX 8 at 60.

Under re-cross, Dr. Durkin testified he did not ask Petitioner about any rotation of his knee as he fell. PX 8 at 61.

On further redirect, Dr. Durkin testified that no patient is able to tell a doctor exactly how he fell. Even a video of a fall does not clearly show exact rotation in three different planes. PX 8 at 62. A knee has six degrees of freedom when it moves and a video would not show that, either. PX 8 at 63.

Under re-cross, Dr. Durkin testified he would not change his opinions even if he assumed Petitioner performed full duty for a year and a half before he saw him. It was the fall that seemed to set off Petitioner's pain and it was reasonable for Petitioner to be able to work through that pain. PX 8 at 64.

Dr. Lewis, Respondent's Section 12 examiner, testified by way of evidence deposition on May 23, 2016. RX 10. Dr. Lewis testified he has practiced medicine in Illinois for more than forty years. He is board certified in orthopedic surgery and independent medical examination. RX 10 at 5. Lewis Dep Exh 1.

Dr. Lewis testified he examined Petitioner on December 15, 2015. Petitioner provided a history of his October 7, 2013 work fall on that date. Petitioner indicated he landed on his right knee on a carpeted surface. RX 10 at 8. Petitioner also indicated his job at that time did not require any heavy lifting. RX 10 at 9.

Dr. Lewis testified that, on examination, Petitioner exhibited a "slight limitation of motion of his right knee." RX 10 at 11. The records he reviewed and X-rays he obtained in his office showed that Petitioner had severe degenerative arthritis in that knee. RX 10 at 11. This arthritis would explain the severe pain Petitioner complained of. RX 10 at 12. He felt that Petitioner's complaints were genuine. He viewed Petitioner as a "credible honest person." RX

10 at 14. He would characterize Petitioner's arthritis as "end-stage," meaning it was "very likely that he would need to have treatment in the near future." RX 10 at 14. He saw no evidence of an acute injury that would have accelerated a pre-existing degenerative condition. In his report, he opined that striking one's knee against a carpeted surface would not be a sufficient causative event to accelerate arthritis. RX 10 at 18. Moreover, the severity of Petitioner's arthritis was evidenced by the radiographic studies he underwent within a week of his fall. RX 10 at 18.

Dr. Lewis opined that Petitioner has a permanent disability, i.e., severe degenerative arthritis of his right knee. He finds it "perfectly appropriate" for Petitioner's treating surgeon, Dr. Durkin, to have recommended a total knee replacement. RX 10 at 20. He does not see any reason, however, for Petitioner to undergo a repeat MRI. RX 10 at 20-21. He views Dr. Durkin as "being honest and reasonable" in his causation opinion but he does not agree with that opinion. It is "purely speculative" for Dr. Durkin to opine that Petitioner has meniscal pathology and that the fall worsened an underlying meniscal tear. RX 10 at 22.

Dr. Lewis testified he has seen many, many knee MRIs of patients who have severe degenerative arthritis. It is common for those MRIs to show complex meniscal tears. Those tears are degenerative, not acute. He "respects" Dr. Durkin's opinion that Petitioner's MRI showed acute tearing but disagrees with that opinion. RX 10 at 24.

Under cross-examination, Dr. Lewis testified he assumes he examined Petitioner at the request of the employer. He devotes 10% of his practice to conducting examinations. RX 10 at 28. Over the last two years, however, that percentage may have risen to 15%. RX 10 at 28-29. At the "absolute maximum," the percentage would be 20%. RX 10 at 29. The vast majority of the examinations he performs are for employers. RX 10 at 30. He is an employee rather than a partner of Illinois Bone and Joint and cannot estimate the charges associated with his examination and report. RX 10 at 30. He is able to independently recall Petitioner. Petitioner was a "very sincere gentleman." RX 10 at 32. He cannot recall, however, whether he utilized an interpreter. RX 10 at 33. He "may have made a few handwritten notes" concerning the history Petitioner provided but he does not normally retain such notes. If the notes were scanned into a file, they could be procured from Illinois Bone & Joint's IME department. RX 10 at 34. He has no independent recollection of Petitioner telling him he landed on a carpet. RX 10 at 34. Given the degree of pain Petitioner is experiencing, he would likely benefit from knee replacement surgery, on the right side only, at some point. RX 10 at 35. He reviewed the actual MRI images. RX 10 at 36. He saw no records indicating that Petitioner had problems with his right knee before the October 7, 2013 accident. RX 10 at 37-38. The records he reviewed suggest Petitioner resumed unrestricted duty in December 2013 but he does not know exactly what kind of work Petitioner performed after that time. RX 10 at 38-39. Petitioner told him he picked up garbage outside. He assumes this involved walking, bending and stooping. RX 10 at 39. He is not sure why Dr. Durkin ordered a repeat MRI in 2015. Before the deposition, no one asked him to formulate any opinions concerning Dr. Durkin's reports. RX 10 at 40-41. If Petitioner had been experiencing severe knee pain during the interval between December 2013 and March 2015, he would not have been able to work and would have been seeing a physician

regularly. RX 10 at 42. An acute injury could have consisted of a fracture or ligament rupture but Petitioner's post-accident MRI did not show any acute injury. RX 10 at 43-44. Theoretically, an acute injury could have also included further injury to the lateral meniscus. RX 10 at 44. He does not view Dr. Durkin as out on a limb. He just disagrees with the doctor's conclusions. RX 10 at 44-45. The fact that he disagrees does not mean Dr. Durkin is wrong. RX 10 at 45.

Dr. Peoples testified by way of evidence deposition on January 19, 2017. Dr. Peoples testified he has worked as a physician for IPC Health/Team Health for almost a year. He previously worked as a physician for U.S. Health. RX 11 at 9. He worked for U.S. Health as of March 2 and 3, 2015. RX 11 at 10. He specializes in internal medicine. RX 11 at 12.

Dr. Peoples testified he recalls Petitioner's name but would need to see his records to remember more. After reviewing Peoples Dep Exh 2, he testified he recalled seeing Petitioner on March 2, 2015. He examined Petitioner on that date and completed U.S. Health forms indicating Petitioner could return to work. RX 11 at 19. On one of the forms, he checked boxes indicating that a pathological condition, namely low back pain, prevented Petitioner from bending or lifting more than 10 pounds. He signed this form. RX 11 at 22-23. On March 3, 2015, he issued a revised version of the form indicating that his examination revealed a "non-occupational pathological condition to be followed by the personal physician" and that Petitioner could be assigned to "any work consistent with skills and training." RX 11 at 28.

Dr. Peoples testified he issued the revised form on March 3, 2015 after conversing with a Respondent employee. He does not recall exactly who he spoke with. RX 11 at 29-30. The person he spoke with asked him to issue a revised form. As of March 2, 2015, he did not have all of Petitioner's records. The only information he received on that date was the history Petitioner gave him. RX 11 at 33-34. He understands that Petitioner had previously been off work due to knee and hand injuries resulting from a work fall. RX 11 at 36. He did not treat Petitioner for these injuries. RX 11 at 36-37.

Under cross-examination, Dr. Peoples testified he worked for U.S. Health for less than a year. RX 11 at 37. Most of the patients seen at that facility have work-related injuries or have been referred. RX 11 at 37-38. U.S. Health protocols were kept in a binder at the office. He has no copies of those documents. RX 11 at 39. If a patient came in who wanted to return to work, U.S. Health did not have to seek advance authorization from the patient's employer to deal with that. RX 11 at 39. He is not board certified in any specialty. RX 11 at 40. He saw Petitioner on only one occasion. RX 11 at 41. The only outside record he reviewed was what Petitioner produced to him on that occasion. RX 11 at 41-42. He cannot recall the details of the examination. The history that Petitioner provided would not have been recorded word for word in any document. RX 11 at 42. Nowhere in his original or revised note did he document what, if anything, brought about Petitioner's symptoms. RX 11 at 43. Petitioner did not tell him what caused his low back pain. Petitioner completed a form answering "yes" to a question asking whether he had sustained a work injury. He did not ask Petitioner about this injury. RX 11 at 47. When he completed the revised form, he left the restrictions in place. RX 11 at 47. When Petitioner came to see him on March 2, 2015, a patient-physician relationship was

established. He never obtained Petitioner's authorization to discuss his medical condition with his employer. RX 11 at 48-49. When he spoke with an employer representative, before issuing the revised form, something the representative told him caused him to go back to review Petitioner's records. RX 11 at 51. Those previous records, from October 2013, contained no mention of a back injury. RX 11 at 51. He never asked Petitioner whether an intervening event occurred at some time after October 2013. RX 11 at 52. He revised the form so as to describe Petitioner's condition as non-occupational based solely on his review of the October 2013 records. RX 11 at 52-53. Petitioner said his job involved picking up garbage. RX 11 at 53-54.

Petitioner testified he wants to proceed with the recommended knee replacement surgery. T. 110. He last saw Dr. Durkin on March 8, 2016, at which time the doctor again prescribed this surgery and restricted him to sedentary work. T. 110. If the surgery is awarded, he will undergo it. T. 111-112.

Petitioner testified he continues to experience significant right knee pain. This pain affects his ability to walk. He does not have similar pain in his left knee. T. 111.

Under cross-examination, Petitioner reiterated he orally reported his October 2013 work fall and signed a report concerning that fall. T. 115-116. Respondent accommodated his restrictions after that fall. He was not required to continue to perform full duty. T. 116-118. Respondent authorized him to undergo care at U.S. Health Works after he fell. T. 118. A doctor at U.S. Health Works released him to work in December 2013 but did not tell him the nature of the work he was being released to. T. 121. The doctor also discharged him from care. T. 125. After being discharged from care, he did not return to U.S. Health Works until March 2, 2015. It was always his knee that prompted him to go to U.S. Health Works, although he recalls once complaining about his back at that facility. T. 126-127. If the record dated March 2, 2015 does not indicate he complained of knee pain, he would agree with the record. T. 131. He did not complete any accident report concerning his back. T. 131. No one associated with Respondent authorized him to undergo back-related care at U.S. Health Works. T. 132-133. In March 2015, Respondent sent him a letter indicating it did not have a light duty assignment for him. RX 6 is an accurate copy of this letter. T. 135-136. The subject line of this letter does not mention early retirement. The first sentence of the letter discusses a non-duty-related medical condition. T. 136. He first experienced back pain in approximately 2005 or 2006, at which point he worked for Respondent's administration in the precinct office. His boss at that time was Respondent's interim president, Romero Gonzalez. T. 139. He first reported a back injury to Respondent in approximately 2005, at which point the director of human resources sent him to U.S. Health Works. He did not ask for light duty when he went to U.S. Health Works on March 2, 2015. T. 148. He did not see a doctor for his right knee between December 2013 and March 2, 2015. He complained of back pain to doctors at Garcia Medical Center on several dates in 2014. T. 149. He underwent a low back MRI in 2007. T. 149. He reported an accident to Respondent in June 2010 but that accident involved his chest. The report concerning this accident (RX 9) mentions both chest and back pain but does not specifically mention low back pain. T. 150. He does not know how to complete an accident report but he knows how to sign off on one. If he signs such a report, he is responsible for its contents. T. 151. He does not

recall whether he signed a report concerning his back in March 2015. T. 151. He did not complain of back pain to Dr. Durkin. T. 151-152. RX 7 is not the letter he received from Respondent in September 2015. The letter he received at that time was personally delivered to him by a police officer. T. 152. He never responded to RX 7 because he never saw it. T. 152-153. The knee injection he received in October 2013 helped for only a very short time. T. 153. He does not know how often trash is collected by Respondent employees because he only worked behind a garbage truck for two days. T. 154. He had to drag the garbage cans about 20 feet. A snowplow went down the alleys before the garbage truck went down them. T. 155.

Under additional cross-examination, Petitioner reiterated he was subject to a 10-pound lifting restriction when he began working in Respondent's public works department in 2010. It was the rodent control department, where he used to work, that put him on that restriction, based on his doctors' notes. He provided Respondent's human resources department with those notes. T. 156. In 2010, he worked in rodent control, not the mayor's office. The notes he turned in were from both his own physician, Dr. Garcia, and Respondent's physician, Dr. "Chana" [sic]. T. 157-158. He did not retain copies of these notes. He turned in these notes when he was asked to do so. He does not know the exact dates he turned them in. T. 158. [At this point in the hearing, one of Respondent's attorneys asked Petitioner to roll up his pant legs. The Arbitrator viewed both of Petitioner's knees and did not appreciate any marked difference in their size.] Once a garbage can is moved into position, behind the truck, the truck mechanically lifts the can and dumps its contents. The can is then mechanically lowered to the ground. The can ends up in the same position it was lifted from. T. 163. He was over 65 years of age during the two days he worked behind a garbage truck. Respondent did not provide him with any back belt. T. 164. Tony Tufano arrived at work at 6 AM and left at 2 PM. If he is told that Tufano's stated shift ran from 2 AM to 10 AM, he cannot dispute that. T. 165-166. On March 2, 2015, he went to Dr. Garcia's office before heading over to U.S. Health Works. T. 166. He did not ask Dr. Garcia for a disability note on March 2, 2015. He simply asked for a note concerning his condition so he could present that note to Respondent. T. 167-168.

On redirect, Petitioner testified he received documents in addition to the letter marked as RX 6 at the March 2015 meeting. T. 169. In September 2015, he returned to work the day after he received the light duty offer letter from Respondent. T. 170. He had to get a garbage can into the proper position in order for the can to be mechanically lifted and dumped. T. 170. Tony Tufano was "always" at the public works building. T. 171.

Under re-cross, Petitioner testified that Tony Tufano's regular shift was in the morning. He reiterated that Tufano was "always" at the public works building but admitted he does not know whether Tufano worked around the clock since he had his own work to do outside of the building. T. 172.

Derek Dominick testified on behalf of Respondent. Dominick testified he has held the position of supervisor of Respondent's public works department for almost four years. He held this position in October 2013. T. 178. He sets the schedule for the trucks used by the sixty employees who work during the first shift. He also handles attendance records and other

issues. T. 179. He is one of Petitioner's supervisors. T. 179. Due to his scheduling responsibilities, he is kept apprised of the recovery status of any employees who report injuries. Depending on the situation, Respondent has the ability to send employees to a clinic for medical care. For example, Respondent would send employees for injury-related care, pre-employment physicals and drug testing. T. 179-180. Once an employee reports a work injury and completes an accident report in the office, he is given a form authorizing him to go to a clinic. Respondent's policy is that an accident report must be completed before the start of the day following the accident. T. 181. RX 1 is an accurate copy of the report concerning Petitioner's accident of October 7, 2013. T. 182. The report serves several purposes. It notifies Respondent of the body part(s) involved in the accident and allows Respondent to monitor the employee's condition. T. 183. RX 2 is an accurate copy of a form dated October 7, 2013 authorizing Petitioner to undergo care at U.S. Health Works. T. 184. Once Petitioner began undergoing care at U.S. Health Works, the clinic kept Respondent apprised of his condition and work status. T. 185-186. After December 2013, he did not see any reports from U.S. Health Works concerning Petitioner's knee condition. T. 186. Petitioner resumed full duty in December 2013. He was not subject to restrictions at that time. Petitioner is now on light duty "doing sweeper brushes." T. 186. Petitioner was not on light duty at any time between December 2013 and March 2015. T. 187.

Dominick testified that Respondent employees were off work on March 2, 2015 due to the holiday. T. 187. On or about that date, he received a report from Petitioner or U.S. Health Works regarding a back injury being claimed by Petitioner. T. 187. He is not sure whether he spoke with Petitioner at that time. Petitioner saw Dr. Peoples on March 2, 2015, based on RX 5. U.S. Health Works provided Dr. Peoples' March 2, 2015 slip to him. The slip indicates Petitioner complained of low back pain but, at that time, he did not have any report indicating Petitioner had sustained a back injury. T. 189. Upon receipt of the slip, he "contacted Dr. Peoples to find out who allowed him to see [Petitioner]." Petitioner "went to the clinic without [Respondent] having any idea of what his injury was." Respondent "wasn't sure if it was work-related, non-work-related." Thus, he had to contact Dr. Peoples to find out whether Respondent could let Petitioner work. He did not ask Dr. Peoples to change his report. Dr. Peoples subsequently issued a "revised" report indicating that Petitioner had a non-occupational condition that was to be followed by his personal physician. He did not ask the doctor to issue this revised document. T. 191. [The parties then stipulated that it is Respondent's policy that no light duty has to be offered to an employee unless that employee has established a work-related injury. T. 195.] As of March 3, 2015, he drew a conclusion, based on Dr. Peoples' revised form, as to whether Petitioner sustained a work injury on February 27, 2015. The revised form described Petitioner's condition as non-occupational. It also indicated Petitioner could be assigned to any work consistent with his skills and training. T. 204. He did not schedule Petitioner for light duty in March 2015. After March 3, 2015, he scheduled Petitioner for light duty on September 14, 2015, via a letter bearing that date. The letter is signed by Sam Jelic, Respondent's public works commissioner. T. 205. RX 7. Once Petitioner presented to work, after receiving the letter, he was given the job of assembling and counting street sweeper brushes. T. 206. That job is a light duty assignment, unlike Petitioner's previous pick-up and garbage truck assignments. T. 207. Petitioner has never complained to him of back pain. T. 207.

On further direct examination, Dominick testified that Respondent did not plow alleys as of the period during which Petitioner worked behind a garbage truck. T. 209-210. He is familiar with the van Petitioner described. The van is actually lower to the ground than the pick-up truck. T. 211. Some of Respondent's employees are Hispanic. An employee claiming an injury is required to complete a report. T. 214.

Under cross-examination, Dominick testified he schedules a variety of trucks used by the employees who work morning shifts. He goes out into the areas where the trucks are used. He drives a Respondent-owned pick-up truck. T. 218. It is his position that a Respondent employee claiming an injury has to see a doctor of Respondent's selection before he can see a doctor of his own choice. T. 218. He does not know whether the Workers' Compensation Act states this. T. 221. Sam Jelic is still Respondent's Commissioner of public works. T. 221. The first form he received from Dr. Peoples is page 7 of RX 5. That form, unlike the subsequent revised form, did not describe Petitioner's condition as non-occupational. He contacted Dr. Peoples after receiving the first form. He did not obtain authorization from Petitioner before he made this contact. T. 226. He spoke directly with Dr. Peoples but did not provide him with additional information. Based on the conversation he had with Dr. Peoples, the doctor issued a revised form. T. 227. He had full access to Petitioner at this point, and could have called Petitioner into his office to question him, but never did this. T. 228. He has not read Dr. Peoples' deposition. T. 228. He did not speak with anyone other than Dr. Peoples before he received the revised form. T. 229. He does not know what additional information Dr. Peoples relied on in making the revisions. T. 230. If he had not received the revised form, he would not have agreed Petitioner's condition was work-related. T. 232. Nine days after Dr. Peoples issued the revised form, Respondent tendered the letter marked as RX 3 to Petitioner. T. 234. He does not know what job Petitioner performed before April 2013 because he himself did not begin working in the public works department until April 2013. He believes Petitioner was already working out of the pick-up truck as of April 2013. He does not know how it was that Petitioner was assigned to that job. T. 236-237. Workers who have that job are often assigned to Cermak Road. He did not physically observe Petitioner performing this job between 2013 and February 2015. T. 237-238.

Arbitrator's Credibility Assessment Relative to Both Cases

Petitioner came across as a hard-working, honest individual. The Arbitrator agrees with the assessment of Dr. Lewis, Respondent's examiner, i.e., that Petitioner is a "very sincere gentleman."

The Arbitrator finds credible Petitioner's testimony that he was subject to various back-related restrictions for years before his undisputed October 7, 2013 accident and that Respondent was accommodating those restrictions. Petitioner's testimony on this point is fully supported by the October 7, 2013 records from U.S. Health Works, Respondent's selected medical provider. Those records describe Petitioner's "regular" job as subject to various restrictions, including a 10-pound lifting restriction. In this context, the term "regular job"

clearly refers to the duties Petitioner commonly performed, rather than to unrestricted duty. The Arbitrator also notes that Respondent's witness, public works supervisor Derek Dominick, did not contradict Petitioner's account of the paper collection work he performed after being transferred to public works in 2010. Respondent also offered no evidence to contradict Petitioner's testimony that the need for restrictions stemmed from a work-related back condition he reported to Respondent in approximately 2005. Petitioner credibly testified that the restrictions were imposed by a Respondent-selected physician, Dr. "Cana" [Dr. Khanna of U.S. Health Works] as well as his own physician, Dr. Garcia. Dominick's testimony that Respondent did not technically classify Petitioner's paper collection job as light duty does not mean the job requirements did not meet Petitioner's restrictions.

Also credible was Petitioner's denial of any right knee problems before the October 7, 2013 accident. Respondent's examiner, Dr. Lewis, admitted he saw no records alluding to any such problems.

Also credible was Petitioner's testimony that his right knee was still symptomatic as of December 3, 2013, the date Dr. Khanna of U.S. Health Works discharged him from care, and remained so thereafter. Dr. Khanna did not describe Petitioner's right knee as asymptomatic on December 3, 2013. In fact, he noted positive McMurray's testing on that date. He released Petitioner to his "regular" job, which had originally been accurately described as a restricted job. [The Arbitrator notes that Dr. Khanna had previously described Petitioner as potentially needing knee surgery.] Respondent's witness did not take issue with Petitioner's testimony that he resumed paper collection, using a hand-held device known as a "picker," after being discharged by Dr. Khanna. He readily conceded he did not know how it was that Petitioner had originally been assigned to this job in 2010, since he was not assigned to public works at that time. He only disagreed with Petitioner's description of the height of the van he worked out of after December 3, 2013.

In the Arbitrator's view, Petitioner was able to continue working after December 3, 2013, despite ongoing right knee symptoms, for two reasons: 1) he was motivated to work; and 2) his longstanding back-related restrictions were essentially being accommodated. That ability ended when Respondent abruptly assigned Petitioner to a new job behind a garbage truck in late February 2015. Petitioner's testimony concerning the requirements of this job and the weather conditions that existed at that time was detailed and believable. Dominick contradicted this testimony only to the extent of stating that Respondent did not perform snow plowing and could not have created the piles of snow that inhibited Petitioner's efforts. This testimony does not eliminate the possibility that private snowplows or other vehicles created the piles.

Also credible was Petitioner's testimony that, on the Friday before March 2, 2015, (i.e., February 27, 2015), after working behind the garbage truck for two days, he orally notified Tony Tufano, who was then Commissioner of public works, that his new duties, which violated his longstanding restrictions, were causing back and right knee problems.

Did Petitioner sustain an accident arising out of and in the course of his employment on February 27, 2015?

The Arbitrator finds that Petitioner sustained a work accident on February 27, 2015 in the sense he was not physically able to continue performing his newly assigned garbage truck collection duties after that date. While it is true there is no evidence Petitioner fell or sustained another type of specific trauma on either February 26 or 27, 2015, the word "accidental," as used in the Act is a "comprehensive term almost without boundaries in meaning," Peoria County Belwood Nursing Home v. Industrial Commission, 138 Ill.App.3d 880 (3rd Dist. 1985). It can, for example, refer to the point in time at which a worker's physical structure gives way under the stress of labor. The Arbitrator concludes that the garbage truck duties, which Petitioner performed for two days in severe weather conditions, aggravated Petitioner's underlying back and right knee conditions of ill-being, prompting him to notify Tony Tufano of those conditions on February 27, 2015 and seek care and work capacity clarification on March 2, 2015. The Arbitrator clarifies, however, that she views the lower back aggravation as temporary. See further below.

Did Petitioner provide Respondent with timely notice of his claimed February 27, 2015 work accident?

The Arbitrator finds that Petitioner provided Respondent with timely and sufficient oral notice of his claimed February 27, 2015 work accident. In so finding, the Arbitrator relies in part on Petitioner's credible testimony concerning his conversation with Tony Tufano on the Friday before March 2, 2015, the U.S. Public Health Works records of March 2, 2015 and Dr. Peoples' deposition testimony. The Arbitrator recognizes, however, that, based on the representation of Respondent's counsel, Respondent had no way to rebut Petitioner's testimony, since Tufano is deceased. The Arbitrator thus clarifies that she also relies on the following significant admission of Respondent's witness, Derek Dominick, made on direct examination:

> Q: On or about [March 2, 2015], did you get a report from – either directly from [Petitioner] or from U.S. Health regarding a claimed injury –
>
> A: Yes, I did.
>
> Q: --to [Petitioner's] back?
>
> A: Yes, I did."

This exchange completely deflated Respondent's notice defense. That Dominick conceived of the written information he received from Dr. Peoples of U.S. Health Works on March 2, 2015 as a report of a work injury fully explains the action he took next, i.e., the call he placed to the doctor. Dominick conceded he did not receive authorization from Petitioner to make this call.

Dr. Peoples made a similar concession. He admitted he discussed Petitioner's medical condition with a representative of Respondent (presumably Dominick) despite having formed a doctor-patient relationship with Petitioner the previous day. The ensuing conversation was a clear violation of the Petrillo doctrine, which has been held to apply to workers' compensation claims. Hydraulics, Inc. v. Industrial Commission, 329 Ill.App. 3rd 166 (2nd Dist. 2002).

Did Petitioner establish a causal connection between his accidents and his claimed current conditions of ill-being?

The Arbitrator initially addresses causation vis-à-vis the first case, 15 WC 7807. The Arbitrator finds that Petitioner established a causal connection between the undisputed accident of October 7, 2013 and his current right knee condition of ill-being. The Arbitrator further finds that this accident contributed to the need for the right total knee replacement that Drs. Durkin and Lewis have recommended. In so finding, the Arbitrator relies in part on the unilateral nature of Petitioner's knee complaints. The records in evidence contain no hint of any left knee problems. Respondent's examiner, Dr. Lewis, did not note any left knee abnormalities. The Arbitrator also relies on Dr. Khanna's positive examination findings of December 3, 2013. The Arbitrator also relies on Petitioner's credible testimony that his right knee symptoms persisted after he resumed his "picker" garbage collection job in December 2013. The Arbitrator further relies on the causation opinions voiced by Dr. Durkin. The Arbitrator finds Dr. Durkin's causation opinions more persuasive than those voiced by Dr. Lewis, Respondent's examiner. Dr. Durkin saw Petitioner on several occasions while Dr. Lewis saw him once. At the point at which Dr. Lewis issued his examination report, he mistakenly believed Petitioner struck his knee against a carpeted surface. He attached great significance to this, at that time. It was only later, at his deposition, that he asserted it did not really matter whether Petitioner landed on a hard or soft surface. He found Petitioner to have "end stage" degenerative arthritis in his right knee, and very likely to require treatment in the near future, as of the work fall, but Petitioner was successfully performing a garbage "picker" job for Respondent at that point and was not seeking out any right knee care. Dr. Lewis also exhibited bias. Under cross-examination, he initially testified he devotes only 10% of his practice to conducting examinations. He quickly revised that estimate upward to 20%. He conceded the vast majority of the examinations he performs are for employers. He did not have a clear understanding of the "picker" job Petitioner performed between December 2013 and late February 2015. He incorrectly assumed this job required bending and stooping. RX 10 at 39. While he indicated he disagreed with Dr. Durkin's causation opinion, he emphasized that this disagreement did not mean Dr. Durkin was "wrong." RX 10 at 45. He took no issue with the treatment rendered to date and conceded Petitioner requires a right knee replacement.

Overall, the Arbitrator found Dr. Durkin to be better informed, more consistent and more persuasive than Dr. Lewis.

In the second case, 15 WC 30570, the Arbitrator finds that the accident of February 27, 2015, i.e., the vigorous activities Petitioner performed in snowy conditions on that date, further aggravated Petitioner's right knee and prompted him to resume care. The Arbitrator views this

accident as contributing to the need for the right total knee replacement surgery Drs. Durkin and Lewis have recommended. The Arbitrator recognizes that Dr. Durkin's records do not mention any February 27, 2015 accident. The Arbitrator does not find this surprising since Petitioner did not sustain a fall or other specific trauma on February 27, 2015. As noted previously, an employee need not show any external violence to his body in order to prove an accidental injury. Zion-Benton Township High School District 126 v. Industrial Commission, 242 Ill.App.3d 109 (2nd Dist. 1993). That Petitioner did not complete or sign a written report, as he did following the October 7, 2013 accident, is understandable, in the absence of a specific event.

The Arbitrator further finds that the accident of February 27, 2015 aggravated Petitioner's longstanding lower back condition but only temporarily. The Arbitrator views this condition as returning to baseline following the accident. Dr. Durkin's initial records contain no mention of back pain. It was not until shortly before his deposition, in March 2016, that Dr. Durkin mentioned any back condition. Dr. Durkin did not render any causation opinion concerning Petitioner's back. The Arbitrator finds that Petitioner did not establish a causal connection between the February 27, 2015 accident and his claimed current low back condition of ill-being.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from March 13, 2015 (the day after he met with Tufano, et al.) through September 15, 2015 (the day he received a written offer of accommodated duty), a period of 26 5/7 weeks. Respondent disputes this claim based on its accident and causation defenses.

The Arbitrator has previously found that Petitioner established an accident of February 27, 2015. The Arbitrator has also found a causal relationship between each of Petitioner's accidents and his current right knee condition of ill-being. The Arbitrator finds that condition to be unstable as of March 10, 2015, the date on which Petitioner resumed right knee care with Dr. Durkin. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010). On that date, the doctor recommended treatment and imposed sedentary duty. He continued to recommend care and work restrictions at subsequent visits. There is no dispute that, following the meeting of March 12, 2015, Respondent did not provide restricted duty to Petitioner until September 16, 2015. The Arbitrator awards temporary total disability benefits from March 13, 2015 through September 15, 2015.

Is Petitioner entitled to reasonable and necessary medical expenses?

In 15 WC 7807, Petitioner claims one outstanding bill, in the amount of $111.00, relating to his last visit to Dr. Durkin on March 8, 2016. PX 6. Respondent's examiner did not take issue with any aspect of Dr. Durkin's care. He agreed with Dr. Durkin's surgical recommendation. The Arbitrator awards this bill, subject to the fee schedule.

Is Petitioner entitled to prospective care in the form of a right total knee replacement?

The Arbitrator has previously found that Petitioner established a causal connection between his two work accidents and his current right knee condition of ill-being. The Arbitrator has also found that Petitioner established causation, via an aggravation theory, as to the need for a right total knee replacement, as recommended by Drs. Durkin and Lewis. The Arbitrator awards Petitioner prospective care in the form of this surgery.

Is either case ripe for a permanency determination?

Based on the foregoing findings and award of prospective right knee surgery, the Arbitrator does not view either of Petitioner's cases as ripe for a permanency determination, as requested by Respondent.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marcus Barbee,

Petitioner,

vs.

Nos. 15 WC 36827
16 WC 21817

Jewel Foods,

Respondent.

17IWCC0607

DECISION AND OPINION ON REVIEW

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

The Commission corrects the clerical error in the Order part of the Arbitrator's Decision to reflect, consistently with the Findings of Fact and Conclusions of Law, an award of temporary total disability benefits from October 29, 2015 through December 18, 2015, and from April 28, 2016 through June 8, 2016. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 1, 2017, is hereby corrected as stated herein, and otherwise affirmed and adopted.

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

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

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

No bond is required for 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.

SEP 29 2017

DATED:
o-08/31/2017
SM/sk
44

Stephen Mathis

David L. Gore

Deborah Simpson

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

BARBEE, MARCUS
Employee/Petitioner

Case# **15WC036827**

16WC021817

JEWEL FOODS
Employer/Respondent

17IWCC0607

On 2/1/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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17IWCC0607

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)

Marcus Barbee
Employee/Petitioner

v.

Jewel Foods
Employer/Respondent

Case # **15** WC **36827**

Consolidated cases: **16 WC 21817**

An *Application for Adjustment 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 **11-18-16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **07-31-15 & 04-25-16**, 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 **$53,190.28**; the average weekly wage was **$1,022.89**.

On the date of accident, Petitioner was **32** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of **$9,059.93** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$9,059.93**.

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

ORDER

Credits

Respondent shall be given a credit of **$9,059.93** for TTD, **$0** for TPD, and **$0** for maintenance benefits, for a total credit of **$9,059.93** .

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,525.00 to Elmhurst Orthopedics, $7,200.00 to LaClinica, as provided in Sections 8(a) and 8.2 of the Act.

Prospective medical is denied.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $681.93/week for 13 2/7 weeks, commencing 10-19-15 to 12-18-15; then from 04-28-16 to 06-08-16, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $9,059.92 for temporary total disability benefits that have been paid.

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

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

17IWCC0607

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

Signature of Arbitrator

01-30-17
Date

ICArbDec19(b)

FEB 1 + 2017

FINDINGS OF FACT

The petitioner, Marcus Barbee, testified that he worked for the respondent, Jewel, as an assembler. (T. 9) Barbee organized and distributed packages for the warehouse. (T. 9)

Barbee stated that he had prior claims against Jewel. Those claims involved injuries from 2011 and 2012. Barbee testified that he had not received any treatment for his back since at least 2013. (T. 10)

On July 31, 2015 Barbee was lifting in the potato aisle when he felt back pain. He stated that it was kind of vague to him and he could not recall the details since it happened so long ago. (T. 10-11)

Barbee sought medical treatment at the company clinic, Concentra, on July 31, 2015 (Px #3) He was diagnosed with a lumbar strain. Concentra recommend a 20 lb. lifting restriction. He returned to Concentra on August 5, 2015. At that time he was prescribed physical therapy. His work restrictions continued. (Px #3) Barbee was seen again at Concentra on August 17, 2015. The diagnosis and recommendations remained the same. (Px #3)

On August 20, 2015, Barbee came under the care of Dr. Koutsky at Elmhurst Orthopedics. (T. 12, Px #4) Dr. Koutsky is on the collectively bargained panel of physicians. Barbee stated that he felt as though he was beginning to deteriorate and could not move. (T. 13) Dr. Koutsky performed trigger point injections to the lumbar spine at the initial office visit. He also prescribed a course of physical therapy. Dr. Koutsky provided him with an exercise kit that consisted of some rubber bands. (T. 31) He also prescribed a cold therapy unit and TEN unit. (T. 34, Px #4). Dr. Koutsky also prescribed medications that included some creams. (T. 35)

On September 17, 2015 Barbee underwent a lumbar MRI at Elmhurst Open MRI. (T. 13) The MRI report indicated that axial images showed no disc bulge, herniation or stenosis at L1-2, L2-3, L3-4, L4-5, or L5-S1. (Px #4) The radiologist impressions included partial fusion of the anterior aspect of the sacroiliac joints suggesting possible mild sacroiliitis. Otherwise the sacroiliac joints were unremarkable. The radiologist noted that the study was otherwise negative with the disc spaces appearing normal. (Px #4)

Barbee discussed the MRI results with Dr. Koutsky on September 22, 2015. (Px #4) Dr. Koutsky advised that there was no evidence of any large herniated disc or severe canal stenosis or fracture.

He then saw Dr. Koutsky again on September 24, 2015. Dr. Koutsky's notes from that date indicated that the MRI scan showed some changes consistent with some sacroiliitis. He also indicated that generalized protrusions were noted at multiple levels. (Px #4) Dr. Koutsky's assessment was low back pain, sacroiliac pain, and radiculopathy. He performed bilateral paralumbar muscle trigger point injections. He ordered an EMG/NCV. He also referred Barbee to Dr. Patel for pain management. (T. 14)

Barbee testified that he recalled speaking to Dr. Koutsky on September 30, 2015 about his urine samples with regard to his prescription medications. However, he did not recall Dr. Koutsky advising him that his urine test was positive for cannabinoids and hydrocodone. He did not recall Dr. Koutsky explaining to him that he could not prescribe narcotic pain medicines while taking Illicits. (T. 36) The records from Dr. Koutsky on September 30, 2015 indicated that he spoke with Barbee about his urine toxicity screen. Dr. Koutsky noted that it was positive for cannabinoids as well as hydrocodone. Dr. Koutsky noted that Barbee understood that he could not prescribe him any narcotic pain medicines while taking illicitis. (Px #4) Barbee stated

that following the phone conversation, Dr. Koutsky continued to prescribe him the same medications. (T. 37)

Dr. Koutsky examined Barbee again on October 29, 2015. The recommendations and diagnosis remained the same. Barbee was to follow up after undergoing the EMG.

On December 3, 2105 Barbee returned to Dr. Koutsky. He was waiting for his pain clinic evaluation. It was noted that he had an EMG test a while back that showed evidence of S1 radiculopathy. However, he was still waiting for a new EMG as it pertained to this case. (Px #4)

On December 4, 2015 Barbee was seen by Dr. Tack for an independent medical evaluation at the request of the respondent. (Rx #1) Dr. Tack diagnosed a lumbar sprain. He opined that the MRI of September 17 documented no abnormalities of the lumbar spine. He noted that the only findings present on the MRI were a partial fusion of the SI joints which was either developmental or congenital and did not reflect an injury. Dr. Tack did not find any objective evidence from the physical examination to recommend additional medical treatment. He did not believe that any further treatment was necessary and that Barbee did not require work restrictions.

Barbee had his initial pain management consult on December 17, 2015 with Dr. Patel at Elmhurst Orthopedics. (Px #4) Dr. Patel noted that the MRI findings showed a partial fusion of the anterior SI joints. Barbee described pain primarily in the lower right lumbar spine that radiated to the bilateral buttocks. Dr. Patel noted that his pain symptoms were unusual since his MRI did not match his pain. Dr. Patel recommended holding off on any procedures until he underwent his EMG. (Px. #4)

Barbee stated that he returned to work for Jewel on January 4, 2016. (T. 16) After returning to work, Barbee had continued back pain that went down his leg. During this time he continued physical therapy and treatment at Elmhurst Orthopedics. (T. 16)

On January 6, 2016 Barbee underwent an EMG/NCV. The impression of the test was evidence of left L5 and bilateral S1 subacute and chronic radiculopathy. He saw Dr. Koutsky on January 6 as well. Dr. Koutsky assessed him with L5-S1 bilateral radiculopathy. He continued to recommend pain management for injections.

Barbee saw Dr. Patel on January 21, 2016. (T. 39) Barbee testified that Dr. Patel advised him the finding from the EMG did not correlate with his physical exam and that he could not elicit reproduction of the pain. (T. 39-40, Px #4) Dr. Patel recommended an epidural injection, but it was for diagnostic purposes. (T. 40) On January 28, 2016 Dr. Patel performed an epidural steroid injection at the S1 level. (T. 17, Px #4)

On February 24, 2016, Barbee returned to Dr. Patel. (Px #4) He noted that the injection provided complete relief of pain in the lower extremity, but he had weakness that developed after activity in the lumbar spine. Dr. Patel prescribed additional physical therapy.

On March 10, 2016 Barbee saw Dr. Koutsky. (Px #4) It was note noted that the lumbar radiculopathy was getting better. Dr. Koutsky noted that authorization had not been received for additional therapy or a second injection (even though no second injection was recommended by Dr. Patel). Dr. Koutsky commented that his EMG was consistent with his MRI. The assessment was bilateral L4-5, L5-S1 radiculopathy. He was provided with a full duty release by Dr. Koutsky. (T. 40).

On April 8, 2016 Barbee spoke with Dr. Koutsky's physician assistant via phone and was given a release from care. (Px #4)

Barbee testified that he worked full duty for Jewel through April 25, 2016. (T. 18) On April 25, Barbee stated that he was repetitively lifting 50 to 70 pound cases. He picked up a case of cake icing and felt sharp pain in his back. (T. 18) Following this incident Barbee went back to Concentra. (T. 20) They diagnosed him with a lumbar strain. He was given a 10 lb. lifting restriction and prescribed physical therapy. (Px #3)

On April 28, 2016 Barbee returned to Dr. Koutsky. (Px #4) It was noted that he had a flare of his back pain with radicular symptoms into his left lower extremity. He was taken back off work. Dr. Koutsky prescribed physical therapy and another epidural injection. (Px #4)

He resumed physical therapy. He stated that therapy was at the same facility, but the name changed from Physico to ATI. (T. 21)

Dr. Tack performed a second independent medical evaluation of Barbee on June 1, 2016. (Rx #1) He opined that nothing had changed with regard to Barbee's physical condition. He believed the physical examination was suggestive of symptom magnification. Dr. Tack did not believe that Barbee required any further medical care or work restrictions.

On June 2, 2016 Barbee returned to Dr. Koutsky. Barbee reported significant pain in his back and lower extremities to the point that it was beginning to affect his ability to walk. (Px. #4) Dr. Koutsky continued to recommend another epidural injection and held him off work.

Barbee returned to Dr. Patel on June 24, 2016. Dr. Patel did not prescribe or perform an epidural injection. He recommended continued physical therapy. (Px #4)

Dr. Koutsky examined Barbee again on July 7, 2016. He recommended physical therapy and continued to hold him off work. Dr. Koutsky also stated that they continued to request authorization for a second epidural injection. (Px #4) Barbee was taking over the counter medications as needed for pain. No prescriptions were provided.

On August 11, 2016 Dr. Koutsky examined Mr. Barbee. All of the recommendations remained the same. The same finding and recommendations were also present at the appointment with Dr. Koutsky on September 15, 2016.

Barbee saw Dr. Patel on October 14, 2016. Dr. Patel noted that it had been recommended that Barbee undergo another epidural injection. However, Dr. Patel recommended that Barbee undergo additional physical therapy before undergoing another epidural injection.

The most recent visit with Dr. Koutsky took place on October 26, 2016. It was noted that Dr. Patel had recommended additional physical therapy before performing another epidural injection. Dr. Koutsky also recommended an updated MRI of the lumbar spine. He continued to hold Barbee out of work. (Px #4)

Barbee stated that he has continued to see Dr. Koutsky on a monthly basis. He continues to remain off work. Barbee testified that he feels pain in the lower middle part of his back and that it goes into his legs. He is not currently taking any prescription medication for his pain or to treat his back. (T. 41) Barbee could not recall the last time that he took any prescription medication. He thought that it might have been June of 2016. (T. 45) He testified that despite all of the treatment that he had received at Elmhurst Orthopedics, that he felt no better. (T. 41) He testified that he would like additional treatment at Elmhurst Orthopedics.

CONCLUSIONS OF LAW

WITH REGARD TO ISSUE "F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY REALTED TO THE INJURY", THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds the Barbee's condition of ill-being with regard to his low back is causally related to his injuries of July 31, 2015 and April 25, 2016. In support of this finding the Arbitrator relies on the medical records of Concentra and Elmhurst Orthopedics. The Arbitrator also relies upon the IME reports of Dr. Tack, which both confirmed a lumbar strain related to the respective work accidents.

WITH REGARD TO ISSUE "L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE? TTD", THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Barbee is entitled to temporary total disability from October 29, 2015 through December 18, 2015 and from April 28, 2016 through June 8, 2016. The Arbitrator denies temporary total disability after June 8, 2016.

In support of this finding, the Arbitrator relies upon the treating medical records. The lumbar MRI report of September 17, 2015 indicated that the exam was normal. There radiologist noted that there were no bulges, herniations or stenosis. It was noted that the disc spacing was normal.

The EMG/NCV of January 6, 2016 noted left L5 and bilateral S1 subacute and chronic radiculopathy. However Dr. Patel did not appear to put much credence into this finding. On January 21, 2016 Dr. Patel noted that the EMG results did not correlate with the physical exam. On December 17, 2015 Dr. Patel had noted that Barbee's pain symptoms were unusual as they did not match his MRI findings. Thus, Dr. Patel did not find any objective tests to correlate with Barbee's complaints of pain. It is also noted that Dr. Patel did not recommend any additional pain management options other than continued physical therapy.

The Arbitrator also relies upon the opinions of Dr. Tack as set forth in his reports of December 4, 2015 and June 1, 2016. He opined on both occasions that Barbee was capable of full duty work based upon his review of the medical records and his physical exam.

The Arbitrator also notes that at the time of the hearing Barbee testified that he was not taking any prescription medication and had not taken any since June of 2016. In assessing credibility the Arbitrator finds it significant that Barbee testified that he could not work due to his injury, however the pain was not of a level that it required him to utilize prescription medications.

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 FINDS AS FOLLOWS:

The Petitioner offered seven medical bills into evidence. (Px #1) The Arbitrator will address each medical bill separately.

The first bill submitted was from Elmhurst Orthopedics in the amount of $3,155.00. (Px #1) The Arbitrator denies all medical bills after the June 1, 2016 IME report of Dr. Tack. Per that report, Dr. Tack opined that Barbee was at MMI and required no further medical treatment. The total amount awarded of this bill is $2,525.00 subject to the Worker's Compensation Act Fee Schedule.

The second bill submitted was from Integrity Billing Solutions in the amount of $14,048.01. (Px #1) This bill is for prescriptions from Dr. Koutsky on August 20, 2015 and September 24, 2015. The Arbitrator relies upon the UR reports submitted by respondent and the IME report of Dr. Tack from 12/14/15 in denying these charges. The Arbitrator also

independently notes that these charges appear to be unreasonable and excessive. Therefore this bill is denied.

The third bill submitted was from Equi-Med Cort (pactox) in the amount of $1,178.00. This is for prescription medication on September 28, 2015. The Arbitrator relies upon the UR reports submitted by respondent and the IME report of Dr. Tack from 12/14/15 in denying these charges. The Arbitrator also independently notes that these charges appear to be unreasonable and excessive. Therefore this bill is denied.

The fourth bill submitted was from La Clinica in the amount of $7,200.00 for the EMG/NCV (Px #1) This bill is awarded per the Illinois Workers' Compensation Act fee schedule.

The fifth bill submitted was for physical therapy from ATI in the amount of $2,755.04. This bill is denied based upon the IME report of Dr. Tack. The Arbitrator finds that this treatment was not reasonable or necessary. The charges on this bill are from June 23, 2016 through October 5, 2016.

The sixth bill submitted is for Concierge Compounding Pharmaceuticals in the amount of $13,046.32 for prescriptions from January 7, 2016 through March 3, 2016. The Arbitrator relies upon the UR reports submitted by respondent and the IME report of Dr. Tack from 12/14/15 in denying these charges. The Arbitrator also independently notes that these charges appear to be unreasonable and excessive. Therefore this bill is denied.

The seventh and final bill is from cockerel Dermatopathology/Origen in the amount of $11,599.92. The Arbitrator has reviewed the bills and it appears that they were for the drugs screens ordered by Dr. Koutsky. However, this is not clear from the bills or records. There was

no evidence presented at trial explaining the bills and nature of the charges. The Arbitrator finds that if they were indeed drug screens that the charges for 5 visits (10/20/15, 12/3/15, 1/6/16, 2/4/16, 3/10/16) appear to be excessive and unreasonable. Therefore these bills are denied.

WITH REGARD TO ISSUE "K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?", THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator denies the request for prospective medical care. The Arbitrator relies upon the same rational as the basis of denial as was set forth above in the TTD section of this decision. Specifically, the MRI of the lumbar spine was negative. Dr. Koutsky has continuously recommended a second lumbar epidural injection. However Dr. Patel has steadfastly refused to perform a second injection. It is noted that Koutsky referred Barbee to Dr. Patel. The only recommendation by Dr. Patel has been for additional physical therapy. Furthermore Dr. Patel has opined that Barbee's complaints of pain do not correlate with either the lumbar MRI report or the EMG/NCV report. The Arbitrator also finds it significant that Barbee testified that he has not taken any prescription medication since June of 2016.

Barbee has been provided with a multitude of treatment modalities by Elmhurst Orthopedics, yet he feels no better. This therapy has included an exercise kit, cold ice unit, TENs unit, physical therapy, pain management, trigger point injections, prescription medications, and an epidural injection. Despite all of this treatment, Barbee stated that he has not improved.

The Arbitrator finds the opinions of Dr. Tack to be more credible. He opined that Barbee did not require any further medial treatment.

Finally, the Arbitrator had the opportunity to observe Barbee on the date of trail. He did not walk with a limp or appear to have any difficult ambulating. He also did not appear to be in

any pain. It is noted that his symptoms could not have been masked by medications since he stated that he has not taken any prescriptions for his back since June of 2016.

The Arbitrator therefore denies prospective medical care based upon these reasons.

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

Geoffrey L. Ely,

Petitioner,

vs. NO: 14WC 29708

Illinois Department of Transportation,

Respondent.

17IWCC0608

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, permanent disability, causal connection, medical expenses, and 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 16, 2016 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.

17IWCC0608

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: SEP 29 2017
SJM/sj
o-9/7/2017
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ELY, GEOFFREY L
Employee/Petitioner

Case# **14WC029708**

15WC022916

ILLINOIS DEPT OF TRANSPORTATION
Employer/Respondent

17IWCC0608

On 8/16/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2937 LESKERA LAW FIRM
JOHN H LESKERA
120 E CHRUCH ST
COLLINSVILLE, IL 62234

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

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

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

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

AUG 16 2016

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

17IWCC0608

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

Geoffrey L. Ely
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # **14** WC **29708**

Consolidated cases: **15** WC **22916**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **June 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 31, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned **$72,800.00**; the average weekly wage was **$1,400.00**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **0** dependent children.

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

ORDER

Petitioner has failed to prove, by a preponderance of the evidence, that he provided Respondent timely notice of his alleged accidental injuries within 45 days of the March 18, 2014 accident date and his claim is barred. As the remaining issues of accident, causal connection, medical bills and permanent partial disability benefits are moot, the Arbitrator makes no conclusions as to those issues.

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

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

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

Melinda M. Rose Sullivan

Signature of Arbitrator

8/10/16

Date

AUG 16 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Geoffrey L. Ely
Employee/Petitioner

Case # 14 WC 29708

v.

Consolidated cases: 15 WC 22916

Illinois Department of Transportation
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is employed by Respondent as a highway maintainer and has worked there for 13½ years. He testified that he uses various power tools, including pneumatic tools and different machines like chippers, chainsaws and pole saws. He testified that his job is hand-intensive and that it requires frequent and constant gripping as well as lifting, carrying and grasping.

Petitioner testified that he noticed symptoms in hands and arms including numbness and tingling, and that he eventually sought treatment. He testified that he saw Dr. Florendo on July 31, 2013 and that he told him he might have carpal tunnel syndrome. He testified that he did not learn on July 31, 2013 what was the cause of the carpal tunnel syndrome and that he did not know what was causing the carpal tunnel syndrome. He testified that he was sent for an EMG on August 27, 2013, but that he did not learn on that date what was the cause of his carpal tunnel syndrome. He further denied knowing on August 27, 2013 what was the cause of the carpal tunnel syndrome.

Petitioner testified that he then came under the care of Dr. Beatty and that he first saw him March 18, 2014. He testified that Dr. Beatty examined by him, including his wrists and elbows. He testified that he did not learn on March 18th what was the cause of either his carpal tunnel syndrome or cubital tunnel syndrome. He testified that when he presented to Dr. Beatty's office, he paid cash for the services rendered and also gave them a copy of his insurance card. He testified that when seen by Dr. Florendo in July, he turned it in under his private insurance.

Petitioner testified that he learned the cause of his carpal tunnel syndrome and cubital tunnel syndrome on approximately July 22, 2014 when he received notice from Dr. Beatty. He then testified that he believed it was July 24, 2014 as referenced on the Application for Adjustment of Claim. He testified that once he became aware his condition was causally related to work, in August he filed a workers' compensation claim. He testified that he prepared the Workers' Compensation Notice of Injury on August 18, 2014. When asked about the date of injury or illness to which he responded he was unsure and indicated July 31, 2013, Petitioner testified that that was the date he was directed to use by Respondent. When asked if he knew why he was directed to use the date of July 31, 2013, Petitioner responded that that was the first day that he had originally gone to the doctor to find out what was wrong.

Petitioner testified that when he filed the Application for Adjustment of Claim in August of 2014 and used the date of July 31, 2013, he did so because that was what he was directed to use by safety and claims through Respondent. He testified that he notified his lead worker, John Hicks, that he had gone to the doctor and was going to undergo testing. He testified that Mr. Hicks was made aware on or about

August 26, 2013 that the following day he was going to have an EMG. He testified that he kept Mr. Hicks informed of the status of his treatment, but did not prepare the Notice of Injury until August 18, 2014. When asked why he did not prepare the Notice of Injury as soon as he discovered he had carpal tunnel syndrome, Petitioner responded that he thought it might possibly be work-related but did not know for sure and did not want to file a fraudulent claim. He testified that there was a notice up in the yard that if you filed a fraudulent workers' compensation claim you could be disciplined, terminated or even prosecuted.

Petitioner testified that it became apparent to him that it was a work-related condition when he was notified by Dr. Beatty in July of 2014. He testified that Dr. Beatty's treatment included surgery in January and February of 2015. He testified that the surgeries that he had relieved some of the symptoms that he had initially reported to Dr. Florendo back in July of 2013, but that not all of his symptoms resolved. He testified that in his right hand his fingers still tingle, he has a loss of grip in his hand and he has constant soreness in his elbow and wrist. He testified that for the left hand, it still tingles, he has a loss of grip and soreness in his elbow and wrist. He testified that when he touches his left elbow against things or bumps it, it feels like he is hitting his funny bone. He testified that if he tries to pick something up with just his hand and move it to the side, he has pain in the elbow area. He agreed that he is still able to do his duties at Respondent and that he is working full-time.

Petitioner testified that he was sent to see Dr. Emanuel by Respondent. He testified that Dr. Emanuel stated that his condition was work-related. He testified that he was paid temporary total disability while off work following the two surgeries. He testified that he believed Respondent had paid Dr. Beatty's bill. and that the only bill that remained unpaid was the $14,259.36 owed to Anderson Hospital.

On cross examination, Petitioner testified that Dr. Beatty has told him that he would need additional treatment and that in order to get rid of the pain in his elbow and the sensation when he bumps his elbow, he would require more surgery to move the nerve. He testified that he has not undergone the surgery because he does not want additional surgery nor does he want to take the time off work. He agreed that he was refusing to undergo surgery at this time.

On cross examination when asked when he first saw Dr. Beatty in March if he filled out paperwork saying it was a workers' compensation claim, Petitioner responded that he was told to fill out a lot of paperwork. He testified that he remembered filling out a form as contained in Petitioner's Exhibit 2, and agreed that he indicated on the form that it was work-related. He agreed that the form was completed on March 18, 2014. He agreed that when he was seen on March 18, 2014 he filled out a form that had him describe in detail the job duties he performed for Respondent. He agreed that when he goes to the doctor for a cold or headache, he does not indicate all of his duties for Respondent. He agreed that when he went for his hands not only did he mark "yes" that this was a work-related injury, but he also filled out a very comprehensive list of his job duties at Respondent.

On cross examination, Petitioner testified that in March of 2014 he believed his condition might be work-related, but did not know for sure. He agreed that he marked on the paperwork that it was work-related. He agreed that on the form that he completed in August he indicated that he was unsure of the accident date, but that he indicated on the paperwork in March that it was work-related.

On cross examination, Petitioner testified that he was not sure how many of his co-workers had carpal tunnel syndrome. He testified that he believed that there were two others that had work-related carpal tunnel syndrome, but that was not certain of their diagnoses. He testified that he did not remember when he became aware that they had carpal tunnel syndrome, and that he was not sure if it was prior to his diagnosis in 2013 but agreed that it was possible.

On cross examination, Petitioner agreed that he testified that he put the date of July 31, 2013 on the Application for Adjustment of Claim because he was told to do so by Respondent. He agreed that the Application had his signature as well as his attorney's, and that he filled it out the paperwork with his attorney on August 26, 2014. He testified that he believed that he answered the questions himself on the Application.

On cross examination, Petitioner testified that his supervisor was Steve Wheeler and that he used to be the yard technician. He testified that he did not remember when Mr. Wheeler became a supervisor. He testified that he did not remember who his supervisor was back in 2013. He testified that he did not know who was in charge at that time, and that anything that they needed done was reported to their lead workers. When asked why he did not tell Mr. Hicks until August of 2014, Petitioner responded that when he found out it was work-related from his doctor, he filed the claim. He agreed that he did not tell Mr. Hicks that he had carpal tunnel syndrome that was affected by work until August 18, 2014 because he was not told so until July of 2014. He agreed that when he alerted Mr. Hicks of his testing and EMG, he did not tell him that work had caused the need for the test and further testified that Mr. Hicks was only concerned because he was taking sick time off from work.

On redirect examination, Petitioner testified that when he was keeping Mr. Hicks advised of his treatment, he notified him that he was being tested for carpal tunnel syndrome. When asked if he was instructed by Mr. Hicks to fill out an Employee Notice of Injury back in 2013, Petitioner responded that he did not and that he was instructed to fill out a claim if he found out that it was work-related. He testified that Dr. Beatty's office asked him about his hobbies and recreational activities as well as his job duties. He testified that after Dr. Beatty reached the conclusion that it was work-related, they had him come back and fill out additional paperwork and asked for the claim number. He testified that he had to contact "Angela" to figure out what was date of injury because at that time he did not know what to put down for a date of injury and that she was the one that told him he needed to use the first date that he originally went to the doctor.

On redirect examination, Petitioner agreed that Mr. Wheeler signed the Supervisor's Report of Injury and that for the accident date he indicated "Unsure 7/31/13." He testified that his supervisor was not able to give him clarification as to which date to use, and that he used the accident date on the first Application for Adjustment of Claim that he was instructed to use by Respondent.

On further cross examination, Petitioner testified that he talked to Mr. Wheeler about his claim, and that he approached him while he was filling out the paperwork and asked him what he meant by "Unsure" on the form. He testified that he told him that he had to call "Angela" who informed him to use the original date that he went to the doctor instead of the date when he was notified from Dr. Beatty.

On further cross examination, Petitioner agreed that he described his hobbies to Dr. Emanuel, and that he told him that he fished and rode his motorcycle. He testified that he was unable to recall if those were the only two hobbies that he mentioned. He testified that he did not know why Dr. Emanuel would indicate in his report that Petitioner had no outside hobbies.

The medical records of Dr. Florenda were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner was seen on July 31, 2013, at which time it was noted that he presented with carpal tunnel symptoms. It was noted that the symptoms began one year ago, the onset was gradual, that his pain was 0/10, that the problem had worsened and that the frequency of symptoms was intermittent. It was noted that the problem initially presented with numbness in the fingers, pain in the bilateral hands and a tingling sensation in the palms. It was noted that aggravating factors included sustained hand position and while sleeping, and that Petitioner was experiencing numbness and tingling in

the arms. The assessment was that of carpal tunnel syndrome and Petitioner was instructed to follow-up with Dr. Florendo with NCV test results in two weeks. (PX1).

The transcript of the deposition of Dr. Michael Beatty was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Dr. Beatty testified that practices plastic surgery and did a residency in general surgery and plastic surgery, along with a subspecialty in hand surgery. (PX2).

Dr. Beatty testified that he first saw Petitioner on March 18, 2014 at the recommendation from co-workers in his place of employment. He testified that Petitioner's problems centered around complaints relative to carpal tunnel syndrome and elbow issues. He testified that a nerve conduction study was performed on August 27, 2013 and revealed bilateral ulnar neuropathy at the elbow and evolving changing issues of bilateral carpal tunnel syndrome. He testified that his diagnosis after examining Petitioner and reviewing the EMG study was that of bilateral carpal tunnel syndrome and ulnar compressive neuropathy at the elbows. He testified that he did not include any statement related to causal relationship in his March 18, 2014 note. (PX2).

Dr. Beatty testified that he saw Petitioner on January 20, 2015 and that the first surgery was performed prior to then on January 13, 2015 at which time Petitioner underwent release of the right carpal tunnel and also release of ulnar nerve compression of his elbow. He testified that Petitioner underwent additional surgery on February 3, 2015, at which time he underwent release of the left carpal tunnel and also release of his ulnar compressive neuropathy/cubital tunnel release of the left elbow. He testified that he saw Petitioner post-operatively on February 10th. (PX2).

Dr. Beatty testified that Petitioner was taken off work from the date of his first surgery of January 13, 2015 and was allowed to return to work on May 18, 2015, and that he saw Petitioner on June 22, 2015 at which time he had relative to the left hand a positive Tinel's sign over the incision site of a previous carpal tunnel release of the left, necessitating his recommendation for a nerve conduction/EMG study. He testified that he believed the conditions in Petitioner's left palm were causally related to the stitches, and that he recommended an elbow sleeve. He testified that Petitioner did not have residual nerve injury to the left wrist area since he had no other complaint from him since. (PX2).

Dr. Beatty testified that Petitioner also had a positive Tinel's sign on his right hand for which he recommended a wrist support and further observation. He testified that the incisional cyst in the scar would need to be removed, and that Petitioner had clinical evidence of epicondylitis on the left elbow that was managed with cortisone and an elbow sleeve. He testified that the cyst removal occurred in the office, and that it was causally related to the surgery. He also testified that Petitioner had two follow-up visits on July 2nd and July 24th that were directed toward the palm incision, and that he has not seen Petitioner since July 24, 2015. (PX2).

Dr. Beatty testified that based upon the information that was presented to him and in the record substantiated that Petitioner's type of work would reasonably be the causal basis for his problem, and that 11 years would be sufficient duration of time to cause the conditions. He testified that Petitioner may have issues of intermittent numbness and tingling, but that he would only know if Petitioner came in and related it to him. (PX2).

On cross examination, Dr. Beatty testified that he did not recommend any further treatment for Petitioner. (PX2).

On redirect examination, Dr. Beatty confirmed that Deposition Exhibit 1 included the job description that Petitioner prepared at his request and identified the specific tasks that he performed. He testified that it also included records from Apex Physical Therapy where he sent Petitioner for treatment

of his hands and elbows, and that the treatment was reasonable and necessary to cure or relieve the ill effects of the injury. (PX2).

The medical records of Anderson Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on January 9, 2015 for an initial anesthesiology evaluation. The operative report dated January 13, 2015 noted pre-operative diagnoses of (1) median nerve compression, right carpal tunnel syndrome; (2) ulnar compressive neuropathy, right elbow. The records reflect that Petitioner was seen on February 3, 2015 for an initial anesthesiology evaluation. The operative report dated February 3, 2015 noted pre-operative diagnoses of (1) median nerve compression, left carpal tunnel syndrome; (2) ulnar compressive neuropathy, left elbow. The procedure performed was that of release ulnar compressive neuropathy left elbow, release carpal tunnel. (PX3).

The IME report of Dr. James Emanuel was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The report reflects that Petitioner was seen for an IME on October 16, 2014 for bilateral carpal tunnel syndrome. It was noted that Petitioner worked for Respondent as a highway maintainer and had been employed by Respondent for 12 years. It was noted that in approximately May of 2013, he started to notice significant progression of numbness and tingling in both hands that radiated up his arms to above his elbows. It was noted that Petitioner indicated his job activities were very physical and required a significant amount of power gripping and repetitive wrist and elbow range of motion, and that he did electrical work, concrete work, used vibratory tools and power air wrenches and operated a snowplow with 3 different joysticks with his right upper extremity while driving with his left. It was also noted that noted that Petitioner was not diabetic or hypothyroid but that he was a smoker. (PX4).

The IME report noted that Dr. Emanuel's assessment was that of bilateral carpal tunnel syndrome and ulnar nerve palsy – cubital tunnel syndrome – of the elbow. It was noted that Dr. Emanuel opined that Petitioner's job activities could cause bilateral cubital tunnel syndrome and bilateral carpal tunnel syndrome based on the physical activities performed over the course of years. It was noted that Petitioner did not have any risk factors of any significance and that there were no outside hobbies. It was noted that Petitioner's subjective complaints matched objective findings by nerve conduction EMG study, and that the physical exam was positive for both median nerve and ulnar involvement from peripheral entrapment. It was noted that Dr. Emanuel did not find evidence of subluxing ulnar nerves at the cubital tunnel on physical exam but believed Petitioner required bilateral exploration of the ulnar nerve. It was noted that Dr. Emanuel also opined that Petitioner was a candidate for bilateral carpal tunnel release, and that the surgeries were reasonably and medically necessary to cure or relieve the effects of Petitioner's symptoms related to his work activities. The report further noted that Dr. Emanuel opined that Petitioner could continue to work full duty without restrictions, and that he did not believe Petitioner had reached maximum medical improvement. (PX4).

The letter of Dr. Michael Beatty dated July 22, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The letter was directed to Petitioner's counsel and indicated that Petitioner had, based on his job description and information provided, work-related compressive neuropathy of both upper extremities. The letter indicated that Dr. Beatty believed Petitioner would be a candidate for ongoing care in the form of surgical decompression of the nerves, and that Petitioner's history of hand or power tool use was impressive to reasonably relate to the causation of the compressive neuropathies. (PX5).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 6.

The Injury Reports to Dr. Beatty were entered into evidence at the time of arbitration as Respondent's Exhibit 1. The form was dated March 18, 2014 and indicated, among other things, that

Petitioner drives a dump truck and operates a snow plow; shovels asphalt, rock and dirt; operates a front loader, backhoe and skidster; and jack hammers concrete. The forms also reflect that Petitioner also reported that his hobbies include fishing, motorcycle riding, softball and swimming. (RX1)

The Supervisor's Injury Reports were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The e-mail from Angela Blackburn to Steven Wheeler dated July 28, 2014 noted that Petitioner was filing a claim for carpal tunnel syndrome and that he needed the forms completed for the injury. The e-mail from Steven Wheeler to Angela Blackburn dated August 19, 2014 noted that Petitioner "finally gave info last night." The Supervisor's Report of Injury was dated August 19, 2014 and noted "Unsure 7/31/13" for the date of accident/incident and that the report was received on August 18, 2014. The body parts affected were noted to include the left and right hands. (RX2).

The Applications for Adjustment of Claim were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The Applications were duplicative of those as contained in Arbitrator's Exhibits 3 and 4. (RX3; AX3; AX4).

The Incident Reports for the date of accident of July 31, 2013 were entered into evidence at the time of arbitration as Respondent's Exhibit 4. The Illinois Form 45 dated August 18, 2014 referenced a date and time of accident of July 31, 2013 at 9:00 a.m. It was noted that Petitioner stated that the repetitive motions of work using tools, etc. was the cause of carpal tunnel, and that the injury or illness was that of carpal tunnel syndrome. It was noted that Petitioner had no follow-up appointments at that time but that the doctor wanted to schedule surgery, that Petitioner was referred for nerve conduction studies on July 31, 2013 and that he was last seen in April. The Workers' Compensation Employee's Notice of Injury dated August 18, 2014 noted a date of injury or illness of "Unsure 7/31/13" and that he was referred for nerve conduction test. (RX4).

The Incident Reports for the date of accident of July 24, 2014 were entered into evidence at the time of arbitration as Respondent's Exhibit 5. The letter dated September 16, 2015 directed to Diana Wise noted that Respondent did not have an open file or any documentation for an injury of July 24, 2014. (RX5).

The medical records of Dr. Oscar Florendo/Osbec Medical of Southern Illinois were entered into evidence at the time of arbitration as Respondent's Exhibit 6. In addition to the July 31, 2013 office note as included in Petitioner's Exhibit 1, the records reflect that Petitioner was seen on August 5, 2013 for a bite injury that occurred one week ago and that the symptoms related to the injury had worsened. At the time of the August 20, 2013 visit, Petitioner presented with a rash after cutting down trees. At the time of the August 26, 2013 visit, it was noted that the rash was improving. (RX6).

The records of Osbec Medical of Southern Illinois reflect that Petitioner was seen on April 14, 2014 for back pain and sinus symptoms. At the time of the June 19, 2014 visit, Petitioner was seen for back pain. At the time of the June 24, 2014 visit, Petitioner was seen for follow-up of back pain and an abnormal CT scan. At the time of the October 6, 2014 visit, Petitioner was seen for musculoskeletal pain and restless legs. It was noted that Petitioner needed to have disability paperwork filled out for the Department of Veteran's Affairs. (RX6).

The medical records of Gateway Regional Medical Center were entered into evidence at the time of arbitration as Respondent's Exhibit 7. Petitioner underwent nerve conduction & EMG studies on August 27, 2013, which were interpreted as revealing bilateral ulnar neuropathy around the elbow and mild evolving bilateral carpal tunnel syndrome. (RX7).

Documentation pertaining to prior claims was entered into evidence at the time of arbitration as Respondent's Exhibit 8. The documentation reflects that 08 WC 36624 filed against Respondent resulted

in an award of 10% of the left arm, and that 07 WC 8598 was settled for 27.5% of the left shoulder (*i.e.*, arm). (RX8).

Various notice-related e-mails were entered into evidence at the time of arbitration as Respondent's Exhibit 9.

CONCLUSIONS OF LAW

With respect to disputed issues (D) and (E), given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

Section 6(c) of the Act states that an injured employee must give notice to the employer as soon as practicable, but no later than 45 days, after sustaining an accidental injury arising from the employment. 820 ILCS 305/6(c). The Illinois Supreme court in the case of *Durand v. Industrial Commission* noted that "[w]hen the accident is a discrete event, the date of the accident is easy to determine: it is, obviously, the date that the employee was injured. When the accident is not a discrete event, this date is harder to specify. 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. See *AC&S v. Indus. Comm'n*, 304 Ill. App. 3d 875, 879, 710 N.E.2d 837, 238 Ill. Dec. 40 (1999); *Nunn v. Indus. Comm'n*, 157 Ill. App. 3d 470, 480, 510 N.E.2d 502, 109 Ill. Dec. 634 (1987), as set forth in *Durand v. Indus. Comm'n*, 224 Ill.2d 53, 65, 862 N.E.2d 918, 308 Ill.Dec. 715 (2006). The Court noted that that means, *inter alia*, an employee suffering from a repetitive-trauma injury must still point to a date within the limitations period on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person. *Williams v. Indus. Comm'n*, 244 Ill. App. 3d 204, 209, 614 N.E.2d 177, 185 Ill. Dec. 43 (1993), as set forth in *Durand*.

In the case at hand, the Arbitrator finds that the manifestation date is that of March 18, 2014, and that Petitioner has failed to prove by a preponderance of the evidence that he provided Respondent timely notice of his alleged accidental injuries within 45 days of the March 18, 2014 accident date. As such, the Arbitrator finds that his claims are barred, consistent with Section 6(c) of the Act.

The Arbitrator notes that the evidence in these cases demonstrate that by March 18, 2014, Petitioner had been diagnosed by his family doctor with bilateral carpal tunnel and cubital tunnel syndromes and that diagnostic testing had confirmed the diagnoses. (PX1; RX6; RX7). Additionally, the evidence in these cases demonstrate that on March 18, 2014 Petitioner completed various forms at Dr. Beatty's office stating that he was referred there by co-workers, and that this was the date on which Petitioner completed additional forms on which he described his job duties in significant detail. (PX2; RX1). Furthermore, the evidence in these cases demonstrate that Petitioner himself indicated on one of the forms at Dr. Beatty's office on March 18, 2014 that it was work-related. (PX2; RX1). Perhaps most significantly, the Arbitrator notes that on cross examination, Petitioner himself admitted that in March of 2014 he believed that his condition might be work-related. As such, in light of the totality of the evidence, the Arbitrator finds that March 18, 2014 was the date on which the injury and its causal connection to Petitioner's work became plainly apparent to a reasonable person.

The Arbitrator further finds that Petitioner did not give Respondent notice of an *industrial* accident until August 18, 2014. As confirmed by Petitioner's own testimony and as substantiated by the Illinois Form 45, the Worker's Compensation Employee's Notice of Injury and the Supervisor's Report of Injury or Illness forms, Petitioner did not give notice that his upper extremity condition was related in any way to his work or job duties until August 18, 2014 (RX2; RX4). Although Respondent might have

known Petitioner had a medical condition prior to August 18, 2014, the record does not show Respondent was apprised of *industrial* injuries. In fact, the Arbitrator finds that the record tends to show the opposite, as Petitioner used his own sick time and group health insurance prior to August 18, 2014 rather than filing a workers' compensation claim – despite his belief that it was work-related as admitted by Petitioner at the time of arbitration. While Petitioner testified that he notified his lead worker, John Hicks, that he had gone to the doctor and was going to undergo testing, Petitioner on cross examination agreed that he did not tell Mr. Hicks that he had carpal tunnel syndrome that was affected by work until August 18, 2014. Petitioner further agreed on cross examination that when he alerted Mr. Hicks of his testing and EMG, he did not tell him that work had caused the need for the test.

As the Arbitrator notes that the purpose of the notice requirement is to enable the employer to investigate the employee's alleged industrial accident, under the facts of this case Respondent had no basis for knowing that any such accident existed to investigate until August 18, 2014. Therefore, the Arbitrator finds that Petitioner failed to provide Respondent notice of his accidents within 45 days of his manifestation date on March 18, 2014. As such, the Arbitrator finds that his claims are barred, consistent with Section 6(c) of the Act. As the remaining issues of accident, causal connection, medical bills and permanent partial disability benefits are moot, the Arbitrator makes no conclusions as to those issues.

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

Geoffrey L. Ely,

Petitioner,

vs. NO: 15 WC 22916

Illinois Department of Transporation,

Respondent.

17IWCC0609

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, permanent disability, causal connection, medical expenses, and 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 16, 2016 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.

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: SEP 29 2017

Stephen J. Mathis

SJM/sj
o-9/7/2017
44

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ELY, GEOFFREY L
Employee/Petitioner

Case# **15WC022916**

14WC029708

ILLINOIS DEPT OF TRANSPORTATION
Employer/Respondent

17IWCC0609

On 8/16/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2937 LESKERA LAW FIRM
JOHN H LESKERA
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0502 STATE EMPLOYEES RETIREMENT
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PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

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

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

AUG 16 2016

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

17IWCC0609

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

Geoffrey L. Ely
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # **15** WC **22916**

Consolidated cases: **14** WC **29708**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **June 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] 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 **July 24, 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.

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

In the year preceding the injury, Petitioner earned **$72,800.00**; the average weekly wage was **$1,400.00**.

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

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

ORDER

Petitioner has failed to prove, by a preponderance of the evidence, that he provided Respondent timely notice of his alleged accidental injuries within 45 days of the March 18, 2014 accident date and his claim is barred. As the remaining issues of accident, causal connection, medical bills and permanent partial disability benefits are moot, the Arbitrator makes no conclusions as to those issues.

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

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

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

Melinda M. Rose Gallivan

Signature of Arbitrator

8/10/16

Date

ICArbDec p 2

AUG 16 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Terrianne Foster-Gause,

Petitioner,

vs. NO: 15 WC 27415

State of Illinois/Lincoldn's Challenge Academy,

17IWCC0610

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 21, 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.

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review

DATED: SEP 29 2017

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

SJM/sj
o-9/7/2017
44

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

FOSTER-GAUSE, TERRIANNE
Employee/Petitioner

Case# **15WC027415**

14WC036398

SOI/LINCOLN'S CHALLENGE ACADEMY
Employer/Respondent

17IWCC0610

On 2/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0969 RICH RICH & COOKSEY PC
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4948 ASSISTANT ATTORNEY GENERAL
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0498 STATE OF ILLINOIS
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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

FEB 21 2017

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

17IWCC0610

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)

Terrianne Foster-Gause
Employee/Petitioner

v.

State of Illinois/Lincoln's Challenge Academy
Employer/Respondent

Case # **15** WC **27415**

Consolidated cases: **14** WC **36398**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **December 20, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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, **November 18, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$44,941.00**; the average weekly wage was **$864.25**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **0** dependent children.

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

Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

ORDER

As Petitioner has failed to prove that her current condition of ill-being in the lumbar spine is causally related to the accident of November 18, 2014, Petitioner's request for prospective medical treatment to the lumbar spine as recommended by Dr. Raskas 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.

Melinda M. Pope-Sullivan

Signature of Arbitrator

2/16/17

Date

ICArbDec19(b)

FEB 21 2017

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Terrianne Foster-Gause,

Petitioner,

vs. NO: 14 WC 36398

State of Illinois/Lincoln's Challenge Academy, 17IWCC0611

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 21, 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.

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

17IWCC0611

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: SEP 29 2017

Stephen J. Mathis

SJM/sj
o-9/7/2017
44

Deborah L. Simpson

David L. Gore

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

FOSTER-GAUSE, TERRIANNE
Employee/Petitioner

Case# **14WC036398**

15WC027415

SOI/LINCOLN'S CHALLENGE ACADEMY
Employer/Respondent

17IWCC0611

On 2/21/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

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

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

FEB 21 2017

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

17IWCC0611

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)

Terrianne Foster-Gause
Employee/Petitioner

v.

State of Illinois/Lincoln's Challenge Academy
Employer/Respondent

Case # 14 WC 36398

Consolidated cases: 15 WC 27415

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **December 20, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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, **April 23, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being **in the cervical spine** *is* causally related to the accident, but Petitioner's condition of ill-being **in the lumbar spine** *is not* causally related to the accident.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$44,941.00**; the average weekly wage was **$864.25**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **0** dependent children.

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

Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

ORDER

As Petitioner has failed to prove that her current condition of ill-being in the lumbar spine is causally related to the accident of April 23, 2014, Petitioner's request for prospective medical treatment to the lumbar spine as recommended by Dr. Raskas is denied.

Respondent shall pay Petitioner temporary partial disability benefits of **$576.17**/week for **61 3/7** weeks, commencing **April 14, 2015 through June 17, 2016,** as provided in Section 8(a) of the Act.

Respondent shall pay **for all treatment rendered to the cervical spine and for treatment rendered to the lumbar spine up to and including November 11, 2014** as contained in Petitioner's Exhibit 1 as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses **for all treatment rendered to the cervical spine and for treatment rendered to the lumbar spine up to and including November 11, 2014** directly to the provider(s). Respondent shall pay any unpaid, related medical expenses **for all treatment rendered to the cervical spine and for treatment rendered to the lumbar spine up to and including November 11, 2014** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

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

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

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

Melinda M. Pace Sullivan
Signature of Arbitrator

2/16/17
Date

ICArbDec19(b)

FEB 21 2017

17IWCC0611

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Terrianne Foster-Gause
Employee/Petitioner

Case # 14 WC 36398

v.

Consolidated cases: 15 WC 27415

State of Illinois/Lincoln's Challenge Academy
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on April 23, 2014, she was employed by Respondent as a Regional Coordinator for the southern district. She testified that on that date, she sustained accidental injuries at work. She testified that she returned to the base after hours and got there at about 6:00 p.m. She testified that usually someone was there to help with the gate, but no one was there at that time. She testified that the gate was stuck and that she felt pain through her back when opening the gate.

Petitioner testified that before April 23, 2014, she had sought treatment for low back discomfort before and that she went through chiropractic treatment with Dr. Nobbe. She testified that she also saw Dr. Robacker for medications and low back symptoms as well and that she had an MRI in 2011.

Petitioner testified that she was also injured on November 18, 2014 while doing an orientation. She testified that there were heavy conference tables, that she had to move a table and that there was no one there to help her. She testified that when she pulled the table, pain shot through her back and that she injured her neck and lower back. She testified that she eventually came under care of Dr. Raskas for her neck and back. She testified that he recommend surgery on her cervical spine, which was performed.

Petitioner testified that since the two accidents, her low back has been symptomatic. She testified that the treatment since 2014 up to the date of arbitration for her low back had included therapy, four injections and that additional therapy had been ordered. She testified that she has also taken medications and has tried a home exercise program and stretching. She testified that her low back pain has never returned to baseline before these accidents.

Petitioner testified that she notices a continual burning sensation and has shooting pain down her legs. She testified that she has throbbing in her hips, lower buttocks and the baseline of lower back. She testified that her pain is worse with activity and that her day consists of continually moving from sitting to laying to standing in an attempt to relieve the pain. She testified that moving around helps and that being in one position makes it worse. She testified that she attended two IMEs with Dr. Petkovich and Dr. Robson and that she cooperated with both examinations.

Petitioner testified that Dr. Raskas most recently has referred her to pain management. She testified that she wants more treatment to avoid surgery. She testified that she really does not want to have another operation and that she wants to do all that she can to strengthen her back and repair it without surgery.

On cross examination, Petitioner testified that she was honest and complete with all of the physicians that she had seen, including the IME physicians. She testified that she recalled doing motion testing and agreed that she was accurate in her reporting. She testified that she filled out questionnaires and that the answers given were honest.

On cross examination, Petitioner agreed that she was not using any braces or walking devices such as a cane. She testified that the shoes she wore at the time of arbitration were leather booties that had heels. She agreed that she regularly wears high-heeled shoes. The Arbitrator observed that at the time of arbitration, Petitioner was wearing heels that were approximately three inches in height.

On cross examination, Petitioner agreed that she was not working. She testified that the last time she was gainfully employed was in February of 2015 and that her employment with the State of Illinois had been discontinued.

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

The medical records of Nobbe Family Chiropractic were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on May 2, 2014, at which time it was noted that Petitioner's low back pain "moved up" and that she had low back pain and headaches. It was noted that Petitioner had a burning sensation in the upper back, that it was uncomfortable to sleep, that she was taking no pain medications and that after her last visit she went home and rested/slept. At the time of the May 1, 2014 visit, it was noted that Petitioner reported low back pain, upper back pain which kept her up all night and a headache, left greater than right. It was noted that Petitioner had difficulty using the toilet but that she slept better last night. At the time of the April 30, 2014 visit, it was noted that Petitioner's low back pain was better compared to the last visit, that her upper back pain was the same and that her headache was worse. It was noted that Petitioner was recommended to use a TENS unit and that chiropractic/therapy was helping. (PX3).

The records of Nobbe Family Chiropractic reflect that Petitioner was seen on April 25, 2014, at which time she reported issues with upper back/neck pain and headache. At the time of the April 24, 2014 visit, it was noted that Petitioner reported that while shutting the gate at work she noticed a strain in her upper back and neck. It was noted that Petitioner closed the gate each day, that it was heavy and awkward to close and that closure of the gate was more difficult in winter months due to snow and ice. It was noted that Petitioner's symptoms started April 23, 2014, that she had pain and numbness, that it was bilateral with left greater than right and that it radiated to her head. It was noted that ice packs/heat, a TENS unit and Flexeril all gave her temporary relief, that her health was worsening in all aspects and that she was seated at a desk all day with some walking. The diagnoses were noted to be that of lumbar spine spondylosis without myelopathy, sciatica, neuritis or radiculitis of the lumbar spine, muscle spasm, cervical spine subluxation, lumbar spine subluxation, thoracic sprain/strain and cervical sprain/strain. (PX3).

The medical records of Belleville Family Health Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on May 8, 2014 at which time it was noted that she presented with back pain. It was noted that Petitioner's problem was worsening, that the location of the pain was the upper back and the lower back and that the pain had radiated to the left arm, right arm, left calf, right calf, left foot and right foot. It was noted that Petitioner was lifting a heavy object at work on April 23, 2014 and that her symptoms were aggravated by daily activities, sitting, standing and walking. It was noted that Petitioner's symptoms were relieved by heat, ice and TENS. It was noted that Petitioner had acute on chronic back pain and that she had no red flags of low back pain including saddle anesthesia, urinary incontinence or retention or bilateral lower

extremity weakness or numbness. Petitioner was given home physical therapy exercises and was prescribed medications, and she was also referred to physical therapy. The assessment was that of low back pain, rhomboid muscle strain and cervicalgia. (PX4).

The records of Belleville Family Health Center reflect that Petitioner was seen on August 8, 2014. It was noted that Petitioner worked for Lincoln Challenge Academy and that on April 23, 2014, she was closing the armory gate. It was noted that Petitioner had pain in the cervical spine area with some radiation into her shoulders, that she had pain in the mid to low back which went into the buttocks and legs bilaterally, that she now had pain more in the hips and that she also had bilateral knee pain. The assessment was that of bilateral knee pain, low back pain and bilateral hip pain. Petitioner was recommended to undergo x-rays of the bilateral knees, lumbar spine, bilateral hips and pelvis. Petitioner was also referred to physical therapy. Included within the records was an e-mail dated May 8, 2014 indicating that Petitioner may not return to work and could return to work on May 19, 2014 working light duty. (PX4).

The medical records of Preferred Spine & Rehab Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on May 12, 2014, at which time it was noted that on April 23, 2014, Petitioner was pulling open the security gate to get her car into the work parking lot and that as she was pulling it open, she felt a strain in her upper back. It was noted that Petitioner proceeded to pull her car into the lot and when she went to close the gate, she felt a strain in her mid-back and low back. It was noted that Petitioner was currently taking pain medications that helped to take the edge off, but it still left her in significant pain. It was noted that Petitioner had been treated by a chiropractor, but the treatments they were using caused her to be in more pain. It was noted that Petitioner stated that she was experiencing constant severe low back pain which was achy, burning, dull, sharp, shooting, stiff and tingling in quality and that she described having frequent, severe upper mid-back pain which was achy, shooting, sore and throbbing/pulsating in quality. It was also noted that Petitioner described having constant severe neck pain which was sharp, shooting, sore, stiff and throbbing/pulsating in quality. The assessment was that of cervical sprain/strain with myospasm and cervical disc degeneration, thoracic sprain/strain with costovertebral segmental dysfunction, facet syndrome with sacroiliac somatic dysfunction and lumbar disc degeneration. It was noted that the treatment schedule would be three times per week for four weeks and then twice per week for six weeks. (PX5).

Included within the records of Preferred Spine & Rehab Center was an interpretive report for x-rays of the lumbar spine performed on May 12, 2014, which were interpreted as revealing (1) degenerative disc disease; (2) hypolordosis; (3) right leg length inequality 5mm; (4) structural changes as described. The report for x-rays of the cervical spine performed on the same date noted that the films were interpreted as revealing (1) degenerative disc disease; (2) hypolordosis; (3) structural changes as described. (PX5).

The records of Preferred Spine & Rehab Center reflect that Petitioner was seen on May 13, 2014, at which time it was noted that her overall condition was about the same since the last visit. It was noted that Petitioner's pain in the low back, mid-back and neck was 10/10. At the time of the May 14, 2014 visit, it was noted that her overall condition was about the same since the last visit. It was noted that Petitioner's pain in the low back, mid-back and neck was 10/10. It was noted that Petitioner was progressing as expected and her prognosis was good at that time. At the time of the May 15, 2014 visit, it was noted that Petitioner stated that her condition was improving since the last visit. It was noted that Petitioner stated that she felt like she was moving better and the pain was slightly less. At the time of the May 20, 2014 visit, it was noted that Petitioner stated that her overall condition was worse since the last visit. It was noted that Petitioner had increased soreness in her low back and hips, that she returned to work and that walking increased her pain. (PX5).

The records of Preferred Spine & Rehab Center reflect that Petitioner was seen on May 21, 2014, at which time it was noted that she stated that her condition was improving since the last visit. It was noted that Petitioner stated that she was moving much better but did not sleep well last night. At the time of the May 23, 2014 visit, it was noted that Petitioner stated that her overall condition was about the same since the last visit. At the time of the May 28, 2014 visit, it was noted that Petitioner stated that her condition was improving since the last visit. It was noted that Petitioner stated that her pain was now more intermittent rather than constant, and that she was getting periods of relief but then certain movements at work caused spasms again. At the time of the May 29, 2014 visit, it was noted that Petitioner stated that her overall condition was about the same since the last visit. At the time of the June 3, 2014 visit, it was noted that Petitioner stated that her overall condition was worse since the last visit. It was noted that Petitioner had been feeling better so she started doing more around the house, and that on that date she was achy with increased pain in her low back. At the time of the June 5, 2014 visit, it was noted that Petitioner stated that her overall condition was about the same since the last visit. It was noted that Petitioner had increased left lower back pain after walking on the concrete at work, that she brought in the shoes that she wore to work on a regular basis and that they had 5-inch high heels. It was noted that it was discussed that Petitioner wear flats or tennis shoes to work based on the flooring that she worked on, and that she stated that she was not willing to change her footwear. (PX5).

The records of Preferred Spine & Rehab Center reflect that Petitioner was seen on June 10, 2014, at which time it was noted that she stated that her overall condition was worse since the last visit. Petitioner was a no show for her appointments on June 12, 2014 and June 16, 2014. At the time of the June 18, 2014 visit, it was noted that Petitioner stated that her overall condition was about the same since the last visit. It was noted that Petitioner explained that when she was not at work her pain level was much lower, but that when she was at work her pain level went up. It was noted that Petitioner stated that her soreness had decreased overall and that she felt more mobile and flexible. It was noted that Dr. Renner recommended that Petitioner take time off work until they could get a better hold of her condition, and that she stated that it was not a possibility at that time. At the time of the June 24, 2014 visit, it was noted that Petitioner stated that her overall condition was about the same since the last visit. It was noted that Petitioner just came from work on that date so she stated that her symptoms were much worse, and that over the weekend when she was not working her pain level was down to 4 to 5 again. It was noted that Petitioner was progressing slower than expected but her prognosis was still good at that time. At the time of the June 25, 2014 visit, it was noted that Petitioner stated that her overall condition was about the same since the last visit. (PX5).

The records of Preferred Spine & Rehab Center reflect that Petitioner was seen on July 1, 2014, at which time it was noted that she stated that her condition was improving since the last visit. At the time of the July 2, 2014 visit, it was noted that Petitioner stated that her overall condition was about the same since the last visit. At the time of the July 3, 2014 visit, it was noted that Petitioner stated that her overall condition was about the same since the last visit. Petitioner was a no show for her appointments on July 8, 2014 and July 10, 2014. At the time of the July 15, 2014 visit, it was noted that Petitioner stated that her overall condition was about the same since the last visit. At the time of the July 16, 2014 visit, it was noted that Petitioner stated that her overall condition was about the same since the last visit. It was noted that Petitioner still stated that when she was not at work she felt better and her pain levels were not this high, and that she usually came to the clinic after working so she tended to have more pain and discomfort. At the time of the July 17, 2014 visit, it was noted that Petitioner stated that her overall condition was about the same since the last visit. Petitioner was a no show for her appointments on July 18, 2014 and July 21, 2014, and it was noted that on July 18th Dr. Renner called Petitioner, who stated that she was running errands and her low back was too sore to get in to the office on that date. (PX5).

The records of Preferred Spine & Rehab Center reflect that Petitioner was seen on July 22, 2014, at which time it was noted that she stated that her overall condition was about the same since the last visit.

At the time of the July 23, 2014 visit, it was noted that Petitioner stated that her overall condition was about the same since the last visit. It was noted that Petitioner had soreness in her low back and hips that was radiating to her thighs. At the time of the July 25, 2014 visit, it was noted that Petitioner stated that her overall condition was worse since the last visit. At the time of the July 29, 2014 visit, it was noted that Petitioner stated that her overall condition was worse since the last visit. It was noted that Petitioner stated that her quality of pain had changed since starting there, and that she no longer had the sharp, stabbing pain but rather more of a deep achy feeling. It was noted that Dr. Renner did not feel that Petitioner's subjective findings were consistent with the objective findings observed. It was noted that Dr. Renner was referring her back to her primary care physician for pain management. (PX5).

Included within the records of Preferred Spine & Rehab Center was an interpretive report for an MRI of the lumbar spine performed at Imaging Center of Southern Illinois performed on May 18, 2011, which noted an indication of low back pain with difficulty walking. The films were interpreted as revealing (1) disk pathology in the lower thoracic and lumbar spine with some neural foraminal involvement and central canal narrowing without significant stenosis; (2) probable ovarian cyst incidentally noted, left greater than right. (PX5).

The medical records of St. Elizabeth's Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner underwent x-rays of the lumbar spine on August 8, 2014, which were interpreted as revealing mild lumbar spondylosis. The report for x-rays of the pelvis performed on the same date noted that the films were interpreted as revealing no acute abnormality; mild degenerative changes in the hips. The report for x-rays of the left and right knees performed on the same date noted that the films were interpreted as revealing mild osteoarthritis. The report for x-rays of the hips performed on the same date noted that the films were interpreted as revealing mild degenerative changes. (PX6).

The medical records of Dr. Raskas were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner was seen on November 24, 2014, at which time it was noted that she reported that she was initially injured at work on April 23, 2014 while working as a recruiter at a military base. It was noted that there was a large, heavy gate to the main entrance which she was required to open and close, and that upon opening the gate she had immediate mid-line low back pain and also complained of pain in her neck and in between her shoulder blades. It was noted that despite feeling the initial twinge as she described it, she did go ahead and close the gate to be in compliance with base regulations. It was noted that Petitioner was treated by Dr. Renner who she felt was not listening to her complaints and paying attention to what she was describing, and that she told him that they had an argument and he discharged her from care. It was noted that Petitioner had been seeing her primary care physician. It was noted that Petitioner described diffuse low back pain, that her symptoms did not seem to be worse on one side more than the other, that she described intense burning in both buttocks slightly worse on the right than the left and that she denied any radiating leg pain, but stated her legs intermittently went completely numb with prolonged sitting. It was noted that Petitioner described parascapular pain worse on the right than the left, and that she also complained of numbness in both hands. It was also noted that Petitioner noted some left-sided neck pain and clicking in her neck and also complained of headaches. It was further noted that Petitioner was treated for a bulging disc in her low back in 2010 and had not seen a physician for this problem since that time, and that all of her symptoms were brought on with the initial injury on April 23rd. It was noted that Petitioner stated that she filled out a subsequent claim on November 18th as well, stating that she was pulling a table up closer for a parent to sit at during a recruitment session, and that she felt immediate pain in between her shoulder blades. The assessment was that of possible cervical and lumbar disc injury, and Petitioner was recommended to undergo an MRI of her cervical and lumbar spine. It was noted that Dr. Raskas recommended that Petitioner continue working at her same job. (PX7).

The records of Dr. Raskas reflect that Petitioner was seen on December 5, 2014, at which time it was noted that she continued to have neck pain and numbness going into both of her arms and pain between her scapulae, that her MRI clearly showed that she had a disc herniation at C5-6 that created spinal cord compression, that she also had a disc herniation at C6-7 which narrowed the foramen moderately and that she had changes and findings consistent with cervical myelopathy and radiculopathy. It was noted that Dr. Raskas recommended a two-level cervical anterior disc replacement and that Petitioner wished to proceed with surgery. It was noted that with regard to her low back Petitioner had a disc protrusion type herniation at L4-5 for which Dr. Raskas recommended some epidural steroid injections and continued conservative management, and that the need for the epidural steroid injection was directly attributable to her work injury. (PX7).

The records of Dr. Raskas reflect that Petitioner was seen on February 24, 2015, at which time it was noted that her chief complaint was that of neck pain that radiated into her arms and low back pain that radiated into her legs. It was noted that Petitioner had been taking Hydrocodone and Morphine for another unrelated issue and that she stated that her back and neck were feeling better on that, but since she had come off the pain was returning. It was noted that Petitioner's insurance carrier felt that the disc replacement was experimental and that the only thing they would cover would be a two-level ACDF. It was noted that Petitioner wished to proceed. (PX7).

The records of Dr. Raskas reflect that Petitioner was seen on April 28, 2015, at which time she was seen regarding her neck and low back. It was noted that Petitioner underwent a two-level cervical disc replacement and that she had had marked relief of her pre-operative neck and arm symptoms. It was noted that what bothered Petitioner most was her low back, that it bothered her with flexion activities going from a seated to standing position and that leaning back she did very well with but leaning forward brought on her pain. It was noted that Petitioner was being evaluated for lap band surgery, and that Dr. Raskas recommended weight loss and activity modification to treat her back symptoms. It was noted that if those things were not successful, Petitioner would likely need a fusion at L4-5. It was noted that from the standpoint of her back, Petitioner remained off work and was to return in three months. At the time of the September 1, 2015 visit, it was noted that since she was last seen, Petitioner had undergone a lap band procedure and had lost 40 pounds. It was noted that Petitioner also reported being attacked by a pit bull while walking her small dog, that she fell to the ground, that she sustained some scrapes and that her right shoulder was quite sore. Petitioner was recommended to undergo physical therapy to be aimed at strengthening and stretching exercises for both the neck and low back. A work slip was also issued on that date, allowing Petitioner to return to work with restrictions. (PX7).

The records of Dr. Raskas reflect that Petitioner was seen on October 6, 2015, at which time it was noted that since last being seen she had had physical therapy for her low back. It was noted that Petitioner had had an injection in the past that gave her some temporary relief but did not last more than a few weeks at L4-5 for spondylolisthesis at that level. It was noted that Petitioner had had physical therapy which had not really changed her continued back pain and radiation down into her legs. It was noted that Petitioner had tried NSAIDs for over six weeks without sustained relief, that she had tried activity modification and weight loss and that she continued to be symptomatic. Petitioner was recommended to undergo a CT scan to evaluate for spondylolisthesis and it was noted that she may need a laminectomy and posterior lumbar interbody fusion. At the time of the November 13, 2015 visit, it was noted that Dr. Raskas had seen the results of her myelogram CT scan, and that Petitioner had either a herniated disc at L4-5 lateralizing to the left side or a facet cyst. It was noted that Petitioner's complaints, however, were primarily back, bilateral buttock pain. It was noted that given that Petitioner's complaints were back and primarily buttock and that she had pain down her legs, Dr. Raskas wanted to try to avoid surgery. Petitioner was recommended to see Dr. Hurford for facet blocks and epidurals. (PX7).

The records of Dr. Raskas reflect that Petitioner was seen on June 17, 2016, at which time it was noted that she continued with significant back and buttock pain, left greater than right, and that it was

aggravated by extension, relieved a little bit by flexion but it only went away temporarily when she went into flexion. It was noted that Dr. Raskas thought that Petitioner had a disc herniation or neurologic compression in the lumbar spine that was producing her symptoms and that he suggested some facet blocks and epidural injections. It was noted that the need for the treatment was directly attributable to her work injury. (PX7).

The medical records of Professional Imaging were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner underwent an MRI of the lumbar spine on November 26, 2014, which was interpreted as revealing (1) multilevel degenerative disc disease and facet arthropathy; changes are greater at L4-L5 where broad-based bulge or protrusion extends into the inferior foramen on the left; correlate clinically; prominent dorsal epidural fat is also noted at this level; (2) no compression fracture deformity or edema is seen. (PX8).

The medical records of St. Louis Spine & Orthopedic Surgery Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner underwent an L4/5 epidural steroid injection on December 16, 2014 by Dr. Hurford for a diagnosis of herniated nucleus pulposus/leg pain. The records reflect that Petitioner also underwent an L4/5 epidural steroid injection on December 10, 2015 for a diagnosis of lumbar spinal stenosis; bilateral radiculopathy. (PX9).

The medical records of Belleville Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner underwent pre-operative testing related to her cervical surgery on April 2, 2015. (PX10).

The medical records of Apex Physical Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The Initial Evaluation performed on October 6, 2014 noted that Petitioner stated that she had a radiating burning sensation in the low back and down the back of the thigh, that she had tingling in both feet and that if she bent her wrists/hands and elbows she had numbness in the hands. It was noted that Petitioner reported that her symptoms began April 23, 2014 when she was opening and closing a gate that required significant force due to being bent and off track. It was noted that Petitioner had attended therapy from May 19 through July 2014, and that since July she had not had any therapy. It was noted that Petitioner was a recruiter for students in 31 counties, that she spent the majority of the day sitting at a desk, walking, driving between 1-3½ hours at a time multiple times a day, that she stated that she had to carry and lift a computer, projector and supplies and that she moved tables and chairs. It was noted that Petitioner demonstrated severely guarded movement through the evaluation and self-limited due to pain, and that she demonstrated significantly impaired active range of motion of the hips and lumbar spine due to complaints of pain. It was noted that the findings were inconsistent with the diagnosis. (PX11).

The records of Apex Physical Therapy reflect that at the time of the Re-Evaluation on November 5, 2014, it was noted that Petitioner stated that she continued to have the burning sensation across the low back, that the tightness was not as severe but was still present, and that the tingling in the feet was not as severe and less frequent. Petitioner was discharged as of December 9, 2014 as she was scheduling cervical surgery with Dr. Raskas. (PX11).

The records of Apex Physical Therapy reflect that an Initial Evaluation was performed on September 9, 2015, at which time it was noted that Petitioner complained of burning in the low back and hip with the right being more affected than the left, that she had lost 40 pounds in the last few months that had helped her back pain but it was not completely relieved. It was noted that Petitioner stated that her pain increased with forward trunk flexion and transitioning between sit/stand, and that she complained of popping and stiffness of the cervical spine since surgery. At the time of the September 18, 2015 visit, Petitioner reported that she continued to have the burning sensation in her bilateral hips. At the time of the September 21, 2015 visit, it was noted that Petitioner stated that her neck was stiff and that she woke

up with a headache, that her neck/trapezius area hurt when she went for her walks and that she stated that she wanted to return to the gym. At the time of the Re-Evaluation on October 2, 2015, it was noted that Petitioner reported that she felt like her range of motion was improving in the neck and was starting to try driving again. It was noted that Petitioner continued to complain of burning in the bilateral hips and into the leg, and that she complained of stiffness with cervical exercises. At the time of the October 22, 2015 visit, it was noted that Petitioner stated that her low back pain was about the same. At the time of the November 2, 2015 visit, it was noted that Petitioner's low back pain was an 8/10 with pain medication. The records reflect that Petitioner was discharged on November 13, 2015 as they were unable to reach her after her physician follow-up appointment. (PX11).

The medical records of St. Louis Surgical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The records reflect that Petitioner underwent surgery on April 14, 2015, which consisted of (1) C5-6 complete diskectomy with disk replacement; (2) C6-7 complete diskectomy with disk replacement for a pre- and post-operative diagnosis of herniated disk with spondylosis, C5-6 and C6-7. (PX12).

The medical records of Advanced Neuro Solution were entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The records reflect that Petitioner underwent intraoperative neurophysiology monitoring on April 14, 2015, which was unremarkable. (PX13).

The medical records of Ballas Anesthesia, Inc. were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The records pertained to general anesthesia performed on April 14, 2015 during the course of the cervical surgery. (PX14).

The medical records of Excel Imaging were entered into evidence at the time of arbitration as Petitioner's Exhibit 15. The records reflect that Petitioner underwent a lumbar myelogram on November 10, 2015, which was interpreted as revealing (1) disc level extradural defects L3-4, L4-5 and L5-S1; there is mild central canal stenosis at the L4-5 level; no other central canal stenosis is detected. The CT lumbar spine post-myelogram was interpreted as revealing (1) annular disc bulges L3-4, L4-5 and L5-S1 with associated facet arthropathy and ligamentum flavum hypertrophy; mild central canal stenosis is present at L4-5 and to a lesser degree at L3-L4; there are bilateral foraminal stenoses at all three levels, worse at L405. (PX15).

The Workers' Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Petitioner's Exhibit 16. The document reflects that Petitioner reported a date of accident of April 23, 2014, and that the injury occurred locking the gate for the evening after hours. It was noted that Petitioner was closing and locking the gate, and that she was opening and closing the gate to secure the parking facility. The body parts affected were noted to be that of the lower back, upper back and swelling in the shoulder blade area. The report was completed on April 29, 2014. (PX16).

The transcript of the deposition of Dr. Raskas was entered into evidence at the time of arbitration as Petitioner's Exhibit 17. Dr. Raskas testified that he is a board-certified orthopedic spine surgeon. He testified that he limits his practice to treating patients with spinal disorders. (PX17).

Dr. Raskas testified that at the conclusion of the history, clinical examination, review of the prior records, review of the prior diagnostic films and review of the MRI, his diagnosis was that of cervical myelopathy and radiculopathy. He testified that his opinion as to the cause of Petitioner's symptoms that needed treatment was that of the work injury that occurred on April 23, 2014. He testified that he recommended a two-level cervical decompression and disc replacement. He testified that no conservative care with regard to the neck was attempted before surgery because Petitioner had myelopathy. He testified that he did not think when someone had spinal cord compression and they had balance disturbances that it was considered to be contraindicated to not offer surgical intervention. He testified

that he performed a two-level surgical disc replacement. He testified that Petitioner had marked relief of her pre-operative neck and arm symptoms as of April 28, 2015 and she was pretty much asymptomatic by September. He further testified that he last saw Petitioner on November 13, 2015 and that, with regard to the neck, she was doing excellent. (PX17).

Dr. Raskas testified he disagreed with Dr. Petkovich's assertion that the incident Petitioner described at work on April 23, 2014 caused any aggravation of the degenerative changes in the spine that were present prior to April 23, 2014, as he did not know that Petitioner had a cervical myelopathy ever before the accident at work. He testified that he did not have any indications that Petitioner was off work and missing time from work prior to the accident in 2014 for any cervical condition, nor did he have any indication in any of the records that he reviewed that Petitioner was recommended for surgery prior to seeing him. (PX17).

Dr. Raskas testified that he agreed with Dr. Robson's indication that he believed that Petitioner sustained an injury to her cervical spine at C5-6 and C6-7 due to the April 23, 2014 injury, and that he further agreed with Dr. Robson's opinion that he believed that the medical care and treatment after August 20, 2014 was necessitated by the April 23, 2014 injury to the cervical spine. He testified that he agreed with Dr. Robson's opinion that Petitioner's treatment had been reasonable and necessary for the cervical spine. He testified that he and Dr. Robson were in practice together for 15 years. He testified that he was familiar with Dr. Petkovich and that he did not perform surgery with regard to the cervical or lumbar spine. (PX17).

Dr. Raskas testified that as to the lumbar spine, he examined the low back and that Petitioner was dragging her right leg a little bit and veered to the left side with ambulation. He testified that Petitioner had a fair amount of tenderness over her right posterior superior iliac spine. He testified that his interpretation of the MRI of the lumbar spine was that Petitioner had a protrusion-type herniation at L4-5. When asked to compare and contrast the findings between the 2011 MRI and the one done in 2014, Dr. Raskas testified that there was discussion of a bulge at L4-5 but that this was not a disc protrusion. He testified that Petitioner had sustained further injury to the disc and it had also been complicated by the development of instability at the L4-5 level since 2011, which was a combination of the injury to the disc and "time and life." (PX17).

Dr. Raskas testified that he believed that the cause of Petitioner's low back symptoms was a combination of the injury that she sustained at work and the pre-existing problems that she had in her back. He testified that in addition to the April 2014 accident, Petitioner reported that in the summer of 2015 she indicated she was attacked by a pit bull when walking her small dog, that she stated that she fell to the ground, that she sustained some scrapes and that her right shoulder was quite sore. He testified that Petitioner also reported another incident at work when she was pulling a table closer for a parent to sit at during a recruitment session and that she felt pain between her shoulder blades. (PX17).

Dr. Raskas testified that they did not immediately treat Petitioner's low back while he was treating her cervical spine because they wanted to get the cervical problem taken care of first. He testified that he recommended some epidural steroid injections and that he referred her to Dr. Hurford, a physiatrist and pain management specialist in his office. He testified that the injections were to be performed at L4 and L5, and that they took place in December 2014 and November and December of 2015. He testified that with regard to Petitioner's low back they were dealing with a pain problem and not a neurological deficit, and that he thought that they would try to do everything to try to avoid surgery. He testified that if the symptoms persisted in spite of a trial of injections, time, therapy and weight loss, it would be normal to offer a fusion-type procedure to the low back. (PX17)

Dr. Raskas testified that from the time that he first saw Petitioner up until the time of the dog incident, her low back symptoms had not abated. When asked what, if anything, the incident with the dog

did to Petitioner's low back, Dr. Raskas responded that she did not really describe it to do anything to her low back and that maybe it aggravated things temporarily but she did not really mention that it really caused her back any problems. He denied that it changed the underlying pathology in any way. He testified that he was treating L4-5 and that Petitioner had a herniated disc and spondylolisthesis at that level. He testified that he had recommended some injections and a reevaluation in 3-4 months, and that Petitioner needed to be reevaluated for her low back. (PX17).

Dr. Raskas testified that as of the last time that he saw Petitioner, he did not have any restrictions on her with regard to the neck. He testified that he had placed Petitioner under restrictions with regard to the low back. He testified that the CT myelogram indicated to him that there was a herniated disc or a facet cyst lateralizing to the left at L4-5 and that there was also stenosis at that level. He testified that it was probably a herniated disc given the findings on the other scans. He testified that he thought that part of Petitioner's symptoms correlated with a herniated disc at L4-5, but that the other part that correlated with it was the spondylolisthesis that she had at that level. He testified he referred Petitioner to Dr. Hurford for facet blocks and epidurals on November 13, 2015. He agreed that before any further treatment was rendered, he needed to see Petitioner again. (PX17).

Dr. Raskas testified that he believed the cause of Petitioner's current low back symptoms was a combination of the work injury that occurred on April 23, 2014 and the pre-existing back condition that she had. He testified that he believed that the November 2014 incident caused an aggravation of her symptoms, and that he did not believe that the dog incident caused any aggravation of her symptoms. He testified that he did not believe that the dog incident caused an intervening trauma which broke the chain of causal connection from the original injuries in April and November of 2014. (PX17).

On cross examination, Dr. Raskas agreed that his single point of information regarding the incident was Petitioner. He testified that Petitioner reported that, upon opening a heavy, large gate at the main entrance which she was required to open and close, she had immediate midline and low back pain and pain in her neck between her shoulder blades. He testified that Petitioner reported that despite feeling a twinge, he did not have any information regarding exactly how much the gate weighed. When asked if the weight of the gate or the body stress required to manipulate the item was a significant factor in the degree of trauma caused by the activity, Dr. Raskas responded that he thought that that made the assumption that everyone was going to move something the exact same way and the same posture, which he did not think it would. He agreed that different people doing the same activity were going to do it in different ways. (PX17).

On cross examination when asked if it was his impression that Petitioner regularly manipulated the gate, Dr. Raskas responded that he did not know that to be true or not. When asked if he had any more information about the November 2014 incident where she was pulling a table during a presentation, Dr. Raskas denied having any more information about the incident other than what was contained in his note. He agreed that the pain associated with that incident was between her shoulder blades, which was in the thoracic spine area. He testified that he did not think there was any other treatment besides her having seen him in six days, nor did he see any evidence that it altered the course of her treatment. (PX17).

On cross examination, Dr. Raskas agreed that he first saw Petitioner in November of 2014 and that her accident was in April of 2014. He agreed that it was his impression that Petitioner had some intervening treatment in those seven months. He agreed that he reviewed the medical records of Preferred Spine & Rehab. He agreed that on the record of July 29, 2014, it was indicated that there was a disconnect between Petitioner's subjective complaints and her objective findings. He testified that it was not important as it indicated that the examiner failed to recognize myelopathy. He testified that he thought it was an error on the part of the examiner. (PX17).

On cross examination, Dr. Raskas agreed that he relied upon Petitioner's history as provided and her relating her symptoms to him, and that was for both his treatment and for his causation opinion. When asked to review the Apex Physical Therapy note of October 6, 2014 wherein it was noted that Petitioner reported that her functioning for the lower extremities was 95% impaired and whether that was consistent with the physical examination that he performed, Dr. Raskas responded that it was not. He agreed that Petitioner had at least two positive Waddell's findings based on the note, and that he considered those to be inorganic findings. He agreed that he was familiar with the McGill Pain Questionnaire that indicated that scores over 30 may indicate exaggeration of symptoms and that the note indicated that Petitioner had a score of 34. He agreed that the findings of Apex Physical Therapy would be consistent with the findings from Preferred Spine & Rehab with reference to the low back. He testified that those were the opinions of a chiropractor and a physical therapist, but agreed that they were not retained by Respondent for any purpose and were treaters. (PX17).

On cross examination when asked if Petitioner had risk factors for progressive degeneration of her lumbar spine, Dr. Raskas responded that she had nothing. He testified that age was normal and that Petitioner had lost weight and was still having trouble, so he could not see where weight was actually an issue. (PX17).

The Worker's Compensation Documentation Log was entered into evidence at the time of arbitration as Petitioner's Exhibit 18. The Supervisor's Report of Injury or Illness dated May 1, 2014 noted that Petitioner indicated that she was closing the security gate for the Armory, that the gate was a rolling gate approximately 7' high and 16' long when she felt a twinge in her upper and lower back. (PX18).

The medical records of Dr. Nobbe were entered into evidence at the time of arbitration as Respondent's Exhibit 1. The records reflect that Petitioner was seen on May 16, 2011, at which time it was noted that her chief complaint was that of low back pain. It was noted that the condition was new, that Petitioner had pain, that the location was on the left and that it was a sharp quality. It was noted that the symptoms started 2½ weeks ago and worsened on May 12, 2011. It was noted that 23 years ago Petitioner had two disc bulges, and that she had had spasms off and on for years but nothing this bad. The assessment was that of disc bulge lumbosacral, muscle spasm and segmental dysfunction. It was noted that Petitioner was sent for an MRI, that she was in extreme pain and had very limited movement and that she was having difficulty walking due to pain. Petitioner was recommended to undergo manipulation, electrical stimulation with heat and ultrasound three times per week for two weeks, and to use a TENS unit and ice at home. (RX1).

The records of Dr. Nobbe reflect that Petitioner underwent chiropractic therapy through July 11, 2011. At the time of the May 26, 2011 visit, it was noted that Petitioner was having numbness into the left buttock and that her pain had decreased slightly. At the time of the June 8, 2011 visit, it was noted that Petitioner's numbness was worse but her pain was better. The remainder of the records were duplicative of those as contained in Petitioner's Exhibit 3. (RX1; PX3).

The medical records of Dr. Robacker were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The records reflect that Petitioner was seen on March 8, 2013 for a number of issues, including low back pain. It was noted that Petitioner's onset was gradual without injury, that the problem was fluctuating, that it occurred intermittently, that the location of the pain was the lower back, that there was no radiation of pain and that Petitioner described the pain as deep. At the time of the May 15, 2013 visit, it was noted that Petitioner's musculoskeletal examination was negative for back pain, joint pain, joint swelling, muscle weakness and neck pain. At the time of the November 21, 2013 visit, it was noted that Petitioner had been involved in a motor vehicle several years ago and had back pain, that her back was worse in the last year and that she was using a TENS and ice with some relief. It was noted that exercises were discussed along with weight loss. At the time of the January 14, 2014 visit, it was

noted that Petitioner's musculoskeletal examination was negative for back pain, joint pain, joint swelling, muscle weakness and neck pain. The remainder of the records were duplicative of those as contained in Petitioner's Exhibit 4. (RX2; PX4).

The transcript of the deposition of Dr. Petkovich was entered into evidence at the time of arbitration as Respondent's Exhibit 3. Dr. Petkovich testified that he is an orthopedic surgeon and is board-certified by the American Board of Orthopedic Surgery and the American Board of Independent Medical Examiners. He testified that he stopped performing spinal surgery 3-4 years ago due to an eye injury. (RX3).

Dr. Petkovich testified that he performed an IME of Petitioner on August 20, 2014 and that the corresponding report was dated August 27, 2014. He testified that Petitioner gave a history of sustaining an injury while at work when she was moving a gate on April 23, 2014. He testified that Petitioner reported that she moved a gate and subsequently developed some pain in her upper back and neck area and some pain in her lower back. He testified that the physical examination of the lumbar spine performed showed a normal clinical appearance, that range of motion of the lumbar spine was mildly subjectively limited with forward flexion at 80 degrees, extension at 10 degrees, and left and right bends each at 10 degrees. He testified that Petitioner told him that she had some tenderness in the right and left paraspinous lumbar areas but he could not palpate any muscle spasm, and that she had no tenderness over her right or left sacroiliac joints or her right or left sciatic notch areas. He testified that there were no positive objective physical findings with regard to her lumbar spine on examination, and that the neurologic examination of both lower extremities was completely intact. (RX3).

Dr. Petkovich testified that he reviewed outside x-rays of the cervical spine and lumbar spine taken on May 12, 2014, which showed some mild degenerative changes in the cervical and lumbar spine areas. He testified that thoracic spine x-rays taken in his office revealed no acute findings. He testified that Petitioner reported to him that she was having some pain in her neck with some headaches and that she had occasional numbness in her right upper extremity, but that she denied any pain in either of her upper extremities. He testified that Petitioner told him that she had some intermittent discomfort in her upper back and that she had some pain in her lower back, and that she had some occasional pain in the left lower extremity but denied any pain into the right lower extremity. (RX3).

Dr. Petkovich testified that his review of the various medical records in the case were significant in that Petitioner had a long-standing history of seeing a chiropractor for her spinal conditions, which was in the history that Petitioner gave him when he saw her on August 20, 2014. He testified that Petitioner indicated to him that she had been going to the Nobbe Family Chiropractic for a number of years prior to April 23, 2014 and that she had a disc problem in her spine secondary to an automobile accident a number of years prior to that time. He testified that the medical records that he reviewed from Nobbe Chiropractic were from May 16, 2011 through April 1, 2012. (RX3).

Dr. Petkovich testified that he believed that on April 23, 2014, Petitioner sustained a cervical strain, thoracic strain and lumbar strain. He testified that when he saw her on the date of the IME, she had completely recovered from the strains from the incident on April 23, 2014. He testified that he believed that Petitioner had reached maximum medical improvement regarding her thoracic and lumbar spine strains when she was seen for evaluation and examination on August 20, 2014. He testified that he did not believe that Petitioner required any further medical treatment for her thoracic or lumbar spines as of the time of his examination. He testified that Petitioner should have recovered from her soft tissue strains within six weeks of the incident. He testified that Petitioner described to him the work that she was doing for the State of Illinois, and that he believed that she was able to continue working at that job at that time. (RX3).

On cross examination, Dr. Petkovich testified that he has done disc replacements. He agreed that the word "Apex" was not used in his report. He testified that he did not remember whether Petitioner had any cervical symptoms before the incident, but he knew that she had thoracic and lumbar symptoms. He agreed that he testified that he expected cervical sprains and strains to resolve in approximately six weeks after an injury. He testified that he did not remember whether Petitioner ever had a prior MRI of her cervical spine and agreed that his report did not mention any prior MRI of her cervical spine. He agreed that his report of August 27, 2014 did not mention anything about the findings of the prior MRI of the lumbar spine. (RX3).

On cross examination, Dr. Petkovich denied that he was asked to do an AMA rating. He denied having spoken or examined Petitioner since August 20, 2014. (RX3).

The transcript of the deposition of Dr. Robson was entered into evidence at the time of arbitration as Respondent's Exhibit 4. Dr. Robson testified that he is a board-certified orthopedic spine surgeon. He testified that he performs approximately 300 spine surgeries per year. He testified that he was asked to perform an IME of Petitioner on April 21, 2015. (RX4).

Dr. Robson testified that Petitioner told him that on April 23, 2014, she was working for Respondent and sustained an injury to her neck and low back, that she was pushing and pulling while trying to open a stubborn gate and that she developed pain. He testified that Petitioner described pain in her neck and low back, and that she complained of pain, numbness and tingling in both hands and in the back of both legs. He testified that on physical examination, Petitioner had some tenderness in her neck area as it had recently been operated on and that there was limited range of motion of her cervical spine due to her recent surgery. He testified that in her lumbar spine, Petitioner was restricted in flexion to 45 degrees, which would be half of what normal would be. He testified that he felt that Petitioner sustained a herniated disc at C5-6 and C6-7, had a disc replacement which was appropriate surgery, and had degenerative disc disease in her lumbar spine between the 4th and 5th vertebrae, a little bit worse on the left side, which was present prior to the April 23, 2014 injury. (RX4).

Dr. Robson testified that he opined that the accident as described accounted for her herniated discs in her neck at two levels and the strain of her lumbar spine, which was somewhat symptomatic and being treated prior to the accident. He testified that Petitioner had medical records going back to at least 2011 when she had an MRI of her lumbar spine, and that there were pre-injury medical records which talked about low back pain in March and November of 2013. He testified that there was a May 18, 2011 MRI which showed an annular tear at 4-5 and moderately severe left foraminal stenosis, which was roughly equivalent as compared to the November 26, 2014 MRI from Professional Imaging. He testified that he agreed with the treatment of the C5-6, C6-7 disc replacement, and that as to the lumbar spine, he felt that Petitioner had already had physical therapy which he thought was reasonable and that any further treatment would relate to her pre-existing condition. He testified that he has not reviewed any other medical records regarding Petitioner since April 21, 2015. (RX4).

On cross examination, Dr. Robson testified that it was his understanding that Petitioner was pulling and pushing to open a stubborn gate when she began to have low back pain and neck pain and that the first struggle was her low back and the second struggle was her neck. He agreed that the event had a sufficient amount of force to cause the disc herniation in her cervical spine, and testified that Petitioner never really had pre-existing cervical symptoms so he attributed the incident to causing her herniated discs. When asked if the mechanism of injury could also produce an aggravation of someone's pre-existing lumbar spine condition, Dr. Robson testified that he thought it would temporarily but that he did not see any evidence that it would do it on a long-term basis based on the fact that there was no real change in the imaging studies. (RX4).

On cross examination, Dr. Robson agreed that he was familiar with and used to practice with Dr. Raskas. He denied having reviewed Dr. Raskas's deposition. He testified that he thought the foraminal stenosis on the two MRIs were comparable and maybe minimally worse. He agreed that an annular tear could cause symptoms in the low back. When asked if an annular tear could be made symptomatic by a traumatic event, Dr. Robson responded that Petitioner was already symptomatic from her annular tear and was seeking treatment and complaining about her back as recent as a few months before her accident. (RX4).

On cross examination, Dr. Robson agreed that Petitioner was seen in November of 2013 for her low back and was recommended to continue exercises and weight loss. He agreed that when Petitioner started seeing Dr. Raskas, he recommended things for her that were different and more extensive than exercises and weight loss and that he recommended injections. He testified that he did not have any records that showed what intervention occurred as a result of the MRI in May of 2011, and that he did not review any records talking about injections. When asked if he would agree that someone could have an increase in their symptoms that could be a permanent aggravation without necessarily seeing a change in pathology on the MRI, Dr. Robson responded "I guess you can fantasize that that might occur, yes." (RX4).

On cross examination, Dr. Robson testified that Petitioner reported to him that her symptoms got worse after the accident. He denied ever suspecting Petitioner to be dishonest with him as to her symptoms. He agreed that the cervical spine condition was related to the accident and that the surgery that she had was reasonable, necessary and related to the accident. He agreed that to his knowledge, Petitioner was working full duty with no restrictions prior to April 23, 2014 to the best of his knowledge and then was unable to work full duty following that injury for some time. He agreed that he did not see any records with any restrictions for the lumbar spine prior to the April 2014 accident. (RX4).

On cross examination, Dr. Robson agreed that he did not have any information regarding a November 18, 2014 injury. He testified that he did not have any opinions about whether the November 2014 incident caused any aggravation to either her cervical or lumbar spine. He agreed that with regard to the lumbar spine, he felt that Petitioner was at maximum medical improvement when he saw her and that he believed that she reached maximum medical improvement at the time of her last visit with Apex Physical Therapy. He agreed that Dr. Raskas had not released her at maximum medical improvement. (RX4).

On cross examination, Dr. Robson denied having seen any other reports of any other accidents that occurred that would have accounted for her continued lumbar complaints and further testified that foraminal stenosis was a degenerative condition. (RX4).

CONCLUSIONS OF LAW

The parties stipulated at the time of hearing that on April 23, 2014 and November 18, 2014, Petitioner sustained accidents that arose out of and in the course of her employment with Respondent. (AX1; AX2).

With respect to disputed issue (F) pertaining to causal connection, the Arbitrator finds that Petitioner has failed to prove that her current condition of ill-being in the lumbar spine is causally related to either the accident of April 23, 2014 or November 18, 2014, but that Petitioner has proved that her current condition of ill-being in the cervical spine is causally related to the accident of April 23, 2014.

In so concluding, the Arbitrator finds to be significant in this case the fact that pre-accident medical records reflect complaints of ongoing low back pain within mere months of the accident of April 23, 2014. Furthermore, the records entered into evidence at the time of arbitration demonstrate that Petitioner's complaints in 2011 were apparently significant enough to warrant the performance of an MRI of the lumbar spine on May 18, 2011 which, per Dr. Robson, showed an annular tear at L4-5 and moderately severe left foraminal stenosis and was "roughly equivalent" as compared to the November 26, 2014 MRI from Professional Imaging. (RX4). Additionally, the Arbitrator finds to be highly significant the fact that at the time of the July 29, 2014 visit at Preferred Spine & Rehab Center, it was noted that Dr. Renner did not feel that Petitioner's subjective findings were consistent with the objective findings observed and, similarly, that at the time of the Initial Evaluation at Apex Physical Therapy performed on October 6, 2014, it was noted that Petitioner demonstrated severely guarded movement through the evaluation and self-limited due to pain, that she demonstrated significantly impaired active range of motion of the hips and lumbar spine due to complaints of pain, and that the findings were inconsistent with the diagnosis. (PX5; PX11). These inconsistencies, when coupled with Petitioner's presentation at the time of arbitration wearing heels approximately three inches in height, causes the Arbitrator to question the veracity of Petitioner's testimony as to her ongoing subjective complaints in the lumbar spine. As a result thereof, the Arbitrator places greater reliance upon the opinions of Dr. Robson as to the issue of causation as it pertains to the lumbar spine and finds that Petitioner reached maximum medical improvement in the lumbar spine on November 11, 2014, which was the conclusion of her initial period of physical therapy directed at the lumbar spine. The Arbitrator further finds that any medical treatment for the lumbar spine performed after November 11, 2014 was not reasonable, necessary or causally related to the underlying accident of April 23, 2014.

Additionally, as it pertains to the accident of November 18, 2014, the Arbitrator finds that Petitioner's testimony regarding the body parts allegedly injured as a result of the accident is wholly inconsistent with the medical records entered into evidence at the time of arbitration. The Arbitrator notes that Petitioner testified that when she pulled the conference table, pain shot through her back and that she injured her neck and lower back. The initial post-accident treatment records of Dr. Raskas, however, noted that Petitioner felt immediate pain in between her shoulder blades. (PX7). As a result of such a significant inconsistency, the Arbitrator finds that Petitioner has failed to prove that her current condition of ill-being in the lumbar spine is causally related to the accident of November 18, 2014.

In sum, the Arbitrator finds that Petitioner has failed to prove that her current condition of ill-being in the lumbar spine is causally related to either the accident of April 23, 2014 or November 18, 2014, but that Petitioner has proved that her current condition of ill-being in the cervical spine is causally related to the accident of April 23, 2014.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, the Arbitrator finds that Petitioner's care and treatment related to the cervical spine was reasonable, necessary and causally related to the work accident of April 23, 2014 but that only the treatment **rendered to the lumbar spine up to and including November 11, 2014** was reasonable, necessary and causally related to the work accident of April 23, 2014. As a result thereof, Respondent shall pay **for all treatment rendered to the cervical spine and for treatment rendered to the lumbar spine up to and including November 11, 2014** as contained in Petitioner's Exhibit 1 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to prospective medical treatment, in light of the Arbitrator's finding that Petitioner has failed to prove that her current condition of ill-being in the lumbar

spine is causally related to either the accident of April 23, 2014 or November 18, 2014. Petitioner's request for prospective medical treatment as recommended by Dr. Raskas is hereby denied.

With respect to disputed issue (L) pertaining to temporary total disability benefits, the Arbitrator notes that the parties stipulated at the time of arbitration that Petitioner was entitled to temporary total disability benefits for the timeframe of April 14, 2015 through June 17, 2016. (Transcript, pp. 6-7). As such, the Arbitrator awards temporary total disability benefits for this timeframe as agreed to by the parties. (AX1; AX2).

As to the additional temporary total disability benefits sought by Petitioner for the timeframe of June 18, 2016 through December 20, 2016, in light of the Arbitrator's finding that Petitioner has failed to prove that her current condition of ill-being in the lumbar spine is causally related to either the accident of April 23, 2014 or November 18, 2014, Petitioner's request for temporary total disability for the timeframe of June 18, 2016 through December 20, 2016 is hereby denied.

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

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Flora Massey,

Petitioner,

vs. NO: 13 WC 39278

State of Illinois/Secretary of State,

Respondent.

17IWCC0612

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 25, 2017 is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: SEP 29 2017

Stephen J. Mathis

SJM/sj
o-9/7/2017
44

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MASSEY, FLORA
Employee/Petitioner

Case# **13WC039278**

STATE OF ILLINOIS-SOS
Employer/Respondent

17IWCC0612

On 4/25/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0352 LaMARCA LAW OFFICES PC
WILLIAM LaMARCA
1118 S 6TH ST
SPRINGFIELD, IL 62703

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0514 ASSISTANT ATTORNEY GENERAL
GLISSON, RICHARD C
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

APR 25 2017

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

17IWCC0612

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Flora Massey
Employee/Petitioner

v.

State of Illinois - SOS
Employer/Respondent

Case # **13** WC **39278**

Consolidated cases: **N/A**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **February 24, 2017**. By stipulation, the parties agree:

On the date of accident, **May 1, 2013**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$50,622.00**, and the average weekly wage was **$973.50**.

At the time of injury, Petitioner was **74** years of age, ***married*** with **0** dependent children.

Necessary medical services as set forth in PX 12 will be paid by Respondent as stipulated.

Respondent shall be given a credit for any medical bills paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act. Temporary compensation benefits were not an issue.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of **$584.10/week** for a further period of **28.5 weeks**, as provided in Section **8(e)** of the Act, because the injuries sustained caused **15% loss of use of the left hand.**

Respondent shall pay Petitioner compensation that has accrued between **May 1, 2013** and **February 24, 2017** and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

April 17, 2017
Date

ICArbDecN&E p.2

APR 25 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW regarding NATURE & EXTENT

The Arbitrator finds:

Petitioner sustained an injury to her left hand due to repetitive job duties as a janitor for Respondent. Petitioner testified that she had been employed by Respondent as a janitor for approximately twenty years. Her job duties consisted of cleaning bathrooms, picking up trash, vacuuming, dusting and mopping. She was also required to polish brass requiring the use of both hands. Petitioner testified to developing left hand symptoms while engaged in the foregoing activities. Petitioner initially presented to her family doctor, Dr. Saunders, regarding her left hand complaints. Dr. Saunders referred her to Dr. Maender, an orthopedic surgeon.

Petitioner was examined by Dr. Maender on September 19, 2012. Dr. Maender ordered an EMG which showed left carpal tunnel syndrome. In his office note dated January 29, 2013 Dr. Meander described Petitioner's symptoms of left hand numbness and tingling and referred to the EMG results revealing severe left carpal tunnel syndrome. Dr. Meander recommended surgery. On May 2, 2013 Dr. Maender performed a left carpal tunnel release to address Petitioner's complaints of numbness and tingling in her left hand. (PX 3; PX 4)

After her surgery Petitioner followed up with Dr. Maender and she was referred for physical therapy. During this time her symptoms and complaints included edema and range of motion limitations. Therapy was addressing both of the foregoing and Dr. Maender was monitoring same. Dr. Maender examined Petitioner on May 29, 2013 at which time he released Petitioner to return to work on June 10, 2013 without any restrictions. At that visit Petitioner was still experiencing swelling in her left wrist but no warmth or ecchymosis. She also complained of pain around the dorsal and volar aspects of her hand. Motion had improved but she had not yet gained easy full range of motion. Dr. Maender wished for Petitioner to continue with occupational therapy and to return in one month. (PX 1)

When Petitioner returned to see Dr. Maender on June 25, 2013 she was reporting that her hand "felt cold" at times and that she was still attending physical therapy twice a week and it appeared to be helping. Examination of her wrist revealed no warmth, no erythema, no swelling, no induration, no ecchymosis and no tenderness. Her "strength [was] as expected given [her] post-op status." Dr. Maender described Petitioner's progress as "progressing slowly" but with excellent pain control and no signs of infection. He continued occupational therapy for an additional 4 to 6 weeks and wished to see her thereafter. (PX 1)

Petitioner went on a long distance trip to Atlanta after which she saw her primary care doctor on August 2, 2013. At that time Petitioner complained that her legs and feet had become swollen while on the trip. She wished for her blood sugars to be checked and they were. As of September 12, 2013 her legs and feet were still "a little swollen." (PX 3)

Dr. Maender continued to see Petitioner in September of 2013. Petitioner's complaints included residual numbness in her index and middle fingers, intermittent in nature. Range of motion and strength were "progressing." As of August 6, 2013 Dr. Maender felt Petitioner might not get complete return of her sensation due to the long-standing nature of her carpal tunnel prior to surgery. Petitioner agreed that her night-time pain and wakening that bothered her before surgery was gone. (PX 1)

Dr. Maender last examined Petitioner on January 21, 2014. At that time she was still reporting persistent numbness in two of her fingers and no improvement since their last visit. She denied any problems with her ring

or little finger. Dr. Maender described her finger range of motion as good with 5/5 strength to finger abduction and thumb opposition. No thenar or interossei atrophy was noted. Dr. Maender noted that Petitioner had undergone a left carpal tunnel release in May of 2013 with pre-existing severe carpal tunnel syndrome and polyneuropathy. She had received some improvement but she still had some residual numbness. She had not seen any improvement in the last several months. With her pre-existing numbness, he felt she might not get full relief of her numbness. He further felt that the release should, at least, keep her from getting any worse. Petitioner wished to simply observe things for a while and understood she could contact the doctor if they worsened. (PX 1)

At the request of Respondent, Petitioner underwent an independent medical exam with Dr. Li on June 3, 2014. A written report followed. (RX 1) It was Dr. Li's understanding that Dr. Maender had found Petitioner to be an maximum medical improvement as of January of 2014. He noted that Petitioner had returned to work as a janitor for Respondent. As part of the exam Petitioner completed a QuickDASH flow sheet[1] and her score was noted to be "75." Petitioner, who was an insulin dependent diabetic, had a well-healed scar on her left hand. Range of motion of her wrist was from 60 degrees of extension and 60 degrees of flexion. She had a positive Tinel sign at her wrist but a negative Phalen's test. There was decreased sensation to two-point discrimination at the longer finger. She had no evidence of any thenar or hypothenar atrophy. (RX 1)

Dr. Li's diagnosis was that of left carpal tunnel syndrome with residual dysfunction post-surgery. He noted that the objective findings on exam included severe loss or reduction of both sensory and moderate loss of motor conduction in the EMG/NCV test by Dr. Smucker. "It is impossible to distinguish symptoms from carpal tunnel versus diabetic neuropathy." (RX 1, p. 3/4) He felt her functional grade based on her QuickDASH score was severe and rated her upper extremity impairment at 6% and her whole person impairment at 4%. He felt she was at maximum medical improvement. (RX 1)

Petitioner returned to her primary care doctor, Dr. Saunders, on September 23, 2014 regarding her diabetes. At that time Petitioner also mentioned that her left hand had been cold ever since her carpal tunnel surgery. She also reported left lower leg pain that had started two days earlier. Petitioner's blood sugars were noted as well as the fact that she had osteoarthritis of multiple sites and could hardly walk from the handicap spot and needed a new placard. Petitioner was having some issues with vision but denied any numbness in her feet. With regard to her hand, Petitioner was referred to SIU Neurology. (PX 3)

Dr. Mueed at SIU Neurology examined Petitioner on December 17, 2014 noting her complaints of numbness and coldness in the left hand, especially digits 2, 3, and 4 which she dated back to her left carpal tunnel release. She also reported occasional hand pain. Physical examination of her hand revealed normal touch sensation, normal temperature sensation, and normal proprioception in both hands. Strength was normal. Dr. Mueed saw no specific symptoms or signs for carpal tunnel syndrome but did note the sensation of coldness followed the median nerve distribution. Gabapentin was prescribed for the symptoms with no guarantees. If that didn't help an EMG might be ordered. (PX 7)

Petitioner returned to see Dr. Mueed on July 21, 2015. Petitioner reported little relief with the Gabapentin. Her symptoms remained about the same. She was to increase the Gabapentin and an EMG was ordered. (PX 7)

Petitioner underwent an EMG with Dr. Mueed on August 17, 2015 and they revealed electrodiagnostic evidence of moderate left carpal tunnel syndrome affecting sensory and motor components as well as a mild

[1] Not included with the report

slowing of the ulnar nerve believed to be secondary to underlying peripheral neuropathy due to diabetes. Petitioner was to follow up with Dr. Mueed but it does not appear that she did. (PX 8)

Petitioner had another visit with Dr. Saunders on November 30, 2015 at which time she was seen for her diabetes and leg pain. Petitioner reported having undergone surgery for her left hand and seeing Dr. Mueed from SIU for ongoing pain, cold, and numbness. Petitioner described her hand as "a mess", noting that it felt dirty all the time. Another surgery had been suggested but she didn't wish to proceed. Treatment for Petitioner's hand was not discussed. Her diabetes was noted to be well controlled. (PX 3)

Petitioner presented to Dr. Brian Mailey on February 12, 2016 regarding her left carpal tunnel symptoms. Petitioner reported having undergone an endoscopic procedure earlier with some relief but now a recurrence of her symptoms although they weren't as severe as the first time. Petitioner reported severe cold intolerance, especially in this kind of weather. Petitioner reported numbness and tingling in the radial 3 ½ fingers of her left hand and pain throughout the entire hand making it difficult to perform activities of daily living. On examination Petitioner had a positive Tinel's sign and compression test of the carpal tunnel. Other aspects of the exam were negative. There was no numbness in the ulnar nerve distribution. Dr. Mailey's diagnosis was carpal tunnel syndrome and he suspected her cold intolerance could be related to vascular insufficiency. He recommended a trial of splinting and a work-up for vascular problems. Petitioner returned to see Dr. Mailey on March 11, 2016 reporting no change in her symptoms and no improvement with the splints. On exam she had no evidence of thenar atrophy and the digits appeared warm and well vascularized. Botox injections were discussed. Petitioner had not undergone the vascular studies but agreed to go forward with them. Those studies were performed on March 18, 2016 and were normal. (PX 9, 10)

Petitioner was examined by Dr. Nada Berry on April 25, 2016. On examination Petitioner had no evidence of any thenar atrophy. The digits were warm and well vascularized. Capillary refill was normal. Radial ulnar pulses were palpable. There was no appearance of Raynaud's Syndrome. She did have a positive Tinel's over the left carpal tunnel. Petitioner was diagnosed with carpal tunnel syndrome. Her nighttime symptoms in the radial nerve distribution were also noted as well as the fact that the cock-up splint had helped some. Petitioner did not wish to pursue any additional procedures at that time and her decision was felt reasonable as long as her symptoms were not persistent. She was released to return as needed. (PX 11)

Petitioner is right hand dominant. (PX 1)

Petitioner's case proceeded to arbitration on February 24, 2017 with the only disputed issue being the nature and extent of Petitioner's injury. Petitioner was the only witness testifying at the hearing.

Petitioner testified that upon returning to work after her surgery she noticed decreased grip strength in her left hand making it more difficult for her to perform her job duties. Petitioner testified she retired at the end of 2015. At the time of arbitration Petitioner testified that presently she continues having numbness and tingling, reduced grip strength and cold intolerance in her left hand.

Petitioner further testified to "working her hand" to feel better and described trouble taking a top off, a tendency to drop things, and a need to look at what she's doing when she uses her left hand because she can't feel. She also described a burning sensation at the tips of her fingers.

On cross-examination she acknowledged working full duty without any restrictions until she retired on December 31, 2015. After returning to work and prior to her retirement, she received her usual raises and step

increases. On redirect examination she added that after she returned to work it was a little harder to perform some of her job duties.

On further cross-examination Petitioner acknowledged being an insulin-dependent diabetic for the last five years because the pills she was taking made her sick. She also acknowledged that doctors wanted to perform further surgery but she didn't wish to undergo anything further.

On redirect examination Petitioner denied experiencing numbness in any other parts of her body.

With regard to the nature and extent of Petitioner's injury, the Arbitrator concludes:

Section 8.1(b) of the Act establishes the criteria for determining permanent partial disability. It states:

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.

Pursuant to §8.1b (b) the Arbitrator bases her determination of permanent partial disability on the following factors:

i) The reported level of impairment. Respondent submitted an impairment rating issued by Dr. Li; however, Petitioner was not through with her medical treatment at that point in time. He rated her upper extremity impairment at 6% and her whole body impairment at 4%. The Arbitrator gives less weight to this factor due to the timing of the report. That is, Petitioner went on to seek treatment from other doctors thereafter and Respondent did not obtain a more current impairment rating.

ii) The occupation of the injured employee. Petitioner was a janitor for Respondent. She was released to return to work as a janitor with no restrictions. She retired as of December 31, 2015. While Petitioner's injury was to her non-dominant hand, her job did require the use of both hands and arms and she testified credibly to having more difficulty performing some job duties upon her return. Petitioner has retired and no evidence was presented suggesting her retirement related to her injury herein. The Arbitrator gives some weight to this factor.

ii) The age of employee at the time of the injury was 74 years old. Given Petitioner's more mature age, the Arbitrator reasonably infers that Petitioner will have to live with the effects of her injury for a shorter time than that of a younger worker. Petitioner has also retired. The Arbitrator gives some weight to this factor.

iii) The employee's future earning capacity. Petitioner has voluntarily retired from her job with Respondent. She provided no testimony regarding employment since retiring or future employment plans, if any, or how her injury herein might affect any future earning capacity. Therefore, the Arbitrator gives less weight to this factor.

v) Evidence of disability as corroborated by the treating medical records. Petitioner underwent a left carpal tunnel release to her non-dominant hand with a less that excellent recovery. Her testimony

as to ongoing symptoms was credible and unrebutted as Respondent did not obtain an IME or an impairment rating. Petitioner's testimony regarding her ongoing complaints of numbness, coldness, and difficulties with her left hand was corroborated by her treating medical records, including extensive occupational therapy notes. It has been recommended that she undergo another surgery; however, she does not wish to do. The Arbitrator gives the most weight to this factor.

Based upon the foregoing factors, the Arbitrator awards Petitioner 15% loss of use of the left hand pursuant to §8(e)1.

****

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rhonda Jones,

Petitioner,

vs. NO: 13 WC 19079

SBM Business Equipment,

17IWCC0613

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

17IWCC0613

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: SEP 29 2017

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

SJM/sj
o-8/31/2017
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

JONES, RHONDA
Employee/Petitioner

Case# **13WC019079**

SBM BUSINESS EQUIPMENT
Employer/Respondent

17IWCC0613

On 6/29/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.34% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4129 WOLFE LAW PC
KENNETH WOLFE JR
200 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

1408 HEYL ROYSTER
LINDSEY D'AGNOLO
PO BOX 1288
ROCKFORD, IL 61105

17IWCC0613

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Rhonda Jones
Employee/Petitioner

Case # 13 WC 19079

v.

Consolidated cases: n/a

SBM Business Equipment
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Rock Island, on May 12, 2016. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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, December 21, 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 $29,992.56; the average weekly wage was $576.78.

On the date of accident, Petitioner was 52 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $2,526.85 for TTD, $9,122.48 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $11,649.33. The parties stipulated that all TTD and TPD benefits had been paid until the date of trial.

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 authorize and pay for prospective medical treatment including, but not limited to, the total knee replacement surgery recommended by Dr. Shawn Hanlon.

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)

June 15, 2016
Date

JUN 29 2016

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on December 21, 2012. The Application alleged that "Petitioner injured while working" and she sustained an injury to her right knee (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical expenses and prospective medical treatment, specifically, a total knee replacement. There was no dispute that Petitioner sustained a work-related injury; however, Respondent disputed liability on the basis of causal relationship. At trial, Petitioner and Respondent stipulated that all temporary total disability and temporary partial disability benefits had been paid in full (Arbitrator's Exhibit 1).

Petitioner testified that she had worked for Respondent for approximately 22 years. At the time of the accident, Petitioner was a sales manager. On December 21, 2012, Petitioner had shoveled snow off of the sidewalk adjacent to Respondent's place of business. When Petitioner walked back in to Respondent's premises, she did the splits and fell with her right leg going behind her. Petitioner's right knee cap struck the surface of the floor. Petitioner's right leg and knee became stiff and swollen, but Petitioner was able to finish her shift at work.

Petitioner's right leg/knee symptoms worsened and she went to the ER of CGH Medical Center the next day, December 22, 2012. The ER record contained a history of the work-related accident. Petitioner's right knee was x-rayed, she was given some medications and a knee immobilizer and instructed to follow up with her primary care physician (Petitioner's Exhibit 1).

Petitioner was subsequently seen at CGH Medical Center by Jennifer Vance, a Physician's Assistant. P.A. Vance saw Petitioner on December 27, 2012, and January 18, 2013. P.A. Vance ordered an MRI scan which was performed on February 18, 2013. The MRI revealed a mild to moderate tear of the lateral meniscus, a mild lateral tibial plateau fracture, severe tricompartmental osteoarthritis, severe lateral subluxation/dislocation of the patella and a Grade 2 musculotendinous strain with evidence of a ganglion cyst near the lateral tibial plateau. P.A. Vance referred Petitioner to Dr. Shawn Hanlon, an orthopedic surgeon (Respondent's Exhibits 4 and 5).

Petitioner was initially evaluated by Dr. Hanlon on February 20, 2013. Dr. Hanlon noted that Petitioner had some right knee issues prior to the accident of December 21, 2012, and that Petitioner had been seen by Joshua Wade, a Physician's Assistant, in June, 2012. Dr. Hanlon examined Petitioner and reviewed the MRI scan. He opined that Petitioner had sustained a lateral tibial plateau fracture secondary to the accident. He treated Petitioner conservatively with continued use of the knee immobilizer, therapeutic exercises and medication. He also discussed possible injections for the arthritic condition and eventual arthroscopic treatment of the lateral meniscus tear. He also imposed some work/activity restrictions (Petitioner's Exhibit 2).

Petitioner continued to be treated by Dr. Hanlon from March through October, 2013. During this time, Dr. Hanlon continued to treat Petitioner's right knee conservatively with physical therapy, Synvisc injections and medication. He also continued to impose work/activity restrictions.

Petitioner's condition did not improve to any significant degree so Dr. Hanlon ordered another MRI scan (Petitioner's Exhibit 2; Respondent's Exhibit 5).

The MRI was performed on October 16, 2013, and it revealed a prior fracture of the tibial plateau, a complex tear of the body and anterior horn of the lateral meniscus, evidence of a partial tear of the lateral collateral ligament, severe chondromalacia of the patella and degenerative changes (Respondent's Exhibit 4).

Dr. Hanlon was deposed on October 7, 2015, and his deposition testimony was received into evidence at trial. Following the MRI performed on October 16, 2013, Dr. Hanlon evaluated Petitioner on October 24, 2013, and reviewed the MRI scan. He opined that because Petitioner's condition had not improved that arthroscopic surgery to address the lateral meniscus tear was appropriate. While waiting for authorization to proceed with the surgery, Dr. Hanlon saw Petitioner on November 27 and December 26, 2013, as well as January 28 and March 3, 2014 (Petitioner's Exhibit 3; p 8).

At the direction of Respondent, Petitioner was examined by Dr. Stephen Weiss, an orthopedic surgeon, on February 12, 2014. In connection with his examination of Petitioner, Dr. Weiss reviewed medical records provided to him by Respondent. Dr. Weiss diagnosed pre-existing degenerative joint disease of the right knee. He also diagnosed a lateral tibial plateau fracture and labral meniscal tear which he opined were secondary to the incident of December 21, 2012. In reaching his opinion as to causality, Dr. Weiss compared the MRIs performed in February and October, 2013, and noted that the more recent MRI revealed a "maturation" of the injury first documented in the earlier MRI. Dr. Weiss did not opine whether or not the pre-existing degenerative joint disease was aggravated by the accident of December 21, 2012 (Petitioner's Exhibit 5).

Subsequent to the examination by Dr. Weiss, Respondent authorized the arthroscopic surgery that had been previously recommended by Dr. Hanlon. On April 7, 2014, Dr. Hanlon performed arthroscopic surgery on Petitioner's right knee which he described as a partial lateral meniscectomy and debridement of the right knee (Petitioner's Exhibit 3; p 8).

Dr. Hanlon testified that he continued to treat Petitioner following the surgery. He ordered physical therapy and continued to impose work/activity restrictions; however, Petitioner's right knee condition did not improve. When he saw Petitioner on July 23 and September 11, 2014, he advised that he would attempt to secure approval for Synvisc injections, but that knee replacement surgery was an option (Petitioner's Exhibit 3; pp 9-10).

At the direction of Respondent, Petitioner was examined by Dr. Kevin Walsh, an orthopedic surgeon, on December 21, 2014. In connection with his examination of Petitioner, Dr. Walsh reviewed medical records provided to him by Respondent. Dr. Walsh noted that Petitioner had severe osteoarthritis in her right knee prior to the accident of December, 2012. He opined that this condition was not caused, aggravated or accelerated by the December 2012 accident. He also opined that the meniscal tear was a degenerative change and not related to trauma. The only knee condition which Dr. Walsh opined was related to the accident was the tibial plateau fracture. Based upon the preceding, Dr. Walsh opined that the arthroscopic procedure that was performed

was not necessitated by the accident. In regard to a total knee replacement, he opined that procedure could benefit Petitioner, but that the need for surgery would be related to Petitioner's severe osteoarthritis and not to the December 2012 accident (Respondent's Exhibit 2).

Petitioner was subsequently seen by Dr. Hanlon on January 26, 2015, and her condition was unchanged. He renewed his recommendation that Petitioner have total knee replacement surgery; however, he referred Petitioner to Dr. Steven Glascow, an orthopedic surgeon, for a second opinion (Petitioner's Exhibit 3; p 11).

Dr. Glascow evaluated Petitioner on February 18, 2015. At that time, Petitioner advised Dr. Glascow of the accident of December 21, 2012, and that she had no prior knee injuries or arthroscopic surgeries to the right knee. Dr. Glascow opined that Petitioner should have a total knee replacement. In regard to causality, Dr. Glascow initially noted that Petitioner "... was without complaint or prior injury to her right knee until 12/21/12." He then opined that Petitioner tore the lateral meniscus and aggravated pre-existing arthritis of the patellofemoral joint (Petitioner's Exhibit 4).

Dr. Hanlon testified that he saw Petitioner in June, July, August and September, 2015, and that her right knee condition remained unchanged. He has continued to impose work/activity restrictions. In regard to causality, Dr. Hanlon testified that the lateral tibial plateau fracture and lateral meniscus tear were related to the accident. In regard to the arthritis, Dr. Hanlon acknowledged that Petitioner had pre-existing arthritis in her right knee, but that the accident aggravated it to where a total knee replacement is her only viable option (Petitioner's Exhibit 3; p 12).

Dr. Walsh was deposed on January 11, 2016, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Walsh's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. In explaining his opinion regarding causality, Dr. Walsh stated that the osteoarthritis pre-existed the accident and the medical records did not state that Petitioner was diagnosed with an aggravation of that condition. In regard to the meniscal tear, he noted that it was in the lateral compartment of the knee where Petitioner also has osteoarthritis. Dr. Walsh stated that it was a complex tear consistent with a degenerative change. In regard to the tibial plateau fracture, Dr. Walsh stated that it was related to the accident; however, it was a minimal fracture that healed uneventfully (Respondent's Exhibit 1; pp 21-25).

Dr. Walsh also testified that Petitioner's degenerative osteoarthritis was progressive and likely to get worse. He agreed that the cure for this would be a total knee replacement, but related this to the osteoarthritic condition and not the accident (Respondent's Exhibit 1; pp 25-27).

On cross-examination, Dr. Walsh was asked whether the Petitioner falling, striking and twisting the right leg behind her could cause a meniscal tear. He agreed that it could, but stated that this was not how the injury was described to him. Dr. Walsh stated that the accident, as it was described to him, would not aggravate the pre-existing degenerative osteoarthritis because it was not substantial enough. In regard to injuries that he would consider to be substantial, he used the

example of fracturing the femur or tibia. He opined that the tibial plateau fracture was only minimal and not such a substantial injury (Respondent's Exhibit 1; pp 29-31).

At trial, Petitioner agreed she has some right knee problems that pre-dated the accident of December 21, 2012. However, Petitioner's treatment was minimal and limited to some anti-inflammatory medications. Petitioner did not lose any time from work and was not subject to any work/activity restrictions because of the right knee symptoms prior to December 21, 2012.

The medical records of CGH Medical Center for treatment Petitioner received on June 12, 2012, indicated that Petitioner twisted her right knee and had experienced pain since June 1 and that the pain was worse with activity. An x-ray of the right knee was obtained which revealed degenerative joint disease with lateral subluxation of the patella. Petitioner was again seen at CGH Medical Center on June 14, 2012, for knee pain. The only treatment recommendation indicated in the record was that Petitioner was given some medication (Respondent's Exhibit 5).

At trial, Petitioner testified that she has continued to be treated by Dr. Hanlon who she sees on a monthly basis. Petitioner still has work/activity restrictions of working no more than seven hours per day, a maximum of 35 hours per week and a 30 pound lifting restriction. Petitioner is still employed by Respondent as sales manager; however, Petitioner no longer receives holiday pay, sales commissions or overtime. Petitioner still has severe right knee pain and wants to proceed with the surgery recommended by Dr. Hanlon.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to her right knee is causally related to the accident of December 21, 2012.

In support of this conclusion the Arbitrator notes the following:

Petitioner's description of how she sustained the work-related accident on December 21, 2012, was unrebutted. Immediately following the accident, Petitioner's right knee became stiff and swollen and she sought medical treatment the following day.

Petitioner had some right knee symptoms in June, 2012, approximately six months prior to the accident of December 21, 2012. However, the medical treatment Petitioner received at that time was limited to two medical appointments, an x-ray and some anti-inflammatory medications. Petitioner did not lose any time from work and no work/activity restrictions were imposed prior to the accident of December 21, 2012.

Petitioner's treating physician, Dr. Hanlon, opined that the torn lateral meniscus and tibial plateau fracture were related to the accident of December 21, 2012. In regard to the degenerative osteoarthritis of the right knee, Dr. Hanlon opined that this condition was aggravated by the accident of December 21, 2012.

Respondent's first Section 12 examiner, Dr. Weiss, opined that the tear of the lateral meniscus and tibial plateau fracture were related to the accident of December 21, 2012. He did not express an opinion as to whether the arthritic condition was aggravated by the accident.

Dr. Hanlon performed arthroscopic surgery to address the torn lateral meniscus and has continued to provide extensive conservative treatment for Petitioner's knee symptoms while recommending that she undergo total knee replacement surgery. He has also imposed work/activity restrictions which were still in effect at the time of trial.

At Dr. Hanlon's request, Petitioner was evaluated by Dr. Glascow, who agreed that Petitioner's pre-existing arthritic condition was aggravated by the accident of December 21, 2012, and that Petitioner should have a total knee replacement surgery. While Dr. Glascow's report erroneously stated that Petitioner had no right knee complaints prior to the accident, his report accurately stated that Petitioner had no prior knee injuries or arthroscopic procedures performed.

Respondent's second Section 12 examiner, Dr. Walsh's, opinion in regard to whether the accident caused the lateral meniscus tear was contrary to the opinion of Respondent's first Section 12 examiner, Dr. Weiss. Dr. Walsh opined that the accident was not substantial enough to aggravate the pre-existing arthritic condition.

The Arbitrator finds that Petitioner's testimony that she had only minimal right knee symptoms before the accident of December 21, 2012, and severe symptoms thereafter was credible. Petitioner only had minimal medical treatment for her right knee pain prior to December 21, 2012, and extensive medical treatment thereafter. Further, Petitioner had no work/activity restrictions imposed upon her prior to December 21, 2012, but had, and continues to have, significant work/activity restrictions imposed on her following the accident of December 21, 2012.

Based upon the preceding, the Arbitrator finds the opinions of Dr. Hanlon and Dr. Glascow to be more credible than that of Dr. Walsh. He also finds the opinion of Dr. Weiss in regard to causality of the lateral meniscus tear and tibial plateau fracture to be credible.

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

The Arbitrator concludes that Petitioner is entitled to prospective medical treatment including, but not limited to, the total knee replacement surgery as recommended by Dr. Hanlon.

In support of this conclusion the Arbitrator notes the following:

Dr. Hanlon, Dr. Glascow and Dr. Walsh all agree that Petitioner needs right total knee replacement surgery.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bryan Ritzel,

Petitioner,

vs.

NO: 15 WC 42612

State of Illinois/Chester Mental Health,

Respondent.

17IWCC0614

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 18, 2017 is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: SEP 29 2017

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

SJM/sj
o-9/21/2017
44

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RITZEL, BRYAN
Employee/Petitioner

Case# **15WC042612**

17IWCC0614

SOI/CHESTER MENTAL HEALTH CENTER
Employer/Respondent

On 4/18/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.94% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
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

1745 CMS - RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

APR 18 2017

DONALD A. RASCHIA, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0614

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

BRYAN RITZEL
Employee/Petitioner

v.

STATE OF ILINOIS/CHESTER MENTAL HEALTH CENTER
Employer/Respondent

Case # **15** WC **42612**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **October 12, 2016**. By stipulation, the parties agree:

On the date of accident, **August 9, 2015**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$64,088.44**, and the average weekly wage was **$1,232.47**.

At the time of injury, Petitioner was **39** years of age, ***single*** with **0** dependent children.

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

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

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of **$739.48**/week for a further period of **25** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **5% loss of use of the person as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **June 28, 2016** through **October 12, 2016**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

April 12, 2017
Date

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

17IWCC0614

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT

BRYAN RITZEL
Employee/Petitioner

v.

Case #: 15 WC 42612

STATE OF ILLINOIS/CHESTER MENTAL HEALTH CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on August 9, 2015, Petitioner sustained an accident which arose out of and in the course of his employment with Respondent, resulting in multiple injuries. Respondent has paid, or will pay, all related medical bills directly to the providers, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. The parties further stipulated that the only issue in dispute was the nature and extent of Petitioner's permanent partial disability.

On the date of accident, August 9, 2015, Petitioner was 39 years old, single, and had no dependent children. He was employed as a Registered Nurse at Respondent's facility. On that date, Petitioner was walking into the module to set up his medication and was struck in the face by a combative mental health patient. Petitioner testified that prior to the accident he had received no care, treatment, diagnostic testing, or claims for his cervical spine, face or head.

Petitioner sought treatment at the emergency room and then followed up with his family physician, Dr. Molnar. He missed five days of work, for which he was paid by Respondent, and then returned to full duty. He was subsequently seen by Dr. Raskas, who performed diagnostic testing and restricted his work to only eight hours a day and 40 hours a week. He worked with those restrictions for about three months, as looking downward when working caused a lot of pain in his neck. He testified that he eventually asked Dr. Molnar to lift the hour limitations in February 2016, and that he has worked overtime hours since then. Currently, his nose and head are not causing issues, but he continues to have symptoms related to his neck. His job as a Registered Nurse requires him to have his head in a flexed position while reading charts, which bothers him a good deal. He is especially bothered when he works overtime, which is mandated once or twice a week. He also experiences symptoms when driving down a bumpy road on the highway, attempting to ride a 4-wheeler, or bending his neck forward. He has limited the use of

his motorcycle, as the pressure from the helmet and the wind when he rides irritates his neck. He takes 800mg of Ibuprofen three to four times a week for his symptoms.

On cross-examination, Petitioner acknowledged he had not returned to Dr. Raskas since May 2016 and had not returned to Dr. Molnar since June 2016. He agreed that he had been working in excess of 40 hours a week for the past three to four months. He acknowledged his job performance evaluation had not suffered due to this injury, and he had not missed any pay raise due to the injury.

Respondent's Exhibit 1 consisted of several reports regarding the accident, including Employer's First Report of Injury, Supervisor's Report of Injury, and Employee's Notice of Injury. All of the reports are consistent with each other and with Petitioner's testimony. RX1.

Following the accident, Petitioner presented to Chester Memorial Hospital Emergency Room. He reported a consistent history of the accident and complained of headache and severe pain in his neck, at the base of his skull. He was diagnosed with a neck strain and instructed to follow up with his family physician. PX3.

On August 10, 2015, Petitioner followed up with his family physician at Chester Clinic and was examined by Physician's Assistant Angela Albertini. He gave a consistent history of the accident and reported he had continued headache, neck pain, and bilateral shoulder pain. On examination, he had mild tenderness over the cervical paraspinals. PA Albertini diagnosed cervicalgia, discussed possible referral to physical therapy, and instructed continued use of Flexeril. Petitioner followed up with PA Albertini and Dr. Molnar at Chester Clinic throughout August, September, and October and continued to report neck pain. On November 3, 2015, he underwent a cervical MRI, which revealed a mild disc protrusion at C3-4 "slightly more prominent than before", possible small disc protrusion at C4-5, and mild bulge at C5-6. The report noted comparison was made to a prior MRI of December 19, 2014. Petitioner continued to follow up with Chester Clinic in January, February, and March 2016 with continued complaints of neck pain. He participated in two courses of physical therapy, which seemed to exacerbate his symptoms. He was referred to Dr. Raskas. PX4.

On March 4, 2016, Petitioner presented to Dr. David Raskas of Orthopedic Sports Medicine & Spine Care Institute. He reported a consistent history of the accident and his treatment to date. He noted the pain was aggravated with sitting, twisting, stress, bending forward, and work activities. On examination, cervical range of motion was full and without pain; strength and sensation were intact. Dr. Raskas ordered a repeat MRI, which was performed on March 18, 2016. Petitioner returned to Dr. Raskas that same day, who advised the MRI revealed disc herniations at C3-4 and C4-5 and diffuse disc displacement at C5-6. Dr. Raskas noted there was no spinal cord compression. He recommended a trial of anti-inflammatory medication and no working more than 40 hours per week. PX6, PX8.

On May 6, 2016, Petitioner returned to Dr. Raskas and reported continued neck pain. He stated it was especially exacerbated with looking downwards and charting constantly at work and that the pain became intractable if he worked more than eight hours a day. On examination, his neck range of motion was not limited, strength was normal, sensation was intact, reflexes were

symmetric, nerves and pulses were intact, and gait was normal. Dr. Raskas recommended Petitioner continue work restrictions of no more than 40 hours per week and continue use of Ibuprofen. He noted, "It may be that he may come to surgery in the future or he may improve in the future to the point where he does not need any restrictions at all, but I think for now his situation is unlikely to change in the immediate time." He released Petitioner at that time and instructed him to return if things worsened or changed. PX6.

Petitioner returned to Chester Clinic and Dr. Molnar on May 31 and June 28, 2016. He continued to report neck pain which was exacerbated by looking down. On June 28 he advised he was still able to work eight hours, did not need to take Ibuprofen on a daily basis, and believed he was capable of working without restrictions. He reported he had been adjusting to his neck pain and knew it was going to be there on a daily basis. He had been making adjustments from a mechanics factor to keep his neck in anatomic positions to avoid looking up or down for an extended period of time, which aggravated his neck pain. It was noted, "He reports that he feels that he can work more than 8 hours a day." Dr. Molnar noted his neck pain was ongoing and likely to be chronic. He released him to return to work without restriction, placed him at maximum medical improvement, and released him from care. PX4.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Facts, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. The parties stipulated to all issues, including average weekly wage. The only issue in dispute at the time of hearing was the nature and extent of permanent partial disability. With regard to the nature and extent of disability, for accidents occurring on or after September 1, 2011, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors.

In regard to factor **(i) the reported level of impairment pursuant to Subsection (a)**, although Petitioner's date of accident was after the effective date of Section 8.1b of the Act, neither party offered into evidence a reported level of impairment pursuant to subsection (a). As such, the Arbitrator gives no weight to this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a Registered Nurse at the time of the accident. He worked with restricted hours for several months before requesting a full release. The record is consistent that the specific task of looking down for an extended period of time to chart patient's records exacerbated Petitioner's neck pain. The Arbitrator notes this task is an integral part of Petitioner's job duties. The Arbitrator places significant weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 39 years old at the time of the accident. He has returned to his prior position without restrictions. He can be expected to continue working for a number of years and over time his condition could improve, stay the same, or get worse. The Arbitrator gives some weight to this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner returned to his prior position full duty, with no change in pay. There was no evidence offered to show that his future earning capacity has been impacted, and the Arbitrator has no basis to expect he will have any decreased earning capacity in the future. The Arbitrator gives no weight to this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes that Petitioner's complaints are well-documented in his medical records throughout his treatment with both Chester Clinic and Dr. Raskas. He testified that he continued to have pain with certain activity, most significantly when his head was in a flexed position while reading charts. The MRIs reveal herniations at C3-4 and C4-5 and diffuse disc displacement at C5-6. The Arbitrator notes, however, that the MRI report of November 3, 2015, referenced a prior MRI of December 19, 2014, and noted the current findings at C3-4 were "slightly more prominent than before". The Arbitrator takes this into consideration, especially in light of Petitioner's testimony that he had never had a prior injury to his neck. Dr. Raskas' note following Petitoner's final visit of May 6, 2016, documents Petitioner continued to have neck pain, but further documents his physical examination was entirely normal. Dr. Molnar's note following Petitioner's final visit of June 28, 2016, documents Petitioner continued to have neck pain. He had made adjustments to his neck positioning and activities, had reduced his use of Ibuprofen, and felt he could work without the time restrictions. Dr. Molnar noted his neck pain was likely going to be chronic. The Arbitrator places significant weight on this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration, and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 5% loss of use of the person as a whole (25 weeks) pursuant to Section 8(d)2 of the Act. The parties stipulated that Petitioner's average weekly wage was $1,232.47. The Arbitrator finds that his permanent partial disability rate is $739.48.