STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DELORES AMMONS-LEWIS,

Petitioner,

vs. No. 02 WC 24977

WATER RECLAMATION DISTRICT OF GREATER CHICAGO,

Respondent.

ORDER

This matter comes before the Commission on Petitioner's "Motion for Supplementing her Statement of Exceptions and Brief with Exhibits 1 to 5." In her motion, Petitioner asks that the record before the Commission be supplemented with e-mail correspondences between herself and Workers' Compensation Commission Executive Director Carolyn Parks, e-mail correspondence between herself and her lawyer, and from her lawyer to Arbitrator Pulia, as well as certain other records of the Commission. Petitioner asks the Commission to include extraneous material which is not within the record before us. We are specifically prohibited from considering such material. The Workers' Compensation Act provides: "Decisions of an arbitrator or a Commissioner shall be based exclusively on evidence in the record of the proceeding and material that has been officially noticed." 820 ILCS 305 §1.1(e). Therefore, we deny Petitioner's motion.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's "Motion for Supplementing her Statement of Exceptions and Brief with Exhibits 1 to 5" is hereby DENIED.

DATED: MAY 18 2016

Ruth W. White

Charles J. DeVriendt

Michael J. Brennan

RWW/dw
O-4/27/16
46

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DELORES AMMONS-LEWIS,

Petitioner,

16IWCC0337

vs.

No. 02 WC 24977

WATER RECLAMATION DISTRICT OF GREATER CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Petitioner's Review of the Decision of Arbitrator Carlson refusing to reinstate Petitioner's Application for Adjustment of Claim. This matter had been previously dismissed and reinstated three times. It was dismissed on December 12, 2003, February 6, 2009, and December 8, 2009. It was then reinstated on January 22, 2004, May 18, 2009, and February 22, 2010. In the instant dismissal, the fourth, a hearing was held on Respondent's Motion to Dismiss before Arbitrator Carlson on June 13, 2014. Both parties were represented by counsel and a record was taken.

At the hearing, the Arbitrator noted that no Request for Hearing was submitted and the lawyers tried to have a pretrial at that time. Counsel for Petitioner informed the Arbitrator that he did not have all outstanding medical bills and did not know exactly how many days Petitioner lost from work. It was determined that Petitioner was back at work with Respondent and continued therapy and medications were prescribed but no surgery was recommended. The Arbitrator stated the matter "got a trial date today" because it had been pending for 12 years. Petitioner's lawyer indicated he understood that fact.

The Arbitrator also informed Petitioner's lawyer that he had to "have a good reason why the case hasn't been tried in the last three years." Petitioner's lawyer responded that they had tried to settle the case, "and then there have been the intervening cases," and there were outstanding subpoenas. Respondent's lawyer replied that it complied with the outstanding subpoena "years ago," and there had not been any action to enforce any subpoena. Petitioner's lawyer also conceded that he had not issued a letter for continuance prior to the hearing date.

16IWCC0337

The Arbitrator then indicated he was going to dismiss the case because "of the inability to move this case along through the system." Petitioner's lawyer asked that the case be tried the following Monday. The Arbitrator denied that request stating that Monday was not one of his trial dates, and the date of the hearing (regarding the dismissal) was the scheduled trial date. Petitioner's lawyer then asked to arbitrate the case *instanter*. The Arbitrator refused that request noting that he did not believe Petitioner's lawyer was actually ready to try the case. The record belies Petitioner's attorney's contention that he was ready to proceed to trial.

There appears to be two separate documents in the record memorializing the dismissal, an "Order" and a "Decision." Both documents are dated June 13, 2014, but neither of the copies in the record is file stamped. The "Order" dismissing the claim appears to be a form document in which it was noted the case was dismissed for want of prosecution by the Arbitrator because "the petitioner failed to appear at the status call or trial date." The case was dismissed "accordingly." That order appears to bear a stamped signature.

The "Decision" is more accurate, much more detailed, and includes "FINDINGS OF FACT AND CONCLUSION OF LAW." It appears to be hand-signed by the Arbitrator. There it is noted that the trial date had been set at a May 21, 2014 status call, no continuance letter had been sent to the Arbitrator as required under the Rules of the Commission, and at the pretrial Petitioner's lawyer was unable to provide specifics about medical treatment or temporary total disability claimed. Nevertheless, after being informed the claim was going to be dismissed, Petitioner's lawyer "incredibly stated that he was willing to try the matter." The Decision also noted that Petitioner had been back to work for some time and no surgery was recommended.

Petitioner filed her Petition to Reinstate on August 18, 2014 and a hearing was held on that petition on September 10, 2014. Once again the parties were represented by counsel and a record was taken.

At the beginning of the September 10, 2014 hearing, Petitioner's lawyer was not yet present. The Arbitrator began the hearing *ex parte* with Respondent's lawyer. He noted that the order of dismissal had a factual error in that Petitioner did in fact appear, but he also noted that the transcript made clear that she was not ready to proceed with trial at that time. Respondent's lawyer agreed with the Arbitrator's statement but added that the fact that Petitioner's lawyer asked for a continuance supported the Arbitrator's conclusion that he was not ready to try the claim. Petitioner's lawyer arrived after the Arbitrator began the hearing and stressed that error in the dismissal order. In arguing for reinstatement, he referred to the error in the order but did not mention the "Decision."

In addition, Petitioner's lawyer disputed the Arbitrator's assumption that nothing had been done on the case and indicated that they "have put forth the witnesses and the exhibits as far back as July 2011 by stipulation, in fact, at least by proposed joint exhibits with the district in July 2011, and we were prepared to, of course, to go to arbitration at that time before Judge Pulia. She was transferred, and then we went through a similar process" before Arbitrator O'Malley, but he was transferred as well. Petitioner's lawyer then once again asserted he was prepared to go forward with trial, asked for the matter to be reinstated, and asked that the Arbitrator set a trial date. Arbitrator Carlson denied Petitioner's Motion to Reinstate.

In denying the petition to reinstate the Arbitrator again noted Petitioner's lawyer's unpreparedness to proceed with trial when the Arbitrator indicated his intention to dismiss the case despite his request to arbitrate the matter *instanter*. Because it is not clear from the records of the Commission which or whether both of the documents memorializing the dismissal, the Order and the Decision, were actually filed, the Commission finds it prudent to issue a detailed decision upholding the decision of the Arbitrator rather than simply affirming and adopting.

Since the hearing on the Motion to Reinstate, Petitioner's latest lawyer withdrew on May 19 2015, and Petitioner is currently representing herself *pro se*. On review, Petitioner filed three documents all *pro se*: her brief; her "Motion for Supplementing her Statement of Exceptions and Brief with Exhibits 1 to 5 and Motion to Reinstate and Dismissal Order;" and her response to Respondent's response.

In her initial brief Petitioner again notes the error in the dismissal order without mentioning the decision. She also indicates that neither Petitioner nor her lawyer had received a copy of the order of dismissal until July 17, 2014, despite concerted effort. She also notes that Petitioner, her lawyer, and Arbitrator Carlson were not present at the status hearing on May 21, 2014, when the trial date was set.

Petitioner then recites actions allegedly preceding the hearing on June 13, 2014, in which Respondent's lawyer "saluted" the Arbitrator and informed the Arbitrator that Petitioner had filed for a "change of venue" based on the possibility that the Arbitrator was related to a person who worked for Respondent. Arbitrator Carlson then allegedly responded that he was not from Chicago but from Minnesota "and that should take care of that." Petitioner then asserts more facts not in the record, again indicating her lawyer did not receive a copy of the dismissal order and inserting her e-mail correspondence with Executive Director of the Commission Carolyn Parks.

Petitioner appears to base her Motion to Reinstate on the Arbitrator's error in the order of dismissal, a trial date was set despite the fact that neither party requested one, the Arbitrator's incorrect statement at the time of dismissal that any petition to reinstate should be filed with a Commissioner, that the parties had completed all pre-trials with Arbitrator Pulia and had been ready for trial, and that the Arbitrator erred and should have allowed Petitioner to proceed with arbitration when requested by Petitioner's lawyer at the time of the dismissal hearing.

In her supplemental brief, Petitioner asserts more alleged facts outside the record. She alleged that before the court reporter was present Respondent's lawyer told Arbitrator Carlson Petitioner's lawyer "wanted to file a motion for a change of venue, that Arbitrator Kurt Carlson turned **a settled case** in to a trial date and repeatedly said to the Petitioner's former attorney and her his boss told him to **get rid of the case** before he called for the IWCC court reporter" was called into the dismissal hearing. (emphasis in original). Petitioner also asks that the record before the Commission be supplemented with e-mail correspondences between herself and Executive Director Parks, e-mail correspondence between herself and her lawyer, and from her lawyer to Arbitrator Pulia, as well as certain other records of the Commission.

Commission Rule 7020.60 (C) provides in pertinent part:

16IWCC0337

"Cases on file 3 or more years.

i) In all cases which have been on file at the Industrial Commission for three years or more, the parties or their attorneys must be present at each status call on which the case appears. The case will be set for trial unless a written request has been made to continue the case for good cause. Such request shall be made part of the case file. The written request must be received by the Arbitrator at least fifteen days in advance of the status call date and contain proof of service showing that the request for a continuance was served on all other parties to the case and/or their attorneys. Any objection to a continuance in such case must be received by the Arbitrator at least seven days prior to the status call date and contain a similar proof of service. The Arbitrator shall rule on such requests for continuances or objections thereto at the status call. The parties must appear at the status call even if there is no objection to the continuance.

ii) Failure of the Petitioner or the Petitioner's attorney to request or answer a request for a continuance in accordance with subsection (b)(2)(C)(i) above and to appear at the monthly status call on which the case appears shall result in the case being dismissed for want of prosecution, except upon a showing of good cause.

iii) Where the Arbitrator has set the matter for trial, the case shall proceed on the date set by the Arbitrator."

Section 7030.90 of the Commission Rules basically provides that upon written Motion for Reinstatement, the principles of fairness and equity shall be applied.

The Arbitrator is correct that Petitioner did not comply with the requirements of Section 7020.60 of Commission rules and was within his right to dismiss the claim for want of prosecution. Petitioner's argument that she and her lawyer did appear at the status hearing appears to work against rather than for her because attendance at the status call was mandatory. Petitioner did not file a letter asking for a continuance as required by rule and under the rule if such a letter of continuance is not filed the case shall be tried on the trial date in over-the-line cases once set. It also appears the Arbitrator was correct not to grant a continuance at the hearing because no notice of the request had been made previously.

The Commission does not find persuasive Petitioner's and her lawyer's allegations that they had substantially pre-tried the case with Arbitrator Pulia and they were ready for trial years earlier. There is nothing in the record to support those assertions. In addition, Arbitrator Pulia actually dismissed the case on February 6, 2009. Finally, in this proceeding, Petitioner asks the Commission to consider extraneous allegations of fact which are not within the record before us. We are specifically prohibited from considering such matters. The Workers' Compensation Act provides: "Decisions of an arbitrator or a Commissioner shall be based exclusively on evidence in the record of the proceeding and material that has been officially noticed." 820 ILCS 305 §1.1(e). Therefore, we find the denial of reinstatement was proper and that decision is affirmed.

16IWCC0337

IT IS THEREFORE ORDERED BY THE COMMISSION that the denial of Petitioner's Motion to Reinstate her Application for Adjustment of Claim is hereby AFFIRMED.

DATED: MAY 18 2016

Ruth W. White

Charles J. DeVriendt

Michael J. Brennan

RWW/dw
O-4/27/16
46

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brian Cluskey,
Petitioner,

16IWCC0286

vs.

NO: 04 WC 17632

Henry-Senachwine CUSD #5,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 24, 1015, is hereby affirmed and adopted.

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

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

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

DATED: MAY 4 - 2016
o4/12/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

16IWCC0286

CLUSKEY, BRIAN
Employee/Petitioner

Case# **04WC017632**

HENRY-SENACHWINE CUSD #5
Employer/Respondent

On 4/24/2015, 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 0.09% shall accrue from the date listed above to the day before the 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:

0080 WINNE LAW OFFICE LLC
JOSEPH E WINNE
416 MAIN ST SUITE 300
PEORIA, IL 61602

1337 KNELL LAW LLC
MATTHEW BREWER
504 FAYETTE ST
PEORIA, IL 61603

16IWCC0286

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Brian Cluskey
Employee/Petitioner

v.

Henry-Senachwine CUSD #5
Employer/Respondent

Case # **04** WC **17632**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **January 23, 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 **Permanent Total Disability**

FINDINGS

On **April 15, 2003**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**46,199.95**; the average weekly wage was $**888.46**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **5** dependent children.

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

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

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

Respondent is entitled to a credit under Section 8(j) of the Act for all bills paid by its group health provider.

ORDER

- Respondent shall pay reasonable and necessary medical services causally related to Petitioner's headaches, depression and cervical injuries, as identified in Petitioner's Exhibit #20, as provided in Sections 8 (a) and 8.2 of the Act. Respondent shall be entitled to credit under Section 8 (j) for medical bills paid, as identified in Respondent's Exhibit # 16.

- Petitioner is not entitled to Temporary Total Disability benefits, as explained in the attached conclusions of law.

- Respondent shall pay Petitioner permanent disability benefits of 100 weeks at a rate of $533.08, as the accident caused injuries to the extent of 20 % Person As A Whole under Section 8 (d) (2) of the Act.

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

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

D. D. McCarthy
Signature of Arbitrator

April 21, 2015
Date

APR 24 2015

FINDINGS OF FACT

Brian Cluskey [hereinafter Petitioner] testified he was employed by Henry Senachwine High School [hereinafter Respondent] as an English teacher and coach on April 15, 2003. Petitioner testified that on this date, he was traveling on a school bus, returning to school from a track meet in Seneca, Illinois, when the bus made a sharp turn causing a large pop-up tent, weighing 60 pounds, to strike him his head on the right temple. Petitioner testified he was looking ahead he did not see the tent strike his head as he was looking ahead with one hand on the bus seat in front of him.

Petitioner testified that after he was struck, he saw stars, and his first memory was of the Assistant Coach pulling him off the floor. Petitioner testified that when he was struck by the tent, the left sick of his neck snapped. Petitioner testified his head and neck were sore and he had pain on the right side of his head in the temple area.

Petitioner testified that shortly after the accident, the bus arrived back at the school parking lot. Petitioner testified he was acting erratically and was using four letter expletives. Petitioner testified the Assistant Coach took him into the locker room away from the students, talked to him, and settled him down. Petitioner testified the Assistant Coach made sure all the student athletes were picked up and then followed Petitioner to his home.

Petitioner testified he woke up morning following the accident with excruciating headaches and he went to see his primary provider, Dr. Henry Gross. Petitioner presented to Dr. Gross on April 16, 2003 and provided a history of being struck on the right of the head by a tent pole weighing close to 100 pounds. (PX-8). Petitioner reported that he did not lose consciousness but he saw stars. (Id.). Petitioner indicated to Dr. Gross that he developed some generalized head pain and nausea and was having some difficulty focusing and concentrating. (Id.). Dr. Gross assessed a head injury and probable grade 0 concussion with post concussion syndrome.

Petitioner testified that prior to the accident, he was very active and enjoyed the outdoors, hiking, being outside, playing tennis, basketball, and running. Petitioner testified that he was training to run a marathon in June of 2003, was running several times a week, and had completed a long run of 18 miles prior to the injury.

Petitioner testified that in the days that followed the accident, he completed a 20 mile long run on a Saturday and chopped wood the day after that. Petitioner testified that after completing these activities, he lapsed into a bad headache.

Petitioner followed up with Dr. Gross on May 1, 2003 with complaints of recurrent headache, dizziness, nausea, and difficulty focusing that started three days ago after he ran 20 miles on 4/26/03 and chopped wood on 4/27/03. (PX-8). Dr. Gross' assessment was post concussion syndrome. (Id.).

A CT of Petitioner's sinuses was performed at OSF hospital on May 8, 2003 with an impression of trivial mucosal thickening in the maxillary sinuses with significant change since the previous study on December 3, 2002. (PX-8). A CT Scan of Petitioner's head was also performed on May 8, 2003 at OSF Hospital with an impression of unremarkable unenhanced CT of the head and paranasal sinuses; no imaging findings to account for symptoms. (Id).

Petitioner was next evaluated by Dr. Gross on May 28, 2003 with complaints of continued episodes of severe headache and dizziness. (PX-8). Petitioner noted he had some nausea, had difficulty sleeping, and complained of a right earache with the headache. (Id.). Dr. Gross' assessment was head injury and post concussion syndrome. (Id.).

Petitioner testified that in April and May of 2003 he had no big headaches. Petitioner testified by the summer of 2003, he was doing okay. Petitioner testified that on September 30, 2003, he was in the teacher's work room at lunch and a bad headache come over him. Petitioner testified that September 30, 2003 was one of the first times he had a headache to that degree. Petitioner testified that his bad headache was associated with extreme pain, nausea, and dizziness.

Petitioner presented to the OSF Emergency department on September 30, 2003 with a history of an abrupt headache. (PX-8). The records note Petitioner had a history of sinus headaches and also had a concussion in 2003 from getting hit in the head by a metal pole. (Id.). The records noted that usually sinus headaches come on slowly, whereas Petitioner's headache that day came all at once. (Id.). A CT scan of Petitioner's head were performed at OSF Hospital on September 30, 2003 with an impression of no acute intracranial abnormality. (Id.).

Petitioner followed up with Dr. Gross on October 2, 2003 where it was noted Petitioner had experienced a sudden onset of severe headache on September 30, 2003 in the right frontotemporal region. Dr. Gross' assessment was syncope, headache, and skin lesion, and he noted that the Petitioner had been having difficulty with headaches and dizziness since his accident. Dr. Gross referred Petitioner to undergo an EEG study. The EEG study was performed on October 6, 2003 at OSF with an impression of normal EEG awake. (PX 8)

Petitioner was evaluated by Dr. Christopher Zalleck of OSF Medical Group Neurology on November 5, 2003. (PX-11). It is reported in April, 2003 he experienced a mild head injury in which he was riding in a bus and a tent fell from its storage position down onto him striking the right side of his head. (Id.). Dr. Zalleck's records note that Petition potentially experienced a brief loss of consciousness, developed a headache that was located over the right hemi-cranium but also involved holocranial, and was intermittent but occurred almost daily. (Id.). Records note that Petitioner had reduction of headache over the summer and felt that it was going away. (Id.). Records note if the headache was more severe, Petitioner would have some dizziness and nausea. (Id.).

Dr. Zalleck's records note that Petitioner had an increase in headache without precipitating factor on September 30, 2003 with development of neck ache, pain, and stiffness. (PX-11). Records note that the only time Petitioner had a more severe headache is when he had viral meningitis in 1996. (Id.). Dr. Zalleck's impression was Petitioner was experiencing headache syndrome with suggestion of post-concussive syndrome. (Id.).

A CT scan of Petitioner's head was performed on November 22, 2003 at OSF with an impression of normal examination. (PX-8). A CT scan of Petitioner's cervical spine was performed on December 10, 2003 at OSF with an impression of mild degenerative disc desiccation at the C5-6 level with mild uncovertebral degenerative osteoarthropathy with narrowing of the neural foramen greater on the left than the right and mild degenerative disc change at the C4-5 level without specific encroachment of the neural elements. (Id.).

Petitioner testified that he did have sinus headaches prior to the work accident. Petitioner testified that a sinus headache was behind the nose, under the eyes, behind the eyes, and a surface type of headache that did not go into the head. Petitioner testified that he only would take over the counter type medication for his sinus headaches. On re-cross examination, he acknowledged that not all of his pre accident headaches were sinus headaches.

Prior to the accident, Petitioner presented to Dr. Robert Parrish of the Midwest Ear, Nose and Throat Associates on November 13, 2002 with complaints of terrible sinus pain and pressure. (PX-17). Records note that Petitioner had this several weeks prior and was treated with a 15 day course of Augmentin and had gotten better and then three weeks later it came back with a vengeance. (Id.). Dr. Parrish's assessment was possible chronic sinusitis. (Id.). Dr. Parrish recommended another course of Augmentin and a CT scan of the sinuses at the end of the treatment. Petitioner followed up with Dr. Parrish on December 13, 2002 where it is noted that he

obtained no response with the long term antibiotic treatment of his facial headache but that the headaches had gone away over the last few days prior to the visit. (Id.). Dr. Parrish's records note that the headaches are not related to the sinuses given the normal CT scan and may be more neurologic in origin either due to a muscle contraction or possibly even migraine. (Id.). Dr. Parrish noted that the headaches had gone away over the last few days prior to the visit. (Id.).

Petitioner was first evaluated at the Michigan Head Pain and Neurological Institute on April 21, 2004. (PX-16). Records indicate that Petitioner was struck in the right temporal area by a tent pole weighing about 60 pounds. (Id.). The poles and the tent itself were in a bag. (Id.). Records note that after being struck Petitioner fell to the floor of the bus. Records note that the next thing Petitioner remembers is his assistant coach helping him off the floor and pulling the tent off him. Records note that the Petitioner has a daily headache that is located in the right temporal area that lasts all day and is described as dullness or pressure with moderate pain. Records note there had been a period of improvement in the summer of 2003 but he suddenly began to experience daily headache again in September of 2003 that has continued. The records note that the petitioner has a second type of headache which begins in the right temporal area and extends across the head to the left and involves the neck as well. (PX-16). Records note that this headache is throbbing and sharp with associated migrainous symptoms such as sensitivity to sound, blurred vision, vertigo, dizziness, and nausea. Stress, deficit of sleep, travel, cervical range of motion, exercise or exertion, missed meals and hunger, as well as loud sounds will all seem to precipitate this headache which may occur at a moderate level several days a week and a more severe level three to four days a month. Petitioner reported that he did have occasional headaches prior to the work related accident in April of 2003. Petitioner described the first as a tension type headache at the top of the head, a dull ache that would occur once or twice a year, never associated with migraine symptoms and typically relieved by over the counter Excedrin. The second type of headache that he had prior to the accident of April of 2003 was sinus in type, located periorbitally and described as pressure. Petitioner testified he did recall being treated on August 11, 1995 with the worst headache of his life. Petitioner testified that he had meningitis. Petitioner reported to Michigan Head Pain and Neurological Institute that he had memory difficulty, concentration problems, sleep disturbance, depression, anxiety, and isolative behavior, as well as irritability associated with intensification of the headache. (PX-16). Records note he has withdrawn himself from coaching track because of the physical demands of that additional work load. Records note the Petitioner is an English teacher and finds it difficult enough to complete his workday as a teacher.

The Michigan Head Pain and Neurological Institute impression on April 21, 2004 was, assuming the accuracy of the history, was that the Petitioner was experiencing symptoms of post-traumatic headache with features of neuralgia and migraine. (PX-16). Records note that direct blow to the right temporal area may have also resulted in some injury to the left cervical facets and this area may also be a trigger for migrainous headache associated with exertion. (Id.). Records note that Petitioner is experiencing symptoms typical of a post-trauma, post-concussive syndrome, i.e., mood disturbance, sleep disturbance, and cognitive dysfunction. Michigan Head Pain and Neurological Institute's plan included a right temporal block and psychotherapy was recommended due to Petitioner's depression.

Petitioner followed up with the Michigan Head Pain and Neurological Institute on May 5, 2004, June 28, 2004, and his last examination took place on July 7, 2004. (PX-16). Petitioner's record on July 7, 2004 note that he has been denied further authorization of services at MHNI and will be returning to Dr. Gross for follow up treatment. On this date, Petitioner felt that overall he was improved and felt that he could go back to work. (Id.). Diagnosis on July 7, 2004 with MHNI was post-traumatic headache with neuralgia and migraine features.

Petitioner was referred to Dr. John Marshall of the Central Illinois Pain Management Center by Dr. Gross and was first evaluated on June 30, 2004. (PX-12). Dr. Marshall noted in his initial examination that Petitioner was struck on the right frontal temporal area by a 60 pound folded tent on April 15, 2003. (Id.). Petitioner indicated he experienced daily headaches emanating from the area where he was struck along with pain in his left upper

neck. (Id.). Dr. Marshall's assessment was Petitioner chronic daily posttraumatic headaches and performed a series of trigger point injections into the right frontotemporal scalp and his left upper later neck. (Id.). Petitioner underwent a series of injections with Dr. Marshall up through August 26, 2004.

Petitioner was examined by Dr. Koteswara Narla in an independent medical examination at the request of Respondent on February 13, 2004. (RX-10). The evidence deposition of Dr. Narla was taken on June 14, 2013. (RX-13). Dr. Narla testified he is board certified in neurology. (RX-13, p.8). Petitioner provided a history to Dr. Narla of being struck in the right side of the head and jaw when he was riding on a school bus on April 15, 2003, when the bus made a sharp turn causing a fold up tent to fall and strike Petitioner knocking to the floor. (RX-10). Dr. Narla indicated that Petitioner did not lose consciousness, and that the patient on careful questioning is not certain. (Id.). Dr. Narla noted that Petitioner noted that he did not lose consciousness, but he saw stars according to the record of Dr. Gross on April 16, 2003. (Id.). Dr. Narla noted Petitioner subsequently developed some generalized head pain and nausea and was having some difficulty in concentration and difficulty focusing. (Id.)

Dr. Narla testified that Petitioner's headaches were not associated with the photophobia but occasionally phonophobia. (RX-13, p.11). Dr. Narla explained that photophobia is bright light hurting his eyes and phonophobia is noise bothering people. (Id.).

Dr. Narla testified that he is not familiar with the grading of a concussion and did not know the difference between a grade 0 and a grade 1 concussion. (RX-13, pp.46-47). Dr. Narla testified that Petitioner did not have a constant pattern of headaches to be able to determine whether the headaches are the same from the injury headaches or different headaches that developed afterwards. (RX-13, p.26). Dr. Narla testified that "there is no way I can tell these headaches are not from the trauma." (RX-13, p.43). Dr. Narla testified that given the several month gap in between after the trauma, it is very unusual. (Id.). Dr. Narla admitted that Petitioner's sudden severe onset of headaches on September 30, 2003 in the right frontal temporal region was consistent with the area of trauma described by Petitioner. (RX-13, pp.37-38). Dr. Narla testified that he was not able to differentiate the headaches Petitioner had before his accident to after, except for the fact that Petitioner's headaches started in the temporal area after the head injury. (RX-13, p.63). Dr. Narla testified, "That was the one thing that he kept on mentioning, and it spreads through the whole head. It can happen." (Id.).

Dr. Narla testified that he would not classify Petitioner's condition as post-concussive syndrome but would instead call it a post-headache syndrome, as a concussion required one to lose consciousness. (RX-13, pp.38-39).

Dr. Narla was asked if he agreed with the statement that Petitioner's diagnosis was persistent headache with a post-traumatic component and likely contributory depression. (RX-13, p.51). Dr. Narla testified that any headaches will cause depression and if you have constant headaches, he did not disagree with the statement. (Id.).

Dr. Narla was asked if he agreed with the opinions of Dr. Peeples that the Petitioner sustained a concussion as a result of the incident of April 15, 2003 and that the Petitioner's subsequent symptoms of progressive headaches and depressive symptoms are possibly related to his head injury. Dr. Narla testified that the one thing Dr. Peeples said was the Petitioner had no significant history of headache. (RX-13, p.54). Dr. Narla cited an incident in 1995 where Petitioner reported to OSF Emergency Room with a very severe headache and several lumbar punctures were attempted. (RX-13, p.54). Dr. Narla had previously testified that it was felt on August 11, 1995 that Petitioner had viral meningitis as a suspected diagnosis. (RX-13, p.29). Dr. Narla testified that all of the Petitioner's pre-accident records in general speak to a finding of sinusitis except Dr. Parris (RX-13, p.30). Dr. Narla testified that he agreed that Dr. Parrish did not come to a conclusion for the type of headaches

Petitioner was experiencing on 11/13/02 and he noted that Dr. Parrish thought the headaches were not sinus related.

Dr. Narla testified that he has no idea what Petitioner's condition has been since his evaluation on February 14, 2004. (RX-13, p.43). Dr. Narla testified that he would have expected Petitioner to be better. (Id.).

Petitioner was examined by Dr. David Peeples in an Independent Medical Examination at the request of Respondent on August 16, 2005. (RX-11, Ex. 3). The evidence deposition of Dr. Peeples was obtained on April 23, 2008. (RX-11).

Petitioner provided a history to Dr. Peeples of being struck on the right temple region by a 60 pound tent on April 15, 2003 while traveling back from a track meet on a school bus. (RX-11, Ex. 3). Petitioner presented with a history of experiencing a daily headache occurring on the right side of his head. (Id.). Petitioner indicated that generally his headache is between 2-4 on a scale of 10 and he is able to function and teach with these, however, if the headache is between 5-6 he has difficulty with reading, and if intensity reaches 8/10 level he needs to go home. (Id.). Petitioner indicated to Dr. Peeples that he missed 35 days of work in 2003-2004 and 12 days of work in 2004-2005. (Id.). Petitioner admitted to Dr. Peeples that he was very depressed and he frequently cries when alone, has decreased energy, disruptive sleep, and at times has suicidal thoughts but does not have an actual plan. (Id.).

Dr. Peeples diagnosis was a post-traumatic headache syndrome, as well as depression. (RX-11, Ex. 3). Dr. Peeples opined that Petitioner sustained a blow to the head with a grade I concussion as a result of the incident on April 15, 2003. (Id.). Dr. Peeples opined that the Petitioner's subsequent symptoms of recurring headaches in the first few months after the incident are very clearly related to the episode of head trauma. (Id.). Dr. Peeples opined that the return of Petitioner's headaches in September of 2013 were somewhat atypical for post-traumatic headache syndrome, however, given the lack of prior history of headaches, in all likelihood the April 15, 2003 incident was a significant contributing factor, at least by way of precipitation of Petitioner's subsequent headache syndromes. (Id.). Dr. Peeples indicated that the previous documented problems that Petitioner had with sinus headaches would appear to be unrelated. (Id.). Dr. Peeples indicated it was reasonable for Petitioner to continue with his medications and he could continue to carry out his normal work activities as he has been doing. (Id.). Dr. Peeples opined that Petitioner was at maximum medical improvement and has a small amount of permanent partial disability as a result of the April 15, 2003 incident and residual symptomatology. (Id.).

Dr. Peeples also felt that Petitioner was having post-concussive headaches and also, depression was likely playing a roll. (Id.). Dr. Peeples testified that he was quizzical about the time lapse between the time of Petitioner's head injury and the apparent worsening of the headaches, which was a number of months later. (RX-11, pp.16-17). Dr. Peeples testified that the apparent worsening of the headaches was not what he would see with post-traumatic headaches, which made him think that perhaps there were other factors contributing, such as depression. (Id.).

Dr. Peeples testified that the treatment that Petitioner was receiving was appropriate for his ongoing headache complaints. (RX-11, p.17). Dr. Peeples felt that the Petitioner was at maximum medical improvement and would need to continue to treat with medications as indicated and that he could work without restrictions. (RX-11, p.17). Dr. Peeples testified that you can have post-concussive headache of varying severity with variable degrees of head injury and that headaches can occur after relatively mild head trauma. (RX-11, pp.17-18). Dr. Peeples testified that Petitioner got hit fairly forcibly on a moving vehicle with a 60 pound tent poll that knocked him to the ground, causing a welt on his head, so he had no question that Petitioner had a head injury. (RX-11, p.18). Dr. Peeples testified that you can have headaches of varying intensity following head injury and loss of consciousness is not required. (Id.).

Dr. Peeples testified that it is possible that Petitioners headaches had resolved, but he thinks that it is unlikely. (RX-11, p.21). Dr. Peeples testified that after traumatic induced headache disorders, if there is not resolution of symptoms or a plateauing of improvement within a year, then they are usually permanent. (RX-11, p.22). Dr. Peeples testified that Petitioner's medical treatment rendered up until the time of his independent medical examination on August 16, 2005 was "definitely reasonable." (RX-11, p.23). Dr. Peeples testified, "I've said all along, I feel that his headaches are related to his injury and post-traumatic in etiology." (RX-11, p.27).

Dr. Peeples testified that if Petitioner was seen at the Diamond Headache Clinic in Chicago on July 6, 2006, and made complaints of dizziness, nausea, photophobia, blurry vision, tingling of the fingers, and difficulty concentrating, then those symptoms, with the exception of the tingling in the fingers, would be consistent with the type of head injury that Petitioner suffered. (RX-11, p.27). Dr. Peeples further testified that if Petitioner told the doctor he was waking up every morning with a headache that would be consistent with Petitioner's type of injury. (Id.).

Petitioner was evaluated by Dr. George Nissan of the Diamond Headache Clinic on July 6, 2006. (PX-15). Petitioner presented with complaints of headaches that began in April, 2003 after he was hit in the head by an expandable tent. (Id.). Petitioner stated that his headache began immediately after this and became daily on September 3, 2003 with a daily baseline headache of approximately three to four on the pain scale located primarily in the right temple but could increase up to a nine out of ten approximately five to six days per month. Records note Petitioner missed several day of school since 2003 as a teacher, although in this most recent year he missed only 14 days due to his headaches. (Id.). Dr. Nissan's impression was intractable post-traumatic chronic daily headache and intractable post-traumatic chronic daily headache and analgesic rebound. (Id.). Dr. Nissan indicated that he discussed the possibility of inpatient admission with the patient and his wife due to the failure of previous outpatient treatments in the past. (Id.).

Petitioner testified that he has daily headaches that go deep into his head starting on the surface. Petitioner testified that his right temple is tender to the touch. The Petitioner testified that on a good day, he can manage the extent of his every day headache with relaxation. Petitioner testified that a bad headache will radiate all over his head and down his neck and up his back.

Petitioner testified that his worst headaches would be an eight or nine out of ten. The Petitioner testified that he had previously experienced a ten out of ten when he had meningitis in 1995. Petitioner testified that when he suffered from a bad headache, he was able to cope, but could do very little. Petitioner testified he had problems with his equilibrium. Petitioner testified that his disposition in the classroom became more edgy following the accident. Petitioner testified that he tried to explain to the students what was going on with him and asked them to try to bear with him.

Petitioner testified that of the approximate ten or eleven medications that he currently is prescribed, the only medication that he took prior to the work accident is related to gastric reflux. Petitioner's Exhibit # 3 is an outpatient medication list as of 1/16/2015 from OSF Family Practice indicating Petitioner's current medications include: hydroxyzine, aripiprazole, clonazepam, duloxetine, CPEP, trazodone, methylphenidate, meclizine, topiramate, amlodipine, prazosin, omeprazole, multi-vitamin, and osteo bi-flex.

The evidence deposition of Petitioner's primary care provider, Dr. Henry Gross, was obtained on April 2, 2013. (PX-18). Dr. Gross testified that Petitioner first presented to him after the April 15, 2003 work on April 16, 2003. (PX-18, p.5). Dr. Gross testified that he has continued to see Petitioner off and on regularly since April 16, 2003. (PX-18, p.6). Dr. Gross testified that since April 16, 2003, Petitioner has gotten a lot worse and has had spells of getting better and spells of getting worse. (Id.).

Dr. Gross testified that Petitioner was evaluated on January 9, 2013. (Id.). He was still having headaches and had been to see Dr. Bitar, a psychiatrist, who had increased Clonazepam. Petitioner indicated to Dr. Gross he was feeling quite a bit better and he was ready to teach another four to five years and that most of his days were good. (PX-18, pp.7-8).

Dr. Gross testified that on December 3, 2012, Petitioner indicated he was in a deep depression again and complained of both headache and depression worsening severely. (PX-18, p.42). Dr. Gross testified that Petitioner's headache pain was a 7/10 that day and his work energy and drive were dropping and that work was eating up all of his family time. Dr. Gross noted that the Petitioner had taken 12 out of 16 sick days that were available to him that year as of December 3, 2012. Petitioner indicated to Dr. Gross on December 3, 2012 that he felt like quitting work and giving up teaching. (Id.).

Dr. Gross testified that as of his most recent visit with Petitioner on March 13, 2013, Petitioner had had a downturn and reported feeling frustrated because he had been having his headaches for nearly ten years. (PX-18, p.8). Dr. Gross further noted that Petitioner had had another migraine and a Torodal injection and that he had missed work again.

Dr. Gross testified that his diagnoses of Petitioner included chronic headache, post-traumatic stress disorder, depression, chronic migraine, and hypertension. (PX-18, p.9). Dr. Gross testified that as of his last visit with Petitioner on March 13, 2013, it was his recommendation that Petitioner be referred to the Mayo Clinic for additional evaluation and treatments. (Id.). Dr. Gross further recommended a TENS unit and noted that Petitioner had some experience with that and thought that may be helpful. (Id.).

Dr. Gross testified that there is a causal relationship between Petitioner's head injury on April 15, 2003 and the conditions for which he has treated, the initial presentation, the ongoing difficulty in managing the problems. (PX-18, p.10). Dr. Gross testified that he believes Petitioner's injury itself is responsible for Petitioner's ongoing headaches and occasional neck pain. (PX-18, p.11). Dr. Gross testified that Petitioner will likely require medication for management of his headaches and depression and anxiety indefinitely. (PX-18, pp.10-11). Dr. Gross testified that at various times since April 16, 2003 when Petitioner reported depression, fatigue, headaches, incidents of crying, suicidal thoughts, difficulty focusing, anxiety, and forgetfulness are conditions related to the April 15, 2003 work injury. (PX-18, p.11). Dr. Gross testified that he did not relate Petitioner's previous sinus problems and diagnosis of sinus headaches prior to the injury did not relate in any way to Petitioner's prior sinus condition. (PX-18, p.12).

Dr. Gross testified that the condition of Petitioner's ability to teach at the high school level could permanently disabled him from his job as a high school teacher. (PX-18, p.13). Dr. Gross testified that Petitioner's condition could disable him from the work force in general. (PX-18, p.13). He also testified, however, that as of the date of his deposition, the Petitioner is on no work restrictions. (Id at 41)

Dr. Gross testified that he has treated Petitioner since around 1992. (PX-18, p.17). Dr. Gross testified that he was aware of Petitioner's sinus headaches that predated the accident. (Id.). Dr. Gross testified that Petitioner's complaints on October 17, 2002 when Petitioner presented with complaints of headaches, head pressure, dizziness, nasal draining, nausea, facial pressure, scratchy throat, fatigue, and body aches was consistent with sinusitis. (PX-18, p.45). Dr. Gross was asked on cross-examination whether the Petitioner's headaches prior to the accident based upon the normal sinus study had no correlation to his sinuses even though there was a normal diagnostic study. (PX-18, pp.27-28). Dr. Gross testified that diagnostic study can be useful in the setting how aggressive management needs to be with CT scans that don't show very much but the patients do finally respond to treatment for sinus-related conditions for allergies and so forth. (PX-18, p.28). Dr. Gross testified that he felt like the Petitioner's headaches prior to the accident had a greater sense of being related to the sinuses in front of the head. (PX-18, p.28).

Dr. Gross indicated that, "according to Dr. Bitar's record of January 18, 2013, Petitioner reported he had a depressive episode since his last visit and felt like the depression was worsening". (PX-18, p.43). Petitioner reported to Dr. Bitar that he was experiencing low energy, no enjoyment of activities, a hard time engaging in work activities, and having night terrors. Dr. Gross testified that as of January 18, 2013, Petitioner was a bit worse than where he had been before and that his state was taken into consideration when a recommendation was made for Petitioner to be evaluated at the Mayo Clinic in March of 2013.

Petitioner testified that his depression became worse in 2008. Petitioner testified that he felt that his teaching was deteriorating and that he wasn't getting back in a timely fashion to the students, asked the students to perform less writing, and relied on objective tests. Petitioner felt like he was providing bad teaching and that he and other people knew it.

Petitioner testified that he did receive an anonymous letter from parents in 2010. A letter dated May 27, 2010, signed by a "A small group of parents of Mr. Cluskey's English students" was written to Mike Miller, principal for Henry-Senachwine High School. (PX-6). The letter discusses the parent's concerns regarding Petitioner's teaching and absences. The letter notes the parents' awareness of Petitioner's head injury years back, the terrible headaches that he's suffered since then, and the fact that Petitioner misses a lot of school and is frequently absent two to three days in a row. (Id.). The letter continues that the parents have decided that this problem is not a new one and that it has been going on for several years. (Id.). The parents indicated they felt that Petitioner's teaching has gotten worse and cited several examples where Petitioner failed to grade papers and provide feedback to students. (Id.) The parents asked that Petitioner's quality of teaching and all aspects of his teaching and critiquing be improved. (Id.)

Petitioner testified that he felt that he suffered a personality change and became more prone to irritability and anger at home with family and children. Petitioner testified that at school he was saying and doing things that did not represent what he wanted to be.

Petitioner testified that he participated in an outpatient program in behavioral health to deal with a variety of mental health issues. In late 2010 Petitioner testified that he went on a leave of absence and upon his return, he was allowed to work outside the classroom researching curriculum.

Petitioner first presented to Dr. Ghassan Bitar, Board Certified Psychiatrist, on December 13, 2011. (PX-10). Dr. Bitar records indicate that Petitioner reported his problems beginning in 2003 after an injury when he was hit in the head. (Id.). Petitioner reported that since the accident, he started having severe problems with headaches and in 2004 he started feeling depressed. (Id.). Petitioner reported that in the beginning, the depression would come and go, however, lately the depression was staying for a long time. (Id.). Petitioner testified that Petitioner also reported significant problems with anxiety and reported frequent panic attacks. (Id.). Petitioner reported a deterioration of his functioning as a teacher. Petitioner reported he had no energy and no motivation. (Id.). Dr. Bitar's diagnosis was major depression, recurrent, severe, no psychosis, and panic disorder without agoraphobia. (Id.). Dr. Bitar adjusted Petitioner's medications on December 13, 2011 and Petitioner continued to treat with Dr. Bitar for his depression condition. (Id.). Petitioner testified that he continues to presently treat with Dr. Bitar for ongoing psychiatric medical treatment. (Id.).

Petitioner returned to Dr. John Marshall of the Central Illinois Pain Management Center on May 15, 2012. (PX-12). Dr. Marshall adjusted Petitioner's medications on May 15, 2012 and administered botox injections on October 24, 2012 and November 8, 2012. (Id.).

Petitioner testified that he returned to teaching in the fall of 2011. Petitioner testified that the fall of 2011 went pretty well at first but then more problems persisted with depression and headaches. Petitioner testified that he had to miss time from school. Petitioner testified that he missed up to 36 days of school in one year.

Petitioner testified that he continued to struggle and keep up with curriculum. He fell behind on work, students did not get quality feedback, and he felt students did not get enough learning with a substitute in and out.

Petitioner testified that his problems with attendance as a result of the headaches made him feel like the students were not receiving a proper education.

Petitioner testified in 2013, a decision was made to pursue disability due to his inability to keep up with school work and provide quality instruction. Petitioner testified that he has been on disability through the Teachers' Retirement System since February 26, 2014.

Petitioner testified that prior to the work injury, he and his wife shared responsibilities. Petitioner testified that now, his wife handles most everything. Petitioner testified that he is not reliable and he does not remember things and has a bad short term memory. Petitioner testified that he often doesn't remember things that his kids tell him and his wife has to maintain all logistical elements of the family.

Petitioner testified that he is no longer able to wrestle with his children. Petitioner testified that he can't play basketball as he is unable to move from side to side. Petitioner testified that he can stand in place and throw a baseball or football.

Petitioner testified that he has been treating with a chiropractor and working with pressure points and acupuncture which has been helpful to his neck pain. Petitioner first presented to Alliance Chiropractic on September 18, 2013 with complaints of chronic headache and neck pain. (PX-13). It was confirmed that Petitioner completed periodic treatment between September 18, 2013 through December 3, 2014. (Id.).

Petitioner testified that a bad headache duration was unknown and could last anywhere from one to five or more days. Petitioner testified that he has not sought employment and he has not felt up to it. Further, Petitioner testified he feels he has been recuperating from what has happened. Petitioner testified he wants to give disability a chance.

Petitioner testified that the school district was comfortable with him continuing to be an educator and Mr. Miller, the principal, was accommodating. The Petitioner testified that it was his own decision and he is not pressured by the school district to pursue disability. Petitioner testified that he recently volunteered for a local parochial grade school track program. Petitioner testified that he missed a lot of practices due to headaches and he declined to coach track the following spring.

Petitioner was evaluated by Dr. Wayne Stillings in a psychiatric independent medical examination at the request of Respondent on September 20, 2012. (RX-6). The evidence deposition of Dr. Stillings was obtained on April 10, 2013. (RX-14).

Petitioner provided a history to Dr. Stillings of being struck in the right temple area by a tent, estimated to be about 60 pounds, when the bus in which he and his student athletes were traveling made a sharp turn causing the tent to shift and strike Petitioner's head. (RX-6). Petitioner presented to Dr. Stillings with complaints of daily headaches, depression, and anxiety. (RX-14, p.10).

Dr. Stillings testified that Petitioner's headaches were a neurologic problem and he would let the neurologist offer opinions with respect to Petitioner's neurologic condition. (RX-14, p.45). Dr. Stillings testified that, "I

think he had a ding to the head...I think he had some neurologic problems from that. But the neurologists can talk about that." (RX-14, p.31).

Dr. Stillings testified that Petitioner's work injury of April 15, 2003 was extremely mild and he didn't even lose consciousness. (RX-4, p.62). Dr. Stillings testified that Petitioner's diagnosed depression was not related to the injury of April 15, 2003 because of Petitioner's partially preexisting and family constellation and genetic constitution, and because the depression emerged some 16 months after the injury at a point in his life that is classical for males to suffer a mood disorder or major depression or dysthymic disorder, chronic depression. Dr. Stillings testified that Petitioner was at maximum medical improvement from a psychological standpoint. (RX-14, p.31). Dr. Stillings testified that Petitioner did not have any permanent impairment psychologically from the accident. (Id.).

Dr. Stillings testified that Petitioner's MMPI-2 revealed chronic depression. (RX-14, p.38). Dr. Stillings testified that chronic depression can wax and wane and "that's the nature of the beast." (Id.). Dr. Stillings testified that chronic depression could be triggered by a head injury, but in a low grade concussion, it is extremely unlikely. (RX-14, p.39).

Dr. Stilling's report notes that Petitioner has missed work due to headaches. Dr. Stillings noted that when Petitioner is not feeling well, he is generally off work for one or two days but occasionally for three days at a time. (RX-6). Dr. Stillings noted Petitioner's worst year involved missing 36 days of teaching. (Id.).

Dr. Stillings noted that in 2010 Petitioner was placed on a one year probationary period for being tardy and providing feedback to students on their submitted papers. (Id.). Dr. Stillings noted that in 2011 Petitioner's performance was not up to par due to anxiety. (Id.). Dr. Stillings noted that Petitioner entered in IOP in January of 2012. (Id.).

Dr. Stillings noted Petitioner's assignment for the remainder of the 2011-2012 school year whereby he researched a common core program for the school. Dr. Stillings noted that Petitioner denied a previous history of depression and denied any psychiatric treatment, counseling, or taking of psychotropic medications prior to the work injury. (RX-6).

Petitioner reported to Dr. Stillings he went on a leave of absence from November of 2011 through February of 2012. (RX-14, p.10). Petitioner reported that upon return to teaching in February, 2012, he was given initiative in support for a nationwide core curriculum, which Dr. Stillings noted is more in keeping with his philosophy of education. (RX-14, p.11).

Dr. Stillings noted Petitioner was out for three months or so when he was in an IOP at. St. Francis Hospital. (RX-14, p.11). Dr. Stillings noted that Petitioner then began psychiatric treatment with Dr. Bitar with Prozac, Klonopin, and BuSpar. (Id.)

Dr. Stillings testified that he believed Dr. Bitar would be in a worse position that he to assess causation, despite the fact that Dr. Bitar has treated the Petitioner for years, because a treater is sympathetic in trying to help the patient and loses objectivity. (RX-14, pp.45-46). Dr. Stillings testified that he did not think Dr. Bitar reviewed all the medical records and Dr. Bitar did not do any psychological diagnostic testing. (RX-14, p.46).

Dr. Stillings testified that Petitioner's "bump on the head, the minor concussion he had, which in my opinion is being overplayed in this case, but I think that minor head injury is red herring to his major depressive disorder. There is absolutely no causal relationship." (RX-14, p.58).

Dr. Stillings testified that with treaters, their sympathy is toward their patient, they don't have neutrality, and Dr. Stillings believes they are biased. (RX-14, p.60). Dr. Stillings testified that he disagreed with Petitioner's diagnosis of post-concussive depression and anxiety noting that the diagnosis was not made by psychiatrist except for Dr. Bitar, who is a treater. (RX-14, p.60).

Dr. Stillings testified that Petitioner would benefit from staying at least on some psychotropic medication and anti-depressants for his depression and anxiety. Dr. Stillings testified that he did not see any malingering at all as Petitioner passed several validity tests. (RX-14, pp.35-36).

Petitioner was examined by Dr. Jean Clore, a clinical psychologist, on February 20, 2014 for an independent medical examination at the request of Petitioner. Dr. Clore submitted a report following her interview of Petitioner and her evidence deposition was obtained on August 14, 2014. (PX-18).

Dr. Clore testified that it was her understanding that in 2003, Petitioner was on a school bus coming from a track meet, and while he was on the bus, a tent pole weighing 60 pounds struck him in the head and he fell and experienced an altered conscious state at the time. (PX-19, p.8).

Dr. Clore testified that Petitioner's symptoms included a persistent depressed mood and loss of interest in things that he previously enjoyed doing. (PX-19, p.9). Dr. Clore testified that the symptoms started approximately a month or two after the head injury and continued to worsen over the course of the next year when he was being formally diagnosed with a depressive mood disorder. (PX-19, pp.9-10). Dr. Clore indicated Petitioner's other symptoms were lack of energy, decreased concentration, decreased energy and fatigue, feelings of worthlessness, excessive guilt, and significant changes in weight and sleep patterns and some thoughts about self-harm. (PX-19, p.10).

Dr. Clore testified that she diagnosed depressive disorder due to traumatic brain injury. (PX-19, p.11). Dr. Clore testified that the basis of her opinion was the temporal association, or the chronological happenings of things. (PX-19, p.11). Dr. Clore testified that Petitioner was 40 or 41 years old when he had injury, had no previous signs of mood disorder, had not received psychiatric care prior to that, and did not have a family history of psychiatric conditions and subsequently started to develop symptoms of depression again until they worsened within that first year. (PX-19, p.11).

Dr. Clore testified that the mechanics of the head injury itself was an object fell off the top of the bus striking him on the right temporal area, and was consistent with her subjective and objective findings and diagnosis the Petitioner's current condition. (PX-19, p.12). Dr. Clore testified that the medical records often describe the headaches as starting on the right side and then moving to a more general location. (PX-19, p.12). Dr. Clore testified that the location of the impact by the tent pole to the right side of the head was consistent with Petitioner's complaint of pain, headaches, and earaches. (Id.).

Dr. Clore testified that she did not know if Petitioner's condition was permanent but thought there was a possibility of improvement. (PX-19, p.14). Dr. Clore testified that she did not know at this point if Petitioner would see complete remission of his depressive disorder. (Id.).

Dr. Clore was asked on cross-examination if Dr. Stillings statement that men aged approximately 40-50 would be a classic age for an individual to begin experiencing symptoms of a depressive disorder. (PX-19, pp.32-33). Dr. Clore testified she would disagree with that statement in that the peek concept of depressive disorder is typically in the mid-twenties. (PX-19, p.33).

Dr. Clore was asked on cross-examination that given the diagnosis of a mild head injury and grade zero concussion, would it be unlikely that a mild head injury would cause long term depression. (PX-19, p.34). Dr.

Clore testified that up to about 20% of those patients suffering from depression caused by a mild traumatic brain injury can have persistent cognitive and emotional behavioral, and psychological problems. (PX-19, pp.34-35).

Respondent objected to the submission into evidence of Petitioner's Exhibit # 4, two Teachers' Retirement System of the State of Illinois Physician's Certifications of Disability. The parties agreed to redact the first half of page 1 and the first half of page 3 of the exhibit relating to Dr. Gross and Dr. Bitar's assessment of Petitioner's qualifications for Teacher Retirement System disability benefits . The parties agreed that the second of half of page 1 beginning with History of Symptoms through the end of page 2 and the second half of page 2 beginning with History of Symptoms through the end of page 4 would be allowed as evidence.

Admissible portions of Petitioner's Exhibit # 4 were completed by Dr. Henry Gross, Petitioner's primary care physician, on February 26, 2014, and Dr. Ghassan Bitar, Petitioners' psychiatrist, on March 20, 2014. The history provided by Dr. Gross indicates head injury on school trip 4/15/2003, post concussion syndrome with chronic headaches followed by cognitive impairment and mood disorder. (Id.). Dr. Gross indicated "Intermittent absences" under the section relating to the date the patient became unable to work. (Id.). Dr. Gross indicated Petitioner was unable to perform present teaching employment or any other full-tiem employment while undergoing treatment or therapy for the impairment and noted that Petitioner has been trying to work with impairments but is not functioning adequately as symptoms worsen. (Id.). Dr. Gross noted that ongoing treatment has not helped. (Id.).

The history provided by Dr. Bitar in Petitioner's # 4 indicate problems started in 2003 after an accident on school trip, developed headache and started having problems with depression and anxiety. Dr. Bitar also noted decreased motivation, decreased sleep, and fatigue. (Id.). Dr. Bitar indicated that when depression, anxiety, or headache are sever, Petitioner is unable to perform any work. Dr. Bitar indicated that patient has been trying but symptoms are worse. (Id.). Dr. Bitar indicated that Petitioner was compliant with treatment, but there was limited improvement for short periods of time. (Id.).

Petitioner was examined by James Ragains, a senior vocational consultant, at the request of Petitioner's attorney on November 10, 2014. (PX-5). Mr. Ragains noted it was his understanding that Petitioner sustained a blow to his head while at work on April 15, 2003. (Id.).

Petitioner indicated to Mr. Ragains that he experiences constant headaches and dizziness on a daily basis. (PX-5). Petitioner also indicated he experiences problems with depth perception. Petitioner indicated that physical exertion such as lifting a heavy bag, bending at the waist, and running all exacerbate his headaches. (Id.). Petitioner indicated to Mr. Ragains that being in crowds of people, loud noises, and heat are situations that trigger an exacerbation in pain and dizziness. (Id.).

Mr. Ragains' report notes Petitioner's ongoing treatment with Dr. Gross and Dr. Bitar. Mr. Ragains noted that Dr. Gross had completed a Physician's Certification of Disability on February 26, 2014 and Dr. Biar had also completed a Physician's Certification of Disability on March 20, 2014. (Id.). Mr. Ragains noted that Dr. Gross indicated that Petitioner was not able to perform his present teaching employment or other full-time employment stating that ongoing treatment has not helped. Mr. Ragains noted that Dr. Bitar diagnosed Petitioner with major depression and generalized anxiety and explained that Petitioner's problems began in 2003 after the work-related accident. Mr. Ragains also noted his review of the reports of Dr. Clore, Dr. Peeples, and Dr. Stillings. (Id.)

Mr. Ragains opined that in light of the permanent impairments described by Drs. Gross and Bitar and sanctioned by Dr. Clore with respect to Petitioner's chronic pain and permanent impairments in his cognitive abilities and mental status, Petitioner would not represent a candidate for vocational rehabilitation and would not be employable. (PX-5).

Petitioner was evaluated by Tracy Fortenberry, a vocational consultant, at the request of Respondent on December 2, 2014. (RX-17). Ms. Fortenberry authored a report that includes a summary of her review of records, Petitioner's background information, her opinions regarding Petitioner's employability following her review of records, and a labor market survey listing employment positions available to Petitioner. (Id.).

Ms. Fortenberry report notes that Dr. Peeples diagnosed Petitioner with post-traumatic headaches syndrome and depression, felt that the depression was adding to the headaches, and that Petitioner was at maximum medical improvement. (RX-17). Ms. Fortenberry also reported that Dr. Peeples "Stated that his headaches were pre-existing from sinus headaches." (Id.). Ms. Fortenberry noted Dr. Stillings's conclusion that he could not relate Petitioner's current mental state to the April 2003 injury, that Petitioner was psychiatric MMI, and that Petitioner has no psychiatric activity restrictions. Ms. Fortenberry noted that Dr. Narla gave the impression that Petitioner's headaches and symptoms were not related to the work injury. (Id.).

Ms. Fortenberry's report notes that Dr. Gross has found that Petitioner's diagnoses of a head injury with Grade 0 concussion, post-concussion syndrome, post-traumatic headache, depression, and anxiety were due to Petitioner's accident. (RX-17). Ms. Fortenberry states that Petitioner continues to treat with Dr. Gross but not restrictions were placed on the September 7, 2010 note. (Id.). Ms. Fortenberry's report noted Dr. Clore's diagnosis of depressive disorder due to a traumatic brain injury, with major depressive-like episodes, her recommendations to continue psychotherapy, and psychotropic medications. (Id.)

Ms. Fortenberry notes Petitioner related complaints to her of having many issues with headaches, loss of memory, and other things. (RX-17). Petitioner stated he always wakes up with a headache. Petitioner informed Ms. Fortenbery that prior to his head injury, his only health issue was acid reflux. (Id.). Petitioner further indicated that he has difficulty standing for a long period of time, walking, driving, and sitting for long period time. The report notes Petitioner has difficulty carrying items more than fifteen pounds and he is unable to kneel, stoop, squat, or climb. (Id.). Petitioner indicated he has no issues with sitting and has difficulty driving on occasion stating that sunlight bothers him and he often wears sunglasses. (Id.).

Ms. Fortenberry obtained and noted Petitioner's personal information, activities of daily living, hobbies, education background, and employment history. (RX-17). Ms. Fortenberry's report includes a labor market survey listing ten positions which she felt Petitioner was qualified. (Id.). Positions listed included a tutor, student teach supervisor, parent educator, online teacher, and therapeutic mentor. (Id.) Ms. Fortenberry reports notes that due to her records review, she is of the opinion that Petitioner can work full time with no restrictions. (Id.). Ms. Fortenberry noted that Petitioner feels he is unable to work due the instability of his headaches and the frequency of them. (RX-17).

Petitioner called Ms. Carolyn Orsborn to testify. Ms. Orsborn testified she is currently a substitute teacher at Henry-Senachwine High School and has worked at the high school for the last 33 years teaching Spanish and Psychology. Ms. Orsborn testified that prior to her retirement in 2000, she taught in the room next door to Petitioner. Ms. Orsborn testified she was able to observe Petitioner's teaching skills and testified that Petitioner was a very good and passionate teacher and that she loved listening to him teach. Ms. Orsborn testified that the walls between her rooms were thin, and she would often sit in her room during the prep period and listen to him teach.

Ms. Orsborn testified she had understanding of what happened to the Petitioner on the bus and that the bus turned a corner and Petitioner was hit by a tent in the side of the head. Ms. Orsborn testified that after the accident, she would substitute 40-50 times a year. Ms. Orsborn estimated that she substituted approximately 80 times for the Petitioner after the accident.

Ms. Orsborn testified that she noticed a difference in Petitioner in that he was in pain. Ms. Orsborn testified that on one occasion, Petitioner was unaware that she observed him walking down the school hallway, carrying a cup of coffee, began listing and walking to the right, and then bounced off the lockers. Ms. Orsborn testified that she observed Petitioner moving this way on three or four occasions. Ms. Orsborn testified that she observed Petitioner having pain, being depressed, anxious, and experiencing panic attacks. Ms. Orsborn testified that on one occasion Petitioner had a panic attack in front of the class.

Ms. Orsborn testified that she authored a letter to Petitioner on December 3, 2004. (PX-28). Ms. Orsborn wrote that she felt Petitioner was an excellent teacher and she knew that the students would agree with her. (Id.). Ms. Orsborn wrote that Petitioner ha a definite passion for his subject matter and his lesson plans are always precise and informative. (Id.). Ms. Orsborn's letter expressed thanks for making the substitute job not much of a job at all and for caring about his students in his English classes. (Id.). Ms. Orsborn wrote that she was glad Petitioner could be present and was feeling well. (Id.).

Petitioner called Janna Clusky to testify. Ms. Cluskey testified she has been married to the Petitioner for the last 22 years and they have five children ages 12, 13, 15, 18, and 20. Ms. Cluskey testified that prior to the accident, she and Petitioner had a very active and solid family. Ms. Cluskey testified that prior to the accident, a great deal of their time was spent being pregnant or with infants. Ms. Cluskey testified that her family enjoyed hiking, being active, family visits, and going to church. Ms. Cluskey testified that prior to the accident, Petitioner would teach and coach from early morning till ten o'clock at night.

Ms. Cluskey testified that Petitioner did not immediately have bad headaches after the accident. Ms. Cluskey testified that the bad headaches came over time and took more and more of a toll on Petitioner. Ms. Cluskey testified when Petitioner has a bad headache, he needs to lay down, needs quiet, and often lays down in the bedroom. Ms. Cluskey testified that Petitioner finds that activities that may jar his head have a higher potential for bad headaches and so Petitioner avoids activities he used to enjoy such as wrestling with their children. Ms. Cluskey testified that noise and crowds would bother Petitioner's head.

Ms. Cluskey testified that Petitioner constantly has a headache. Ms. Cluskey testified that a bad headache has a length that is variable and can last three to four days. Ms. Cluskey testified that Petitioner has been to the ER a couple of times this year for headaches. Ms. Cluskey also testified that Petitioner has memory loss when he has a bad headache. Ms. Cluskey testified that sometimes Petitioner has no recollection of talking to one of their children.

Ms. Cluskey testified that Petitioner used to be a runner and got her into the sport of running. Ms. Cluskey testified that Petitioner is no longer able to go for runs. Ms. Cluskey testified that the Petitioner used to be fit enough to run 20 miles. Ms. Cluskey that the Petitioner has put on a lot of weight. Ms. Cluskey testified that Petitioner found it harder and harder to get through a day of work. Ms. Cluskey testified that she encouraged her husband to stay with teaching and he would try. Ms. Cluskey testified that Petitioner has issues with depth perception and that can affect his ability to drive long distances. Ms. Cluskey testified that Petitioner takes a lot of medications that make him drowsy. Ms. Cluskey testified that Petitioner also sometimes becomes dizzy, however, not very often.

CONCLUSIONS OF LAW

First of all, while the Respondent placed the issue of accident in dispute, it offered no evidence nor made any arguments that the Petitioner was not involved in an accidental injury arising out of and in the course of his

employment on April 15, 2003. The Arbitrator finds a compensable accident did occur when the Petitioner was struck in the head by a falling track tent on the date in question.

The first main issue is causation. The Arbitrator will analyze the issue separately as it pertains to the Petitioner's headaches and cervical pain, and his diagnosed depression.

With respect to the timeline before and after the accident, the Arbitrator does not believe the Petitioner's pre accident headaches are of much importance. His headache treatment prior to the accident was sporadic and related to some definite medical issues. He had a severe headache in 1995 after receiving a spinal tap. It went away in a day. He had some headaches of a sinus nature after he broke his nose in 1996. After about a week, there was no follow up care. In November 2001, he had headaches along with what looks like upper respiratory symptoms. In April 2002, he had sinus pressure along with a fever, and was given antibiotics. In the late fall of 2002, he again treated for what sounded like sinus problems to Dr. Gross. The fact that Dr. Parrish determined that they were not sinus headaches is not significant, given the fact that he noted that they were resolved by December 13, 2002.

After the accident, the nature and location of the Petitioner's headaches changed. Also, except for a four month period during the summer of 2003, he has been receiving various medical treatments for his headaches. The Petitioner testified that he was struck in the right temple by a falling tent which the evidence established weighed in the neighborhood of sixty pounds. When he saw Dr. Gross the next day, he was experiencing a mild headache over that part of his head. His two follow up appointments with Dr. Gross in May were for essentially the same problems. On May 28, the Petitioner reported that he had ongoing episodes of severe headaches and dizziness. He had nausea. He said it limited his activities. He and his wife testified that it caused him to end his training to run a marathon. Dr. Gross continued to diagnose a post concussion syndrome.

Respondent argues that his headaches ended at that time, and didn't come back for a period of four months. Accordingly, they argue the causal chain was broken, and any further headaches were no longer causally related to the accident. However, while the Petitioner did testify at his hearing in 2015 that he was okay during the summer of 2003, the histories he provided to his doctors soon after his accident establish that he still had headaches during that time which were intermittent and treatable with medication.

When the Petitioner saw Dr. Gross on October 2, 2003, he said he'd experienced a sudden severe headache two days earlier. It was again located over the right temple area. He also told the doctor that he'd been having difficulty with headaches and dizziness since his accident in April. (PX 8) Four days later, he told Dr. Kimm, who was performing an EEG, that he'd had headaches since his accident. (PX 9) Several years later when he was seen by Dr. Peeples, a neurologist, he said that he had done reasonably well during the summer of 2003 but still had occasional headaches for which he took Darvocet. (RX 11)

The Arbitrator concludes that the above evidence shows that while the Petitioner was improved with respect to headaches over his right temple in the summer of 2003, those headaches had not gone away. More importantly, almost all of the doctors who treated or examined the Petitioner with knowledge of his temporary improvement still opined that his headaches for which he treated after September 30, 2003 were causally related to his accident. Dr. Peeples first noted that the Petitioner's pre accident headaches were in the sinus area while his post accident headache began where he was hit in the right temple. (Id) He concluded that the accident was a contributing factor in the headache syndrome he diagnosed during his examination, which took place August 16, 2005. Later in an amended report requested by the Respondent, Dr. Peeples opined that the major cause of the headaches the Petitioner was experiencing was his depression. He did not, however, retract his earlier written and oral opinions that the accident was a cause of those headaches. (Id) Dr. Zalleck, the first neurologist who treated the Petitioner after his accident, wrote that he was experiencing a headache syndrome, suggestive of post

concussive syndrome. (PX 11) Similar causation opinions came from Dr. Saper of the Michigan Head Pain Institute on April 21, 2004 and Dr. Nissan of the Diamond Headache Clinic on July 6, 2006. (PX 16, 15)

The only opinion against causation came from Dr. Narla. He said it would be unusual to have a gap in headache symptoms for several months and have subsequent headaches still be related to the accident. (RX 13 at 43) The Arbitrator notes, however, that the evidence did not show the Petitioner as symptom free during the summer of 2003. Also, Dr. Narla agreed that the area where the Petitioner noticed his headaches after September 2003, the right temple area, was consistent with the area where the Petitioner was struck by the tent. (Id at 38)

The evidence shows that the Petitioner's headaches have continued to bother him since 2003. Dr. Gross' treatment records show the condition has waxed and waned. When it has been most problematic, it has been accompanied by symptoms of dizziness, nausea and fatigue. (PX 8; 11-21-04; 11-30-05; 11-12-07; 8-6-09; 4-17-13; 1-29-14)

Based upon the timeline referenced above, along with the opinions of the various doctors, the Arbitrator finds a causal relationship between the accident and the Petitioner's current condition of ill being as it pertains to his post concussive or traumatic headaches. Again, based on a timeline of no complaints prior to the accident and steady complaints thereafter, the Arbitrator finds the Petitioner's cervical complaints also causally related.

With regard to Petitioner's depression , the records first discuss the Petitioner having problems concentrating in December 2003 when he was seen by Dr. Zalleck. When he followed up with the doctor in January 2004, he said his problems had cleared up. At the Michigan Clinic in April 2004, the Petitioner reported that he was having trouble concentrating, was weak and had anxiety and suicidal thoughts. Psychiatric testing was done, and a diagnosis of a mood disorder characterized by depression related to a medical condition was made. At his final visit that summer in July, Dr. Saper noted that the Petitioner was improved and wanted to resume teaching and coaching. He apparently had some counseling with the Antioch Group in 2005, but on October 6, 2005 he reported he was not depressed and on October 27, 2005, he said things were going well. Dr. Gross' records show periodic references to depression through his last treatment note in May 2014. (PX 8)

Despite his treatment and testimony concerning his depression, the Petitioner worked at his regular job as a teacher and coach from his accident date until February 26, 2014. He received numerous evaluations during that time and was always found to be an excellent teacher. He did have a problem in 2010 with respect to complaints by parents as to his teaching, and it was worked out to everyone's satisfaction. He also was reprimanded in 2009 for actions in the classroom. The records of both of those disciplinary actions do not indicate that the Petitioner's depression had anything to do with those actions. (RX 2) At no time prior to February 2014, did any of his doctors place restrictions on his ability to work.

Dr. Stillings testified that Petitioner's work injury of April 15, 2003 was extremely mild and he didn't even lose consciousness. (RX-4, p.62). He said that the Petitioner told him that his discipline in 2011 was the result of his being frustrated with the students' motivation, something which had bothered him for fifteen years. (Id at 10, 11) At the time he saw Dr. Stillings, September 20, 2012, the Petitioner said he was doing fine with his teaching. Dr. Stillings diagnosed a long standing occupational problem; depressive disorder in partial remission and a pre existing personality disorder. He said the Petitioner was functioning normally. (Id at 26, 27) Dr. Stillings testified that Petitioner's diagnosed depression was not related to the injury of April 15, 2003 because of Petitioner's partially preexisting and family constellation and genetic constitution, and because the depression emerged some 16 months after the injury, because it emerged at a point in his life that is classical for males to suffer a mood disorder or major depression or dysthymic disorder, chronic depression.

Dr. Clore, who examined the Petitioner in February 2014 when he voluntarily left his job, said his diagnosis was a depressive disorder due to his injury. (PX 19 at 10) She further said she did not have an opinion as to whether the condition was permanent. (Id at 14)

The Arbitrator believes that the Petitioner has proven some depression causally related to his accident. He still treats with Drs. Gross and Bitar with medication. The extent of the depression will be addressed in the conclusions concerning permanency.

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 that the medical services that were provided to Petitioner were reasonable and necessary. Based on the Arbitrator's findings with regard to Issue (F), the Arbitrator finds that Respondent is liable for medical bills included within Petitioner's Exhibit #20 limited to the Illinois Medical Fee Schedule. Respondent is entitled to a credit for all medical bills as indicated in Respondent's Exhibit # 16.

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

The Arbitrator finds Petitioner is not entitled to temporary total benefits. The Petitioner's conditions had reached a point of maximum medical improvement long before he went off work in February 2014 when he is requesting TTD benefits. His periodic headaches are permanent, as Dr. Peeples opined in his deposition. He is and will continue to be treated symptomatically by Dr. Gross. Dr. Bitar sees him on a monthly basis for depression, prescribing medication.

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

The Petitioner continues to treat with Dr. Gross for his headaches. A review of Dr. Gross' treatment notes over the past several years show that the headaches have generally waxed and wane in severity. In 2013, the doctor always described them as being intermittent. In late 2013 and early 2014, the records show that the petitioner was experiencing a headache for several weeks. It was severe. He was given two Toradol injections which didn't clear the headache as late as January 29. It does appear that the headache did resolve itself and the frequency of the headaches returned to intermittent through the doctor's last note of May 5, 2014. (PX 8)

He has treated with Drs. Gross and Bitar for his depression. Again, the treatment notes show the condition has fluctuated in severity over the past several years. In the summer of 2013, the Petitioner's depression and anxiety was said to be increased due to his apprehension in returning to the classroom. On September 25, Dr. Gross noted the Petitioner had experienced a good month at school and was more confident. Since he left his job, his depression appears to have increased. Dr. Gross noted in May 2014 that the Petitioner was struggling with his unscheduled time. He suggested more structured activities. Dr. Bitar's notes submitted into evidence covered his care from December 2011 through January 2013. They also show an up and down pattern concerning his depression. (PX 10)

There are some inconsistencies between what the Petitioner reported to Dr. Gross concerning his ability to function and the other evidence in the record. On May 16, 2013, the Petitioner reported to Dr. Gross that it had been a very bad year with frequent absences from school. He complained that his headaches were increasing in frequency. However, on May 27, 2013, the Petitioner received a glowing evaluation of his abilities to teach in the classroom. He was said to have a good relationship with his students, did a good job engaging and challenging them in class, was enthusiastic and had a good knowledge of the materials. (RX 2)

The Petitioner is seeking an award under Section 8 (f) of the Act for permanent total disability. The Arbitrator does not believe such an award is supported by the evidence. First of all, no doctor suggested that the Petitioner was unable to work until he approached his family doctor in February 26, 2014 seeking such an opinion. He also made the same request of Dr. Bitar. Prior to that time, neither Dr. Gross nor Dr. Bitar suggested work restrictions in their office records. Dr. Gross testified as such in his deposition taken April 2, 2013. (PX 18 at 41) Dr. Stillings opined on September 20, 2012 that the Petitioner required no restrictions regarding his depression. Dr. Peeples had the same opinion when he authored his report on January 11, 2011. He also noted that it appeared that the Petitioner's complaints exceeded what he saw in Dr. Gross' records. (RX 11) It does not appear that the Petitioner's various conditions make him obviously unemployable.

He has also failed to prove he is an odd lot permanent total. He has not looked for work, testifying that he feared losing his teacher's disability. Dr. Ragains' opinion that he is unemployable is not persuasive as he based it on the two statements from doctors prepared at the Petitioner's request.

The Petitioner does, however, have disability from his ongoing headaches and depression. Those conditions have and continue to cause him problems in his personal and professional activities. Based upon all of the evidence, the Arbitrator finds the Petitioner disabled to the extent of 20 % Person As A Whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kenneth Lenhart,

Petitioner,

vs. NO: 05 WC 04674

USF Holland,

16IWCC0340

Respondent.

DECISION AND OPINION ON REMAND

This case comes before the Commission on remand from the Appellate Court of Illinois, Third District in case number 3-13-0743WC. On January 31, 2011, Arbitrator Robert Falcioni issued a decision finding that Petitioner was permanently and totally disabled. On review, the Commission modified the Arbitrator's decision and found that Petitioner sustained injuries that caused the loss of use of 75% of the whole person. The Commission further awarded Petitioner temporary total disability for 308 and 5/7 weeks, medical expenses, and mileage reimbursement.

The Respondent appealed the Commission's decision to the circuit court. The Petitioner appealed the circuit court's decision to the Appellate Court. The Appellate Court issued an opinion dated March 20, 2015, remanding the case to the Commission. The court reversed the Commission's permanent partial disability (PPD) award, and remanded the matter for a determination of whether the Petitioner is entitled to a PPD award based on a wage differential calculation. The Court specified: "In the event that Commission determines that the claimant is entitled to a wage differential award, it should make the award. If, on the other hand, the Commission decides that he is not entitled to a wage differential [a]ward under section 8(d)(1) of the Act, it is directed to reinstate its award of PPD benefits for [75%] loss of use of a person as a whole under section 8(d)(2)," quoting *Levato v. Illinois Workers' Compensation Comm'n*, 2014 IL App (1st) 130297WC.

The Commission has considered whether the Petitioner is entitled to a PPD award based on a wage differential calculation. The Commission finds that an award of PPD benefits for 75% loss of use of a person as a whole under section 8(d)(2) is the most appropriate award in this case for the reasons set forth below.

As the Appellate Court noted in its Order, a Petitioner must prove the following to qualify for a wage differential calculation: "A partial incapacity which prevents the Petitioner from pursuing his 'usual and customary line of employment,' and an impairment in earnings." Petitioner met the first prong because he was given a 25 pound lifting restriction at the light end of the light-medium demand level. Petitioner met the second prong because the vocational rehabilitation counselors opined that Petitioner could obtain positions between $10 and $15 per hour. However, both of those prongs are tainted by Petitioner's disingenuousness with regard to his level of disability.

The extensive video surveillance evidence reveals that Petitioner's physical abilities did not comport with his behavior with his treating physicians. Because of this misleading behavior, the Commission finds it particularly challenging to determine Petitioner's alternative earning capacity. Petitioner's efforts with the vocational rehabilitation program cannot be deemed to have been wholly made in good faith; thus, it is impossible to know what Petitioner's true capabilities were. Therefore, we decline to award Petitioner a wage differential award under Section 8(d)(1) of the Act.

The Commission acknowledges that the two rehabilitation counselors that Respondent hired, Edward Steffan and Duane Bigalow, reported that Petitioner was placeable and employable in positions earning between $10.00 and $15.00 per hour. Mr. Steffan testified about the basis of his opinion: "His rehabilitation variables, which we described as his age, which is approximately 40 years, *his available physical capacities*[emphasis added]...his level of education, his training, his previous experience and acquired skills and knowledge allow him to access to a readily available and stable labor market." Given that it is unclear what Petitioner's physical capacities are, the Commission is of the opinion that the vocational counselors would not be able to make an accurate assessment as to Petitioner's earning capacity.

Petitioner's actions leave the Commission doubtful that he wanted to reenter the workforce or that he conducted a diligent job search. Mr. Steffan testified that he heard a voicemail that Petitioner had left a potential employer stating that the employer could "throw away" Petitioner's résumé. Petitioner also had to be counseled several times about not sharing his workers' compensation claim status and other "inappropriate information regarding his available physical capacities" with potential employers, according to a rehabilitation services progress note. Of note, Petitioner worked as a paid village trustee who performed management oversight for town projects, and he worked in some capacity for Ken's Computers (a family business) in the same time frame that Petitioner claimed to have debilitating physical and mental symptoms. For the reasons above and due to Petitioner's credibility issues, the vocational rehabilitation counselors' opinions are given less weight. Accordingly, the Commission declines to award Petitioner a wage differential award under Section 8(d)(1) of the Act.

16IWCC0340

Although the record contains medical opinions that Petitioner is medically unable to work, we find these opinions to be contradicted by the surveillance footage showing Petitioner to be far more physically and mentally capable than his treating physicians were led to believe. Therefore, the Commission finds that Petitioner failed to prove that he is medically permanently and totally disabled.

At the Arbitration hearing, Respondent submitted into evidence three surveillance videos recorded by a private investigator. The first video contains footage recorded on October 4, 2007, October 5, 2007, and October 23, 2007. On October 4, 2007, Petitioner attended a homecoming parade and pep rally. On October 5, Petitioner attended a football game. Although Petitioner appeared to have a difficult time climbing the bleacher stairs, he was able to sit on the bleachers for the duration of the game. He occasionally clapped and stomped his feet and he spent time talking to people around him.

The second video contains footage from April 28, 2008, April 30, 2008, September 19, 2008, and September 21, 2008. The April 2008 footage captured Petitioner driving his car and attending a medical examination in Chicago. On September 19, 2008, Petitioner attended a football game and can be seen standing, walking, talking to people, and leaning on a fence. We note that Petitioner walked with a slight limp. On September 21, 2008, Petitioner attended a group motorcycle ride. He can be seen interacting with people prior to the start of the ride. While sitting astride his motorcycle, Petitioner engaged in jerky, full-body movements.

The third video contains footage from October 3, 2009, and October 4, 2009. On October 3, 2009, Petitioner attended a football game. He can be seen moving without difficulty, talking to numerous people, and standing and watching the game from the sidelines. Later, the footage shows Petitioner working on a truck engine. He bends over the engine, lies on a creeper on the ground to work under the truck, and kneels next to the truck. His son helps him stand, after which he appears to be walking stiffly. On October 4, 2009, Petitioner attends another football game. He walks throughout the bleachers and appears to be moving without difficulty.

Respondent also submitted into evidence video footage recorded by Petitioner's neighbor. On this series of videos, Petitioner can be seen using a leaf blower and a leaf vacuum, pushing a lawn mower, shoveling snow, and riding his motorcycle, all without any apparent difficulty. In one video, Petitioner stands next to a ditch being dug in the neighbor's yard. Petitioner bends over to pick up large pieces of wood without any difficulty. He walks without limping. He uses a rake to rake the dirt and is able to bend over, pick up debris, and throw it into a truck with ease.

The surveillance footage detailed above contradicts the medical opinions that Petitioner is medical permanently and totally disabled. Without having seen the surveillance footage, Petitioner's treating physician, Dr. DePhillips, opined on March 21, 2008, that Petitioner was permanently and totally disabled and unemployable. When confronted with the surveillance footage during his July 16, 2008, deposition, Dr. DePhillips testified that Petitioner's condition was progressively worsening, and that the Petitioner's activities on the surveillance videos could have occurred before his condition worsened. We note, however, that the video surveillance footage was recorded in October 2007, April 2008, September 2008, and October 2009, both

16IWCC0340

before and after Dr. DePhillips rendered his opinion that Petitioner was unable to work. On cross examination, Dr. DePhillips admitted that he would not have recommended Petitioner ride his motorcycle for 100 miles in September 2007, nor would he have recommended that Petitioner engage in lifting or digging in the fall of 2007. He agreed that the medical records would suggest that Petitioner would not be able to perform those activities without significant pain and discomfort. While Dr. DePhillips never recanted his opinion that Petitioner is permanently and totally disabled, the activities Petitioner performs in the surveillance videos runs counter to Dr. DePhillips's understanding of Petitioner's capabilities. We therefore find his opinion unreliable.

Dr. Hawley, Petitioner's treating psychiatrist, also restricted Petitioner from working based on his mental condition, specifically irritability, self-reports of impaired concentration, attention, memory, and difficulty performing new or sustainable tasks. After reviewing some of the surveillance footage recorded by Petitioner's neighbor, Dr Hawley admitted that Petitioner appeared significantly more mobile on the video than he was in Dr. Hawley's office. He also noted that Petitioner engaged in more social interaction than he reported being able to do. After viewing still photographs taken from the neighbor's surveillance footage, Dr. Hawley noted the level of activity depicted in the photos is inconsistent with Petitioner's self-reported capabilities.

Comparing the treatment notes from counselor Pam Wolf to Petitioner's contemporaneous activities shown on the surveillance footage further supports our finding that Petitioner exaggerated his functional incapacity to his treating physicians. In October 2007, Petitioner reported being immobilized and unable to perform light tasks. He rated his pain level after performing light tasks at ten out of ten. In contrast, the surveillance footage from October 2007 shows Petitioner at a football game, talking to people, sitting on bleachers, and clapping and stamping his foot. In April, 2008 Petitioner expressed frustration to Ms. Wolf that he was unable to accomplish tasks and stated he was struggling to accept his physical limitations. In September 2008, Petitioner talked about his need to find new activities now that vigorous yard work and house maintenance were no longer realistic pursuits, and in October 2008, he discussed his need to stop doing yard work because he would physically "pay for it." Surveillance footage from these months show Petitioner attending football games, standing for long periods, walking with only a slight limp, talking to people, and participating in a long motorcycle ride during which he engaged in full-body movements while astride his motorcycle. The neighbor's footage from this time period shows Petitioner engaged in significant yard work. In October 2009, Petitioner reported being unable to stand on his feet or sit in one position for several hours without great trouble and pain. Surveillance footage from October 2009 shows Petitioner attending at least two football games. He moved well as he interacted with people. While he sometimes walked stiffly or with a slightly hunched posture, he was still able to bend over and work on a truck, lie down on a creeper, and kneel down. These are not the activities of a man who is unable to stand or sit without great pain.

We find the opinion of Respondent's Section 12 examiner, Dr. Espinosa, to be the most reliable. Dr. Espinosa initially determined that Petitioner was restricted from work activities based on his examination of Petitioner and the history Petitioner provided. However, after reviewing the video surveillance footage, he concluded that Petitioner appeared to be a "different person completely" than the person he had examined. Petitioner appeared "uplifted" and happy, which Dr. Espinosa felt demonstrated the success of Petitioner's treatment. However, Dr.

Espinosa did not go so far as to say that Petitioner could return to work full duty. Instead, he concluded that based on Petitioner's two lower back surgeries, he would be able to return to work with a twenty-five pound lifting restriction at the light end of the light-medium demand level.

We also rely on the report of Respondent's section 12 examiner, psychologist Dr. Glenellen. Dr. Glenellen administered a number of objective tests indicating that Petitioner had an investment in portraying himself as an invalid and was exaggerating his functional limitations. These results are borne out by the discrepancies between the surveillance footage and Petitioner's self reports. Dr. Glenellen testified during his deposition that the surveillance footage undermined Petitioner's subjective reports of his capabilities.

We further find that Petitioner failed to prove that he is permanently and totally disabled pursuant to an odd lot theory of disability. Based on the discrepancies between Petitioner's self-reports and his activities on the surveillance footage, we find Petitioner's testimony to be unreliable. Further, these discrepancies render expert opinions based on Petitioner's subjective reporting of his capabilities and limitations similarly unreliable. We find it likely that Petitioner is readily capable of pursuing additional training and job searching. While we note that the job search logs show that Petitioner contacted a large number of potential employers, we also note numerous days when Petitioner reported being in too much pain to pursue his job search. We note that Petitioner focused a significant amount of time and energy on defending himself against perceived attacks from Mr. Steffan and Respondent. After reviewing the evidence, particularly the surveillance footage, we find the discrepancy between what Petitioner claims to be capable of doing and what he is actually capable of doing is vast, and therefore we decline to find that he is permanently and totally disabled under an odd lot theory.

Because Petitioner has a permanent twenty-five pound lifting restriction and has exhibited some acknowledged difficulties obtaining work within his restrictions, we find that Petitioner is entitled to permanent partial disability benefits representing 75% loss of use of the whole person.

Regarding the award for mileage reimbursement, we find the Arbitrator properly relied on *General Tire v. Industrial Commission*, 221 Ill. App. 3d 641 (1991). We find nothing in the court's language that would limit mileage reimbursement to specific circumstances:

> "The record shows that the petitioner lived in the Mt. Vernon area and sought treatment from Dr. Marrese, who practiced first in Evansville, Indiana, and then in Wood River, Illinois. Evansville is approximately 100 miles from the petitioner's home and Wood River is approximately 90 miles away. The record also shows that Marrese had been the petitioner's treating physician since 1984.
>
> The Commission found that it was reasonably necessary for the petitioner to travel to and from Dr. Marrese's office and to and from the Wood River Hospital. As such, it included $ 1,588 in the petitioner's medical expenses award for travel. We find that the

Commission's decision was not against the manifest weight of the evidence." *General Tire & Rubber Co. v. Industrial Comm'n*, 221 Ill. App. 3d 641, 651 (1991).

Like the claimant in *General Tire*, this Petitioner had to travel long distances for reasonable and necessary medical treatment, and so is entitled to reimbursement.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision filed January 31, 2011, is hereby modified.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $893.11 per week for a period of 308 and 5/7 weeks, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $567.87 per week, the maximum permanent partial disability rate, for a period of 375 weeks, as provided in Section 8(d)(2) of the Act, for the reason that the injuries sustained caused the loss of use of 75% of the whole person.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $109,870.73 for medical expenses under Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $5,795.26 for mileage reimbursement.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $174,914.46 for temporary total disability benefits paid, $1,079.34 for temporary partial disability benefits paid, $49,531.55 for maintenance benefits paid, and $22,714.80 for other benefits paid, for a total credit of $248,240.15.

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.

16IWCC0340

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: MAY 19 2016
TJT/ gaf
O: 3/21/16
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF KNOX)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William R. Gross,
Petitioner,

vs. NO: 05 WC 53322

Freeman United Coal Mining Company,
Respondent.

16IWCC0309

DECISION AND OPINION ON SECOND REMAND

This matter comes before the Commission pursuant to a second remand Order of the Appellate Court on the issue of whether disablement exists and if so, the nature and extent of the disability caused by Petitioner's chronic obstructive pulmonary disease.

In his Decision filed October 14, 2008, Arbitrator Holland found Petitioner failed to prove he sustained injuries as a result of exposure to an occupational disease arising out of and in the course of his employment on November 7, 2003, the date Respondent's mine closed. The Arbitrator also found that Petitioner failed to prove a causal relationship. The Arbitrator gave greater weight to the opinions of Dr. Renn and Dr. Wiot than the opinions of Dr. Houser and Dr. Whitehead. The Arbitrator found that if Petitioner's condition of histoplasmosis is related to his employment, that exposure ended in 1991 and his claim for that was not timely filed. The Arbitrator concluded Petitioner failed to prove the presence of coal workers' pneumoconiosis or a causal relationship to his last exposure.

Petitioner reviewed on the issues of disease covered by the Act, arising out of employment and in the course of employment, causal relationship and nature and extent. Oral arguments were held on November 19, 2009. In its Decision and Opinion on Review dated November 25, 2009, the Commission affirmed and adopted the Arbitrator's Decision. Petitioner appealed to the Circuit Court of Sangamon County. On July 26, 2010, the Circuit Court confirmed the Commission's Decision.

Petitioner appealed to the Appellate Court. In its Opinion filed October 6, 2011, the Appellate Court noted that although Petitioner originally asserted potential claims for coal workers' pneumoconiosis and histoplasmosis, which the Commission found Petitioner had failed to prove, he abandoned those claims in this appeal and limited the review to his claim for chronic obstructive pulmonary disease (COPD). Petitioner argued that the Commission's decision that his condition of COPD did not arise out of and in the course of his employment was against the manifest weight of the evidence. The Appellate Court reversed, agreeing with Petitioner that the Commission erred in accepting the opinion of Dr. Renn that coal dust exposure did not contribute to cause his COPD when Dr. Renn failed to give an adequate explanation of the basis of his opinion. When asked how he could determine that Petitioner's COPD was caused solely by cigarette smoking, Dr. Renn stated that his opinion was based on the pattern of pulmonary function testing "associated with tobacco smoking versus the pattern that you would see in coal workers' pneumoconiosis." The Court noted that Dr. Renn did not state that pulmonary function testing would differentiate whether COPD was caused by cigarette smoking rather than coal dust inhalation, and he did not explain how the pattern seen in coal workers' pneumoconiosis would reveal the specific etiology of Petitioner's COPD. Dr. Renn did opine that the long-term inhalation of coal dust can cause or aggravate obstructive lung disease and that Petitioner had sufficient coal dust exposure to cause COPD in a susceptible host. The Appellate Court noted that the arbitrator gave the opinions of Dr. Renn greater weight than those of Dr. Houser, apparently adopting Dr. Renn's opinion that "none of the [claimant's] diagnoses were either caused, or contributed to, by his exposure to coal mine dust." The Appellate Court agreed with Petitioner's argument that he only needed to prove that the inhalation of coal dust was a causative factor in his COPD, not that it was the only factor or that his cigarette smoking was not also a contributing factor.

The Appellate Court noted that of great significance in this case is the fact that Petitioner had been exposed to both coal dust and cigarette smoke for a period of nearly 40 years. Both Dr. Houser and Dr. Renn agreed that either exposure could have caused obstructive lung disease. Both experts testified that obstructive lung disease may be multifactorial in origin. Both experts agreed that pulmonary function testing reveals the nature and severity of a defect, but not its specific etiology. Dr. Houser concluded that since Petitioner had significant exposure to both coal dust and cigarette smoke, his obstructive lung disease was caused by a combination of those exposures. On the other hand, Dr. Renn opined that despite Petitioner's significant exposure to coal dust, his obstructive lung disease was caused solely by cigarette smoking. The Appellate Court concluded that Dr. Renn did not adequately explain his conclusion, noted above. The Appellate Court found that there was insufficient evidence in the record to support Dr. Renn's opinion that Petitioner's significant history of inhalation of coal dust was not a contributing or aggravating cause of his COPD. The Appellate Court found that the Commission's finding that his COPD was solely caused by cigarette smoking is against the manifest weight of the evidence. The Appellate Court reversed the Commission's decision that Petitioner failed to prove an exposure to an occupational disease arising out of and in the course of his employment and that his condition of ill-being is causally related to his employment. The Appellate Court remanded

to the Commission for a determination of whether disablement exists and if so, the nature and extent of the disability caused by Petitioner's COPD.

In its Decision and Opinion On Remand dated March 29, 2013, the Commission modified the Decision of the Arbitrator finding that, although Petitioner has proven exposure to the occupational disease of COPD arising out of and in the course of his employment and that his condition of ill-being is causally related to his employment, Petitioner failed to prove disablement and denied his claim. The Commission otherwise affirmed and adopted the Decision of the Arbitrator. Petitioner appealed to the Circuit Court of Sangamon County. On May 6, 2014, the Circuit Court confirmed the Commission's Decision.

Petitioner appealed to the Appellate Court. In its Rule 23 Order filed November 13, 2015, the Appellate Court reversed the Commission's Decision and Opinion On Remand, holding that it was contrary to the manifest weight of the evidence where the clearly evident, plain and substantial evidence established claimant suffered a disablement during the relevant statutory period set forth in the Occupational Disease Act. The Appellate Court noted that the Commission's finding that Petitioner did not suffer disablement rested solely on its rejection of Petitioner's testimony that he experienced shortness of breath for a year prior to his January 10, 2006 visit to Dr. Houser based on its observation that this testimony was not corroborated by other medical records. The Appellate Court noted that it was well settled that "a claimant may recover on his own testimony without corroboration." *Old Ben Coal Co. v. Industrial Commission*, 198 Ill.App. 3d 485, 492 (1990).

Based on the November 13, 2015 Order of the Appellate Court, the Commission finds that Petitioner proved he suffered disablement during the statutory period set forth in the Occupational Disease Act. The Commission further finds that Petitioner sustained permanent disability to the extent of 10% of the person as a whole for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner testified that he worked at the Industry Mine in March 1992 and worked there until he was laid off on November 7, 2003. Petitioner testified he first noticed a breathing change probably in 1999, while working at the Industry Mine. The plant area where he worked was three floors tall and to the top of the plant was nine floors tall. Petitioner's job was to fix any machine that broke down and the machines usually broke down high. Petitioner had to climb steps and carry tools to reach the machines. Petitioner testified he noticed breathing problems with climbing the steps. Petitioner would have to stop at least twice and take a couple minute break. His tool pouch probably weighed 20 to 25 pounds. Petitioner testified that he currently noticed that on level ground, he can walk a mile or more on a better day, but on a bad day he could force himself to walk that distance. Petitioner lived in a ground floor apartment. Stairs bother him some still. From 1999 until the present time, Petitioner has noticed that his

breathing has gotten somewhat worse. His breathing is not real bad, but worse. On the days that his breathing problems are bad, it bothers him if he takes the laundry or trash out and it slows him down somewhat. Petitioner does not climb stairs if he does not have to. He golfed a lot until the end of 2005 and has golfed very little since then. For a long time Petitioner would walk for 9 holes and ride in a cart for 9 holes, which did not feel that bad. Currently he could not walk the 9 holes. Most days he just did not feel like walking 9 holes, so he just gave up golf. He played once and rode a cart. He was not currently taking any breathing medications.

On cross-examination, Petitioner testified he was laid off and then on November 7, 2003 resigned his employment with Respondent and took his retirement effective February 1, 2004, when he began receiving retirement benefits. It did not look like he was going to get recalled, so he went ahead and took retirement pension. Petitioner was going to work until age 65, but he was 62 years old when he resigned. In 2005, Petitioner stopped playing as much golf as he had been. He had been a member of Gold Hills Golf Club in Macomb and he played 5 days a week, but not on Saturday or Sunday. As part of therapy rehabilitation for his heart condition, Petitioner was encouraged to walk. He did not currently walk very often. Petitioner has been trying to do some swimming at his daughter's outdoor pool at her home. During the season, he goes there and swims. He swims one lap, then rests, and then swims another lap. At his attorney's request, Petitioner saw Dr. Houser for a black lung claim. Petitioner has not worked anywhere since he left Respondent's employment.

On re-direct examination, Petitioner testified he saw Dr. Houser in January 2006. Petitioner testified that his breathing condition has probably changed since he saw Dr. Houser. Certain days it will be a little worse than other days and he could not say a percentage.

2. Marshall Browning Hospital, Dr. Fulk records, Joint Ex1, show Petitioner was seen on October 5, 1988 for complaints of his lungs being congested and he was wheezing. He was diagnosed with bronchitis and the flu. A chest x-ray report from that date indicated there were several small opacities projected through the periphery of the right mid lung field. These were not seen in the lateral view and the radiologist noted these probably represented screen artifacts. The lungs were otherwise clear. The radiologist's impression was the densities on the right were probably artefactual and there was no apparent active disease. On May 7, 1990, Petitioner complained of chest pains for the last 2 weeks and 4-5 episodes while at rest. It was noted that Petitioner smoked 2 packs a day for 30 years. On examination his lungs were clear. He was diagnosed with chest pain and was referred to a cardiologist. On May 8, 1990, Petitioner had a positive treadmill stress test at a high level of exercise. On May 14, 1990, Petitioner had a negative treadmill stress test. On December 20, 1991, it was noted that Petitioner was not smoking and that he quit in August 1991.

3. Lamoine Valley Clinic records, Joint Ex5, show that Petitioner was seen on January 20, 1997 and assessed with bronchitis. McDonough District Hospital records, Joint Ex2, indicate Petitioner underwent a thorax CT scan on May 17, 1999, which was compared to a study done on November 22, 1996. A right upper lobe nodule was slightly increased in size since the prior

exam. Right lower lobe nodules were not significantly changed. Both were non-calcified. A June 3, 1999 Surgical Report indicated Petitioner underwent a fiberoptic bronchoscopy with brushings and washings. Indications were pulmonary nodules and rule out occult carcinoma. The impression was noted as left upper lobe and right lower lobe pulmonary nodules with left upper lobe increased in size on chest CT scan compared to 1996 and there was no evidence of endobronchial neoplasm or extrinsic mass effect, but there was evidence of chronic bronchitis. A June 17, 1999 Specimen Report indicated that from the left upper lobe washing there were a few fungus colonies isolated. In an October 25, 1999 CT scan of the abdomen, a non-calcified nodule in the medial right lung base was again noted.

4. Petitioner was seen at McDonough District Hospital on October 16, 2000 for complaints of chest pain. Chest x-ray revealed no infiltrates or effusion and a left upper lobe nodule was present. Chest CT revealed increased size of the nodule present in the left upper lung field. Petitioner was diagnosed with angina pectoris and left pulmonary nodule. (Joint Ex2). Prairie Cardiovascular Consultants records, Joint Ex3, indicate that in an October 21, 2000 Operative Report, it was noted that pre-operatively Petitioner was diagnosed with: 1) coronary artery disease with unstable angina; 2) left upper lobe nodule. Procedures performed were: 1) octopus coronary bypass grafting; 2) wedge resection of left upper lobe nodule. The nodule was later determined to be consistent with histoplasmosis.

5. Lamoine Valley Clinic records show that on August 14, 2001, Petitioner was diagnosed with bronchitis. On September 11, 2001, his bronchitis was not better and he was prescribed medications. His bronchitis was better on October 9, 2001. On December 12, 2001, Petitioner was assessed with sinusitis and bronchitis. (Joint Ex5).

6. On February 5, 2002, Petitioner was seen at McDonough District Hospital for complaints of chest pain. Petitioner reported chest discomfort at work at 1:00 p.m., which had resolved by 5:00 p.m. A past surgical history was significant for partial pneumonectomy secondary to lung neoplasm in 2000 was noted as was a past history of tobacco use. Petitioner complained of occasional shortness of breath and dyspnea on exertion. (Joint Ex2).

Memorial Medical Center records, Joint Ex4, indicate that on February 6, 2002, Petitioner was admitted for evaluation and treatment of an acute myocardial infarction. On examination, the lungs were clear to percussion and auscultation, breath sounds were a bit distant, but otherwise unremarkable with no wheezes and no rales.

7. Petitioner was seen at Lamoine Valley Clinic on April 30, 2002 for complaints of chest congestion, headache and cough and was assessed with bronchitis and prescribed medications. (Joint Ex5).

8. Petitioner presented at McDonough District Hospital on January 13, 2003 with complaints of chest pain. A chest x-ray showed the lungs well expanded and there was some scarring with no evidence of an active process. The radiologist's impression was no evidence of active chest disease. (Joint Ex2).

Petitioner was seen by Dr. Mishkel of Prairie Cardiovascular Consultants on January 14, 2003 for cardiac consultation for angina chest discomfort. Dr. Mishkel noted a past surgical history of bypass grafting in 2000. Petitioner reported a recurrent ischemic event the previous Sunday, January 12, 2003. (Joint Ex3).

Lamoine Valley Clinic records show that on January 21, 2003, it was noted that Petitioner had another myocardial infarction on January 12, 2003 and could not breathe, but was improving. (Joint Ex5).

9. Prairie Cardiovascular Consultants records indicate that on August 11, 2003 and August 13, 2003, Petitioner underwent a Dipyridamole Dual Isotope Thallium/Sesta-Mibi scan. The results of perfusion and wall motion study were within normal limits. There was no evidence of myocardial ischemia or previous myocardial infarction. On August 19, 2003, Dr. Kacich noted that stress tests ECG and nuclear portions were satisfactory. Dr. Kacich noted that nuclear images showed Petitioner's heart muscle pumping normally and did not suggest that he had significant blockages currently that were not effectively bypassed. The results suggested low risk of significant un-bypassed coronary blockages at that time. (Joint Ex3).

10. Petitioner was seen at McDonough District Hospital on December 6, 2004 for complaints of abdominal fullness. CT scan of the abdomen was performed and showed there was a right basilar lung nodule, which appeared to have a small calcific nidus and appeared unchanged over the study of October 25, 1999. (Joint Ex2).

11. In his January 10, 2006 report, Px1, DepExPx2, Dr. Houser noted that Petitioner reported being "out of breath" for over the past year. Petitioner reported he is dyspneic climbing stairs or walking hills when he plays golf. Petitioner reported he had previously been able to walk 18 holes playing golf and currently had difficulty with this. Petitioner reported he walked fairly regularly 1½ to 3 miles at a pace of 1 mile in 20 minutes. Petitioner reported having an occasional cough and occasional wheezing. Dr. Houser opined Petitioner had mild COPD.

Based on Petitioner's testimony and the medical records noted above, the Commission finds that Petitioner sustained permanent disability to the extent of 10% of the person as a whole for his work-related condition of mild COPD. Petitioner's average weekly wage was $890.00.

16IWCC0309

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $534.00 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 10%.

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 $26,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 9 - 2016
MB/maw
o04/21/16
43

Mario Basurto

Joshua D. Luskin

David L. Gore

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

Olubayo Okunola Deceased
& Helen Okunola,
Petitioner,

vs.

NO: 06 WC 020336

Jackson Park Hospital,
Respondent,

16IWCC0355

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 27, 2014 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: MAY 26 2016

MB/mam
o:5/12/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OKUNOLA, OLUBAYO
Employee/Petitioner

Case# **06WC020336**

10WC021225

16IWCC0355

JACKSON PARK HOSPITAL
Employer/Respondent

On 1/27/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5271 LEADERS LAW CENTER
OINOLABI ALABA
407 S DEARBORN ST SUITE 407
CHICAGO, IL 60605

4027 ODELSON & STERK LTD
MATT DALEY
3318 W 95TH ST
EVERGREEN PARK, IL 60805

16IWCC0355

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

Olubayo Okunola
Employee/Petitioner

v.

Jackson Park Hospital
Employer/Respondent

Case # 06 WC 20336

Consolidated cases: 10 WC 21225

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Lynette Thompson-Smith, Arbitrator of the Commission, in the city of Chicago, on **October 30, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0355

FINDINGS

On July 20, 2004, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$49,920.00** average weekly wage was **$960.00.**

On the date of accident, Petitioner was 54 years of age, ***married*** with 0 dependent children.

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

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

ORDER

The petitioner has not proven, by a preponderance of the evidence, that an accident arose out of in the course of his employment therefore no benefits are awarded, pursuant to the Act.

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

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

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

Anthony Minnice,
Petitioner,

vs.

NO: 06 WC 26092
07 WC 16689

State of Illinois,
Respondent,

16IWCC0341

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, temporary total disability, permanency and additional compensation and/or attorneys' fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof with the exceptions noted below.

The Commission finds that on page 12 of the Arbitration decision it indicates that Petitioner's second temporary total disability period commenced on December 2, 2006 when it actually commenced on December 21, 2006. The Commission further strikes the paragraph on page 12 of the decision which states that Petitioner's permanent and total disability benefits commenced on July 10, 2015 and finds that said benefits actually commenced on August 17, 2009. Lastly, the Commission finds that Respondent's nonpayment of temporary total disability benefits occurred after his service-connected disability leave of absence elapsed and was of such a short duration that it does not warrant additional compensation and/or attorneys' fees to be paid to the Petitioner.

16IWCC0341

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 9, 2015 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 in the amount of $196,576.20 for temporary total disability payments and $3,935.47 for disability/maintenance payments paid, to or on behalf of Petitioner on account of said accidental injury.

DATED: MAY 20 2016

MB/jm

O: 3/24/16

43

Mario Basurto

Stephen Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MINNICE, ANTHONY
Employee/Petitioner

Case# **06WC026092**

07WC016689

STATE OF ILLINOIS
Employer/Respondent

16IWCC0341

On 9/9/2015, 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 0.27% shall accrue from the date listed above to the day before the 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:

1505 SLAVIN & SLAVIN LLC
DAVID VanOVERLOOP
20 S CLARK ST SUITE 510
CHICAGO, IL 60603

4390 ASSISTANT ATTORNEY GENERAL
ERIN DOUGHTY
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

SEP 9 - 2015

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Anthony Minnice
Employee/Petitioner

v.

State of Illinois
Employer/Respondent

16IWCC0341

Case # 06 WC 26092

Consolidated cases: 07 WC 16689

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maria S. Bocanegra**, Arbitrator of the Commission, in the city of **Chicago**, on **7/10/15**. 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 **Permanent Total Disability**

16IWCC0341

FINDINGS

On **4/6/06 and 12/20/06**, Respondent ***was*** operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

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

Timely notice of the accidents ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$11,321.90 over 16-5/7 weeks**; the parties stipulate average weekly wage was **$677.38**.

On the date of accident, Petitioner was **40 and 41** years of age respectively, ***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 **$196,576.20** for TTD, **$0** for TPD and **$3,935.47** in disability/ maintenance benefit payments.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$451.59**/week for **175-3/7**th weeks, commencing **4/7/06** through **12/19/06** and **12/21/06** through **8/17/09**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of benefits paid to Petitioner.

Respondent shall pay reasonable and necessary medical services of **$2,075.00**, subject to Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid.

Respondent shall pay Petitioner permanent total disability benefits of **$451.59**/week for **307-4/7** weeks, commencing **8/18/09** through **7/9/15**, as provided in Section 8(f) of the Act. Respondent shall be given a credit of benefits paid to Petitioner.

Respondent shall pay Petitioner permanent and total disability benefits of $451.59/week for life, commencing **7/10/15**. 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

9/8/2015
Date

SEP 9 - 2015

FINDINGS OF FACT

Anthony J. Minnice ("Petitioner") testified that on 4/6/06 he was employed with the Illinois Secretary of State ("Respondent") as an Administrative Assistant III through the physical services department and had been so employed with Respondent since 1999. Duties entailed supervision of delivery of mail on a daily basis for all state facilities. Prior to that job, he worked as an auto parts auditor. He also previously worked as safety inspector with the county investigating workers compensation accidents.

On 4/6/06, Petitioner testified fine and was in a healthy condition. On that date he worked for Respondent loading and unloading a van with license plates and supplies. In the early afternoon, Petitioner was pulling a cart of license plates and other supplies, weighing approximately 170 pounds, up a handicap ramp when he felt severe back pain with pain and weakness in the right leg. He immediately notified his supervisor and ended his shift. Petitioner testified he had experienced back injuries in the past, but never felt pain this severe before. On direct examination, Petitioner admitted and acknowledged that he had a prior lower back workers' compensation claim. He stated he had a prior cervical fusion. He stated he last treated for these around 1999. Petitioner stated he also had prior knee surgeries.

On 4/13/16, an Initial Workers' Compensation Medical Report for the Respondent was completed, noting Petitioner injured himself on 4/6/06 while pulling a hand cart up ramp, twisting his low back.

On that same date, Petitioner saw Dr. Howard Konowitz, who noted Petitioner presented with "exacerbation of his low back pain and right anterolateral radicular leg pain that stops at the lateral knee." The doctor noted he previously had answered an emergency phone call over the prior weekend relating to Petitioner's work accident occurring on 4/6/06. Dr. Konowitz noted Petitioner's initial onset of back pain following pulling a cart up a handicap ramp followed by an increase in low back pain as well as the right anterolateral pain at the knee the next day. Exam on that date showed full lumbar spine flexion, limited right side bend, postural alignment and normal gait. Subjectively, Petitioner complained of right leg radicular pain. Straight leg raise was positive on the right in sitting and lying. Petitioner's weight was noted to be 5'7'' in height and 220 pounds in weight. The doctor prescribed Mobic, Meloxicam, Lidoderm, and continued Ultram and Skelaxin. The doctor ordered an MRI of the lumbar spine, therapy and ordered Petitioner off of work. Petitioner was referred back to his primary care doctor for unrelated workers' compensation conditions. Petitioner filed an Application for Adjustment of Claim for the 4/6/06 injury which was assigned case number 06 WC 26092. Ax2.

On 5/19/06, Dr. Konowitz continued to diagnose low back pain and right radicular leg pain. MRI of the lumbar spine was ordered. Petitioner reported mild to moderate improvement in symptoms with medical management. Subjectively, petitioner also reported constant stabbing, sharp, dull and diffuse pain, worse in the morning and afternoon. Dr. Konowitz noted Petitioner remained off of work since 4/13/06.

On 6/6/06, MRI of lumbar spine revealed small to moderate central disc protrusion at L5-S1 centered just to the right of the midline and abutting the right S1 nerve root within the lateral recess. Upon reviewing the MRI, Dr. Konowitz recommended physical therapy and epidural steroid injections. On 6/12/06, Dr. Konowitz reevaluated Petitioner and noted continued and unchanged right radicular leg pain with numbness. The doctor ordered medications, therapy and referred Petitioner for a caudal epidural steroid injection

On 6/20/06, Petitioner underwent caudal injections with Dr. Konowitz. Px1. Petitioner testified that he had received injections in the past for his prior back injury, and on those occasions he experienced immediate and lasting relief. However, this time he had no relief from steroid injections or therapy.

On 7/7/06, Petitioner returned to Dr. Konowitz following his injection. He complained of continued central low back pain and right radicular leg pain, distributing in a lateral distribution down the right buttock and hip stopping just below the knee. He also complained of a new sensation of numbness overlying the same area and a feeling of giving out in the knee area. The doctor noted petitioner was set to begin home exercise at his local community swimming pool following a delay in physical therapy. The doctor prescribed Trileptal and EMG testing.

On 7/13/06, Petitioner underwent a physical therapy initial evaluation through Illinois Bone & Joint Institute. Px1. Petitioner related he injured himself after pushing supplies on a two wheeled cart up a ramp and that his back locked up as he attempted to take a turn. Therapists noted that Petitioner had back pain going back 20 years but was resolved since 1999 following epidural steroid shots. At that visit, Petitioner complained of 7 out of 10 pain and 5-6 out of 10 pains at best. He also complained of right low back pain with numbness down to his right knee that started a couple of days later. Petitioner reported pain with sitting, standing, walking, worse with coughing and sneezing. Objectively, Petitioner was observed sitting with a slumped forward posture, leaning to the right along with a lateral shift to the right. Palpation showed tenderness to the right low back, right buttock and right lateral thigh. Active range of motion in trunk flexion was within functional limits and with radiculopathy. Trunk extension and rotation was decreased by 25%-50% with radiculopathy and right low back pain. Functional deficits included pain and difficulty with stairs, sitting, standing and walking. Neurologically, Petitioner reported decreased light touch in the right L2-4 dermatomal regions in the thigh. Therapists assessed low back pain and S1 disc "after sustaining work injury" on 4/6/06. Physical therapy was determined medically necessary to address intermittent right leg radiculopathy, moderate weakness in the right and restrictions in trunk extension and rotation.

On 7/27/06, Dr. Konowitz issued a reevaluation note addressed to Dr. Yapor indicating that Petitioner's recent caudal injection was of no help. Subjectively, Petitioner continued to report the same symptoms and noted delay in treatment approval as well as some cervical pain in doing therapy exercises. The doctor continued to recommend therapy, home exercise such as swimming pool exercises, medications and an EMG, to be used both diagnostically and therapeutically to determine appropriate injection, if any. On 7/27/06, Dr. Yapor's office completed physician statement forms for Respondent and diagnosed Petitioner with right L5-S1 disc protrusion, low back pain and right radicular leg pain. Px1.

On 8/22/06, physical therapy progress summary showed continued right low back pain with mild radiculopathy into the right posterior thigh. Additional therapy was recommended. On 8/24/06, Dr. Konowitz re-examined Petitioner, noting continued right low back pain radiating in a posterolateral fashion down the right buttock into the lateral leg at the lateral knee. Petitioner had already begun physical and aquatic therapy. Subjectively, Petitioner complained of constant burning, stabbing, sharp, dull, diffuse pain. Active problem list included small moderate central disc protrusion at L5-S1 right of the midline abutting the right S1 nerve root, right lower extremity radiculopathy, low back pain and unrelated hypertension. The doctor continued therapies and withheld any additional injections pending follow up with Dr. Yapor.

On 8/30/06, EMG results showed chronic L5-S1 bilateral radiculopathy on the right "most likely related to his severe L5-S1 degenerative disk disease with both central (S1 impingement) and foraminal (L5

impingement) protrusion of the disk." The doctor recommended L5 and S1 selective nerve root blocks on the right and if the results were not satisfactory he would need a neurosurgical opinion about foraminotomy and microdiscectomy at L5-S1 level. Px1.

On 9/21/06, Petitioner followed up with Dr. Konowitz's office. Symptoms were unchanged and non-responsive to Cymbalta. Physical therapy was voluntarily ceased due to lack of progress. The doctor noted that EMG results showed right L5-S1 radiculopathy. Petitioner related he continued to perform home exercise and had recently been placed on medications for unrelated hypertension. The doctor's assessment was unchanged.

On 10/3/06, Petitioner underwent and Dr. Konowitz performed a lumbar transforaminal selective nerve root block on the right at L5-S1 with C-arm guidance. On 10/11/06, Petitioner was discharged from physical therapy. Therapists noted Petitioner complained of increasing radicular pain. On 10/12/06, Petitioner was evaluated by Dr. Yapor. Px2. The doctor noted that Petitioner had no complaints and had a full recovery with respect to his prior cervical spinal surgery and that on 4/6/06, Petitioner began complaining of severe low back pain radiating into both thighs and gluteal regions. Physical exam showed no focal deficit but extremely limited range of motion of the lumbar spine secondary to discomfort. The doctor interpreted Petitioner's most recent MRI of the lumbar spine as showing L3-L5 degenerative disk disease. Yapor read the EMG to show chronic bilateral radiculopathies at L5-S1, worse on the right. Dr. Yapor recommended a decompression and fusion of the L5-S1 levels. Px2. On 10/19/06, Petitioner followed up with Dr. Konowitz, reporting continued right low back pain radiating down in the posterolateral distribution down the right leg and new left anterior thigh pain. He also continued to note areas of numbness, tingling and dysesthesias. The doctor noted that Petitioner was non-responsive to his most recent TESI. The doctor diagnosed chronic right L5-S1 radiculopathy and small to moderate central disc protrusion at L5-S1 on the right of the midline. Petitioner was encouraged to follow up as needed both pre and post operatively.

On 11/20/06, Petitioner underwent a section 12 exam with Dr. Kern Singh at the request of Respondent. Petitioner testified that the exam lasted approximately fifteen minutes. Dr. Singh diagnosed the Petitioner with an aggravation of preexisting degenerative disc disease in his lumbar spine and opined that Petitioner was not in need of surgical intervention and could return to work at full duty. Dr. Singh placed Petitioner at maximum medical improvement. Rx4. Respondent subsequently issued several letters denying payment of various medical bills, citing Dr. Singh's MMI date for Petitioner. Px1.

On 12/11/06, Petitioner again followed up with Dr. Konowitz. He presented with continued right low back pain with a radicular component radiating in a posterolateral distribution down the right leg with numbness, along with a perceived weakness in the right lower extremity for which he used a cane. Subjectively, petitioner described his pain as burning, throbbing, stabbing, sharp, cramping, tingling and numbing in nature. Physical exam showed non-antalgic gait, ability to heel-toe walk, negative Flamingo exam, diminished sensory and vibration at right lower extremity and trace reflex at the right Achilles, otherwise 1+ and symmetric. Diagnosis was unchanged and Petitioner was directed to follow up with Dr. Yapor.

On 12/12/06, Dr. Yapor re-evaluated Petitioner and continued to recommend a fusion and decompression from L4-S1. Dr. Yapor encouraged Petitioner to seek another opinion. Px2. On 12/14/06, Petitioner was evaluated by Dr. Butler at Illinois Bone and Joint Institute. Dr. Butler noted Petitioner's work injury after pulling a cart up a handicap ramp and feeling severe pain in the low back when turning the cart to the left. Dr. Butler noted Dr. Singh, whose records were available for review at the time of the initial evaluation; found causal connection. After reviewing the medical records, including the lumbar x-ray and

lumbar MRI, Dr. Butler diagnosed Petitioner with lumbar disc degeneration at L5-S1 and mild to moderate degeneration at L4-L5. Dr. Butler felt that Petitioner would be a candidate for a lumbar discogram to verify whether or not the L4-L5 level was a pain generator. Px1, Px2.

Petitioner testified that based on Dr. Singh's recommendations, he attempted to return to work. On 12/20/06, Petitioner re-injured his low back after moving a file box weighing approximately twenty pounds from the counter to the floor. He testified he felt severe pain in his back that radiated through his right leg and buttocks. Petitioner alerted his supervisor and immediately ended his work shift. Petitioner followed up with Dr. Konowitz the next day and was taken back off of work. Petitioner filed a second Application for Adjustment of Claim for the 12/20/06 injury, which was assigned case number 07 WC 16689. Ax3.

Petitioner completed Respondent's Worker's Compensation Employee's Notice of Injury form, noting he injured his low back after attempting to lift a 20 pound box from the counter to the floor. A witness named John Hampilos provided a written witness report indicating he witnessed the accident. Px1. According to Petitioner's medical record, Dr. Yapor removed Petitioner from work indefinitely beginning 12/21/06. Px1.

On 12/21/06, Petitioner saw Dr. Konowitz, who noted that Petitioner presented with an "exacerbation of his existing pain state in the right low back and buttock radiating in a lateral distribution down his right leg with continued numbness at the right lateral and anterior thigh," after lifting a box off of a table from a right to a left twisting position and dropped the box due to increase sharp pain in the right low back. The doctor noted no new areas of pain or weakness but there was an increase in intensity of the pain state. Subjectively, Petitioner described his pain as burning, stabbing, sharp, cramping and spasm-like. Physical exam showed normal gait, ability to heel-toe walk, negative Flamingo testing, full range of motion of the lumbar spine, decreased sensation at the right lower lateral extremity and tenderness to palpation at the right PSIS and sciatic notch along with positive straight leg raise on the right. Dr. Konowitz concluded that there was no change in examination state from Petitioner's most recent prior visit but that there was a subjective increase in his pain state. Therefore, the doctor removed Petitioner from work and placed him on Zonegran.

On 4/2/07, Petitioner was re-evaluated by Dr. Kern Singh at Respondent's request. Rx5. The doctor diagnosed chronic L5-S1 radiculopathy on the right and recommended a right sided L4-5 and L5-S1 hemilaminotomy and foraminotomy to decompress the nerve roots. The doctor noted that Petitioner reported that 70% of his pain was low extremity pain and 30% was low back pain.

On 6/20/07, Petitioner underwent and Dr. Yapor performed a L4-L5 laminectomy, L4-5 and L5-S1 posterior lumbar interbody fusion (PLIF), L4-S1 with bilateral posterior instrumentation along with intra-operative somatosensory evoked potential (SEPs or SSEPs) monitoring. Px2. Petitioner testified that after surgery he was in a lot of pain but felt some relief in his right leg. However, he had new numbness in his left leg. Petitioner was hospitalized for seven days. Px9. On 6/27/07 Petitioner is evaluated and eventually cleared for physical therapy. Px9. Neurological exam showed greatly diminished reflex in the upper limbs and lower limbs. Lower limb exam showed good movements in ankle plantar flexion and dorsiflexion and extensor hallucis longus bilaterally. Petitioner also had good isolated strength in knee extension and flexion as well with decrease sensation over the dorsum of the left foot. Therapists assessed lumbar myelopathy, status post fusion surgery. Physical and occupational therapy was recommended.

On 7/3/07, Dr. Konowitz re-evaluated who at that time was 2 weeks status post L3-S1 fusion per Dr. Yapor. Dr. Konowitz noted continued right lateral leg pain with dysesthesias and a new pain in the left lateral

leg radiating down to the ankle with dysesthesias, swelling and numbness in the toes and heel. The doctor diagnosed bilateral radicular leg pain and dysesthesias, low back and coccygeal pain. Follow up was ordered. On 7/5/07, Petitioner presented to Resurrection Medical Center Emergency Room for severe swelling and pain in the left calf and DVT was ruled out. Px9.

On 7/10/07, Petitioner followed up with Dr. Yapor, who noted Petitioner's recent emergency room visit for left foot swelling, where DVT was ruled out. The doctor noted Petitioner remained brace compliant and he recommended a CDT scan in one month. On 7/24/07, Petitioner followed up with Dr. Konowitz. Px1. Petitioner reported overall improvement in low back and radicular leg pain. He continued to report numbness in the bilateral feet. The doctor diagnosed post laminectomy pain syndrome, bilateral foot numbness and dysesthesias and right lower extremity radiculopathy.

On 8/17/07, Petitioner underwent a CT scan of the lumbar spine as recommended by Dr. Yapor. Px2. Impression showed canal stenosis of a moderate degree at L5-S1, probable bone graft material along the anterior portion of the epidural space and that disc spacers appeared somewhat more posteriorly located as was seen at L4-5. The doctor concluded that the bone grafting material may have been present along the anterior epidural space or imaging represented calcified disc material. Clinical correlation was suggested. On 8/28/07, Dr. Yapor re-evaluated Petitioner and noted continued complaints of numbness in the left foot. The doctor reviewed the CT, concluded excellent progression of fusion and intact hardware. On 9/18/07, Dr. Yapor completed Respondent's physician statement indicating Petitioner remained temporarily and totally disabled. Px15.

On 10/2/07, Petitioner was re-evaluated by Dr. Konowitz. Px1. Physical exam showed ability to heel-toe walk, normal gait, negative straight leg raise in sitting position, 5 out of 5 manual muscle testing and absent reflexes for the right quadriceps and Achilles .5 for the left. Sensory and vibration were symmetrical. The doctor recommended Ultram or Skelaxin and Napralen. On 11/13/07, Petitioner followed up with Dr. Yapor and reported he was progressing in therapy but still has some numbness in the left foot. Petitioner was recommended to continue therapy, to drive on a tolerated basis and to remain off of work. Follow up after completion of therapy was ordered.

On 12/18/07, Petitioner again followed up with Dr. Yapor. Petitioner had only attended 3 sessions of pool therapy due to administrative delays in insurance approval. Petitioner continued to complain of numbness in the left lower extremity and discomfort along the hips bilaterally and the lateral aspect of the upper thigh. Dr. Yapor recommended a functional capacity evaluation. On 1/2/08, Dr. Yapor completed his physician statement to Respondent and his recommendations and opinions remain unchanged. On 1/29/08, Petitioner returned to Dr. Yapor stating that his right lower extremity has given out on three occasions. The left lower extremity remained unchanged. Based on the new symptomology, the doctor ordered a new MRI of the lumbar spine, along with a CT scan and EMG/NCV testing.

These recommended tests were not completed until 8/13/08, at which time MRI of the lumbar spine showed extradural soft tissue defect elevating the posterior longitudinal ligament at L5-S1 posteriorly likely relating to bone stimulating agent or bone graft with mild posterior translation of the spacers at L5-S1. CT scan of the lumbar spine showed an "increase in the moderate to severe canal stenosis at the level of L5-S1 with increased ossification of the bone graft material in the anterior portion of the epidural space along with moderate bilateral neural foraminal narrowing." There was no evidence of mechanical hardware failure of screws or rods.

On 8/19/08, Petitioner followed up with Dr. Yapor, who noted that Petitioner had residual symptoms in the lower extremities and that he had not changed significantly. Petitioner related that he had been experiencing new symptoms in the left knee joint and feels a thought the knee is going through changes including intermittent swelling and palpable bony ridges. An MRI of the knee as thoracic spine was recommended, due to mid-thoracic discomfort complaints. The doctor reviewed the MRI and CT scan and felt that the bony prominence at L5-S1 visualized was not symptomatic since Petitioner did not have any S1 radicular complaint. The doctor concluded Petitioner was permanently and totally disabled from his pre-injury job. Throughout recovery, Petitioner testified he had few improvements and struggled with numbness in his left leg. He testified that his left leg gave out several times and he struggled with continuous swelling and pain.

On 4/21/09, Petitioner returned to Dr. Yapor and continued to complain of left knee pain and bony palpable projection in the lateral aspect. Review of systems was positive for continued thoracic pain, left leg pain and numbness. Dr. Yapor's impression was that Petitioner remained permanently and totally disabled and should continue to limit his activities. The doctor did note that Petitioner's weight was a factor detrimental to his overall state of health, including this low back.

Four months later, on 8/18/09, Petitioner followed up with Dr. Yapor, who noted Petitioner's complaints were identical and that he presented with a cane to help stabilize his gait. Petitioner, according to Dr. Yapor, remained permanently disabled. Petitioner was encouraged to follow up as needed.

Six months later, on 2/17/10, Petitioner again followed up with Dr. Yapor. Petitioner remained unchanged and permanently disabled per doctor order. Px15.

Six months later, on 8/18/10, Dr. Yapor completed Respondent's Office of the Secretary of State's Department of Personnel Medical Leave Certification indicating Petitioner medical leave was to begin on 8/18/10 and that such leave would be permanent based on a diagnosis of advanced spinal degenerative disease. Px15. Dr. Yapor considered Petitioner permanently and totally disabled such that he is and would be unable to continue to do any kind of work related to gainful employment.

Six months later, on 2/10/11, Petitioner followed up with Dr. Yapor. Px5. Petitioner was unchanged in complaints and unchanged neurologically. Dr. Yapor completed Respondent's State Retirement Systems (SERS) Disability Medical Report and concluded Petitioner remained permanently and totally disabled. Px5, 15. The doctor also again completed Respondent's Office of the Secretary of State's Department of Personnel Medical Leave Certification and his opinions remained unchanged. Px15.

On 6/27/11, Petitioner was again re-evaluated by Dr. Kern Singh at the request of Respondent. Rx6. The doctor diagnosed residual spinal stenosis at L5-S1. Further, the doctor concluded that it appeared Petitioner had a persistent L5 radiculopathy and was concerned that the CT scan and MRI, dated 3 years earlier, showed ossification of the posterior longitudinal ligament as well as bone graft in the neural foraminal space at the L5-S1 level, which the doctor felt correlated with Petitioner's current L5 radiculopathy. Dr. Singh recommended a myleogram to determine whether revision surgery was needed to address "residual motor weakness." On that same date, Dr. Nikhil Verma evaluated Petitioner for recent left knee complaints and concluded those were unrelated to any work accidents. Rx7.

On 7/5/11, Dr. Singh reiterated his prior recommendation in an addendum, wherein he specifically identified posterior vertebral bone growth into the intervertebral space and neural foramen bilaterally. Rx8. Dr.

Singh opined the continuing stenosis could be due to such a diagnosis and that a myelogram would confirm such a diagnosis. Furthermore, if such a diagnosis would be confirmed, the Petitioner would benefit from a revision fusion, done posteriorly instead of anteriorly. Dr. Singh related the need for the myelogram to Petitioner's most recent injury. Dr. Singh indicated the claimant's work capacity to be "off duty until further intervention."

Petitioner testified he was apprehensive about the recommended test and did not want to undergo the procedure. Petitioner testified that he researched the procedure and its effectiveness. During follow up, Dr. Yapor felt that the need for Myelogram was suspect because existing CT scans and MRI reports showed the anatomy in fairly good detail.

On 8/2/11, Petitioner again followed up with Dr. Yapor, who continued to state that an increase in limited activities caused Petitioner to become more symptomatic. The doctor reviewed Dr. Singh's most recent evaluation report and noted that Petitioner's left knee was unrelated to his back but that Petitioner remained permanently and totally disabled as a result of his "advanced degenerative spinal disease." Petitioner was encouraged to continue taking over the counter Ibuprofen.

Six months later, on 2/9/12, Petitioner again followed up with Dr. Yapor who noted unchanged complaints. Px6. The doctor also again completed Respondent's Office of the Secretary of State's Department of Personnel Medical Leave Certification and his opinions remained unchanged. Px15.

Six months later, on 8/9/12, Dr. Yapor re-evaluated Petitioner. The doctor reviewed Dr. Singh's recommendation for a myelogram but questioned its efficacy in light of existing studies in Petitioner's medical record. Nevertheless, Dr. Yapor wrote a prescription for a lumbar myleogram and post myelogram CT. The doctor again completed Respondent's Office of the Secretary of State's Department of Personnel Medical Leave Certification as well as Respondent's State Retirement Systems (SERS) Disability Medical Report and concluded Petitioner remained permanently and totally disabled. Px15.

On 8/23/12, Petitioner underwent the lumbar CT myelogram. Petitioner testified that after the myelogram he was in severe pain. On 11/23/12, Dr. Singh reviewed the CT myelogram and found it to confirm the suspicions outlined in his prior reports. Dr. Singh recommended a left-sided L5-S1 hardware removal, exploration of Petitioner's fusion mass, neurolysis of the L5 nerve root with a revision laminoforaminotomy. Petitioner testified that he was aware of Dr. Singh's recommendation for surgery, but that he had been through enough and did not want any more surgical intervention. Petitioner testified that he discussed the recommendation with Dr. Yapor who advised him he believed surgery would not help and maintained Petitioner's permanent disability status.

Six months later, on 2/7/13, Petitioner followed up with Dr. Yapor and remained unchanged. Px7. The doctor again completed Respondent's Office of the Secretary of State's Department of Personnel Medical Leave Certification as well as Respondent's State Retirement Systems (SERS) Disability Medical Report and concluded Petitioner remained permanently and totally disabled. Px15.

As before, six months later, on 8/15/13, Petitioner followed up with Dr. Yapor, who noted Petitioner remained unchanged. The doctor continued to recommend Petitioner limit his activities. The doctor again completed Respondent's Office of the Secretary of State's Department of Personnel Medical Leave

Certification as well as Respondent's State Retirement Systems (SERS) Disability Medical Report and concluded Petitioner remained permanently and totally disabled. Px15.

On 2/7/14, Petitioner underwent a Functional Capacity Evaluation at Accelerated Rehabilitation at the referral of Respondent's doctor, Dr. Kern Singh. Px14, Rx10. Results highlighted that Petitioner was able to function minimally at the light to medium category of work, which consisted of two handed occasional lift/carry of 30 pounds from floor to waist level and two had frequent lift of 20 pounds from floor to waist. Therapists noted Petitioner gave questionable effort secondary to varied efforts demonstrated during performance of a variety of functional tasks. Therapists concluded that Petitioner demonstrated 50% inconsistent reliability of pain, he was capable of greater functional abilities that demonstrated during the FCE and that he was therefore employable at that time. Petitioner testified that after the FCE he was in bed with extreme pain for two days.

On 2/13/14, Petitioner followed up with Dr. Yapor. Px7. Yapor reviewed the FCE and found that Petitioner's condition was not as stable as it had been at prior visits. Dr. Yapor determined that despite the findings indicating Petitioner was physically capable of some activity, Petitioner should continue with his prior permanent total disability restriction in order to minimize symptoms. The doctor again completed Respondent's Office of the Secretary of State's Department of Personnel Medical Leave Certification as well as Respondent's State Retirement Systems (SERS) Disability Medical Report and concluded Petitioner remained permanently and totally disabled. Px15.

Six months later, on 8/19/14, Petitioner returned to Dr. Yapor, who noted Petitioner's advanced lumbar disc disease and recent findings of highly malignant bladder cancer. Px8. Petitioner's permanent disability was continued. The doctor again completed Respondent's Office of the Secretary of State's Department of Personnel Medical Leave Certification as well as Respondent's State Retirement Systems (SERS) Disability Medical Report and concluded Petitioner remained permanently and totally disabled. Px15.

Six months later, on 2/12/15, Petitioner followed up with Dr. Yapor. Px8. The doctor noted Petitioner had been undergoing chemotherapy from bladder cancer. Petitioner remained permanently disabled per Dr. Yapor. The doctor again completed Respondent's Office of the Secretary of State's Department of Personnel Medical Leave Certification as well as Respondent's State Retirement Systems (SERS) Disability Medical Report and concluded Petitioner remained permanently and totally disabled. Px8, 15.

On 5/27/15, Respondent issued a letter to Petitioner indicating that workers' compensation benefits were suspended as of 5/1/15 pursuant to Illinois' Administrative Code covering Personnel Rule 420.760(g)(4).[1] Px11. The letter, introduced into evidence over Respondent's objection at trial, indicated that Petitioner had the option of returning to work as an Administrative Assistant III in the Physical Services Department, as an Operations Associate in the Vehicle Services Department, the option to request a different type of leave or to resign. The letter also requested a release from Dr. Yapor for a return to work for either position, that Petitioner pass a written exam and request a voluntary reduction for the operations associate position. The letter describes the responsibilities and physical requirements of both positions.

Regarding his medical bills, Petitioner testified that Dr. Yapor still has an unpaid balance of $510.00, and that he had paid $450.00 out of pocket for visits he was required to attend in order to maintain the disability

[1] Rule 420.760(g)(4) provides that "An employee who suffers an on the job injury or illness and is unable to perform a substantial portion of the regularly assigned duties in accordance with subsection (a) shall also be subject to . . ." "In the event that the service-connected injury or illness is not deemed subject to benefits under the Act, the employee will be placed on non-service disability leave of absence or may use accumulated benefit time to cover any absences related to the incident." The Arbitrator, in taking judicial notice of the aforementioned applicable Rule, notes that the Rule's citation to "the Act," is in reference to the Illinois Workers' Compensation Act.

paperwork required by Respondent. Petitioner also testified to an outstanding bill with RMC Emergency Physicians in the amount of $865.00 for date of service 7/5/07. Px12. That account is in collections with Illinois Collection Service, account number 10638528 for the same amount.

Regarding his current condition, Petitioner noticed he has gained about 100 pounds, that he cannot do a lot of activities like before such as golf, hockey, baseball or softball. On cross, he stated he played golf, hockey and baseball since around age 12 but that the last time he had tried to play these was in the late 90s. He admitted that Dr. Konowitz recommended back in the late 90s that he refrain from participating in those activities and sports.

Petitioner also testified that as of the date of trial, he has low back has pain, numbness down his left leg all way down to foot, along with numbness down the right leg. In a typical day, Petitioner testified he experiences difficulty sleeping, he is up most of the night and sleeps on and off during the day. He spends time watching TV in the garage. He testified he occasionally drives, takes Hydrocodone daily as needed and has applied for social security disability benefits.

CONCLUSIONS OF LAW

ISSUE (F) Is Petitioner's current condition of ill-being is causally related the work accident?

The Arbitrator concludes that Petitioner's current condition of ill-being, namely Petitioner's L4-S1 lumbar disc disease, left foot pain and numbness and ultimate posterior lumbar interbody fusion at L4-S1 as well as all related pre and post operative medical treatment, to be causally connected to the undisputed work accidents of 4/6/06 in case 06 WC 26092 and 12/20/06 in case 07 WC 16689. In doing so concluding, the Arbitrator relies on the credible testimony of Petitioner, Petitioner's consistent and contemporaneous medical records as well as the opinions of Drs. Konowitz, Yapor, Butler and Dr. Singh.

Petitioner credibly testified that prior to starting work on 4/6/06 he was free from back pain, symptoms or injury. He was candid and forthcoming at trial that prior to 4/6/06, he had prior cervical (neck) injury resulting in fusion surgery following a work place injury. Petitioner's medical records support and corroborate his testimony in this regard. Px1. Of note, the medical records, which are extensive, are void of any lower back or lumbar back treatment from approximately 2003 leading up to the undisputed work accident of 4/6/06. Px1. The medical records for the time period of 2002-2003 are specifically for cervical (neck) and shoulder treatment. Petitioner's medical record further corroborates Petitioner's testimony that he last treated for his lower back (lumbar) around 1999. The record does show that as of the first accident in question occurring 4/6/06, Petitioner had permanent restrictions as to the cervical (neck) spine. Following Petitioner's 4/6/06 accident, Petitioner began treating for the low back (lumbar) once again. Px1-10. Petitioner's medical record shows his identified levels of the lumbar spine at that time causing pain and/or symptoms were L4-5 and L5-S1, based upon various imaging studies, diagnostic and therapeutic injections and targeted medical management.

Leading up to Petitioner's second work accident occurring 12/20/06, Petitioner credibly testified he was not pain free or symptom free in his low back (lumbar) but that he attempted to return to work per Respondent's doctor, Dr. Singh's, recommendations. Immediately upon returning to work, Petitioner credibly testified he re-injured and aggravated his low back (lumbar) after lifting a box at work. Records corroborate Petitioner's trial testimony regarding the details of his re-injury and the location of his symptoms, which were essentially the same if not identical as the 4/6/06 injury.

In addition to Petitioner's credible testimony, the Arbitrator relies on Petitioner's medical records and the opinions of his treating physicians. Petitioner's prior medical history leading up to the 4/6/06 accident is positive for prior low back injury and treatment, specifically at the L5-S1 level. This treatment occurred in 1999 and is corroborated by Petitioner's testimony. Following Petitioner's 4/6/06 injury, Petitioner reported experiencing severe low back pain eventually radiating primarily to the right leg. Petitioner's medical record showed disc protrusion at L5-S1 impinging on the S1 nerve root on the right, which was found to be consistent with Petitioner's subjective complaints of radicular pain. In addition to diagnostic studies being consistent with Petitioner's subjective complaints, the Arbitrator notes that both are also consistent with Drs. Konowitz's and Yapor's diagnosis, which was that of right L5-S1 disc protrusion, low back pain and right radicular pain. Respondent's doctor, Dr. Kern Singh, also confirmed Petitioner's state of ill-being, concluding at the 11/20/06 exam that Petitioner had suffered, as a result of the 4/6/06 accident, an "aggravation of preexisting degenerative disc disease," in the lumbar spine. Petitioner's second opinion doctor, Dr. Butler, agreed with Dr. Yapor that Petitioner was a surgical candidate based on the history of injury and treatment. At this point in the record, relying on the history and opinions of Drs. Yapor and Singh, the Arbitrator could reasonably find Petitioner's condition of ill-being causally related to the 4/6/06 accident based on a chain of events theory as evidenced by an absence of significant immediate prior low back injury, pain or treatment, followed by an immediate onset of severe low back and lower extremity pain.

Following Petitioner's second work accident, the medical record established Petitioner's mechanism of injury and noted Petitioner's increased low back pain. Dr. Konowitz opined that Petitioner suffered "an exacerbation of his existing pain state in the right low back and buttock radiating in a lateral distribution down his right leg with continued numbness at the right lateral and anterior thigh." The Arbitrator finds Dr. Konowitz's analysis persuasive and credible in highlighting the exact nature of Petitioner's re-injury. In fact, Dr. Konowitz's noted no change in physical examination but a change in Petitioner's subjective complaints of increased pain. Eventually, Dr. Singh agreed that Petitioner was in need of surgical intervention, although the type of surgery recommended differed. The Arbitrator finds the need for surgical intervention at the affected lumbar spine levels causally related to his condition of ill-being.

Following surgery, Petitioner suffered several complications, requiring hospitalization and ongoing treatment. Doctors diagnosed post laminectomy pain syndrome, bilateral foot numbness and dysesthesias and right lower extremity radiculopathy. This diagnosis is corroborated by Dr. Yapor's concern that petitioner continued to experience residual symptoms following surgery, including foot numbness, feeling of his leg giving way and weakness. Dr. Singh also expressed concern in his 2011 re-evaluations that Petitioner appeared to have a persistent L5 radiculopathy as the result of his neural foraminal stenosis secondary to bone growth into the cage at L5-S1. Dr. Singh suggested Petitioner's condition to be related to his most recent work accident. Since then, Petitioner's ongoing condition of ill-being has rendered him unable to return to work at any full duty capacity per Dr. Yapor. The Arbitrator finds Dr. Yapor's conclusions on Petitioner's ability to return to work consistent with Dr. Singh, who similarly suggested Petitioner could not return to work pending further intervention.

In addressing whether Petitioner's current condition is related to one or both accidents, the Arbitrator notes that although Dr. Singh believed Petitioner to be at MMI for his first accident, the medical records suggest otherwise. It is clear that Petitioner's subjective complaints continued into his return to work on 12/20/06 and his treating doctors had not changed their opinions with respect to diagnosis, MMI or return to work capabilities. In addition, Dr. Konowitz noted no change in examination following the second work accident,

only an increase in Petitioner's subjective complaints. Thus, Petitioner's treatment records show a continuum of lower back and lower extremity complaints, increasing on 12/20/06. However, surgery had already been recommended prior to the second work accident. Read as a whole, the medical records and the opinions of Drs. Konowitz, Yapor, Butler and Singh suggest that Petitioner's current condition is causally related to both of his work accidents, both of which were a causative factor in causing and/or contributing to Petitioner's conditions, subjective complaints and ultimate need for surgery.

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

Petitioner submitted the following medical bills and out of pocket payment receipts into evidence:

Northwestern Neurosurgical Associates / Dr. Yapor (Px10)	
8/15/13	$200.00
2/13/14	$160.00
8/19/14	$200.00
2/12/15	$200.00
RMC Emergency Physicians/Pathology (Px12)	
6/20/07	$351.00
7/5/07	$514.00
Out of Pocket Payment Receipts (Px10, Px16)	
9/7/10 Northwestern Neurosurgical Associates	$200.00
2/13/14 Northwestern Neurosurgical Associates	$150.00
2/12/15 Northwestern Neurosurgical Associates	$100.00

Regarding Northwestern Neurosurgical Associates, the Arbitrator notes that the relevant time is from 10/12/06 through 2/12/15. The Arbitrator finds that the identified dates of services, *supra*, correspond to dates of service wherein Dr. Yapor completed the disability paperwork required by Respondent on a semi-annual basis. Accordingly, such charges are reasonable and necessary. The Arbitrator is able to identify payments of $200.00 made by Petitioner evidenced on pages 12 and 13 reflecting credit card payments. Px10. In addition, there are out of pocket charges totaling $250.00. Respondent is ordered to reimburse Petitioner directly $450.00 in out of pocket expenses. Further, the Arbitrator orders Respondent to pay directly to Petitioner the outstanding balance of Dr. Yapor's bills, subject to Sections 8(a) and 8.2 of the Act.

Regarding the RMC Emergency Physicians/Pathology bill, the Arbitrator finds the bill associated with reasonable and necessary treatment. Px12. Specifically, the 6/20/07 date of service corresponds to Petitioner's date of lumbar surgery with Dr. Yapor. Similarly, the 7/5/07 date of service corresponds to Petitioner's emergency room visit as a result of post-operative complications, which were acknowledged by Dr. Singh in his examination report. Respondent is ordered to pay directly to Petitioner the outstanding balances identified in Px12 subject to Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Ax1, Rx2-3.

ISSUE (L), (O) ***What is the nature and extent of the injury?***

Having found in favor of Petitioner on the issue of causal connection and medical liability, the Arbitrator finds that Petitioner's condition has reached a state of permanency and therefore consideration of the nature and extent of his injury, if any, is ripe for consideration. In reaching this finding, the Arbitrator relies on the medical opinion of Dr. Yapor indicating on 8/17/09 that Petitioner was permanently and totally disabled and subsequent opinions that Petitioner remained as such. Petitioner did not receive any further medical treatment and to the extent that he did after this date, it was primarily for follow up, re-fill of medications and to complete Respondent's disability paperwork.

Dr. Yapor's medical opinion that Petitioner cannot return to work, even in the face of an FCE, is unrebutted and not contradicted by any credible evidence. Dr. Singh did not refute Petitioner was permanently and totally disabled, did not indicate Petitioner could return to work either within the restrictions in the FCE or within the job offer details contained in Px11. Neither Dr. Yapor or Dr. Singh adopted the recommendations of the therapist in the FCE.

Regarding the job offer made by Respondent to Petitioner on or about 5/27/15, the Arbitrator is not persuaded that these job offers are bonafide job offers as they are not within any restriction give by Drs. Yapor or Singh, nor do they even comport with any FCE, whether or not that FCE is valid. A closer examination of the job offers requires Petitioner be completely medically cleared to return to either position. At the time of the job offer letter, the most recent evaluation by Dr. Yapor, which occurred in February 2015, indicated Petitioner could not return to any work and that he was permanently and totally disabled. In addition, the most recent prior medical evaluation by Dr. Singh, which occurred in November 2012, did not return Petitioner to work but rather recommended surgery. Dr. Singh never reviewed the FCE from February 2014. Further, at the time of the February 2014 FCE, no job offer was made to Petitioner then, which supports that no bonafide job offer in fact existed. In summary, the Arbitrator is not persuaded that Petitioner can return to work as the purported job offer is not supported by any available medical evidence.

Therefore, the Arbitrator concludes that Petitioner is medically permanently and totally disabled and relies on the medical opinion of Dr. Yapor in so concluding. The Arbitrator orders Respondent to pay **307-3/7** weeks of permanent and total disability benefits at the rate of **$451.59** for the period of **8/18/09** through **7/9/15**. Respondent shall be given a credit of benefits paid to Petitioner.

The Arbitrator further orders that Respondent shall pay Petitioner permanent and total disability benefits of $**451.59**/week for life, commencing **7/10/15**, as provided in Section 8(f) of the Act. Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

ISSUE (K) ***What temporary benefits are in dispute?***

Having found in favor of Petitioner on the issue of causal connection and permanent total disability, the Arbitrator concludes Petitioner is entitled to temporary total disability (TTD) from 4/7/06 through 12/19/06 and 12/2/06 through 8/17/09. The Arbitrator does not award TTD for 12/20/06, as that is the date Petitioner returned to work.

In declining to adopt Dr. Singh's opinion that Petitioner was at MMI on 11/20/06, the Arbitrator again notes and incorporates Petitioner's then medical records showing that his condition and complaints had not yet stabilized and therefore additional TTD would be appropriate.

The Arbitrator concludes Petitioner's condition of ill-being had reached a state of maximum medical improvement as of 8/17/09, when Dr. Yapor opined that Petitioner was permanently and totally disabled and when it was clear Petitioner was not wanting further surgical intervention. In adopting Dr. Yapor's medical opinion on this issue, the Arbitrator notes that Dr. Yapor thereafter consistently indicated the Petitioner to be permanently and totally disabled and he would never be able to return to his prior work. Dr. Yapor's opinions are also suproted by Dr. Singh who indicated in his July 2011 addendum that Petitioner should not work until further medical intervention.

The Arbitrator orders that Respondent shall pay Petitioner temporary total disability benefits of $451.59/week for 175-3/7th weeks, commencing 4/7/06 through 12/19/06 and 12/21/06 through 8/17/09, as provided in Section 8(b) of the Act. Respondent shall be given a credit of benefits paid to Petitioner. Ax1.

ISSUE (M): Whether the Petitioner is entitled to penalties and fees under Sections 16, 19(k) and 19(l)?

Petitioner seeks penalties and fees for interruption of disability benefits and for non-payment of medical bills. The Arbitrator declines to assess penalties and attorneys' fees as requested by Petitioner on the issue of unpaid medical bills. There is no evidence that Respondent was made aware of the existence of the outstanding balances of the bills as outlined in Ax1 or that demand for payment was made. In addition, Px1 contains evidence that Respondent denied certain bills following Dr. Singh's initial medical examination. Thus, the Arbitrator cannot determine whether non-payment was unreasonable, for delay, vexatious or for any other improper purpose contemplated by Sections 16, 19(k) and 19(l).

Likewise, the Arbitrator declines to assess penalties and attorneys' fees against Respondent on the issue of suspension of disability benefits. The evidence shows Petitioner's benefits were suspended pursuant to notice from TRISTAR. Px11. In seeking penalties and/or attorneys' fees, Petitioner how, if at all, Respondent's reliance on information from TRISTAR would or would not justify suspension or termination of benefits. At trial, it was not established by either party who TRISTAR was or its role in payment of benefits. The Arbitrator is unable to conclude that suspension of benefits was without good cause, unreasonable and/or deliberate.

MARIA S. BOCANEGRA, ARBITRATOR

9-8-2015
DATE

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James A. Uridel,
Petitioner,

vs.

NO: 06 WC 31379

16IWCC0357

Universal Lighting Corporation and
Injured Workers' Benefit Fund,
Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant to Opinion and Order of the Circuit Court of Cook County, Judge James McGing, dated October 16, 2014. On July 24, 2012, Arbitrator Carlson dismissed the case. A Petition to Reinstate the case was filed by Petitioner on August 25, 2012. A hearing on the Petition to Reinstate was held on October 25, 2012 before Arbitrator Carlson and the Petition to Reinstate was denied. Petitioner filed a timely review. In its Decision and Opinion on Review dated July 2, 2013, the Commission affirmed Arbitrator Carlson's denial of Petitioner's Petition to Reinstate. The Commission made the following findings of fact and conclusions of law based on information obtained from the IWCC file contents, the mainframe computer system and briefs of the parties.

In its Decision and Opinion on Review the Commission found:

1. Petitioner, through his attorney Brian Morrow, filed an Application for Adjustment of Claim on July 20, 2006, alleging a date of accident of June 29, 2006.

2. A Stipulation to Substitute Attorneys was filed on January 3, 2008 by attorney Michael Block of Block, Klukas & Manzella, P.C., substituting for withdrawing attorney Brian Morrow.

3. An Amended Application for Adjustment of Claim was filed on January 3, 2008, adding the Illinois Workers' Benefit Fund as Respondent.

4. On November 10, 2009, attorney Stephen Debboli of Serpico, Petrosino & DiPiero, Ltd filed an Appearance of Representative for Respondent Universal Lighting Corporation.

5. Petitioner's brief indicates Petitioner's attorney made an Injured Workers' Benefit Fund Certification Request on May 14, 2010.

6. Respondent Universal Lighting Corporation scheduled a §12 evaluation for Petitioner with Dr. Trotter on September 12, 2010, which Petitioner attended.

7. Petitioner's brief indicates that Arbitrator Pulia continued the case from time to time in 2010 and 2011 due to Petitioner's inability to obtain appropriate documentation from the IWCC Insurance Compliance Division sufficient to proceed to trial and was awaiting medical records from Stroger County Hospital.

8. On June 3, 2011, attorney Joseph Branky from Ganan & Shapiro, P.C., sent correspondence and several documents to Petitioner's attorney and advised he would seek a dismissal of Respondent Universal Lighting Corporation during the July 2011 trial cycle of Arbitrator Pulia so that Petitioner could properly seek benefits against the Injured Workers' Benefit Fund. No Substitution of Attorneys or Appearance of Representative had been filed at that time.

9. Petitioner's brief indicates there was a substantial delay in obtaining the Certificate of Non-Insurance from the IWCC. It was finally received on or about July 25, 2011, only after Arbitrator Pulia personally escorted Petitioner's attorney to the IWCC Insurance Compliance Division to inquire why it had not been issued.

10. Petitioner's brief indicates that on August 17, 2011, Petitioner's attorney received correspondence and a Stipulation to Substitute Attorneys file-stamped August 9, 2011 from attorney Joseph Branky substituting for withdrawing attorney Stephen Debboli.

11. Petitioner's brief indicates that during the pendency of this case, whether Respondent Universal Lighting Corporation was represented or not, both Petitioner and the Illinois Attorney General's Office for the IWBF would appear at the status call dates/trial dates.

12. Petitioner's brief indicates that with the Certificate of Non-Insurance from the IWCC now in hand, Petitioner's attorney sent a Notice of Motion/Request for Hearing for Arbitrator Pulia's November 8, 2011 status call date.

13. On November 18, 2011, the matter was set for trial before Arbitrator Pulia. Petitioner's brief indicates that on that morning, Petitioner's attorney had two simultaneous court calls, one before Arbitrator Pulia and the other before an ALJ on two cases in the Court of Claims at the Thompson Center, 9th floor at 9:00 a.m. Petitioner's attorney was unable to leave the Court of Claims until 10:00 a.m. and he immediately went to Arbitrator Pulia to check in. Arbitrator

Pulia advised Petitioner's attorney she had dismissed the case in her computer, but if he could find Respondent's attorney, she would vacate the dismissal. Petitioner's attorney could not find Respondent's attorney nor the Assistant Attorney General and so advised Arbitrator Pulia. Arbitrator Pulia informed Petitioner's attorney that she would make a note in her computer system that he did appear on the trial date and that she would vacate the dismissal upon proper motion.

14. On November 22, 2011, the Notice of Case Dismissal was sent from the IWCC to the parties. Petitioner's brief indicates that he received the Notice of Case Dismissal on December 7, 2011 and filed a Petition to Reinstate on December 8, 2011.

15. It is noted on the IWCC mainframe computer that on December 13, 2011, a Petition to Reinstate was filed by Petitioner.

16. It is noted on the IWCC mainframe computer that on January 20, 2012, the Petition to Reinstate was granted. Petitioner's brief indicates that Arbitrator Fratiani, newly assigned to the case, granted the Petition to Reinstate.

17. Petitioner's brief indicates that on April 20, 2012, Petitioner's attorney and Respondent Universal's attorney appeared before Arbitrator Fratiani for trial. Petitioner's attorney advised Arbitrator Fratiani that he had lost contact with Petitioner, who was not present at this hearing. Respondent Universal's attorney requested the case be dismissed. Arbitrator Fratiani granted Petitioner's attorney's request for a continuance to continue to locate Petitioner.

18. Petitioner's brief indicates that following this, Petitioner's attorney obtained a new mailing address for Petitioner and established contact.

19. At the July 10, 2012 status call, the case was set for trial on July 24, 2012. Arbitrator Carlson was re-assigned to the case.

20. Petitioner's brief indicates that on July 23, 2012, Bryan Shell, an associate attorney at Petitioner's attorney's law firm, called Respondent Universal's attorney and left a message. The substance of the message was that Attorney Thomas Manzella was engaged in a wrongful death case trial in Will County and would be unable to appear at the IWCC on July 24, 2012. Attorney Shell asked Respondent Universal's attorney to tell Arbitrator Carlson that and request the case be returned to the call. Attorney Shell was unable to personally appear at the IWCC on July 24, 2012 as he had to appear on a medical negligence case in Galesburg, IL, in place of Attorney William Rock, who was also in trial with Attorney Manzella. Attorney Shell did not hear back from Respondent Universal's attorney prior to the morning of July 24, 2012.

21. On July 24, 2012, Arbitrator Carlson dismissed the case.

16IWCC0357

22. Petitioner's brief indicates that on July 26, 2012, Respondent Universal's attorney sent Petitioner's attorney correspondence indicating that the case had been dismissed by Arbitrator Carlson for Petitioner's failure to appear at the July 24, 2012 hearing.

23. On August 10, 2012, Notice of Case Dismissal was sent from the IWCC to the parties. Petitioner's brief indicates that this was received.

24. It is noted on the IWCC mainframe computer that on August 25, 2012, a Petition to Reinstate was filed by Petitioner.

25. It is noted on the IWCC mainframe computer that on August 30, 2012, another Petition to Reinstate was filed by Petitioner.

26. Petitioner's brief indicates that a hearing on the Petition to Reinstate was held on October 25, 2012. Attorney Manzella appeared on behalf of Petitioner and Respondent Universal's attorney appeared. An Assistant Attorney General did not appear. Petitioner's attorney informed that on July 24, 2012, he was engaged in a wrongful death case trial in Will County and could not appear the IWCC at that time, that an attorney from his office had called Respondent Universal's attorney the day before and had left a message that Attorney Manzella was in trial and would not be able to be present on July 24, 2012 and had requested that Respondent Universal's attorney advise Arbitrator Carlson of that and request a continuance based on that. Petitioner's brief indicates that Respondent Universal's attorney denied receiving a call from Petitioner's attorney's office, argued that Petitioner's attorney was lying to Arbitrator Carlson and that Petitioner had not been located since the last trial date with Arbitrator Fratiani and objected to reinstatement. Arbitrator Carlson asked if Petitioner was present and was advised he was not present for this reinstatement hearing. Petitioner's attorney advised that his firm had established contact with Petitioner at a new home address since the April 20, 2012 hearing before Arbitrator Fratiani, but that Petitioner was not present because the case was up at this time for Petitioner's Petition for Reinstatement, not trial. Arbitrator Carlson denied the reinstatement. No record of this hearing was made. It is noted on the IWCC mainframe computer that on October 25, 2012, the Petition to Reinstate was denied.

27. Petitioner's brief indicates that on November 9, 2012, Petitioner's attorney filed a Petition to Reconsider Denial of Reinstatement and/or To Make a Record. The date set for hearing on this Petition to be before Arbitrator Carlson was set for November 27, 2012. This Petition was withdrawn on that date as the Arbitrator lost jurisdiction to the Commission by the timely filed Petition for Review.

28. On November 20, 2012, a Petition for Review was filed by Petitioner on the issue of Arbitrator Carlson's denial of the Petition to Reinstate.

16IWCC0357

In his brief, Petitioner's attorney noted that Section 7020.90 of the Rules state that, "both parties must appear at the time and place for hearing and that the Arbitrator shall apply standards of fairness and equity in ruling on the Petition to Reinstate and shall consider the grounds relied upon by Petitioner, the objections of Respondent and the precedents set forth in Commission decisions." Petitioner's attorney argued that all parties were not present as an Assistant Attorney General did not appear, there was no record made and no basis was provided by Arbitrator Carlson for his denial of the Petition to Reinstate. Petitioner's attorney argued that Arbitrator Carlson did not apply standards of fairness and equity in ruling on the Petition to Reinstate. Petitioner's attorney noted that he was involved in a wrongful death case in Will County at that time and there were no other attorneys in his office able to cover the case. Petitioner's attorney requested the Commission reverse Arbitrator Carlson's order and grant Petitioner's Petition to Reinstate and remand to the Arbitrator for further proceedings.

Respondent's brief indicates that the case was above the red line after June 1, 2009. A Notice of Non-Compliance was issued by the Insurance Compliance Department on September 18, 2009. On June 3, 2011, Respondent's attorney sent Petitioner's attorney a copy of the Notice of Non-Compliance. The rest of the factual portion of his brief is the same as above. Respondent's attorney argued that there is no requirement in the Rules that a record be made and that the Arbitrator considered evidence and arguments presented at the hearing on the Petition to Reinstate. The case was over 6 years old at the time of the hearing. Respondent's attorney argued that Petitioner failed to prove that the Arbitrator failed to apply standards of equity and fairness. The hearing itself was due process. Both parties were present at the hearing on the Petition to Reinstate. The basis for Arbitrator Carlson's denial of the Petition to Reinstate was based on Petitioner's want of prosecution. Neither Petitioner nor Petitioner's attorney showed up for the July 24, 2012 trial date.

Based on the above, the Commission affirmed Arbitrator Carlson's denial of Petitioner's Petition to Reinstate and dismissed Petitioner's claim, finding that Petitioner had ample opportunity to prosecute his claim and had failed to do so. Petitioner appealed the Commission's Decision and Opinion on Review. In his Opinion and Order dated October 16, 2014, Circuit Court Judge McGing reversed the Commission's Decision and Opinion on Review finding that it was against the manifest weight of evidence. Judge McGing noted that Petitioner's attorney had demonstrated good cause in his Petition to Reinstate for his nonappearance on the last missed date of July 24, 2012 inthat Petitioner's attorney and another member of the firm were prosecuting a wrongful death case in Will County on July 24, 2012 and his other associate was appearing out of county in another matter at that time. Judge McGing also noted that much of the delay in this case was attributable to the IWCC Insurance Compliance Division. Petitioner had continued to make appearances at the IWCC status calls. Judge McGing concluded that Petitioner clearly demonstrated his desire to prosecute his claim even when he did not have the required documentation from the IWCC Insurance Compliance Division to proceed with the case. Judge McGing remanded to the Commission for further determination consistent with his Order.

16IWCC0357

Pursuant to the Opinion and Order of the Circuit Court of Cook County, the Commission reverses Arbitrator Carlson's denial of Petitioner's Petition to Reinstate, grants Petitioner's Petition to Reinstate and remands to the Arbitrator for trial on the merits.

IT IS THEREFORE ORDERED BY THE COMMISSION that Arbitrator Carlson's denial of Petitioner's Petition to Reinstate is hereby reversed and Petitioner's Petition to Reinstate the case is hereby granted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case is remanded to the Arbitrator for trial on the merits.

DATED: MAY 26 2016
MB/maw
r05/12/16
43

Mario Basurto

Stephen J. Mathis

David L. Gore

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Helgeson,
Petitioner,

vs. NO. 06 WC 40380

Menard's Inc.
Respondent.

ORDER

This matter came before the Commission on Respondent's motion to dismiss Respondent's Petition for Review filed May 19, 2015. Timely Petition for Review under §19(b) had been filed by the Respondent and the matter had been set for oral argument May 12, 2016. Respondent, on that date, advised the Commission they were dismissing their Review. The Commission herein, dismisses Respondent's Petition for Review. 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 Respondent's Motion to dismiss their Petition for Review is hereby granted.

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

DATED: MAY 23 2016

David L. Gore

Stephen Mathis

Mario Basurto

DLG/jsf
5/ 12/16
045

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

JENNIFER LUZADDER n/k/a
RICKENBERG,

Petitioner,

vs. NO: 07 WC 23876

CATHOLIC CHARITIES/
DIOCESE OF JOLIET,

16IWCC0299

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 medical and permanent partial disability (PPD), and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. This matter was consolidated at trial with case 09 WC 25371 and 09 WC 25372, for which a separate decision was issued.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective.

The Commission vacates the award of 10% loss of use of the right hand. Petitioner sustained an undisputed work-related accident on February 28, 2007. She was diagnosed with DeQuervain's Tenosynovitis of the right hand as a result of the accident. Respondent subsequently obtained a Section 12 opinion on July 18, 2007 from Dr. Thomas Wiedrich. Dr. Wiedrich opined that Petitioner reached maximum medical improvement (MMI) by the time of his examination. Petitioner subsequently returned to work and worked until December 2007. She was then off of work from December 2007 until March 2008 due to a family related issue.

16IWCC0299

Petitioner alleged a second work-related accident on March 14, 2008, which is adjudicated in case 09 WC 25371 and 09 WC 25372. The Commission notes that Petitioner presented to Morris Hospital on March 17, 2008. Per the report, Petitioner indicated that her pain had worsened over the past couple of months. Petitioner then presented to Dr. Daniel Mass on April 3, 2008. Per that report, Petitioner reported increasing pain on the radial aspect of both wrists with increasing difficulty lifting. The report further indicated that by December 2007, Petitioner was unable to fully extend her thumbs secondary to significant pain.

The Commission finds the second accident represents a continuation and an aggravation of her condition from the first accident. Accordingly, the Commission vacates the PPD award and finds that the issue of PPD is to be addressed in case 09 WC 25371 and 09 WC 25372. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on October 22, 2013, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $276.50 per week for a period of 13-1/7 weeks, March 10, 2007 to April 9, 2007 and May 13, 2007 to July 12, 2007, 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 $12,859.00 for medical expenses under §8(a) of the Act, and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $7,237.21 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 credit, as provided in Section 8(j) of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 5 - 2016

Michael J. Brennan

MJB/tdm
O: 3-7-16

052

16IWCC0299

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RICKENBERG, JENNIFER (F/K/A LUZADDER)
Employee/Petitioner

Case# 07WC023876
09WC025371
09WC025372

CATHOLIC CHARITIES DIOCESE OF JOLIET
Employer/Respondent

16IWCC0299

On 10/22/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0924 BLOCK, KLUKAS & MANZELLA PC
THOMAS MANZELLA
19 W JEFFERSON ST SUITE 100
JOLIET, IL 60432

2122 McNAMARA PHELAN McSTEEN LLC
BRIAN CICHON
3601 McDONOUGH ST
JOLIET, IL 60431

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jennifer Rickenberg (f/k/a Luzadder)
Employee/Petitioner

v.

CATHOLIC CHARITIES DIOCESE OF JOLIET
Employer/Respondent

Case # 07 WC 23876

Consolidated cases: 09 WC 25371
09 WC 25372

16IWCC0299

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **New Lenox, Illinois**, on **June 17, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0299

On **February 28, 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 $**21,567.00**; the average weekly wage was $**414.75**.

On the date of accident, Petitioner was **35** 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 $**3,446.12** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**3,446.12**.

Respondent is entitled to a credit of $**7,237.21** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $276.50/week from 3/10/07 to April 9, 2007 and May 13, 2007 to July 12, 2007 for 13-1/7 weeks as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $12,859.00, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $248.50/week for 20.5 weeks, because the injuries sustained caused the 10% loss of the use of the right hand, as provided in Section 8(e) of the Act.

Respondent shall be given a credit of $7,237.21 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 credit, as provided in Section 8(j) of the Act.

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

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

Signature of Arbitrator

10/18/13
Date

ICArbDec p. 2

OCT 22 2013

FINDING OF FACTS:

Petitioner, Jennifer Rickenberg (f/k/a) Luzadder, is 41 years old and lives in Diamond, Illinois. Petitioner is a high school graduate, with a bachelor's degree and continuing education in early childhood education. Petitioner is currently employed by ISA where she works in a gatehouse wherein they allow trucks to bring in oil containers.

In February 2007, Petitioner was working for Catholic Charities Diocese of Joliet, Early Head Start, located at 1704 Alexandria Drive, Joliet. Petitioner started her employment with Respondent in 2004. When she started, Petitioner was a teacher's assistant and maintained that position until late 2007 or early 2008 when she was promoted to Teacher 3. The duties and responsibilities of a teacher's assistant were: to help assist the teacher in creating lesson plans, keeping files on children; daily corresponding with parents; assist in feeding the children their meals; changing children [diapers] according to DCFS regulations; taking the children outside; tending to all their physical needs; and documentation and paperwork required for DCFS.

In February 2007, Petitioner worked primarily in a room that could accommodate 6 children, ranging in ages 10 months to 18 months. Most of the children were either still crawling or learning to walk. Most of Petitioner's job was physically "hands on." Petitioner's job included lifting and grasping. Respondent provided high chairs that she had to lift the children in and out of; diaper changing tables; cribs and a big buggy for taking the children outside. Diapers needed to be changed at a minimum of every two hours or as needed. The children were taken outside twice a day. The children were required to be fed breakfast in the morning, a morning snack, lunch and an afternoon snack. Petitioner was required to lift the children into the high chairs or seats and would either physically feed them or help develop their self-help skills by serving food and assisting with the utensils.

In February 2007, Petitioner worked the 8 a.m. to 6 p.m. shift. She earned $11.06 per hour and worked 37.5 hours per week for an Average Weekly Wage of $414.75. Her immediate supervisor was Corliss Wright.

On February 28, 2007, while Petitioner was working, a little girl was walking down a wooden stair climber and lost her balance. Petitioner caught the child from falling and twisted her right wrist. Petitioner could not recall the exact mechanism of the twist as her attention was focused on the little girl. Following the accident, Petitioner's right wrist was sore but she went on with her day thinking she had pulled a muscle. Petitioner did not report the accident to anyone that day. Over the next ten days, her right wrist continued to be sore; however, the pain did not go away. On March 6, 2007, Petitioner worked a 10 hour day because Respondent was short of employees. She worked with the pain in her wrist but when she went home and tried to open something with a can opener, she didn't have the strength to turn the opener. At that point, Petitioner realized that there had to be something more seriously wrong with her right hand and wrist. Between the accident date and March 7, 2007, Petitioner took Ibuprofen for pain.

On March 7, eight days after the accident, Petitioner told her supervisor what had occurred on February 27 and that she was still having pain. Petitioner was instructed to fill out an Incident Report as did PeaLock Shivers- the assistant who was in the room at the time of the accident. (PX39 and 40) Petitioner's supervisor instructed her to go to the company doctor, Dr. Kota, who performed an x-ray and placed her on light duty.

Petitioner saw Dr. Kota at Family Health Center on March 7, 2007, reporting hurting her right wrist on February 28, 2007, while she was trying to hold a child who was 30lbs and 18 month old who was falling off of wooden stairs and climber. (PX1 at 4) She did not report the incident on February 28, 2007, however she

started complaining of pain, which had gotten progressively worse, which was reported to the employer who sent her here today. (4) Pain was 7 to 8 on 10 scale and was worse with movement. (4) Physical examination showed right wrist pain and tenderness with decreased range of motion with tenderness in the right styloid area. (5). Impression was right wrist strain. (5) Plan was to ice, use a wrist splint, Ibuprofen, no lifting more than 2 pounds with the right hand, no twisting motions of the right wrist and no lifting of children, x-rays and follow-up. (5) On March 9, 2007, Dr. Kota noted complaints of pain with movement of the right wrist. (8) Right wrist pain was mostly at the base of the thumb. (8) Impression was right wrist strain. Plan was to keep her off work with complete rest of the right arm. (9) On March 13, 2007, Petitioner presented with a history of hurting her thumb and wrist as well as the hand after trying to hold a 30lb baby. (14) She had been in severe pain and off work, with pain now 6 to 7 of 10. (14) Pain was worse with twisting movements with the wrist like driving or holding anything with the right hand. (14) Pain was described as shooting going to the proximal aspect of the right forearm with tingling, numbness and weakness. (14) Notes reflect right-sided wrist pain, hand pain and thumb pain. (14) Examination showed tenderness for active and passive extension and flexion of the right hand of the thumb area with the extensor pollicis as well as abductor pollicis, longus with pain radiating into the radial styloid area of the lateral aspect of the forearm. (15) Impression was tenderness of the right thumb metacarpal and radial styloid area secondary to strain. (15) Ligamentous pathology should be ruled out. (15) MRI to be ordered. (15) Since she was not improving, was encouraged to do no work with right hand and was provided an order for physical therapy. (15) Continue Ibuprofen. (15)

On March 20 Petitioner was still waiting for approval from her employer for the MRI and for physical therapy. (18) Pain was 7 to 8 of 10 and shoots all the way from the forearm. Pain was described as excruciating with some tingling and numbness and associated weakness. (18) Examination and Impression remained the same as she waited for approval from her employer for the ordered medical care and continue off work restrictions. (19)

Petitioner's final visit with Dr. Kota was on March 30. She presented with complaints of severe pain occasionally with certain specific movements when she tried to twist her wrist and also pain shooting down the thumb and forearm. (22) MRI was completed and physical therapy has started. (22) She had swelling of the right hand following physical therapy and pain during therapy. (22) Results of the MRI show abductor pollisis longus and extensor pollicis tendinopathy and tenosynovitis consistent with de Quervain syndrome. Mid-grade injury to the dorsal intercarpal ligament with no definitive tear, along with joint effusion. (22) Examination showed decreased range of motion of the wrist as well as tenderness in the base of the first metacarpophalangeal joint and some swelling with minimal radial deviation of the right hand. (23) Impression was de Quervain's syndrome in the right wrist and right thumb strain. Plan was to continue therapy and follow up with an orthopedic doctor for further care. (23)

Physical therapy was performed at Momentum Physical Therapy beginning March 21, 2007. (PX2) The MRIs were performed at Provena Health CEI in Bourbonnais on March 23, 2007. (PX3)

Following her treatment with Dr. Kota, Petitioner requested to see a doctor of her own and chose Dr. Marc Cohen at Midwest Orthopaedics at Rush. (PX4) She first saw Dr. Cohen on April 4, 2007. (PX4 at 5) Petitioner presented a history of working as a teaching assistant and reported an injury to her right wrist and hand on February 28, 2007 when she tried to stop a child from falling. (5) She twisted her right wrist and hand. (5) Examination was remarkable for decreased range of motion in the right wrist; dorsal and radial-sided wrist pain on the right with flexion. (5-6) Grip strength was diminished at 20 pounds on the right and 70 on the left. Pinch strength measured 8 pounds on the right and 22 pounds on the left. Tenderness was noted over the first dorsal compartment and clearly had a positive Finkelstein test. (6) Impression was right wrist tendinitis. (6) She was given a cortisone injection into the first dorsal compartment which provided relief. (6) Dr. Cohen hoped that conservative treatment would alleviate the pain and returned her to work on April 9, 2007. (6)

On April 16, Petitioner contacted Dr. Cohen's office stating that she continued to have problems with the radial aspect of her wrist and that she was not having relief from the cortisone shot. (10) Petitioner advised the office that she was frustrated because her work required her to use her hands quite frequently and she has to write for long periods of time in school. (10) On April 18, Petitioner saw Dr. Cohen who noted that the cortisone shot provided little relief and continued to report radial-sided wrist pain and "pulling." (11) She reported having difficulty lifting children at work. (11) Examination showed tenderness over the first dorsal compartment and a positive Finklestein test. (11) Impression was continued de Quervain's tenosynovitis about the right wrist. (11). Dr. Cohen injected cortisone into the first dorsal compartment. (11)

On April 24, Petitioner called Dr. Cohen's office with an update on her condition. (15) She advised no relief from the injection. (15) She was informed that tendinitis takes time to resolve. (15) She was given three options at that point: 1) informed that she could be put on light duty; 2) reassurance that she is not causing any long-term problems with her wrist pain; or provide the name of a doctor for a second opinion. (15) Petitioner was provided the contact information for Dr. Dave Kalainov at Northwestern. (15)

Petitioner testified when she returned to work in April she continued to have a lot of pain and struggled lifting the children and doing what she needed to do. Petitioner started using her left hand and relying on her left hand to compensate for her right.

Petitioner saw Dr. David Kalainov on May 8, 2007. (PX5) Petitioner dated the onset of her symptoms to a work episode on February 28, 2007, assisting a toddler from a small stair-climber when the child slipped. (30) She sustained a "twisting" injury to her right wrist. (30) The records related Petitioner's subsequent medical care and complaints of pain (wherein Dr. Kalainov reviewed all of Petitioner's records to date). Dr. Kalainov noted that Petitioner returned to work activities as a teaching assistant on April 9, 2007. (30) She noted tightness and aching pain at the radial aspect of her right hand with radiation into her forearm. (30) Physical examination had a reproducible right hand pain with a grinding maneuver of the thumb basal joint. (32) Impression was 1) sprain basal joint right thumb; 2) de Quervain's tenosynovitis right wrist; and 3) sprain dorsal radiocarpal ligaments right wrist. (32-33) Plan was to provide Petitioner with two neoprene thumb splica splints for activities that produce aggravated pain, intermittent use of Ibuprofen; unrestricted duty only if allows for thumb splint. (33)

The next appointment with Dr. Kalainov was on May 30 for reassessment of right hand pain. (11) There was no appreciable change in the character of her pain from visit three weeks prior. (11) Complained of discomfort along the radial aspect of the right wrist and hand with activities. (11) No appreciable pain at rest. (11) No noticeable benefit from use of thumb splint. (11) There were diminished grip strength and key pinch on the right. (11) Grinding maneuver of thumb basal joint caused discomfort. (11) Majority of her pain was reproducible with palpation along the volar radial margin of the trapeziometacarpal joint. (11) Finkelstein's test elicited discomfort along the dorsal aspect of the thumb. (11) Impression was sprain basal joint right thumb. (11) Dr. Kalainov injected cortisone and Lidocaine with Kenalog in right basal joint. (11) Work release with restrictions was completed with 10 pound lifting restriction for her right hand and a full return to work on June 9, 2007. (11)

Petitioner's last visit with Dr. Kalainov was June 12, 2007 for reevaluation. (7) She was unable to return to work with restrictions. (7) Within the last two days she had developed at flexion posture of her right thumb. (7) Again, grip strength and key pinch measurements were diminished. (7) Impression was healed sprain basal joint right thumb and writer's cramp right thumb. (7) Dr. Kalainov recommended a trial return to work or a short course of occupational therapy. (7) A return to work on a trial basis on June 28, 2007 was provided. (8)

Petitioner sought additional physical therapy at Midwest Hand Care. (PX6)

The next doctor seen by Petitioner was Dr. Weiderich for an IME on July 16, 2007. After examination, Dr. Weidrich provided the opinion that Petitioner did have de Quervain's syndrome and irritation of the first CMC joint that had completely resolved as of his examination date. He also thought that she might have clenched fist syndrome but that this was not as a result of her work injury. He believed that any subjective complaints were not consistent with any anatomic finding and that she was able to return to work in a full duty capacity. (RX 9)

Approximately July 19, 2007, Petitioner received a letter from Respondent's insurance company instructing her to go back to work following the IME with Dr. Weidrich. Petitioner's doctor still had her off of work with restrictions and not at MMI. She returned to work but provided a copy of the letter to her employer indicating that she still had weakness in her hands and was returning because Respondent's IME examiner said she had to. (PX 41) Petitioner was concerned about returning to work stating, "...my thumb is still bent backwards and my right hand strength is still decreased – however I am returning to work because the [doctor] says to return to full duty – so I am." (PX41)

Petitioner testified that she worked despite the pain and weakness in her right thumb and wrist.

IN SUPPORT of the Arbitrator's Decision regarding "J" (Medical), the Arbitrator finds as follows:

The Arbitrator notes that the medical bills (PX0) and specials' list (PX38) were admitted into evidence with the objection only on the basis of liability. A review of the records (PX1-PX7) provide that Petitioner was within the appropriate line of doctors. Petitioner testified that the submitted bills were paid by her BlueCross BlueShield Group Health Insurance; her husband's Union Local 705 Group Health Insurance or self-pay; however, some balances were outstanding. Respondent claims credit for certain amounts paid ($7,237.21) for the February 27, 2007 work accident. Based upon Arbitrator's Exhibit 1, the evidence presented, including Petitioner's credible testimony, the Arbitrator's review of the medical records and bills, the fact that causation is not in dispute, as well as Respondent's failure to produce any evidence that Petitioner's treatment and bills were unreasonable or unnecessary, or unrelated to the work accident, the Arbitrator finds the bills submitted in (PX0; 10-17) and (PX38) are reasonable and necessary. The Arbitrator oders Respondent to pay said bills in full as set forth below to Petitioner or by per Fee Schedule or reimburse Petitioner for any amounts paid, as follows:

Srinivas C. Kokta, M.D. (Family Health Care) (PX10)	$697.00
Brady, Inc. (Momentum Physical Therapy) (PX11)	$1,524.00
Provena Health Center (PX12)	$5,875.00
Midwest Orthopaedics at Rush (PX13)	$1,200.00
Northwestern Center for Orthopaedics (PX14)	$1,055.00
Midwest Hand Care (PX15) (6/18/07-6/26/07)	$1,820.00
Midwest Orthopaedic Consultants (PX17)	$698.00

Total: $12,859.00

16IWCC0299

IN SUPPORT of the Arbitrator's decision regarding "L" (Nature and Extent), the Arbitrator finds as follows:

Based upon the medical evidence, Petitioner's testimony, the medical records (PX1-PX7) as well as Petitioner's complaints of pain, current findings and conclusions, the Arbitrator finds Petitioner sustained 10% loss of use of the right hand pursuant to Sections 8(e) 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 Accident/Causation	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify:	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANTONIO ROSALES,

Petitioner,

16IWCC0333

vs.

NO: 07 WC 34719

SULLIVAN'S FOODS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the both the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, notice, and the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, reverses the Decision of the Arbitrator, finds that Petitioner did not sustain his burden of proving a compensable accident or causal connection to a current condition of ill-being of his left leg, and denies compensation.

This claim was consolidated with two other claims, 07 WC 34735, & 07 WC 35234, alleging different accident dates and injuries to different parts of the body. The dates of the other alleged accidents were June 16, 2006 and July 2, 2007, and alleged injuries to his back/shoulder and repetitive traumatic injuries to his hands, respectively. The Arbitrator denied compensation in those other claims. Petitioner sought review of the claims that were denied, which are adjudicated by the Commission in separate decisions. In this claim, the Arbitrator found that Petitioner proved a compensable accident on June 12, 2006 which caused a current condition of ill being of his left leg. He awarded Petitioner $5,408.52 in current medical expenses and 32.25 weeks of permanent partial disability representing loss of 15% of the left leg.

This claim only deals with Petitioner's alleged June 12, 2006 accident which Petitioner asserts caused a left knee injury and current condition of ill-being. Obviously, that condition and associated treatment will be the focus of this decision. Nevertheless, it is important to present some details about his testimony concerning the other alleged accidents, injuries, and treatment to put this claim in proper context.

Findings of Fact and Conclusions of Law

1. Petitioner testified he worked for Respondent, a grocery store, cleaning the floors at night and opening the doors for night deliveries. He was on duty until relieved when the "meat department guys arrived and took over." Petitioner also testified that at times there was water on the floor from leakage from the meat cooler and that he reported it.

2. On June 12, 2006, when he was sweeping the floor it was clean with no water. However, when he came back to mop there was water on the floor that he did not see and he "slipped and the buffer took off and" he fell. He tried to get up and his left knee started to bother him. He told his manager, Mark, about his knee. Petitioner's son, who works with him at Respondent's facility, could have told the manager about the accident as well. Mark responded that they were going to let him go so that his knee could heal. Petitioner did not work anywhere since July 2, 2007.

3. Petitioner eventually saw Dr. Mitchell around September 25, 2007. It took him over a year to see a doctor because he was out of a job and had no money. Dr. Mitchell eventually performed surgery on his knee. Petitioner testified that currently his knee was a lot better than it was prior to the surgery but still was "not too good." Sometimes it gives out on him, as does his back.

4. Petitioner also testified that on June 16, 2006 he was working in the produce section and put some mats down after he cleaned the floor. His left knee gave out and he fell backwards. He was not sure whether his shoulder hit the salad bar behind him. But when he "woke up" the mat was on top of him and it took "like 5 minutes to get out of there," and his back started hurting. He reported the accident before he went home, but he did not remember to whom because his boss was not there at the time. He went home and laid down. Later he could not get up. He had to take vacation time because he could not work. Petitioner returned to work about a week later.

5. The first doctor he saw was Dr. Piller, a chiropractor, for treatment for his back. After about four months he discharged Petitioner from treatment. He saw Dr. Piller "a long time" previously for "like a pulled muscle" in the left side of his back and treated four or five times for that condition. Petitioner testified that currently his back was "not too good." Part of his back is kind of numb, though it used to be worse. His back locks up. Petitioner also had left shoulder surgery in 2011, but it was fine now.

6. Petitioner also claimed carpal tunnel syndrome on the left side which manifested on July 2, 2007. He thought it was caused by running the buffer. After tests, left carpal tunnel release surgery was performed. Currently, he has no problems with his left hand. Petitioner does have vision problems due to diabetes.

7. On cross examination, Petitioner testified he did not have any treatment and did not know of having any symptoms of numbness for his left hand or arm prior to working for Respondent. He did have two surgeries prior to working for Respondent for "tendonitis or something." Petitioner denied he saw Dr. Piller on and off for several years.

16IWCC0333

8. Petitioner did not remember whether the first time he complained of back pain to Dr. Piller was in March 2008, after he was terminated by Respondent. Dr. Piller helped him fill out forms because he had not had "too much schooling" not because of his vision problems. Petitioner only learned of his diabetes in 2006 and his vision was still good then.

9. Petitioner started having symptoms in his hands in 2005 and only "started telling them" that his "hands kind of bothered" him in 2006. Petitioner did not remember whether he mentioned his hand symptoms when he first saw Dr. Mitchell, but he thought he already saw Dr. Schlenker about his hands by that time.

10. Petitioner again testified he had two slip and fall accidents in June 2006, but did not see a doctor until after he was terminated; nobody sent him to a doctor and he had no money. He tried to fill out accident reports but was told he should do it later. Besides using the buffer, Petitioner also ran the register in the morning for a while. He also straightened boxes for about an hour.

11. Petitioner did not remember whether he had a previous workers' compensation claim when working for another employer. But he did remember that a long time ago they "gave" him something for his sutures in his elbows, but he did not remember "how much they gave" him. However, he then remembered filing a previous claim, when asked whether records indicating there was a previous claim were correct.

12. Mark Castiglioni was called by Respondent. He testified he worked with Petitioner for several years. He was store manager. He would see Petitioner "pretty much every day" and he thought they had a good relationship. They would talk about everything, including personal things.

13. Mr. Castiglioni also testified Petitioner never told him he slipped and fell on June 12, 2006 or that he had any injury at that time. Mr. Castiglioni did not recall Petitioner ever telling about a second accident/injury at work. He did not recall Petitioner complaining to him about injuring his knee or back at work. If he had, Mr. Castiglioni would have filled out proper paperwork. Petitioner never asked for treatment of his knee or back.

14. July 2, 2007 was Petitioner's last day at work. At that time Mr. Castiglioni informed him he was being suspended for "sampling the food" at work, which was against company policy. Petitioner was unhappy about being suspended. After the Fourth-of-July weekend, the witness found Petitioner's keys on his desk. He never saw or spoke to Petitioner since.

15. Mr. Castiglioni never had any issue with Petitioner prior to July 2, 2007. Petitioner's job entailed janitorial duties, cleaning the washrooms, scrubbing and waxing the floors, and straightening the shelves every morning. Petitioner never worked the register. He would use the buffing machine a couple of hours a day. Mr. Castiglioni has operated that machine.

16. On cross examination, Mr. Castiglioni testified the length of Petitioner's suspension was not yet determined because he never returned, but it would have been three days per policy. Mr. Castiglioni considered Petitioner's action "job abandonment" but he was unsure whether that technically meant he quit. After Petitioner did not return to work the witness terminated him for theft. Petitioner was a good, hard worker. He agreed that Petitioner did use the buffer and had to hang onto it when in operation.

17. Mr. Castiglioni also testified Petitioner's son worked at his store, but was not on the payroll. He talked to Petitioner's son on occasion but no injury to his father ever came up. Any freezer could have leaked. If they are aware of leakage, it is fixed. He was not aware of any particular freezer leaking. Mr. Castiglioni agreed that they put rugs in the produce department to catch water; "the produce department is the largest trip and fall."

18. On redirect examination, Mr. Castiglioni testified neither Petitioner nor his son ever mentioned Petitioner slipping and falling "on a leaking freezer." Petitioner never mentioned falling on any rugs.

19. The medical records indicated that on September 25, 2007, Petitioner presented to Dr. Mitchell with the main complaint of left knee pain with buckling and giving away. He had experienced such episodes since a work accident on June 12, 2006 when he slipped on the floor and twisted his knee. Dr. Mitchell recommended an MRI to rule out meniscus tear, but Petitioner did not want one then because he had no insurance. Dr. Mitchell prescribed Naprosyn and Petitioner would have the MRI if he did not improve.

20. On May 21, 2009, Dr. Mitchell sent correspondence to Petitioner's lawyer. He indicated he saw Petitioner on September 25, 2007 who reported left knee pain after he slipped on the floor and twisted his left knee on June 12, 2006 at work. He opined that an MRI was indicated and that Petitioner's knee condition was the result of his work injury.

21. Petitioner returned to Dr. Mitchell twice in 2011 complaining of continued left knee pain with popping, cracking, and buckling. Dr. Mitchell recommended an MRI, but Petitioner was unable to pay.

22. Petitioner eventually had an MRI on August 11, 2011 which showed an oblique tear of the horn of the medial meniscus. On September 16, 2011, Dr. Mitchell performed left knee arthroscopy with partial medical and lateral meniscectomy and debridement for medial and lateral meniscal tear with mild osteoarthritis.

23. On October 6, 2011, Petitioner returned to Dr. Mitchell with the main complaint of right knee pain. He also had left shoulder pain. X-rays showed moderate arthritis in the AC joint with type II acromion and minimal degenerative changes in the right knee.

24. Dr. Mitchell referred Petitioner to Dr. Whitehurst for evaluation of his left shoulder. Petitioner attributed his shoulder condition to a June 16, 2016 work accident.

25. Dr. Whitehurst diagnosed a ruptured rotator cuff tear, impingement syndrome, and AC arthritis. On April 27, 2012, Dr. Whitehurst performed rotator cuff repair, subacromial decompression, Mumford distal clavicle excision, and limited debridement of the biceps and labrum for severe impingement syndrome, rotator cuff tear, partial labral tear, biceps tendinosis, and AC arthritis.

26. Petitioner sought treatment for his back after his alleged 2006 work accident on March 10, 2008 from Dr. Piller, a chiropractor. He treated Petitioner 18 times through September 2009 at which time he released Petitioner from treatment. The records also indicated that Dr. Piller first treated Petitioner in 1989 for lower back pain, as well as other complaints. Petitioner also was treated by Dr. Piller on numerous occasions in 1990, 1994, 1996, 1997, and 1998.

27. Petitioner first sought treatment for his hands on September 30, 2007 from Dr. Schlenker. Petitioner related his hand condition to the use of a buffing machine for six hours a day. Dr. Schlenker had previously treated Petitioner for epicondylitis and radial tunnel syndrome.

28. Petitioner was examined at Respondent's request by Dr. Weiss on July 24, 2009, pursuant to Section 12 of the Act. Petitioner reported he slipped and fell on June 12, 2006. His feet split apart and he landed on his knees. His knees both hurt, but the left was worse than the right. Four days later one of his knees gave out, he did not remember which one, and he fell backwards striking his back against a pole protecting the salad bar. He did not receive treatment until September 2007, when he visited Dr. Mitchell regarding his left knee.

29. After his examination and review of Petitioner's records, Dr. Weiss opined he did not believe the reported accident caused the meniscus tear. First, the mechanism of the accident was unlikely to cause such an injury, and second if he had suffered an acute tear, he likely would have needed treatment sooner than a year and a half later.

30. On August 20, 2013 at his lawyer's direction, Petitioner presented to Dr. Eilers for an examination pursuant to Section 12 of the Act. Dr. Eilers noted that Petitioner worked as a janitor for 10 years and operated floor buffers and moved mats to keep people from slipping. Petitioner reported slipping on the floor and twisting his left knee on June 12, 2006. His feet split apart and he landed on his knees. He had pain in his knees, left worse than right. He also reported on June 16, 2006, his left knee gave out because of his previous injury and fell backwards on his left shoulder and back, injuring his low back. His back and shoulder struck part of the salad bar and he heard a cracking in his arm. Dr. Eilers concluded all of Petitioner's conditions were caused by work-related accidents.

In finding Petitioner proved he suffered an accident on June 12, 2006 causing his left knee condition, the Arbitrator found Petitioner's testimony credible and consistent with the medical records. He also noted that while Mr. Castiglioni testified Petitioner did not notify him of an accident he confirmed that the freezers leaked. The Arbitrator also found credible Petitioner's testimony that he notified his supervisor on the day of the accident.

The Commission finds noteworthy that while the Arbitrator found Petitioner's testimony credible regarding this claim, he specifically found Petitioner's testimony inherently not credible regarding the other two claims. These findings are somewhat inconsistent because Petitioner's testimony concerning all these alleged accidents, alleged injuries, and medical treatment was all done at one time at the same hearing and is all part of the record now before us. Specifically, regarding the shoulder/back conditions, the Arbitrator noted "the blaring inconsistencies between the Petitioner's testimony and the medical records," and that he gave different accounts of the alleged incident and did not mention any shoulder injury until 2011, about five years after the alleged accident. On that claim the Arbitrator wrote, "because of the Petitioner's lack of credibility, the Arbitrator concludes that the Petitioner has failed to meet his burden of proof."

The Commission notes that while we are charged with reviewing the factual findings and legal conclusions of the Arbitrator, we are also charged to act as original finders of fact. In looking at Petitioner's testimony in the consolidated cases as well as in the instant case, the Commission does not find Petitioner credible. In addition, in this case the Arbitrator necessarily found the testimony of Mr. Castiglioni to be not credible because he found that Petitioner did in fact report his accidents/injuries to him, which Mr. Castiglioni denied. Contrary to the conclusion of the Arbitrator, the Commission finds the testimony of Mr. Castiglioni completely plausible and more credible than that of Petitioner.

Petitioner reported the mechanism of injury as splitting of his legs and landing on his knees to Dr. Weiss and Dr. Eilers, Respondent's and Petitioner's Section 12 medical examiners, respectively. The Commission finds persuasive Dr. Weiss' opinion that such a mechanism would not likely result in such an acute meniscal tear. Finally, the Commission finds noteworthy that Petitioner was apparently able to work full duty for more than a year after his alleged accident, and did not seek treatment for his knee for more than 15 months, and only after he was terminated. In conclusion, in looking at the entire record before us, the Commission finds that Petitioner did not sustain his burden of proof that he suffered a work-related accident/injury on June 12, 2006 or that any work activity caused the condition of ill-being of his left knee.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator date April 23, 2015 is hereby reversed and compensation is denied.

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

DATED: MAY 16 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-4/12/16
46

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

Antonio Rosales,
Petitioner,

16IWCC0331

vs.

NO: 07 WC 34735

Sullivan's Foods,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, notice, 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 23, 2015, is hereby affirmed and adopted.

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

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

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

DATED: MAY 16 2016
o4/12/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ARCHIVE COPY

Thank you for visiting

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0331

ROSALES, ANTONIO
Employee/Petitioner

Case# 07WC034735

07WC034719
07WC035234

SULLIVAN'S FOODS
Employer/Respondent

On 4/23/2015, 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 0.09% shall accrue from the date listed above to the day before the 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:

0400 LOUIS E OLIVERO & ASSOC
DAVID W OLIVERO
1615 4TH ST
PERU, IL 61354

0563 WILLIAMS & McCARTHY LLP
CAROL A HARTLINE
120 W STATE ST SUITE 400
ROCKFORD, IL 61101

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

16IWCC0331

- ☐ 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

ANTONIO ROSALES
Employee/Petitioner

v.

SULLIVAN'S FOODS,
Employer/Respondent

Case # **07** WC **34735**

Consolidated cases: **07 WC 34719**
07 WC 35234

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Ottawa**, on **02/26/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

16IWCC0331

On **06/16/06**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**20,072.00**; the average weekly wage was $**386.00**.

On the date of accident, Petitioner was **53** years of age, ***single*** with **no** dependent children.

Petitioner has not received all reasonable and necessary medical services.

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

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

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

ORDER

Petitioner has failed to meet his burden of proof on the issue of accident. Therefore, the Petitioner's claim for benefits is denied.

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

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

Signature of Arbitrator

4/20/15
Date

APR 23 2015

16IWCC0331

FINDINGS OF FACT

At the time of the arbitration hearing, Petitioner presented three consolidated claims. Each claim will be addressed in separate decisions. This decision relates to Petitioner's claim stemming from an alleged work injury on June 16, 2006, in which Petitioner's claimed injury involves his back and left arm. In this case, the issues in dispute are as follows: 1) accident; 2) notice; 3) causation; 4) medical expenses; and 5) the nature and extent of Petitioner's injuries.

Petitioner testified that he worked as a janitor for ten years in Respondent's grocery store. Petitioner testified that on June 16, 2006, he was putting mats down on the floor, when he fell down, allegedly from his left knee giving out. He noticed that his back began bothering immediately. Petitioner does not remember who he told about this incident, but he did recall going home and having to lay down.

Respondent's store manager, Mark Castiglioni, testified that Petitioner never reported to him the incident from June 16, 2006. Mr. Castiglioni testified that the Petitioner was suspended from work in July, 2007 for "sampling" the store food in the back of the store – in violation of the company policy. Mr. Castiglioni testified that the suspension period is usually for 3 days, but the Petitioner never returned to work after his suspension on July 2, 2007.

A review of the medical records show Petitioner did not seek medical treatment for any condition alleged to have occurred in the course of his employment until September 25, 2007. At that time he saw Dr. Mitchell, and reported only left knee pain. (Petitioner Exhibit 8 at pgs. 4-5). At that time Petitioner did not report the same accidents he testified to have occurred, but rather only told him one incident occurred when he slipped and twisted his knee. (Id. at 5).

When Petitioner saw Dr. Piller in March of 2008 for back pain, he gave a completely different report. He indicated that he was cleaning and replacing rugs when his left knee gave out, and he fell against a pole by the salad bar injuring his back. (Petitioner Exhibit 9 at pg. 13). Dr. Pillar indicated that the claimant had blindness and had to assist him in filling out the paper work. (Id at pgs. 35-36). Dr. Piller indicated petitioner told him he had diabetes. (Id. at pg. 36). Dr. Piller had seen Petitioner on many occasions over the years, however Petitioner testified that he had only seen him a few times. (see Petitioner Exhibit 9 at pgs. 6-12). Petitioner testified that he did not seek treatment while he worked for the Respondent because he did not have any money, however he had been a walk in patient with Dr. Piller over many years, and Piller would have taken Petitioner at the time of any of the alleged accidents. (see Petitioner's Exhibit 9 at pgs. 24-26). Dr. Piller testified that the Petitioner had no disability to the back as a result of the alleged slip and fall incident.

The medical records from Rockford Orthopedic Associates show that on December 7, 2011 Petitioner told Dr. Whitehurst that he fell backwards and landed flat on his back injuring his left shoulder. (Petitioner Exhibit 6). There is no indication that the claimant sought treatment for any shoulder complaints before being seen at Rockford Orthopedics Associates. In addition, there was no prior report in the medical records of any injury to the shoulder as a result of an accident at work.

Petitioner testified that he continues to experience low back pain radiating down his leg. He also underwent surgery to the left shoulder for repair of the rotator cuff. He testified that his left shoulder currently has no problems.

16IWCC0331

Petitioner later underwent evaluations by Dr. Weiss at the request of Respondent and Dr. Eilers at the request of his own counsel.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has failed to meet his burden of proof. This finding is based on the Petitioner's lack of credibility when comparing his testimony to the medical evidence. In support of this finding, the Arbitrator notes the blaring inconsistencies between the Petitioner's testimony and the medical records. The medical records show the Petitioner has given differing accounts as the number of incidents that occurred at work, and how the alleged incident occurred. The Arbitrator finds it significant that Petitioner failed to seek any medical treatment for his shoulder or back until years after the alleged incident. Petitioner did not seek medical treatment for the alleged back injury until 2008. Further, he gave no report of any shoulder injury until 2011. The initial medical records - where Petitioner provides a history of injury to his left knee for his earlier accident from June 12, 2006 (see 07 WC 34719) - do not mention an incident from June 16, 2006 where Petitioner alleges to have fallen and injuring his back or shoulder. Because of Petitioner's lack of credibility, the Arbitrator concludes that the Petitioner has failed to meet his burden of proof.

2. Based on the Arbitrator's findings with regard to the issue of accident, all other issues are rendered moot.

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

Antonio Rosales,
Petitioner,

vs.

Sullivan's Foods,
Respondent.

16IWCC0332

NO: 07 WC 35234

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, notice, 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 23, 2015, is hereby affirmed and adopted.

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

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

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

DATED: MAY 16 2016
o4/12/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0332

ROSALES, ANTONIO
Employee/Petitioner

Case# 07WC035234

07WC034719
07WC034735

SULLIVAN'S FOODS
Employer/Respondent

On 4/23/2015, 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 0.09% shall accrue from the date listed above to the day before the 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:

0400 LOUIS E OLIVERO & ASSOC
DAVID W OLIVERO
1615 4TH ST
PERU, IL 61354

0563 WILLIAMS & McCARTHY LLP
CAROL A HARTLINE
120 W STATE ST SUITE 400
ROCKFORD, IL 61105

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE)

16IWCC0332

- [ ] 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

ANTONIO ROSALES
Employee/Petitioner

v.

SULLIVAN'S FOODS,
Employer/Respondent

Case # **07** WC **35234**

Consolidated cases: **07 WC 34719**
07 WC 34735

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Ottawa**, on **02/26/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0332

FINDINGS

On **07/02/07**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$20,072.00**; the average weekly wage was **$386.00**.

On the date of accident, Petitioner was **53** years of age, *single* with **no** dependent children.

Petitioner has not received all reasonable and necessary medical services.

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

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

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

ORDER

Petitioner has failed to meet his burden of proof on the issue of accident. Therefore, the Petitioner's claim for benefits is denied.

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

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

Signature of Arbitrator

4/20/15
Date

APR 2 3 2015

16IWCC0332

FINDINGS OF FACT

At the time of the arbitration hearing, Petitioner presented three consolidated claims. Each claim will be addressed in separate decisions. This decision relates to Petitioner's claim stemming from an alleged work injury on July 2, 2007, in which Petitioner's claimed injury involves carpal tunnel syndrome from repetitive trauma. In this case, the issues in dispute are as follows: 1) accident; 2) notice; 3) causation; 4) medical expenses; and 5) the nature and extent of Petitioner's injuries.

Petitioner testified that he worked as a janitor for ten years in Respondent's grocery store. Petitioner testified that his job involved running a buffer machine, which he believed caused carpal tunnel syndrome in his left hand. He would operate this buffer machine with both hands on the machine. He noticed that the fingers in his left hand would lock up in the morning. On cross examination, Petitioner testified that his duties would vary throughout the day and included operating the cash register, straightening boxes on the shelves and sweeping.

Respondent's store manager, Mark Castiglioni, testified that Petitioner never reported to him any complaints of problems with his left hand. Mr. Castiglioni testified that the Petitioner was suspended from work in July, 2007 for "sampling" the store food in the back of the store – in violation of the company policy. Mr. Castiglioni testified that the suspension period is usually for 3 days, but the Petitioner never returned to work after his suspension on July 2, 2007 – which coincides with the date of accident for this claim.

A review of the medical records show Petitioner did not seek medical treatment for any condition alleged to have occurred in the course of his employment until September 25, 2007. At that time he saw Dr. Mitchell, and reported only left knee pain. (Petitioner Exhibit 8 at pgs. 4-5). At that time Petitioner did not report any problems he was having with his left hand.

Petitioner saw Dr. Schlenker on September 30, 2007. (Petitioner Exhibit 10 at pg. 7; Petitioner Exhibit 4). At that time Schlenker believed the Petitioner had left carpal tunnel syndrome due to the performance of his work duties, but also recommended an EMG and testing to rule out diabetes. (Petitioner Exhibit 10 at pgs. 13-15). The EMG was performed on December 14, 2009. By December 14, 2009 Petitioner had bilateral hand and upper extremity numbness and tingling. It is noted that the claimant hadn't worked since July 2, 2007, but symptoms are worsening. Petitioner reported to doctors that he had diabetes and had a loss of vision. (Respondent Exhibit 6; Petitioner Exhibit 9 pgs. 35-36). Although he denied it during his testimony, the medical records indicate that prior to working at Sullivan's Foods Petitioner had complaints of left hand pain, and bilateral upper extremity symptoms. (Respondent Exhibit 5).

On May 7, 2008, Petitioner saw Dr. Wiedrich for an independent medical examinationfor evaluation of the left hand/wrist symptoms. (Respondent Exhibit 4, pg. 6). Dr. Wiedrich is board certified, and specializes in hand surgery. (Id. at pgs. 4-5). At the time of the examination, Petitioner's complaints were localized in the left hand only. (Id. at pg. 8). Petitioner told Dr. Wiedrich that he never reported his injury or symptoms to his employer (Respondent Exhibit 4 at pg. 9, and Wiedrich Deposition Exhibit 2). Dr. Wiedrich testified via evidence deposition on December 1, 2011 that Petitioner reported that he was terminated on July 2, 2007, and did not seek any treatment for left hand complaints until September 30, 2007. (Id. at pgs. 9-10). When Dr. Wiedrich examined Petitioner, he had one positive finding out of three for carpal tunnel. At that time Rosales did not reveal to Wiedrich that he had diabetes. (Respondent Exhibit 4 at pg. 16). Dr. Wiedrich recommended an EMG. (Id. at pgs. 11-12). Dr. Wiedrich testified the EMG study showed peripheral neuropathy, which was likely diabetic neuropathy. (Respondent Exhibit 4 at pgs. 13-14). The test also showed bilateral ulnar nerve compression consistent with cubital tunnel syndrome. (Id. at pgs. 14-15). Dr. Wiedrich testified that it was

16IWCC0332

significant that Petitioner waited three months after he left his employment before he sought treatment. (Id. at pg. 19). The records also revealed that the symptoms had increased in the left hand and arm in the years after Petitioner stopped working for the Respondent. In addition, Petitioner began to have right hand symptoms as well. (Respondent Exhibit 4 at pgs. 14-15). Dr. Wiedrich opined that given the constellations of Petitioner's symptoms, diabetes could cause the conditions. (Id. at pg. 19). Dr. Wiedrich testified that he understood the claimant's job duties, and it could be possible to develop carpal tunnel syndrome, however he did not formulate that opinion in this case because of the findings on examination and the timing issues. (Id. at pgs. 20-21).

Petitioner testified that at the time of the arbitration hearing, he had no problems with his left hand, and that he is currently on social security disability for a number of conditions, including his vision and diabetes.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has failed to meet his burden of proof. This finding is supported by both the Petitioner's testimony and the medical evidence. Petitioner is claiming repetitive trauma over the course of 10 years working for the Respondent and attributes his left hand carpal tunnel syndrome to operating a buffer machine with both hands. However, there was no evidence presented as to the frequency of Petitioner operating the machine, the duration of Petitioner operating the machine, the amount of hand force required to operate the machine or any indication that the Petitioner had complaints in his left hand contemporaneous with using the machine. The Arbitrator finds it incredible that the Petitioner was experiencing his alleged carpal tunnel symptoms in his left hand, but not in his dominant right hand despite the fact that he testified the operation of the buffer machine required the use of both hands. Petitioner himself admitted that his job with the Respondent varied in that he would also operate the cash register, organize shelves, mop, and clean the bathroom. Furthermore, the Arbitrator finds persuasive the opinions of Dr. Wiedrich, who attributes Petitioner's condition to his diabetes, which would explain why the Petitioner's condition worsened after he stopped working for Respondent and also began to manifest in his right hand. Based on these factors, the Arbitrator concludes that the Petitioner failed to prove that he sustained an accident that manifested itself on July 2, 2007.

2. Based on the Arbitrator's findings with regard to the issue of accident, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Santa Roman,

Petitioner,

vs.

Caraastar,

NO: 07WC 39792
07WC 49616
08WC 28309

Respondent,

16IWCC0327

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 27, 2014, 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.

16IWCC0327

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 13 2016

Michael J. Brennan

MJB/bm
o-5/10/16
052

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
ORDER TO DISMISS CASE FOR WANT OF PROSECUTION

ATTENTION. The parties have 60 days from the receipt of this order to file a *Petition to Reinstate Case.*

Santa Roman
Employee/Petitioner

v.

Caraustar
Employer/Respondent

Case # **07** WC **39792**

07 49616

16IWCC0327

After this case was filed by the petitioner, all parties received due notice, but the petitioner failed to appear at a status call or trial date. Accordingly, as provided by law, I order that this case is dismissed for want of prosecution.

David A. Kane
Signature of arbitrator or commissioner

10/27/14
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Timothy Hopkins,

Petitioner,

vs. NO: 07 WC 50020

Leggett & Platt,

16IWCC0283

Respondent.

DECISION AND OPINION ON §19(h) AND §8(a) PETITION

This case comes before the Commission on Petitioner's §19(h) and §8(a) Petition, alleging a material increase in his disability since the January 28, 2008 hearing held by Arbitrator Kinnaman, claiming additional medical expenses and permanency. Arbitrator Kinnaman's February 13, 2008 decision awarded Petitioner permanent partial disability to the extent of 10% person-as-a-whole pursuant to Section 8(d)2 of the Act. A hearing on the current petition was held before Commissioner Thomas Tyrrell on September 24, 2015, in Chicago, Illinois and a record was made.

The Commission, having considered the entire record, finds that Petitioner has shown a material increase in disability and that as a result Petitioner is entitled to additional medical expenses set forth in PX4, PX5, PX6, PX8 and PX9 pursuant to §8(a) and the fee schedule provisions of §8.2 as well as additional permanency partial disability benefits of 15% person-as-a-whole pursuant to §8(d)2 of the Act.

I. HISTORY OF THE CASE

A hearing at arbitration was held before Arbitrator Jacqueline Kinnaman on 1/28/08 in Geneva, Illinois. The Arbitrator issued a decision on 2/13/08 finding that Petitioner proved he sustained accidental injuries arising out of and in the course of his employment on 1/17/07, that

16IWCC0283

Petitioner's "... current low and mid back conditions are causally related to his undisputed accident ..." and that Petitioner is permanently disabled to the extent of 10% person-as-a-whole under §8(d)2 of the Act "... based on his T12 compression fracture, aggravation of his prior L4/5 condition and his residual complaints which were credible. However, he has had no treatment since April, 2007 and manages his symptoms with aspirin." (Arb.Dec. [Addendum], pp.1-2).

Thereafter, a Petition for Review was filed by Respondent and the Commission affirmed and adopted the Arbitrator's decision in a Decision and Opinion on Review (09 IWCC 0149) dated 2/9/09.

Petitioner subsequently filed a "Petition for Review under Section 19(h) or 8(a) of the Act" on 5/29/09. A hearing on Petitioner's §§19(h)/8(a) Petition was eventually held before Commissioner Tyrrell on 9/24/15.

II. FINDINGS OF FACT

A) Arbitration Hearing

At the arbitration hearing held on 1/28/08, Petitioner testified that on 1/17/07 he was working for Respondent as a retail manager when a raised conveyor that he was on collapsed, causing him to fall in a seated position approximately six (6) feet. (PX1, pp.9-10). Following the injury, he noticed excruciating pain in his back, "pretty much all over, more so in the middle." (PX1, pp.10-11).

Petitioner visited Dr. Keith Schaible on 1/25/07 at which time it was recorded that he had undergone L4-5 disc surgery in 1991 and that "[h]e had apparently been doing well, but recently, last week, 1/17/07, while at work a conveyor collapsed and he sort of fell. It sounds like he landed on his buttock, or sitting, and this caused significant pain, sort of upper lumbar, band-like pain. It does not seem to radiate into the legs, although he has the sense that his right leg feels fatigued. He doesn't have numbness or tingling or sharp pain like he had previously. He seems to note that this back pain is increased by hiccupping. His pain feels about the same in the last week..." (PX1 [1/28/08 hearing]). Upon exam, Dr. Schaible noted "... some mild sort of upper lumbar palpation percussion tenderness" and negative straight leg-raising, as well as "... good and symmetric strength in his lower extremities..." (PX1 [1/28/08 hearing]). Dr. Schaible indicated that the exam "... fails to demonstrate a radiculopathy..." and that "[g]iven his previous history of surgery, [and] his persistent pain, he seems quite interested in pursuing an MRI to make sure he didn't cause another disk injury..." (PX1 [1/28/08 hearing]).

Petitioner subsequently underwent a lumbar MRI on 1/31/07. (PX1, p.11). This study was interpreted as revealing "... an abnormal appearance ... of the T12 vertebral body compatible with a relatively recent compression fracture. There is approximately 25% loss in height of the superior aspect of the vertebral body with marrow space edema being present. There is no evidence of significant resultant spinal stenosis. There is probable marrow space edema also present within the superior aspect of the T11 vertebral body. Post surgical changes are present at the level of L4-5 without evidence of recurrent disc herniation. Additionally, degenerative changes are present ..." (PX1 [1/28/08 hearing]).

16IWCC0283

Petitioner agreed the MRI showed a compression fracture at T-12. (PX1, p.28). Dr. Schaible recommended a back brace and Petitioner was fitted for same. (PX1, pp.11-12).

Petitioner visited Dr. Schaible on 4/10/07. In a progress note on that date, Dr. Schaible recorded the following: "Timothy comes in and states his brace broke for a few days, and he did not wear it, and it seems that without it he was having quite a bit of discomfort. Again, it is back pain. There is some pain in the tailbone, he thinks he bruised it. Back with the brace he is a little bit better. I am surprised he has not shown much improvement or healing. I thought it would be reasonable to get a CT scan, and see how much healing we have. I would like to see him after that." (PX1 [1/28/08 hearing]).

Petitioner agreed that he never saw a doctor after 4/10/07, and that Dr. Schaible never referred him to anyone thereafter. (PX1, pp.29-30). Furthermore, while he claimed that Dr. Schaible offered medication, Petitioner agreed that Dr. Schaible never actually prescribed same or any physical therapy. (PX1, p.30). In addition, Petitioner agreed that no surgery had been recommended for the L4-L5 region and that he does not have any future appointments scheduled. (PX1, p.34).

Petitioner underwent a lumbar CT scan on 4/13/07 which was interpreted as revealing an endplate depression fracture with associated anterior wedging of the T12 vertebral body as well as findings of degenerative arthritis seen throughout the lumbar spine. (PX1 [1/28/08 hearing]). In addition, Petitioner underwent a CT scan of the pelvis dated 4/13/07 which was interpreted as revealing a "[n]ondisplaced linear fracture involving sacral ala on the right side at about the S2 level ..." as well as mild gaseous degenerative change within the sacroiliac joints bilaterally. (PX1 [1/28/08 hearing]).

Petitioner did not return to Dr. Schaible following the CT, noting that Dr. Schaible told him that "... if you need to see me, see me in ten weeks." (PX1, p.14). Petitioner indicated that Dr. Schaible called him on the phone and told him this. (PX1, p.31). Petitioner continued to work thereafter. (PX1, p.32).

Petitioner testified that following the CT scan he was still in pain, and that he contacted another physician, Dr. Brown, who had performed back surgery on him in 1991. (PX1, p.14). He agreed that this prior surgery involved a laminectomy at L4-5. (PX1, pp.14-15). The operative report actually shows that he underwent a right L-4/5 hemilaminotomy with excision of herniated nucleus pulposus on 11/26/91. (PX7 [Bernstein dep.], PX3). Petitioner noted that he had had leg pain and numbness as well as back pain at the time of this prior surgery. (PX1, p.15). He testified that he was "a hundred percent" following this surgery, and that he had no back pain and did not lose any mobility. (PX1, p.20).

With respect to the 1/17/07 accident, Petitioner noted he missed two days of work. (PX1, p.15). He noted that he is currently employed as a plant manager by Advance Urethane Technologies, formerly Leggett and Platt. (PX1, p.15).

At the time of the 1/28/08 hearing, when asked to describe the difficulties he was experiencing, Petitioner testified as follows: "I can't sit for a long period of time. I can't walk

16IWCC0283

around the plant for a very long time." (PX1, p.16). He noted that he could sit without pain in his back for "[m]aybe an hour at most. I got to get up and walk around." (PX1, p.16). In addition, he indicated that he could walk without pain in his mid or lower back for "... maybe a block." (PX1, p.16). He also noted "... like a pain in [his] tailbone. When I'm sitting mostly, I get the pain there. When I'm walking, I'll get pain." (PX1, p.16). Petitioner stated that he did "[n]o running" and that he can kneel but that "[i]t's painful getting up. I've got to have something to help me get up." (PX1, p.17). He testified that walking probably causes the most pain in his lower and middle back at work, and that he "... get[s] pain in [his] back [climbing stairs]. Coming down is easier." (PX1, p.17). He also noted that he experiences intermittent numbness in his right leg from the knee down a couple times a week. (PX1, pp.17-18). On the date of trial, he indicated that sitting in the pew outside the hearing room caused numbness from about the knee down. (PX1, p.18). In addition, he noted numbness with walking, sitting and anything else where he exerts himself. (PX1, p.18).

At the same hearing Petitioner testified that he can drive "maybe a half hour" and that "[i]t's hard getting out of the car after that amount of time." (PX1, p.18). He noted that when he gets out of the car he notices pain in his mid and low back, and that he "... will get some pains down [his] [right] leg when [he's] driving." (PX1, p.18). He indicated that he takes aspirin to relieve these symptoms. (PX1, pp.18-19). Petitioner also testified that he was not taking any prescribed medications at the time of this hearing, and that he was no longer wearing the back brace because it was causing sores below his waist. (PX1, p.19).

When asked whether there was anything else he wanted to say about his condition, Petitioner testified as follows: "Just the pain. I mean I have a hard time – I can't stay in bed more than six, seven hours at night. My wife and daughters have learned blowing the snow was a lot harder than they thought. You know, chopping wood. I like to go hunting and where I go hunting is all hilly. It's not – I didn't go this year." (PX1, p.19). He also noted that he doesn't play golf anymore. (PX1, p.20).

On cross examination, Petitioner agreed that his mid and low back pain were different and in two distinct areas. (PX1, p.21). He also noted that he did not have any numbness or tingling of his lower extremities at the time he was taken to the hospital on the date of the accident. (PX1, pp.21-22). However, he would disagree with the records if they only reflect lower back pain and not mid back pain. PX1, p.22). In addition, he agreed that he had been given restrictions of no lifting over ten (10) pounds and that he returned to work within these restrictions on 1/20/07. (PX1, p.25). He noted that at no time did Dr. Schaible take him off work thereafter. (PX1, p.25).

On re-direct, Petitioner testified that since 1/25/07 the feeling of "fatigue" in his right leg described by Dr. Schaible has persisted, and that as time went on he experienced numbness and "a little heaviness in the leg." (PX1, p.35).

B) §§19(h)/8(a) Hearing

At the hearing held before Commissioner Tyrrell on 9/24/15, Petitioner testified that as previously adjudicated he was injured on 1/17/07 when the conveyor he was sitting on collapsed and he fell about six (6) feet, landing on his buttocks. (T.8-9). Petitioner indicated that he had

16IWCC0283

previously undergone surgery on his low back at the hands of Dr. Frederick Brown in 1991. (T.26). However, he noted that prior to the subject accident on 1/17/07 he was not experiencing any problems with his lower back and that he "... did anything and everything [he] was able to do." (T.26-27). In addition, he denied having any symptoms extending into his legs in the interval (i.e. between 1991 and 2007). (T.27).

Following the accident on 1/17/07, Petitioner noted excruciating pain in his lower back and was treated at the Central DuPage Hospital emergency room. (T.9). Thereafter, Petitioner treated with Dr. Schaible from 1/25/07 through 4/10/07. (T.9). He underwent an MRI on 1/31/07 and a CT scan of his low back and pelvis on 4/13/07. (T.10). He also filed a workers' compensation claim and the matter was tried before an arbitrator on 1/28/08. (T.10).

Petitioner agreed that his last visit to Dr. Schaible was in April of 2007, or about nine (9) months prior to the arbitration hearing. (T.44). He also acknowledged that he had several routine visits with his primary care physician, Dr. Obert-Hong, between April 2007 and about a year thereafter. (T.44). And while he could not recall not making any complaints relative to his back at the time of those visits – specifically on 7/13/07, 7/28/07, 11/27/07 and 4/12/08 -- Petitioner would not dispute the records if they reflect the absence of any such complaints. (T.45-47).

Petitioner testified that from 4/13/07 through 5/13/08 he did not receive any treatment for his lower back, a period of thirteen (13) months. (T.11). However, he claimed that during that time he "... still had a lot of pain, [his] lower back, it started radiating into [his] right leg at that point." (T.11).

Petitioner noted that from time to time during this period he visited his primary care physician, Dr. Obert-Hong. (T.14). He noted that these were primarily routine visits and that he did not see Dr. Obert-Hong for his low back at that time. (T.14). When asked why not, Petitioner responded: "Well, that's not what he does, I mean that would be like me asking the neurosurgeon to check my throat." (T.14-15). As a result, Petitioner did not believe that he mentioned any ongoing low back problems to Dr. Obert-Hong, and Dr. Obert-Hong did not specifically ask him about his low back. (T.15).

Petitioner agreed that he visited Dr. Obert-Hong on 4/12/08 for a complete physical, although he could not recall when he made the appointment. (T.51-52). He acknowledged that he did not make any complaints at that time, and that Dr. Obert-Hong was aware of his T12 compression fracture. (T.53-54). He agreed that he did not tell Dr. Obert-Hong that walking caused him the most pain, and that Dr. Obert-Hong did not make any diagnosis or order any treatment for his low back, including a referral to an orthopedic surgeon or a neurosurgeon, following his examination on that date. (T.56-57).

When asked why he did not receive treatment for his lower back during this period, Petitioner testified as follows: "After I had the CT Scan, Dr. Schaible called me, told me at that point that I had broken my pelvis also in the fall, and I asked him, okay, what do we do now and he said well, if you think you need to see me come back in ten weeks." (T.12). Petitioner noted that about a month after he talked to Dr. Schaible he "... tried to contact Dr. Brown (at the University of Chicago) at that point because [he] was still having problems and [he] was told by

16IWCC0283

them at [Dr. Brown's] office that [Dr. Brown] didn't do Workers' Compensation cases." (T.12-13). Petitioner went on to state that "[t]hey said they wouldn't see [him] because it was a Workers' Compensation case and [Petitioner] thought, well, [Dr. Schaible] told [him] to wait ten weeks. So [Petitioner] thought maybe something will get a little better, but it never did. So then [Petitioner] contacted Dr. Brown's office again and said [they] would do it through [Petitioner's] regular insurance rather than Workers' Compensation." (T.13-14).

On redirect, when asked why he did not talk to Dr. Obert-Hong about pain in his low back from April 2007 through May of 2008, he noted that in his opinion "... [Dr. Obert-Hong]'s a family physician, and you know, it would be like asking a neurosurgeon to give me a prostrate exam ... [a]nd, you know, Dr. Brown did the surgery earlier in '91 and I was great and that's why I wanted to see [him] because he did such a good job the first time, so that's why I held out." (T.85-86).

On re-cross, Petitioner maintained that he was truthful with Dr. Obert-Hong when he did not make complaints relative to his low back during this time, describing it as "... an omission, not a lie." (T.92). He went on to then acknowledge that he did not want Dr. Obert-Hong to treat him for his low back. (T.95).

Petitioner visited Dr. Brown at the University of Chicago Medical Center on 5/13/08. (T.15). He noted that Dr. Brown allowed him to come in and see him using his group insurance. (T.15,58). In an office note dated 5/13/08, Dr. Brown recorded that Petitioner "... is well known to me. He came for a right L4-5 hemilaminotomy and discectomy in 1991. He was doing well until he fell in January of 2007 and developed low back pain that has basically remained the same. There was worsening of the pain recently. He has also recently developed some right calf numbness that goes into the top of his foot and into the toes." (PX3). Dr. Brown noted that the "... MRI shows evidence of an old fracture at T12. There is no evidence of spinal stenosis or disk herniation. However, there is severe disk degeneration at L4-5 with a bone on bone appearance." (PX3). Dr. Brown's impression was "[p]robable discogenic low back pain." (PX3). Petitioner testified that Dr. Brown prescribed physical therapy as well as a GMI exam of his lumbar spine, which was performed that day. (T.15-16). Petitioner agreed that this was the first time, since he saw Dr. Schaible in April 2007, that he told a physician about his lower back pain. (T.58).

Petitioner testified that he attended about eight (8) physical therapy sessions from 5/20/08 through 6/20/08. (T.16). In an initial physical therapy evaluation report dated 5/20/08, it was recorded that "[h]e tells me symptoms commenced as a result of a fall from a 7 foot elevated work platform, onto a conveyor belt in February 2007. Apparently, he suffered a vertebral fracture to T-12 and in the sacroiliac region. He explains that the fracture stabilized, but this particular injury severely re-aggravated the lumbar radiculopathy that was present in 1991, prior to his surgery." (Emphasis added)(PX4).

Petitioner acknowledged that a Palos Community Hospital "verification" form completed at this time noted that he was not applying under workers' compensation. (T.62; RX1). The same can be said of an admitting registration record at the University of Chicago dated 9/30/08. (T.66; RX3). Petitioner even admitted that he lied on this form when he indicated that his

16IWCC0283

admission was not related to a work accident or illness. (T.69). On re-direct, Petitioner indicated that he marked that it was not work related on "[b]ecause Dr. Brown didn't take Workers' Compensation cases and I had called earlier and they turned me down some months earlier." (T.86). Therefore, he felt he had to mark "no" in order to treat with Dr. Brown. (T.87).

Petitioner followed up with Dr. Brown on 7/8/08 at which time the latter prescribed a discography for his lower back, which was performed on 8/21/08. (T.16-17). Petitioner underwent a CT of the lumbar spine on 9/30/08 which revealed the previous compression fracture of the superior endplate of the T12 vertebral body, spinal stenosis and "[l]ocalized advanced degenerative disk disease at L4-L5 with significant loss of height and vacuum disk phenomenon ..." (PX3). Also on that date, Petitioner underwent a lumbar MRI which revealed an old mild T12 anterior wedge compression deformity, post-surgical change at L4-L5 with no evidence of recurrent disc herniation and degenerative changes at T11-12, L4-L5 and L5-S1. (PX5).

On 10/6/08, Dr. Brown performed surgery in the form of a lumbar spine fusion at L4-5 and L5-S1 with hardware. (T.18). Dr. Brown eventually recommended removal of the hardware, which was performed on 1/18/10. (PX3). Thereafter, he underwent a procedure by Dr. Variakojis to break up epidural adhesions in his lower spine on 4/26/10. (T.20-21; PX6). In addition, Petitioner received a series of injections on 6/7/10 and 8/2/10. (PX6). In a letter dated 10/26/10, Dr. Variakojis recorded that Petitioner's "... problems started in 2007 when he fell, sustaining a compression fracture of T12, rupture of the disc at L5-S1, and sacral ala fracture on the right ..." (PX6).

On 3/30/11, Petitioner underwent surgery for the placement of a trial spinal cord stimulator in his lower back. (T.22-23). A permanent spinal cord stimulator was eventually implanted on 4/6/11. (T.24). Thereafter, Petitioner continued to follow up with physicians at the University of Chicago Medical Center through 6/10/11. (T.24). Since that date, Petitioner has not had any further treatment relative to his lower back other than routine visits pertaining to his spine stimulator. (T.25). This routine care concerning the spine stimulator has been provided by Dr. Shashoua at the University of Chicago Medical Center. (T.41). He indicated that Dr. Shashoua also prescribes his medication and orders tests, including a CAT scan with a myelogram. (T.41-42). Petitioner noted that he has not seen Dr. Brown since 6/10/11 for the reason that the latter has since retired. (T.25).

On 11/25/13, Mr. Hopkins visited board certified orthopedic surgeon Dr. Avi Bernstein at the request of Petitioner's attorney for purposes of a §12 examination. (T.25). Dr. Bernstein testified by way of evidence deposition on 5/27/15. (PX7). Following his examination and review of the records, Dr. Bernstein noted that Petitioner "... was status post a L4 to S1 decompression and fusion with residual low back pain and radiculopathy, that he was status post spinal cord stimulator implantation, and status post T11-T12 compression fractures that subsequently healed." (PX7, p.15). Dr. Bernstein was of the opinion that a causal relationship existed between Petitioner's work accident on 1/17/07 and his subsequent treatment and condition of his back based on the fact that "... he suffered a trauma that resulted in complaints of low back pain that were reasonably expected following the type of trauma that he had, that he reported the onset of the right lower extremity radicular pain relatively early on, and he

16IWCC0283

subsequently underwent all the surgery, all the treatment, and efforts to try to relieve that pain, so for that reason I believe it was related. I also am unaware of a pre accident history of low back pain and radiating leg pain." (PX7, p.16). With respect to Petitioner's prior history of low back injury, Dr. Bernstein noted that his understanding was that "... many years prior he had a low back operation for a pinched nerve, that he did well, that he went about his life, and that prior to this accident he was functioning well without symptoms." (PX7, p.16). Dr. Bernstein also opined that Petitioner's treatment was reasonable and necessary. (PX7, p.17).

When asked to comment on Dr. Itkin's differing opinion on the question of causation, Dr. Bernstein testified that "... one of the main foundations for [Dr. Itkin's] opinion is a gap in treatment for this patient following his arbitration and before seeking care with Dr. Brown, and my opinion is based on the fact at the time of the arbitration and included in the arbitration transcript are complaints of right lower extremity radicular pain, pain that developed subsequent to the work incident, pain that's been a problem for him, and it's the type of pain that is clearly not related to the fracture, it's clearly related to the low back, so I believe that the condition for which he saw Dr. Brown was a condition that was ongoing through that year where there was a gap in treatment, and that the history that the patient provided has been consistent to the surgeon that the symptoms developed as a result of the accident." (PX7, p.20). Dr. Bernstein also testified that he thought it was "... meaningless whether he had [a herniated disc] or not. I think the issue here is that he had discogenic pain, he had a lumbar discogram, and I think that was the main indication preceding the surgery of Dr. Brown was the positive discogram." (PX7, p.56).

At the request of Respondent, Petitioner visited board certified neurologist Dr. Arthur Itkin on 3/6/14 for purposes of a §12 examination. (T.26). Dr. Itkin noted that he does "general neurology" but that his interest is neuro immunology and multiple sclerosis and that he specializes in clinical trials at the MS center. (RX5, p.7). Dr. Itkin had previously performed a forensic record review in this case in 2012, also at the request of Respondent. (RX5, p.10). Dr. Itkin issued a report dated 5/19/12 following that review wherein he noted that Petitioner had "... a very long-standing history of degenerative lumbosacral arthritic disease" and that on 1/17/07 he suffered a work-related injury to his thoracic spine. (RX5, pp.10,13). However, Dr. Itkin did not think that Petitioner's "... industrial injury of January 17th, 2007 resulted in the sequelae, specifically his progression of his degenerative arthritic changes for which he needed to continue treatment." (RX5, p.14). He went on to state that he felt that Petitioner had "... a spontaneous worsening of his degenerative arthritic disease and the fact that for close to a year he did not have any complaints further confirms that opinion." (RX5, pp.14-15). Dr. Itkin pointed to the fact that there was no mention of back problems in the records of Dr. Schaible or Dr. Obert-Hong during this period, and that the back problems surfaced when he saw Dr. Brown again. (RX5, p.15).

Furthermore, Dr. Itkin testified that he has absolutely no criticisms regarding the medical treatment that was provided in this case. (RX5, pp.20-21). He indicated that the pre- and post-operative diagnosis at the time of Dr. Brown's surgery in 2008 was the same – lumbosacral degeneration. (RX5, p.22). Dr. Itkin also noted that the surgical report did not mention any work related accident as an indication for surgery, but instead references progressively worsening low back pain and diagnostic evidence of severe degeneration of the L4-L5 disc as well as loss of disc space height. (RX5, pp.22-23). In addition, Dr. Itkin agreed with Dr. Bernstein that

16IWCC0283

Petitioner sustained a thoracic fracture and that his medical treatment was reasonable, but that he disagreed with him "... on causality or association of [Petitioner's] work-related injury on January of 2007 to his existing condition of lumbosacral spine." (RX5, p.33). Furthermore, Dr. Itkin agreed that Petitioner will need additional care for his lower back in the future. (RX5, p.34).

On cross, Dr. Itkin conceded that Petitioner suffered an aggravation of his degenerative condition of his lumbar spine at the time of the 1/17/07 accident. (RX5, p.36). He also acknowledged that this is what he said in his 2012 report and what the arbitrator "[g]enerally" found in her decision. (RX5, pp.36-37). In addition, Dr. Itkin agreed that the treatment Petitioner received for his lower back and lumbar spine condition from May of 2008 through June of 2011 was reasonable and necessary, including the lumbosacral surgery, pain management and stimulator implant. (RX5, p.43). Likewise, he agreed that there was no intervening accident between the January 2007 accident at work and when he began treating with Dr. Brown in May of 2008. (RX5, p.43). He also conceded that if Petitioner had continuous low back pain from the time of his work accident in 2007 through his treatment with Dr. Brown beginning in May of 2008, that it would likely be that the pain stemmed from that accident. (RX5, pp.44-45).

On re-direct, Dr. Itkin testified that he still agrees with the statement in his 2012 report to the effect that there was no evidence that the 1/17/07 injury resulted in any form of lumbosacral radiculopathy. (RX5, p.54).

Currently, Petitioner noted that his back condition "... actually has worsened, especially recently. I have a lot of problems during the week. One of the problems that I have is when I have a bowel movement and this happens at least twice a week, I get excruciating pain in my back and both legs and my legs get a little numb. I don't even like the feel of pants rubbing on them. And then, after a bowel movement I have to clean myself at least three other times because it doesn't stop. That's all. So I have that problem." (T.27). In addition, Petitioner testified that he has difficulty with excessive walking and sitting, noting that he can sit for an hour or so in one spot before his back and legs hurt and his legs "begin to jump uncontrollably." (T.27-28). He also noted that standing is worse and that he can "... stand for probably five minutes before it starts to hurt and then [he] ha[s] to walk a little bit. That helps relieve some of it but walking too much makes it bad also..." (T.28). He also indicated that when he walks for extended periods of time his back hurts and his right leg is painful and swells up a little bit. (T.29). Petitioner noted that he uses a cane any time he is doing extended walking, and that he keeps a collapsible cane in his bag for work that he uses. (T.29). He also uses the cane anytime he goes grocery shopping or goes to the mall. (T.29). Specifically, he noted that on the date of the hearing on 9/24/15 he had to use the cane to walk from the parking lot. (T.29). In addition, Petitioner noted that he is "up and down probably 4 or 5 times a night" because of his back condition, and that he "get[s] maybe 5 or 6 hours asleep [sic] at most now", compared to the eight (8) hours a night he used to get before the accident. (T.29-30).

In addition, Petitioner indicated that he can drive for an hour, hour and a half before he has to get up, and that some car seats are worse than others. (T.30). As far as household chores are concerned, he noted that he can cut the grass using a lawn tractor, but that he has to use the lowest gear so he doesn't bounce around too much. (T.30). However, he indicated that his wife does most of the yard work, and that he has to sit and watch her from the driveway. (T.30). He

16IWCC0283

testified that he used to bowl in a league and golf, but that he can't bowl anymore and that he hasn't golfed since the accident. (T.31). He indicated that he hunts and fishes, but that he can't get a whole day of hunting in anymore. (T.31). He also stated that "[w]hen it gets cold if I didn't keep my back warm it is excruciating." (T.31).

Petitioner testified that he worked for Respondent for eleven (11) years, starting in 2002 or 2003, and that he worked in costing for the first couple of years before moving to plant manager. (T.31-32). He currently works as a business analyst for Plano Energy where he does a lot of work on the computer and trains others on how to use the computer system. (T.32). He indicated that his job also involves a lot of travel in that he has to go into the plants, where he noted that "... most of the places will make sure I have a place to sit and that to work." (T.32). When asked what he notices about his lower back as he performs his job duties for his current employer, Petitioner responded as follows: "I am up and down from my desk all the time wherever I am working because I sit there. I would like to get the company to buy me a desk that I can move up and down so I can work standing when I need to. But I pace, I stand, I sit. The only bad part is I can't lay down at work." (T.33). He went on to state that "[t]ravel days are the worst. The morning flight is not too bad because I had a night[']s rest. When I come home on a flight it is two painkillers and a muscle relaxer to get me through the flight. ... I don't go out to dinner on a day that I travel because I need to go to the room to lay down. It is rough." (T.33).

Petitioner stated that he started working at Plano Energy on 2/27/15, and that prior to that his employer was Sleep Innovations where he did the same type of work as a business analyst. (T.77-78). He indicated that he believed that he was already working for Sleep Innovations at the time of the 1/28/08 hearing. (T.79). He agreed that he worked there another 6 or 7 years until his current job. (T.79).

On cross examination, Petitioner testified that his current job does not require him to do any heavy lifting. (T.42). However, he indicated that with the amount of travel involved he would consider the job more than light duty, although the amount of pulling, pushing and lifting would be considered light duty. (T.42). He also acknowledged that his doctors are aware of his current complaints and that they have not restricted his physical activities, including non-work related activities, in any manner. (T.43). In addition, he agreed that he has not suffered any loss in earning capacity. (T.43).

With respect to his prior testimony at arbitration on 1/28/08, Petitioner agreed that his complaints at that time included an inability to sit or walk for a long time, that his back was painful getting up and that walking caused the most pain. (T.49). In addition, he complained of numbness in his right leg from the knee down and that the numbness resulted from such activities as walking, sitting and when he tried to exert himself. (T.49). He agreed that he may have also represented that he could drive a car for maybe a half hour and that he can't stay in bed for more than 6 to 7 hours a night due to back pain. (T.49-50). He also acknowledged that at the time of his testimony he did not have any future medical appointments scheduled, and that he continued to work and live through the pain. (T.50-51).

When asked to compare how he feels now to how he felt at the time of the arbitration hearing in 2008, Petitioner testified that he "... ha[s] more numbness. [He] ha[s] more pain.

16IWCC0283

Now it has gone into both legs. [His] lower back still hurts." (T.74). He also claimed that the surgeries he has undergone have not been successful in relieving his pain and symptoms, and that he is worse now than he was before the surgeries. (T.75). With respect to the spinal cord stimulator, Petitioner testified that "[i]t takes about anywhere from 25 to 50 percent of [his] pain away. If it is not too severe, it gets to a certain paint [sic] where it doesn't help anymore." (T.75). He noted that he takes medication daily as prescribed by Dr. Shashoua in the form of Norco, Hydrocodone, Flexeril and a low dose Cymbalta. (T.76-77).

With respect to his cane, Petitioner noted that he did not have a prescription for same, but that "Dr. Shashoua knows that [he] use[s] it and approves it." (T.79). He also agreed that no other doctor has recommended anything else to help relieve his symptoms. (T.79).

Petitioner acknowledged that medical bills totaling over a half a million dollars had been paid through his group insurance carrier, and that he is requesting that Respondent reimburse the group carrier for same. (T.83-84).

III. CONCLUSIONS OF LAW

Section 19(h) of the Act provides, in pertinent part, that

> ". . . as to accidents occurring subsequent to July 1, 1955, which are covered by any agreement or award under this Act providing for compensation in installments made as a result of such accident, such agreement may at any time within 30 months, or 60 months in the case of an award under Section 8(d)1, after such agreement or award be reviewed by the Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased, diminished or ended."

At the commencement of the §§19(h)/8(a) hearing, counsel for Respondent indicated that there were "... no disputes regarding the actual treatment that was rendered. Our dispute rather goes to the issue of causation, not whether or not the treatment was necessary." (T.5-6).

In her decision, the Arbitrator specifically found that Petitioner's "... current ***low and mid back*** conditions are causally related to his undisputed accident ..." (Emphasis added)(Arb.Dec. [Addendum], p.1). Furthermore, the Arbitrator found that Petitioner was permanently partially disabled to the extent of 10% MAW "... based on his T12 compression fracture, ***aggravation of his prior L4/5 condition*** and his residual complaints which were credible..." (Emphasis added)(Arb.Dec. [Addendum], pp.1-2).

Furthermore, Respondent's §12 examiner, Dr. Itkin, agreed that Petitioner suffered an aggravation of his degenerative condition of his lumbar spine at the time of the 1/17/07 accident. (RX5, p.36). Dr. Itkin also acknowledged that this is what he said in his 2012 report and what the Arbitrator "[g]enerally" found in her decision. (RX5, pp.36-37).

Therefore, the question is not whether there was a lumbar spine component to the Arbitrator's original award, in addition to the T12 compression fracture, but whether Petitioner's

16IWCC0283

current condition of ill-being with respect to the lumbar spine continues to be causally related to the accident on 1/17/07.

Along these lines, Petitioner testified that he following his testimony at arbitration he continued to experience pain in his lower back radiating into his right leg. However, the medical records do not reference any low back complaints until Petitioner visited Dr. Brown on 5/13/08, or almost four (4) months after his testimony at arbitration on 1/28/08. Petitioner testified that he did not complain about his back prior to that date during office visits to his primary care physician, Dr. Obert-Hong, because Dr. Obert-Hong was not a back doctor and he wanted to treat with Dr. Brown, the back doctor who had operated on him in 1991. Petitioner also explained that he was initially unable to see Dr. Brown because he had been told that Dr. Brown did not treat workers' compensation patients. He noted that when he finally did see Dr. Brown he was able to do so by using his group health insurance

Dr. Brown's office note at the time of this 5/13/08 visit recorded that Petitioner "...***was doing well until he fell in January of 2007 and developed low back pain that has basically remained the same***. There was worsening of the pain recently. He has also recently developed some right calf numbness that goes into the top of his foot and into the toes." (Emphasis added)(PX3).

Likewise, in an initial physical therapy evaluation report dated 5/20/08, it was recorded that "[h]e tells me ***symptoms commenced as a result of a fall from a 7 foot elevated work platform, onto a conveyor belt in February 2007***. Apparently, he suffered a vertebral fracture to T-12 and in the sacroiliac region. He explains that the fracture stabilized, but ***this particular injury severely re-aggravated the lumbar radiculopathy that was present in 1991, prior to his surgery***." (Emphasis added)(PX4).

In addition, Dr. Variakojis noted in a letter dated 10/26/10 that Petitioner's "... problems started in 2007 when he fell, sustaining a compression fracture of T12, ***rupture of the disc at L5-S1***, and sacral ala fracture on the right ..." (Emphasis added) (PX6).

Furthermore, Petitioner's §12 examiner, Dr. Bernstein, was of the opinion that a causal relationship existed between the work accident on 1/17/07 and his subsequent treatment and condition of his back based on the fact that "... he suffered a trauma that resulted in complaints of low back pain that were reasonably expected following the type of trauma that he had, that he reported the onset of the right lower extremity radicular pain relatively early on, and he subsequently underwent all the surgery, all the treatment, and efforts to try to relieve that pain, so for that reason I believe it was related. I also am unaware of a pre accident history of low back pain and radiating leg pain." (PX7, p.16).

With respect to this prior history, the record shows that Petitioner had previously undergone surgery on 11/26/91, or almost seventeen (17) years prior to the accident in question. This procedure consisted of a right L-4/5 hemilaminotomy with excision of herniated nucleus pulposus. (PX7 [Bernstein dep.], PX3). Petitioner testified at the arbitration hearing held on 1/28/08 that he was "a hundred percent" and that he had no back pain and did not lose any mobility following this surgery. (PX1, p.20).

Respondent's §12 examiner, Dr. Itkin, testified that he did not think Petitioner's "... industrial injury of January 17th, 2007 resulted in the sequelae, specifically his progression of his degenerative arthritic changes for which he needed to continue treatment." (RX5, p.14). He went on to state that he felt Petitioner had "... a spontaneous worsening of his degenerative arthritic disease and the fact that for close to a year he did not have any complaints further confirms that opinion." (RX5, pp.14-15). However, on cross examination, Dr. Itkin agreed that Petitioner suffered an aggravation of his degenerative condition of his lumbar spine at the time of the 1/17/07 accident. (RX5, p.36). Similarly, he agreed that there was no intervening accident between the January 2007 accident at work and when he began treating with Dr. Brown in May of 2008. (RX5, p.43). Finally, Dr. Itkin conceded that if Petitioner had continuous low back pain from the time of his work accident in 2007 through his treatment with Dr. Brown beginning in May of 2008, that it would be likely that the pain stemmed from that accident. (RX5, pp.44-45).

In response to Dr. Itkin's report, Dr. Bernstein testified that "... one of the main foundations for [Dr. Itkin's] opinion is a gap in treatment for this patient following his arbitration and before seeking care with Dr. Brown, and my opinion is based on the fact at the time of the arbitration and included in the arbitration transcript are complaints of right lower extremity radicular pain, pain that developed subsequent to the work incident, pain that's been a problem for him, and it's the type of pain that is clearly not related to the fracture, it's clearly related to the low back, so I believe that the condition for which he saw Dr. Brown was a condition that was ongoing through that year where there was a gap in treatment, and that the history that the patient provided has been consistent to the surgeon that the symptoms developed as a result of the accident." (PX7, p.20). Dr. Bernstein also testified that he thought it was "... meaningless whether he had [a herniated disc] or not. I think the issue here is that he had discogenic pain, he had a lumbar discogram, and I think that was the main indication preceding the surgery of Dr. Brown was the positive discogram." (PX7, p.56).

Based on the above, and the record taken as a whole, the Commission finds that Petitioner's current condition of ill-being relative to his lower back is causally related to the accident on 1/17/07 and that said condition has materially increased or worsened since the previous award. This finding is based on the credible testimony of Petitioner as to the ongoing nature of his lower back complaints subsequent to arbitration, as well as the medical records noted above. Along these lines, the Commission finds the opinion of Dr. Bernstein to be more persuasive than that offered by Dr. Itkin.

In support of this holding the Commission notes that while the medical records do not document complaints of low back pain from the date of his visit with Dr. Schaible on 4/10/07 until his visit to Dr. Brown on 5/13/08, the Commission affirmed the Arbitrator's determination that Petitioner's residual complaints relative to his thoracic and lumbar spine conditions, at the time of his testimony arbitration on 1/28/08, were credible. In addition, Petitioner testified that about a month after he spoke to Dr. Schaible he tried to contact Dr. Brown, the surgeon who had operated on his back in 1991, about his ongoing back problems but that he was told by Dr. Brown's office that he "... didn't do Workers' Compensation case." (T.12-13). Indeed, Petitioner acknowledged that he misrepresented, on various medical forms, that the condition was not work related in order to be able to see Dr. Brown under his regular insurance. (T.69,86-87). Along these lines, the Commission notes that "[i]ndicating on a form or application for

group health insurance benefits that an injury is not work related does not necessarily mean that compensation will be denied." *Thrall Car Manufacturing Co. v. Industrial Commission*, 64 Ill.2d 459, 356 N.E.2d 516, 1 Ill.Dec. 328 (1976); *Rockford Clutch Division, Borg-Warner Corp. v. Industrial Commission*, 37 Ill.2d 62, 224 N.E.2d 830 (1967)).

Thus, the evidence shows that Petitioner had ongoing complaints relative to his lower back at the time of and subsequent to his testimony at arbitration and that he attempted to seek treatment for same thereafter with the same doctor who had operated on his back in 1991. As a result, the Commission finds the lack of documented back complaints in the medical record between the date of arbitration on 1/28/08 and the date of Dr. Brown's examination on 5/13/08, or a period of less than four (4) months, to be reasonable under the circumstances and by no means dispositive on the question of causation.

Furthermore, the Commission finds that Petitioner is entitled to medical expenses incurred since the prior arbitration proceedings. In this respect, Dr. Bernstein opined that Petitioner's treatment was reasonable and necessary. (PX7, p.17). Likewise, Dr. Itkin, Respondent's §12 examiner, testified that he had absolutely no criticisms regarding the medical treatment that was provided in this case. (RX5, pp.20-21). Therefore, in light of the above holding as to causation, the Commission finds that Petitioner is entitled to the reasonable and necessary medical expenses contained in PX4, PX5, PX6, PX8 and PX9 pursuant to §8(a) of the Act and the fee schedule provisions of §8.2 of the Act. The Commission further finds that Respondent is entitled to a credit pursuant to §8(j) of the Act for any and all amounts paid on account of this injury by the group health insurance carrier, with Petitioner being held harmless for any outstanding balances.

Finally, the Commission finds that as a result of his worsening condition, Petitioner is entitled to additional permanent partial disability benefits. In this regard, the record shows that since the prior arbitration proceedings, Petitioner underwent surgery in the form of a lumbar spine fusion at L4-5 and L5-S1 with hardware on 10/6/08. Thereafter, Dr. Brown recommended removal of the hardware, which was performed on 1/18/10. Thereafter, Petitioner underwent a procedure by Dr. Variakojis to break up epidural adhesions in his lower spine on 4/26/10 and received a series of injections on 6/7/10 and 8/2/10. (PX6). On 3/30/11, Petitioner underwent surgery for the placement of a trial spinal cord stimulator in his lower back. (T.22-23). A permanent spinal cord stimulator was eventually implanted on 4/6/11. (T.24). Thereafter, Petitioner continued to follow up with physicians at the University of Chicago Medical Center through 6/10/11. (T.24). Since that date, Petitioner has not had any further treatment relative to his lower back other than routine visits pertaining to his spine stimulator. (T.25)

Currently, Petitioner noted ongoing complaints with his back, particularly with excessive walking and sitting. Petitioner also noted that he is "up and down probably 4 or 5 times a night" because of his back condition, and that he "get[s] maybe 5 or 6 hours asleep [sic] at most now", compared to the eight hours a night he used to get before the accident. (T.29-30). In addition, Petitioner indicated that he can drive for an hour, hour and a half before he has to get up, and that some car seats are worse than others. (T.30). As far as household chores are concerned, he noted that he can cut the grass using a lawn tractor, but that he has to use the lowest gear so he doesn't bounce around too much. (T.30). He also testified that he used to bowl in a league and golf, but that he can't bowl anymore and that he hasn't golfed since the accident. (T.31).

16IWCC0283

Therefore, based on the above, and the record taken as a whole, the Commission finds that Petitioner sustained additional permanent partial disability to the extent of 15% person-as-a-whole pursuant to §8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under §19(h) and §8(a) are hereby granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $619.97 per week for a period of 75 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the permanent loss of 15% of the man as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the medical expenses contained in PX4, PX5, PX6, PX8 and PX9 pursuant to §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 shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest 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: MAY 3 - 2016
o: 3/7/16
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
CHICAGO, ILLINOIS

Illinois Workers' Compensation Commission Insurance Compliance Division,	)	**CASE NO.: 08 INC 259**
Petitioner,	)	
v.	)	**Commissioner David Gore**
Vinny's Bar, Inc. a/k/a Cousin Vinny's Ltd., Rafael Cuellar, Individually & President of Cousin Vinny's Bar & Grill,	)	
Respondent.	)	

STIPULATION AND AGREEMENT BETWEEN THE ILLINOIS WORKERS COMPENSATION COMMISSION, INSURANCE COMPLIANCE DIVISION AND RAFAEL CUELLAR, INDIVIDUALLY AND AS PRESIDENT OF COUSIN VINNYS BAR AND GRILL

NOW COMES THE PETITIONER, the Illinois Workers Compensation Commission, Insurance Compliance Division and the Respondent, Rafael Cuellar, Individually and as President of Cousin Vinnys and stipulate and agree to the following facts:

1) That Respondent, Rafael Cuellar filed Articles of Incorporation with the Illinois Secretary of State on the 20th day of May 1997.

2) That on December 5, 2007, Luz Pina filed an Application for Adjustment of

Claim alleging injuries she sustained while working for Cousin Vinnys. The Application named Cousin Vinnys Bar & Grill as well as the Injured Workers Benefit Fund inasmuch as Cousin Vinnys did not carry workers compensation insurance.

3) That a trial was held with notice given to the owner of Cousin Vinnys as well as the IWBF. That no one appeared on behalf of Cousin Vinnys. An Arbitration Decision was filed on February 18, 2014 awarding Petitioner, Luz Pina, compensation under the Act. That amount was paid to Petitioner by the Injured Workers Benefit Fund.

4) On May 22, 2013, a Notice of Non Compliance was mailed by certified mail to Rafael Cuellar, Individually and as President of Cousin Vinnys Bar & Grill. The notice alleged non-compliance of 4(a) of the Act from July 20, 2005 through May 22, 2013. The notice required Mr. Cuellar to submit evidence of compliance with the provisions of 4(a) of the Act or otherwise respond in writing to the Commission within thirty days of the date of the receipt of the Notice. No proof of insurance was submitted.

5) Respondents attorney, James Miller and the Illinois Workers Compensation Commission, Insurance Compliance, through its attorneys, the Illinois Attorney Generals Office have stipulated to a penalty of $39, 750.00 to be entered against Rafael Cuellar individually and as President and owner of Cousin Vinnys Bar & Grill. Respondent admits to a willful and knowing violation of the Act.

6) That this stipulation to pay the sum of $39,750.00 pertains only to Respondent Rafael Cuellar, since Mr. Cuellar purchased all of Vince Dublinos stock effective May 31, 2005. The period of non-compliance alleged in Petitioners Complaint commences July 20, 2005.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent, **RAFAEL CUELLAR INDIVIDUALLY AND AS PRESIDENT AND OWNER OF COUSIN VINNYS BAR & GRILL** is found to be an employer who was in non-compliance with the insurance provisions of 4(a) of the Act and Section 7100.100 of the Commission Rules, and is hereby ordered to pay the Commission a fine of $ 10,000.00 pursuant to 4(d) of the Act and 7100.100 of the Commission Rules as well as reimbursing the Injured Workers Benefit Fund pursuant to the Arbitration award paid to Petitioner Luz Pina for a total amount of $39,750.00.

Pursuant to Commission Rule 7100.100(f), once the Commission assesses a penalty against an employer in accordance with 4(d) of the Act, payment shall be made according to the following procedure: 1) payment of the penalty shall be made by certified check or money order made payable to the State of Illinois; 2) payment shall be mailed or presented within thirty days of the final order of the Commission or the order of the court of review after final adjudication to:

Illinois Workers Compensation Commission
Insurance Compliance
100 West Randolph, 8th Floor

Chicago, Illinois 60601

I, Rafael Cuellar, agree to the provisions set forth, which include stipulating to a fine of $39,750.00.

Charlene Copeland,
Attorney for IWCC

RAFAEL CUELLAR,
Individually and as President
of Cousin Vinny's Bar & Grill

James Miller
Attorney for Rafael Cuellar
Individually and as President
of Cousin Vinny's Bar & Grill

David Gore

Mario Basurto

Stephen Mathis

MAY 12 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHRISTIE DILLMAN,

Petitioner,

vs. No. 08 WC 307

STATE OF ILLINOIS – CHOATE MENTAL HEALTH & DEVELOPMENTAL DISABILITIES CENTER,

Respondent.

ORDER

This matter comes before the Commission on Petitioner's Petition to Reinstate 08 WC 307. A hearing was held before Commissioner White in Mt. Vernon on April 5, 2016. The parties were represented by counsel and a record was taken.

By way of background, there were two separate claims filed by Petitioner against Respondent. 06 WC 4896 alleged an accident date of August 20, 2005 and an injury to the right knee. The instant claim, 08 WC 307, alleged an accident date of August 30, 2007 and an injury to the lower back. The Commission approved a settlement contract between the parties on June 2, 2008.

The settlement contract specified only the date of the knee injury and the language of the settlement specifies approximately 15% loss of the right leg only. However, the contract also included the instant low back claim, 08 WC 307, in the heading of the contract. The parties' lawyers who represented Petitioner at the time of the settlement contract, filed a joint affidavit attesting that the 08 WC 307 claim number was inadvertently included in the heading, the parties did not intend to settle 08 WC 307, and there was no "meeting of the minds" regarding settlement of that claim. On February 21, 2012, Commissioner Donohoo issued an order reopening 08 WC 307. Nevertheless, the Commission had already dismissed 08 WC 307 based on the settlement contract cited above.

A hearing was held before Commissioner Luskin in Mt. Vernon on May 29, 2015. The parties were represented by their current lawyers, who were different from the lawyers involved in the settlement contract, and a record was taken. At that hearing the parties presented Commission Luskin with a Petition to Vacate the Settlement Contract, a revised settlement contract including only claim number 06 WC 4896, and the order by Commissioner Donohoo reopening 08 WC 307. Commissioner Luskin instructed the parties to amend the revised contract to include a specification that no additional costs or fees were claimed and the permanency award specified in the contract had already been paid; thereby ensuring it was clear that Respondent currently owed nothing on that settlement.

At the current hearing before Commission White, the parties again noted that the 08 WC 307 claim was inadvertently included in the settlement contract and the parties actually proceeded on that claim for "several more years" without incident. However, Petitioner's previous lawyer asked Petitioner's current lawyer to take over that claim. In his initial investigation, Petitioner's current lawyer discovered that the claim had been dismissed based on the settlement contract. That realization precipitated the current proceedings.

The Commission notes that Commissioner Donohoo's February 21, 2012 order, reopening claim 08 WC 307, was neither reviewed nor appealed and therefore became a final order of the Commission. In light of the agreement between the parties and in the interests of fundamental fairness, the Commission believes it prudent to vacate the settlement contract approved on June 2, 2008, reinstate 08 WC 307, and remand the matter to an Arbitrator for further proceedings

IT IS THEREFORE ORDERED BY THE COMMISSION that the settlement contract identifying claims 06 WC 4896 and 08 WC 307 approved by the Commission on June 2, 2008 is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that claim number 08 WC 307 is hereby reinstated.

IT IS FURTHER ORDERED BY THE COMMISSION, that the matter be remanded to an Arbitrator for further proceedings consistent with this order.

DATED: MAY 2 0 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
R-4/5/16
46

STATE OF ILLINOIS	)	
	) SS	BEFORE THE ILLINOIS WORKERS'
COUNTY OF DUPAGE	)	COMPENSATION COMMISSION
Philip Vena,	)	
Petitioner,	)	
	)	No. 08 WC 27766
vs.	)	16IWCC0275
	)	
Benq USA Corp.,	)	
Respondent,	)	

ORDER

This matter comes before the Commission on its own Petition to Recall the Commission Decision to Correct Clerical Error pursuant to Section 19(f) of the Act. The Commission having been fully advised in the premises finds the following:

The Commission finds that said Decision should be recalled for the correction of a clerical/computational error.

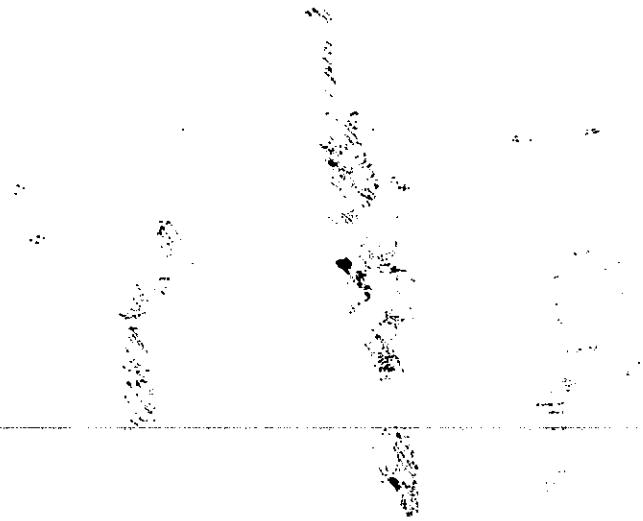
IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission Decision and Opinion dated April 28, 2016, is hereby recalled pursuant to Section 19(f) of the Act. The parties should return their original decisions to Commissioner David L. Gore.

IT IS FURTHER ORDERED BY THE COMMISSION that a Corrected Decision and Opinion on Review shall be issued simultaneously with this Order.

David L. Gore

DLG/mw
045

DATED: MAY 1 1 2016



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

Philip Vena,

Petitioner,

vs. NO: 08 WC 27766
16IWCC0275

Beng USA Corp.,

Respondent,

CORRECTED 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, causal connection, medical, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 6, 2015, 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 $17,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 1 1 2016
o041416
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VENA, PHILIP
Employee/Petitioner

Case# 08WC027766

16IWCC0275

BENQ USA CORP
Employer/Respondent

On 8/6/2015, 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 0.16% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0000 PHILIP VENA
4551 CORNELL AVE
DOWNERS GROVE, IL 60515

0532 HOLECEK & ASSOCIATES
CARTER ESTERLING
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

16IWCC0275

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

Philip Vena
Employee/Petitioner

v.

Beng USA Corp.
Employer/Respondent

Case # 08 WC 27766

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**, on **May 22, 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 **May 13, 2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$51,333.36**; the average weekly wage was **$987.18**.

On the date of accident, Petitioner was **57** years of age, *married* with **0** dependent children.

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

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

Respondent shall be given a credit of **$154,000.08** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$154,000.08**.

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

ORDER

Respondent shall pay $0 in disputed medical bills as provided in Section 8(a) of the Act, because Petitioner failed to establish by a preponderance of the evidence that the alleged unpaid bills of Pain Specialists of Greater Chicago ($1,419.00), Injured Workers' Pharmacy ($95.23), and out-of-pocket expenses ($123.69) were incurred for treatment causally related to the work injury of May 13, 2008.

Respondent shall be given a credit of $154,000.08 for temporary total disability benefits that have been paid to date, and shall owe no additional temporary disability benefits as Petitioner failed to establish by a preponderance of the evidence that he remains restricted from working as a result of the work injury of May 13, 2008.

Respondent shall pay Petitioner permanent partial disability benefits of $592.31/week for 30 weeks, because the injuries sustained caused disability equaling 6% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

8/4/15
Date

AUG 6 - 2015

STATE OF ILLINOIS)
) SS:
COUNTY OF KANE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Agatha Kofa,
Petitioner,

v.

Case No. 08 WC 46335
09 WC 17148

Good Samaritan Hospital,
Respondent.

ORDER

A Motion to Dismiss the reviews filed in the above claims having been filed by Respondent herein, and due notice having been given, this cause came before Commissioner Thomas J. Tyrrell for hearing on March 24, 2016 in Geneva, Illinois. The Commission having jurisdiction over the persons and subject matter and after being advised in the premises, finds:

Following a hearing on 2/4/15, Arbitrator Cronin issued decisions dated 7/30/15 with respect to the above captioned claims. Commission records show that Petitioner's attorney received copies of said decisions on 8/5/15 with respect to claim 08 WC 46335 and on 8/7/15 with respect to claim 09 WC 17148.

Petitioner, as a pro se, subsequently filed Petitions for Review with respect to both claims on 9/23/15, or 50 days after the receipt of the decision regarding claim 08 WC 46335 and 48 days after receipt of the decision in claim 09 WC 17148. Counsel for Respondent represented that he did not believe his office ever actually received a filed copy of Petitioner's Petitions for Review.

On 12/29/15 Petitioner's attorney, Kevin H. Millon, of the firm of Millon & Peskin, Ltd., filed a Motion to Withdraw as attorney of record in the matter. This motion was subsequently granted by Commissioner Tyrrell on 3/24/16.

On 1/22/16 Respondent filed the present Motion to Dismiss the reviews. On 3/24/16 a hearing was held on said motion before Commissioner Tyrrell, at which time

Petitioner appeared pro se as well as attorney Kevin Millon and defense counsel Daniel J. Ugaste of the firm Nyhan, Bambrick, Kinzie & Lowry, P.C.

The Commission notes that §19(b) of the Act provides, in pertinent part, that "[u]nless a petition for review is filed by either party within 30 days after the receipt by such party of the copy of the decision and notification of time when filed, and unless such party petitioning for a review shall within 35 days after the receipt by him of the copy of the decision, file with the Commission either an agreed statement of the facts appearing upon the hearing before the Arbitrator, or if such party shall so elect a correct transcript of evidence of the proceedings as such hearings, then the decision shall become the decision of the Commission in the absence of fraud shall be conclusive."

Based on the above, and the record taken as a whole, the Commission finds that Petitioner's Petitions for Review were not timely filed in that they were filed more than 30 days following receipt of the decisions at arbitration, as set forth in §19(b) of the Act. Furthermore, no allegations of fraud have been alleged by Petitioner in this matter. Therefore, the Commission finds that Petitioner's Petitions for Review are hereby dismissed and the decisions of the Arbitrator shall become the decision of the Commission.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petitions for Review regarding claim numbers 08 WC 46148 and 09 WC 17148 are hereby dismissed.

DATED: MAY 24 2016

Thomas J. Tyrrell

r-03/24/16
TJT/pmo
51

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

JENNIFER LUZADDER n/k/a
RICKENBERG,

Petitioner,

vs.

NO: 09 WC 25371
09 WC 25372

CATHOLIC CHARITIES/
DIOCESE OF JOLIET,

16IWCC0298

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, temporary total disability (TTD), permanent partial disability (PPD), and credit, and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. This matter was consolidated at trial with case 07 WC 23876, for which a separate decision was issued.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective.

Based upon its review of the evidence from case 07 WC 23876 in relation to the evidence from the present case, the Commission modifies the Decision of the Arbitrator for case 09 WC 25371 and 09 WC 25372. The Commission finds that Petitioner is entitled to 25% loss of use of the right hand and 20% loss of use of the left hand. The Commission finds that Petitioner's right hand condition was a continuation of the February 28, 2007 accident that was aggravated by the March 14, 2008 accident. The Commission's award of permanency for the right hand is,

therefore, in consideration of the evidence surrounding both work accidents.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 22, 2013 is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $386.50 per week for a period of 28-7/8 weeks, March 14, 2008 to October 1, 2008, 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 $347.85 per week for a period of 92.25 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 25% loss of use of the right hand and 20% loss of use of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $111,729.74 for medical expenses under §8(a) of the Act, and subject to the medical fee schedule.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: MAY 5 - 2016

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 3-7-16
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RICKENBERG, JENNIFER (F/K/A LUZADDER)
Employee/Petitioner

Case# 09WC025371

07WC023876

09WC025372

CATHOLIC CHARITIES DIOCES OF JOLIET
Employer/Respondent

16IWCC0298

On 10/22/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0924 BLOCK, KLUKAS & MANZELLA PC
THOMAS MANZELLA
19 W JEFFERSON ST SUITE 100
JOLIET, IL 60432

2122 McNAMARA PHELAN McSTEEN LLC
BRIAN CICHON
3601 McDONOUGH ST
JOLIET, IL 60431

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jennifer Rickenberg (f/k/a Luzadder)
Employee/Petitioner

v.

Case # 09 WC 25371

Consolidated cases: 09 WC 25372
07 WC 23876

CATHOLIC CHARITIES DIOCESE OF JOLIET
Employer/Respondent

16IWCC0298

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **New Lenox, Illinois**, on **June 17, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0298

On **March 14, 2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$30,131.40**; the average weekly wage was **$579.75**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, $ for TPD, $ for maintenance, and $ 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 $386.50/week from 3/14/08 to 10/1/08 for 28-7/8 weeks as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $111,729.74 as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $347.85/week for 92.25 weeks, because the injuries sustained caused the 25% loss of use of the right hand (51.25 weeks) [Together with the prior award of 10% of the right hand (See 07 WC 23876), Petitioner has a total loss of use of the right hand to the extent 35%] and 20% loss of use of the left hand (41 weeks), as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

10/18/13
Date

OCT 22 2013

ICArbDec p. 2

FINDING OF FACTS:

Petitioner, Jennifer Rickenberg (f/k/a) Luzadder, is 41 years old and lives in Diamond, Illinois. Petitioner is a high school graduate, with a bachelor's degree and continuing education in early childhood education. Petitioner is currently employed by ISA where she works in a gatehouse wherein they allow trucks to bring in oil containers.

In February 2007, Petitioner was working for Catholic Charities Diocese of Joliet, Early Head Start, located at 1704 Alexandria Drive, Joliet. Petitioner started her employment with Respondent in 2004. When she started, Petitioner was a teacher's assistant and maintained that position until late 2007 or early 2008 when she was promoted to Teacher 3. The duties and responsibilities of a teacher's assistant were: to help assist the teacher in creating lesson plans, keeping files on children; daily corresponding with parents; assist in feeding the children their meals; changing children [diapers] according to DCFS regulations; taking the children outside; tending to all their physical needs; and documentation and paperwork required for DCFS.

In February 2007, Petitioner worked primarily in a room that could accommodate 6 children, ranging in ages 10 months to 18 months. Most of the children were either still crawling or learning to walk. Most of Petitioner's job was physically "hands on." Petitioner's job included lifting and grasping. Respondent provided high chairs that she had to lift the children in and out of; diaper changing tables; cribs and a big buggy for taking the children outside. Diapers needed to be changed at a minimum of every two hours or as needed. The children were taken outside twice a day. The children were required to be fed breakfast in the morning, a morning snack, lunch and an afternoon snack. Petitioner was required to lift the children into the high chairs or seats and would either physically feed them or help develop their self-help skills by serving food and assisting with the utensils.

In February 2007, Petitioner worked the 8 a.m. to 6 p.m. shift. She earned $11.06 per hour and worked 37.5 hours per week for an Average Weekly Wage of $414.75. Her immediate supervisor was Corliss Wright.

On February 28, 2007, while Petitioner was working, a little girl was walking down a wooden stair climber and lost her balance. Petitioner caught the child from falling and twisted her right wrist. Petitioner could not recall the exact mechanism of the twist as her attention was focused on the little girl. Following the accident, Petitioner's right wrist was sore but she went on with her day thinking she had pulled a muscle. Petitioner did not report the accident to anyone that day. Over the next ten days, her right wrist continued to be sore; however, the pain did not go away. On March 6, 2007, Petitioner worked a 10 hour day because Respondent was short of employees. She worked with the pain in her wrist but when she went home and tried to open something with a can opener, she didn't have the strength to turn the opener. At that point, Petitioner realized that there had to be something more seriously wrong with her right hand and wrist. Between the accident date and March 7, 2007, Petitioner took Ibuprofen for pain.

On March 7, eight days after the accident, Petitioner told her supervisor what had occurred on February 27 and that she was still having pain. Petitioner was instructed to fill out an Incident Report as did PeaLock Shivers- the assistant who was in the room at the time of the accident. (PX39 and 40) Petitioner's supervisor instructed her to go to the company doctor, Dr. Kota, who performed an x-ray and placed her on light duty.

Petitioner saw Dr. Kota at Family Health Center on March 7, 2007, reporting hurting her right wrist on February 28, 2007, while she was trying to hold a child who was 30lbs and 18 month old who was falling off of wooden stairs and climber. (PX1 at 4) She did not report the incident on February 28, 2007, however she

started complaining of pain, which had gotten progressively worse, which was reported to the employer who sent her here today. (4) Pain was 7 to 8 on 10 scale and was worse with movement. (4) Physical examination showed right wrist pain and tenderness with decreased range of motion with tenderness in the right styloid area. (5). Impression was right wrist strain. (5) Plan was to ice, use a wrist splint, Ibuprofen, no lifting more than 2 pounds with the right hand, no twisting motions of the right wrist and no lifting of children, x-rays and follow-up. (5)

On March 9, 2007, Dr. Kota noted complaints of pain with movement of the right wrist. (8) Right wrist pain was mostly at the base of the thumb. (8) Impression was right wrist strain. Plan was to keep her off work with complete rest of the right arm. (9) On March 13, 2007, Petitioner presented with a history of hurting her thumb and wrist as well as the hand after trying to hold a 30lb baby. (14) She had been in severe pain and off work, with pain now 6 to 7 of 10. (14) Pain was worse with twisting movements with the wrist like driving or holding anything with the right hand. (14) Pain was described as shooting going to the proximal aspect of the right forearm with tingling, numbness and weakness. (14) Notes reflect right-sided wrist pain, hand pain and thumb pain. (14) Examination showed tenderness for active and passive extension and flexion of the right hand of the thumb area with the extensor pollicis as well as abductor pollicis, longus with pain radiating into the radial styloid area of the lateral aspect of the forearm. (15) Impression was tenderness of the right thumb metacarpal and radial styloid area secondary to strain. (15) Ligamentous pathology should be ruled out. (15) MRI to be ordered. (15) Since she was not improving, was encouraged to do no work with right hand and was provided an order for physical therapy. (15) Continue Ibuprofen. (15)

On March 20 Petitioner was still waiting for approval from her employer for the MRI and for physical therapy. (18) Pain was 7 to 8 of 10 and shoots all the way from the forearm. Pain was described as excruciating with some tingling and numbness and associated weakness. (18) Examination and Impression remained the same as she waited for approval from her employer for the ordered medical care and continue off work restrictions. (19)

Petitioner's final visit with Dr. Kota was on March 30. She presented with complaints of severe pain occasionally with certain specific movements when she tried to twist her wrist and also pain shooting down the thumb and forearm. (22) MRI was completed and physical therapy has started. (22) She had swelling of the right hand following physical therapy and pain during therapy. (22) Results of the MRI show abductor pollisis longus and extensor pollicis tendinopathy and tenosynovitis consistent with de Quervain syndrome. Mid-grade injury to the dorsal intercarpal ligament with no definitive tear, along with joint effusion. (22) Examination showed decreased range of motion of the wrist as well as tenderness in the base of the first metacarpophalangeal joint and some swelling with minimal radial deviation of the right hand. (23) Impression was de Quervain's syndrome in the right wrist and right thumb strain. Plan was to continue therapy and follow up with an orthopedic doctor for further care. (23)

Physical therapy was performed at Momentum Physical Therapy beginning March 21, 2007. (PX2) The MRIs were performed at Provena Health CEI in Bourbonnais on March 23, 2007. (PX3)

Following her treatment with Dr. Kota, Petitioner requested to see a doctor of her own and chose Dr. Marc Cohen at Midwest Orthopaedics at Rush. (PX4) She first saw Dr. Cohen on April 4, 2007. (PX4 at 5) Petitioner presented a history of working as a teaching assistant and reported an injury to her right wrist and hand on February 28, 2007 when she tried to stop a child from falling. (5) She twisted her right wrist and hand. (5) Examination was remarkable for decreased range of motion in the right wrist; dorsal and radial-sided wrist pain on the right with flexion. (5-6) Grip strength was diminished at 20 pounds on the right and 70 on the left. Pinch strength measured 8 pounds on the right and 22 pounds on the left. Tenderness was noted over the first dorsal compartment and clearly had a positive Finkelstein test. (6) Impression was right wrist tendinitis. (6)

She was given a cortisone injection into the first dorsal compartment which provided relief. (6) Dr. Cohen hoped that conservative treatment would alleviate the pain and returned her to work on April 9, 2007. (6)

On April 16, Petitioner contacted Dr. Cohen's office stating that she continued to have problems with the radial aspect of her wrist and that she was not having relief from the cortisone shot. (10) Petitioner advised the office that she was frustrated because her work required her to use her hands quite frequently and she has to write for long periods of time in school. (10) On April 18, Petitioner saw Dr. Cohen who noted that the cortisone shot provided little relief and continued to report radial-sided wrist pain and "pulling." (11) She reported having difficulty lifting children at work. (11) Examination showed tenderness over the first dorsal compartment and a positive Finklestein test. (11) Impression was continued de Quervain's tenosynovitis about the right wrist. (11). Dr. Cohen injected cortisone into the first dorsal compartment. (11)

On April 24, Petitioner called Dr. Cohen's office with an update on her condition. (15) She advised no relief from the injection. (15) She was informed that tendinitis takes time to resolve. (15) She was given three options at that point: 1) informed that she could be put on light duty; 2) reassurance that she is not causing any long-term problems with her wrist pain; or provide the name of a doctor for a second opinion. (15) Petitioner was provided the contact information for Dr. Dave Kalainov at Northwestern. (15)

Petitioner testified when she returned to work in April she continued to have a lot of pain and struggled lifting the children and doing what she needed to do. Petitioner started using her left hand and relying on her left hand to compensate for her right.

Petitioner saw Dr. David Kalainov on May 8, 2007. (PX5) Petitioner dated the onset of her symptoms to a work episode on February 28, 2007, assisting a toddler from a small stair-climber when the child slipped. (30) She sustained a "twisting" injury to her right wrist. (30) The records related Petitioner's subsequent medical care and complaints of pain (wherein Dr. Kalainov reviewed all of Petitioner's records to date). Dr. Kalainov noted that Petitioner returned to work activities as a teaching assistant on April 9, 2007. (30) She noted tightness and aching pain at the radial aspect of her right hand with radiation into her forearm. (30) Physical examination had a reproducible right hand pain with a grinding maneuver of the thumb basal joint. (32) Impression was 1) sprain basal joint right thumb; 2) de Quervain's tenosynovitis right wrist; and 3) sprain dorsal radiocarpal ligaments right wrist. (32-33) Plan was to provide Petitioner with two neoprene thumb splica splints for activities that produce aggravated pain, intermittent use of Ibuprofen; unrestricted duty only if allows for thumb splint. (33)

The next appointment with Dr. Kalainov was on May 30 for reassessment of right hand pain. (11) There was no appreciable change in the character of her pain from visit three weeks prior. (11) Complained of discomfort along the radial aspect of the right wrist and hand with activities. (11) No appreciable pain at rest. (11) No noticeable benefit from use of thumb splint. (11) There were diminished grip strength and key pinch on the right. (11) Grinding maneuver of thumb basal joint caused discomfort. (11) Majority of her pain was reproducible with palpation along the volar radial margin of the trapeziometacarpal joint. (11) Finkelstein's test elicited discomfort along the dorsal aspect of the thumb. (11) Impression was sprain basal joint right thumb. (11) Dr. Kalainov injected cortisone and Lidocaine with Kenalog in right basal joint. (11) Work release with restrictions was completed with 10 pound lifting restriction for her right hand and a full return to work on June 9, 2007. (11)

Petitioner's last visit with Dr. Kalainov was June 12, 2007 for reevaluation. (7) She was unable to return to work with restrictions. (7) Within the last two days she had developed at flexion posture of her right thumb. (7) Again, grip strength and key pinch measurements were diminished. (7) Impression was healed sprain basal joint right thumb and writer's cramp right thumb. (7) Dr. Kalainov recommended a trial return to

work or a short course of occupational therapy. (7) A return to work on a trial basis on June 28, 2007 was provided. (8)

Petitioner sought additional physical therapy at Midwest Hand Care. (PX6)

The next doctor seen by Petitioner was Dr. Weiderich for an IME on July 16, 2007. After examination, Dr. Weidrich provided the opinion that Petitioner did have de Quervain's syndrome and irritation of the first CMC joint that had completely resolved as of his examination date. He also thought that she might have clenched fist syndrome but that this was not as a result of her work injury. He believed that any subjective complaints were not consistent with any anatomic finding and that she was able to return to work in a full duty capacity. (RX 9)

Approximately July 19, 2007, Petitioner received a letter from Respondent's insurance company instructing her to go back to work following the IME with Dr. Weidrich. Petitioner's doctor still had her off of work with restrictions and not at MMI. She returned to work but provided a copy of the letter to her employer indicating that she still had weakness in her hands and was returning because Respondent's IME examiner said she had to. (PX 41) Petitioner was concerned about returning to work stating, "...my thumb is still bent backwards and my right hand strength is still decreased – however I am returning to work because the [doctor] says to return to full duty – so I am." (PX41)

Petitioner testified that she worked despite the pain and weakness in her right thumb and wrist. She continued to compensate with her left hand and began experiencing pain in her left hand. Petitioner explained that she would lift the children (toddlers) under the armpits with her thumb and hands in an "L" shape to get under the child.

Petitioner explained that while continuing to work at Respondent she was still having pain and problems with her hands and noticed that her thumbs were starting to bend in toward her palms. On December 28, 2007, Petitioner sought treatment with Dr. Fakhouri at Midwest Orthopaedics Consultants, who performed x-rays and a brief examination. However, Petitioner had to leave the appointment prematurely as she received an emergent call that her father was unresponsive at a nursing home. Petitioner had no additional medical treatment until March 2008.

The record of Dr. Fakhouri (PX7) notes prior medical treatment by hand specialists for chronic wrist conditions. (2) She had a history of de Quervain's tenosynovitis of the right wrist. (2) Examination showed mild tenderness in the first dorsal compartment of the right wrist. (2) Dr. Fakhouri recommended continued conservative measures and a return to her treating physician. (2)

Petitioner received a promotion and her job title was Teacher 3. The difference between a teacher's aide and a Teacher 3 is that the aide has a lower education requirement and Petitioner had taken courses, through Joliet Junior College, in early childhood education. She finished the child development associate credential for infants and toddlers which allowed her to obtain the teaching position. Her rate of pay increased to $15.46 per hour and worked 37.5 hours per week. Her hours changed to 6:45 a.m. to 2:45 p.m. Petitioner's responsibilities now included the curriculum, maintaining relationships with the parents and specific screening to be in compliance with federal programs. She continued to work in the toddler room as she had before the promotion.

Between December 2007 and March 2008, Petitioner's father passed away and she took a short bereavement leave from work. When she returned to full duty work, she had severe pain in her arms every day.

Petitioner testified that on March 14, 2008, she had already given the kids breakfast and diapered them. As she was putting them in and out of the buggy she struggled to get the buckles in and out. She told her co-

worker, Lydia, that something was definitely wrong and that her hands were going to "give out" on her. Petitioner reported to her supervisor, Angie Lee, that she was having pain in both of her hands. Specifically, the Incident Report (PX42) stated: "Notified Angie Lee I was leaving to see Dr. regarding pain from lifting and weakness in both hands and arms. Both of my thumbs are bent backwards. My right thumb feels like it is popping in and out of socket. I had a previous workers comp injury to my right hand." Petitioner told Angie Lee that she wasn't comfortable doing her job and she felt it was unsafe for the children. Ms. Lee told Petitioner to go home. She tried to contact work comp, but no one responded. Due to the severity of the pain; she went to Morris Hospital Emergency Room.

Petitioner described the pain as progressively worse. It felt like the muscles were stuck and the pain was constant. She also felt progressive weakness in her hands and could not do the things with her hands that she used to do and needed to do. She was most afraid of being unable to safely lift the children at work.

The Morris Hospital records (PX8) state that Petitioner presented complaining of bilateral; hand and wrist pain, worse on the right side. (3) Petitioner reported that she had a work injury one year prior that she had been cleared from but over the past couple of months the pain has worsened. (3) Pain was rated as severe. Additional notes show Petitioner arrived with complaints of bilateral hand wrist cramping pain. Petitioner reported that she had chronic pain for the last 2 months and had prior injury to right wrist but pain has been getting worse. (5) Petitioner indicated that she worked in child care and stated "I've been afraid I'll drop the babies this week." (5) Also noted was that Petitioner exhibited weak hand grasps bilaterally and right thumb was contracted into hand and her pain was 8 of 10. An examination showed both thumbs opposed over the palms and positive Finkelstein's test. (4) A splint was provided. Vicodin was prescribed and she was advised to follow up with orthopaedics in 1-2 days. (4)

Petitioner testified that Respondent denied her workers' compensation. As a result, she applied for Family Medical Leave. Same was denied. (PX43) A description of the circumstances is contained therein.

Upon referral from Morris Hospital, Petitioner sought medical care from Dr. Daniel Mass at the University of Chicago on April 3, 2009. (PX9) The University of Chicago Records show she complained of pain and weakness in her hands and thumbs, and that her thumbs were bent toward her palms. Dr. Mass performed two (2) surgeries on Petitioner: the first on April 14, 2009 on her right wrist and thumb; and the second on July 29, 2009 on her left thumb (basal joint tendon transfer). Petitioner testified that she had near immediate relief of the pain and the tightness was released and she no longer had restricted movement. Petitioner also had relief from the second surgery.

Dr. Daniel Mass, Professor of Surgery at the University of Chicago and Board certified in Orthopaedic Surgery and has a Certificate for Advanced Qualification in Hand Surgery testified in an evidence deposition on April 30, 2009. (PX37 at 4-7) Dr. Mass and Dr. Baer (a Fellow and another orthopaedic surgeon working with Dr. Mass) first saw Petitioner on April 3, 2008. (7) The history recorded was a 36 year old, right hand dominant female with bilateral hand pain that started in the fall of 2007. (9) She was having increasing pain on the radial or thumb side of both wrists with difficulty lifting. (9) By December 2007 she was unable to extend her thumb secondary to pain. (9) She was seen by other physicians who diagnosed her with tendinitis and injections into the first dorsal compartment for a problem called de Quervain's stenosing tenosynovitis and had six sessions of physical therapy. (9) She remained symptomatic, had a second injection and came to Dr. Mass seeking a second opinion. (9)

On examination she had evidence of basilar joint instability and mild tendinitis over the first dorsal compartment or de Quervain's. (10) The more positive signs were of the basilar joint on both hands. (10) Petitioner related that she was a teacher at a day care center and lifts small children. (10) She also stated that she was afraid that she was going to drop them because of the pain. (10) On April 3, 2008, Dr. Mass injected

her first dorsal compartment in the right wrist and basilar joint injection in the left wrist- so it was a test to see which one helped more. (10-11) Following the injections, Dr. Mass had Petitioner do some lifting exercises, including lifting a chair up to replicate lifting of children. (11-12) Petitioner was unable to lift the chair prior to the injection secondary to pain but after the injection she was able to lift the chair stating that the pain on the right was resolved. (12)

Diagnosis on April 3, 2008 was bilateral de Quervain's tendinitis and bilateral basilar joint instability. (12) The plan at that time, since she had failed conservative treatment, was that Petitioner would benefit from releasing the tendon surgically and tightening the joint with what's called a basilar joint ligament reconstruction procedure. (12-13) Dr. Mass would start with the right side and if successful, would do the left. (13)

Surgery was performed on Petitioner's right hand on April 14, 2008. Preoperative and postoperative diagnoses were tendinitis of the wrist and basilar joint instability. (15) The surgery was a de Quervain's release and a capsulorrhaphy of the basilar joint using a part of the flexor carpi radialis tendon. (16) The first post-op visit on April 21, 2008 showed no pain, removal of the splint and dressing and she was pleased. (16) She was placed in a removable splint and taught home exercises and an order to start physical therapy in three weeks. (16) The doctor provided that often at six weeks in a brace post-op she could return to work at the type of work she did, but if she was going to be brace-free, it would be a couple of months. (17) Petitioner was allowed to return to work as of May 27, 2008 noting that she may need to wear a splint but no problems with child care. (19) On June 19, 2008, Petitioner returned for a follow-up appointment and she was pain free, full range of motion and was happy with the results and wanted to proceed with surgery on the other side. (20) Petitioner's surgery was a success and her results were achieved faster than most, at two months post-op. (20)

Surgery on the left was performed on July 29, 2008. (20) At that time, the tendinitis seemed to have resolved and all she had was instability of the basilar joint. (20) Surgery included taking part of a tendon that comes into the forearm and attach it to the base of the second metacarpal right near where the base of the thumb is, and then drill a hole and pull it through and re-sling the joint. (21) The first post-op visit was on August 7, 2008 and Petitioner was doing well. (21) Dr. Mass gave her a splint for that hand and a prescription for physical therapy. (21) On October 2, 2008, Petitioner had essentially pain free range of motion with good strength in both hands except for a little weakness in the right hand. (22) Dr. Mass gave Petitioner a prescription to continue therapy or to just work on that on her own. (22) Dr. Mass released her to return to work full duty and discharged her from his care. (22-23)

Dr. Mass concluded to a reasonable degree of medical and surgical certainty that the repetitive work activities that Petitioner did as a day care provider, lifting and grabbing, were causally related to her bilateral injuries for which he performed surgeries. (24) The basis of the opinions are that people who have unstable joints are more susceptible to developing pain in those joints with activities that put stress through them and it's more likely to be aggravated after an injury. The doctor noted that particular repetitive pinching, gripping and lifting puts stress through those joints. He noted that where someone without the instability would have no problem with it, someone with instability has an increased risk of that problem. (24) Dr. Mass believed that Petitioner had instability in these parts of the body called congenital laxity. (25) He felt Petitioner was born looser than other people. (25) Dr. Mass believes that the repetitive work activities were at least a cause of the medical condition and treatment on the right hand. (25) The medical treatment that she received from Dr. Mass was also reasonable, necessary and customary. (25) The medical charges related to the University of Chicago for surgeries and examinations were also reasonable, necessary and customary. (25) Dr. Mass believes that repetitive activities of Petitioner's right hand could cause her preexisting condition to become symptomatic. (26)

As it relates to the left hand, Dr. Mass believes that the overcompensation of the left hand for the right, while working with toddlers, i.e. changing diapers and clothes, the things most likely to aggravate fine pinching

activities, would be causally related to the condition and surgery in her left hand. (27-29) Dr. Mass also believed that with Petitioner's congenital makeup and pinching and lifting incorrectly, the activities could aggravate, accelerate or exacerbate a preexisting condition and make it symptomatic. (29) Again, the treatment and bills for the left hand were also reasonable, necessary and customary. (29-30) Dr. Mass believed Petitioner's prognosis was that she would "do well." (31)

On cross examination Dr. Mass concluded that the need for the surgeries performed was that she was predisposed to a certain condition and her activities could have been a cause as to why she needed the surgery. (32) Dr. Mass also stated that if she had a prior injury, it may have expedited the cause. (32) Dr. Mass stated that the activities that aggravated her condition can be different for everyone and it is a quantitative amount of use but it does not have to be the same motion. (34) It does not have to be just diapering. (34) Diapering, dressing, lifting all put pressure on the thumb, as well as anything using a pinching motion. (34) Dr. Mass testified that the activities of Petitioner's job could have been a contributory cause of the need for surgery.

Petitioner had physical therapy at Midwest Hand Care from May 12, 2008 to July 24, 2008 and September 5, 2008 to October 1, 2008. (PX6) She believes therapy was very helpful.

She was released by Dr. Mass on October 2, 2008. Upon release, she still had a little weakness in her left hand but her thumbs were no longer bent toward her palm. She no longer had problems with daily activities and she considered the surgeries a success. Petitioner has not sought any additional medical care for her hands, wrists or thumbs.

In March 2011, Dr. Wiedrich reviewed records for a follow up Report. Dr. Wiedrich (RX9) testified that in forming his opinions in 2011, he reviewed a video that was not of Petitioner, does not know when it was taken, did not have it at the time of the deposition, and could not provide a general description of the video-other than it showed someone working in a day care facility. (RX9 at 19) He did not examine Petitioner nor have the chance to ask her any questions. When asked of his knowledge of Dr. Mass, Dr. Wiedrich characterized him as only a "competent surgeon." (20) Dr. Wiedrich also reviewed Dr. Mass' deposition transcript. (21) Dr. Wiedrich did not review the medical records from Morris Hospital from March 2008 or any medical records from his examination in July 2007 until Dr. Mass' records in April 2008. (22) Dr. Wiedrich disagreed with Dr. Mass' causal connection opinions. (23) Dr. Wiedrich testified that relative to the de Quervain's tendonitis, after he saw her on July 16, 2007, he never saw Petitioner again so she could have developed it and he cannot comment on that surgery. (23) He also commented on one of Dr. Mass's findings that there was a congenital laxity in Petitioner that made her predisposed to these conditions. Dr. Wiedrich indicated that he specifically tested for this laxity and did not find any type of laxity in Petitioner. In that respect, he would disagree with Dr. Mass that Petitioner had a congenital laxity which would have predisposed her to this condition. Dr. Wiedrich's opinions relative to laxity are based upon his examination in July 2007. (24) He agreed that the surgeries performed by Dr. Mass alleviated Petitioner's complaints of pain. (25-26) Dr. Wiedrich would not provide a causation opinion to any potential psychological component of his alleged "hysterical clenched syndrome" or somatoform disorder. (26-27) Dr. Wiedrich agreed that the treatment of Dr. Mass was reasonable but could not comment on necessary or customary as he had not seen Petitioner since July 2007. (29) Dr. Wiedrich said that two surgeries (right and left) were not work related. (30-31) In Dr. Wiedrich's Report of March 2011, he stated that "it was possible but not likely that the work activities in the videotape would be sufficient on their own to cause de Quervain's tenosynovitis in a patient who has not had a baby." (31) Dr. Wiedrich agreed that the activities that he saw in the videotape could have been "a" cause of the injuries. (32) He agreed that there is no test to rule out what Petitioner was doing from the time he saw her in July 2007 until the time she saw Dr. Mass, there is nothing to rule out it being a cause. (32) Dr. Wiedrich had no idea if Petitioner went back to work after his initial report in July 2007 or what her complaints to her employer were. (32-33) He was not aware of the workers' compensation filings for the March 2008 work accidents citing repetitive activities. (34) Dr. Wiedrich was unaware of the March 14, 2008 Incident Report

prepared by Petitioner at work. (34) Dr. Wiedrich based his lack of causation opinion on whether Petitioner's work activities could be causing or aggravating a patient's condition. (34-35) He did not know the following when providing his causation opinions: what room or rooms Petitioner worked in for Respondent; ages of the kids she was looking after; number of kids she was responsible for; the requirements for each child; whether there were any special needs children; changing of diapers; hours that Petitioner worked per shift; (although he states it was in the job description but could not remember at the time of testimony); whether Petitioner had an assistant; whether she opened the facility in the morning and was the sole caregiver for several hours on her own; the number of diapers she changed or how often during her shift; the number of times she had to lift each child on and off toys, into cribs or playpens or tables for eating; the number of times that Petitioner had to feed the kids each day and lifting them up and down; the number of cribs they had; the number of buggies they had; or the weight of the kids that she was lifting. (35-37) Dr. Wiedrich agreed that De Quervain's tendonitis occurs outside of pregnancy. (38) Dr. Wiedrich also agreed that "mommy thumb" has been diagnosed in persons other than actual women who gave birth, including nannies, due to awkward hand positions, grabbing the baby in a crib and lifting the baby and it is a combination of those activities that leads to the formation of de Quervain's tendonitis. (39) The development can be a mechanical issue not a pregnancy issue. (39) Dr. Wiedrich agreed that both Dr. Mass and Petitioner believe that the surgeries were successful. (42) Dr. Wiedrich does not believe that Dr. Mass deviated from the standard of care. (46) He does not disagree with the time period Petitioner was off work from April 14, 2008 to May 27, 2008 and July 29, 2008 to October 2, 2008. (47) He stated that people who have had de Quervain's where the pain went away and they start back to work, the pain can come back. (49) He would not disagree with a report out of the University of Colorado that states that de Quervain's can be aggravated and recur when people constantly lift children, bend down to a crib, put hands in an "L" shape under the armpits and lift children so that the weight on the child is on the thumbs. (49) Dr. Wiedrich agreed that if evidence was presented at trial that showed Petitioner's job duties were in excess of what was shown on the video and written in the job description, his opinion to causation could change. (55-56)

Petitioner testified that prior to her second surgery and while still in physical therapy, Respondent advised her that she needed to return to work full duty or she would forfeit her job. She was given a date of return. Petitioner testified that she returned in between the two surgeries. Respondent advised her that she would be transferred to a preschool classroom at a different school. Petitioner provided that her CDA and credentialing was in infant and toddlers, and by going to preschool, same would invalidate her pay and credentialing. As a result, Petitioner gave her letter of resignation. (RX5) Petitioner indicated she didn't feel it was fair to the children.

Petitioner was off work from March 14, 2008 to October 2, 2008 per Dr. Mass. She was not paid any TTD or provided any benefits under FMLA, and was not at MMI until October 2, 2008. Respondent denied payment of any medical treatment in 2008. Most of Petitioner's medical bills have been paid by self-pay, her BCBS insurance through the Diocese, or her husband's group insurance (Local 705) which has submitted an itemization of payments seeking reimbursement.

At the time of trial, Petitioner stated that she doesn't have many issues with her hands and thumb and generally is able to do what she needs to do. Her left hand remains slightly weak but is functional and she is grateful for the results that Dr. Mass provided.

Petitioner testified she had no issues with her left hand prior to 2007. She first noticed pain in her left hand (opposite, non-dominant hand) after overcompensating for her right hand.

Petitioner confirmed the bills and amounts related to her care provided in Petitioner's Exhibits 10-36 (identified on Petitioner's Exhibit 0). She also confirmed (PX38) as balances to bills as she is aware.

Angela Lee was called by Respondent to testify. She is currently employed at Martha's Youth Services as Head Start Director and was formerly employed by Catholic Charities Diocese of Joliet. She knows Petitioner as a teacher at Catholic Charities. Ms. Lee was early childhood services manager and was Petitioner's supervisor. She has no recall of Petitioner making complaints of pain from October 27, 2007 to March 14, 2008, other than March 14, 2008. Ms. Lee stated that the kids in Petitioner's classroom were just beginning to be mobile, crawling and walking on their own. She provided Petitioner would have to lift to carry them to the changing table or crib. She would also have to lift them in and out of the highchairs and buggy. She would also lift to hold a child. Ms. Lee reviewed (PX42) being the March 14, 2008 Incident Report where Petitioner notified her of her specific injury.

Ms. Lee agreed that "occasional" lifting could be actually lifting for one-third of a work day. Ms. Lee agreed that handling and simple grasping is categorized as "frequent." Frequent could be up to two-thirds of a work day. She believes grasping is anything using pinching with fingers or full hand. Ms. Lee could not describe the meaning of "knee to waist; waist to chest; or chest to shoulder" as she did not prepare the Report and only reviewed it in preparation of trial. Ms. Lee agreed that Respondent's Job Analysis did not take into account every specific incident or circumstance that Petitioner would find in her work. She might have to hold a child all day if inconsolable. Ms. Lee was Petitioner's supervisor for several years (Lee had left and come back to work for Respondent). Ms. Lee stated that Petitioner was very comfortable with her job; generally always at work until she had time off when her father was sick. She came to work on time, always prepared her lesson plans and was a dependable worker.

Ms. Lee never questioned Petitioner's honesty or integrity; never wrote her up for honesty or credibility issues. Ms. Lee stated that when Petitioner came to her in March 2008 reporting that she was injured or in pain, Ms. Lee had no reason to disbelieve her. When Ms. Lee returned to work for Respondent in October 2007, she did not know of Petitioner's prior work comp case with her right hand. March 2008 was the first notice that Ms. Lee had of any complaints or prior medical problems with Petitioner's hands.

IN SUPPORT of the Arbitrator's Decision regarding "C" (Accident), the Arbitrator finds as follows:

A claimant must prove by the preponderance of evidence that an injury both arose out of and was in the course of employment in order to receive compensation under the Act. See, e.g., *Orsini v. Industrial Commission*, 117 Ill.2d 38, 44-45 (1987), *Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1993). "In the course of" refers to the time, place and circumstance under which the accident occurred, while "arising out of" refers to the origin or cause of the accident that gave rise to the injury. *Illinois Bell Telephone Co. v. Industrial Commission*, 131 Ill.2d 478, 483 (1989). In this case, there is no dispute the Petitioner was at her usual place of work, during usual business hours. Therefore, she has satisfied the "in the course of" element. Petitioner has also satisfied the "arose out of" element as well. Petitioner was in the employ of Respondent and working in furtherance of her employment at the time of her injuries.

For an accidental injury to arise out of employment, its origin must be in some risk connected with or incidental to the employment, rather than simply location or a positional risk, in order to establish a causal connection. *Caterpillar Tractor Co.*, 129 I11.2d at 63. There are three categories of risks to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics.

In repetitive trauma cases, the Arbitrator also looks to manifestation and the nature of the repetitive activities when making his determination. The issue was addressed by the Illinois Supreme Court in *Durand v. Industrial Commission,* 224 Ill.2d 53, 862 N.E.2d 918 (October 19, 2006). In *Durand,* an employee had carpal

tunnel symptoms as early as 1997. At that time, she told her supervisor her condition was work related, but no doctor had diagnosed it. It was her belief that at that time that the condition was due to her job duties. She first sought medical treatment in August 2000, and filed an Application on January 12, 2001. The Commission ruled that in September or October of 1997, the accident manifested itself and that was the date of the injury, and consequently she filed her claim outside the three (3) year statute of limitations.

The Illinois Supreme Court reversed as being against the manifest weight of the evidence. The Court noted:

> When the accident is a discrete event, the date of the accident is easy to determine; it is obviously, the date 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. Industrial Commission,* 304 Ill.App.3d 875; *Nunn v. Industrial Commission,* 157 Ill.App. 470 (1987). That means, *inter alia,* an employee suffering from a repetitive-trauma injury must still point to a date within the limitations period on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person. *Williams v. Industrial Commission,* 244 Ill.App.3d 204. Setting this so-called manifestation date is a fact for the Commission.

The Court then quoted from the *Peoria County Nursing Home* case, 115 Ill.2d 527, 505 N.E.2d 1026 (1987):

> Requiring complete collapse in a case like the instant one would not be beneficial to the employee or the employer because it might force employees needing the protection of the Act to push their bodies to a precise moment of collapse. Simply because an employee's work related injury is gradual, rather than sudden and completely disabling, should not preclude protection and benefits...To deny an employee benefits for a work-related injury that is not the result of a sudden mishap...penalizes an employee who faithfully performs job duties despite bodily discomfort and damage.

Further, citing the *Peoria County Nursing Home* case, the Court noted that the manifestation date is the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person. Fairness and flexibility are common themes. Citing an Appellate case, the Court noted that the fact of the injury is not synonymous with the fact of discovery. Instead, the date on which the employee became unable to work, due to physical collapse or medical treatment, helps determine the manifestation date. Concluding, the Court held that various factors have typically set the manifestation date on either the date on which the employee requires medical treatment, or the date on which the employee can no longer perform work activities. The Court noted since *Durand's* testimony that she thought her carpal tunnel was work related in 1997, was not based on "expert" medical testimony, but rather than that of a lay person, it would discount that as a manifestation date. Finally, and importantly, the Court stated: "We decline to penalize an employee who diligently worked through progressive pain until it affected her ability to work and required medical treatment."

In this case, Petitioner had bilateral symptoms severe enough to report to her supervisor, complete the required Incident Report and report to the Morris Hospital Emergency Room. She remained off work due to her medical condition and was able to begin care under Dr. Mass at the University of Chicago. Dr. Mass has provided documentation in his medical records about Petitioner's history as a day care teacher and more specifically, his testimony provided by evidence deposition he provides the necessary causal connection opinions for Petitioner's bilateral injuries based upon a repetitive trauma theory

When workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. *Sisbro v. Industrial Commission*, 207 Ill.2d 193, 797 N.E.2d 665, (2003).

Petitioner provided credible testimony regarding her day-to-day duties and responsibilities in the day care. Specifically, she was required to lift, grab, twist and pinch with her fingers and thumb on a very consistent basis. Petitioner worked primarily in a room that could accommodate 6 children, ranging in ages 10 months to 18 months. Most of the children were either still crawling or learning to walk. Most of Petitioner's job was physically "hands on." Petitioner's job also included lifting and grasping. Respondent provided high chairs that she had to lift the children in and out of; diaper changing tables; cribs and a big buggy for taking the children outside. Diapers needed to be changed at a minimum of every two hours or as needed. The children were taken outside twice a day. The children were required to be fed breakfast in the morning, a morning snack, lunch and an afternoon snack. Petitioner was required to lift the children into the high chairs or seats and would either physically feed them or help develop their self-help skills by serving food and assisting with the utensils.

Respondent's witness, Angela Lee, agreed with Petitioner's description of her job duties and agreed also to the frequency that Petitioner was required to lift, grab, twist and pinch with her fingers and thumb. Ms. Lee stated that the kids in Petitioner's classroom were just beginning to be mobile, crawling and walking on their own. Petitioner would have to lift to carry them to the changing table or crib. She would also have to lift them in and out of the highchairs and buggy. She would also lift to hold a child. Ms. Lee agreed that "occasional" lifting could be actually lifting for one-third of a work day. Ms. Lee agreed that handling and simple grasping is categorized as "frequent." Frequent could be up to two-thirds of a work day. She believes grasping is anything using pinching with fingers or full hand. Ms. Lee could not describe the meaning of "knee to waist; waist to chest; or chest to shoulder" as she did not prepare the Report and only reviewed it in preparation of trial. Ms. Lee agreed that Respondent's Job Analysis did not take into account every specific incident or circumstance that Petitioner would find in her work.

Respondent's IME did not have the video of the job duties that he referred and based his opinions upon when he testified. Dr. Wiedrich could not remember the video or its contents other than it was a day care, and could not be cross examined on its accuracy or relevancy during his testimony. No video was presented as evidence at trial.

Accordingly, there is a sufficient record to deem this matter compensable, as an award of benefits in this case is not based upon speculation or conjecture, but rather facts. *County of Cook v. Industrial Commission*, 68 Il1.2d 24 (1977). As such, the Arbitrator finds that Petitioners accidents were work-related within the meaning of the Act.

IN SUPPORT of the Arbitrator's Decision regarding "F" (Causation), the Arbitrator finds as follows:

Petitioner provided credible testimony regarding her day-to-day duties and responsibilities in the day care. Specifically, she was required to lift, grab, twist and pinch with her fingers and thumb on a very consistent basis. Dr. Mass provided the requisite causal connection opinions for both cases with the manifestation date of March 14, 2008. Respondent's witness, Angela Lee, agreed with Petitioner's description of her job duties and agreed also to the frequency that Petitioner was required to lift, grab, twist and pinch with her fingers and thumb. Furthermore, Respondent's IME (who provided causal connection for the February 27, 2007 work accident) agreed during cross examination that he did not have information to qualify what amounts of lifting, grabbing, twisting and pinching that Petitioner did with her fingers and thumb. The was a litany of information gleaned on cross examination that Dr. Wiedrich did not know and therefore, his opinions relative to causation are not persuasive. Additionally, the IME did not examine Petitioner in March 2011, but rather based

his opinions on a review of incomplete medical records (not including any medical treatment between his IME Report in July 2007 until Dr. Mass, i.e. Dr. Fakhouri or Morris Hospital). Dr. Wiedrich stated that he reviewed a job description and a video from which he based his opinions. Neither the job description nor the video were available at the time of deposition. Presumably, (RX6) is the Job Description provided to Dr. Wiedrich; however, there is no way to be certain because the doctor did not have a copy to refer to in his file or rely upon at his deposition. Additionally, Dr. Wiedrich could not remember the video or its contents other than it was a day care, and could not be cross examined on its accuracy or relevancy during his testimony. Despite not having the video available, Dr. Wiedrich opined as to no causal connection based upon the video. Furthermore, no video was presented as evidence at trial.

The complaints of pain contained within the records and those testified to by Petitioner have a temporal relationship to her work activities while employed by Respondent and the mechanism of her activities also supports the Arbitrator's findings. Among Petitioner's Exhibits is Evidence Deposition of Dr. Daniel Mass (PX37), wherein Dr. Mass opined, in summary, that he believes that the repetitive work activities were at least a cause of the medical condition and treatment on the right hand. The medical treatment that she received from Dr. Mass was also reasonable, necessary and customary. Dr. Mass believes that repetitive activities of Petitioner's right hand could cause her preexisting condition to become symptomatic. As it relates to the left hand, Dr. Mass believes that the overcompensation of the left hand for the right, while working with toddlers, i.e. changing diapers and clothes, the things most likely to aggravate fine pinching activities, would be causally related to the condition and surgery in her left hand. Dr. Mass also believed that with Petitioner's congenital makeup and pinching and lifting incorrectly, the activities could aggravate, accelerate or exacerbate a preexisting condition and make it symptomatic.

Accordingly, he Arbitrator finds Dr. Mass' causation opinions to be credible and therefore, finds that a causal relationship exist between Petitioner's work activities and her repetitive injuries and condition of ill being.

IN SUPPORT of the Arbitrator's Decision regarding "J" (Medical), the Arbitrator finds as follows:

The Arbitrator notes that the medical bills (PX0; 18-36) and specials' list (PX38) were admitted into evidence with the objection only on the basis of liability only. A review of the records (PX1-PX9) and the Deposition of Dr. Daniel Mass (PX37) provide that Petitioner was within the appropriate line of doctors. Petitioner testified that the submitted bills were paid by her BlueCross BlueShield Group Health Insurance; her husband's Union Local 705 Group Health Insurance or self-pay; however, some balances were outstanding. Respondent claims no credit for any amounts paid on either of the March 14, 2008 work accidents. Based upon Arbitrator's Exhibit 1, the evidence presented, including Petitioner's credible testimony, the Arbitrator's review of the medical records and bills, and Dr. Mass' Deposition, as well as Respondent's failure to produce any evidence that Petitioner's treatment and bills were unreasonable, the Arbitrator finds the bills submitted in (PX0; 18-36) and (PX38) to be reasonable, necessary, customary and causally related to the March 14, 2008 work accidents. The Arbitrator orders Respondent to pay said bills in full to Petitioner, or by per Fee Schedule; pay Petitioner or reimburse Local 705 Union Lien (PX32); pay Petitioner or reimburse BCBS (PX33); and to Petitioner for any amounts paid out of pocket, as follows:

Epic Group	(PX18)	$443.00
Morris Hospital	(PX19)	$561.72
University of Chicago	(PX20)	$2,402.00
University of Chicago	(PX21)	$9,665.00

University of Chicago	(PX22)	$298.00
University of Chicago	(PX23)	$318.00
University of Chicago	(PX24)	$127.00
University of Chicago	(PX25)	$127.00
University of Chicago	(PX26)	$259.00
University of Chicago	(PX27)	$9,881.50
University of Chicago	(PX28)	$343.00
University of Chicago	(PX29)	$162.00
University of Chicago	(PX30)	$162.00
University of Chicago	(PX31)	$56,696.00
Midwest Hand Care (5/12/08-7/24/08)	(PX15)	$4,515.00
Midwest Hand Care (9/5/08-10/1/08)	(PX16)	$1,132.00
Total:		**$87,092.22**

Respondent shall be solely responsible for the payment to Petitioner and/or reimbursement to BlueCross BlueShield (PX33) in the full amount of its lien as submitted, $17,036.86.

Respondent shall be solely responsible for the payment to Petitioner and/or reimbursement to Local 705 International Brotherhood of Teamsters Health and Welfare Fund (PX32) in the full amount of its lien as submitted, $7,373.19.

Total:	**$24,410.05**

The Arbitrator notes that Petitioner paid monies out of pocket and reimbursement of these amounts should be made payable to Petitioner, as follows:

Epic Group (PX18)	$8.40
Morris Hospital (PX19)	$68.51
University of Chicago (PX31)	$30.00

University of Chicago Medical Center (PX34)	$90.56
Dr. Daniel Mass, M.D. (PX35)	$10.00
Walgreens (PX36)	$20.00
Total:	**$227.47**
GRAND TOTAL:	**$111,729.74**

IN SUPPORT of the Arbitrator's Decision regarding "K" (TTD), the Arbitrator finds as follows:

Petitioner received emergent medical care on March 14, 2008 at Morris Hospital after filling out an Incident Report at work wherein she was placed on restricted duties and referred to an orthopedic surgeon. (PX42) Petitioner was finally able to see Dr. Daniel Mass at the University of Chicago. Dr. Mass continued Petitioner's work restrictions from April 3, 2008 to October 2, 2008, either fully restricted or with modified restrictions. Petitioner followed the orders and recommendations of Dr. Mass, underwent bilateral surgeries: Right (April 14, 2008) and left (July 29, 2008). Petitioner complied with all treatment and restrictions, including physical therapy and use of splint. Petitioner was off work on doctor's restrictions from March 14, 2008 to May 27, 2008, for a total of 10-4/7 weeks. Petitioner testified that she attempted to return back to work following her first surgery with the splint and light restrictions but Respondent would not return Petitioner to her prior place of employment, position or classroom. Respondent made a disingenuous attempt to return Petitioner to another location in a classroom she was not certified to be in and at reduced pay. Petitioner remained afraid of her continued pain on the left side which had yet to be operated on, as she has not yet been released to MMI for the right hand and the left hand still required operative treatment. Respondent refused workers' compensation benefits and FMLA for Petitioner. Petitioner submitted her Letter of Resignation on June 3, 2008 as Respondent had put her in a constructive termination position. Respondent has provided no evidence to rebut Petitioner's testimony relative to its refusal to accommodate her attempts to return to work.

Petitioner had a second surgery on July 29, 2008 and was released to full duty work on October 2, 2008 for a total of 9-1/7 weeks.

In *Interstate Scaffolding, Inc. v. I.W.C.C.*, 385 Ill.App.3d 1040, 896 N.E.2d 1132, 324 Ill.Dec. 913 (3rd Dist. 2008), it was held that the dispositive inquiry when determining whether a workers' compensation claimant is entitled to TTD benefits is whether the claimant's condition has stabilized, i.e., whether the claimant has reached MMI. In this case, the evidence submitted at trial, including, but not limited to, medical records and Petitioner's credible testimony, provided that Petitioner had not reached MMI, at any time from March 14, 2008 to October 2, 2008. Therefore, TTD benefits are due and owing to Petitioner.

Accordingly, Petitioner is entitled to TTD from March 14, 2008 to October 2, 2008, for a total of 28-7/8 weeks.

IN SUPPORT of the Arbitrator's decision regarding "L" (Nature and Extent), the Arbitrator finds as follows:

Based upon the medical evidence, Petitioner's testimony, the medical records (PX8-PX9) and the Evidence Deposition of Dr. Daniel Mass (PX37) including his findings, conclusions and opinions as cited above; and with specific weight being afforded to the surgical results, as well as Petitioner's complaints of pain,

current findings and conclusions, the Arbitrator finds Petitioner sustained 25% loss of use of the right (dominant) hand. Together with the prior award of 10% of the right hand (See 07 WC 23876), Petitioner has a total loss of use of the right hand to the extent 35%. The Arbitrator further finds that Petitioner sustained 20% loss of use of the left hand pursuant to Sections 8(e) of the Act.

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

Before the Illinois Workers' Compensation Commission

JENNIFER LUZADDER
n/k/a RICKENBERG,
Petitioner,

vs.

No. 09 WC 25371
09 WC 25372
16 IWCC 298

CATHOLIC CHARITIES/
DIOCESE OF JOLIET,
Respondent.

ORDER

On May 11, 2016, Respondent filed a Motion to Correct Clerical/Computational Error pursuant to Section 19(f) of the Act asking the Commission to recall its Decision and Opinion on Review filed May 5, 2016 due to a clerical/computational error.

Upon consideration of said Motion, the Commission is of the Opinion that said Motion should be denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Motion to Correct Clerical/Computational Error filed on May 11, 2016 is hereby denied.

Dated: MAY 19 2016

MJB/tdm
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

Carl Schmitz,

Petitioner,

vs. NO. 09WC 26144

Harrison's Poultry,

Respondent.

16IWCC0358

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, benefit rates, wage calculations, temporary disability, maintenance benefits, wage differential, penalties and fees, 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 January 5, 2015 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.

16IWCC0358

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: MAY 26 2016
SJM/sj
o-5/19/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCHMITZ, CARL
Employee/Petitioner

Case# **09WC026144**

HARRISON'S POULTRY
Employer/Respondent

16IWCC0358

On 1/5/2015, 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 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0247 HANNIGAN & BOTHA LTD
KEVIN S BOTHA
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

0507 RUSIN & MACIOROWSKI LTD
THEODORE POWERS
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK

16IWCC0358

☐ 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

Carl Schmitz
Employee/Petitioner
v.
Harrison's Poultry
Employer/Respondent

Case # **09 WC 26144**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **July 23, 2014, August 20, 2014, September 23, 2014, and October 27, 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 **February 4, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**67,600.00**; the average weekly wage was $**1,300.00**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **1** dependent child.

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

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

Respondent shall be given a credit of $**143,969.83** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**143,969.83**.

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 $**866.67**/week for **122** weeks, commencing **February 5, 2009** through **June 8, 2011**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **February 5, 2009** through **October 27, 2014**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $**143,969.83** for temporary total disability benefits that have been paid.

Respondent shall pay $**167,571.51** for medical services, as provided in Section 8(a) 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 issue. Respondent is to pay any unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule or the negotiated rate and shall provide documentation with regard to said fee schedule or negotiated rate calculations to Petitioner. Respondent is to reimburse Petitioner directly for any out-of-pocket medical payments.

Respondent shall pay Petitioner permanent partial disability benefits of $**664.72**/week for **250** weeks, because the injuries sustained caused the **50**% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

January 2, 2015
Date

JAN 5 - 2015

FACTS

Petitioner sustained an undisputed accident on February 4, 2009 when he slipped and fell in icy conditions onto the loading dock sustaining injuries to his right shoulder (Arbitration Transcript #1 from July 23, 2014, hereafter "Tr.1" p.15-16). Petitioner had worked for the Respondent for 35 years as a general manager and part of his job was to load trucks, poultry trucks, and food trucks. While loading, he would have to lift boxes of product weighing up to100 pounds (Tr.1 p.17) and overhead lifting and stacking up to 8 feet high (Tr.1 p.18).

Petitioner was seen emergently at Glenbrook Hospital with right shoulder pain (Px.1 p.4-10). He followed up at Omega Glenbrook on February 5, 2009, an MRI of the right shoulder was ordered and the Petitioner was placed on restricted duty work with no use of the right arm (Px.2 p.3). The MRI of the right shoulder showed a complex full thickness tear of nearly the entire supraspinatus tendon which was severely degenerated, a high grade near complete partial tear of the subscapularis tendon insertion associated with early bicep tendon subluxation and prominent fluid within the bursa (Px.1 p.11-12). On February 12, 2009, Dr. Piazza referred Petitioner for an orthopedic evaluation of the right shoulder, and restrictions of no use of the right arm remained in effect (Px.2 p.2). On February 18, 2009, he was evaluated by Dr. Jeffrey Visotsky, who noted a history of employment at Harrison Poultry as a butcher, driver and delivery and the accident while walking to the loading dock. Petitioner slipped and fell on a ledge on the ice striking his right elbow, driving it into his shoulder and striking the side of his head and his left arm. He reviewed the MRI which revealed a complex full thickness tear of the supraspinatus tendon with detachment and retraction and also a subscapularis tear and subluxation of the biceps together with a bloody effusion within the shoulder joint. Dr. Visotsky examined Petitioner and diagnosed him with a supraspinatus tear, a subscapularis tear and a biceps tear and recommended surgical repair (Px.3 p.50-52).

On February 23, 2009, Dr. Visotsky performed a right shoulder arthroscopic subacromial decompression, arthroscopic supraspinatus tendon repair, a right open capsular plication, interval between the supraspinatus and subscapularis and open subscapularis repair. The postoperative diagnosis was a right rotator cuff tear, right subscapularis tear, right shoulder ligamentous injury and right shoulder anterior subluxation and dislocation (Px.3 p.47-49). He followed up postoperatively with Dr. Visotsky on February 27, 2009 and he was to remain off of work (Px.3 p.46). On March 4, 2009 Dr. Visotsky removed the sutures and Petitioner was to begin physical therapy (Px.3 p.45).

Petitioner began physical therapy at Illinois Bone and Joint Rehabilitation, and an initial physical therapy evaluation was performed on March 9, 2009 (Px.4 p.32-33). Upon follow up with Dr. Visotsky on June 17, 2009, he was released to clerical work only with a 20 pound lifting restriction (Px.3 p.39). Petitioner testified that he presented the work restrictions to his employer, however he was not offered any position within those restrictions (Tr.1 p.22). He remained in physical therapy and followed up with Dr. Visotsky on October 28, 2009, where the doctor noted he was making continued progress however his strength was only at 20 lbs with

occasional pain. Dr. Visotsky noted that he had a massive rotator cuff tear and prescribed a work hardening program (Px.3 p.32). Petitioner attended his last session of physical therapy at Illinois Bone and Joint Rehabilitation on November 4, 2009. A physical therapy discharge summary was issued on November 25, 2009, and noted that Petitioner was discharged from physical therapy after 67 visits (Px.4 p.22).

Petitioner underwent his initial work hardening assessment including a baseline evaluation at Lake Forest Hospital Center for Rehabilitation on November 12, 2009. The baseline evaluation placed Petitioner at a sedentary to light, light to medium physical demand level. He did not meet the physical demands of his job according to the Dictionary of Occupational Titles (Px.5 p.8). During the evaluation Petitioner also expressed anxiety, depression and lack of sleep (Px.5 p.10). The occupational therapist recommended 2 weeks of work hardening as well as psychology services to give Petitioner support as well as receive biofeedback to assist in decreasing right upper extremity guarding (Px.5 p.13).

Upon follow up with Dr. Visotsky on November 25, 2009, the doctor noted that Petitioner was having adjustment problems due to the injury, needed a psychological evaluation and to continue work hardening (Px.3 p.30). On December 16, 2009, Dr. Visotsky recommended continued work hardening and noted that Petitioner was motivated to return to work and there was no evidence of submaximal performance or malingering (Px.3 p.28). On December 17, 2009 Petitioner saw his primary care physician Dr. David Vigder to discuss his depression. Petitioner voiced his concerns that he had no job to return to. He was concerned about his depression, he was crying frequently and mostly said. He also had sleep disturbances and difficulty falling asleep. Dr. Vigder's assessment was depression with anxiety and prescribed Wellbutrin XL and referred him to Dr. Neil Mahoney for psychological evaluation (Px.7 p.37-38).

Petitioner was evaluated by Neil Mahoney Ph.D. on December 18, 2009. Dr. Mahoney had observed the patient working hard in the program and his therapist confirmed that he had made progress despite his injury and chronic pain. It was obvious to the therapy staff that the patient was quite depressed. Petitioner was tearful throughout his appointment and he felt very depressed. He had insomnia, weight loss, low mood and occasional feelings of hopelessness. He had no prior history of depression or anxiety and was never diagnosed with a disorder, nor received any psychiatric treatment. Petitioner completed the Beck Depression Inventory-II questionnaire and scored 34, indicating severe range on the screening for depression. Dr. Mahoney's diagnostic impression was adjustment disturbance with depressed mood and psychological factors affecting medical condition. He recommended that Petitioner follow up with his medical doctor for anti-depressant medication and opined that psychological counseling would be of benefit (Px.6 p.2-3). He began psychotherapy counseling on January 6, 2010 with Dr. Mahoney and on several occasions through June 30, 2011 (See Px.6).

Respondent secured a Section 12 neuropsychological examination on January 9, 2010 by Dr. Christopher Grote. Dr. Grote concluded that Mr. Schmitz did seem to be depressed, but to what degree the depression and pain-related symptoms were legitimate versus exaggerated were to be determined. He opined that there was clear evidence that psychological factors including both depression and exaggeration account for at least part of his current experience of and reaction to claimed pain symptoms and any "legitimate" depressive symptoms would seem to be due to his February 2009 injury. Dr. Grote believed that individual counselling sessions would be useful in further examining his motivation to be well and how psychological factors were influencing his current functioning (Px.8 p.1-5).

Petitioner was discharged from the work hardening program at Lake Forest Hospital on January 15, 2010, having maximized his work hardening program load lifts. The assessment/recommendation noted that Petitioner was currently at the medium work level range (Px.5 p.22).

He followed up with Dr. Visotsky on January 20, 2010. Dr. Visotsky ordered a CT arthrogram of the right shoulder to determine if there were any functional muscle deficits (Px.3 p.27). The CT arthrogram, from March 17, 2010 at St. Joseph Hospital, showed evidence of an anterior superior glenoid labral tear with an intact rotator cuff repair (Px.3 p.25-26). On April 21, 2010, Dr. Visotsky reviewed the CT scan and noted some labral tearing, but an intact rotator cuff, with some elevation in the subscapularis anteriorly, but no complete tear. It appeared that the symptoms were coming from labral pathology. On examination crepitation was noted in the glenohumeral joint and he had pain along the biceps area and pain along the insertion site of the labrum. Dr. Visotsky's diagnosis was a partial thickness subscapularis tear and a superior labral tear and recommended surgical intervention (Px.3 p.21-22). On May 13, 2010 Dr. Visotsky performed an arthroscopic subacromial decompression, an arthroscopic biceps tenodesis, a superior labrum anterior and posterior lesion repair, and arthroscopic rotator cuff repair of the supraspinatus. The postoperative diagnosis was right shoulder subacromial impingement, biceps degeneration, superior labrum anterior and posterior lesion with labral tearing, partial healing of the anterior rotator cuff with internal fiber thinning and degeneration (Px.3 p.18-19). Postoperatively, Dr. Visotsky ordered another course of physical therapy and that Petitioner was to remain off of work (Px.3 p.15, 79).

Petitioner then underwent his initial evaluation at Illinois Bone and Joint Rehabilitation on June 18, 2010 (Px.4 p.3) and attended 20 sessions of physical therapy until being discharged from physical therapy on August 11, 2010 because he had reached his 20 visit insurance maximum. He was to continue his physical therapy at another clinic (Px.4 p.2).

Petitioner resumed physical therapy at Sports Physical Therapy and Rehabilitation Specialists (SPTRS) on August 16, 2010 and underwent an initial evaluation (Px.9 p.24-26). He continued to follow up with Dr. Vigder for depression and Dr. Visotsky for the right shoulder and remained off of work (Px.3 p.13-14) until his August 25, 2010 follow up with Dr. Visotsky, he was to continue in physical therapy and remain off of work (Px.3 p.11, 94). He was advanced in physical therapy to include strengthening exercises and made gains through December 15, 2010, and remained off of work per Dr. Visotsky's orders (Px.3 p.5-10 and 84,92). On December 14, 2010, Petitioner underwent a baseline evaluation to begin a work hardening/conditioning program at SPTRS, and at that time he could only perform 74% of the physical demands of his job and they outlined the work hardening/conditioning program, and anticipated approximately 12 weeks of progressive work hardening/conditioning (Px.9 p.40-41). He was discharged from work hardening/conditioning on April 8, 2011, having increased his functional abilities to 78.3%, however he was still limited to lifting no more than 37.5 lbs., frequent lifting of 32.5 lbs, no carrying more than 35 lbs., shoulder lifting of 20 lbs, no pushing more than 65 lbs. of force and no pulling more than 60 lbs. of force. He was at the medium physical demand level and did not meet all of the requirements of his job (Px.9 p.12-14). Dr. Visotsky kept Petitioner off of work while he was undergoing work hardening/conditioning (Px.3 p.75,76,80,81). Petitioner underwent an FCE on May 17, 2011 ordered by Dr. Visotsky which placed him at the medium physical demand level. His material handling abilities were bilateral lifting of 37.5 lbs., frequent bilateral lifting of 25 lbs., bilateral carrying of 35 lbs., bilateral shoulder lifting of 25 lbs., pushing of 55 lbs. and pulling of 60 lbs. His job with the Respondent was classified within the heavy physical demand level. The FCE was consistent and reliable as Petitioner put forth a valid and consistent effort. He demonstrated the ability to perform only 67.5% of the physical demands of his job. He was

to try to avoid in and out of truck with reaching and vocational rehabilitation measures were recommended (Px.9 p.2-11). On June 8, 2011 Dr. Visotsky released Petitioner to go back to alternative duty work within the restrictions set forth in the FCE. Dr. Visotsky indicated that these restrictions were permanent (Px.3 p.100). Petitioner's final visit with Dr. Visotsky was on December 7, 2011 where it was noted that he still had limited endurance and fatigue in his shoulder and pain, tenderness and weakness in the paratrapezial area and crepitation in the subacromial space. The rotator cuff had healed, but he had sustained a massive rotator cuff tear and there was limited functionality of the remaining cuff muscles. Petitioner had limited endurance, limited strength, and the inability to perform overhead tasks and strength tasks. He opined that all injuries related to his right shoulder were related to his accident sustained at work, that there was no intervening cause and that no other co-morbidities that created problems with the patient or were the source of permanent level of dysfunction. Dr. Visotsky placed him at maximum medical improvement.The FCE documented his permanent restrictions with no evidence of submaximal performance. He could use anti-inflammatories and flector patches on an as-needed basis (Px.3 p.3-4).

Petitioner testified he was never offered any position by Respondent that accommodated the restrictions set forth in the FCE and that his employment was terminated in January 2010 when he received a letter from Jim Zimmerman (Tr.1 p.37). Following his release with permanent restrictions, he began looking for alternative work. He obtained employment with Jetpower Aerospace, LLC., beginning on July 18, 2011, initially to supervise relocation of a warehouse from Elk Grove Village to Gurnee, Illinois (Tr.1 p.37). When the move was completed, his job was to do a complete inventory of all the airplane equipment using a computer inventory program called Quantum, an airline specific inventory program (Tr.1 p.38). He never received any training on this computer program and was on a 90-day probationary period. He found the computer program extremely complex and therefore ordered his own software to try and learn the computer program (Tr.1 p.40). He paid $100 for 2 training CDs from Component Control on October 6, 2011 (Px.18) and $84.99 for Microsoft Office Outlook with Business Contact Manager from Discount Giant on October 25, 2011 (Px.18). He was unable to self-learn the program and due to his lack of computer skills and lack of training on the Quantum program he was unable to fully comprehend the program and was terminated on September 30, 2011 (Tr.1 p.41-42). Petitioner testified that he is self-taught on a computer. He never took any computer classes and uses a home computer to surf the Internet and e-mail. He is familiar with Microsoft Word but not Microsoft PowerPoint or Excel. Following his termination he continued looking for alternative employment (Tr.1 p.43). His earnings from Jetpower Aerospace, LLC., were identified and entered as Petitioner's Exhibit 19.

Following his termination, he continued to look for employment and was also provided with hypothetical labor market surveys from Charlotte Bishop which he used as leads for some jobs. Petitioner kept records of his job search activities for the period January 10, 2011 through January 31, 2012 (See Px.16) and July 18, 2010 through January 31, 2011 (See Rx.20). He applied for or sent resumes to more than 365 prospective employers (See Px.16 and Rx.20). Petitioner testified that he recalled having 2 or 3 prospective employers call him back for interviews (Tr.1 p.66).

Petitioner began working for a landscape company, 4 Everything Green, on October 24, 2011 and he remained employed there at the time of trial. He was hired as a laborer supervisor and his job entailed making sure the crew was doing what was asked of them and to pitch in where needed (Tr.1 p.48). He testified to pruning trees and shrubs using a hand pruner weighing approximately 1-1/2 pounds (Tr.1 p.50). His earnings are documented in Petitioner's Exhibit #20 and he testified that he earns $8.25 per hour, did not receive bonuses because his boss called them gifts (Tr.1 p51). He was never offered any positions with any potential employers

identified in the labor market surveys provided by Charlotte Bishop and he never met Charlotte Bishop nor any person associated with her company (Tr.1 p.53).

Petitioner testified he was hired by Donald Zimmerman, father of Jim Zimmerman the current owner of the Respondent 34 years ago. He began working for Respondent at age 15 and in addition to his regular pay he was offered what Donald Zimmerman told the Petitioner was profit sharing (Tr.1 p.56). Since the inception of the Petitioner's employment, he received additional compensation at the end of the year as what he believed to be profit sharing. He did not know how the profit sharing was calculated, but it was not consistent every single year. He recalled a time where the profit sharing decreased in one year and increased the following year. (Tr.1 p.59-60). At the time of the injury Petitioner was receiving a gross salary of $1,300.00 per week for a 40 hour work week (Tr.1 p.61). A wage statement was entered as evidence showing the gross earnings for 52 weeks of $93,350.00 which included a bonus in the amount of $25,750.00 (Px.13). Petitioner testified he never had any conversations with current owner Jim Zimmerman regarding any profit sharing payment and he had no idea how the profit sharing was calculated (Tr.1 p.63). Copies of profit sharing checks that the Petitioner received annually 1997 through 2008 were entered as evidence in Petitioner's Exhibit #14. Petitioner testified that although the earnings statements reflect the payments as bonuses it was his understanding that it was profit sharing (Tr.1 p.66). Upon cross examination he testified that he never saw the books and never discussed the percentage of profits he would receive.

On cross examination Petitioner testified he was hired at 4 Everything Green by his brother-in-law, Craig Caldwell (Tr.1 p.76). He testified that he would supervise a crew that is employed by Craig Caldwell and if he needed to communicate with one of the Spanish only speaking employees he would do so through Baltazar a Spanish-speaking employee (Tr.1 p.80). His other job tasks would be to make sure the equipment was in proper repair, if not take it to be repaired, get fertilizer if needed however he would not do any heavy lifting whatsoever (Tr.1 p.81). In response to questions regarding his bank records, the Petitioner testified that he owned rental property, and received rent through direct deposits from certain tenants (Tr.1 p.88-91). He denied receiving any income on the side in the form of cash (Tr.1 p.92).

Petitioner testified he does pruning and admitted to being a bad pruner, but tries to avoid overhead pruning because it causes him pain (Tr.1 p.102-104). He testified to taking pain pills and using Flector patches for pain (Tr.1 p.105). He testified having trouble over extending his arm and pulling up, he has problems with repetitive motions and he does not have turning strength anymore and has difficulties using wrenches and sockets to remove bolts (Tr.1 p.113). He has trouble removing laundry and usually uses his left hand, and limits vacuuming to about 10 minutes because the vibrations caused him fatigue (Tr.1 p.114).

Charlotte Bishop testified at an evidence deposition that she was a certified rehabilitation counselor employed by Creative Case Management. At the request of Respondent, she prepared 6 hypothetical labor market surveys (Rx.3 p.10). She explained that a labor market survey was a snapshot in time of some, not all but some jobs that are available within a given labor market and it did not cover all jobs and did not reflect that the jobs were 100% appropriate (Rx.3 9-10). She explained that the process included being provided with the basic medical information as to what Petitioner's current, or at that time of disability what his restrictions were as far as being able to return to work and the fact that he could not return to his original job (Rx.3 p.12). She obtained the job duties that the Petitioner performed at his job with Respondent and information regarding his educational and employment background from "Mr. Harrison" the owner of the poultry shop (Rx.3 p.12,). She also tried to get the most recent medical information including an FCE, physical, and IME reports (Rx.3 p.15). She testified

that Petitioner had good skills, that he could sell, and there were grocery store jobs available (Rx.3 p.22). She testified that he had real tangible skills that could apply to a variety of occupations in the marketplace and the grocery store business and that he had a customer service skill set (Rx.3 p.22-23). She testified that there were over 38,000 potentially medically appropriate jobs for Petitioner, however not all of them would be appropriate if you drilled down into the specific job duties or if there were any educational requirements (Rx.3 p.35). Based upon her April 2013 hypothetical labor market survey the salary range that she established was between $26,060 and $63.000 per year (Rx.3 p.37).

Upon cross examination, Ms. Bishop testified that medical information is important in developing a hypothetical labor market survey and that the diagnosis would be an important factor (Rx.3 p.46). She developed her hypothetical labor market survey on the diagnosis of "status post a right arthroscopic subacromial decompression on February 23, 2009" and this diagnosis remained consistent throughout her reports even through the most recent report dated August 14, 2013. She testified that her assignment was to work with what Dr. Lieber stated and his only restriction was no work above shoulder level (Rx.3 p.47-48). Ms. Bishop was unaware that Petitioner underwent a supraspinatus tendon repair, a right open capsular plication and open repair of the supraspinatus and subscapularis tendon and he was diagnosed with a right rotator cuff tear, a right subscapularis tear and right shoulder anterior subluxation and dislocation (Rx.3 p.49). She could not recall if she reviewed any of Dr. Visotsky's records, the treating physician (Rx.3 p.50) however conceded that if she had reviewed Dr. Visotsky's records she would have noted his findings in her reports. She was unaware that at the time of her initial hypothetical labor market survey in February 2010 that Petitioner was completely off of work pursuant to Dr. Visotsky's orders (Rx.3 p.51). She was further unaware of Petitioner's psychological issues going on at the time of her hypothetical labor market surveys (Rx.3 p.53). She acknowledged never meeting Petitioner.

Craig Caldwell testified at an evidence deposition that he is the owner of a business named 4 Everything Green and is Petitioner's current employer. He described it as a landscape maintenance business with some cemetery business which included grave openings and closings, and some snow plowing in the winter (Rx.17 p.4). He testified that he is Petitioner's brother-in-law and that his wife Janet (Petitioner's sister) asked him to hire Petitioner because he needed a job (Rx.17 p.9). Petitioner was hired full-time for a position "to be determined" at minimum wage of $8.25 (Rx.17 p.10-11). Mr. Caldwell was aware that Petitioner had some restrictions regarding his right shoulder but was not sure of the specifics. If Petitioner were asked to do a job and could do it, he would do it; if he could not, then he would not ask him to do it again (Rx.17 p.12). He testified that Petitioner mowed for approximately 25 to 40 minutes and was done (Rx.17 p.13). Mr. Caldwell testified that for safety reasons he did not ask people to do jobs that they could not do for whatever reason (Rx.17 p.14). Mr. Caldwell classified Petitioner's position as a "step and fetch", where he would fill up gas cans, pick up fertilizer, pick up seed, run materials to workers at another job, clean the mowers, clean the air filters, sweep the floors, and whatever it takes to keep the production crews going (Rx.17 p.14). He testified that Petitioner did not have to pick up the bags of fertilizer physically and they were usually loaded onto his truck for him (Rx.17 p.15). He testified that Petitioner tried pruning and that Petitioner was not very good at it (Rx.17 p.15). He testified that Petitioner did very little office work (Rx.17 p.16). He testified that all of his employees start at minimum wage. Petitioner has not had a raise since beginning employment there and that his employees generally do not get a lot of raises unless they prove that they can do something more than labor. Petitioner had never received nor asked for a raise (Rx.17 p.18). Mr. Caldwell testified that he has had some issues with Petitioner, that he has questioned whether he should keep him as an employee (Rx.17 p.22), and that if Petitioner had asked for a raise he would have told him no (Rx.17 p.29). The reason why Petitioner would not get a raise is because he cannot fill out

paperwork, he is argumentative and abusive to other employees, has a hard time working comfortably with clients and he lacks skills dealing with other people (Rx.17 p.34-35).

Upon cross examination he confirmed all employees began at the minimum wage unless they had some specific skill or something more to offer (Rx.17 p.23). Mr. Caldwell testified that he had a hard time with the word "bonus" and that he did not pay bonuses for doing a job well, however stated that although called a bonus he gives out Christmas gifts. He testified it was only a Christmas thing and had nothing to do with production or capability (Rx.17 p.24-25). Mr. Caldwell testified that he had seen Petitioner wince if he tried to do any overhead work or operate a tool or something and stated that one would see a change in his body language (Rx.17 p.31). He testified that there are jobs that Petitioner is unable to do. He testified that he would not ask Petitioner to perform certain jobs such as load a truck full of gravel or sand, or digging a ditch by hand because that kind of work would be too laborious for him (Rx.17 p.34).

Mr. Zimmerman testified he has been the president of Harrison's poultry since 1982. He testified that bonuses have always been a Christmas bonus, never anything else and given on Christmas day. Beginning in 1975, Jim Zimmerman and his father would sit down a couple weeks before Christmas and determine that everybody always got a discretionary bonus depending on how they worked. He testified there was no formula (Tr.1 p.153-155).

Upon cross examination he testified that if someone were performing better, he would get a bigger bonus then someone who was slacking off (Tr.1 p.163-164). Mr. Zimmerman testified that the bonus would be based on who had been working the hardest and also what their yearly salary was. Mr. Zimmerman did not recall having a conversation with Charlotte Bishop regarding the Petitioners job duties (Tr.1 p.171-172).

Dr. Visotsky testified that as a result of the injury, Petitioner sustained a complete full-thickness tear of the rotator cuff with retraction greater than 12 mm (Px.10 p.7) with surgical repair on February 23, 2009. His operative findings showed a disruption full thickness tear of the supraspinatus and subscapularis tendons with retraction, a substantial tear, he noted blood within the joint and some defects in the posterior aspect of the humeral head indicating an acute significant injury and probably a dislocation accompanying the rotator cuff tear and he classified the injury as a massive rotator cuff tear which usually involved at least two tendons. He performed an arthroscopic rotator cuff repair using a double row technique by using 6 anchors, a number of anchors spanning across the large rotator cuff tear (Px.10 p.8-9). Postoperatively, Dr. Visotsky prescribed a course of physical therapy and then a course of work conditioning at Lake Forest Rehabilitation Center, which only improved the Petitioner up to a medium level of work activity. Petitioner had ongoing limitations with pain in forward flexion at 85 degrees with a catching sensation and he had plateaued in strength (Px.10 p.11), therefore Dr. Visotsky prescribed a CT arthrogram, and by his reading there were some areas of incomplete healing, and based upon Petitioner's consistent pain, limitations, and plateauing in therapy and the changes on the CT scan consistent with what could be partial tearing of the subscapularis as the origin of his pain, Dr. Visotsky recommended a revision arthroscopic surgery (Px.10 p.12-13). The revision surgery was performed on May 13, 2010, and the intraoperative findings showed a large amount of synovitis or inflamed tissues around the shoulder, some thinning of the labral complex, and a thinning of the supraspinatus with exposed sutures internally. Dr. Visotsky testified that exposed sutures indicated that an area did not heal, either the tendon hadn't healed or the tendons around that had stretched out. Exposed sutures were also a sign of a re-tear of the rotator cuff or failure of that initial cuff to heal (Px.10 p.15-16). Dr. Visotsky referred to the intraoperative photographs, and a spinal needle in place localized an area that he saw where an area of the tendon pulled off. He explained that one could clearly see the tendon pulled off, as one could see a blue and white suture called tiger-striped sutures. Those were the sutures that he used on the open repair in the past and there was a segment of 6-8 mm of

suture exposed which indicated that the tendon hadn't healed (See Petitioner's Exhibit #5 on Evidence Dep. Picture #2 and Px.3 p.57 # 2) (Px.10 p.18-19). He placed new sutures which were the white sutures in the rotator cuff to repair that area and debrided the tissue to get good bleeding for healing purposes (See Petitioners Exhibit #6 on Evidence Dep. Picture #2 and Px.3 p.58 # 2) (Px.10 p.20). Dr. Visotsky further explained that when looking at the pictures in Petitioners Exhibit #7 on Evidence Dep. Picture #1, 2 and 3 and Px.3 p. 59 #1,2 and 3 he placed the sutures in picture #1, picture #2 and picture #3 which showed the re-approximation of the tendon. The sutures had tightened the tendon up and that's what a repaired rotator cuff should look like (Px.10 p.20). He testified that this was the same area that was previously operated on in February 2009 because of the exposed blue and white tiger sutures (Px.10 p.21). He again prescribed a course of physical therapy and advanced him to work conditioning (Px.10 p.22-23) then prescribed a functional capacity evaluation (FCE) on May 12, 2011 to help identify gaps or deficiencies in what the patient could do and what his job demands were (Px.10 p.24). He reviewed the FCE which was valid and consistent, where the Petitioner put forth maximal effort (Px.10 p.27) and noted deficits that may interfere with his ability to work in his previous job which would be permanent in nature (Px.10 p.27-28).

Dr. Visotsky testified that based upon a reasonable degree of medical and surgical certainty both surgeries were directly related to the injury and rotator cuff tear. He could not find any other comorbidities to explain the rotator cuff tear. During each of the surgeries, he found pathology consistent with what Petitioner complained of and after each surgical procedure Petitioner did improve (Px.10 p.28-29). He did not recommend any further surgical intervention, but did prescribe anti-inflammatory medication and Flector patches (Px.10 p.30). Dr. Visotsky testified that large and massive tears in the rotator cuff yielded a higher percentage that does not heal (Px.10 p.31). Dr. Visotsky validated the five to six months of work conditioning, reasoning that as long as the patient was making progress and did not plateau, then the work conditioning was appropriate. He further explained that the muscles had become deconditioned and it was about getting the endurance back to those muscle groups. He testified that to rebuild the muscles in atrophy and that it takes approximately 2-3 days to get better each day a person has had the problem. If someone had a problem for 3 months it may take 9 months to a year to get that muscle function back (Px.10 p.32-33). He opined that based upon a reasonable degree of medical and surgical certainty that the physical therapy and work conditioning he prescribed following the May 13, 2010 surgery was reasonable and necessary (Px.10 p.34). Petitioner followed up with Dr. Visotsky for his last visit on December 7, 2011. Dr. Visotsky placed him at maximum medical improvement, and Petitioner was released to go back to work within the permanent restrictions set forth in the FCE (Px.10 p.42-43).

The FCE was completed on May 17, 2011 which placed Petitioner at the medium physical demand level. His material handling abilities were bilateral lifting 37.5 lbs., frequent bilateral lifting 25 lbs., bilateral carrying 35 lbs., bilateral shoulder lifting 25 lbs., pushing 55 lbs. and pulling 60 lbs. His prior job was classified within the heavy physical demand level. The FCE was consistent and reliable as the Petitioner put forward a valid effort. He was to try to avoid climbing in and out of a truck with reaching and vocational rehabilitation measures were recommended (Px.3 p.62-71).

Petitioner was examined by Dr. Lieber at Respondent's request on January 20, 2010. Upon physical examination, Dr. Lieber noted a decreased range of. Orthopedic impingement tests were performed and were positive (Rx.2 p.9), and he opined that these symptoms were symptomatic complaints about the shoulder joint associated with the extremes of motion and stress (Rx.2 p.10). Dr. Lieber felt that the Petitioner had reached maximum medical improvement and required no further medical treatment, despite his subjective complaints (Rx.2 p.11). Dr. Lieber felt that the Petitioner should be restricted from any overhead work, but could lift from

waist to chest level without restriction and perform all activities with the right upper extremity to chest level with no lifting restriction (Rx.2 p.11).

In his addendum report dated May 5, 2010, Dr. Lieber opined that the CT arthrogram was not needed, that there was no evidence of any rotator cuff tear and he felt that any potential findings were degenerative in nature and were neither caused nor related to the work injury nor aggravated by the work injury of February 4, 2009 (Rx.2 p.15). Following the Petitioners revision surgery on May 13, 2010, Dr. Lieber reviewed the operative report and the intraoperative photographs and maintained his opinion that labral surgery was not caused or related to the injury of February 4, 2009. Dr. Lieber, however, felt that the rotator cuff tear was related to the work injury, and testified that the further stabilization of the rotator cuff, was related to the work injury, and was still related and necessary based upon Dr. Visotsky's surgical expertise (Rx.2 p.19-20). When Dr. Lieber re-examined Petitioner on April 6, 2011, he complained of right arm and shoulder pain with some stiffness and weakness at night. He also had some numbness but no swelling and had difficulty with overhead activity (Rx.2 p.20). Dr. Lieber again noted decreased range of motion with stiffness and some pain to the extremes, (Rx.2 p.21). Dr. Lieber testified that Petitioner did not need any further treatment for his shoulder injury of February 4, 2009, and that this was based upon his medical knowledge, the record reviews and his 2 prior independent medical evaluations (Rx.2 p.22). Dr. Lieber felt that Petitioner could go back to work, however he would be restricted from any overhead activity (Rx.2 p.22-23). At Dr. Lieber's final examination of the Petitioner in February 2012, he noted Petitioner still had decreased range of motion at the extremes of flexion and extension, abduction, abduction, external and internal rotation with positive impingement and apprehension and 4+ weakness about the shoulder joint (Rx.2 p.24) and he felt that limiting Petitioners activities to no overhead work only would be appropriate.

The parties viewed surveillance footage of Petitioner performing his work at 4 Everything Green on July 11, 2012 (Rx.12). The footage began at 10:36 a.m. when Petitioner was seen pruning a flower bush on his knees using hand pruners in his right hand. At 10:42 a.m. he was seen retrieving two sprayers from his truck. At 11:10 a.m., he retrieved an empty plastic bucket. He was seen pulling a tarp with his left hand at 12:29 p.m. and he continued pruning until 12:49 p.m. the footage also depicted various yard work including Petitioner using a sprayer, holding the sprayer in his left hand and the wand in his right hand to spray, carrying a metal rake in his right hand, and using a shovel using his left foot to push the shovel into the ground. He was also seen retrieving a broom to sweep a walkway. At 12:45 p.m. Petitioner was seen holding his right shoulder with his left hand.

Petitioner was surveilled again on July 20, 2012 (Rx.13 and Rx.14). At 9:47 a.m. he was again seen pruning trees with hand pruners in his right hand. The pruning consisted of Petitioner pulling down branches above his head with his left arm cutting the branches with his right hand at, or below shoulder level. There was some pruning with his right hand at shoulder level but with his right elbow below shoulder level, most pruning was seen at chest level. Petitioner was seen loading clippings into a garbage can. At 1:59 p.m. Petitioner was seen carrying grocery bags in his right hand and in his left hand, and he could be seen shaking out his right shoulder.

Petitioner was seen on August 31, 2012 between 11:19 a.m. and 12:24p.m., the footage depicted use of the right hand below shoulder level while pruning and using a rake in his left hand to shake out a bush (Rx.15).

In rebuttal, Petitioner testified that the sprayer seen in the surveillance video weighed at most about 5 pounds (Arbitration Transcript #2 from October 27, 2014, hereafter "Tr.2" p.18). When filled with 1 gallon of fluid, the sprayer weighed approximately 10-11 pounds (Tr.2 p.21). The pruning work Petitioner was seen doing during the surveillance video is sporadic and on an as needed basis. The hand-held pruners weighed

approximately a pound and a half (Tr.2 p.19). The garbage can used by Petitioner was a plastic Brute 55 gallon garbage can that he used for gathering up clippings from pruning and Petitioner estimated the weight of the garbage can and its contents when fully loaded, to be approximately 20 or 25 pounds (Tr.2 p.20). Petitioner estimated that the tarp and the contents that he was seen pulling in the surveillance video weighed approximately 15 pounds (Tr.2 p.20). Petitioner testified that after a day of pruning, he had fatigue in the right upper extremity and that he uses Flector patches and anti-inflammatories on a regular basis (Tr.2 p.22).

CAUSATION

Petitioner sustained an undisputed accident which resulted in a severe injury to his right shoulder. The Arbitrator finds the testimony of Dr. Visotsky to be more persuasive and more credible than the testimony of Dr. Lieber. Dr. Visotsky testified that based upon a reasonable degree of medical and surgical certainty that both surgeries were directly related to the injury and rotator cuff tear, reasoning that there were no other comorbidities to explain the rotator cuff tear and that the pathology seen in each surgery was consistent with Petitioner's complaints. Dr. Visotsky's explained that the surgery performed on May 13, 2010 on the rotator cuff was in the exact same area of the original tear repaired on February 23, 2009 as evidenced by the exposed sutures.

Dr. Lieber agreed with Dr. Visotsky that the area of the rotator cuff was related to the original injury.

Petitioner never had any problems with his right shoulder prior to February 4, 2009, and the sequence of events as well as the medical opinions rendered, indicate that since the date of accident Petitioner has had problems with his right shoulder.

Based upon the foregoing, the Arbitrator finds that Petitioner has established by a preponderance of the credible evidence that the Petitioner's current condition of ill-being regarding the right shoulder is causally related to the accident.

EARNINGS

Based upon the evidence presented herein, Petitioner was paid a salary by respondent of $1,300.00 a week or $67,600.00 per year.

Petitioner alleges that the yearend bonus paid by Respondent was, in actuality, payment under a profit sharing plan. However, Petitioner failed to produce evidence to support that claim. The evidence shows that the payment tendered at the end of the year was around Christmas time. The testimony of Mr. Zimmerman was unrefuted that the payment of bonuses was solely within his discretion.

MEDICAL

The dispute as to the Respondent's liability for payment of medical expenses is based upon the issue of causation. Having found that the Petitioner's condition of ill-being is causally related to the accident of February 4, 2009, the Arbitrator finds that Petitioner has established by a preponderance of the credible evidence that the medical bills related to the treatment of Petitioner's right shoulder and subsequent treatment including the surgery of May 13, 2010, diagnostics, the post-operative follow ups with Dr. Visotsky, post-operative physical therapy, work hardening program, psychological counselling by Dr. Mahoney, and Petitioner's out of pocket medical expenses contained in Petitioner's Exhibit 11 are reasonable, necessary and causally related to the

accident of February 4, 2009, and that the Respondent shall pay to the Petitioner, the amount of $167,571.51 in medical expenses under Section 8(a) of the Act and pursuant to the Illinois Fee Schedule as follows:

1.	Chicago Imaging Associates	$227.00
2.	Illinois Sports Medicine and Orthopedic Surgery	$40,262.40
3.	Illinois Bone and Joint Institute	$13,254.68
4.	Illinois Bone and Joint Institute – Dr. Visotsky	$282.00
5.	Illinois Bone and Joint Institute – Physical Therapy	$13,320.08
6.	Injured Worker's Pharmacy	$1,368.84
7.	Lake Forest Hospital	$17,399.00
8.	Lincoln Park Anesthesia Pain Management	$660.00
9.	North Shore Psychological Services	$3,390.00
10.	Occucare Systems and Solutions (Sports PT & Rehab)	$70,648.61
11.	Park Ridge Anesthesiology	$2,530.00
12.	St. Joseph Hospital	$4,228.90
13.	Walgreens Pharmacy (Petitioner's out-of-pocket expenses)	$498.19
	Total Medical Expenses	**$167,571.51**

TEMPORARY TOTAL DISABILITY BENEFITS

Petitioner was released to go back to light duty work with no use of the right arm on February 5, 2009. These restrictions could not be accommodated by Respondent. Petitioner was then taken off of work completely by Dr. Visotsky on February 18, 2009. Dr. Visotsky released Petitioner to go back to work with permanent restrictions as per the FCE on June 8, 2011. Petitioner then began seeking alternative employment, because his employment with Respondent had been terminated.

The dispute as to Petitioner's entitlement to temporary total disability benefits is based upon the issue of causation. Having found that the Petitioner's injuries are causally related to the accident of February 4, 2009, the Arbitrator finds that the Petitioner has established that Respondent shall pay to the claimed temporary total disability benefits.

TEMPORARY PARTIAL DISABILITY BENEFITS

Petitioner is seeking temporary partial disability benefits for the time period of July 18, 2011 to September 30, 2011. However, at this juncture, Petitioner was no longer temporarily disabled. He had been released to return to work with the restrictions as set forth under the FCE. Temporary partial disability is, by definition, interim and not permanent.

Because Petitioner was not temporarily disabled during the claimed time period, Respondent is not liable for temporary partial disability benefits.

MAINTENANCE

Petitioner seeks maintenance benefits from the time of the FCE in June, 2011 until he found employment at Jet Power and then from his termination of employment at Jet Power on September 30, 2011 until he found employment at 4 Everything Green. However, Petitioner did not provide evidence that he

required any additional vocational training. Petitioner did not present evidence that he had skills that were insufficient to obtain employment without further training or education. After Petitioner's release to work, he found employment at Jet Power. After that employment was terminated, he found employment at 4 Everything Green.

Based upon the foregoing, the Arbitrator finds that Petitioner has not established by a preponderance of the credible evidence a right to the claim for maintenance.

NATURE AND EXTENT

Petitioner claims that he is entitled to wage differential benefits.

Based upon the evidence, Petitioner has failed to prove that he is only capable of earning minimum wage of $8.25 per hour. Prior to obtaining employment with his brother-in-law, at minimum wage, he had secured employment at Jet Power earning more.

The Arbitrator does not find Petitioner's testimony credible regarding the claimed inability to find employment or limitations within his physical abilities. Petitioner has the skills and experience to perform work in the food industry, having done so for 35 years.

The testimony of Charlotte Bishop indicated that Petitioner could earn anywhere from $40,000.00 to $70,000.00 based upon the job market and his skills and experience in the food industry. However, Petitioner has worked at minimum wage for his brother-in-law.

Based upon the foregoing, the Arbitrator finds that Petitioner has not established by a preponderance of the credible evidence that he has become partially incapacitated from pursuing his usual and customary line of employment.

Based upon the evidence in this case, the Arbitrator further finds that Petitioner has sustained severe and permanent right shoulder injuries that have caused the loss of 50% of the person as a whole.

PENALTIES AND ATTORNEYS' FEES

Respondent's failure to pay TTD and medical expenses is based upon Dr. Lieber's opinions. Although the Arbitrator does not agree with Dr. Lieber's opinions, it was not unreasonable for Respondent to rely upon those opinions.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Demetria Henderson,
Petitioner,

vs.
Illinois Stte University,
Respondent,

NO: 09 WC 32325
12 WC 19360

16IWCC0329

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical, notice, permanent partial disability, whether or not 8d(1) is the correct award, 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 15, 2015 is hereby affirmed and adopted.

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

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

No bond or summons required for State of Illinois cases.

DATED: MAY 13 2016

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:5/5/16
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HENDERSON, DEMETRIA
Employee/Petitioner

Case# **09WC032325**
12WC019360

ILLINOIS STATE UNIVERISTY
Employer/Respondent

16IWCC0329

On 9/15/2015, 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 0.26% shall accrue from the date listed above to the day before the 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
STEVE WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

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

4138 ASSISTANT ATTORNEY GENERAL
WARREN WILKE
500 S SECOND ST
SPRINGFIELD, IL 62706

0903 ILLINOIS STATE UNIVERSITY
1320 ENVIRONMTL HEALTH SAFETY
NORMAL, IL 61790

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

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

SEP 15 2015

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

16IWCC0329

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Demetria Henderson
Employee/Petitioner

v.

Illinois State University
Employer/Respondent

Case # **09** WC **32325**

Consolidated cases: **12 WC 19360**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Bloomington**, on **July 29, 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

16IWCC0329

FINDINGS

On **March 16, 2009 and August 24, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On **March 16, 2009**, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

On **August 24, 2010**, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**26,710.32**; the average weekly wage was $**513.66**.

On the date of accident, Petitioner was **46** 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 $**94,376.11** for TTD, $**0.00** for TPD, $**17,998.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**112,374.57**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**342.44**/week for **52** weeks, commencing **July 21, 2009** through **July 18, 2010**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $35,961.00 to Orthopedic & Sports Medicine Center, $191.00 to Ft. Jesse Imaging, and $$750.00 to Central Illinois Orthopedic Surgery, $204.46 to OSF Occupational Health, as provided in Sections 8(a) and 8.2 of the Act provided that these charges do not exceed the Illinois Workers' Compensation Fee Schedule.

Respondent shall pay Petitioner permanent partial disability benefits of $**308.20**/week for **200** weeks, because the injuries sustained caused the **40%** 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.

Arbitrator Anthony C. Erbacci

September 11, 2015
Date

SEP 15 2015

16IWCC0329

FACTS:

The Petitioner has filed two claims for compensation which were consolidated for hearing, claim number 09 WC 32325 alleges an injury to both of the Petitioner's shoulders on March 16, 2009 and claim number 12 WC 19360 alleges an injury to both of the Petitioner's shoulders on August 24, 2010, the last day the Petitioner performed work for the Respondent.

The Petitioner testified that on March 16, 2009, she was cleaning a bathroom when she attempted to close a window which was half open. The Petitioner testified that the window was stuck and she put her hands at the top of the window and pulled down. She testified that when the window didn't close, she pulled down harder and felt a pop and pain in both of her shoulders. The Petitioner testified that she reported the incident to her supervisor, Sonny Garcia, and that she then completed an accident report which she gave to Sonny Garcia.

The Petitioner testified that while she had experienced some soreness and pain in her shoulders prior to March 16, 2009, that pain was "manageable" and she only took ibuprofen for that pain. The Petitioner testified that, prior to March 16, 2010, she had not had any shoulder surgeries or recommendations for shoulder surgeries and that she was able to perform her full duty work without any restrictions.

The Petitioner testified that she first sought medical treatment for her injuries from Dr. Liu, her family physician, and that Dr. Liu referred her to Dr. Tudtud. She testified that Dr. Tudtud prescribed medications, took her off work, and referred her to Dr. Li. The Petitioner testified that Dr. Li ordered MRIs of her shoulders and then performed injections and ordered physical therapy. The Petitioner testified that in July of 2009 she underwent surgery for her right shoulder and in October of 2009 she underwent surgery for her left shoulder. The Petitioner testified that she then underwent a second surgery for her left shoulder followed by a course of physical therapy and then work conditioning.

The Petitioner testified that on July 19, 2010 she returned to work with restrictions and that she continued to work with restrictions until August 24, 2010 when she felt pain in her shoulders when she tried to mop. She testified that she was then sent to OSF Occupational Health and that she was, ultimately, referred to Dr. Nord by Dr. Liu. The Petitioner testified that she has not returned to any type of work since August 24, 2010.

The medical records admitted into the record demonstrate that the Petitioner saw Dr. Joseph Liu on April 24, 2009 with complaints of left sided lumber back pain for four weeks. It was noted that the Petitioner reported that "she has had back pain before and it seems to recur quite frequently." It was also noted that "working also seems to hurt". The Petitioner was noted to also have complaints of shoulder pain "for the last 2 months" which she rated as 7/10 when "she is working and moving around feels like it pops." No history of any work injury or incident is noted in the record of that visit.

On May 4, 2009 the Petitioner saw Dr. Nenita Tudtud with complaints of bilateral shoulder pain "for about two months now." It was noted that "A month ago, she claims that

she developed more pain in the shoulders while trying to close a window at work." The Petitioner's history of chronic low back pain was also noted as well as the Petitioner's report that her back pain had increased recently. The Impression at that time included bilateral shoulder pain, chronic low back pain, and degenerative disc disease. Dr. Tuttud prescribed x-rays and Flexeril and referred the Petitioner for physical therapy for the neck and low back.

On June 3, 2009, the Petitioner saw Dr. Lawrence LI for evaluation of her bilateral shoulder pain. It was noted that the Petitioner reported that her pain began on March 16, 2009 while she was pushing down on a window at work. Dr. Li recommended an MRI of the right and left shoulders and, on June 5, 2009, Dr. Li noted that the MRIs demonstrated "high grade tendinopathy with partial-thickness tearing of both the supraspinatus and infraspinatus tendons". Dr. Li recommended bilateral corticosteroid injections and exercises. The Petitioner followed up with Dr. Li and it was noted that the injections did not provide lasting relief. On June 24, 2009 Dr. Li recommended a rotator cuff repair.

On July 21, 2009 Dr. Li performed a right shoulder arthroscopy with debridement of anterior superior and posterior labral tear, bicep tenodesis, arthroscopic subacromial decompression and rotator cuff repair. The diagnosis was right shoulder rotator cuff tear with involvement of the supraspinatus tendon, high grade partial biceps tendon tear, extensive type I tearing of the anterior superior and inferior labrum and impingement syndrome.

The Petitioner continued to follow up with Dr. Li and, on October 27, 2009 the Petitioner underwent a left shoulder arthroscopy with rotator cuff repair. The diagnosis was left shoulder rotator cuff tear, impingement syndrome, type 1 anterior and type 1 superior labral tear.

On January 29, 2010 the Petitioner had another MRI to her left shoulder which was noted to demonstrate postoperative changes, a partial-thickness tear of the posterior aspect of the distal supra and anterior aspect of the distal infraspinatus tendons, and subacromial-subdeltoid bursitis. On February 2, 2010, Dr. Li noted that the Petitioner had pain with strength testing and that the MRI showed a tear just posterior to the repair. Dr. Li indicated that the Petitioner had an already weakened area of the rotator cuff that got further injured when she was doing her strengthening exercises.

On February 16, 2010 the Petitioner underwent another left shoulder arthroscopy with rotator cuff repair, lysis of adhesions, debridement of scar tissue and manipulation. The diagnosis was left shoulder recurrent rotator cuff tear with adhesive capsulitis. Following surgery, the Petitioner participated in a course of physical therapy and, on June 7, 2010 she began a course of work hardening.

On July 9, 2010 the Petitioner underwent an MRI of the right and left shoulders which were reported to demonstrate moderate tendinopathy in both shoulders, and some diffuse interstitial microtearing in the right shoulder. On July 16, 2010 Dr. Li authorized the Petitioner to return to work as of July 19, 2010 with restrictions of up to 25 lbs. lift and carry at waist level with two hands, up to 15 lbs. lift and carry at waist level with one hand and no overhead lifting greater than 10 lbs. The Petitioner testified that she did return to work with those

restrictions on July 19, 2010.

On August 9, 2010 the Petitioner was discharged from work hardening. The note of that date indicates that the Petitioner could perform most of the duties of her job with the Respondent although some accommodations might be necessary. On August 10, 2010 Dr. Li issued restrictions which were consistent with the restrictions indicated in the work conditioning progress note of August 9, 2010 and he indicated that those restrictions were permanent.

The Petitioner continued to work with those restrictions until August 24, 2010. The Petitioner testified that on August 24, 2010 she was mopping floors and felt pain in her shoulders. This incident is the subject of claim number 12 WC 19360. The Petitioner has not returned to any type of work since that time.

On August 25, 2010 the Petitioner saw Dr. Liu complaining of shoulder pain. The Arbitrator notes that August 25, 2010 was a Wednesday. Dr. Liu's note reflects that the Petitioner reported that she had not been to work "this week" and that "Friday was getting ready for students to come back. Had to do it periodically. 5 minutes then had to stop because it felt like arm was going to fall off." She complained of 8/10 pain right after mopping and 6/10 pain at the examination. The Petitioner requested referral to a different doctor and she was referred to Central Illinois Orthopedics and either Dr. Keller or Dr. Nord.

On August 25, 2010 the Petitioner was also seen at OSF Occupational Health with complaints of bilateral shoulder pain, and she was noted to report that "mopping aggravated her shoulders". The Petitioner was also noted to report that she had seen Dr. Liu that same day and that he had referred her to Dr. Nord. The physician at OSF Occupational Health indicated that the Petitioner could return to work with restrictions of no lifting greater than five pounds and no use of both shoulders. The Petitioner returned to OSF Occupational Health on September 9, 2010 and the same restrictions were continued.

On August 31, 2010 the Petitioner saw Dr. Lawrence Nord complaining of "low-grade discomfort" in both shoulders which seemed to be aggravated by overhead activities and pulling and pushing. The Petitioner reported that her shoulders now hurt worse than they did before the surgeries she had undergone. Dr. Nord noted the Petitioner's prior care and treatment and he diagnosed her as having tendinosis in both upper extremities in the supraspinatus area. Dr. Nord recommended symptomatic care and treatment only and he opined that further surgical treatment would not benefit the Petitioner. Dr. Nord also indicated that the Petitioner should be limited from activities that involve overhead work along with any abduction type activities.

The Petitioner returned to Dr. Liu on September 8, 2010 complaining of pain and requesting medication. It was noted that the Petitioner had seen Dr. Nord and that he had recommended cortisone shots.

The Petitioner returned to Dr. Li on September 21, 2010 complaining of painful range of

motion in both shoulders. Dr. Li noted the prior MRI findings and indicated that the Petitioner should continue under the same restrictions until she was seen for a second opinion at Rush Hospital. The Petitioner never obtained a second opinion from Rush Hospital.

The Petitioner testified that she currently finds it hard to do anything due to her shoulder pain. She testified that she has difficulty mopping, doing overhead work, and lifting. She testified that she can drive with difficulty and that she has difficulty sleeping. The Petitioner testified that prior to her employment with the Respondent she held jobs as a cashier, bill collector, assembler, waitress and housekeeper. The Petitioner testified that she has not looked for any work since her employment with the Respondent ended.

No testimony from Sonny Garcia was offered into the record but the Respondent introduced a CMS Workers' Compensation Employee's Notice of Injury form and a CMS Supervisor's Report of Injury form into the record as Respondent's Exhibit 7. The Employee's Notice of Injury form appears to have been completed by the Petitioner on June 29, 2009 and indicates that the Petitioner reported an injury to her right and left shoulders on March 16, 2009 when she was trying to close a window. The Supervisor's Report of Injury form indicates that it was completed by Sonny Garcia on June 30, 2009 and that he noted that the Petitioner reported hurting both shoulders while closing a window in a bathroom on March 16, 2009. The form also indicates that oral notice of the injury was received from the Petitioner on March 16, 2009.

The August 27, 2012 evidence deposition testimony of Dr. Li was admitted into the record as Petitioner's Exhibit 1. Dr. Li testified as to the course of treatment he rendered to the Petitioner through September 21, 2010 and he testified that he has not seen the Petitioner since that date. Dr. Li opined that the injury described by the Petitioner was the cause of the shoulder conditions for which he treated her. Dr. Li explained that "the amount of work that she's been doing over the years has caused her to have some inherent problems in her rotator cuffs, and that pushing down on the window was simply the straw that broke the camel's Back." Dr. Li further opined that the restrictions listed in the August 9, 2010 work conditioning note were the Petitioner's permanent restrictions.

The September 24, 2012 evidence deposition testimony of Dr. Brent Johnson was admitted into the record as Respondent's Exhibit 4. Dr. Johnson examined the Petitioner at the request of the Respondent on March 16, 2011. Dr. Johnson's report of that date was admitted into the record as Respondent's Exhibit 3. Dr. Johnson testified as to his examination of the Petitioner and the medical records that he reviewed. Dr. Johnson opined that the Petitioner had reached maximum medical improvement from her injuries as of the date of his examination and that she would not benefit from any further medical care or treatment for her shoulders. Dr. Johnson further opined that while the Petitioner would not be able to return to her full duty work, she was capable of returning to work within the restrictions set forth in the August 9, 2010 work conditioning note. With regard to causation, Dr. Johnson reported that it was "difficult to correlate the condition of both of her shoulders directly to the incident occurring on March 16, 2009. He also opined that "it would be very difficult to say you would injure both shoulders simultaneously in the way that she described." Dr. Johnson

acknowledged, however, that assuming the mechanism of injury was correct, it was possible to injure one rotator cuff but it was extremely unlikely that you could injure both rotator cuffs simultaneously. Dr. Johnson also conceded that the mechanism of injury described could aggravate the condition for which Dr. Li performed surgery.

The evidence deposition testimony of Dennis Gustafson, a certified vocational rehabilitation counselor retained by the Petitioner was admitted into the record as Petitioner's Exhibit 2. Mr. Gustafson testified that he interviewed the Petitioner and reviewed her work history and her work restrictions as well as the job description of her job with the Respondent. Mr. Gustafson opined that the Petitioner would not meet the physical requirements of her job with the Respondent in terms of the reaching aspects and the weights involved and he ruled out the Petitioner's return to her job with the Respondent as a possibility. Mr. Gustafson opined that the Petitioner could find employment but that her earnings would be limited to the vicinity of $9.00 per hour and it would be very unlikely that she could earn more than $10.00 per hour.

The evidence deposition testimony of Charlotte Bishop, a certified vocational rehabilitation counselor retained by the Respondent was admitted into the record as Respondent's Exhibit 9. Ms. Bishop opined that based on the restrictions of the Petitioner in this case the Petitioner would not be able to perform her past work as a building service worker for the Respondent. Ms. Bishop further opined that the Petitioner would most likely be able to earn between minimum wage and $10.50 per hour in some suitable employment.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

The Petitioner testified that on March 16, 2009 she was pulling and pushing down a window which was stuck in an open position when she experienced pain in both of her shoulders. The Petitioner testified that she reported the incident to her supervisor, Sonny Garcia, and that she subsequently sought medical treatment for her shoulder pain. The Petitioner's testimony was not contradicted or rebutted and the medical records contain a consistent history of the incident. The Petitioner's testimony is also supported by Respondent's Exhibit 7 which indicates that on March 16, 2009 the Petitioner reported an injury to her right and left shoulders when she was trying to close a window in a bathroom. That Exhibit also indicates that oral notice of the injury was received from the Petitioner on March 16, 2009.

Based upon the unrebutted testimony of the Petitioner which is corroborated by the

histories contained in the medical records, as well as Respondent's Exhibit 7, the Arbitrator finds that on March 16, 2009, an accident did occur which arose out of and in the course of the Petitioner's employment by the Respondent. The Arbitrator further finds that timely notice of the accident was provided to the Respondent.

With regard to the Petitioner's alleged injury of August 24, 2010 (case number 12 WC 19360), the Arbitrator finds that the Petitioner failed to prove that an accident occurred which arose out of and in the course of her employment by the Respondent. The Arbitrator notes that, other than the Petitioner's testimony of increased pain while mopping, there is no evidence in the record which supports a finding that this was an "accidental injury" as opposed to a manifestation of the Petitioner's then current condition.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions relating to the issue of accident are adopted and incorporated herein.

The Petitioner testified that while she had experienced some soreness and pain in her shoulders prior to March 16, 2009, that pain was "manageable" and she only took ibuprofen for that pain. The Petitioner testified that, prior to March 16, 2010, she had not had any shoulder surgeries or recommendations for shoulder surgeries and that she was able to perform her full duty work without any restrictions. There is no evidence in the record that the Petitioner had any previous recommendations for surgery. Similarly, there is no evidence in the record that the Petitioner had any difficulty performing the duties of her employment with the Respondent prior to March 16, 2010.

Dr. Li, the Petitioner's treating physician, opined that the Petitioner's injuries caused her condition, indicating that, at the least, the injury was a permanent aggravation of her condition. While Dr. Johnson, the Respondent's examining physician, testified that he could not correlate the condition of both of the Petitioner's shoulders directly to the incident occurring on March 16, 2009, he acknowledged that the mechanism of injury described by the Petitioner could aggravate the condition for which Dr. Li performed surgery.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that there is a causal relationship between the Petitioner's March 16, 2009 injury and her condition of ill-being.

With regard to the Petitioner's alleged injury of August 24, 2010 (case number 12 WC 19360), the Arbitrator finds that the Petitioner failed to prove any condition of ill-being which is causally related to that alleged injury. The Arbitrator notes that the Petitioner merely testified to experiencing increased pain while mopping, and there was no evidence presented which indicates that the Petitioner's condition of ill-being was in any way changed by the alleged incident. Similarly, there was no medical testimony or opinion offered into the record which

indicates that the alleged injury was anything other than a continuation of the Petitioner's previous condition. The Arbitrator finds that, at most, the Petitioner's complaints on August 24, 2010 were the result of a temporary aggravation of her then existing condition.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions relating to the issues of accident and causation are adopted and incorporated herein.

The Petitioner introduced evidence of unpaid medical expenses as Petitioner's Exhibit 32. The Petitioner testified that those medical expenses were incurred as a result of the injuries she sustained on March 16, 2009.

Based on the above the Arbitrator finds that the Respondent is liable for the following charges pursuant to the Illinois Workers' Compensation Fee Schedule. Dr. Lawrence Li, $35,961.51; Ft. Jesse Imaging, $191.00; Central Illinois Orthopedic Surgery, $750.00; OSF Occupational Health, $204.46. The Respondent is entitled to a credit for any of those medical expenses that it has already paid.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions relating to the issues of accident and causation are adopted and incorporated herein.

The Petitioner claimed to be entitled to Temporary Total Disability benefits from July 21, 2009 through July 18, 2010 and from August 29, 2010 through August 19, 2014 and Maintenance benefits from August 19, 2014 through June 30, 2019. The Respondent disputed its liability for Temporary Total Disability benefits and Maintenance benefits based upon the dispute as to the issue of causation.

The Petitioner testified that, subsequent to her injury, she was taken off work by Dr. Tudtud and that she remained off work until she returned to work with restrictions on July 19, 2010. The Petitioner testified that she continued to work through August 24, 2010 when she noticed pain in her shoulders while mopping. The Petitioner testified that she has not returned to any type of work since that time and that she has not looked for any work, since that time.

The Petitioner introduced as Petitioner's Exhibit 28, a collection of off-work slips issued by her various physicians. Those slips demonstrate that Dr. Li took the Petitioner off work on July 21, 2009 and he continued her off work through July 19, 2010 when he authorized her to

return to work with restrictions. The Petitioner testified that she did return to work within those restrictions at that time. On August 10, 2010, Dr. Li released the Petitioner from his care, with the restrictions listed in the August 9, 2010 work conditioning note. The work conditioning note of that date indicates that the Petitioner could perform most of the duties of her job with the Respondent although some accommodations might be necessary. The Petitioner testified that she continued to work within her restrictions until August 24, 2010 when she stopped working due to pain in her shoulders. On August 25, 2010 the Petitioner was seen at OSF Occupational Health and her work restrictions were increased to no lifting greater than five pounds and no use of both shoulders. On August 31, 2010 the Petitioner saw Dr. Lawrence Nord who recommended symptomatic care and treatment only and indicated that the Petitioner should be limited from activities that involve overhead work along with any abduction type activities.

In order to be entitled to Temporary Total Disability benefits, it is not sufficient that the claimant merely did not work but, rather, a claimant must prove that they were unable to work. In the instant matter, there is no evidence that the Petitioner was held off work completely by any physician after July 19, 2010. The evidence indicates that the Petitioner merely stopped working after August 24, 2010 and that her work restrictions were then increased temporarily. Subsequently, Dr. Li testified that that the restrictions listed in the August 9, 2010 work conditioning note were the Petitioner's permanent restrictions. Dr. Li last saw the Petitioner on September 21, 2010.

The Arbitrator notes that there was no specific evidence presented as to whether the Petitioner sought to return to work for the Respondent within her restrictions or that the Respondent offered the Petitioner work within her restrictions. Similarly, there was no specific evidence presented as to whether the Petitioner requested vocational rehabilitation or assistance or the Respondent offered vocational rehabilitation or assistance to the Petitioner. In any case, the Petitioner testified that she did not look for any type of work after August 24, 2010. While the Petitioner did seek some additional medical treatment for her complaints after August 24, 2010, that treatment was primarily palliative and, on August 31, 2010 Dr. Nord indicated that the Petitioner needed only symptomatic care and treatment.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that, the Petitioner was entitled to Temporary Total Disability benefits from July 21, 2009 through July 18, 2010, a period of 52 weeks. The Arbitrator finds that the Petitioner failed to prove that she was entitled to any temporary benefits after July 19, 2010.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions relating to the issues of accident and causation are adopted and incorporated herein.

16IWCC0329

As a result of her work injury on March 16, 2009, the Petitioner sustained bilateral rotator cuff tears. On July 21, 2009 the Petitioner underwent a right shoulder arthroscopy with debridement of labral tears, subacromial decompression and rotator cuff repair. On October 27, 2009 the Petitioner underwent a left shoulder arthroscopy with rotator cuff repair. On February 16, 2010 the Petitioner underwent another left shoulder arthroscopy with rotator cuff repair, lysis of adhesions, debridement of scar tissue and manipulation. Following her surgeries the Petitioner underwent a course of physical therapy and then a course of work hardening. On August 9, 2010 the Petitioner was discharged from work hardening. The note of that date indicates that the Petitioner could perform most of the duties of her job with the Respondent although some accommodations might be necessary. On August 10, 2010 Dr. Li issued restrictions which were consistent with the restrictions indicated in the work conditioning progress note of August 9, 2010 and he indicated that those restrictions were permanent. The Petitioner returned to restricted work on July 19, 2010 and she continued to perform restricted work until August 24, 2010 when she stopped working due to complaints of pain. The Petitioner has not returned to any type of work since that time and she has not looked for any type of work since that time.

The Petitioner testified that she currently finds it hard to do anything due to her shoulder pain. She testified that she has difficulty mopping, doing overhead work, and lifting. She testified that she can drive with difficulty and that she has difficulty sleeping. The Petitioner testified that prior to her employment with the Respondent she held jobs as a cashier, bill collector, assembler, waitress and housekeeper. The Petitioner testified that she has not looked for any work since her employment with the Respondent ended.

The Petitioner offered the testimony of Dennis Gustafson, a certified vocational rehabilitation counselor who interviewed the Petitioner and reviewed her work history and her work restrictions as well as the job description of her job with the Respondent. Mr. Gustafson opined that the Petitioner would not meet the physical requirements of her job with the Respondent in terms of the reaching aspects and the weights involved and he ruled out the Petitioner's return to her job with the Respondent as a possibility. Mr. Gustafson opined that the Petitioner could find employment but that her earnings would be limited to the vicinity of $9.00 per hour and it would be very unlikely that she could earn more than $10.00 per hour.

The Respondent offered the testimony of Charlotte Bishop, a certified vocational rehabilitation counselor who opined that based on the Petitioner's restrictions, the Petitioner would not be able to perform her past work as a building service worker for the Respondent. Ms. Bishop further opined that the Petitioner would most likely be able to earn between minimum wage and $10.50 per hour in some suitable employment.

While the Arbitrator notes the opinions of Mr. Gustafson and Ms. Bishop, the Arbitrator finds them to be unpersuasive. In so finding, the Arbitrator notes that when the Petitioner was discharged from work conditioning on August 9, 2010, it was noted that the Petitioner could perform most of the duties of her job with the Respondent although some accommodations might be necessary. Dr. Li adopted the work restrictions indicated in the August 9, 2010 work conditioning note and indicated that the restrictions indicated in that note were the Petitioner's

16IWCC0329

permanent restrictions. The Petitioner never sought any work within those restrictions. The opinions of Mr. Gustafson and Ms. Bishop are based upon the assumption that the Petitioner cannot return to her previous work and that she is more limited in her abilities than is indicated in the August 9, 2010 work conditioning note, which Dr. Li indicated were the Petitioner's permanent restrictions. Additionally, as the Petitioner never looked for any type of work within her restrictions, the opinions of Mr. Gustafson and Ms. Bishop are too speculative to be reliable or persuasive.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that as a result of the work injury of March 16, 2009, the Petitioner sustained bilateral shoulder injuries which resulted in disability to her whole person to the extent of 40% thereof.

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

Wayne Hubbard,
Petitioner,
vs. NO: 09WC 53203

Chicago Transit Authority,
Respondent,

16IWCC0324

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 14, 2015, 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.

MAY 12 2016

DATED:
MJB/bm
o-5/9/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HUBBARD, WAYNE
Employee/Petitioner

Case# **09WC053203**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

16IWCC0324

On 10/14/2015, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0996 WILLIAM B MEYERS & ASSOC
NICHOLAS A RUBINO
100 W KINZIE SUITE 325
CHICAGO, IL 60654

0515 CHICAGO TRANSIT AUTHORITY
ARGY KOUTSIKOS
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

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

WAYMAN HUBBARD
Employee/Petitioner

Case # **09** WC **053203**

v.

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

16IWCC0324

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **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. ☒ 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 _____

16IWCC0324

FINDINGS

On **11/16/2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,574.40**; the average weekly wage was **$1,107.20**.

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

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services through its group coverage and a Section 8(j) credit is hereby awarded.

Respondent shall be given a credit of $**960.00** 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 under Section 8(j) of the Act for all reasonable and necessary medical expenses paid by its group health insurance coverage.

ORDER

Petitioner has not proven, by a preponderance of the evidence that an accident occurred which arose out of and in the course of his employment therefore, no benefits are awarded, pursuant to the Act.

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

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

Findings of Fact

16IWCC0324

The disputed issues in this matter are: 1) accident; 2) causal connection; 3) temporary total disability; and 4) the nature and extent of Petitioner's injuries. *See*, AX1.

Petitioner, who was 65 years old as of the hearing date, testified that he has been employed by the Chicago Transit Authority, ("Respondent") for 12-13 years. During his employment with Respondent, he was a bus operator, responsible for picking up and dropping off passengers on his designated routes. Petitioner testified that in November, 2009, he was assigned to the "36-Broadway" route with a start time of 3:00 or 4:00 p.m.

Petitioner testified that on November 16, 2009, at approximately 9:00 p.m., he was operating a standard bus on the 36-Broadway route when a motor vehicle pulled in front of his bus to inform him that he ran over someone at or near the intersection of Devon and Broadway. Petitioner testified that he was travelling approximately 10-20 m.p.h. when he turned off Devon and onto Broadway. He had travelled approximately two blocks to the first service stop, when the occupant of the other car stopped him. Petitioner testified that once he was advised of the accident, he stopped the bus, got off and used a cell phone to call CTA Control Center ("CTA"), which in turn dispatched Chicago Police Department personnel ("CPD") and CTA management.

Petitioner testified that he was never aware of his bus making contact with any pedestrian; never heard any noise or a scream or felt a bump, while operating the bus at or near the aforesaid intersection. He stated that there was nothing to indicate that he had run over a person. Petitioner testified that he never walked back to where the alleged contact occurred; petitioner never saw the pedestrian he allegedly struck at any time thereafter.

Petitioner testified that after he contacted Control Center, a CTA supervisor was the first to arrive at the scene and approximately 15-20 minutes later, CPD arrived. When the CTA supervisor arrived and asked Petitioner what occurred, the petitioner stated that he had picked up two passengers at the intersection of Devon and Broadway and that there was no one else at the service stop. He proceeded to turn onto Broadway when a passing motorist stopped and told him that he had run over a person at that intersection. He then passed out courtesy cards and spoke to passengers on board the bus. One young girl claimed to see a man running up along the side of the bus, knocking on the back of the bus; who then fell down.

Petitioner testified that when CPD arrived at the scene he never spoke to them but saw them looking at the back of the bus and taking pictures. He testified that that caused

him to think that he might have hit someone and he "started going into a frenzy". Petitioner felt as though "things got out of hand". He testified that he had difficulty breathing, numbness in his hand and thought he was having a stroke. Petitioner requested an ambulance. The Chicago Fire Department dispatched an ambulance and upon its arrival, Petitioner gave a history that he was anxious over possibly hurting someone. When the police came to question him, Petitioner became scared and nervous and felt his blood pressure go up so he called 911. He complained of numbness in his hands and of anxiety, although he denied any chest pain or shortness of breath. The paramedics recorded his vital signs and noted that his blood pressure as 170/108. The ambulance arrived at petitioner's location at approximately 11:19 p.m. and left for the emergency room, ("ER") at 11:33 p.m. PX1.

Petitioner was transported to St. Francis Hospital where he was treated in the ER. The chart note states that Petitioner was feeling anxious and his mind was racing after someone pulled over and told him he had hit someone with the bus. It was further recorded, that other than the symptoms caused by the event of that evening, the review of systems revealed that his recent psychiatric health included... "(+) emotional stress".

Petitioner testified that while in the ER, he heard a man moaning and screaming, but did not know where the man was situated nor did he ever see the man who was making the noise. Petitioner testified that at some point, one of the nurses came into his curtained off area and when he stated that he was a bus driver and was in the ER due to an accident, the nurse stated that another person was in the ER who had been involved in an accident with a bus. Petitioner testified that after he heard that, he became extremely nervous and scared and started crying. Petitioner testified he was discharged in the early morning on November 17, 2009. The diagnosis on discharge was that the petitioner had had a panic attack. PX2.

After he was released from the ER, Petitioner went back to his work location, i.e. the north park garage, to fill out the requisite accident reports. Petitioner completed a Miscellaneous Incident Report for an "allege bus and person incident" that occurred on November 16, 2009, at 21:25 stating that he had "no knowledge " of how the incident occurred; damage to CTA property was "none"; remarks of other parties was "none". RX3.

An Employee Interview Record was also signed by the petitioner, dated November 17, 2009, that stated in the employee's comments section: "operator reported he has no knowledge of a bus and person incident which was reported to him by an unknown

motorist that he had made contact with a male at Devon-Broadway.....Operator later req. med. H. Bld Pr"[1]

Petitioner sought additional medical treatment for what he testified to as his emotional state, i.e., being upset, nervous, withdrawn and depressed. He came under the care of Dr. Munoz, M.D., M.P.H. [2] at Work Care Occupation Medicine Center. PX3.

Petitioner treated with Dr. Munoz from November 17, 2009 to March 1, 2010. Petitioner relayed a history of driving his bus when he was told that he ran over a pedestrian. Thereafter he experienced difficulty sleeping, an inability to focus, he felt anxious, slightly depressed and at times, would break down crying. Petitioner testified that prior to the November 16, 2009 event; he never had a past history of any psychiatric care or a diagnosis of a psychiatric condition.

Dr. Munoz recorded that the petitioner's past medical history was unremarkable and during the examination, it was noted that petitioner was in no acute distress, he was cooperative, his short term memory and cognitive skills were intact, he was anxious and his effect and mood was flat. Dr. Munoz felt ..."he is anxious and depressed as well as suffering possibly from post-traumatic stress syndrome". Petitioner was taken off work, prescribed Valium and referred to Marie-Claude Riguad MD, MPH.

By November 30, 2009, Dr. Munoz recorded a history that Petitioner's episodes of crying and becoming despondent were less frequent; his mind was still recalling and reliving the incident. By December 21, 2009, Dr. Munoz suggested that Petitioner attempt regular duty; and by December 28, 2009, his return to work status was sedentary, office based duties.

Petitioner testified that he returned to work as of December 29, 2009, at the CTA garage where he was "vaulting" buses, which meant when the buses pulled into the garage, he would pull the fare box, take the money out and put it in a vault. Petitioner further testified that he was assigned to this job activity for approximately two (2) months. Thereafter he was back to driving a CTA bus. Petitioner also testified that in November, 2010, he was involved in another work-related accident that resulted in physical injuries from which he never recovered.[3]

Petitioner testified that within one (1) week after first seeing Dr. Munoz, he felt worse. He didn't want to talk to anyone and shut himself off from his family, in his bedroom.

[1] The Arbitrator understands the abbreviation to mean high blood pressure.
[2] The Arbitrator notes that the acronym MPH means "Master of Public Health".
[3] Petitioner's November 20, 2010 injury was filed as 11 WC 47928.

He testified that his reaction was brought on by the thought of being in an accident and that he had never been involved in something like that before; it made him scared and he couldn't function.

On December 2, 2009, the petitioner was evaluated, at Dr. Munoz's request, by Dr. Marie-Claude Riguad MD, MPH, who identified herself as a "consultant, workplace psychiatry", in the December 17, 2009 report that she authored. Dr. Riguad noted that: "he was unable to describe the 11-16-09 accident because according to him he neither saw or felt anything; at the alleged location he picked up two female passengers then proceeded in making a right turn and onto the next service stop when he was told that he ran over someone; he reported feeling upset when police confirmed something occurred which caused his blood pressure to rise and he was transported to the hospital; he experienced a feeling of unreality and not believing this had happened; he began to dwell on possible repercussions on CTA and on his own record; he subsequently started to feel better until two days after the event when there was an accident investigation meeting and the topic was raised [4]; ... He reports episodic crying spells and that he has been feeling "scary" about the future." PX5.

Under "medical/psychiatric/surgical data", the petitioner indicated that he was diagnosed with hypertension 7 to 10 years prior, and that it was mostly controlled with medication except for the recent blood pressure increase at the time of the accident; and there was no recording of any prior psychiatric/psychological treatment or diagnosis. Under "personal/social/familial data" petitioner described his relationship with siblings and family members as "distant" and claimed to have "been distant since (his) addiction days"; he again described his relationship to his current wife as "distant"; he characterized his relationship with social or family members as "I do not get along with anybody".
Dr. Riguad opined that the petitioner had an initial acute stress reaction that was triggered by the accident involving the bus he was driving; he continued to experience residual acute symptoms and manifestations that supported a diagnosis of moderate PTSD; some of the defects were longstanding and related to his personality features and past life experiences, but were exacerbated by the recent work-related traumatic event.

The last mental health provider Petitioner saw was Dr. Yoglackshan Kuma Ahluwalia, Chief of Psychiatry, at Mount Sinai Hospital. On January 23, 2010, Dr. Ahluwalia performed an initial evaluation and noted petitioner's history of ... "Recent stress includes accusation of having run over a person while operating CTA bus. Pt states that

[4] As recorded in the report the Arbitrator concludes the topic is referencing possible repercussions on CTA and his own record.

for which he also received immediate care. Petitioner was off work and was seen by his PCP, who at the time was Dr. Bryan Moline. Petitioner testified that he needed to be cleared by his doctor and submit a fit for duty medical form, before he could return to work. Petitioner identified Respondent's Exhibit 2, as the form related to that accident. The medical condition for which Petitioner was treated, regarding that accident, was post-traumatic stress disorder. RX2.

Respondent offered into evidence hard drive video footage of the event and what occurred after Petitioner executed his right turn onto Broadway and was stopped by a motorist. The video footage also has audio if the front door image is isolated and enlarged or if all image screens are opened on real time. When the footage is slowed down, there is no audio. RX5.

The video-audio footage admitted into evidence has seven separate vantage points, depicting activity in and outside of the bus, from 21:20 to 22:36. The following is shown/heard: At 21:21 the bus starts up from having been stopped and a man can be seen coming up from behind the bus, running in the street along the curb. The man continues to run behind the bus and gets to the rear right side of the bus, when he lifts his left arm and hits the side of the bus. He continues to run parallel with the bus' right rear side and then the man brings his right hand up and also uses it to hit the bus while in motion. At 21:21:42, the man appears to stumble and starts to fall forward, putting both hands out in front of him –when he comes to a stop, the man is on the curbside of the street on all fours. At 21:21:44-45, the bus starts into its right turn and the rear outside vantage point shows the man on all fours; a young girl who is seated in the first row seat on the right side of the bus, looks behind her and outside the bus window. At 21:21:52, the bus completes its turn onto Broadway and proceeds down the street. At 21:22:57, the bus makes a stop and a passenger boards; audio is heard of a male voice outside of the bus on the driver's side, presumably directed at the petitioner, stating that a man was hit. At 21:23:15-18, an Asian man is seen walking toward the front door of the bus where he states to Petitioner that he just ran a man under his bus and points in the direction behind the bus. The petitioner is heard saying "not under my bus" to which the man states "I behind you I saw it"-to which petitioner is heard saying "you're crazy" as the man walks away. At 21:24-21:25, petitioner beeps his horn and the Asian man walks back to the front door and boards the bus where a conversation takes place between he and Petitioner. The Asian man tells Petitioner that a man was hit by the bus and cut his leg and now he lies on curb to which petitioner asks "How did he get there? I didn't see anyone there. Are you sure it was my bus?" to which the Asian man replies that he was behind the bus and saw it and that's why he followed and stopped to let him know. At 21:25:44-45, the Asian man gets off the bus and petitioner says "Aahh I don't believe this". At 21:26:16, the petitioner gets up out of his seat and turns to the

buses are equipped with video recorders and there is no such evidence on record, however couple of witnesses have come forward confirming the accident.....Other stress includes marital problems which pt. did not elaborate on." Petitioner denied a past psychological history, medications or treatment. He was diagnosed with "MDD single episode with PTSD features."[5] Petitioner was prescribed Lexapro but discontinued its use as it made him dizzy and by early February, 2010 was prescribed Effexor which again he did not take. By April 3, 2010, the petitioner was discharged from Dr. Ahluwalia's care. PX3, 4.

The last time Petitioner was seen by Dr. Ahluwalia was on December 28, 2010, when he presented for an unscheduled appointment. The topic was the legal repercussions of being implicated in bus accident that ran over a pedestrian; Petitioner was confused and highly anxious and fearful of being sued. PX4.

Petitioner testified that at all times, he maintained that he did not believe that he struck the pedestrian, as alleged. Petitioner was able to view the video of the event, after he was contacted by a CTA attorney. Petitioner testified that he viewed the footage and it was very hard to discern or confirm that contact had been made. He requested that the video be enhanced to show close up vantages but that was not possible.

Upon cross-examination, the petitioner testified that after he viewed the hard drive footage, he felt that it was a close call as to whether contact had been made. Petitioner testified that he received a court summons and was scared at the possible legal actions that would be taken against him. When he met with the CTA attorney he was advised that he would not be sued and received something that verified that he would not be sued. Petitioner acknowledged that as a result of the November 16, 2009 incident, he was fearful of losing his job, a fear he did not have before that date.

On cross-examination, Petitioner also acknowledged that he had previously been diagnosed with high blood pressure and in fact had filed for an FMLA request, as recent as September, 2009; and he had been treating for this condition, just weeks before the incident. RX1.

Petitioner also testified about a November, 2006 incident that involved him coming to a service stop and nearly hitting a pedestrian with the bike rack, on front of the bus. Petitioner explained that at that time he had a similar episode of elevated blood pressure

[5] The Arbitrator notes that the previous diagnosis of PTSD was made by physicians who did not specialize in the discipline of psychiatry. The distinction made by Dr. Ahluwalia was that petitioner had major depression disorder with PTSD features. The Arbitrator also notes that the chart note dated 1-29-10 is the exact duplication of the chart note on 1-23-10.

16IWCC0324

Conclusions of Law

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? Did Petitioner establish a compensable psychological injury under the "mental-mental" theory of recovery?

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

Petitioner alleges a psychological disability as a result of an incident that occurred on November 16, 2009, when the bus he was operating, unbeknownst to him, may or may not have made contact with a male pedestrian.

Respondent denies that Petitioner is entitled to benefits in that the occurrence does not rise to the level of compensability in the severity of the event; i.e., Petitioner's lack of knowledge of any actual event and his persistent denial that any contact occurred with a

passengers to ask if anyone saw anything and asks to borrow a cell phone to call it in – petitioner tells the passengers "I didn't see anything-it's not my fault". At 21:27, petitioner calls the incident in to CTA and is heard conveying his exchange with the Asian man and states "I didn't feel nothing-didn't see nothing- there was no guy there-picked two ladies up-if ran over something or body should have felt a bump- no one in the street – the ladies I picked up and that's it".

At 21:33, Petitioner tells the passengers to sit tight and through conversation with the passengers, the petitioner learns that the young girl claimed to have seen a man that fell down in the location in question. Between 21:33 to 21:58, the petitioner is seen on and off the bus, interacting with passengers or just waiting; at 21:58 and at 22:04, CPD squad units pull up in front of the bus. Between 21:58 to 22:08 various CPD officers enter the bus and start conducting an investigation. They question whether the bus is an accordion bus because witnesses say that an accordion bus was involved. Petitioner advises that his is not an accordion bus, the officers advise the petitioner that the man was intoxicated and ran up to bus, banged on it and fell down to ground. Between 22:08 and 22:09, CPD officers proceed to interview the passengers on the bus while Petitioner leans over the railing. By 22:09 to 22:14, CTA personnel arrive and petitioner steps off the bus to talk and then gets back on and off again conversing. At 22:14 to 22:15, CPD gets on the bus and obtains specific bus information from petitioner; the CPD officer explains to Petitioner that it is his information that the man was extremely intoxicated and was running after the bus when he fell. At 22:19 to 22:21, a police officer advises the petitioner that according to hospital staff, the man's leg is severely damaged; that the man probably fell, injuring his leg. From 22:22 to 22:23 CPD and CTA agents look to the rear right of the bus; at 22:26 another CTA manager arrives and enters bus and starts asking questions of the passengers. From 22:27- 22:29, Petitioner gets off the bus and smokes a cigarette. At 22:30, one of the CPD squad cars leave, at 22:34 to 22:36 the last CTA manager that arrived on the scene interviews Petitioner; and at 22:35, the second squad that had pulled up in front of the bus leaves.

16IWCC0324

pedestrian, lacks the requisite sudden and severe emotional shock necessary to establish a compensable claim. Petitioner's main concern was losing his job and or any personal legal liability that would result from this incident; and this is not a sufficient cause to deem the claim compensable.

Pathfinder v. Industrial Commission, 62 Ill. 2d 556, 343 N.E. 2d 913 (1976), was the first case in which the Illinois Supreme Court allowed recovery for psychological injury in the absence of any physical trauma to the petitioner. The Court noted that the claimant suffered a "gruesome" experience and authorized recovery for a "mental-mental" injury, when the claimant suffers a "sudden, severe emotional shock, traceable to a definite time, place and cause which causes psychological injury or harm". *Id* at 563, 917.

Since *Pathfinder,* the courts have strictly adhered to the precedent of requiring a shocking event, which produces an immediate disability or injury, in order to recover for purely-psychological injury. In *General Motors Parts v. Industrial Commission,* 168 Ill. App. 3d 678, 522 N.E. 2d 1260, 119 Ill. Dec. 401 (1988), the First District concluded that *Pathfinder* does not permit recovery for every non-traumatic, psychological injury from which an employee suffers, merely because the employee can identify some work-related event which contributes in part to his/ her anxiety, stress or depression. The court in *General Motors* referred to the Pathfinder events as "horrific".

What is clear from *Pathfinder* and subsequent decisions from the First District Appellate Court is that a "gruesome, horrific" event, actually has to occur for there to be a "mental-mental" compensable claim under the Act. [6]

More recently in *Chicago Transit Authority v. Timms,* 989 N.E. 2d 608,616 (2013) the Appellate Court offered an example of the kind of "exceptionally distressing" and "uncommon" work- related experience that might support an award under *Pathfinder.* The claimant in that case, like Petitioner in the instant case, was a bus driver. The claimant Timms started up from a red light and was proceeding through an intersection when a passenger at the rear of the bus called out that someone, who had been chasing and hitting the bus, had been hit. The claimant brought the bus to a stop, exited the bus and observed saw a man lying cured up in the street with his mouth silently moving.

6. In the instant case there has been no testimony of a gruesome or horrific event as petitioner testified he did not see anything, hear anything or feel anything to suggest that he struck a pedestrian. Furthermore he never saw the pedestrian at any time after he was stopped by the motorist. See *Marvin Boyd v. CTA,* 13 IWCC 0628 wherein the Commission affirmed a denial of benefits on a mental-mental claim for a rail operator who made contact with an unauthorized person on the right of way. The rail operator heard the impact at time of contact and thought the person had been killed. He looked out his window and saw the injured person lying on the tracks but by the time he exited the train and entered the tracks he observed that same person run away from the scene.

Paramedics arrived and took the man away. The claimant remained at the scene for four hour, during which time she spoke with police officers and various CTA supervisors. Later that same evening the claimant learned the man had died. The Appellate Court held that the claimant's experience, i.e., that of striking a pedestrian and "watching the pedestrian dying on the side of the road," was "exactly" the type of experience contemplated by *Pathfinder*.

The subject incident is considerably less dramatic. Whether there was contact between the bus and the pedestrian, versus he just fell into the street, is unclear even by viewing the video footage of the event. What is clear is that Petitioner never saw the pedestrian at any time nor did he testify to having any knowledge as to the extent of the pedestrian's injuries. Moreover petitioner denied ever talking to the responding police officers at the scene and claimed to have only spoken to responding CTA personnel.

In addition, contrary to Petitioner's testimony, the video footage establishes that not only did petitioner have lengthy interaction with the investigating CPD officers, he was told that the pedestrian was intoxicated and probably fell in the street and that the injury was to his leg that was "severely damaged", which the officer went on to define as having a "deep wound". Also evident from the video footage is Petitioner's response to the claim by the motorist that he struck a pedestrian and his response to information conveyed to him by CPD. His response is not suggestive of a sudden and severe emotional shock.

The Arbitrator concludes that the reason the petitioner requested an ambulance to take him to the hospital was his elevated blood pressure, of which he has a long standing history and treatment as recent as October 1, 2009.

Furthermore the Arbitrator concludes, by review of the medical records and petitioner's testimony, that the real effect on his mental state was his concern for his job security as well as possible legal action that could be taken against him. It is clear from his testimony that in the week after the event, he started to feel worse than he did on November 17, 2009, his first visit to Dr. Munoz. That would coincide with the report from Dr. Riguad, on December 2, 2009, which noted that within two days after the event, his condition worsened after an investigation meeting into the incident, and he began to dwell on possible repercussions on his record and feeling scary about his future. Job discipline and security are not sufficient causes for recovery under a "mental-mental" theory.[7]

[7] See *Skidis v Industrial Comm'n*,309 Ill. App. 3d 720, 722 N.E. 2d 1163, 243 Ill. Dec. 94 (5th Dist. 1999) that held transfers, demotions, new responsibilities, layoff or termination are normal and expected conditions of

Petitioner's testimony that as a result of the incident, he became estranged and isolated from his family is also contrary to what he disclosed to the health providers. In the history given to Dr. Riguad, he described his relationship with siblings and family members as "distant", he claimed to have "been distant since (his) addiction days"; he again described his relationship to his current wife as "distant" and characterized his relationship with social or family members as "I do not get along with anybody".

Lastly the Arbitrator finds that contrary to petitioner's testimony that he never had a pre-existing psychological injury, he was previously diagnosed with PTSD in November, 2006 by his then treating physician, after he almost struck a pedestrian with front of his bus. Petitioner specifically denied any prior psychological history to Drs. Munoz, Rigaud and Ahluwalia. In *Bard vs. Hayward Baker Geotechnical,* 08 IL.W.C. 21829 (2012), the petitioner was found to have embellished his history and statements made to the medical providers. The Commission, in affirming the Arbitrator's decision, found that the medical opinions of Petitioner's condition of ill-being, which were based on misleading, dishonest statements, were not credible and thus held no evidentiary weight. Similarly, in the instant case, the medical opinions of Petitioner's ill-being should not be given any evidentiary weight, as they also lack credibility.

In the case at bar it is clear that Petitioner was not exposed to the kind of sudden, severe emotional shock contemplated by *Pathfinder*. The Arbitrator finds that Petitioner has not proven, by a preponderance of the evidence, that an accident occurred, which arose out of and in the course of Petitioner's employment by Respondent therefore, no benefits are awarded, pursuant to the Act.

The Arbitrator having found that Petitioner failed to prove a compensable work-related injury under a "mental-mental" theory of recovery, views the remaining disputed issues as moot and they will not be addressed.

employment life along with accompanying insecurity at work and although any of these events happening can be traumatic it does not constitute a sufficient event to bring it into the confines of *Pathfinder.*

16IWCC0324

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
09WC53203
SIGNATURE PAGE

Signature of Arbitrator

October 14, 2015
Date of Decision

OCT 14 2015

STATE OF ILLINOIS)
)
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission
Insurance Compliance Division,

Petitioner,

vs. No. 10 INC 00270

Nicholas Sanchez, Individually and as President d/b/a A & N Construction,

Respondents.

ORDER

This matter comes before the Commission as a result of non-compliance proceedings initiated against Respondents by the Commission's Insurance Compliance Division. The Insurance Compliance Division has issued to Respondents a notice of non-compliance with the mandatory insurance coverage provisions of section 4(a) of the Illinois Workers' Compensation Act (the Act) during the time period from July 20, 2005, through June 30, 2010. The matter came for hearing before Commissioner Stephen Mathis on July 15, 2015, and September 2, 2015. The Commission finds and orders as follows:

During the hearing, Abel Cruz Tapia testified that Respondents did roofing and siding work. Mr. Cruz Tapia worked for Respondents as a roofer from approximately 2001 through 2007. In the mornings, Mr. Cruz Tapia reported to Respondent Nicholas Sanchez's house at Pershing Road and California Avenue or, subsequently, his house near Rockwell Street and 38th Street. There were work trucks parked at or near the house. Neither the house nor the work trucks were marked with the name A & N Construction. However, Mr. Sanchez had business cards with the logo of A & N Construction and his cell phone number, which he gave to clients at the jobsites. Mr. Sanchez or his assistant supervised the work crew. Mr. Sanchez paid Mr. Cruz Tapia cash or with a personal check. Mr. Cruz Tapia did not receive any checks from A & N Construction, which made him think that A & N Construction was not registered with the Illinois Secretary of State. Mr. Cruz Tapia also never received a W-2 form from A & N Construction.

Mr. Cruz Tapia further testified that on June 15, 2007, he sustained significant injuries while working for Respondents when he slipped and fell off a ladder. Mr. Sanchez was present at the jobsite and suggested that Mr. Cruz Tapia see a massage therapist. Mr. Cruz Tapia ended up needing surgery. Mr. Sanchez stopped taking phone calls from Mr. Cruz Tapia and refused to pay his medical bills.

Mr. Cruz Tapia filed a workers' compensation claim against A & N Construction and the Injured Workers' Benefit Fund (the Fund), which was assigned docket number 08 WC 14193. On August 30, 2012, an arbitrator awarded workers' compensation benefits to Mr. Cruz Tapia in case No. 08 WC 14193. The arbitrator's decision was received into evidence during the hearing. The Commission's mainframe database shows the arbitrator's decision was not appealed. Mr. Cruz Tapia testified he received money from the Fund.

Nicholas Sanchez, who was represented by counsel at the hearing, admitted that Mr. Cruz Tapia used to work for A & N Construction. Mr. Sanchez denied having any ownership interest in A & N Construction. Mr. Sanchez testified the owner of A & N Construction was an individual named John Soto, and he worked for John Soto as a job supervisor. Mr. Sanchez admitted he used to live at 2741 West Pershing Road, and he used to meet workers at that location at the start of the workday. Mr. Sanchez further admitted he knew about Mr. Cruz Tapia's work accident, but did not pay workers' compensation benefits to Mr. Cruz Tapia.

Miguel Zamarripa testified on Respondents' behalf that he worked for A & N Construction in the past for eight years. Mr. Zamarripa knew Mr. Cruz Tapia from working for A & N Construction. According to Mr. Zamarripa, A & N Construction was owned by John Soto and located in Norridge. Mr. Zamarripa maintained John Soto "has always been the owner," and Mr. Sanchez was never the owner of A & N Construction.

Frank Capuzi, Chief of Investigators for the Insurance Compliance Division, testified that Mr. Cruz Tapia's attorney referred the matter to the Insurance Compliance Division. Mr. Capuzi's investigation of Respondents revealed that Mr. Sanchez lived in Burr Ridge and owned an apartment building at 2741 West Pershing Road in Chicago. Mr. Capuzi's investigation confirmed that Respondents did not carry workers' compensation insurance and were not self-insured. The Insurance Compliance Division therefore brought non-compliance proceedings against Respondents. At some point, Mr. Capuzi learned that the arbitrator's decision in case No. 08 WC 14193 was final, and the Fund paid to Mr. Cruz Tapia $42,287.97.

The Commission finds credible the testimony of Mr. Cruz Tapia that Mr. Sanchez owned and operated A & N Construction. The Commission does not find credible the testimony of Mr. Sanchez and Mr. Zamarripa to the contrary. Furthermore, in case No. 08 WC 14193 the arbitrator found that A & N Construction was operating under and subject to the Workers' Compensation Act and Mr. Sanchez was the owner of A & N Construction. Since the arbitrator's decision is final, Respondents are collaterally estopped from challenging these findings in the non-compliance proceedings. See City of Chicago v. Workers' Compensation Comm'n, 2013 IL App (1st) 121507WC ¶¶ 47-54.

The Commission finds that Respondents must reimburse the Fund in the amount of $42,287.97. Turning to the issue of penalties, section 4(d) of the Act provides, in pertinent part: "An investigator with the Illinois Workers' Compensation Commission Insurance Compliance Division may issue a citation to any employer that is not in compliance with its obligation to have workers' compensation insurance under this Act. The amount of fine shall be based on the period of time the employer was in non-compliance, but shall be no less than $500, and shall not exceed $2,500. An employer that has been issued a citation shall pay the fine to the Commission

and provide to the Commission proof that it obtained the required workers' compensation insurance within 10 days after the citation was issued." 820 ILCS 305/4(d). Section 4(d) further provides: "Upon a finding by the Commission, after reasonable notice and hearing, of *** the knowing and willful failure of an employer to comply with a citation issued by an investigator with the Illinois Workers' Compensation Commission Insurance Compliance Division, the Commission may assess a civil penalty of up to $500 per day for each day of such failure or refusal ***. The minimum penalty under this Section shall be the sum of $10,000. Each day of such failure or refusal shall constitute a separate offense." 820 ILCS 305/4(d). The penalties under section 4(d) are payable to the Fund. 820 ILCS 305/4(d).

The Attorney General seeks $135,000.00 in reimbursement to the Fund and penalties based upon knowing and willful non-compliance. Having carefully considered the totality of Respondents' conduct in this matter, the Commission grants the Attorney General's request.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondents pay to the Injured Workers' Benefit Fund the sum of $135,000.00.

Bond for the removal of this cause to the Circuit Court by Respondents 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: MAY 18 2016
d-05/05/2016
SM/sk
44

Stephen Mathis

Mario Basurto

David L. Gore

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Grady,

Petitioner,

vs. NO: 10WC 7088

Bernardi Brothers, Inc., d/b/a Sully's,

16IWCC0276

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 18, 2015, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 2 - 2016
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CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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Under the Influence

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

GRADY, JAMES
Employee/Petitioner

Case# **10WC007088**

16IWCC0276

BERNARDI BROTHERS INC D/B/A SULLY'S
Employer/Respondent

On 5/18/2015, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0980 HASSELBERG GREBE SNODGRASS
BOYD O ROBERTS
124 S W ADAMS ST SUITE 360
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

James Grady
Employee/Petitioner

v.

Bernardi Brothers, Inc. d/b/a Sully's
Employer/Respondent

Case # **10** WC **007088**

Consolidated cases: **n/a**

16IWCC0276

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Gregory Dollison, Arbitrator of the Commission, in the city of **Peoria, Illinois**, on March 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. ☐ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Approval of Prospective Medical Treatment**

FINDINGS

On the date of accident 07/06/2009, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**12,636** the average weekly wage was $**243**.

On the date of accident, Petitioner was 49 years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $0 or TTD.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $206.67 per week for 285 and 2/7 weeks commencing October 1, 2009 through March 20, 2015, as provided in Section 8(b) of this Act.

Respondent shall pay reasonable and necessary medical services of $48,158.02 as provided in Section 8(a) of the Act. Respondent shall be given a credit of $3,478.66 for medical bills that have been paid and Respondent shall hold Petitioner harmless for any claims from any providers of the services for which Respondent is receiving this credit, as provided in Section (j) of the Act.

Respondent shall authorize and pay for the functional capacity examination requested by Dr. Kube along with the surgical installation of a spinal cord stimulator if Dr. Kube finds the stimulator would be appropriate upon review of the FCE results.

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

5/16/15
Date

ICArbDec19(b)

MAY 18 2015

16IWCC0276

FINDINGS OF FACT

Petitioner, James Grady, performed food services work at restaurants, bars or bakeries for 37 years. He worked as a cook and kitchen manager for 30 years in a family business that sold out and after that, he worked at restaurants and a bakery before beginning to work in the kitchen at Respondent, Sully's Restaurant, in Galesburg, Illinois in October 2007. Grady testified that he has never had a worker's compensation claim before and did not have any back injuries or back pain prior to his July 2009 injury at work at Sully's

Grady worked as a prep cook at Sully's. He explained that his duties included working in the kitchen and as part of his job he would fill and carry a pasta kettle. On July 6, 2009, Grady filled a large pasta kettle with eight gallons of water and was carrying the pasta kettle to the stove to be heated. They would typically keep the pasta kettle on the stove all day to be used to warm up pasta. Grady testified that while carrying the pasta kettle he slipped on water on the floor and fell. Grady explained he held the kettle against his chest and was not able to protect himself as he fell backwards. Grady explained that he landed on his upper back and felt pain in his spine in his upper back right away. Grady could not get up for some period of time. Ultimately, he was able to get up off of the floor and he stayed and worked the rest of the day in the kitchen. Grady provided that he did not do any heavy lifting after his fall on the day of his injury.

Grady testified that he took the next day off work because of back pain and took another couple of days off after the injury due to having regularly scheduled days off from work. After missing a few days of work he returned to work at the kitchen and worked what he called informal light duty where his employer provided someone to help him lift and carry things in the kitchen. Grady stated that in the days following his injury, his back pain did not get better.

Ultimately, due to the ongoing pain Grady saw Dr. Weichert at Prompt Care in Galesburg on July 14, 2009. When he went to see Dr. Weichert, Grady had difficulty turning his head and reaching over his head and felt pain along the spine in the upper back. Dr. Weichert ordered x-rays of the back, prescribed medicine, placed Grady on light duty and recommended Grady use cold compresses. Grady returned to work and worked light duty and continued to treat with Dr. Weichert.

Dr. Weichert's records from July 14, 2009 note that Grady had been carrying a full kettle of water when he slipped on the floor and landed on his upper back between his shoulder blades (PX10 p. 104). Dr. Weichert's records show that Grady indicated he could not look side to side and Dr. Weichert diagnosed a thoracic contusion (PX 10 p. 104). Dr. Weichert put restrictions on Grady in regards to returning to work of no lifting, pushing/pulling over 10 pounds, no repeated lifting over 10 pounds and no work over shoulder height (PX10 p. 105). Grady returned to Dr. Weichert on July 22, 2009. The doctor prescribed medication including Vicodin and kept the same restrictions in place for work (PX10 p. 108-109). On July 30, 2009, Grady saw Dr. Weichert again and Dr. Weichert continued the work restrictions and referred Grady for physical therapy.

On August 5, 2009, Grady began treatment at Azer Physical Therapy. Azer's records show that Grady fell at work while carrying a pot of water and slipped falling backward on his back. Records from Azer Clinic show treatment from August 6, 2009 through September 9, 2009 with complaints of pain, tenderness and/or stiffness in the thoracic area. The records also show signs of improvement with the physical therapy (PX 4 p. 1-8). Grady testified that during the physical therapy he performed stretching and some exercises and they had him use a Nautilus machine. Grady explained that the Nautilus machine caused him pain in the upper spine. Grady cancelled his last appointment at the physical therapist on September 10, 2009. Grady indicated that he understood that therapy on the 10th would be work on the Nautilus machine which was not providing him help.

Grady saw Dr. Weichert on August 19, 2009. Dr. Weichert noted there was 50% improvement with the pain. However back pain was still noted and medication was continued (PX10 p. 113). As of August 19, 2009, Dr. Weichert increased the amount of weight Grady could lift at work and placed him on work restrictions with a 20 pound limit for lifting, pushing and pulling and kept a no working above shoulder height restriction (PX10 p. 114). On September 9, 2009, the last day that Grady had physical therapy in September 2009, Grady also saw Dr. Weichert who kept Grady on the same work restrictions of no lifting over 20 pounds and no work above shoulder height. Dr. Weichert also noted tenderness in the thoracic area (PX10 page 115).

On September 9, 2009 Dr. Weichert scheduled Grady to return on September 29, 2009. Grady explained that after the September 9, 2009 visit and throughout August and September, he continued to have pain in his back which did not get better. Grady testified that he had a death in his family at the end of September which caused him to miss one day of work because of the funeral and also caused him to miss the doctor appointment with Dr. Weichert. Grady stated that when he missed the day of work because of the funeral his employer was upset and told him not to come in for the rest of the week. Grady explained that from the time the injury until the end of September, Respondent had to pay another employee to help Grady lift things in the kitchen. When Grady tried to return to work after the funeral, Respondent, through Brad Bernardi the owner, told Grady that Respondent had to pay two people to do his job and Grady should get his problems resolved before coming back to work. Grady provided that his employment with Sully's was terminated. He was on light duty the last day he worked at Sully's which was around October 1, 2009.

Grady provided that during the last months of 2009 from October through December, he continued to have pain in his upper back. Grady testified he did not go back to the doctor during that timeframe in part because he was waiting to see if he would get better. Grady also explained that he received a letter from his employer's insurance dated November 18, 2009 (PX15). In the relevant part, the letter states:

> "We are the worker's compensation insurance carrier for your employer and have been providing benefits for the above injury. We understand that you have been released from medical care and that all benefits have been paid. Therefore, it appears this matter is concluded and we are now closing our file."

Grady explained that he had never had a worker's compensation claim before and he understood the letter as saying he was no longer entitled to worker's compensation benefits and/or payment for treatment. Grady explained that the receipt of this letter gave him additional reason to not seek medical treatment at the end of 2009.

In January 2010 due to the consistent back pain, Grady scheduled a visit to Dr. Weichert but was unable to see Dr. Weichert as the treatment was not approved by worker's compensation insurance. He ultimately saw the doctor in February 2010 at which time, Grady paid for the visit out of his own pocket. Dr. Weichert's record from July 6, 2009 noted the back pain from July 2009 had not gone away and that the pain was between the scapula on the spine (PX 10 page 118). Dr. Weichert's records further reflect that he diagnosed a thoracic strain and would recommend further evaluation with an MRI of the thoracic spine (PX10 page 118). On February 19, 2010, Dr. Weichert wrote a letter reiterating his opinion that Grady needed an MRI and continued Grady on the same restrictions he had been on namely no lifting, pushing or pulling over 20 pounds and no work above shoulder height (PX10 page 119).

Grady was referred to Dr. Potaczek, an orthopedic doctor at the Galesburg Clinic, by Prompt Care (PX9 p. 97). Records from Dr. Potaczek for February 22, 2011 indicate Grady injured himself at work and that he had relatively constant pain in the left interscapular area (PX 9 p. 98). Dr. Potaczek diagnosed thoracic pain on the left side (PX 9 p. 98). The doctor's records reflect issues in regards to getting the MRI paid for as of

16IWCC0276

February 2011 and apparently the doctor told Grady to talk to his attorney to see if they can pursue the MRI (PX 9 p. 98).

Grady explained that when Dr. Weichert requested an MRI the worker's compensation carrier ordered an IME with Dr. Soriano. Five months later in July 2010, Grady saw Dr. Soriano and after the Dr. Soriano visit the MRI was not approved. Dr. Soriano gave the opinion that Grady had a soft tissue injury to his thoracic spine from the fall at work that was resolved (RX1). Grady explained that the MRI was not performed while efforts were made in the worker's compensation claim to get the MRI approved including taking the depositions of Dr. Weichert and Dr. Soriano. At the end of October 2011, a 19(b) hearing was scheduled for approval of the MRI and TTD. Ultimately a pre-trial was held at which time the arbitrator recommended the MRI be obtained prior to the hearing.

On November 4, 2011, Grady returned to Dr. Potaczek requesting the MRI and the MRI was ordered (PX 9 p. 99). The MRI showed fractures of T3 and T4 (PX12 p. 177). Dr. Potaczek saw Grady again on November 11, 2011. Dr. Potaczek did not believe there was anything further he could do for Grady (PX 9 p. 101).

Dr. Weichert then referred Grady to Dr. Busse at Galesburg Orthopedic Services. Dr. Busse saw Grady on December 20, 2011 (PX 11 p. 11). Medical records show a history of back injury from a slip and fall on a wet floor while carrying a full kettle of water (PX 11 p. 45). Dr. Busse performed an examination and found Grady to be tender around the T3-T4 area to the touch (PX 11 p. 147). Dr. Busse wanted to get an MRI of the lower spine noting that there could be a referred pain situation because the previous MRI showed a healed compression fracture at the superior end plate (PX 11 p. 147). Dr. Busse reviewed the cervical MRI and noted forminal narrowing at C4 and C5 on the left and recommended a treatment of steroid injections in the neck (PX 11 p. 149). Ultimately, Grady received injections in the neck and low back. The doctor had Grady return to physical therapy at Azer Physical Therapy Clinic (PX 11 p. 152). Grady saw Dr. Busse again on April 24, 2012 at which time, Dr. Busse did not have any recommendation for further treatment (PX 11 p. 154).

Grady testified that he was still having back pain and was not getting relief from his symptoms. He spoke with a physical therapist at Azer who recommended he see Dr. Kube in Peoria. Grady saw Dr. Kube on September 11, 2012 at the Prairie Spine and Pain Institute who noted the referral from Azer Clinic (PX 13 p. 190). The doctor noted Grady had continued pain at T3 and T4 and ultimately diagnosed chronic pain due to trauma (PX 13 p. 193). Dr. Kube recommended Grady get a nerve study to determine if there was specific radiculopathy that could be causing Grady's problem (PX 13 page 194). Dr. Kube noted that the compression fractures of T3 and T4 may add up to a 30% loss of height which could cause chronic pain with this degree of collapse (PX 13 p. 194).

Grady had a consultation visit with Dr. Trudeau at the Memorial Medical Center for Neuromuscular Sciences on October 8, 2012. Dr. Trudeau performed a number of tests and ultimately identified denervation changes in the left T3-T4 inner space region thoracic paraspinals consistent with irritability and distribution of the dorsal primary ramus of the left T3 spinal nerve root. The doctor also noted a clinical presentation compatible with left T3 thoracic radiculopathy (PX 6 p. 53).

Grady returned to Dr. Kube on November 13, 2012 and after reviewing the report of Dr. Trudeau and meeting with Grady, Dr. Kube noted that he suspected Grady injured the nerve root at the time of the trauma and continued to have chronic pain from this (PX 13 p. 215). Dr. Kube kept the diagnosis of chronic pain due to trauma and noted he would like to move Grady into the chronic pain management program and that Grady may be a candidate for a spinal cord stimulator in the future (PX 13 p. 216). At that time, Dr. Kube wanted to schedule Grady for a work and exercise conditioning program to follow up with the functional capacity evaluation (PX 13 p. 216).

161WCC0276

Per Grady, he could not get approval for the work hardening or the conditioning but continued to have significant back pain. Grady saw Dr. Kube again on October 15, 2013 who noted that Grady still had the same problems and that he had not had any luck getting authorization for any of the therapy recommended (PX 13 p. 240). Dr. Kube further noted that Grady had pain that was fairly classic for the thoracic spine injury he had with the fracture in the upper thoracic spine and signs of radiculopathy into the rib cage region (PX 13 p. 240). At that time, Dr. Kube continued to recommend chronic pain management including a spinal cord stimulator and getting Grady set up for some kind of physical therapy program for conditioning and at least a functional capacity evaluation to determine what can and cannot be done (PX 13 p. 240).

Grady testified that he would have obtained an MRI sooner if it was approved sooner. Grady testified he would have gotten the stimulator if it had been approved by worker's compensation. Grady noted that the delays in his treatment were due in large part to waiting for approval of treatment and/or waiting for depositions of doctors or IMEs to be done.

Grady was directed to go to an IME with Dr. O'Leary after the deposition of Dr. Kube had been taken. After the IME, Grady had to wait until the deposition of O'Leary was taken. The matter was delayed further for the taking of deposition of Dr. Trudeau. Similarly, after Dr. Weichert recommended the MRI, Grady's treatment was delayed while Grady had to go see Dr. Soriano for an IME. After the IME of Dr. Soriano, depositions had to be taken and there was several months of delay before the taking of the deposition of Dr. Soriano.

Grady testified that he still has constant pain between his shoulder blades and his back. Grady stated he could not do his job at Sully's now. He cannot stand for a long period of time and he has trouble lifting and/or or reaching due to pain. The pain is constant and makes it hard for him to concentrate.

EVIDENCE DEPOSITION OF DR. WEICHERT

On November 9, 2010 Dr. Weichert was deposed in this matter (PX 1 p.1). Dr. Weichert is a family practice physician who works in an urgent care facility and had been a primary care physician for about 21 years (PX 1 p. 3). Dr. Weichert saw Grady on July 14, 2009 at which time Grady told Dr. Weichert that he had fallen and landed square on his back and felt pain between his shoulder blades and had trouble moving his neck and upper extremities (PX 1 p. 5). Dr. Weichert performed a physical examination and noted Grady was remarkable for tenderness, slight swelling and tight musculature in the left paraspinal and medial trapezius area (PX 1 p. 6). Dr. Weichert initially diagnosed a thoracic contusion and gave Grady pain and muscle relaxant medications and directed Grady to ice the area (PX 1 p. 6-7). Dr. Weichert imposed weight restrictions on Grady including no lifting, pushing or pulling over 10 pounds and no work above shoulder height (PX 1 p. 7).

Grady returned on July 22, 2009 and upon examination, Dr. Weichert found Grady tender on both sides of the paraspinal musculature and the trapezius area and diagnosed a thoracic strain and contusion (PX 1 p. 8). At this point, Dr. Weichert also recommended physical therapy (PX 1 p. 9). Dr. Weichert saw Grady again on September 9, 2009. An examination on that date also noted tenderness to the paraspinal musculature around the thoracic spine (PX 1 p. 10). Dr. Weichert confirmed that as of September 9, 2009 he placed Grady on a 20 pound weight restriction (PX 1 p. 11). Dr. Weichert noted that Grady came to Dr. Weichert's office in January 2010 but there was some issue in regards to Grady actually having the visit covered under worker's compensation. Ultimately, Dr. Weichert could not see Grady in January and did not see Grady until February 2010 (PX 1 p. 11-12).

When Dr. Weichert saw Grady on February 10, 2010, he had pain between the shoulder blades which was the same area that Grady complained about when Dr. Weichert treated Grady in July, August and September of 2009 (PX 9 p. 12). Dr. Weichert found in February 2010 Grady to be tender mostly on the left

16IWCC0276

paraspinal trapezius musculature (PX 1 p. 13). As of February 2010 Dr. Weichert recommended an MRI of the thoracic spine. Dr. Weichert was considering other causes of the pain including nerve compression syndrome and occult bony injury (PX 1 p. 13-14). As of February 2010, Dr. Weichert kept Grady on the 20 pound weight restriction and restrictions on lifting above the shoulder (PX 1 p. 14).

Dr. Weichert saw Grady again on November 4, 2010 noting that Grady was point tender over the thoracic vertebrae (PX 1 p. 15). Dr. Weichert reiterated his recommendation for the MRI of the thoracic spine and wrote a prescription for Vicodin (PX 1 p. 15). Dr. Weichert gave the opinion that Grady's injury to his thoracic spine was related to his fall at work in July 2009 (PX 1 p. 15-16). Dr. Weichert further testified that it would be appropriate for Grady to have an MRI to look further into what the problem is with the thoracic area (PX 1 p. 16). Dr. Weichert noted he reviewed an IME report that had been prepared by Dr. Soriano. Dr. Weichert did not see anything in the IME report that changed his opinion in regards to the appropriateness of the MRI (PX 1 p. 17).

DR. KUBE DEPOSITION

Dr. Kube is a spine surgeon and was deposed in the matter on January 31, 2014 (PX 2 p. 1-4). Dr. Kube explained that Grady's MRI showed wedging of the T3 and T4 vertebral bodies (PX 2 p. 7-8). Dr. Kube explained that this wedging of the vertebrae can cause discomfort based upon the vertebrae's collapse which would result in the nerve roots being pinched (PX 2 p. 10). Dr. Kube noted that Grady reported he had slipped and fallen on his back and that type of fall could cause the type of trauma evidenced by the compression fractures (PX 2 p. 12-13). Dr. Kube testified that the fall in July of 2009 caused the compression fractures (PX 2 p. 13). When Dr. Kube saw Grady in September 2012 he performed an exam and noted pain toward the left side in the upper thoracic area (PX 2 p. 17). Dr. Kube noted that the area where he found pain was the same area where the fracture occurred (PX 2 p. 17-18). Dr. Kube initially diagnosed T3 and T4 fractures and noted that Grady was dealing with chronic pain secondary to the trauma (PX 2 p. 18). Dr. Kube determined that Grady should get a nerve study and referred Grady to Dr. Trudeau (PX 2 p. 19).

Dr. Kube noted that Dr. Trudeau found left T3 thoracic radiculopathy (PX 2 p. 19-20). Dr. Kube noted that the findings of Dr. Trudeau were consistent with the complaints provided by Grady (PX 2 p. 20). After reviewing Dr. Trudeau's consultation report along with the diagnostic studies, Dr. Kube talked to Grady about a dorsal column stimulator to help relieve the pain (PX 2 p. 21). Dr. Kube explained that after the September 11, 2012 visit, he placed Grady on sedentary work activity with limited lifting of up to 10 pounds (PX 2 p. 22). Dr. Kube explained that the spinal cord stimulator was an implant that goes into the spinal canal and creates a stimulation effect in the area of the sensory nerves and the stimulator provides sensory overload that drowns out the pain (PX 2 page 27-28). Dr. Kube also kept Grady off of work when he saw him on November 13, 2012 (PX 2 p. 2-20). Dr. Kube noted that as of the date of his deposition he still had the same recommendations for Grady as he did back in 2012 which was that Grady should get a functional capacity evaluation and that short of doing a pain stimulator, Grady was roughly at MMI (PX 2 p. 31). Dr. Kube stated that the next appropriate step for treatment for Grady would be to do the functional capacity evaluation and then if Grady desired a spinal cord stimulator trial then Dr. Kube would go ahead with the spinal cord stimulator trial (PX 2 p. 35). Dr. Kube explained that during the entire time he has treated Grady, he would have Grady on sedentary restriction with the exception of taking him off sedentary to do work conditioning if a work conditioning program were approved (PX 2 p. 38).

On cross examination the defense counsel asked Dr. Kube whether Dr. Weichert's note of no tenderness at T3 and T4 and only tenderness T5-T6 would suggest there was no compression fracture at T3 or T4 when Dr. Weichert saw Grady. Dr. Kube explained that T5 and T6 are close to the same area and he did not think that most people would say that if they are palpating in that area that they could pinpoint within a vertebral body (PX 2 p. 52-53). Dr. Kube was pressed about breaks in treatment and/or the failure to get an FCE and Dr. Kube

16IWCC0278

explained that he understood that Grady had been wanting to get an FCE but such treatment had not been authorized and so he would not qualify that as Grady voluntarily quitting treatment (PX 2 p. 57-58). Dr. Kube explained that while he recommended work conditioning, the treatment had not been taken up because it had not been authorized (PX 2 p. 58). Dr. Kube explained that the nerve issue that Grady was having probably happened as a result of the fracture (PX 2 p. 66). Dr. Kube agreed that as of the date of the deposition, January 31, 2014, Grady would be able to do sedentary light duty work (PX 2 p. 70). Dr. Kube explained that if the breaks in treatment that Grady had were related to issues with getting authorization for treatment, the breaks in treatment for Grady would not affect his opinion (PX 2 p. 76-77).

Dr. Kube reviewed Dr. Weichert's notes from July 2009 and noted that the pain reflected in the records was upper thoracic which was the same area that he was treating Grady (PX 2 p. 78-79). When asked whether the fact the initial x-rays of the thoracic spine did not show a fracture affected his opinion, Dr. Kube explained that medical literature suggests that 47% of compression fractures are not identifiable in x-rays and are in fact missed but caught with a CT scan or MRI (PX 2 p. 80). Dr. Kube further explained that the ability to identify fractures in the upper thoracic area is further complicated by other structures in the body (PX 2 p. 81). Dr. Kube explained that the denervation identified in the records means there is some fibers of the nerve that are damaged (PX 2 p. 82). Dr. Kube explained that Dr. Trudeau's nerve studies are objective findings of injury (PX 2 p. 83). Dr. Kube further stated that the objective findings in the nerve test were consistent with his clinical observations and matched up specifically with the fracture zone (PX 2 p. 83). Dr. Kube further explained that Grady's bones healed but they healed in an abnormal position and/or abnormal shape which was a malunion (PX 2 p. 83).

DR. TRUDEAU DEPOSITION

Dr. Turdeau was deposed in this case on December 18, 2014. Trudeau is the Director of Physiatry Services at Memorial Medical Center (PX 3 p. 4). Dr. Trudeau performed testing on Grady on October 8, 2012 (PX 3 p. 6). Dr. Trudeau performed an examination and found tenderness in the middle of Grady's upper back (PX 3 p. 15). Dr. Trudeau performed electrical impulse testing of the muscles in Grady's body and noted that the muscles in the arms and neck looked good but there were problems in the T3 and T4 area (PX 3 p. 22). Dr. Trudeau explained that the testing revealed denervation changes in the left upper thoracic paraspinal adjacent to the T3 – T4 inner spaces (PX 3 p. 23). Dr. Trudeau noted that his report showed irritability in the distribution of the dorsal primary ramus of the left T3 spinal nerve root (PX 3 p. 30). Dr. Trudeau explained that the dorsal primary ramus is a muscle right beside T3 –T4 (PX 3 p. 30). Dr. Trudeau explained that based upon the way the nerves branch out away from the spinal cord, the findings were consistent with there being a problem at T3 (PX 3 p. 32). Dr. Trudeau explained that the studies showed that there was a nerve that's irritated (PX 3 p. 33). Dr. Trudeau explained that thoracic root irritations are pretty rare and the only time he sees something like thoracic radiculopathy would be from a compression fracture with the exception of diabetes (PX 3 p. 54-55).

DR. O'LEARY DEPOSITION

Dr. O'Leary was deposed on June 24, 2014 (RX 4). He examined Grady on April 17, 2014. Dr. O'Leary is a board certified orthopedic surgeon who specializes in the care and surgery of the spine. (RX 4 p. 5) Dr. O'Leary reviewed records from Dr. Weichert, Dr. Bussey, Dr. Kube, along with depositions from Dr. Kube, Dr. Soriano, and the EMG from Dr. Trudeau. He also reviewed the actual MRI film of Grady's thoracic spine. (RX 4 p. 6-7)

Dr. O'Leary provided that the records suggest that the pain between Grady's shoulder blades is not related to his thoracic spine according to Dr. Bussey. He noted Dr. Bussey believed that Grady may have referred pain from his neck. (RX 4 p. 12) He had an MRI of the cervical spine on December 27, 2011 which showed degenerative disease in his cervical spine. He then underwent epidural steroid

16IWCC0276

injection in the C7-T1 and L4-L5 regions. (RX 4p. 12) Dr. Bussey believed Grady's pain is from the C4-C5 area and not from the thoracic region. (RX 4 p. 12-13)

Dr. O'Leary performed a physical exam on April 17, 2014. The exam was a benign exam. Petitioner had a little bit of tenderness in his upper thoracic spine. Dr. O'Leary finds it exceedingly difficult to pin point one area on the spine and say it's exactly at T4. He did not see any muscle spasm, no tenderness in the upper part of his thoracic spine, or middle to lower. There was just one area with pinpoint tenderness between his shoulder blades. (RX 4 p. 17)

Dr. O'Leary felt Grady's MRI showed in determinant compression fractures at T3-T4 with 20-25% loss of anterior vertebral body height. (RX 4 p. 21) He also showed mild spondylosis and mild degenerative changes at C5-C6 and C6-C7.

Dr. O'Leary reviewed Dr. Trudeau's report. Dr. Trudeau found a specific needle evidence of a T3 radiculopathy on the left. Dr. O'Leary has never encountered a patient that has had radiculopathy at that level that's been detected by an EMG. (RX 4 p. 21-22) Dr. O'Leary would not have ordered the EMG as he only orders EMG's when the patients have radicular complaints or nerve root complaints. He indicated Grady did not demonstrate any radicular or nerve root complaints. (RX 4 p. 22) There was no indication in any of Grady's medical records other than in Dr. Trudeau's report indicating Grady was having any thoracic radiculopathy pain which would be underneath the shoulder and under the armpit and towards the interior chest wall. (RX 4 p. 22-23)

Dr. O'Leary diagnosed Grady with thoracic pain. This diagnosis is based on the subjective complaints of pain. Dr. O'Leary found nothing objective on exam. The only objective findings are the T3-T4 compression fractures healed on MRI. (RX 4 p. 26)

Dr. O'Leary testified that it typically takes 8-12 weeks for a compression fracture to heal. They typically return to work within 4 months. He recommends that Grady return to work and would have placed him at MMI approximately 4 months after his injury. (RX 4 p. 31) Dr. O'Leary believes that Grady's current condition of ill-being is no longer causally connected to his accident of July 2009. He long ago reached a healing plateau in terms of clinical findings. (RX 4 pg. 33)

Dr. O'Leary thinks that it's reasonable to consider some therapy for Grady, but that it's not related to his work accident. He also does not think there is a role for dorsal column stimulator in this case. Specifically, indicating Grady has not responded to normal measures of treatment without any real clinical findings to suggest that there is a benefit to the use of a dorsal column stimulator. (RX 4 pg. 35)

Dr. O'Leary confirmed that the MRI showed a fracture at T3 and T4 (RX 4 p. 45). Dr. O'Leary stated he did a physical examination on Grady that did elicit pain upon examination between the shoulder blades (RX 4 p. 45). Dr. O'Leary agreed that the area where the pain was elicited is generally in the neighborhood of T3 or T4 (RX 4 p. 45-46). Dr. O'Leary agreed that upon reviewing the MRI there was probably a loss of 20-25% of the vertebral height in the front of the vertebrae (RX 4 p. 45). Dr. O'Leary also agreed that a slip and fall could cause a compression fracture in the T-3 – T-4 area (RX 4 p. 46). Dr. O'Leary agreed that in his review of records he was not provided any records indicating Grady had pain in the T3 or T4 area before the fall (RX 4 p. 46). Dr. O'Leary agreed that generally nerve study tests such as an EMG are considered to be objective tests (RX 4 p. 48).

Dr. O'Leary had an issue as to whether Dr. Trudeau could be certain that the nerve test was conducted at T-3 (RX 4 p. 55). Dr. O'Leary explained that nerve irritation as identified in the EMG test is typically caused by some kind of either traction injury or stretch injury something you cannot see on an MRI (RX 4 p. 55-56).

16IWCC0276

Dr. O'Leary agreed that it's theoretically possible that the flexion of the neck that would be related to a fall would stretch the nerves in the area of T3-T4 (RX 4 p. 61-62).

Dr. O'Leary did not have an opinion as to what caused the nerve issue that is identified in the EMG test of Dr. Trudeau (RX 4 p. 63). Dr. O'Leary agreed that he recommends dorsal column stimulators and that the stimulators are used to treat patients with chronic pain (RX 4 p. 64). Dr. O'Leary agreed that the stimulators electronically alter the signals in the nerves to try to alleviate pain (RX 4 p. 64). Dr. O'Leary did not have any experience of placing stimulators in the thoracic region (RX 4 p. 69). Dr. O'Leary did not doubt that Grady was in pain when he saw Grady (RX 4 p. 73-74). Dr. O'Leary also testified that it would not be unusual for someone to have pain following a compression fracture on a permanent basis (RX 4 p. 74). Dr. O'Leary did not believe that a dorsal column stimulator was the reasonable treatment plan for Grady (RX 4 p. 76).

DR. SORIANO DEPOSITION

Dr. Soriano was deposed on March 29, 2011. Dr. Soriano did not believe there was evidence of a fracture in Grady (RX 2 p. 18). (Soriano was deposed when Petitioner was seeking approval for the MRI and before the fracture was found in the MRI.) Dr. Soriano conceded that Grady had complaints of pain around the middle of his back or his thoracic spine upon examination (RX 2 p. 24). Dr. Soriano did not believe Grady suffered from nerve impingement or any type of fracture (RX 2 p. 34).

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

The Arbitrator finds that Petitioner's current condition of ill being in his back is causally connected to the accident on July 6, 2009. Grady fell on his back while carrying a pot with 8 gallons of water and broke two vertebrae. Petitioner was in a state of good health prior to July 6, 2009 and did not have any complaints of back pain prior to the work injury. After the injury he has required extensive treatment for his back. Dr. Kube and Dr. Weichert, both treating doctors, relate the back injury to the fall.

From the time of his injury until the present he has been kept off of work by his medical providers,. Grady has had pain in the middle of his back in the same location since his first visit with Dr. Weichert. Grady's treatment has been delayed due to IMEs and depositions and the lack of authorization for treatment. When an MRI was ultimately taken, it confirmed there was an injury in his upper back and specifically found compression factures at T3 and T4. The ongoing pain and problems Grady continues to experience has been explained and/or confirmed by objective tests performed by Dr. Trudeau who found signs of nerve damage in the area of the fracture.

Dr. Soriano's testimony that there is no objective finding of injury and/or anything beyond soft tissue injury is undermined by the MRI taken after his examination and deposition which confirmed compression fractures at both T3 and T4. This was further undermined by the testing of Dr. Trudeau which showed nerve damage. Dr. O'Leary confirmed that Grady was still in pain as of the date of his examination of Grady which further supports a finding that the injury and pain is ongoing. The consistent location of pain between his shoulder blades in his back further supports a finding that his current problem is causally related to the fall.

Therefore, the Arbitrator finds that the current condition of Petitioners back is causally related to the July 6, 2009 work accident.

WITH RESPECT TO (J) RESPONDENT'S LIABILITY FOR UNPAID MEDICAL BILLS (J) THE ARBITRATOR FINDS AS FOLLOWS:

16IWCC0276

There is no dispute in this matter that Petitioner sustained an accident that rose out of and in the course of his employment in July 2009. Furthermore, as found above the current condition of ill being in Petitioner's back is causally related to that accident.

The Arbitrator notes that Respondent in this case offers no evidence of testimony to dispute the reasonableness or necessity of Petitioner's medical treatment other than Dr. Soriano's testimony which is undermined by the diagnostic tests performed after his examination. After reviewing all the evidence and testimony in this matter, the Arbitrator hereby finds that Petitioner's back treatment to date has been reasonable and necessary to cure his conditions of ill being and hereby Respondent to pay all reasonable and medical costs as reflected in Petitioner's Exhibit 14, to the extent required by the fee schedule. The total medical bills incurred are $48,158.02 (See PX 14) and Respondent should be given credit for $3,478.66.

WITH RESPECT TO (L) WHAT TEMPORARY TOTAL DISABILITY BENEFITS ARE DUE, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner was on light duty on October 2, 2009 when he was fired from Sully's. Grady has continued to be held off work by his medical providers due to the ongoing pain in his back and is currently waiting for treatment and/or authorization for treatment to resolve such pain. Under the existing facts referenced above, the Arbitrator finds the Petitioner is entitled to TTD from October 1, 2009 through the date of the arbitration hearing, a period of 285-2/7 weeks.

WITH RESPECT TO (O) PROSPECTIVE MEDICAL TREATMENT (O), THE ARBITRATOR FINDS AS FOLLOWS:

Dr. Kube recommends an FCE as a prerequisite for pursuing a spinal cord stimulator implant. Dr. Kube has explained that Grady is suffering from chronic nerve pain and that the spinal cord stimulator will provide relief for the nerve pain. Dr. O'Leary gave an opinion that he did not believe that the spinal cord stimulator would be appropriate although he agrees that they are used for helping people with chronic nerve pain. Dr. O'Leary does not have any experience using a spinal stimulator in the thoracic region.

Under the circumstances, the Arbitrator finds that the treatment requested by Dr. Kube should be approved and Respondent shall authorize the functional capacity evaluation and spinal cord stimulation implant assuming the FCE supports the same.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria G. Gonzalez,

Petitioner,

16IWCC0325

vs.

NO: 10 WC 13822

Harrison Limited Partenership D/B/A
Howard Johnson Inn,

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 medical expenses, temporary total disabiliy, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 3, 2015, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 13 2016
KWL/vf
O-5/9/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0325

GONZALEZ, MARIA G
Employee/Petitioner

Case# 10WC013822

HARRISON LIMITED PARTNERSHIP D/B/A HOWARD JOHNSON INN
Employer/Respondent

On 3/3/2015, 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 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0243 JAMES ELLIS GUMBINER & ASSOC
LILIA PICAZO
180 N MICHIGAN AVE SUITE 2100
CHICAGO, IL 60601

1596 MEACHUM STARCK BOYLE ET AL
MICHAEL SPINAZZOLA
225 W WASHINGTON ST SUITE 500
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

16IWCC0325

Case # 10 WC 13822

Maria G. Gonzalez
Employee/Petitioner

v.

Harrison Limited Partnership, d/b/a Howard Johnson Inn
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 **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **November 12, 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. X Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. X What temporary benefits are in dispute?
☐ TPD ☐ Maintenance X TTD
L. X What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **March 26, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 to the extent set forth below.

In the year preceding the injury, Petitioner earned $**18,941.00**; the average weekly wage was $**364.25.**

On the date of accident, Petitioner was **41** years of age, ***married*** with **4** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services related to this accident.

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

Respondent shall be given a credit of $**5,723.85** for TTD, $**0** for TPD, $**0** for maintenance, and $**1,281.65** for other benefits, for a total credit of $**7,005.50.**

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 **$320.00** per week for **24-3/7 weeks,** commencing **4/5/2010** through **9/22/2010** as provided in § 8(b) of the Act. Respondent is entitled to a credit of **$7,005.50** for benefits paid as set forth above.

Respondent shall pay Petitioner permanent partial disability benefits of **$320.00** per week for **10 weeks**, because the injuries sustained caused the **2% loss of use of the person as a whole**, as provided in **§ 8(d) 1** of the Act.

Respondent shall pay Petitioner all compensation that has accrued from 3/26/2010 through 11/12/2014, and shall pay the remainder of the award, if any, in weekly benefits.

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

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

Signature of Arbitrator

March 2, 2015
Date

MAR 3 - 2015

FINDINGS OF FACT

The Application for Adjustment of Claim was amended to name the Respondent as "Harrison Limited Partnership, d/b/a Howard Johnson Inn". An Order allowing same is being entered contemporaneously with this Decision.

Petitioner testified via an interpreter.

Petitioner was employed by Respondent as a housekeeper for 6 to 8 years. Her job duties included cleaning rooms, bathrooms, fixing beds and moving furniture.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on March 26, 2010. She was moving bed bases to clean under the beds. After she did about 6 rooms, she noticed that she could not walk straight and had a lot of pain in her lower back. She had pain of an 8/9 level. She reported this to her supervisor, Jose Romero. Romero told Petitioner to rest for a couple of days.

The first medical treatment was at Stroger Hospital on March 30, 2010. Handwritten physician's notes seem to indicate an 8 day history of back pain "patient is a housekeeper and was cleaning and developed pain." Typed notes reveal a history of "lower back pain for 8 days, no injury." The work up was for back pain-muscular vs. bladder. Urinalysis was negative. She was given medication "for an inflamed back". (PetEx. 5)

The next medical treatment was at Marque Medicos, beginning April 5, 2010. Petitioner presented with a history of low back and leg pain (diagnosis: lumbago) after lifting many mattresses at work and experiencing intense pain in her low back. Petitioner underwent therapy and was prescribed medication. The therapy helped. Petitioner had an MRI and an EMG/NCV test. The EMG/NCV was negative/normal. The MRI showed a left paracentral disc protrusion at L5/S1 and a bulging disc at L4/L5. Petitioner was released to full duty work and released from care by Dr. Engel on September 22, 2010. She had no pain complaints on that date and full range of motion, with negative straight leg raising, full equal strength and equal patellar and Achilles reflexes. Dr. Engel thought that work conditioning was very important in getting Petitioner back to full duty and pain-free work. (PetEx. 1)

Petitioner had work conditioning at Elite Physical Therapy from July 12, 2010 through September 21, 2010. (PetEx. 6)

Petitioner was seen by Dr. Singh for an IME at the request of Respondent on September 8, 2010. Dr. Singh thought that Petitioner had sustained a temporary aggravation of L5/S1 degenerative disc disease as a result of the March 26, 2010 incident at work. Petitioner could return to work at full duty. She was at MMI and did not require work conditioning. The disc pathology was on the left at L5/S1 and this was not consistent with Petitioner's right sided complaints. (ResEx. 1)

Petitioner returned to work for Respondent after being released by Dr. Engel and worked for Respondent until January of 2011, when she had the C-Section delivery of her fifth child. She was off work due to the C-Section through late April of 2011. She returned to work at Respondent on April 30, 2011 and worked for two more days.

On May 2, 2011, Petitioner injured her low back and left shoulder lifting a mattress. She has not returned to work since. She is still under treatment for the 2011 injury. Treatment was at Marque Medicos and Medicos

Pain and Surgical Specialists. It was charted that Petitioner did not have low back pain since the cessation of her prior treatment, until the new injury. A new MRI, of May 10, 2011, showed bulging discs at L4/L5 and L5/S1 with interval resolution of the left paracentral protrusion at L5/S1. (PetExs. 2, 3, & 4)

Petitioner was examined by Dr. Singh at Respondent's request again on February 3, 2014. Dr. Singh thought that Petitioner had subjective complaints that could not be objectified. He did not think that the current back pain complaints were related to the injury of March 26, 2010.

Petitioner testified that, currently, her back hurts. She has decreased her activities a lot. She has difficulty bending. She did not have back problems before March 26, 2010.

The Parties agreed that all bills incurred prior to September 22, 2010 had been paid.

CONCLUSIONS OF LAW

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

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

Based upon the testimony of Petitioner and the medical records, including the reports of Dr. Singh, the Arbitrator finds that Petitioner has proven a causal connection between the injury of March 26, 2010 and her condition of ill-being with respect to her low back (aggravation of degenerative disc disease with negative EMG/NCV results and MRI findings that have improved subsequent to a new injury of May 2, 2011). Any further condition of ill-being documented after September 22, 2010 is not causally related to the March 26, 2010 accidental injuries.

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

Based upon the stipulation of the Parties, all bills incurred prior to September 22, 2010 have been paid. Any bills incurred after September 22, 2010 are not causally related to the March 26, 2010 accident for the reasons set forth above and are denied.

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

Petitioner is entitled to TTD from April 5, 2010 (the date that she was first taken off work by Marque Medicos) through September 22, 2010 (the date that she was released to full duty work by Dr. Engel), a period of 24-3/7

weeks. No TTD subsequent to September 22, 2010 is awarded, based upon the finding regarding causal connection set forth above. Petitioner's TTD rate is $320.00.

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

Based upon the testimony of Petitioner and the medical records and considering the Arbitrator's finding above with respect to causal connection, the Arbitrator finds that the injuries sustained on March 26, 2010 caused permanent partial disability to the person as a whole to the extent of 2% thereof. Petitioner's PPD rate is $320.00.

The nature and extent of any injuries sustained on May 2, 2011 is not the subject of this case.

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

Olubayo Okunola Deceased
& Helen Okunola,
Petitioner,

vs.

NO: 10 WC 21225

Jackson Park Hospital,
Respondent,

16IWCC0356

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 27, 2014 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: MAY 26 2016

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Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OKUNOLA, OLUBAYO
Employee/Petitioner

Case# **10WC021225**

06WC020336

16IWCC0356

JACKSON PARK HOSPITAL
Employer/Respondent

On 1/27/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5271 LEADERS LAW CENTER
OINOLABI ALABA
407 S DEARBORN ST SUITE 407
CHICAGO, IL 60605

4027 ODELSON & STERK LTD
MATT DALEY
3318 W 95TH ST
EVERGREEN PARK, IL 60805

OLUBAYO OKUNOLA, DECEASED
06 WC 30336
10 WC 21225

16IWCC0356

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

Helen Okunola, Widow
Employee/Petitioner

v.

Jackson Park Hospital
Employer/Respondent

Case # 10 WC 21225

Consolidated cases: 06 WC 20336

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Lynette Thompson-Smith, Arbitrator of the Commission, in the city of **Chicago**, on **October 30, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0356

FINDINGS

On July 20, 2004, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**49,920.00** average weekly wage was **$960.00.**

On the date of accident, Petitioner was 54 years of age, ***married*** with 0 dependent children.

Petitioner has received all reasonable and necessary medical services.

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

ORDER

The petitioner has not proven, by a preponderance of the evidence, that an accident arose out of in the course of his employment therefore no benefits are awarded, pursuant to the Act.

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

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

16IWCC0356

FINDINGS OF FACT

The disputed issues in these cases are: 1) accident; 2) causal connection; 3) were medical services necessary; 4) temporary benefits; 5) nature and extent of the injury; 6) penalties; 7) death benefits; and 8) attorney's fees.

On July 20, 2004, it is alleged by petitioner and members of the petitioner's family, that he suffered a work injury due to a fall at work and subsequently died on July 23, 2010, because of this fall. Four (4) witnesses testified on behalf of the petitioner, at trial.

Testimony of Samuel Okunola

Mr. Samuel Okunola is one of the petitioner's sons and is 29 years old. Samuel testified that he learned of his father's fall at work from his mother, Helen, while he was stationed on South Korea. He did not speak directly to his father until approximately August 5, 2004. Samuel testified, over Respondent's objection, that the petitioner told him that he was delivering meds, working on a patient's chart. He was leaning on the cart and fell, hitting the back of his neck. Samuel testified that he saw his father for the first time approximately one (1) year later and that the petitioner had lost a lot of weight, had stability issues and could not speak properly. *See*, Tr. pgs. 22-24.

Testimony of David Okunola

Mr. David Okunola is the petitioner's 31-year-old eldest son. David testified that he was living with his father at the time of the alleged accident on July 20, 2004 and that the petitioner told him of the fall at work the night of July 20, 2004. David testified that his father told him that he was working on a patient's file while leaning on the cart, and the cart gave way, which led him to fall on his buttocks; hitting the back of his neck against the cart. David further testified that following the July 20, 2004 fall, his father's condition deteriorated. David also testified that prior to July 20, 2004, the petitioner did not have instability problems and that to his knowledge, his father had never passed out. *See,* Tr. Pgs. 38-45.

Testimony of Ezekiel Okunola

Mr. Ezekiel Okunola is the petitioner's 26-year-old son. Ezekiel testified that he learned of the petitioner's incident on the night of July 20, 2004. Ezekiel testified that the petitioner told him that he was working on a patient's chart and while working with medications and patient's files; the cart he was working on gave way. That his father fell landing on his buttocks and he hit the back of his neck on the cart. Ezekiel further testified that the petitioner told him he did not faint prior to the fall. Ezekiel further testified that the petitioner never had instability problems prior to July 20, 2004.

16IWCC0356

Ezekiel then testified that after the July 20, 2004 incident, the petitioner's health deteriorated. *See,* Tr. pgs. 53-58.

Testimony of Helen Okunola

Mrs. Helen Okunola is the petitioner's widow. She testified that she received a call from Jackson Park Hospital the night of July 20, 2004, regarding the petitioner's incident. Ms. Okunola went to see her husband at the hospital that same night and when he was discharge, he was not walking normally. Mrs. Okunola testified that the petitioner's physical condition steadily deteriorated after July 2004, until his death on July 23, 2010; and that he had never fainted or lost consciousness prior to July 20, 2004. *See,* Tr. pgs. 63-73.

Petitioner's medical treatment at Jackson Park Hospital

On July 16, 1998, the petitioner presented to Jackson Park Hospital complaining of having headaches for the last two days. His case was marked as one needing urgent care. The petitioner denied having nausea and vomiting. Staff at Trinity Hospital, where the petitioner was apparently treating, was contacted. The petitioner was advised to go to the emergency room at Trinity Hospital, which he apparently did. *See,* PX2.

On July 20, 2004, following a fall, the petitioner was examined at Jackson Park Hospital and it was noted in the medical records, under patient's chief complaint, that the petitioner passed out on the floor and hit his head on a cart. The petitioner was diagnosed with a single, episode, syncope etiology, unclear. A CT scan of the head, performed on the date of the incident, indicated that the petitioner's ventricles and subarachnoid spaces were unremarkable and that there was no mass effect of effacement of the cisterns. There was no acute hemorrhage or infarct seen. The records indicate that the petitioner was in the process of setting up a medicine cart when he collapsed. *See,* PX2, PX3 & RX4.

On July 20, 2004, an "employee work related injury/illness report" was executed, apparently by the petitioner and his supervisor. Sections one (1) and two (2) were to be completed by the employee and section three (3) was to be completed by a supervisor. In section two when requested to described how the injury/illness happened, it is written "Blanked out momentarily and fell to the floor. No loss of consciousness." The report is presumably signed by the petitioner. *See,* PX1 sects. 1-8.

On July 21, 2004, the petitioner was examined for a follow-up. Physician's notes indicate that the petitioner "had a loss of consciousness yesterday at 4:45 pm, few seconds, fell to floor, hit back of head, landed in sitting position...". On July 23, 2004, the progress notes from Jackson Park Hospital indicate, a follow-up for a syncopal episode, no further episodes, awaiting carotid Doppler. A carotid Doppler was performed on July 23, 2004; the results were negative. *See,* RX4.

Petitioner's medical treatment by Dr. Shahida Ahmad

The petitioner was initially examined by Dr. Ahmad on October 5, 2004. Initial complaints were loss of balance approximately in November 2003, when he was in a slight scuffle with a patient and after that incident, he felt his walking was somewhat unstable. The doctor's notes described the fall of July 20, 2004 as "he was at work walking with a cart. Suddenly he felt that his legs were weak and he tried to grab the cart to balance himself but the cart slipped from under him and the patient landed on his gluteal area. Since, then he has noted that his gait is not quite as steady as is (sic) usually has been in the past. He feels that he might fall. He feels slightly more weak on the right." Dr. Ahmad's impressions were that the patient had symptoms of non-specific loss of balance and decreased sensation in both feet, highly suggestive of cervical myelopathy. He opined that this could be due to cervical spondylosis or other etiologies, i.e. subacute combined degeneration.

On December 2, 2004, Dr. Ahmad examined the petitioner and noted more strength in his legs and better balance. The petitioner was diagnosed with residual cervical myelopathy. Dr. Ahmad noted that the petitioner had returned to baseline and recommended that he follow-up if symptoms returned. Subsequently, the petitioner was examined on December 6, 2005 ,with progressive difficulty with balance and walking, and difficulty with speech. Dr. Ahmad noted that a MRI revealed marked pontocerebellar atrophy and recommended that he be examined at UIC for genetic testing for a degenerative process such as olivo-ponto-cerebellar degeneration or some other hereditary disorder. After review of this doctor's records the Arbitrator finds no causal connection opinion regarding the petitioner's current condition of ill-being and the fall on July 20, 2004. *See*, PX5 & RX5.

Petitioner's medical treatment at Trinity Hospital

The petitioner was seen at this facility, for various medical issues, from on or about August 14, 2003 to July 20, 2009. On October 14 2004, an MRI of the cervical spine was interpreted to show mild bilateral facet degenerative disc disease, concentric spinal stenosis and bilateral neural foraminal encroachment at C5-C6.

On July 16, 2008 and EEG of the brain was performed because of the alleged syncope episode. The results were found to be within normal range. On October 26, 2005, an MRI of the brain was performed which showed volume loss involving the Pons and cerebellum with a differential including hereditary/degenerative etiology as well as toxic, vascular etiology of sequela of remote infectious/inflammatory disease. There is no causal connection opinion in these records, relating the petitioner's condition of ill-being with the fall of Jul 20, 2004. *See*, PX4,

Petitioner's medical treatment at Stroger Hospital

On June 27, 2005, it is noted that the petitioner had a medical history of a heart condition, broken bones/fracture and stroke. He claims a fall at work brought on his condition of ill-being and need for physical therapy. The petitioner was examined on July 28, 2005 and a history of a partial stroke is mentioned and noted to have occurred after the date of July 20, 2004. The petitioner had a good prognosis for meeting short-term goals. On August 26, 2005, it was noted that petitioner's walking was better, and that he wanted a referral to Oak Forest Hospital. *See*, PX6, pgs. 8-9.

Petitioner's medical treatment at UIC Hospital

From a review of the medical records, it appears that the petitioner was treated at this facility from approximately July of 2006 through November of 2009. The petitioner was examined for a neurology consult on July 5, 2006. He had a history of a stroke in June 2005 and received a differential diagnosis of inflammatory or demyelinating process/structural pathology, possible myelopathy or cervicomedullary pathology. He was also examined on September 8, 2006 and diagnosed with spinocerebellar degeneration, and prescribed therapy. The petitioner was then examined on December 15, 2006 with no improvement and the same diagnosis of spinocerebellar degeneration. *See,* PX7.

Subsequent radiology reports and an examination on February 26, 2008 resulted in a diagnosis of spinocerebellar ataxia, showing cerebellar hemispheric and vermian atrophy with some degree of associated brain stem atrophy. Therapy was ordered. *See*, PX7, pgs. 63-70.

The findings of an MRI of the brain, performed on July 5, 2006, suggested underlying neurodegenerative disorder involving the cerebellum such as cerebellopontine or spinocerebellar degeneration or paraneoplastic syndrome. *See,* PX7 p. 80.

An MRI of the cervical spine, performed on July 8, 2006, was read as the petitioner having degenerative disc disease of the cervical spine at multiple levels, particularly C5-C6 and C6-C7 with osteophytic disc bulge at C5-C6 and C6-C7, resulting in distortion of subarachnoid space at these levels. There is no evidence for abnormal intrinsic signal of the cord; however, there was suggestion of some degree of atrophy of the cord as well as atrophy of the medulla and pons and significant atrophy of the vermis. PX7, p. 87.

The petitioner performed physical therapy at UIC from July 14, 2006 through December 20, 2009. Initial consult on July 14, 2006 noted that he was unsteady when walking and that his speech is slower than usual. The final therapy record in evidence is December 20, 2006, at which time he was discharged because his improvement had plateaued. There was no opinion relating the petitioner condition of ill-being to the July 20, 2004 incident. *See,* PX7, pgs. 10-18.

16IWCC0356

Petitioner's medical treatment at Pain Net Medical Group

Petitioner was seen at these facilities for physical and speech therapy and neurological treatment. On October 6, 2008, Dr. Herba, a board certified neurologist, examined the petitioner, now four years after the fall at work. Dr, Herba notes, by way of history, state that the petitioner was an employee of Jackson Park Hospital and was injured on July 20, 2004, when he was pushing a cart of hospital charts. That he lost control of the cart and fell onto his buttocks because he lost his balance. Dr. Herba's impressions were that the patient was presenting with a cerebellar syndrome, and that the patient had significant torso imbalance. *See*, PX8 pg. 5.

On November 3, 2008, after review of Petitioner's MRI of the head and notes from Dr. Ahmed; Dr. Herba opines that the "patient has a cervical disc herniation however, the clinical presentation of speech dysarthria and marked dysmetria of both legs on heel-to-knee and the left arm on finger-to-nose suggests that the disorder related to a higher level of cerebral origin including the connections from the cerebellum". He felt that the cervical herniation is not responsible in any manner for the rather generalized neurologic symptoms. *See*, PX8, pg. 9.

On April 14, 2009, the petitioner and his wife again presented to Dr. Herba; the wife stating that her husband never had any difficulties prior to the accident at Jackson Park Hospital and Dr. Herba stating that "it was subsequent to that slip and fall accident that he developed the current neurologic signs". *See*, PX8, p. 14.

On July 6, 2009, Dr. Herba noted that there were no further neurologic changes and that Petitioner's EEG report was within normal limits. He stated that the petitioner "still had speech and swallowing difficulty and he wondered about the possibility of brainstem contusion in the accident which occurred at Jackson Park hospital on 07/20/2004". He then opined that the petitioner "may have had a contusion to the lower brainstem as well as to the cervical spine in the accidental fall at the hospital at which he worked". *See*, PX8 pg. 17.

Petitioner's medical treatment at Golf Diagnostic

On February 1, 2010, a MRI of the brain was performed which showed chronic ischemic/age related changes, white matter, thalami and cerebellar brainstem atrophy. In addition, a PET scan was performed showing abnormalities and a MRA was performed which was read to be normal. *See*, PX9.

Petitioner's medical treatment by Dr. Adeyami Fatoki

Dr. Fatoki has treated the petitioner regarding various ailments, since on or about July of 1998. On July 16, 1998, the petitioner presented for reoccurring nosebleeds, headaches and high cholesterol.

16IWCC0356

Dr. Fatoki examined the petitioner multiple times from July of 1998 through March of 2010. On March 16, 2010, Dr. Fatoki reported that the petitioner was feeling "better on the new regimen and has no new complaints." The doctor noted "speech dysarthria and coordination problems since 2005 h/o cerebellar degeneration h/o hyperlipidermia". The petitioner was reporting dizziness. This was approximately four (4) months before he died. *See*, PX3 pgs, 25, 26 & 31.

Petitioner's medical treatment at St. Margaret Mercy Hospital

The petitioner was admitted to St. Margaret via ambulance on April 23, 2010, after suffering cardiac arrest. The petitioner passed away on that date. *See,* PX11, pg. 20.

Dr. Bryant's autopsy and addendum

Dr. Bryant performed an autopsy on the petitioner on April 24, 2010, finding the immediate cause of death to be acute congestive heart failure due to cardiac arrhythmia, right atrial dilatation, passive congestion of the liver and spleen; and acute pulmonary edema and congestion.

On November 19, 2010, at the request of the petitioner's counsel, Dr. Bryant drafted an addendum to his autopsy indicating that despite the autopsy not focusing on the cause of Petitioner's neurologic problems, it is his opinion that the petitioner's death was causally related to the July 20, 2004 fall. *See,* PX13.

Deposition of Dr. Bryant

On January 28, 2011, Dr. Bryant testified that the petitioner "was pushing something, a cart at work, and he fell down and apparently he injured his neck. And then the injury progresses over a number of months to finally become symptomatic about four or five or six months later and it gets worse and worse. And it's related to some kind of compression due do a disc in the C5-6 or C6-7 area. I'm not sure. And the disc is compressing the spinal cord and this is radiating upwards into the base of the brain causing atrophy of the brain stem and atrophy of the cerebellum. This is a disabling condition that might keep him bedridden, and as a result ultimately he dies from congestive heart failure."

He further testifies that at the time of the initial autopsy he did not perform the type of autopsy to be able to determine a causal relationship of Petitioner's death to the alleged work injury. Further, Dr. Bryant opined that the cervical herniation issues are also partially led to petitioner's death. This opinion is contrary to the opinion of the petitioner's neurologist, Dr. Herba, who specifically testified that the cervical herniation had nothing to with the petitioner's symptoms. Dr. Bryant also testified that he would defer to a neurologist for any neurologic issues.

Dr. Bryant further testified that he is not basing his opinions on the actual autopsy that he performed, but rather on all of the medical reports that were tendered to him by the petitioner's counsel subsequent to the autopsy. In fact, this doctor testified that he sat with the petitioner's attorney, for approximately two hours, and drafted his addendum from records tendered by Petitioner's attorney.

As such, Dr. Bryant's testimony and opinion regarding the cause of this petitioner's death is based entirely upon records and reports outside his field of expertise and on an autopsy that did not determine whether Petitioner's neurologic deficits were related to the fall of July 20, 2004. The Arbitrator is not persuaded by the opinions of this doctor. *See*, PX19, pgs. 11-55.

Depositions of Dr. Edward Herba

On April 15, 2010, Dr. Herba, testified, on direct examination, that he examined the petitioner on October 6, 2008, approximately four (4) years after the alleged injury. Dr. Herba also testified that he review a multitude of petitioner's records from Drs. Ahmed, Fatoki, Jackson Park, Trinity and Cook County Hospitals. Dr. Herba testified that the petitioner stated that he had pre-existing balance issues from a November of 2003, altercation with a patient. He further testified that, to a reasonable degree of medical certainty, the petitioner's neurologic injuries and present condition of ill-being was causally related to the incident of July 20, 2004 and that the petitioner had no prior history of similar neurologic difficulty, as attested to by his wife.

Dr. Herba testified that the petitioner might have aggravated a pre-existing condition, that resulted from the scuffle in November 2003. Dr. Herba ordered an MRA of petitioner's brain on March 15, 2010 and read it as showing evidence of atrophy of both the cerebellar and the brain stem. There was also indication of chronic small ischemic changes surrounding the ventricles. The medical opinions of Dr. Herba are inconclusive as he based his entire treatment and opinions on the diagnosis of head trauma and never actually addressed the reason for the petitioner's fall. This is confirmed by testimony in Dr. Herba's second deposition when he testified, "much of the weight of my thought in relation to this event had to do with the head trauma." A PET scan showed damage to the right thalamus and decreased activity in the left parietal occipital area. *See*, PX17, pgs. 14-19.

Upon cross-examination, Dr. Herba testified that he believes that when Petitioner fell at Jackson Park Hospital, he injured his cerebellum and other areas of his brain. On his March 25, 2010 evaluation, Dr. Herba stated that "given the sequence of events since the slip and fall while at his job at Jackson Park Hospital, it is again my opinion that the trauma incurred has aggravated and exacerbated a prior existing condition". When asked what the prior existing condition was, Dr. Herba replied, "I think that is really kind of had to do with that scuffle that he had, and there was a report that there was instability afterwards". Dr. Herba further testified that the petitioner's condition of ill-being was due to head trauma and that he felt that the incident of 2004 was more likely responsible for his deficit

then the scuffle in November of 2003. It was the doctor's opinion that the petitioner was permanently, totally disabled. *See*, PX17 pgs. 31-39.

In Dr. Herba's second deposition taken on May 17, 2012, he confirmed that it is his opinion that the petitioner suffered a brain injury as a result of the fall on July 20, 2004; which resulted in brain stem atrophy, which resulted in cardiac arrhythmia and the petitioner's death. *See*, PX18, pgs. 12-26.

Dr. Herba admits that he did not examine the petitioner as he had testified to initially; and that the last time that he did examine him was mid-October of 2009. He also reversed his prior opinion that the petitioner's condition was an aggravation of a pre-existing condition. Additionally, Dr. Herba opined that everything was based on the event of trauma that caused the changes in the brain stem. The petitioner's MRI of the cervical spine dated July 8, 2006, indicated degenerative changes to the cervical spine and that there was a possibility of an underlying disorder i.e. spinal cerebellar degeneration. Dr. Herba testified that in his experience, death from such a disorder would not come this quickly. Finally, Dr. Herba testifies that he does not know when the degenerative process began in Petitioner; and that an actual cause had not been determined. He was relying on the comments of Dr. Bryant, whom he acknowledged was not a cardiologist nor a cardiovascular specialist; and also acknowledged that Dr. Bryant did not perform the type of autopsy that would delineate a brain injury as the cause of death. Dr. Herba still stated that the petitioner's death was related to the fall in July of 2004. *See*, PX18, pgs. 17-44.

Deposition of James J. Radke

After a review of this testimony, the Arbitrator does not find it relevant to this matter. *See*, PX20.

Deposition of Dr. Fatoki

On September 20, 2012, the deposition of Dr. Fatoki was taken. He testified that he has been board certified in family medicine since 1993 and was the petitioner's treating physician from approximately 1998, until his death. Further, Dr. Fatoki testified that Petitioner sustained serious injuries from the fall in July 20 2004, because he had treated him before and after the incident and before the fall, Petitioner was fully functional and after the incident, his health deteriorated to the point that he could no longer work and. Then Petitioner eventually died.

Dr. Fatoki testified that his notes after the July 20, 2004 incident indicated that the petitioner had had a stroke with right-sided weakness and speech disturbance. He further testified that whatever balance issues the petitioner had after the November 2003 scuffle with a patient would not change his opinions because "up until I saw him before July of 2004, he was pretty much normal and the balance issues he had then were not chronic or severe enough to impair his ability to be gainfully employed". The doctor further testified that he is not sure how or why the petitioner actually fell on July 20,

2004, only that he knows the petitioner fell. As such, Dr. Fatoki has no opinion as whether the petitioner slipped and fell but that he did not believe that the petitioner had a syncope episode and fell. Dr. Fatoki said that the petitioner gave him a history of the accident as just falling and that he can only rely on the history given. In addition, Dr. Fatoki testified that he would not have reached the conclusion that the petitioner died of arrhythmia, as did Dr. Bryant. Dr. Fatoki also testified that he has no idea what was actually wrong with the petitioner or what caused his death. When questioned about a idiopathic fall as it relates to worker's compensation cases, the doctor stated that he knew the meaning of the word "idiopathic, meaning unknown cause" but had no idea how the term related to workers' compensation. *See,* PX21, pgs. 29-53.

Deposition of Dr. Wayne Owens Adkisson

On February 19, 2013, Dr. Adkisson testified that he is board certified in internal medicine and a cardiac electrophysiologist. Dr. Adkisson reviewed the records of Drs. Fatoki, Herba, Ahmed, the records from Advocate Trinity and Jackson Park Hospitals and the autopsy report from Dr. Bryant. He agreed with Dr. Sorrentino's assessment that the fall in 2004 was unlikely to have contributed to a cardiovascular cause of Petitioner's death but did testify that the fall contributed to his death.

Dr. Adkisson additionally, had no idea how the fall occurred though he disputes the emergency room records that syncope occurred. Dr. Adkisson seems to disregard the ER records and the petitioner's own statement, that he "blanked out momentarily" before he fell. The ER records are absent for a cart causing a slip and fall, as is the incident report completed by the petitioner. The Arbitrator finds that the most telling portion of this deposition is on pages 29-36; where this doctor admits that he is relying on the opinions of other doctors; and that he really does not know, with any degree or medical certainty, what caused the petitioner's death. The Arbitrator does not find Dr. Adkisson's opinions to be persuasive. *See,* PX22.

IME OF Dr. Sorrentino

Dr. Sorrentino performed a records review pursuant to Section 12, and generated a report dated July 14, 2011. In it, he opined that the fall in July 2004, was not related to Petitioner's sudden death in 2010; because there is no physiologic mechanism by which a fall in 2004 can cause an arrhythmia in 2010. The autopsy shows no evidence for heart disease therefore, he opined that the fall in 2004 was not a cause of any underlying heart disease. *See,* RX2.

Dr. Sorrentino's Deposition

On April 10, 2012, Dr. Sorrentino testified that he reviewed the petitioner's medical records from Jackson Park Hospital, Pain Net Medical Group and St. Margaret's Medical Center, the deposition of Dr. James Bryant and the petitioner's work related injury report. Dr. Sorrentino further testified that

16IWCC0356

the incident in July 2004, did not lead to the death of the petitioner approximately six (6) years later. He further testified that he did not review any of the records of Petitioner's neurologists. Petitioner's counsel also suggests that the petitioner may not have filled out or signed the report of a work related injury, however there was no testimony or evidence presented on this issue. Petitioner's medical records from Jackson Park Hospital state that he collapsed and hit his head on a cart. *See*, RX3, pgs. 11-31 & RX4.

16IWCC0356

CONCLUSIONS OF LAW

Did an accident occur that arose out of and in the course of petitioner's employment with Respondent, the Arbitrator finds as follows:

The claimant has the burden of proving, by a preponderance of the evidence, all of the elements of her claim. It is the function of the Commission to judge the credibility of the witnesses and resolve conflicts in medical evidence. *See, O'Dette v. Industrial Comm'n*, 79 Ill. 2d. 249, 253, 403 N.E.2d 221, 223 (1980). In deciding questions of fact, it is the function of the Commission to resolve conflicting medical evidence, judge the credibility of the witnesses and assign weight to the witnesses' testimony. *See, R & D Thiel*, 398 Ill. App.3d at 868; *See also, Hosteny v. Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674 (2009).

For an employee's workplace injury to be compensable to be compensable under the Workers' Compensation Act, she must establish the fact that the injury is due to a cause connected with the employment such that it arose out of said employment. *See, Hansel & Gretel Day Care Center v. Industrial Comm'n*, 215 Ill. App.3d. 284, 574 N.E.2d 1244 (1991). It is not enough that Petitioner is working when accident injuries are realized; Petitioner must show that the injury was due to some cause connected with employment. *See, Board of Trustees of the University of Illinois v. Industrial Comm'n*, 44 Ill.2d 207 at 214, 254 N.E.2d 522 (1969).

It is within the province of the Commission to determine the factual issues, to decide the weight to be given to the evidence and the reasonable inferences to be drawn there from; and to assess the credibility of witnesses. *See, Marathon Oil Co. v. Industrial Comm'n*, 203 Ill. App. 3d 809, 815-16 (1990). And it is the province of the Commission to decide questions of fact and causation; to judge the credibility of witnesses and to resolve conflicting medical evidence. *See, Steve Foley Cadillac v. Industrial Comm'n*, 283 Ill. App. 3d 607, 610 (1998).

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of credible evidence. *See, Illinois Bell Tel. Co. v. Industrial Comm'n.*, 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). This includes the issue of whether Petitioner's current state of ill-being is causally related to the alleged work accident. *Id.* A claimant must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *See, Caterpillar Tractor Co. v. Industrial Comm'n.*, 83 Ill. 2d 213; 414 N.E. 2d 740 (1980). Also, causal connection can be inferred. Proof of an employee's state of good health prior to the time of injury and the change immediately following the injury is competent as tending to establish that the impaired condition was due to the injury. *See, Westinghouse Electric Co. v. Industrial Comm'n*, 64 Ill. 2d 244, 356 N.E.2d 28 (1976). Furthermore, a causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform the duties before the date of the accident

and inability to perform the same duties following that date. *See, Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 193 (1986).

The arising out of "element pertains to the origin or cause of the claimant's injury and requires a determination of the type of risk to which the claimant was exposed, if any: (1) a risk distinctly associated with employment; (2) a risk personal to the employee, such as an idiopathic fall; or (3) a neutral risk that has no particular employment or personal characteristics. *See, First Cash Financial Services v Industrial Comm.*, 367 Ill. App. 3d 102, 105-106, 853 N.E. 2d 799 (2006); *Illinois Consolidated Telephone Co. v Industrial Comm.*, 314 Ill. App. 3d 347, 352, 732 N.E. 2D 49 (2000).

The Arbitrator must determine if the petitioner suffered a syncopal episode or some other reason for the fall, prior to determining compensability. The issue of why the petitioner fell has not been addressed by the petitioner's treating physicians. The emergency room records of Jackson Park Hospital, as well as the follow-up visits at Jackson Park Hospital note that the petitioner passed out and the petitioner was diagnosed with a syncope episode.

Possibly, even more importantly, the petitioner writes that he blanked out momentarily and fell to the floor, with no loss of consciousness. This incident report is the most accurate description related regarding the fall. In addition, pursuant to the emergency room records from Jackson Park Hospital and other evidence, Petitioner's initial complaints of loss of balance were noted in November 2003, after he was in a slight scuffle with a patient; and he felt his walking was somewhat unstable.

The petitioner also gave a history of his fall of July 20, 2004 as "he was at work walking with a cart. Suddenly he felt that his legs were weak and he tried to grab the cart to balance himself but the cart slipped from under him and he landed on his gluteal area. This medical history evidences some manner of pre-existing stability issues, which was never addressed by any of his treating physicians.

The testimony of the petitioner's widow and three children was not consistent with the medical records and incident reports authored by the petitioner. The assertion that the petitioner was working and the cart moved away from him, causing him to fall, is not consistent with the history given by the petitioner in his medical records. Nor is it consistent with the injury report signed by the petitioner.

The petitioner and his witnesses have different versions of how the fall occurred. Initially, the petitioner admits on his injury report that he blanked out momentarily, and fell; then he subsequently tells Dr. Ahmad on October 5, 2004, that his legs became weak and he fell. It is not until two (2) years after the incident that the petitioner changes his history of the accident and tells physicians at UIC on July 5, 2006, that he slipped and fell while working on patient's charts. This change in the history of accident coincides with the filing of the workers' compensation claim on May 9, 2006.

Moreover, the Arbitrator finds that the records from Stroger Hospital indicate that the petitioner suffered a stroke at some point after July 20, 2004. The Arbitrator notes that not a single treating physician commented on the relation of this stroke to the petitioner's symptoms moving forward.

Lastly, the petitioner was diagnosed with spinocerebellar degeneration, by the physicians at UIC on December 16, 2006. Spinocebellar degeneration is hereditary and can be acquired by having a stroke.

The Arbitrator finds that the Petitioner has not proven, by a preponderance of the evidence, that an accident occurred which arose out of and in the course of Petitioner's employment therefore, no benefits will be awarded, pursuant to the Act. As accident has not been proven, by a preponderance of the evidence, the remaining issues are moot and will not be addressed.

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
10WC21225
SIGNATURE PAGE

Signature of Arbitrator

January 27, 2014
Date of Decision

JAN 27 2014

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jo-Ellyn Forcum,

Petitioner,

vs.

NO: 10 WC 26140
10 WC 45795

Shelbyville Rehabilitation and Healthcare,

Respondent.

16IWCC0353

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, notice, causation, temporary total disability benefits, medical expenses, nature and extent and credit, and being advised of the facts and law, affirms the Decision of the Arbitrator with changes as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission corrects the decision of the Arbitrator to show that the Respondent's workers' compensation carrier in claim 10 WC 26140, Traveler's Insurance, is entitled to a credit in the amount of $1,248.00 for payment of a PPD advance.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 5/27/15, with the above correction, 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.

16IWCC0353

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

Bond for the removal of this cause to the Circuit Court by Respondent Travelers Insurance (10 WC 26140) is hereby fixed at the sum of $10,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 26 2016
o:4/4/16
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FORCUM, JO-ELLYN
Employee/Petitioner

Case# **10WC026140**
10WC045795

SHELBYVILLE REHABILITATION AND HEALTHCARE
Employer/Respondent

16IWCC0353

On 5/27/2015, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1083 BRANKEY & SMITH PC
RODNEY SMITH
622 JACKSON AVE
CHARLESTON, IL 61920

1337 KNELL & KELLY LLC
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16IWCC0353

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

JO-ELLYN FORCUM,
Employee/Petitioner

v.

SHELBYVILLE REHABILITATION AND HEALTHCARE,
Employer/Respondent

Case # **10** WC **26140**

Consolidated cases: **10 WC 45795**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **4/20/15**. 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 _____

FINDINGS

On **7/13/07 and 11/20/09**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

On 7/13/07, Petitioner *did* sustain an accident that arose out of and in the course of employment.
On 11/20/09, Petitioner *did not* sustain an accident that arose out of and in the course of employment.

Timely notice of the accident on 7/13/07 *was* given to Respondent.
Timely notice of the accident on 11/20/09 *was not* given to Respondent.

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

In the year preceding the injury on 7/13/07, Petitioner earned $**26,676.00**; the average weekly wage was $**513.00**.
In the year preceding the injury on 11/20/09, Petitioner earned $**27,040.00**; the average weekly wage was $**520.00**

On 7/13/07, Petitioner was **51** years of age, *married* with **no** dependent children.
On 11/20/09, Petitioner was **54** years of age, *married* with **no** dependent children.

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

Respondent *has or will pay* all appropriate charges for all reasonable and necessary medical services through 1/7/08.

Respondent shall be given a credit of $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**00.00**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

The petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 11/20/09. Respondent's claim for compensation is denied.

Respondent shall pay Petitioner temporary total disability benefits of $342.00/week for 0 weeks, as provided in Section 8(b) of the Act because petitioner reached maximum medical improvement with respect to the accident on 7/13/07 by 1/7/08. Having found petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 11/20/09, the arbitrator finds she is not entitled to any temporary total disability benefits after 11/20/09.

Respondent shall pay reasonable and necessary medical services related to petitioner's right shoulder from 7/13/07 through 1/7/08, as provided in Sections 8(a) and 8.2 of the Act, with respect to the accident on 7/13/07. Having found petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 11/20/09, the arbitrator finds the petitioner is not entitled to any medical services after 11/20/09.

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

Respondent shall pay Petitioner permanent partial disability benefits of $307.80/week for 25 weeks, because the injuries sustained caused the 5% loss of the person as a whole, as provided in Section 8(d)2 of the Act, as related to the accident on 7/13/07. Having found petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 11/20/09, the arbitrator finds the petitioner is not entitled to permanent partial disability as it relates to the alleged injury on 11/20/09.

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

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

Signature of Arbitrator

5/22/15
Date

MAY 27 2015

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 51 year old social service worker, sustained an accidental injury to her right shoulder that arose out of and in the course of her employment on 7/13/07. This case was heard in consolidation with case number 10 WC 45795 which is an alleged injury to petitioner's right shoulder on 11/20/09. Although petitioner worked for the same respondent on both dates, respondent's insurance carriers on these dates were different.

Petitioner's duties for respondent included transporting residents to doctor appointments, moving furniture around, and decorating rooms for new residents. Petitioner started working for respondent in February 2001. Petitioner denied any problems to her right shoulder before 7/13/07.

On 7/13/07 petitioner mowed respondent's lawn using a riding lawnmower. When she completed mowing the lawn she went and got the leaf blower to blow the grass off the street. Petitioner made two attempts with the pull start to get the leaf blower started. The first time she pulled it did not start. The second time she pulled it she felt her right shoulder pop and she dropped the leaf blower. Petitioner immediately went inside and reported the accident to Virgil Calvert, a registered nurse. Rhonda Baker, the administrator was also called. Baker told petitioner to come in early on Monday to do an incident report.

On 7/23/07 petitioner presented to Dr. Timothy Gray, an orthopedist. Petitioner complained of right shoulder complaints. Petitioner gave a consistent history of the accident on 7/13/07. She stated that since the accident she had been using a sling and cold packs, and was having pain with rolling or elevating her shoulder. An examination was positive for limited elevation of the right shoulder, weakness on abduction of the shoulder, and positive impingement sign. Dr. Gray was of the opinion that these findings were indicative of rotator cuff pathology. Dr. Gray prescribed pain medications, anti-inflammatories, and ordered an MRI of the right shoulder. He released petitioner to work with activities as tolerated.

On 7/30/07 petitioner underwent an MRI of the right shoulder. It showed a small complete rotator cuff tear, a 2.5 cm diameter tear at the supraspinatus tendon insertion.

On 8/7/07 petitioner returned to Dr. Gray. She was still having some pain and irritation, but was definitely improving with her medications. Dr. Gray went over the MRI results with petitioner and told her that she had a small rotator cuff tear. Dr. Gray gave her the option of continuing with conservative care or undergoing surgery. Petitioner testified that she was doing better and wanted to try and avoid surgical intervention. Dr. Gray continued petitioner's medications and continued her activities as tolerated.

On 9/11/07 petitioner presented to Dr. Bowers with complaints of fatigue and insomnia. Petitioner stated that she was depressed, and her associated symptoms included nausea. Petitioner noted recent stressors, including recent fall with rotator cuff tear.

On 9/26/07 petitioner followed up with Dr. Gray. At that time petitioner was doing much better, and her medications were helping. A physical examination indicated that petitioner was improving, and had minimal impingement sign. Petitioner reported that she was feeling better and was using her arm. Dr. Gray continued petitioner's medications and continued her activities as tolerated.

On 1/7/08 petitioner last followed up with Dr. Gray. Petitioner was feeling well at that time and was doing regular work. She had no complaints. Petitioner was using her shoulder and was doing fine. An examination revealed no instability, motor 5/5, and neurologically intact. Dr. Gray released petitioner without any restrictions at all.

This was petitioner's last treatment for her right shoulder until after the alleged injury on 11/20/09. Petitioner testified that during this period she continued to work full duty, but her mobility was somewhat limited. She testified that she talked to her Administrator, Dan McQuilty about her shoulder problems. She also testified that in August or September of 2008 she began feeling more pain while transporting residents.

Petitioner testified that from February of 2009 through July of 2009 she requested treatment from Shannon Padden, with regional Corporate. She testified that she talked with Padden several different times during this period about getting treatment, and Padden kept telling her she would get back to her but never did.

Petitioner testified that she sustained a repeat accidental injury to her right shoulder on 11/20/09 while working. She testified that the residents were having Thanksgiving Dinner on that day and the room was crowded. She stated that two residents were back to back in wheelchairs and they kept bumping into each other. She stated that the Director of Nursing came over and asked one of the residents to slide over a bit. Petitioner attempted to move the resident over and felt a pull in her right shoulder, tingling and tearing down her arm. Petitioner claims that at this time she was still trying to get in to see a doctor for her right shoulder. Petitioner did not complete an accident report for this incident.

On 2/15/10 petitioner presented to Dr. Bowers with a chief complaint of shoulder pain, severe for the last 2 to 3 weeks. She reported that she could not sleep on her right shoulder. Dr. Bowers performed an injection into petitioner's shoulder joint. Petitioner was advised to avoid strenuous activity to the injected region. She was also advised to use ice and NSAIDs for worsening symptoms during the first two days. Petitioner gave no history of an injury on 11/20/09 or any other day.

Petitioner presented to Dr. Bowers on 3/8/10. She had no complaints regarding her right shoulder. Petitioner gave no history of an injury on 11/20/09 or any other day. On 6/3/10 petitioner returned to Dr. Bowers with complaints of right shoulder pain. Petitioner was therefore offered another right shoulder steroid injection. Petitioner underwent a repeat right shoulder joint injection. She was advised to use ice and NSAIDs for worsening symptoms for the next two days. Petitioner gave no history of an injury on 11/20/09 or anyother day.

On 6/16/10 petitioner presented to Shelby Memorial Hospital for her initial physical therapy evaluation. Petitioner reported that for the past six months she has had right shoulder pain, but gave no history of an injury on 11/20/09. She reported that she had two cortisone injections. She stated that the last one was last week and it helped for several days, but then on Monday her shoulder popped again and all her pain returned. Petitioner reported that about three years ago she had a rotator cuff tear in her right shoulder, and had therapy at that time and it got better, and she had no problems until recently. Petitioner stated that she works at a local nursing home, mainly in an office job. She stated that she enjoys being quite active and probably aggravates the arm doing more strenuous activities. Petitioner underwent 10 visits, and her therapy was discontinued on 7/9/10. Petitioner's goals were unmet.

On 7/2/10 petitioner again returned to Dr. Bowers and reported that she was continuing to have problems with her right shoulder. She gave a history of originally injuring her right shoulder at work in July 2007, and was seen by Dr. Gray at the Bonutti clinic. Petitioner reported intermittent problems with shoulder pain, and stated that the injections in February 2010 did help some. She stated that she was unable to push wheelchairs due to the pain, or even lift a gallon of milk. Petitioner stated that she was attending physical therapy and would probably need to see the orthopedic doctor again. Dr. Bowers restricted petitioner from lifting anything heavy, and limited her use of the right arm. Dr. Bowers referred petitioner to Dr. Brustein for her shoulder pain/injury. Petitioner gave no history of an injury on 11/20/09. On 7/8/10 Dr. Bowers restricted petitioner from lifting greater than 10 pounds, no pushing patients in wheelchairs, and limited use of the right arm. Petitioner gave no history of an injury on 11/20/09.

On 7/9/10 petitioner signed an Application for Adjustment of Claim for the accident on 7/13/07. She did not complete an Application for Adjustment of Claim for the alleged accident on 11/20/09 at that time.

On 8/2/10 petitioner followed up with Dr. Bowers after presenting to the emergency room on 8/8/10 for hypertension and shoulder pain. She complained of intermittent dizziness, headaches, fatigue, diplopia and shoulder pain that was severe over the weekend to the point where it caused her to seek treatment in the

emergency room. She stated that she has an appointment with a specialist for her shoulder on 8/19/10. Dr. Bowers ordered an MRI of the right shoulder. Petitioner gave no history of an injury on 11/20/09.

On 8/11/10 Dr. Tyler Jones, an orthopedist, obtained a history from petitioner on the phone. Petitioner gave a consistent history of the accident on 7/13/07. She told Dr. Jones that she had seen another orthopedic surgeon, Dr. Gray, and treated with him for a while. Petitioner reported that her treatment was essentially conservative, and included physical therapy and injections. Petitioner gave no history of an injury on 11/20/09.

Petitioner testified that she resigned her employment with respondent in August of 2010. Petitioner testified that on 8/16/10 she began working for Taylorville Rehab. Her job was in social services. She did one on one programs with residents. Her employment was full time. This facility was 98 miles round trip from her home.

On 8/19/10 Dr. Jones examined petitioner for the first time. Petitioner was referred to Dr. Jones by Dr. Bowers. Dr. Jones noted that in February 2010 the discomfort in her right shoulder had increased, and she returned back to her family doctor, who referred her to him. An examination of petitioner's right shoulder revealed tenderness at the AC joint, good range of motion, elevation to 180°, and external rotation to 90°. Dr. Jones noted significant weakness with petitioner's supraspinatus muscle, as well as pain. Dr. Jones noted weakness and pain with her external rotation of her two muscles, and good strength with the subscapularis muscle, with discomfort. Dr. Jones did not note any significant atrophy. Petitioner had a positive impingement sign, and a positive crossover test. Dr. Jones did not see any lag signs which would show him that she had a significant rotator cuff tear, and over time her muscles had compensated for it. Dr. Jones ordered an MRI of the right shoulder. Petitioner gave no history of an injury on 11/20/09.

On 8/27/10 petitioner called Dr. Jones's office and told him that she was starting to have more problems with her shoulder that included swelling at the shoulder, and a red mark that was kind of going down her arm. She also reported losing feeling of the arm. Petitioner was referred to the emergency room or her primary care physician for evaluation.

On 10/18/10 petitioner underwent a Section 12 examination performed by Dr. David Fletcher, at the request of the petitioner. Petitioner completed a medical history questionnaire and a pain drawing. A mental status screening examination was performed. Additional observations, measurements, and tests were performed. The medical and social histories were reviewed. Petitioner provided a consistent history of the accident on 7/13/07. Dr. Fletcher noted that petitioner treated with Dr. Gray following this injury, and he diagnosed her with a small rotator cuff tear in 2007. This was confirmed by an MRI of the right shoulder that

showed a small rotator cuff tear. Petitioner reported that she treated conservatively and got better. Petitioner gave a history that on Thanksgiving, 2009 she sustained another work injury involving transporting a patient in a wheelchair. Petitioner noted that she did not report this second work injury, but stated that she had witnesses who saw it. Petitioner stated that respondent had recently got rid of some of her assistants that helped her with transfers/transports of patients, and she was required to transport the patient's by herself, which made her condition worse. Petitioner gave a history of going to her family physician in February 2010 and stating that her right shoulder was worse. She reported that she got a steroid injection. She also gave a history of her treatment with Dr. Jones. Petitioner complained of extreme pain in her right arm and an inability to raise her right arm. She also complained of pain in her right shoulder, pain that moves up towards her neck and down her right arm, and pain worse with any quick movement, and pain when she attempts to reach or move her arm backwards. She reported numbness and tingling. She rated her pain as a 6–7/10. Her clinical examination showed possible early signs of RSD, limited range of motion of her right shoulder, shoulder girdle and atrophy weakness, and mild scapular winging. Dr. Fletcher was of the opinion that petitioner needed electrical studies to rule out suprascapular nerve entrapment and/or long thoracic nerve injury, diagnostic arthroscopy/manipulation followed by appropriate physical therapy, Lyrica or Cymbalta for neuropathic pain, and that petitioner be monitored for RSD. With respect to causation, without reporting a second injury, there is a long break in treatment that would lead one to believe that her present condition is not causally related to her 2007 injury. Dr. Fletcher was of the opinion that petitioner is unable to perform her normal work duties. He limited her lifting to no overhead activities. He was further of the opinion that petitioner had reached maximum medical improvement for her original injury in 2007. Dr. Fletcher opined that petitioner's current problems with her shoulder appeared to have been a result of an intervening injury around Thanksgiving that aggravated her condition. Petitioner reported that she was currently working light duty, and this consisted of paperwork.

On 10/21/10 petitioner presented to Dr. Bowers after going to the emergency room the night before because of her migraines. Petitioner complained of bilateral shoulder pain. She also reported that the pain was exacerbating her migraines. She stated that the Valium they gave her at the ER was not helping. Petitioner gave no history of an injury on 11/20/09.

On 10/25/10 petitioner presented to Dr. Bowers with a chief complaint of anxiety. Petitioner was waiting for Dr. Bowers in the parking lot after lunch. She was tearful, hysterical, and stated that her shoulder pain had been severe, that she could not afford the Lyrica, and the Flexeril upset her stomach. She was worried about her work and finances, and was having a panic attack. Petitioner stated that she had been avoiding the Vicodin and taking the Flexeril. Dr. Bowers talked to petitioner and was able to calm her down. She noted that petitioner's

pain was 6/10, and recommended that she take Vicodin in the morning, and Flexeril at night. She also stated that petitioner might want to consider Neurontin, since it may be cheaper. Dr. Bowers also recommended that petitioner take a trial of Xanax. On 10/25/10 Dr. Bowers authorized petitioner off work until 11/1/10. Petitioner gave no history of an injury on 11/20/09.

On 11/9/10 Dr. Bowers authorized petitioner off work until 11/12/10.

On 11/15/10 petitioner completed her Application for Adjustment of Claim with respect to her alleged accident to her right shoulder on 11/20/09.

On 11/18/10 petitioner underwent an MRI of her right shoulder. The impression was small joint effusion, a full thickness and complete, or near complete, tear involving the supraspinatus, a thin strand of remaining tenderness continuity possible along the anterior periphery of the supraspinatus, remainder of the supraspinatus torn and retracted to the medial aspect of the humeral head, extensive full thickness tear with suspected complete or near complete tear of the infraspinatus, and fluid signal extending into the torn infraspinatus extending to the musculotendinous junction.

On 11/23/10 Dr. Bowers authorized that petitioner was off work from 11/9/10 through 11/19/10 due to shoulder pain.

On 12/9/10 petitioner returned to Dr. Jones. Dr. Jones reviewed the MRI of the right shoulder with her. He also discussed surgery with her. Dr. Jones noted no change in her history or condition since the last time he saw her on 8/19/10. He noted that petitioner was taking Vicodin for pain, Flexeril, and Tylenol. Dr. Jones told petitioner that the planned surgery was for rotator cuff repair, but based on her situation it could not be repaired because some tears essentially shrink the tendon over time and they cannot be repaired. He told her that her 2 tendons had shrunk to the point where they could not be reattached to the humerus bone. Dr. Jones told petitioner that all that could be done was a debridement.

On 12/22/10 petitioner underwent a diagnostic arthroscopy with debridement of the rotator cuff tear, and decompression. Petitioner's postoperative diagnosis was irreparable rotator cuff of the right shoulder. This procedure was performed by Dr. Jones. Dr. Jones was of the opinion that post-operatively functionally petitioner was doing well, but she continued to have pain. Petitioner followed-up postoperatively with Dr. Jones. This treatment included injections and physical therapy. The injections did not help much. Dr. Jones ultimately got to the point with petitioner's follow-up, where he was wondering whether or not she was a candidate for a muscle transfer. Petitioner was taken off work on 12/21/10.

On 1/3/11 petitioner underwent another physical therapy evaluation at Shelby Memorial Hospital following her right shoulder scope for rotator cuff debridement and subacromial decompression. Petitioner reported that she injured her shoulder at work on 7/13/07. Petitioner gave no history of an injury on 11/20/09. She reported that she had problems off and on with the shoulder and it became severe last year. Petitioner had therapy and had severe pain that could not be relieved. She stated that the doctor told her she has a severe tear in the shoulder that he could not repair, and she should go to a specialist in St. Louis to see about that. She rated her pain level at a 4/10. Petitioner underwent 16 sessions of physical therapy through 3/17/11. At that time petitioner was doing light strengthening and range of motion, but still had pain that burned with most activities.

On 2/8/11 petitioner followed up with Dr. Jones. Dr. Jones examined petitioner and released her to return to work with no lifting over 10 pounds, and limited overhead work. He also stated that she could start working three days a week for two weeks, and then return to normal hours.

On 2/13/11 petitioner testified that she was released to work. She testified that she had trouble lifting charts, and could not use a computer, or lift meal trays. Thereafter, petitioner testified that she got lifting restrictions. Petitioner testified that she then got to the point where she could not work due to exhaustion from the pain. After missing several days because of this, she was let go by Taylorville Rehab on 3/4/11. Since this date petitioner has not worked, but has applied for jobs.

On 3/22/11 petitioner returned to Dr. Jones and reported that she still had pain, could not do anything repetitive, and still had trouble with strength. Petitioner's motion was good but slow. She was not taking her medication, but she was using ice when needed.

On 4/21/11 petitioner followed up with Dr. Bowers for an unrelated condition. She did not make any mention of her right shoulder pain.

On 4/25/11 petitioner presented to Dr. Jay Keener at Washington University in St. Louis for her right shoulder. Petitioner reported that she was left hand dominant and sustained an acute traumatic rotator cuff tear in July 2007 while trying to start a leaf blower. Petitioner had persistent pain thereafter, especially with work, which involves transporting residents of a nursing home. Eventually the pain continued to persist despite conservative treatment including subacromial corticosteroid injections, as well as physical therapy. Petitioner gave no history of an injury on 11/20/09. Petitioner reported that she was currently having night pain, as well as pain with overhead and outreaching, and some minimal weakness. Following a physical examination, review of x-rays/studies, Dr. Keener's impression was massive rotator cuff tear of the right shoulder, irreparable. Dr. Keener discussed petitioner's treatment options with her. He noted that she had retained motion and no lag

signs. Although one could consider a lat tendon transfer, he believed in this situation it was not likely to help her. Dr. Keener stated that lag transfers tend to restore some external rotation motion sometimes, but petitioner seemed to have this motion. Her issue was primarily pain. Dr. Keener was of the opinion that there was little chance that a lat transfer would have a significant improvement with petitioner in terms of pain or function. He noted that they could consider a reverse shoulder arthroplasty down the road. He was of the opinion that this would be a more predictable surgery for petitioner, but he would first try to maximize conservative management and consider periodic glenohumeral steroid injections. He was of the opinion that consideration for a reverse shoulder arthroplasty can be made later if petitioner's arthritis progresses and she loses overhead motion. He released petitioner on an as needed basis. Petitioner testified that she is not interested in the surgery recommended by Dr. Keener.

On 10/25/11 petitioner returned to Dr. Jones. Dr. Jones performed an injection into her shoulder joint. He stated that if the steroid injection did not work he could try hyalgan injections. Petitioner told Dr. Jones that she was not working at that time. Dr. Jones continued her restriction of no lifting over 10 pounds.

On 7/13/12 Dr. Mitchell Rotman performed a record review on behalf of respondent. The records Dr. Rotman reviewed included the MRI scans of petitioner's right shoulder, records of Dr. Jones from 2010, records of Dr. Keener, and the records of Dr. Bowers. Dr. Rotman did not have any records from Bonutti Clinic, or any records relative to the 2007 accident to review. Dr. Rotman was of the opinion that petitioner did not have a small rotator cuff tear on the original MRI, but rather a tear the size between a nickel and a quarter. He was of the opinion that the MRI showed a lot of chronic changes including AC joint arthritis and some cysts in the greater tuberosity consistent with the fact that she may have had problems with chronic impingement for quite some time and that the incident of pulling the cord on the leaf blower may have triggered the pain from a pre-existing condition. However, he admitted that he did not see any records suggesting that petitioner had problems with her right shoulder prior to the injury in 2007. He was of the opinion that it may certainly have been repairable at that time. Dr. Rotman opined that pulling the cord on the leaf blower is not exactly a mechanism that is going to cause a rotator cuff tear with all of the chronic changes petitioner had on the MRI. He was of the opinion that it may cause discomfort from an individual with a pre-existing rotator cuff tear. Dr. Rotman was of the opinion that petitioner had chronic, long-standing problems with the right shoulder that would be unrelated to the pulling of a cord of a leaf blower. He was of the opinion that if petitioner had an acute injury on 7/13/07 that would have caused this type of significant rotator cuff tear that was seen on the original MRI scan, she would have had to present with an acute painful condition and an inability to raise her arm up, probably for 2 to 3 weeks at least, before getting some relief from conservative care. Dr. Rotman was

of the opinion that a reverse total shoulder would have a more predictable outcome. He believed she would be a good candidate for a latissimus dorsi transfer based on the fact she could lift arm fairly well, albeit with discomfort. He noted that petitioner may also need further decompression and a biceps tenodesis. Dr. Rotman was of the opinion that petitioner had not yet reached maximum medical improvement. Dr. Rotman was of the opinion that based on her job description petitioner would be able to do all of the activities at the Shelbyville Rehabilitation and Healthcare Center.

Petitioner followed up with Dr. Jones on 7/24/12. Petitioner denied any problems with the previous injection. She stated that relief from the last injection only lasted two weeks. Petitioner hoped the new injection would be different and more helpful. Petitioner denied any recent fall or injury. Dr. Jones injected petitioner's shoulder joint again. He released petitioner on an as needed basis. On 7/26/12 Dr. Jones restricted petitioner from lifting over 12 pounds, and limited overhead work. He noted that she could work full duty with these restrictions.

On 8/14/12 Dr. Rotman drafted an addendum report after receiving additional records related to the July 2007 accident, including the records from Dr. Gray. Based on his further review of records, Dr. Rotman was of the opinion that his original opinions were only strengthened with regard to her having pre-existing rotator cuff problems. He was of the opinion that what petitioner felt at the time of the pulling of the cord incident was merely a triggering of pain from a pre-existing tear of her shoulder which was asymptomatic up to that point, and then improved quickly with conservative care, and then reaggravated later on, secondary to some of her heavier activities that she may have been doing outside of work, that were noted by the physical therapist when she began to have pain again, prior to the 6/16/10 therapy notes.

In 2013 petitioner applied for SSDI and was awarded it. She benefits were back dated to 12/22/10.

On 6/3/13 the evidence deposition of Dr. Mitchell Rotman, an orthopedic surgeon, was taken on behalf of the respondent. Dr. Rotman performed a record review, but did not examine petitioner. Although the radiologist measured the rotator cuff tear following the July 2007 injury to be 2.5 cm, Dr. Rotman placed it at a size between a nickel and a quarter. He did not believe it was a small rotator cuff tear. He referred to it as a moderate rotator cuff tear. He admitted it was not a massive rotator cuff tear. Dr. Rotman was of the opinion that most rotator cuff tears are generally chronic. He opined that as a result of the 7/13/07 accident petitioner merely triggered pain from the pulling of the leaf blower cord twice, and that she did not present acutely with an acute rotator cuff tear. He based this on the fact that petitioner was able to lift her arm up after the accident, and had a fairly quick recovery. He stated that if it had been an acute care there would have been an inability to lift the arm up for several weeks and then improvement. In her situation it was completely the opposite. Dr.

Rotman was of the opinion, based on Dr. Gray's records, that petitioner reached maximum medical improvement in January 2008 with regards to the accident on 7/13/07. At that point petitioner had 5/5 strength, she was working her regular duty job, and had no complaints. Dr. Rotman was of the opinion that after 2008 petitioner did not start complaining of shoulder pain again in her right shoulder until 1/14/10. Dr. Rotman agreed that between 7/7/08 and January 2010 petitioner did not have any problems with her right shoulder. Dr. Rotman opined that petitioner's complaints in 2010 were not causally related to the accident on 7/13/07. Dr. Rotman was of the opinion that the incident on 7/13/07 did not cause her rotator cuff tear, or aggravate her rotator cuff tear. It merely triggered pain from a pre-existing chronic rotator cuff tear. Dr. Rotman believed that petitioner should avoid any job that required overhead or shoulder level work. Dr. Rotman also believed that petitioner would be a candidate for a reverse total shoulder, or muscle transfer. However, Dr. Rotman opined that neither of these procedures would be related to the 7/13/07 accident. Dr. Rotman was of the opinion that over years a degenerative tear of the supraspinatus can lead to a tear of the infraspinatus. He was of the opinion that this was just the natural progression of aging. Dr. Rotman opined that petitioner's condition in 2010 was consistent with an ongoing degenerative process within the shoulder.

On cross-examination Dr. Rotman testified that he does about five independent medical examinations a week, most of them for respondents or insurance companies. He also does IMEs for malpractice cases, which are generally for the plaintiff. Dr. Rotman testified that he did not review the report from Dr. Fletcher, or any hand written notes from Sharon Moore. Dr. Rotman was of the opinion that he did not see any problem with Dr. Gray's opinion in August 2007 that petitioner may be a candidate for surgery. Dr. Rotman opined that not all rotator cuff tears get worse. Dr. Rotman could not opine as to how long petitioner's rotator cuff tear, that was seen on the original MRI, was present, but he believed it had been there for awhile based on the presentation in the greater tuberosity cyst. Dr. Rotman opined that the changes seen on the MRI in 2010 were of a chronic nature. He opined that the tear got much bigger between 2007 and 2010. Dr. Rotman was of the opinion that petitioner would be able to push, pull, move and/or lift a maximum of 30 pounds to a minimum height of 4 feet if she held her shoulders to the side. If she had to reach forward to do it, where her shoulders are elevated to 90°, Dr. Rotman was of the opinion that it would be difficult.

On 11/27/13 the evidence deposition of Dr. Fletcher, a preventive medicine and occupational medicine doctor, was taken on behalf of petitioner. Dr. Fletcher testified that the history he had regarding petitioner's two incidents was gained solely through petitioner's history. Dr. Fletcher testified that he had not reviewed any more records than he had when he examined petitioner. Dr. Fletcher opined that when he examined petitioner in October 2010 she had very obvious abnormal physical findings that correlated with her subjective complaints.

Dr. Fletcher opined that when he saw petitioner in 2010 he had a differential diagnosis that there were several clinical possibilities that needed to be evaluated further that included, concern about a torn rotator cuff with possible frozen shoulder, features of adhesive capsulitis, as well as symptoms and early clinical findings that could be consistent with chronic regional pain syndrome or reflex sympathetic dystrophy. Dr. Fletcher opined that the cause of these conditions was not related to the 2007 injury. He opined that petitioner's condition following that injury in 2007 appeared to have resolved without any sequela, based on the long gap in treatment. Dr. Fletcher opined that these conditions could be related to the incident in November of 2009, if her history was accurate. Dr. Fletcher opined that as a result of the incident on 7/13/07 petitioner sustained a small rotator cuff tear that had clinically resolved. Dr. Fletcher opined that the MRI dated 11/18/10 showed a large rotator cuff tear in contrast to her 2007 MRI. He opined that the pathology on 11/18/10 MRI is much worse than the one in 2007. Dr. Fletcher opined that the mechanism of injury that petitioner reported occurring in November 2008 could cause the present condition for which he saw her for in October 2010.

On cross-examination by Mr. Jennetten, Dr. Fletcher opined that following the incident in 2007 and her release from care on 1/7/08, petitioner's problem with respect to her right shoulder had resolved. He opined that petitioner then had a long gap in treatment followed by another incident with an intervening cause with the necessity for treatment.

On cross-examination by Ms. McCarthy Dr. Fletcher stated that the questionnaire filled out by petitioner did not include a work-related injury in November 2009. He further stated that the history taken by him or his staff also did not include an incident in November of 2009 related to transferring a resident. Dr. Fletcher testified that when petitioner described the incident of November 2009, she specifically told him that she did not report it at work, but there was witnesses. Dr. Fletcher testified that the physical therapy note from 6/16/10 includes a history that petitioner was doing an office job, she enjoyed being quite active and probably aggravated her arm doing more strenuous activities. Dr. Fletcher was of the opinion that from all the records he reviewed there was nothing in them to indicate that petitioner was relating her right shoulder problems or symptoms to the alleged injury in November 2009.

On redirect examination Dr. Fletcher opined that as a result of the accident on 7/13/07 petitioner's rotator cuff did not get progressively worse with regard to daily activity or activities at work based on her lack of treatment between 2008 and 2010. Dr. Fletcher was also the opinion that the rotator cuff that was diagnosed in 2007 could heal itself.

On 7/9/14 the evidence deposition of Dr. Tyler Jones, an orthopedist, was taken on behalf of petitioner. Dr. Jones was of the opinion that the natural history of this type of condition would result in arthritis, and when

it gets significant enough, petitioner could undergo a reverse shoulder replacement. Dr. Jones noted that petitioner might never require a replacement. Dr. Jones opined that it is hard to pinpoint what was causing petitioner's pain in the shoulder area when he examined her. He did note that at that time she did not have significant degenerative changes. Dr. Jones was of the opinion that he could most likely pinpoint her pain to her rotator cuff. Dr. Jones was of the opinion that petitioner may be a candidate for viscosupplementation injections in the future. Dr. Jones opined that the leaf blower incident caused the shoulder pain that petitioner felt. He did not believe that the rotator cuff tear was caused by the pulling of the leaf blower. He opined that pulling the leaf blower aggravated a pre-existing rotator cuff tear. Dr. Jones noted that when Dr. Gray saw petitioner, if she had been pain-free for a longer period of time, then making a causal connection to the leaf blower incident would be more difficult. Dr. Jones opined that once petitioner was released from care following the leaf blower incident, and there were several years that she did not have pain, then it would be difficult to link her current condition of ill being of her right shoulder to the leaf blower incident. Dr. Jones testified that he was not aware of any incident where petitioner was lifting a patient. Dr. Jones opined that as of the last time he saw petitioner on 7/24/12 for a steroid shot he did not have her on any restrictions. Dr. Jones opined that a lifting incident could cause a rotator cuff tear or aggravate a rotator cuff tear.

On cross-examination by Mr. Brewer, Dr. Jones testified that he had not reviewed either the report or the MRI films of the MRI from 2007, but did review the MRI from the time when he was treating petitioner. Dr. Jones testified that he was not aware of any treatment that petitioner had with regards to her right shoulder from January 2008 until the time he saw her in August 2010. Dr. Jones opined that since petitioner was released from care in January 2008 and did not treat again until she saw him in August 2010, it is possible that the recurrence of pain that she experienced and the problems she described to him as coming back in February 2010 could be related to the natural degeneration of a pre-existing condition of her shoulder. He further opined that it is possible that the recurrence of pain in February 2010 may not have had anything to do with the leaf blower incident in 2007. Dr. Jones opined that it is possible that petitioner had an accident that involved movement of a patient that could have caused an increase in a rotator cuff tear, and increase in her pain and the need for the surgery he performed. Dr. Jones opined that it was reasonable and necessary that no treatment was rendered in 2008 by Dr. Gray due to the fact that petitioner had reported that her pain had resolved. Dr. Jones opined that surgery for rotator cuffs is done secondary to pain.

On cross-examination by Ms. McCarthy Dr. Jones testified that there is absolutely nothing in his records regarding an alleged lifting of a patient by petitioner from 8/19/10 through 7/24/12. Dr. Jones testified that he knew nothing of any alleged lifting of a patient by petitioner in November 2009.

On 12/16/14 the evidence deposition of Dr. Timothy Gray was taken on behalf of the petitioner. Dr. Gray is a board-certified in general orthopedics. Dr. Gray opined that the incident on 7/13/07 caused petitioner to irritate and tear her right rotator cuff. He opined that when he released petitioner to full duty work on 1/7/08 he was of the opinion that petitioner was doing well. He was of the opinion at that time that petitioner would have a higher incidence for problems with that shoulder in the future, but that was not by any means a foregone conclusion. As a result he had no further treatment plans for her. Dr. Gray was of the opinion that once you have rotator cuff joint problems, you are at a higher risk for it flaring up and having more problems with it than those in the general population who never had problems with their rotator cuff joint. Dr. Gray was of the opinion that when he released petitioner on 1/7/08 there was no way to tell whether or not her rotator cuff had been fully healed. Dr. Gray testified that some rotator cuff tears will heal, and some don't. He testified that some just maintain a small tear, and it forms an arc, and scars. He testified that it does not necessarily heal completely, but it becomes functional and painless, and he would not do anything about it. Dr. Gray was of the opinion that if petitioner had decided upon a surgery when offered, he would have referred her to Dr. Lee who would have probably performed an arthroscopic decompression rotator cuff repair. Dr. Gray was of the opinion that even with surgery once you've had damage, you are still at risk for further damage.

On cross-examination Dr. Gray testified that he never formally placed any lifting or any weight restrictions on petitioner. He testified that he just limited petitioner to doing what she could tolerate. He testified that he told her to let her pain be her guide. Dr. Gray opined that it is possible that a rotator cuff tear can heal on its own without surgery. He further opined that it is possible that a tear of the rotator cuff can be treated conservatively and never actually need any surgery to repair it. Dr. Gray reviewed an MRI of the shoulder taken 11/18/10 and was of the opinion that it showed a greater degree of tearing them there was on the MRI that he ordered in 2007. He was of the opinion that it showed not only the supraspinatus being torn, but also the infraspinatus being torn. Dr. Gray was of the opinion that the difference between the MRI and 2007 and the MRI in 2010 could not be related to that natural degeneration of the shoulder. He opined that you would probably require further trauma for it to be torn this much more. Dr. Gray was of the opinion that the injury petitioner would have sustained as a result of the leaf blower incident could have resolved as of the last day he saw her on 1/7/08. Dr. Gray was of the opinion that petitioner had reached maximum medical improvement as it relates to the leaf blower incident on 1/7/08. Dr. Gray did not believe petitioner had any limitations as of 1/7/08 with respect to her right shoulder.

On redirect examination Dr. Gray testified that when he released petitioner on 1/7/08 that clinically she was doing very well and his assumption was that her rotator cuff had resolved.

Kelly Walter, Director of Nursing for respondent from 1992-2010, and Director of Nursing at Taylorville Care Center for almost five years. Walter testified that petitioner reported the alleged accident on 11/20/09 to her. She testified that petitioner told her she injured her right shoulder during the residents Thanksgiving dinner when she moved a wheelchair and hurt her right arm. She testified that she did not have petitioner complete an accident report because all petitioner did was say "oh that hurt", and she did not think it was a new accident. Walter noted that she worked with petitioner from 2007-2009. She testified that in 2008 and 2009 petitioner had ongoing issues with her right shoulder since the injury on 7/13/07. Walter testified that petitioner went through the chain of command to get additional treatment, but they kept telling her they would look into it and they never responded. Walter testified that she was not aware that petitioner was on restrictions. Walter also testified that she was aware of the policies to follow if someone was injured. She testified that she is a friend of petitioners and went to work at Taylorville Health Care when petitioner went.

Respondent offered into evidence the job description for Social Service Director at Petersen Healthcare. The pertinent job responsibilities including being able to push, pull, move and/or lift a minimum of 30 pounds to a minimum height of 4 feet; assisted evacuations of residence in emergency situations; and assisting and lifting heavy objects.

Petitioner testified that she sees Dr. Bowers as needed, and takes Mobic for shoulder since February of 2015. She also takes Tylenol arthritis 600mg as needed for pain. Petitioner testified that she cannot lift anything heavy and cannot raise her arm past 90 degrees. Petitioner complained of pain in her right shoulder all the time, and stated that it affects her sleep. Petitioner still uses her TENS unit. She cannot ride a mower or help her husband with the farming. She stated that she cannot drive a truck hauling hay because she has difficulty steering. Petitioner cannot lift her granddaughters or play Frisbee. Although petitioner is left hand dominant, she testified that she only uses her left hand for writing, and uses her right arm for everything else. Petitioner denied any accidents outside of work. Petitioner testified that she was active before the accident on 7/13/07, not after.

Petitioner testified that she looked for jobs at the County Market, Marathon gas station, Yellow Hat, and TNL Locker.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

The parties have stipulated that petitioner did sustain an accidental injury to her right shoulder that arose out of and in the course of her employment by respondent on 7/13/07. However, a dispute exists as to whether

or not petitioner sustained an accidental injury to her right shoulder on 11/20/09. As such, the arbitrator will be addressing this issue only as it applies to the alleged accidental injury on 11/20/09.

Petitioner is alleging an injury to her right shoulder on 11/20/09 while working for respondent. The petitioner testified that she sustained an injury to her right shoulder while the residents at respondent's facility were having Thanksgiving dinner. She testified that on this day two residents were back to back in wheelchairs and they kept bumping into each other. She stated that the Director of Nursing, Walter, came over and asked one of the residents to slide over a bit. Petitioner attempted to move the resident over and felt a pull in her right shoulder, tingling, and tearing down her arm. Petitioner did not complete an accident report for this incident.

The arbitrator finds it significant that petitioner claims she was injured while the residents were eating their Thanksgiving dinner on 11/20/09, but 11/20/09 was the Friday before Thanksgiving, not Thanksgiving Day, or the weekend before or after Thanksgiving. Thanksgiving Day 2009 was on 11/26/09.

Following this alleged accident, in addition to not completing an accident report, petitioner did not seek any treatment for her right shoulder until 2/15/10, almost three months after the alleged accident. The arbitrator finds it significant that petitioner detailed quite a significant incident occurring but when she presented for treatment of her right shoulder on 2/5/10, 6/30/10, 6/16/10, 7/2/10, 8/2/10, 8/11/10, 8/19/10, 8/27/10, 10/21/10, 10/25/10, 12/9/10, 1/3/11, 2/8/11, 2/13/11, 3/22/11, 4/21/11, 4/25/11, 10/25/11, and 7/24/12, she made absolutely no mention of any injury to her right shoulder on 11/20/09. In fact, even when she filed her Application for Adjustment of Claim on 7/9/10, with respect to the alleged injury on 7/13/07, she never mentioned this alleged injury on 11/20/09 to her attorney. She also made no mention of this alleged injury to any healthcare provider, other than to Dr. Fletcher on 10/18/10, when he performed a Section 12 examination at the request of her attorney. The arbitrator finds it significant that it was only after petitioner was examined by Dr. Fletcher on 10/18/10 at the request of her attorney, that she then filled out an Application for Adjustment of Claim on 11/15/10 with respect to her alleged right shoulder injury on 11/20/09.

The arbitrator also finds discrepancies in petitioner's testimony regarding the alleged incident on 11/20/09, and Walters history of what happened significant. Petitioner testified that when she attempted to move the resident on 11/20/09 she felt a pull in her shoulder, had tingling, and experienced a "tearing" down her arm. Alternatively, Walter testified that all petitioner said when she moved the wheelchair was "oh, that hurt".

Petitioner testified that from February of 2009 and July of 2009 she repeatedly requested treatment from respondent's representatives, and was not given authorization. However, petitioner never testified that she had any problems getting into see Dr. Bowers and did not see Dr. Bowers until nearly three months following the

alleged injury, and made no mention of the alleged injury at that time. Petitioner was also seen by various healthcare providers on at least 10 occasions between 11/20/09 and the date she was examined by Dr. Fletcher. At no time during this period did petitioner ever mention an injury at work on 11/20/09. In fact, petitioner made specific mention of the accident on 7/13/07 during this period, and reported on 2/15/10 sever shoulder complaints for the last 2-3 weeks, and reported on 6/16/10 right shoulder pain for the past six months without any mention of an injury being the cause of the onset of her pain. Additionally, on 6/16/10 when petitioner had her physical therapy evaluation she stated that she is active and aggravates her shoulder doing more strenuous activities.

When petitioner was injured on 7/13/07 she immediately reported the injury and completed an accident report. The arbitrator finds she really did not give a reasonable explanation for why she did not complete an accident report following the alleged injury on 11/20/09. The arbitrator also questions the significant delay in treatment following the alleged accident on 11/20/09.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has proven by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 7/13/07, but has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 11/20/09.

The arbitrator bases the finding that petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 11/20/09 on the fact that petitioner's history of the alleged injury sustained on 11/20/09 differs from Walter's history; that petitioner never completed an accident report following the alleged injury on 11/20/09; that petitioner did not make any mention of any alleged injury on 11/20/09 until she presented to Dr. Fletcher, at the request of her attorney on 10/18/10; that petitioner did not make mention of any alleged injury on 11/20/09 when she presented to various healthcare providers between 11/20/09 and 10/17/10; that when petitioner made mention of any accident between 11/20/09 and 10/17/10, it was in reference to the injury on 7/13/07; that when petitioner completed her Application for Adjustment of Claim on 7/9/10 she made no mention of an alleged accident on 11/20/09; that she did not complete an Application for Adjustment of Claim with respect to an alleged accident on 11/20/09 until one month after she saw Dr. Fletcher at the request of her attorney; that Walter testified that she did not think petitioner sustained an accident on 11/20/09; that neither Thanksgiving Day in 2009, nor the weekend before or after Thanksgiving Day 2009 was 11/20/09.

E. WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT?

With respect to the accident on 7/13/07, the parties stipulated that petitioner gave timely notice of this accident to respondent. With respect to the alleged accident on 11/20/09, the respondent claims the petitioner did not provide timely notice.

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 11/20/09, the arbitrator finds this issue moot as it relates to the alleged accident on 11/20/09.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner claims her current condition of ill-being is causally related to the injury she sustained on 7/13/07. Respondent claims petitioner's current condition of ill-being as it relates to her right shoulder is not causally related to the accident on 7/13/07 or the alleged accident on 11/20/09.

Following the injury on 7/13/07 petitioner treated with Dr. Gray through 1/7/08. During this period petitioner underwent an MRI of her right shoulder that showed a small complete rotator cuff tear, a 2.5 cm diameter tear at the supraspinatus tendon insertion. Dr. Gray gave petitioner the option of a referral to Dr. Lee for a surgical evaluation, or continued conservative treatment. Petitioner selected conservative treatment. On 1/7/08 petitioner reported that she was feeling well and was doing regular work. She had no complaints. She was using her shoulder and was doing fine. An examination revealed no instability, motor 5/5, and that she was neurologically intact. Dr. Gray released petitioner without any restrictions at all.

This was the last treatment petitioner had for her right shoulder until 2/15/10, when she complained of right shoulder pain, severe for the last 2-3weeks. She testified that between 1/7/08 and 2/15/10 she began feeling more pain in her shoulder in August or September of 2008 while transporting residents. However, she did not present to Dr. Bowers, even though she stated she could not get a referral to an orthopedic doctor through respondent from February 2009 through July of 2009. Additionally, the arbitrator notes this history is not noted in any medical report and petitioner did not call as witnesses any of the people that worked for respondent that she allegedly asked for a referral to an orthopedic doctor.

Various doctors offered causal connection opinions as they relate to petitioner's right shoulder. They include opinions from Dr. Fletcher, Dr. Rotman, Dr. Jones and Dr. Gray.

Dr. Fletcher, the only healthcare provider that had a history of an alleged accident on 11/20/09, opined that petitioner's current problems with her right shoulder appeared to have been a result of an intervening injury around Thanksgiving, that aggravated her condition. Dr. Fletcher opined that petitioner's current condition of ill-

being as it relates to petitioner's right shoulder is not causally related to the 2007 injury. He opined that the petitioner's condition following the injury in 2007 appeared to have resolved without any sequela, based on the long gap in treatment. He opined that as a result of the injury on 7/13/07 petitioner sustained a small rotator cuff tear that had clinically resolved, and could heal itself.

Dr. Rotman opined that most rotator cuff tears are generally chronic. He opined that as a result of the 7/13/07 accident petitioner merely triggered pain from the pulling of the leaf blower cord twice, and did not present with an acute rotator cuff tear. Dr. Rotman opined that petitioner reached maximum medical improvement as it relates to her 7/13/07 accident in January of 2008. Dr. Rotman found it significant that following her release from care in January of 2008, petitioner did not start complaining of right shoulder pain until 1/14/10. He opined that these complaints were not causally related to the accident on 7/13/07. Dr. Rotman opined that the accident on 7/13/07 did not cause or aggravate a preexisting right shoulder rotator cuff tear. He opined it merely triggered pain from the preexisting rotator cuff tear. He opined that he reviewed the MRI taken after the accident on 7/13/07 and was of the opinion that those findings were chronic in nature, and not acute, thus supporting his opinion that the accident on 7/13/07 did not cause, or aggravate the preexisting right shoulder rotator cuff tear. He based this opinion on the presentation in the greater tuberosity cyst. Dr. Rotman was of the opinion that the natural progression of aging related to the degenerative tear of the supraspinatus could lead to a tear of the infraspinatus over the years.

Dr. Jones opined that the leaf blower incident on 7/13/07 did not cause petitioner's rotator cuff tear. He opined that this incident merely aggravated a preexisting rotator cuff tear. Dr. Jones opined that if petitioner had been pain free for a longer period of time, then making a causal connection to the leaf blower incident would be more difficult. He noted that following her release from care after the leaf blower incident, if petitioner had several years where she did not have pain, it would be difficult to link her current condition of ill being as it relates to her right shoulder to the leaf blower incident. Given the fact that petitioner was released from care in January 2008 and did not treat again until she saw him in August 2010, Dr. Jones was of the opinion that it is possible that the recurrence of pain that petitioner experienced, and the problems she described to him as coming back in February 2010, could be related to the natural degeneration of a pre-existing condition of her shoulder. He further opined that it is possible that the recurrence of pain in February 2010 may not have had anything to do with the leaf blower incident in 2007.

Dr. Gray was of the opinion that the incident on 7/13/07 caused petitioner to irritate and tear her right rotator cuff, but she was doing well when he released her from his care in January of 2008. Dr. Gray was of the opinion that petitioner could have a higher incidence of problems with her shoulder after being released from

care for the 7/13/07 incident, but that was by no means a foregone conclusion. Dr. Gray was of the opinion that once you have rotator cuff joint problems, you are at a higher risk for it flaring up and having more problems with it than those in the general population who never had problems with their rotator cuff joint. Dr. Gray was of the opinion that when he released petitioner on 1/7/08 there was no way to tell whether or not her rotator cuff had been fully healed. Dr. Gray testified that some rotator cuff tears will heal, and some don't. He testified that some just maintain a small tear, and it forms an arc, and scars. He testified that it does not necessarily heal completely, but it becomes functional and painless, and he would not do anything about it. Dr. Gray was of the opinion that it is possible that a tear of the rotator cuff can be treated conservatively and never actually need any surgery to repair it. Dr. Gray reviewed an MRI of the shoulder taken 11/18/10 and was of the opinion that it showed a greater degree of tearing than there was on the MRI that he ordered in 2007. He was of the opinion that it showed not only the supraspinatus being torn, but also the infraspinatus being torn. Dr. Gray was of the opinion that the difference between the MRI in 2007 and the MRI in 2010 could not be related to the natural degeneration of the shoulder. He opined that you would probably require further trauma for it to be torn this much more. Dr. Gray was of the opinion that the injury petitioner would have sustained as a result of the leaf blower incident could have resolved as of the last day he saw her on 1/7/08. Dr. Gray was also of the opinion that petitioner had reached maximum medical improvement as it relates to the leaf blower incident on 1/7/08. Dr. Gray did not believe petitioner had any limitations as of 1/7/08 with respect to her right shoulder.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that her current condition of ill-being as it relates to her right shoulder is causally related to the injury she sustained on 7/13/07. The arbitrator further finds the petitioner reached maximum medical improvement as it relates to her right shoulder following the injury on 7/13/07 by 1/7/08. The arbitrator bases this finding on the opinions of Dr. Fletcher, Dr. Rotman, Dr. Jones and Dr. Gray, who all opined that following the injury on 7/13/07 petitioner reached maximum medical improvement on 1/7/08.

The arbitrator finds the petitioner's current condition of ill-being as it relates to her right shoulder is causally related to the injury she sustained on 7/13/07 only through 1/7/08. Having found the petitioner failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 11/20/09, the arbitrator finds this issue moot as to the alleged injury on 11/20/09.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found the petitioner sustained an accidental injury to her right shoulder on 7/13/07, and that her current condition of ill-being as it relates to her right shoulder is causally related to the injury on 7/13/07 through 1/7/08, the arbitrator finds the respondent shall pay for all reasonable and necessary medical services related to petitioner's right shoulder from 7/13/07 through 1/7/08, pursuant to Sections 8(a) and 8.2 of the Act.

Having found the petitioner failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 11/20/09, the arbitrator finds this issue moot as to the alleged injury on 11/20/09.

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

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner claims she is entitled to temporary total disability benefits from 12/21/10-2/13/11 and 3/3/11-4/20/15 as a result of her accident on 7/13/07 and her alleged injury on 11/20/09. Having found petitioner reached maximum medical improvement with respect to her injury on 7/13/07 on 1/7/08 and failed to prove by a pre preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 11/20/09, the arbitrator finds this issue moot as to the alleged injury on 11/20/09.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

On 7/13/07 petitioner sustained an accidental injury to her right shoulder that arose out of and in the course of her employment by respondent when she pulled the cord on a leaf blower. She felt a pop in her right shoulder and pain.

For this injury petitioner treated with Dr. Gray from 7/23/07 through 1/7/08. Petitioner initially complained of right shoulder complaints. She stated that since the accident she had been using a sling and cold packs, and was having pain with rolling or elevating her shoulder. An examination was positive for limited elevation of the right shoulder, weakness on abduction of the shoulder, and positive impingement sign. Dr. Gray was of the opinion that these findings were indicative of rotator cuff pathology. Dr. Gray prescribed pain medications, anti-inflammatories, and ordered an MRI of the right shoulder.

On 7/30/07 petitioner underwent an MRI of the right shoulder. It showed a small complete rotator cuff tear, a 2.5 cm diameter tear at the supraspinatus tendon insertion.

On 8/7/07 petitioner returned to Dr. Gray. She was still having some pain and irritation, but was definitely improving with her medications. Dr. Gray went over the MRI results with petitioner and told her that she had a small rotator cuff tear. Dr. Gray gave her the option of continuing with conservative care or undergoing surgery. Petitioner testified that she was doing better and wanted to try and avoid surgical intervention. Dr. Gray continued petitioner's medications and continued her activities as tolerated.

On 9/26/07 petitioner followed up with Dr. Gray. At that time petitioner was doing much better, and her medications were helping. A physical examination indicated that petitioner was improving, and had minimal impingement sign. Petitioner reported that she was feeling better and was using her arm. Dr. Gray continued petitioner's medications and continued her activities as tolerated.

On 1/7/08 petitioner last followed up with Dr. Gray. Petitioner was feeling well at that time and was doing regular work. She had no complaints. Petitioner was using her shoulder and was doing fine. An examination revealed no instability, motor 5/5, and neurologically intact. Dr. Gray released petitioner without any restrictions at all.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner sustained a 5% loss of use of her person as a whole pursuant to Section 8(d)2 of the Act as it relates to the accident on 7/13/07. Since petitioner failed to prove by a pre preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 11/20/09, the arbitrator finds this issue moot as to the alleged injury on 11/20/09.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WENDY SIPLA,

Petitioner,

vs.

NO: 10 WC 29290

16IWCC0328

LINCOLN-WAY COMMUNITY SCHOOL,

Respondent.

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner was a school bus driver for Respondent.

2. On February 12, 2009 Petitioner completed her bus route. Then, as advised, she returned to drop off the bus in the employee parking lot and walked to her car. While walking in the lot, she reached in her purse to grab her keys and slipped and fell on black ice. She experienced pain in her tailbone, left elbow and back.

3. After seeking medical treatment she was diagnosed with a left elbow contusion and sacral contusion and was prescribed Flexeril and Vicodin. On February 19, 2009 her primary physician performed a sacral coccyx injection. She then returned to work

until February 24, 2010.

4. On that date Petitioner travelled to work feeling "great." She testified that she had no history of neck or right shoulder pain prior to that date, but stated that she had injured her back in 2006. Following said injury she was eventually released back to work. This occurred prior to her being hired by Respondent.

5. After completing her morning route on February 24, 2010 Petitioner was walking in between 2 buses in the employee lot when she slipped on some ice and tried to catch herself. She ended up twisting her arms and falling because there was nothing to grab onto. She experienced right shoulder, neck, back and tailbone pain.

6. After completing her afternoon route on the same date, Petitioner went home and had her husband take her to the ER. There she was diagnosed with a cervical strain with pain on multiple sides and was given a prescription for Norco.

7. On March 8, 2010 Petitioner was prescribed physical therapy, a cervical MRI and Vicodin and was taken off of work.

8. On March 12, 2010 Petitioner told her physical therapist that she fell in 2008 and fractured her tailbone.

9. On March 15, 2010 Petitioner informed Dr. Sampat that her shoulder issues had resolved, but that she had a recurrence of mid back pain which she rated between 6-8 out of 10 on a pain scale.

10. On March 27, 2010 social media photos depict Petitioner out with friends taking pictures and dancing at a bar.

11. On April 5, 2010 Dr. Sampat reviewed a 2006 thoracic MRI and noted a disc herniation. Petitioner complained of only occasional right shoulder pain. Lyrica is prescribed.

12. In April 2010 Petitioner added right chest pain to her complaints. She was continued off work.

13. On April 26th Petitioner had no shoulder pain. She testified that she was taking the prescribed Lyrica medication, but medical records indicate that she was not taking Lyrica at that time due to nervousness about the side effects. However, Dr. Sampat noted that she was taking 2 tablets of Vicodin every 4 hours, which exceeded 4000mg of Acetaminophen.

14. By May 10, 2010 Petitioner was doing well and was transitioned to work hardening, where she performed exercises such as sit ups, push-ups and use of weight machines. She was diagnosed with cervical whiplash, spondylosis, a thoracic herniated disc at T8-9, and chest radiculopathy. Things were progressing positively until June 21,

2010 when Petitioner cancelled an appointment due to back pain after cleaning floors at home.

15. On June 11, 2010 Petitioner was markedly better and Dr. Sampat anticipated she would reach MMI within 2 weeks.

16. On June 22, 2010 Petitioner told Dr. Sampat that she started having pain while doing stuff at home. By July 26th her cervical whiplash had resolved. On August 16, 2010 Dr. Sampat opined that Petitioner would reach Maximum Medical Improvement (MMI) within 4 weeks, and wanted to wean her off of narcotics.

17. Also on June 22, 2010 Petitioner complained of severe pain radiating from her back down the right side of her chest, along the T8-9 distribution. She was again prescribed Lyrica.

18. On July 26, 2010 Petitioner complained of pain radiating from her low back to her chest. Petitioner indicated that she had forgotten to fill her Lyrica prescription.

19. On August 12, 2010 a thoracic MRI was unremarkable.

20. On August 16, 2010 Petitioner reported improvement but had pain in her right shoulder. A course of work hardening was prescribed and it was hoped that she would reach MMI in 4 weeks. She was referred to Restoration Chiropractic Wellness Center, which managed to relieve her back pain.

21. Petitioner began work hardening again on August 24, 2010. 6 days later she returned to Dr. Sampat complaining of residual right shoulder pain. She received an injection, which helped for 5-6 days. Petitioner told Dr. Sampat that her shoulder problems stemmed from exercises done during work conditioning. She indicated that her back pain had resolved. MMI was expected within the next 2 weeks.

22. On September 13, 2010 Petitioner complained of severe right shoulder pain and mid back pain. An MRI was performed. The following day her MRI results revealed a type 2 acromial process with fraying of the anterior fibers of the supraspinatus with mild tendinopathy.

23. In September 2010 Petitioner was diagnosed with chronic impingement of her right shoulder. Arthroscopic surgery with subacromial decompression was recommended. Surgery was performed October 22, 2010.

24. On October 5, 2010 Dr. Trotter performed an Independent Medical Exam (IME) on Petitioner, finding no causation, aggravation or acceleration which would account for her impingement. He opined that Petitioner suffered a partial muscle tear in the serratus region at the time of accident. Dr. Trotter opined that Petitioner had reached MMI with respect to her work accident.

25. In March of 2011 work conditioning was again prescribed.

26. On May 20, 2011 Petitioner was discharged from conditioning and returned to full duty work. Petitioner was 100% better and had no shoulder pain.

Based on the evidence, The Commission affirms the Arbitrator's finding of causal connection with respect to Petitioner's cervical and shoulder conditions. The Commission also affirms the Arbitrator's ruling on temporary total disability, as Petitioner's shoulder condition is what kept her off of work, even after her back condition was no longer causally related to the accident.

The Commission, however, modifies the Arbitrator's causal connection ruling with respect to Petitioner's back condition. In addition to an August 2010 thoracic MRI being unremarkable after Petitioner complained of severe back pain, the Commission notes the suspicious waxing and waning of back symptoms in both June and August of 2010 on the part of Petitioner. On June 11, 2010 Petitioner indicated that she was doing well, and Dr. Sampat requested that she follow up in 2 weeks for a possible MMI finding. However on June 22, 2010, Petitioner had complaints of severe back pain after performing activities of daily living at home. Similarly, on August 30, 2010 Petitioner stated that her back pain had resolved. At that time Dr. Sampat indicated that he was hopeful she would reach MMI within 2 weeks. But again, on September 13, 2010 Petitioner complained of mid back pain.

Moreover, the Commission notes that, despite Petitioner complaining of back pain on March 15, 2010 that was between 6 and 8 on the pain scale from 1-10, evidence was presented showing her out with friends drinking and dancing at a bar 12 days later.

Additionally, the Commission finds it unbelievable that Petitioner was nervous about taking Lyrica in April 2010, when at the time she was actively taking 2 Vicodin tablets every 4 hours. The Commission also finds it unbelievable that Petitioner would have complaints of back pain in June 2010, yet forget to fill a Lyrica prescription.

The inconsistencies in Petitioner's complaints and behavior with relation to her back pain lead the Commission to a finding of no causal connection to the accident in question. Thus, the Commission reverses the Arbitrator's causal connection finding with respect to Petitioner's back condition.

In keeping with this causal connection modification, the Commission also modifies the award for medical expenses. All expenses related to Petitioner's cervical and shoulder conditions should be upheld, but all expenses awarded in relation to Petitioner's back condition subsequent to the October 5, 2010 MMI finding of Dr. Trotter shall be vacated.

Also in keeping with the causal connection modification, the Commission modifies the award for permanent partial disability to exclude any consideration of Petitioner's back condition. Petitioner's conservative right arm treatment, followed by surgical intervention and eventual full resolution shall be awarded with a 15% loss of use of her right arm.

16IWCC0328

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $228.84 per week for a period of 64-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $228.84 per week for a period of 37.95 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused a 15% loss of use of her right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses related to Petitioner's cervical and shoulder conditions, as well as all expenses related to Petitioner's back condition through October 5, 2010, under §8(a) of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $55,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 13 2016
O: 3/17/16
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SIPLA, WENDY
Employee/Petitioner

Case# **10WC029290**

10WC029289

LINCOLN-WAY COMMUNITY SCHOOL
Employer/Respondent

16IWCC0328

On 8/8/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0307 ELFENBAUM EVERS & AMARILIO PC
ADAM HINRICHS
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

0075 POWER & CRONIN LTD
BRIAN RUDD
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

16IWCC0328

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Wendy Sipla,
Employee/Petitioner

v.

Lincoln-Way Community School,
Employer/Respondent

Case # **10** WC **29290**

Consolidated cases: **10 WC 29289**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **New Lenox**, on **5/15/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **2/24/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**11,899.68**; the average weekly wage was $**228.84**.

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

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

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

Respondent shall be given a credit of $**7,192.11** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**7,192.11**. (See Arb.Ex.#2).

Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act. (See Arb.Ex.#2).

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $228.84 per week for 64-5/7 weeks, commencing 2/25/10 through 5/23/11, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 2/25/10 through 5/15/14, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $7,192.11 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $35,895.00, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $228.84 per week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

8/5/14
Date

ICArbDec p. 2

AUG - 8 2014

STATEMENT OF FACTS:

Petitioner, a 34 year old school bus driver, testified that she was hired by the Respondent in early 2009 and that here job duties included performing a Department of Transportation (DOT) checklist prior to performing her primary duty of driving the bus and transporting students safely. The school buses that Petitioner drives for Respondent are outfitted with large steering wheels that require the Petitioner to fully extend her arms, reaching to achieve the appropriate hand placement for driving. In order to steer the bus' wheel, the Petitioner must internally and externally rotate at the shoulders. Petitioner testified that steering a bus wheel is more difficult than steering a regular automobile wheel, due to the placement of the wheel and additional force necessary to steer the bus wheel.

When Respondent hired Petitioner, she was not under the care of any treating physician for her right shoulder, cervical spine, or thoracic spine. Petitioner passed her DOT physical prior to becoming employed by the Respondent.

On February 24, 2010, Petitioner parked her bus in the Respondent's school bus parking lot, where Respondent's drivers are required to park the buses. Petitioner was traversing an icy patch when she slipped on a patch of ice between her bus and another bus. She fully extended both of her arms to her side to try to catch herself from falling. Petitioner was unable to stop herself from falling, and fell onto her backside injuring her right shoulder, neck, and back. See Px. 12a – 12p.

Petitioner lay on the icy ground for a few minutes before being able to gather herself and report the incident to her boss, Dr. Murphy. Dr. Murphy advised Petitioner to wait and see if she felt better later in the day. Petitioner returned to the school bus lot that afternoon and completed her afternoon shift; however, her pain did not abate. Petitioner testified that she felt great when she reported for work on February 24, 2010, and that she was not under the care of any physician for treatment of right shoulder, neck or back symptoms. Petitioner testified that she had previously injured her thoracic spine in 2006, but had been fully released from care by her physician for that injury prior to starting her employment with Respondent.

On February 24, 2010, Petitioner reported to St. Joseph's emergency room. Petitioner gave a history of a fall on ice, after being unable to catch herself from falling to the ground; and she now felt discomfort in her "neck, shoulder and anterior chest." Px. 2, p. 28. The emergency room record notes that Petitioner's pain was aggravated by movement, and there is no back pain or other extremity pain. Id. All X-Rays taken were negative for fractures, Id. pp. 30-31, 37, 42. Petitioner was diagnosed with a cervical strain and was advised to follow up with her primary care physician. Id, p. 28.

Approximately two weeks later, on March 8, 2010, on referral from her primary care doctor, Dr. Badescu, Petitioner consulted Dr. Chintan Sampat at Parkview Orthopedic. She reported neck pain, pain radiating into both shoulders and behind her scapula (worse on the right side than the left), and back pain. Px. 3, p. 3. Petitioner again gave a history of a slip and fall on ice while at work. Id. Dr. Sampat noted that cervical flexion and extension maneuvers re-created the pain radiating down her neck and into her shoulders. Id. p. 4. Dr. Sampat did not find any impingement signs on physical exam of Petitioner's shoulders. Id. Dr. Sampat diagnosed cervical spondylosis and possible radiculopathy. He prescribed a cervical spine MRI, physical therapy, Vicodin, and placed Petitioner off work. Id. p. 5. Petitioner testified that she discussed treatment of her shoulder with Dr. Sampat, who advised they would focus on her spine first and deal with the shoulder if it did not resolve with the care provided for her spine.

On March 11, 2010, Petitioner underwent an MRI of her cervical spine revealing mild discogenic degeneration at C4-5. Px. 3, p. 8. Petitioner returned to Dr. Sampat on March 15, 2010, to review her MRI. Px. 3, pp. 13-14. She reported that her shoulder symptoms had resolved, but she was having a recurrence of mid back pain radiating to her chest wall. Dr. Sampat again ordered physical therapy, prescribed Norco and Flexeril, and continued Petitioner off work. Id. Petitioner testified that the physical therapy prescribed was helpful. Respondent provided two photographs dated March 27, 2010, showing Petitioner with her right arm raised overhead. Rx. 2d-e. Petitioner testified that she was on Norco during this period that helped alleviate her pain complaints. The medical records indicate Petitioner was not complaining of severe shoulder pain on or about this date.

On April 5, 2010, Petitioner returned to Dr. Sampat who reviewed her 2006 thoracic spine MRI, showing a disc herniation. Px. 3, pp. 17-18. Petitioner reported improvement in her condition, however, noted that she had mid-back pain, occasional right shoulder pain, and right sided chest pain. Id. Dr. Sampat continued conservative care, dispensed a trial of Lyrica and continued her on Norco and Flexeril as needed. Id.

On April 26, 2010, Petitioner returned to Dr. Sampat with increased pain complaints, rated 6/10, with activity and decreased pain with rest. Px. 3, pp. 21-22. Dr. Sampat transitioned Petitioner to Norco and away from Vicodin because he felt she was taking too much acetaminophen. Dr Sampat continued to recommend conservative care in the form of physical therapy as it was helping Petitioner, and to continue her off work status in the hopes that twelve weeks post accident her symptoms would resolve. Id.

On May 10, 2010, Petitioner returned to Dr. Sampat relating that her pain had been decreasing along with her intake of Norco, however, her pain was 7/10 that day. Px. 3 pp. 25-26. Dr. Sampat's continuing diagnosis was cervical whiplash, cervical spondylosis, thoracic herniated disk at T8/9 on the right side with chest radiculopathy. Id. Dr. Sampat continued Petitioner off work, prescribed Naproxen to wean Petitioner off Norco completely, and transitioned her to work conditioning, with work hardening to begin in two weeks, in the hope that Petitioner would be MMI in one month. Id.

On May 17, 2010, Petitioner underwent a comprehensive work conditioning consultation at Newsome Work Performance (Newsome). Px. 4 pp. 32-35. Petitioner complained of neck pain (increased with extension), bi-lateral upper trapezius tightness, and pain in her mid back radiating around her ribs to her right chest region. Id. at 32. Newsome ran Petitioner through a strength test with free weights, including overhead lifting, and standing knuckle dumbbell lifting. Id. at 35.

On May 28, 2010, Petitioner returned to Dr. Sampat who noted Petitioner was doing extremely well, so he continued her off work until she completed the course of work conditioning. Px. 3, p. 27. On June 9, 2010, Jim Balstrode at Newsome updated Dr. Sampat with a work conditioning progress note indicating that Petitioner continued to complete overhead lifting activities, a driving simulation with a bus steering wheel currently at four repetitions of 2.5 minutes, a hatch push open/pull close with 15 pounds of resistance, and opening a bus hood with 10 pounds of resistance. Px. 4, pp. 29-30. Petitioner indicated to Mr. Balstrode that in order to do her full duty job she would be required to simulate driving for at least 10 to 15 minutes at one sitting, perform the hatch push open/pull close with 21 pounds of resistance, and open a bus hood with 15 pounds of resistance. Thus she was not ready for a full duty return to work at that time. Id at 30.

On June 11, 2010, Petitioner returned to Dr. Sampat and reported doing extremely well in work conditioning. Px. 3 p. 29. Dr. Sampat continued Petitioner off work while she completed the work conditioning program. Id. On June 22, 2010, Petitioner returned to Dr. Sampat with complaints of severe pain radiating from her back down to the right side of her chest, along the T8/9 distribution. Px. 3, pp. 31-32. Petitioner testified that two

days prior to this visit to Dr. Sampat she was performing activities of daily living, cleaning her home for her daughter's graduation, when she noticed the increase in pain. Dr. Sampat noted that the cervical whiplash injury was resolved, however, the T8/9 herniation and right sided radiculopathy was not resolved and this was "very similar to what she had when she first visited my office" and that any activity or motion aggravated her pain. Id. Dr. Sampat opined that Petitioner had failed conservative management and referred her to Dr. Bayran for a T8/9 nerve root block. Id., p. 32. Dr. Sampat wrote to the insurance adjuster requesting authorization for this prescribed care following Petitioner's increase in pain after doing "simple activities of daily living." Px. 3 p. 33. Petitioner testified, and the medical records reflect, that the referral to pain management for the nerve root block was never approved.

At the request of Respondent, Petitioner was examined by Dr. Trotter on July 13, 2010 for purposes of a §12 examination. In his report, Dr. Trotter related at incident at work on February 24, 2010, wherein Petitioner slipped on ice between two buses. Rx. 4, p. 1. Petitioner reported recurrent pain in the parascapular area, shoulder area (including some popping), and that she has had a cervical MRI, completed a course of physical therapy, is being prescribed Vicodin and Flexeril, that work hardening was stopped, and a nerve block injection is pending. Rx. 4, p. 2. Dr. Trotter reports that he reviewed some medical records provided to him, however, he makes no mention of reviewing the cervical spine MRI films taken on March 5, 2010, or the prior thoracic spine MRI from 2006.

Dr. Trotter noted pain with full flexion of the cervical spine, full range of motion of the shoulders and parascapular area, and tenderness at the "origin of the serratus anterior muscle, behind the scapula on the left side." Rx. 4. P. 3. Dr. Trotter diagnosed a partial muscle tear in the serratus anterior region related to the slip and fall on ice at work on February 24, 2010. Dr. Trotter opined that her prognosis was guarded for 100% resolution, and felt her ability to return to work as a bus driver was "suspect." Id. p. 4. Dr. Trotter felt that all treatment through the date of exam was reasonable and necessary. He recommended a four week course of work hardening, with MMI being reached in six weeks. Id. p. 5. Dr. Trotter felt that Petitioner was not able to return to work full duty, but could return to work with restrictions of no lifting/pushing/pulling/carrying greater than 10 pounds, no repetitive reaching at or above chest level, and no crawling or ladder climbing. Petitioner provided unrebutted testimony that no light duty within Dr. Trotter's recommended restrictions was ever offered to her by Respondent.

Dr. Trotter felt that given the nature of the injury, Petitioner may never be able to return to work as a bus driver with full functionality. Id. He went on to note that Petitioner may "be at a somewhat increased risk for recurrent pain and shoulder dysfunction in the future." Id., p. 6. Dr. Trotter opined that the pain management being prescribed by Dr. Sampat was not indicated at the time of his exam. Id.

On July 26, 2010, Petitioner returned to Dr. Sampat, who noted that her current complaints of severe pain radiating from her low back down to the right side of her chest along her breast at the T8/9 distribution was an exacerbation of her 2006 prior herniation at that level. Px. 3, p. 34. Dr. Sampat noted a positive Tinel's sign over the midline of the lumbar spine as well as underneath the right T8/9 rib, causing pain to radiate down her right breast region. Internal rotation of her right shoulder was limited by 15 degrees as compared to the left. Id. Dr. Sampat continued to prescribe a T8/9 nerve block, kept Petitioner off work, refilled her Vicodin and Flexeril, and noted that she was unable to continue with work conditioning. Id.

On August 12, 2010, Petitioner underwent an MRI of her thoracic spine, which was read to be unremarkable. Px. 3, p. 44. On August 16, 2010, Petitioner returned to Dr. Sampat reporting that she felt better, but had pain along the serratus anterior muscle and some pain in the right shoulder with some limitation on internal rotation since the injury. Px. 3. p. 36. Petitioner reported a pain level of 6 to 8/10 with the numbness and tingling in her

right chest region being resolved, with Dr. Sampat finding no Tinel sign being present in the T8/9 distribution on exam. Id at 36-37. Dr. Sampat reviewed the thoracic spine MRI, and given that it was unremarkable, ordered another round of work conditioning for the Petitioner. He continued her off work, and prescribed Mobic to help Petitioner wean herself from Norco. Id. at 37. Petitioner testified that Dr. Sampat also referred her to Restoration Chiropractic Wellness Center (Restoration). Over the course of 31 visits at Restoration, she was provided with adjustments, mechanical traction and exercises, all of which Petitioner testified were very helpful in resolving her back pain complaints. Px. 6.

On August 24, 2010, Petitioner was seen for her initial work conditioning consultation. Px. 4. P. 39. The consultation report noted that Petitioner complained of pain with (a) strength testing of right shoulder abduction and right mid to lower thoracic pain upon manual muscle strength testing of the right serratus anterior; (b) cervical flexion at the base of her head; and (c) tenderness at T7-9 inferior to the right scapular region upon palpation. Px. 4, p. 41. Newsome had Petitioner perform strength testing with overhead dumbbell lifts, in which the Petitioner immediately reported right shoulder soreness with two (2) pounds in each hand for three (3) repetitions. Px. 4 p. 42. Newsome scheduled Petitioner to begin work conditioning for 2.5 to 4 hours per day, 5 days per week, with a re-evaluation in 2 weeks. Id.

On August 30, 2010, Petitioner returned to Dr. Sampat complaining of residual right shoulder symptoms with pain rating 5/10. However, she reported that her back pain had "essentially resolved." Px. 3, p. 141. On physical exam, Dr. Sampat noted Petitioner's limited internal rotation on the right shoulder with a positive impingement sign. Id. Dr. Sampat performed a subacromial steroid injection in Petitioner's right shoulder and recommended she continue with work conditioning. Id. p. 142.

On September 13, 2010, Petitioner returned to Dr. Sampat with complaints of severe right shoulder pain, reporting that the injection only lasted "5-6 days." Px. 3. p. 143. Terri Smith, the nurse case manager (NCM) assigned to Petitioner's claim, noted that Petitioner reported for this appointment in great distress with "terrible spasms in the right shoulder girdle area with pain shooting from the anterior shoulder across the shoulder to the scapula." Px. 10, p. 27. Ms. Smith's records note that Petitioner sustained no trauma to the shoulder to account for her increased pain complaints, there was no evidence of infection at the injection site, and the only explanation seemed to be "all those shoulder exercises" Petitioner was performing in work conditioning. Id. p. 28. Petitioner testified that the exercises she was doing in work conditioning, especially the overhead lifting and the bus wheel driving simulation, caused increase in her right shoulder pain. Dr. Sampat placed further work conditioning on hold, and continued Petitioner off work while a right shoulder MRI was obtained. Px. 3, p. 143.

Petitioner returned to Dr. Sampat the following day to review her right shoulder MRI. Px. 3. p. 145. The MRI revealed a Type II acromial process with fraying of the anterior fibers of the suprapinatus with mild tendinopathy. Px. 3. pp. 147-148. As Dr. Sampat saw no further spine problems for Petitioner, he referred her to Dr. Henry Fuentes to assess the right shoulder and took Petitioner out of physical therapy "as more active motion can sometimes worsen patient's symptoms." Px. 3. pp. 145-146. In the progress report from Newsome dated September 13, 2010, Jim Balstrode reported that Petitioner had little to no increase in capacity for overhead lifting or driving the bus driving simulator, and he could not recommend a return to full duty work at that time. Px. 4. pp. 43-44.

On September 20, 2010, Petitioner presented to Dr. Fuentes who reviewed the right shoulder MRI and diagnosed impingement of the right shoulder. Dr. Fuentes recommended arthroscopic surgery with subacromial decompression and partial acromioplasty, as conservative measures had failed to relieve Petitioner's pain. Px. 3. p. 149. Dr. Fuentes continued Petitioner off-work pending surgery. Id.

At the request of Respondent, Petitioner returned to Dr. Trotter for a second §12 examination on October 5, 2010. Dr. Trotter noted decreased range of motion in the right shoulder since her initial visit, noting 170 degrees of abduction and flexion on the left compared to 105 degrees of abduction and 115 degrees of flexion on the right, 70 degrees of external rotation on the left compared with 60 degrees on the right, and 70 degrees of internal rotation on the left compared with 45 degrees on the right. Rx. 4. p. 3. He found tenderness at the anterior region of the shoulder, the outer aspect of the deltoid region, the posterior deltoid and infraspinatus area. Id. p. 4

Dr. Trotter opined there was no causation, aggravation, or acceleration to account for Petitioner's right shoulder impingement and maintained his prior diagnosis of a tear of the serratus anterior muscle at its origin on the medial scapula. Rx 4 p. 4. Dr. Trotter opined that Petitioner was at MMI from her work injury, however, she could not return to work as a bus driver given her shoulder complaints. Id.

Respondent offered an addendum report of Dr. Trotter's dated January 31, 2012, wherein he reviewed the April 18, 2011 narrative report of Dr. Fuentes, and advised that he continued to hold all of his prior opinions. Rx. 6. On October 22, 2010, Dr. Fuentes performed a shoulder arthroscopy with subacromial decompression. Px. 3. p. 161. The operative report indicates "the patient was noted to have a small spur on the inferior aspect of the distal clavicle and a small-to-moderate spur on the anterior-inferior acromion." Id. Dr. Sampat performed a small acromioplasty to remove the spurs. Id. Mrs. Sipla testified that her TTD checks were discontinued as of October 22, 2010.

Dr. Fuentes prescribed physical therapy in Petitioner's initial follow up visit of October 25, 2010. Px. 3, p. 150. Petitioner completed her course of physical therapy at Parkview Orthopedic. On March 7, 2011, Dr. Fuentes noted that the physical therapist felt Petitioner would benefit from work conditioning. Px. 3, p. 90. On exam at that visit, Petitioner was noted to have tenderness at the anterior shoulder and over the AC joint, with good range of motion of the shoulder with no impingement signs. Id. Petitioner was continued off work and prescribed work conditioning. Id.

Petitioner completed her course of work conditioning, and on May 20, 2011, Newsome Work Performance discharged her from the program noting that she felt capable of a full duty return to work, was 100% better, and was without pain in the shoulder. Px. 4. pp. 80-81.

On May 23, 2011, Petitioner met with Dr. Fuentes who noted full range of motion of the right shoulder without pain or tenderness, negative impingement signs, and no weakness of the supraspinatus. Px. 3 p. 95. Dr. Fuentes release Petitioner to return to work full duty. Id.

On May 24, 2011, Petitioner returned to work full duty for the Respondent as a school bus driver. Petitioner testified that the right shoulder arthroscopy Dr. Fuentes performed helped relieve her pre-surgery symptoms. Petitioner testified that she no longer works for the Respondent, as family obligations required her to leave her job as a school bus driver.

Dr. Fuentes provided two narrative reports dated April 18, 2011, and June 28, 2013. In his April 18, 2011, report, Dr. Fuentes relates a history of a slip and fall injury where Petitioner tried to catch herself between two buses. Px. 7, p. 1. This history was consistent with Petitioner's testimony and the treating medical records. Id. Dr. Fuentes reviewed the right shoulder MRI of September 14, 2010, showing fraying of the far anterior fibers, and trace subacromial/subdeltoid bursitis. Id. On physical exam Dr. Fuentes noted tenderness over the anterior rotator cuff, with shoulder pain on abduction beyond ninety degrees with positive Kennedy's and Neer's impingement signs. Id. Dr. Fuentes diagnosed chronic impingement syndrome. Id.

Dr. Fuentes opined that Petitioner's mechanism of injury caused her impingement syndrome in her right shoulder. He noted that Petitioner complained of right shoulder pain from the outset, which was initially attributed to cervical radiculopathy. Id., p. 2. In reliance on this, Dr. Fuentes noted his disagreement with Respondent examiner's opinion that Petitioner's slip and fall at work was not a causative factor in her need for medical care for her right shoulder. Id. He found Petitioner's complaints to be consistent with her objective findings, including the Type II acromion with some fraying of the anterior supraspinatus tendon fibers. Id. Dr. Fuentes opined that all medical care through April 18, 2011, had been reasonable, necessary and related to her work injury of February 24, 2010. Id. In support of his surgical recommendation, Dr. Fuentes noted that Petitioner did not improve with conservative care, including extensive physical therapy and an injection. Id. Dr. Fuentes opined that all Petitioner's time off work from February 24, 2010 through April 11, 2011, the date of his first report, was medically necessary and related to her work injury. Id., p. 3. In his opinion, her prognosis was good considering her findings at surgery. Id. p. 3.

In his second narrative report dated June 28, 2013, Dr. Fuentes agreed with the testimony of his partner and Petitioner's treating spine physician, Dr. Chintan Sampat, that shoulder pain in a patient with a Type II acromion can wax and wane. Id. p. 4. Dr. Fuentes opined that the activities that typically aggravate a Type II acromion are overhead activity and internal rotation. Id. Dr. Fuentes noted that, unfortunately, when a patient avoids those activities that can aggravate a Type II acromion, she may then be pre-disposed to suffer from adhesive capsulitis or frozen shoulder, resulting in a "Catch-22" situation. Id. Dr. Fuentes went on to opine that the persistence of Petitioner's right shoulder symptoms, despite conservative treatment, led to his surgical recommendation. Id. p. 4. Dr. Fuentes' opinion on the issue of causation was unchanged, and he continued to hold the opinion that Petitioner's Type II acromion was aggravated by her slip and fall accident on February 24, 2010, requiring surgical intervention on October 22, 2010. Id.

Dr. Sampat testified by evidence deposition on August 28, 2012. He described a Type II acromion as a portion of the scapula bone, on the top of the shoulder that overlies the rotator cuff, which looks like a hook and predisposes a patient to tendinopathy of the supraspinatus tendon. Id. p. 19. Dr. Sampat testified that shoulder impingement with a Type II acromion will wax and wane over time; in other words, patients will have improvement then worsening of symptoms "on and off." Id. pp. 19-20. He testified that overhead activity and internal rotation were known to aggravate a Type II acromion. Id. p. 20.

Dr. Sampat testified that when conservative measures fail to alleviate symptoms, surgery is recommended to remove a Type II acromion. Id. p. 22. Dr. Sampat testified that a fall on an outstretched extremity, could exacerbate an underlying Type II acromion and shoulder impingement syndrome, which was consistent with Petitioner's mechanism of injury and symptoms. Id., p. 23. Dr. Sampat testified that her decrease, and temporary resolution, of shoulder symptoms during her treatment is typical of Type II acromion when a shoulder is allowed to rest. Px. 3. pp. 23-24. However, Dr. Sampat noted that patients must be encouraged to use their shoulder, as failure to use the shoulder could result in "frozen shoulder." Id. p. 24. Dr. Sampat further testified that, unfortunately, the use of the shoulder to heal it in physical therapy and work conditioning can also exacerbate symptoms. Id.

Dr. Sampat testified that the "Chief Complaint" portion of his chart notes was not "cut and pasted" and was dictated at each visit. Throughout his treatment of Petitioner she did have shoulder complaints along with spine complaints; however, the history portion of the note was more detailed and should be relied upon first. Id. p. 58, 62-63.

In regard to Petitioner's spine complaints, Dr. Sampat testified that Petitioner suffered an exacerbation of a prior disc herniation in the thoracic spine, as well as whiplash injury to the cervical spine, and shoulder injury as a

consequence of her work injury of February 24, 2010. Id. p. 57, 59-60. Dr. Sampat testified that all the medical care he provided and prescribed was necessary and related to Petitioner's work injury of February 24, 2010. Id. pp. 57-58. Dr. Sampat testified that nothing in Respondent's cross exam caused him to reconsider or change his opinions. Id. p. 60.

Respondent submitted approximately six minutes of surveillance video taken on September 20, 2010, approximately ten days after her last work conditioning appointment. The video does not reveal clear shots of Petitioner's face, as the views are obstructed or not seen from the camera angle provided. The video does not show Petitioner doing any weighted overhead activity, or engaged in any forceful internal rotation of her right shoulder as done in work conditioning and required by her job. It shows Petitioner driving an automobile, carrying items in her left arm and closing a door using her left arm. The video also shows Petitioner casually walking and opening a car door with her right hand, and closing the same door with her right arm with her shoulder below shoulder level and using no internal rotation.

Approximately one minute of surveillance footage was taken on October 5, 2010. This video depicts Petitioner using her left hand to talk on the phone, while carrying a light jacket over her forearm and close to her body. Petitioner opens a car door with her left hand, and uses her right hand to shut the door. When getting out of the car, Petitioner is carrying all of her items in her left arm with her right arm free.
Petitioner testified that she is right hand dominant and that her doctors advised she should engage in activities of daily living as tolerated because it would help her recover, and she should let common sense be her guide. She was never instructed by her treating physicians to stop using her right arm. Petitioner testified that driving a school bus is much more difficult than driving a car, given the reaching required and repetitive internal rotation necessary to steer the bus wheel.

Petitioner testified that she no longer works for Respondent, and is now a full time homemaker. Petitioner testified that she has pain, and fatigues earlier than prior to her February 24, 2010, injury when cleaning her home, which includes scrubbing floors by hand, washing windows and walls. Petitioner testified after the February 24, 2010, work injury her pain has greatly increased with cold weather and the recent long, cold winter was especially difficult for her.

Petitioner testified that she was an avid photographer prior to her February 24, 2010, work injury. Now, however, she is unable to maintain the stamina she used to have for long photo shoots, due to pain associated with the activity including overhead photos, keeping her arms extended to get a photo.

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

Petitioner testified that she was working full duty on February 24, 2010, and was performing her duties as a bus driver for Respondent. On that date, Petitioner injured her right shoulder, neck, and back in slip and fall on ice between two school buses in the Respondent's parking lot where she was required to park her bus after completing a shift.

Petitioner had no prior shoulder or neck injuries prior to the fall. Petitioner had previously injured her back in 2006 when she herniated a disc at T8/9, and did have a previously asymptomatic Type II acromion. Petitioner testified that she had recuperated from her prior back injury before beginning to work for Respondent. Petitioner testified that on the morning of her slip and fall, before reporting to work, she was in great health, and was not under the care of any physician for treatment of her neck, back or right shoulder at the time of this accident. Petitioner's testimony is corroborated by the medical evidence.

Petitioner's treating physicians, Dr. Sampat and Dr. Fuentes, diagnosed her with a cervical whiplash injury, an exacerbation of her previously herniated T8/9 disc, and an aggravation of her Type II acromion causing shoulder impingement and the need for surgery. Petitioner's treating physicians related her neck, back and shoulder symptoms to her slip and fall on ice in Respondent's lot. Both physicians testified that all of the treatment Petitioner received was medically necessary and related to her work injury of February 24, 2010.

Dr. Fuentes and Dr. Sampat agreed that a Type II acromion was present before Petitioner slipped and fell, however, it was asymptomatic until the fall. Petitioner's pain was increased with the prescribed work conditioning activity such as overhead lifting and internal rotation which were necessary rehabilitation exercises for her return to full duty work. Because conservative measures failed to cure and relieve the effects of the slip and fall injury to Petitioner's right shoulder, surgical intervention was necessary.

Petitioner's treating physicians support her testimony. The medical records submitted into evidence also support the Petitioner, who gave a consistent history of accident and symptomatology throughout her treatment subsequent to her slip and fall. Petitioner's subjective reports were also consistent with the physical examination findings of her treating physicians and the objective evidence, including MRI studies.

Respondent's examiner, Dr. Trotter, agreed that all treatment through his initial exam on July 13, 2010 was medically necessary and related to the undisputed work injury of February 24, 2010. At that time, Dr. Trotter opined that work conditioning was necessary for Petitioner to return to work. At Dr. Trotter's second exam on October 5, 2010, he failed to consider the overhead lifting and internal rotation of Petitioner's right shoulder required by the work conditioning regimen he had recommended, and came to the conclusion that Petitioner was MMI for her work injury at the time. However, Dr. Trotter did opine that Petitioner remained unable to return to work as of the date of his second exam as she would be unable to complete her full job duties given her right shoulder complaints.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner's current conditions of ill-being with respect to her right shoulder, neck and back are causally related to the undisputed work injury of February 24, 2010. In support of this finding, the Arbitrator finds the opinions of Petitioner's treating physicians – Drs. Sampat and Fuentes -- to be more persuasive than those offered by Respondent's §12 examining physician, Dr. Trotter. The Arbitrator also notes that the surveillance video admitted into evidence did not show Petitioner engaging in activities that could be reasonably interpreted as being outside her medical restrictions and/or limitations, and is therefore of limited if any value.

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

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses submitted at PX11 and totaling $35,895.00 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

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

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from February 25, 2010 through May 23, 2011, or the day prior to her return to full duty work, for a period of 64-5/7 weeks.

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

Petitioner's complaints of pain are consistent with her work injury and related arthroscopy, and spinal injury and related conservative care. Petitioner testified that she has pain, and fatigues earlier than prior to her February 24, 2010, injury when cleaning her home, which includes scrubbing floors by hand, washing windows and walls. Petitioner testified after the February 24, 2010, work injury her pain has greatly increased with cold weather. Petitioner also testified that she was an avid photographer prior to her February 24, 2010, work injury. Now, however, she is unable to maintain the stamina she used to have for long photo shoots, due to pain associated with the activity including overhead photos, keeping her arms extended to get a photo.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% person-as-a-whole pursuant to §8(d) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Isaura Martinez,

Petitioner,

vs. NO: 10 WC 30853

Staffmark,

16IWCC0303

Respondent.

DECISION AND OPINION ON REVIEW

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

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. One should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the Arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

The Petitioner testified that on August 3, 2010, she was working for Stampede Meat, but was paid by Respondent. She worked as a packer there for six months, working 36-40 hours per

16IWCC0303

week and normally from 3 p.m. to 11 p.m. She would pack and weigh meat as it came off of the conveyer belt. (T 13-15).

She further testified that on August 3, 2010 she slipped on grease and meat on the floor of Stampede Meat's facility after returning from break. She fell sideways onto concrete, and she supported herself with her left hand. Her hard hat fell off of her during the fall and she became dizzy at that moment. When she fell she hit her face, hip, and shoulder and felt immediate pain. She told her boss, Ella, what had happened, and then she was taken to Concentra. She was subsequently diagnosed with a left face contusion and left hip contusion. She did not resume working that day. (T 15-17).

The Petitioner testified that she reported the pain in her left shoulder right away, but that the medical personnel did not record all of her pain complaints. She subsequently went to the Illinois Bone & Joint Institute in January 2011 where she was diagnosed with a rotator cuff tear and a SLAP tear of the shoulder. Dr. Daniel Newman performed surgery on her on April 11, 2011. (T 18-21).

A Concentra medical record dated August 5, 2010, two days after her work accident, noted "Tenderness of shoulder diffusely" in regards to Petitioner's left shoulder. (Rx3). Additionally, Dr. Newman wrote on January 27, 2011 that Petitioner reported extending her left upper extremity during her fall while working at Stampede Meat. Dr. Newman's impression was that Petitioner's complaints were directly related to her work accident on July 2, 2010 [*sic*]. He believed that she sustained an impaction-abduction injury to the left shoulder while trying to prevent her fall. (Px1)

Based upon the totality of the evidence and the factual findings above, the Commission finds that Petitioner's left shoulder injury was causally related to her work accident on August 3, 2010. Accordingly, the Commission awards Petitioner prospective left shoulder surgery, previously performed on April 11, 2011.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision, filed on December 1, 2014, is hereby reversed as to the finding of causal connection for Petitioner's left shoulder injury. All else is affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner be awarded prospective medical for her left shoulder injury, previously performed on April 11, 2011.

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 exposure.

16IWCC0303

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 6 - 2016

Thomas J. Tyrrell

Michael J. Brennan

TJT/gaf
O: 3/7/16
51

DISSENT

I respectfully dissent from the decision of the majority. The Arbitrator Simpson's findings are both thorough and well reasoned. This decision is correct and should be affirmed.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARTINEZ, ISAURA
Employee/Petitioner

Case# **10WC030853**

STAFFMARK
Employer/Respondent

16IWCC0303

On 12/1/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
BRANDON C HALL
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

2965 KEEFE CAMPBELL BIERY & ASSOC
SEAN C BROGAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

16IWCC0303

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

Isaura Martinez
Employee/Petitioner

v.

Staffmark
Employer/Respondent

Case # **10** WC **30853**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **September 26, 2014 and October 3, 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. [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 **August 3, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**17,160.00**; the average weekly wage was $**330.00**.

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

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

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

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

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

ORDER

Petitioner failed to prove her current condition of ill-being is causally related to the work incident of August 3, 2010.

In light of the determination Petitioner failed to establish her present condition of ill-being is causally related to the work incident of August 3, 2010, the remaining issues of Respondent's liability for Section 8 medical benefits and the nature and extent of the injury are moot and not reached by the Arbitrator.

Accordingly, benefits are denied.

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

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

Richard L. Simpson
Signature of Arbitrator

Dec. 1, 2014
Date

DEC 1 - 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Isaura Martinez,	)	16IWCC0303
Petitioner	)	
vs.	)	**No. 10 WC 30853**
Staffmark,	)	
Respondent.	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The parties agree that on August 3, 2010, Petitioner and Respondent were operating under the Illinois Workers' Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that Petitioner gave Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They further agree that Petitioner's average weekly wage was $330.00.

At issue in this hearing is as follows: (1) Is Petitioner's current condition of ill-being causally connected to this injury or exposure; (2) Were the medical services that were provided to Petitioner reasonable and necessary; Has Respondent paid all appropriate charges for all reasonable and necessary medical services; and (4) What is the nature and extent of the injury.

Petitioner is not fluent in English and testified with the aid of Noel Cortez, a professional, certified interpreter.

STATEMENT OF FACTS

It is undisputed Petitioner was employed by Respondent Staffmark on August 3, 2010, and was placed at Stampede Meat working as a packer on that date. Petitioner had been working at Stampede Meat as an employee of Staffmark for six months prior to August 3, 2010. Petitioner testified that her job duties at this assignment were to weigh meat and to pack meat as it went across the conveyor belt. She had no idea how much meat she packed, she stated that the conveyor belt moved very fast and ran constantly. She testified she worked the second shift, which started at 3:00 p.m. and finished at 11:00 p.m. She testified further that she worked thirty-six to forty hours per week. She stated that "the agency paid me," the agency being the Respondent, Staffmark.

Several hours into her shift on August 3, 2010, at approximately 7:30 p.m., she testified she was returning from a break, to give someone else a break, when she slipped on meat and grease that was on the floor and fell sideways to the ground. She testified she supported herself with her left hand during the fall, but she hit her face, hip, and shoulder on the ground. She testified she felt immediate pain in those three areas and that she got dizzy from hitting her head.

Petitioner testified she told Ella from personnel what had happened, and was immediately taken to Concentra Occupational Health Center for medical attention. She testified that she went back to work after being treated at Concentra but they sent her home.

When seen at Concentra on August 3, 2010, Petitioner stated "I slipped on some meat and papers that were on the floor and fell, hurting my left leg and left side of my face." RX #3. X-rays of the head and left leg were negative for fractures. Id. She was diagnosed with contusions of the face, scalp, and left thigh. Id. No work restrictions were given. Id. Left shoulder and low back pain is not noted in this initial treatment record. Id. Petitioner testified she reported all of her injuries to the Concentra physician, including her shoulder pain, but Concentra did not include all of her complaints in her medical records. When asked why Concentra would not address her shoulder pain and provide treatment for same, she said "they wouldn't do anything for me." Petitioner further testified that she told the Concentra doctors each time she went back for follow-ups that she had left shoulder and arm pain, but the Concentra doctors would not do anything for her left shoulder or arm pain despite her complaints.

On August 5, 2010, Petitioner returned to Concentra complaining of increased pain in the left lateral thigh and left cheek. RX #3. She denied any radiation of pain. Id. On exam, she had full range of motion and no spasms or tenderness of the cervical or lumbar spine. Id. Her diagnoses remained as contusions of the face, scalp, and thigh. Id. No work restrictions were given. Id.

Petitioner testified she began working for ANB, a cleaning company, on August 6, 2010. She testified the job entailed cleaning tables, dumping trash, and vacuuming at offices in downtown Chicago approximately 38 to 40 hours per week.

On August 11, 2010, Petitioner followed up at Concentra. RX #3. She stated her symptoms were improving, but she still complained of significant lateral left thigh pain with no radiation and left jaw pain. Id. She stated she had been working regular duty. Id. Her diagnoses and work status were unchanged from her previous visit. Id. Left shoulder and low back pain is not noted in this record. Id.

On August 18, 2010, Petitioner followed up at Concentra complaining of continuing but improving left jaw and thigh pain. Id. Her diagnoses and work status remained the same as her previous visit. Id. Left shoulder and low back pain is not noted in this record. Id.

On August 25, 2010, Petitioner returned to Concentra. Id. On exam, she had no tenderness, swelling, or pain with motion of the cervical spine and Spurlings test was negative. Id. She did have minimal swelling at the left lateral thigh with mild tenderness. Id. She was prescribed Naproxen and physical therapy. Id. She remained unrestricted from work. Id. Left shoulder and low back pain is not noted in this record. Id.

On August 30, 2010, Petitioner returned to Concentra with continued complaints of left lateral thigh pain and new complaints of pain in the left lower leg. Id. Her face contusion had resolved. Id. The doctor recommended three sessions of physical therapy and regular duty work;

however, Concentra was informed that Petitioner no longer worked for Staffmark. Id. Left shoulder and low back pain is not noted in this record. Id.

Petitioner began physical therapy on August 31, 2010 at Concentra. Id. At her initial evaluation, she complained of left low back, buttock, and lateral thigh pain. Id. She completed five sessions by September 13, 2010. Id. Left shoulder pain is not noted in any of the physical therapy records. Id. The Petitioner testified she would tell the physical therapist that her left arm and shoulder hurt, but the therapist would do nothing more than merely look at her arm.

On September 9, 2010, Petitioner returned to Concentra. RX #3. She complained of continuing left leg pain as well as low back tenderness. Id. Her lumbar and cervical spine examinations were normal. Id. Continuing physical therapy was prescribed and her medications were adjusted. Id. Left shoulder pain is not noted in this record. Id.

On September 13, 2010, Petitioner returned to Concentra. Id. She stated she was no longer working with Staffmark. Id. She complained of continuing but stable left leg/thigh pain. Id. She denied any radicular symptoms. Id. Her lumbar and cervical spine examinations were normal. Id. The doctor noted it could take several weeks for Petitioner's condition to improve, but opined she had reached maximum medical improvement (MMI). Id. Left shoulder pain is not noted in this record. Id.

Petitioner testified she continued working for ANB cleaning company until January 7, 2011, and her attorney recommended that she see Dr. Daniel Newman of Illinois Bone and Joint Institute. It is undisputed that she did not seek any medical attention in the four and a half month period after September 13, 2010 until she was first seen by Dr. Newman.

On January 27, 2011, Petitioner presented to Dr. Newman. PX #1. She stated she was injured in a work accident on July 2, 2010. Id. Specifically, she stated she was walking when she slipped on some paper and meat products and she landed on her left cheek and hip, but she also attempted to break her fall by extending her left upper extremity. Id. She further stated she injured her low back. Id. Additionally, she stated she was afraid of falling again so she changed jobs and began working for a cleaning company. Id. She reported that she had been let go from the cleaning company recently due to lack of work. Id. She complained of left lateral hip pain radiating down to the ankle and occasionally into her groin as well as achy pain over her left cheek and discomfort in her left eye. Id. She also complained of pain in her left shoulder and left low back and difficulty sleeping on her left side. Id. On exam, she had full range of motion of the left shoulder, but she complained of pain at the extremes. Id. She had positive impingement signs and a positive Speeds test on the left. Id. X-rays of the pelvis, left hip, and left shoulder revealed no bony abnormalities and no significant degenerative changes. Id. Dr. Newman diagnosed a left hip contusion, low back strain, facial contusion, and an impact abduction injury to the left shoulder. Id. He opined all diagnoses were related to the alleged work accident on July 2, 2010. Id. Physical therapy was recommended to address the decreased range of motion of the left shoulder and hip. Id. The doctor noted the mechanism of injury and exam findings were suggestive of a SLAP lesion. Id. Thus, if physical therapy was not successful, an MRI arthrogram would be ordered. Id. Finally, the doctor indicated Petitioner could return to her cleaning job, full duty. Id.

On March 10, 2011, Petitioner returned to Dr. Newman. Id. She reported significant improvement with physical therapy, but stated certain movements still caused shoulder pain. Id. The hip pain radiating into her left lower extremity was almost completely gone. Id. Continuing physical therapy and an MRI arthrogram were recommended. Id.

A March 21, 2011, left shoulder MRI arthrogram revealed a small, full thickness rotator cuff tear involving the distal supraspinatus tendon, a probable tear of the tendon of the long head of the biceps muscle, and a tear of the superior labrum. PX #2.

On March 24, 2011, Petitioner followed up with Dr. Newman. PX #3. She stated her symptoms had plateaued. Id. She had no objective exam findings of the left lower extremity. Id. MRI results were reviewed, and Dr. Newman noted the study showed a tear of the labrum, a small rotator cuff tear, and tendinopathy/possible biceps rupture of the long head of the biceps. Id. The doctor again questioned Petitioner on whether or not she had any prior problems with her left shoulder, which she denied. Id. She stated her only traumatic episode was the one that occurred in 2010. Id. The doctor recommended shoulder surgery as she had failed conservative measures. Id.

On April 11, 2011, Petitioner underwent left shoulder surgery. Dr. Newman performed debridement of the superior labrum, acromioplasty, and mini-open rotator cuff repair. Id. Her postoperative diagnoses were a torn labrum and rotator cuff. Id. She was taken off work. Id.

On June 2, 2011, Petitioner followed up with Dr. Newman. Id. She complained of continuing pain aggravated by movement. Id. The doctor noted he was contacted by Petitioner's physical therapist who was concerned with Petitioner's pain complaints. Id. X-rays revealed no abnormal calcifications in the soft tissue or any other abnormalities. Id. While Dr. Newman noted the presence of a lesion on the proximal humerus, he opined it was likely benign as it did not appear much different than previous x-rays. Id. Dr. Newman administered an injection to the subacromial space which eliminated her pain and ruled out the possibility of pain coming from the lesion; however, the doctor noted he would consider a bone scan if her symptoms persisted. Id. Continuing physical therapy, pain medications, and off work restrictions were prescribed. Id.

On June 9, 2011, Petitioner underwent an initial physical therapy evaluation at Total Rehab. PX #3.

On June 15, 2011, Petitioner returned to Dr. Newman. PX #1. She noted dramatic pain relief following the initial injection. Id. She also reported improvement with range of motion. Id. A second injection was administered, and continuing physical therapy was prescribed. Id.

On June 30, 2011, Petitioner followed up with Dr. Newman. Id. She again noted dramatic pain relief following the second injection, but she declined a third injection. Id. She stated she had been able to participate more vigorously in physical therapy and continued to make progress. Id. She complained of left ankle weakness and noted she had attempted to wear high heels but was unable to balance because her ankle would invert. Id. The doctor noted her previous leg pain

had completely resolved prior to this latest onset. Id. The doctor recommended physical therapy to address same. Id.

On July 28, 2011 Petitioner returned to Dr. Newman. Id. She stated her left shoulder pain was limiting her participation in physical therapy. Id. She also complained of left ankle instability. Id. Because Petitioner responded well to two previous subacromial injections, Dr. Newman administered a third injection. Id. Dr. Newman noted Petitioner should continue with physical therapy and off work restrictions. Id.

On August 2, 2011, Petitioner had an evaluation of the left foot and ankle at Total Rehab. PX #3. She stated she hurt her leg and ankle when she fell at work. Id.

On August 25, 2011, Petitioner followed up with Dr. Newman. PX #1. In addition to shoulder symptoms, she stated she was having symptoms in her left hip radiating down to her foot and ankle. Id. The doctor noted the symptoms had temporarily gotten better but were reoccurring. Id. Dr. Newman administered a fourth injection to the subacromial space of the left shoulder, but there was no significant improvement with her range of motion following the injection. Id. She was able to forward flex at the waist, but complained of tightness in the posterior thigh and left calf when doing so. Id. Her left ankle was swollen but there was no evidence of instability. Id. Dr. Newman recommended Petitioner change physical therapists in search of a more aggressive program. Id. The doctor noted Petitioner was having mild sciatic symptoms again which should respond to conservative measures. Id. Continuing physical therapy and off work restrictions were recommended. Id.

On September 22, 2011, Petitioner returned to Dr. Newman. Id. She stated she was doing better with physical therapy in the new venue. Id. She noted that pain was not her major issue, rather it was range of motion. Id. She also complained of sciatic symptoms in the left leg. Id. Her shoulder range of motion was improved on exam, but she complained of some pain while moving her neck. Id. The doctor noted there was no neurological deficit on exam of the lumbar and cervical spine. Id. He further noted the neck symptoms were most likely muscular and were being aggravated by the chronic shoulder pain. Id. The doctor also noted he suspected that Petitioner bruised her sciatic nerve at the time of the fall and her symptoms were related to same. Id. Continuing physical therapy and off work restrictions were recommended. Id.

On October 19, 2011, Petitioner returned to Dr. Newman noting improving shoulder pain but continuing neck and sciatic symptoms. Id. The doctor injected the trigger point over the piriformis muscle and ordered a lumbar spine MRI to ensure there was no nerve entrapment. Id. Continuing physical therapy and off work restrictions were recommended. Id.

An MRI of the lumbar spine was completed on November 9, 2011. PX #2. No significant spinal or neuroforaminal stenosis was seen. Id.

On November 16, 2011, Petitioner followed up with Dr. Newman. PX #1. On exam, she had improved shoulder range of motion. Id. The doctor noted her sciatic nerve symptoms were likely related to a direct bruise from where she landed when she fell as her MRI results were normal. Id. The doctor ordered an FCE and prescribed pain medications. Id.

An FCE was completed by United Rehab Providers on November 23, 2011. PX #3. The therapist opined Petitioner did not meet the heavy strength requirements of, and may not return to work as, a cleaner. Id. The therapist noted Petitioner's maximum lifting capacity was 22 pounds and her maximum carrying capacity was 20 pounds which placed her in the medium strength category. Id. Contrary to the therapist's classification of the physical requirements of Petitioner's cleaning job, Petitioner testified that only the men would do heavy work at ANB and her job was not very heavy work because she was not allowed to carry heavy objects.

On December 14, 2011, Petitioner returned to Dr. Newman. PX #1. She complained of pain with motion above the shoulder, but she had full passive range of motion on exam. Id. Dr. Newman opined Petitioner had reached MMI with permanent work restrictions consistent with the FCE including no lifting over 22 pounds, no carrying over 20 pounds, no pushing more than 80 pounds, no pulling more than 65 pounds, no crouching, no repetitive reaching with her left arm, no crawling on her hands and feet, and no stooping or kneeling on her left knee. Id.

Petitioner testified that currently she has a lot of headaches. She has hip and shoulder pain. She stated that she cannot turn well, or walk much and she cannot clean her home. She estimated that she has lost 80 to 90 percent of her ability to function. She cannot sweep, has difficulty walking, cannot wear shoes with heels on casual shoes or tennis shoes. She has attempted to find work but when she tells potential employers about her permanent restrictions the will not hire her.

In June 2012, Dr. Ram Aribindi performed a medical record review and authored a written report at the request of Respondent Staffmark. Dr. Aribindi's evidence deposition was taken on June 13, 2014. RX #1. The June 2012 report of Dr. Aribindi is attached to the deposition transcript as Exhibit #2, and the records reviewed by Dr. Aribindi are attached to the deposition transcript as Dr. Aribindi Exhibit #3. Id.

Prior to formulating his opinions, Dr. Aribindi reviewed the records of Concentra and Dr. Newman. Based on his review of the medical records, the doctor testified there was no causal relationship between Petitioner's left shoulder pain noted for the first time in January 2011 which led to her subsequent surgery and the work injury on August 3, 2010. RX #1 at 20, Aribindi Report at 1. The doctor testified his opinion was based on a lack of injury reporting and pain complaints in the left shoulder and left upper extremity upon initial treatment. Id. Further, the doctor testified his opinion was based on Petitioner not reporting any left shoulder or left upper extremity symptoms at multiple follow-ups or to her physical therapist. Id. Specifically, Dr. Aribindi testified that the Concentra medical records do not indicate that Petitioner presented with any left shoulder complaints on the multiple visits with the treating physicians or the physical therapist. RX #1 at 21, Aribindi Report at 1. The doctor further testified that Petitioner's first mention of specifically injuring her shoulder as a result of the August 3, 2010 fall was five months after the incident. RX #1 at 21. Thus, Dr. Aribindi opined that Petitioner sustained only contusions to the face and lateral aspect of the left hip as a result of the fall, and it was the doctor's opinion she reached MMI for the former on August 30, 2010, and MMI for the latter on March 10, 2011. Aribindi Report at 1.

Dr. Aribindi acknowledged that it is possible to have a shoulder injury but not complain about pain within the first couple of days following an injury. RX #1 at 21. However, Dr. Aribindi testified that someone who sustained an impact abduction type injury of the shoulder—as was diagnosed by Dr. Newman—would experience either immediate pain or pain within a day or two following the event. RX #1 at 15. The doctor further testified it would be unusual for a person not to have symptoms until five months after an impact abduction type injury of the shoulder as the pain would get progressively worse within the first week or two, to a point where the person would have difficulty sleeping at night and would experience weakness. RX #1 at 15, 22-23.

Petitioner testified that prior to working as a packer at Stampede Meat as an employee of Staffmark, she worked many different jobs but she could not remember the names of her previous employers. She testified that one of her previous jobs entailed mixing powder to make car light bulbs and welding. She also testified that she worked for 15 years for Compx Fort, a company that makes locks. She testified she never injured her left shoulder or experienced any pain in her left shoulder prior to her fall on August 3, 2010; however, an Illinois Worker's Compensation Commission (IWCC) Settlement Contract which was admitted into evidence indicates otherwise. RX #2.

Petitioner filed a workers' compensation claim against Compx Fort alleging both repetitive and direct trauma to multiple body parts occurring on December 29, 2006 in Chicago, Illinois. Id. She settled her case for 20% loss of use of the left hand, 20% loss of use of the right hand, 7.5% loss of the left arm, and 7.5% loss of the person as a whole. Id. The settlement contract, which was approved by the IWCC on November 24, 2010, indicates the nature of Petitioner's injuries was bilateral carpal tunnel syndrome, lumbar radiculopathy, and left shoulder bursitis. Id. Petitioner confirmed she signed the settlement contract in the Petitioner's Signature section where it notes "I have read this document, understand its terms, and sign this contract voluntarily."

Despite the aforementioned evidence to the contrary, Petitioner testified she had never injured her left shoulder prior to August 3, 2010 and nor did she have any pain in the left shoulder prior to August 3, 2010. She explicitly denied having injured her shoulder while working for Compx Fort, and testified her previous workers' compensation claim had nothing to do with a left shoulder injury. Additionally, when questioned by Dr. Newman on March 24, 2011 about whether or not she had any prior problems with her left shoulder, she denied having any shoulder symptoms prior to August 3, 2010.

CONCLUSIONS OF LAW

The burden is on the party seeking an award to prove by a preponderance of credible evidence the elements of her claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

For treatment of an employee's workplace injury to be compensable under workers' compensation laws, the petitioner must establish the treatment is necessitated by the work injury

and not some other cause or condition. *Hansel & Gretel Day Care Center v. Industrial Commission*, 215 Ill. App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Workers' Compensation Act states "[i]t is unlawful for any person, company, corporation, insurance carrier, healthcare provider, or other entity to: (1) Intentionally present or cause to be presented any false or fraudulent claim for the payment of any workers' compensation benefit. (2) Intentionally make or cause to be made any false or fraudulent material statement or material representation for the purpose of obtaining or denying any workers' compensation benefit." 820 ILCS 305/8(b); 820 ILCS 305/25.5.

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to August 3, 2010 work incident, the Arbitrator makes the following conclusions of law:

The Arbitrator finds Petitioner's current condition of ill-being is not causally related to the work incident of August 3, 2010. In so finding, the Arbitrator relies on the unrebutted medical records of Concentra from August and September 2010 as well as the credible expert testimony of Dr. Aribindi. Further, which will be discussed *infra*, Petitioner lacks credibility. Accordingly, her claim for benefits is denied and all others issues are moot.

First, Petitioner testified that when she slipped on meat and grease and fell sideways, she supported herself with her left hand and hit her face, hip, and shoulder on the ground. She also testified she felt immediate pain in those three areas. Additionally, she testified that she immediately reported her left shoulder injury to the Concentra physician on August 3, 2010, and then reported left shoulder pain each subsequent follow-up at Concentra. However, the August 3, 2010 Concentra note indicates Petitioner stated "I slipped on some meat and papers that were on the floor and fell, hurting my left leg and left side of my face." The note is devoid of any indication that Petitioner fell on an outstretched left arm or injured her left shoulder or low back when she fell on August 3, 2010. Then, on August 5, 2010, Petitioner returned to Concentra complaining of increasing pain in her left thigh and cheek. Again, the note is absent any indication that Petitioner stated she fell on and injured her left shoulder. The remainder of the Concentra medical and physical therapy records make no mention of shoulder symptoms. In fact, the first medical record documenting shoulder symptoms is that of Dr. Newman from January 27, 2011—almost six (6) months after the August 3, 2010 event.

Though Petitioner acknowledged the Concentra records do not note she complained of shoulder symptoms, she testified she told the Concentra doctors and physical therapist at each appointment about her left shoulder and arm pain but they neglected to do anything about it. By extension, that would mean, on August, 3, 5, 11, 18, 25, 30 and 31, 2010 along with September 2, 8, 9, and 13, 2010, four doctors—Drs. Pratumngern, Ross, Garces, and Paloyan—and one physical therapist—Taral Patel—all neglected to document and treat a symptomatic left shoulder. Petitioner suggests that the Concentra doctors and physical therapist acknowledged and treated only some of her complaints and specifically ignored her left shoulder complaints. Such an inference cannot be made. The Arbitrator finds the lack of contemporaneous medical documentation indicative of Petitioner never reporting or experiencing left shoulder symptoms while under the care of Concentra.

Second, and more significant, Petitioner initially testified she never injured her left shoulder or experienced any left shoulder-related symptoms prior to August 3, 2010. She also testified she never experienced any low back or left leg pain prior to August 3, 2010.

Contrary to her testimony however, Petitioner filed a workers' compensation claim against Compx Fort alleging both repetitive and direct trauma to multiple body parts occurring on December 29, 2006 in Chicago, Illinois. She settled her case for 20% loss of use of the left hand, 20% loss of use of the right hand, 7.5% loss of the left arm, and 7.5% loss of the person as a whole. The settlement contract, which was approved by the IWCC on November 24, 2010, indicates the nature of Petitioner's injuries was bilateral carpal tunnel syndrome, lumbar radiculopathy, and left shoulder bursitis. Petitioner confirmed she signed the settlement contract in the Petitioner's Signature section where it notes "I have read this document, understand its terms, and sign this contract voluntarily."

Even when questioned about her past workers' compensation settlement and given a chance to correct her previous testimony, Petitioner denied having injured her left shoulder while working for Compx Fort or experiencing any left shoulder-related symptoms prior to August 3, 2010.

Finally, Dr. Newman's causation opinions were based on questionable statements and material misrepresentations made by Petitioner. When questioned by Dr. Newman on March 24, 2011 regarding whether or not she had any prior problems with her left shoulder, she denied having any shoulder symptoms prior to August 3, 2010. Furthermore, Dr. Newman offered no explanation regarding the lack of documented shoulder symptoms from August 3, 2010 until his initial evaluation on January 27, 2011. Thus, the Arbitrator places greater weight on the testimony of Dr. Aribindi over the opinions of Dr. Newman regarding the causal relationship of Petitioner's left shoulder symptoms and other complaints and the work incident of August 3, 2010.

Dr. Aribindi credibly testified that if a person sustained an impact abduction injury to the shoulder, he/she would experience pain either immediately or within the first couple of days after the injury, and it would be unusual for a person not to experience pain until five months later. As discussed *supra*, the Concentra records do not indicate Petitioner complained of left shoulder pain in August or September 2010. The first documented shoulder complaint is noted in Dr. Newman's note from January 27, 2011. Not only was this note almost six (6) months after the August 3, 2010 event, but also after Petitioner had been working for a cleaning company approximately 38 to 40 hours per week for the previous five (5) months.

Accordingly, after carefully considering the testimony of the witness, along with medical records and exhibits, the Arbitrator finds Petitioner has not carried the burden of proving her current condition of ill-being is causally related to the work incident of August 3, 2010. Rather, her current condition emanates from her non-work related left shoulder condition. Thus, her claim for benefits is denied and all other issues are moot.

Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services? What is the nature and extent of the injury?

In light of the determination Petitioner failed to establish her present condition of ill-being is causally related to the work incident of August 3, 2010, the remaining issues of Respondent's liability for Section 8 medical benefits and the nature and extent of the injury are moot and not reached by the Arbitrator. Accordingly, benefits are denied.

ORDER OF THE ARBITRATOR

Petitioner failed to prove her current condition of ill-being is causally related to the work incident of August 3, 2010. Thus, benefits are denied.

Deborah L. Simpson
Signature of Arbitrator

Dec. 1, 2014
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Danuta Wenc,

Petitioner,

vs. NO: 10 WC 35396

The Marvel Group,

16IWCC0306

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission corrects the computational error in the Arbitrator's award of permanency. The Arbitrator found Petitioner is permanently disabled to the extent of 30% of the person as a whole, but only awarded 100 weeks. The award of 30% of the person as a whole is 150 weeks. Therefore, the Commission corrects the computational error to reflect the correct award of 150 weeks for Petitioner's permanent disability. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 8, 2015 is hereby affirmed and adopted with the above noted correction of computational error.

16IWCC0306

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $352.00 per week for a period of 47 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $316.80 per week for a period of 150 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 30%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $3,500.00 for long-term disability benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $60,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 6 - 2016
MB/maw
o04/14/16
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WENC, DANUTA
Employee/Petitioner

Case# **10WC035396**

16IWCC0306

THE MARVEL GROUP
Employer/Respondent

On 10/8/2015, 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 0.06% shall accrue from the date listed above to the day before the 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:

0208 GALLIANNI DOELL & COZZI LTD
ROBERT J COZZI
20 N CLARK ST SUITE 825
CHICAGO, IL 60602

1153 MARTIN, PATRICK W
203 N LASALLE ST
SUITE 2100
CHICAGO, IL 60601

16IWCC0306

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

Danuta Wenc
Employee/Petitioner

v.

The Marvel Group
Employer/Respondent

Case # **10** WC **35396**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **August 18, 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 _____

16IWCC0306

FINDINGS

On **April 22, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**27,456**; the average weekly wage was $**528.**

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

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

Respondent ***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 $**3,500** under Section 8(j) of the Act for long-term disability benefits paid for by the group disability carrier. However, the respondent will hold the petitioner harmless with respect to claims for reimbursement by the group carrier.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $352/week for 47 weeks commencing 4/23/10 through March 17, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay petitioner permanent partial disability benefits of $316.80 for 100 weeks because the injuries sustained caused the 30% loss of a 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.

FINDINGS OF FACTS

16IWCC0306

Petitioner's Testimony

Danuta Wenc, (the "petitioner") testified that prior to working for The Marvel Group (the "respondent"), since June of 1990 and she never experienced any problems with her lower back. The only doctor with whom she treated was her family physician, Dr. Gierlachowski, for coughs, colds and flus. She speaks and writes only Polish and an interpreter was used for this hearing.

She emigrated from Poland in 1990 and became an American citizen in 1993. She attended school in Poland through the high school level. She has attended no additional classes, schooling or training in Poland or the United States other than the courses necessary to become an American citizen.

After attending high school, she went to work as a salesperson in a grocery store for four to five (4 –5) years. She was then married and began raising a family. She became a stay-at-home housewife until she came to the United States in 1990. As soon as she arrived, she obtained a work visa enabling her to begin employment in the United States. She began working for the respondent in June of 1990.

When she began her employment with for the respondent, her husband also began working there also. They had three children, ages 16, 14 and 5 years old. Her husband worked the first shift and she worked the second shift from 3:30 to midnight. Essentially, her and her husband switched off in mid-afternoon so they could care for the children and work.

The first job that she performed while working for the respondent was cleaning offices which she performed for two years. She was then moved to a different department to work as a machine operator. Initially, she worked four hours cleaning offices and four hours on the machines before becoming a full time machine operator. From that point, she only worked as a machine operator for the respondent, 8 hours a day, 5 days a week for 18 years.

The respondent makes metal cabinets and other types of office furniture. It also makes large metal cabinets, for the United States Army. While working as a machine operator, she was required to work on two machines at a time. These machines were parallel to one another and she stood in between them. She would put the metal sheets into one machine and then move to the other to operate it. Throughout her entire eight-hour day, she was operating two machines simultaneously.

These machines made metal cabinets and she was required to feed large metal sheets into them so the machine could cut them. She would then shake the cut sheet and several pieces would drop onto a table. The metal sheets that she had to feed into the machine were approximately 4 feet long and 4–5 feet wide, weighing between 30–50 pounds. She was required to lift each sheet to feed into the machine and the sheets were oily; which caused them to stick together, making it harder to separate them before feeding them into the machine. She had to feed 200 – 300 sheets of metal per hour.

The metal sheets would be stacked on a table that was approximately 3 feet high. The sheets would be stacked up an additional 2 feet high. The petitioner is 5 foot 4 inches tall. The slit in the machine that she had to feed the sheets into was approximately 3 ½ – 4 feet high.

After she fed the sheets of metal into the machine, the machine would feed back the finished product. She would have to shake the sheet of metal, gather the finished products that had fallen out, and place them onto a separate table. If the sheet weighed about 30 pounds, when it came out of the machine it weighed approximately 5 pounds less. The petitioner testified that the shaking part of her operation was very hard and this is when she felt the pain in her low back the most. Sometimes she would have to shake an individual sheet 10 times to get all of the pieces out of the sheet. The leftover scrap was then placed into bins which, when they were full, weighed 50–60 lbs. She would be required to lift up the bin and throw its contents into a large container. She had to bend over to do so. She did this approximately 3–4 times per hour.

The petitioner did this work for approximately 10–12 years before her back started to hurt. She last worked on April 22, 2010. On that date, her supervisor was Mike Zolla, who did not speak Polish. When she communicated with him, she would do so through a Polish-speaking individual who worked in the office named Maria Sidor.

The petitioner's family doctor since 1999 has been Dr. Ursula Gierlachowski. Between 2000 through 2008, she would occasionally complain to Dr. Gierlachowski of low back pain. However in 2008, her back began getting worse and she also began to notice that her right leg was getting numb. Dr. Gierlachowski prescribed medication, physical therapy, and shots. She was also sent for an MRI in 2008. Yet, she continued working every day but occasionally used sick and vacation days, when she could not work.

The records of Dr. Gierlachowski note that the petitioner was seen on May 13, 2008, complaining of low back pain which was radiating to her right leg. The history reflects that it is worse after work. Dr. Gierlachowski diagnosed low back pain with right sciatica. Medication and physical therapy was prescribed. An MRI of the lumbar spine was performed on September 20, 2008 which showed "a minimal central disc protrusion at L4-5. There is evidence of annular tears at the posterior disc margin of L4-5 and L5-S1." PX1.

In the beginning of 2010, her back began to feel painful all the time and her leg was numb. She took pills that had been prescribed by Dr. Gierlachowski through the last date that she worked on April 22, 2010.

The petitioner was seen by Dr. Gierlachowski on April 23, 2010 and the doctor instructed her to remain off of work. She was given an off work slip which she faxed to Maria Sidor. The petitioner also spoke to her on that date. Dr. Gierlachowski sent her to physical therapy.

The records of Dr. Gierlachowski indicate that the petitioner was seen on April 23, 2010 and reported that her back pain was getting worse and now radiating into her left buttock, thigh, calf and down into the left foot. An examination of the lower back revealed tenderness; muscle spasm; the inability to walk on heel and toe; restriction of forward flexion to 30 degrees and extension to 5

degrees; positive straight leg raising on the left at 25 degrees. The petitioner was diagnosed with low back pain; left sciatica; and degenerative joint disease of the lumbar spine. She was taken off of work; prescribed Flexeril and Norco and sent for physical therapy.

The petitioner underwent physical therapy but did not have significant improvement. Dr. Gierlachowski referred her to Dr. Branovacki, an orthopedic surgeon. In the spring of 2010, Dr. Gierlachowski indicated that Petitioner could do light duty work, lifting up to 5 lbs. She testified that she was told by Mike Zolla through Maria Sidor that there was no such work available.

The petitioner was first seen by Dr. Branowacki on June 24, 2010. His examination revealed, "Very strongly positive left straight leg raising with severe pain that goes down to the foot." He suspected that she had a herniated disc and would require injections. He ordered a new MRI and instructed her to return when completed. The MRI was completed on June 25, 2010 and read to show an anterior disc protrusion at L4-5 as well as an annular tear. When she returned to Dr. Branowacki on June 28, 2010, he noted the annular tear at the L4-5 disc with extrusion. He recommended physical therapy and that Petitioner remain off work. On August 12, 2010, Dr. Branowacki recommended an epidural steroid injection at L4-5. He sent her to Dr. Lim for continued treatment. PX4.

The petitioner was first seen by Dr. Richard Lim of Midwest Orthopedic Consultants on September 14, 2010. He recommended a second epidural injection. When she returned on October 27, 2010 she reported that the injections only helped for 2 – 3 days. Her doctor offered surgery but could not guarantee it would be successful or even help her. In fact, he told her that it might make her condition worse. She decided not to undergo surgery. He recommended additional physical therapy and pain patches. PX1.

The petitioner continued to treat with Dr. Gierlachowski through 2011. She sent her for additional therapy, prescribed medication and told her that she should remain off work.

The petitioner then came under the care of a different primary care physician, Dr. Kakol. Physical therapy, patch, pills and home exercise were prescribed. She has been attending Excel Physical Therapy PXs 3 & 5.

At the present time, she notices that she has difficulty with simple daily activities and that she can only lift up to 10 lbs. She cannot turn quickly and has difficulty taking a shower. The pain is located in her lower back and radiates down her right leg. Her leg gets numb and feels raw. She has difficulty doing any one thing such as standing or sitting for longer than 40 minutes. When her pain gets bad, she puts a patch on her back and also takes medication. Dr. Kakol has prescribing Naproxen and Tylenol which she takes sometimes twice a day. In the morning, she does her home exercises when she first gets up.

Upon cross-examination, Petitioner stated that on April 22, 2010, she felt pain in her back that was so severe that she was unable to get herself in the car. The next day, she called the office and told Maria Sidor that she had to go on sick leave and could not work because of the problem with her back.

Video taken by Respondent

The respondent showed her a video at the hearing, which purports to be her job duties. The petitioner testified that it does not accurately portray what she had to do at work. Specifically, she had to work on two machines simultaneously but the video only showed the operator working on one. In addition, the sheets of metal that she had to use were much bigger. The machine that is shown in the video is the smallest machine that the respondent has. The machine shown on the video depicted only small parts but she used larger pieces of metal. The sheet metal that came out of the machine that she was required to shake was much bigger than the ones depicted in the video. With respect to the stack of sheet metal sitting on the table, the video showed approximately 100 pieces on the table whereas she had to work off of a stack of up to 1,000 pieces. The metal sheets were also thicker than the ones depicted on the video. The total cycle depicted in the movie lasted for several minutes whereas her cycle was much quicker and took seconds, i.e., she had to work much faster than the person depicted in the video. She further testified that her job involved walking, lifting and bending. She would have to walk between the two machines 8 hours per day. Her job also involved squatting when she had to though out the scrap metal in the bin. When the pile of sheet metal was high, she was lifting the material from eye level down to the slit to feed the machine. Eventually, the pile would be reduced to waist level and it would then be replenished.

On re-direct examination, she stated that she would occasionally have pieces of sheet metal as small as the ones depicted in the video but this would occur approximately once or twice per month. The rest of the time, she worked with 4 feet x 5 feet sheets. Also, the metal that was being used in the video was not oiled and the sheets were not sticking together as the operator was taking them off the stack. Her sheets were oiled and stick to one another. In order to move them, she would have to lift and then jerk it before loading it into the machine. In addition, based on the height of the table, it appeared that the operator in the movie was taller than she is.

Finally Petitioner testified that she told her supervisor, Mike Zolla, through the translator, Maria Sidor on several occasions, that she was having problems because of the lifting she was doing at work. When she told him that prior to April 22, 2010, he told her they did not have light duty work and she could quit if she wanted to. Finally, she left work with the respondent, she has not worked or looked for work because Dr. Kakol has instructed her not to.

Respondent's first witness's testimony

Mr. Dane Nakashima testified that he has been the personnel manager for Respondent for the past forty-six years. He also handles insurance grievances, hiring and termination of personnel. He was not aware that the petitioner sustained an isolated, traumatic injury at the workplace between April 19 and April 22, 2010. After the last day, she brought in a doctor's slip stating she could not work. She was paid sick pay for twenty weeks. He testified that Petitioner also provided the respondent with further doctor's notes that she could not work after the twenty-week period of time.

On cross-examination, he stated that he did not speak Polish, only a few phrases or colloquialisms. As personnel manager, he was responsible for keeping personnel files for all the employees. Although he kept one for the petitioner, he did not bring it to the hearing but rather left it at his office.

Respondent's second witness's testimony

Michael Zolla testified that he is a supervisor for the respondent and that he began working there in 1983. He has been a supervisor in the fabrication and welding department for the past fifteen (15) years. His job duties include dictating the workflow, monitoring the operators and schedule the work. The Respondent manufactures office furniture. There are currently 156 employees and 93 of them are machine operators. The machines sheets of steel into certain pieces that are eventually sent someplace else for welding and manufacturing.

The petitioner was one of the machine operators that he supervised in April of 2010. At the end of her employment with the respondent, she was taking time off of work and she brought in doctor's notes. She never complained while she as at work about being in discomfort.

A videotape of the petitioner's purported work tasks and activities was made. He was present while it was being made and he believes it accurately portrays the work tasks she performed as a machine operator. The sheets of metal were 32 inches by 50 inches and were 16 gauge, which would be a normal operation. The operator sometimes works with larger pieces of metal but they would vary. Some sheets could be 48 inches x 70 inches and could be a heavy gauge such as 14 gauge. The petitioner at times worked with metal that was bigger and thicker than what was depicted on the video but only 20% of the time.

The video did not show the operator working on two machines simultaneously. The cycle could last anywhere between 30 second to 4 minutes. The cycle depicted on the video was about 3 minutes. The machine has four speeds. The purpose of shaking the steel sheets was to break the tabs that were holding the cut pieces in the sheet. There are two types of bins for scrap metal. The large one was on wheels and had to be moved out by crane. The smaller bin was kept on the floor by the operator, who would have to pick it up and empty it into the larger bin. It would weigh 30- to 40 pounds. He further testified that there is an oily film on every sheet and it does make it harder to separate the sheets from one another. The cycle that runs only 30 seconds means the operator would have to move 120 pieces of sheet metal into the machine per hour. The average cycle is 2 ½- 3 minutes which would mean 20 to 25 pieces of sheet metal per hour.

Upon cross-examination, he stated that both he and the respondent's attorney were present when the video was made. In fact, the attorney was the individual who shot the video. The particular machine in the video was selected because it was the only one running at the time that the video was being taken. The video was taken approximately 2 & 2 ½ months before the hearing. The respondent makes metal file cabinets that are approximately 4 ½ - 5 feet tall. Sometimes the machines use 11 and 12-gauge metal, which is much heavier than the gauge that was used in the video. The 11-gauge metal which the respondent uses is twice as thick as the one depicted.

The company keeps records for the types of orders that it received for office equipment cabinets back in 2010, but he did not look for them prior to coming to testify nor did he ask anyone at the respondent to look for those records to show the size of the equipment being made.

The operator has to shake the pieces of metal out of the sheet in order to allow the metal pieces to drop. The pieces of metal weigh 30 to 40 lbs. prior to cutting. On the average, the machine operator would have to move 30 to 40 pieces per hour into the machine.

Although the petitioner was working on two machines while employed by the respondent, he did not show the machine operator working the two machines because there was only one machine in operation at the time. He did not tell the individual taking the video that the petitioner was working two machines at the same time because he was not asked.

The oil makes it difficult to split the stacked pieces of sheet metal apart so the operator would have to "snap" the sheet with her/his hands. This breaks the material apart and it would then be put into the machine. The metal pieces were fed into the machine that weighed 30 to 40 pounds do not weigh substantially less after they are taken out, perhaps 5 to 10 pounds lighter. The average piece of sheet metal that would be fed into the machine is 30 – 40 lbs.

Deposition of Petitioner's treating doctor

Dr. Ursula Gierlachowski testified that she has been practicing internal medicine in Illinois since 1994. She was board-certified in 1993 and has been a general practitioner in Illinois since that time. The petitioner has been a patient of hers since 1999 through 2011. Prior to 2008, she would occasionally complain of low back pain and had been seen by a chiropractor but she was not specifically providing any direct medical care to her until 2008.

In May of 2008, the petitioner reported she had to lift metal weighing approximately 30 to 50 pounds at work and as a result, she was in pain. PX2, pp. 4-9.

Her physical examination showed positive straight leg raising; normal deep tendon reflexes. The positive straight leg raising told her that something was touching the nerves. The petitioner continued working through 2010 and she took her off of work only for a day or two at a time. She is also prescribed anti-inflammatories, muscle relaxants and pain medications and DepoMedrol injections. PX2 pp. 10-11.

The doctor further testified that she continued to see the petitioner intermittently through 2010, when on April 23, 2010, the petitioner reported that the pain was getting worse and it was now radiating into her left buttock, side and down to the foot. The physical examination showed tenderness; muscle spasm; the inability to perform heel and toe walking. These findings indicated that there may be bulging or slipped discs. She took her off of work and diagnosed a displaced disc. The MRI that had been taken two years earlier showed that she had degenerative disc disease. She ordered x-rays, referred her to physical therapy, administered an injection and prescribed muscle relaxants and pain medication. PX2, pp. 12-13)

In June of 2010, she referred her to an orthopedic surgeon, Dr. Branowacki of Midwest Orthopedics. He sent her for an MRI and administered epidural injections and kept her off of work. On August 19, 2010, Dr. Gierlachowski prepared a note indicating that the petitioner has L4-5 disc protrusion as a result of heavy lifting at work. She continued to see her intermittently in 2010 and 2011 and kept her off work during this time. PX2, pg. 15.

On March 17, 2011, the petitioner continued to report symptoms of weakness and radiation down the legs. The physical examination revealed tenderness; restriction of motion; and positive straight leg raising.

Based on a reasonable degree of medical certainty, the petitioner diagnosis is degenerative disc disease with herniated disc and radicular symptoms. In her opinion, it is related to the petitioner having to lift 30 to 50 lbs. throughout the day, amounting to over a ton of metal per day for twenty years. This activity aggravated and speeded up the process of degeneration and the aggravation is a permanent. In her opinion, the petitioner cannot return to any form of work as of the date that she last saw her. PX2, pp. 18-19.

On cross-examination, she acknowledged that the petitioner first mentioned low back pain in 2005. She was receiving therapy from a chiropractor, Dr. Buresz, who is now deceased. In 2006, she ordered physical therapy, administered an injection and prescribed medication. In 2008, the condition was getting worse and had been present for several years so she considered it a chronic condition. Since Dr. Buresz was no longer alive, Dr. Gierlachowski ordered the therapy in 2008. She was reporting that the pain was worse after working. An MRI was also ordered at the time that showed a disc protrusion and annular tears at L4-5 and L5-S1. A disc protrusion with an annular tear is a herniation. An EMG was performed on May 11, 2010 which was normal. On April 29, 2010, straight leg raising was positive on both sides. As of March 17, 2011, she was not anticipating much improvement but her condition would wax and wane thereafter. PX2, pp. 22-61.

On re-direct, the doctor testified that Petitioner attributed her chronic, worsening condition in her low back, from 2005 to 2010, by the type of work she was performing. Also, that there was no other injury to the petitioner's low back between 1999 to 2011, other than the heavy lifting she was performing at work. PX2, pg. 62.

IME by Dr. Kern Singh

The petitioner underwent an examination with Dr. Kern Singh, at the request of the respondent on August 10, 2011. His physical examination revealed no positive findings. The MRI study of September 2, 2008 revealed annular tears at L4-5 and L5-S1. The MRI in 2010 revealed a slight disc extrusion at the right L4-5. He indicated she was capable of working only light duty with a 20 pound lifting restriction and minimum bending, kneeling, stooping and squatting. He requested copies of the actual films. Dr. Singh was thereafter provided with films and issued an addendum report which is undated. He indicated that there was no interval change between the MRI's and therefore, the degenerative disc disease was not aggravated by a work-related injury. He opined

that she was at maximum medical improvement ("MMI") and could return to work in a full duty capacity, without restrictions. His diagnosis was muscle strain. RX1 & 2.

The petitioner was examined by orthopedic surgeon, Dr. Michael Treister, on February 9, 2014, by request of Petitioner. He was provided a detailed description of her job duties including the amounts of weight that she had to perform; how often she had to move the weight and what she had to do with the metal. The physical examination showed restriction of motion of the lumbar spine; tenderness over the right sciatic nerve; positive straight leg raising on the right at 60 degrees and negative on the left, absent ankle and knee reflexes; low focal weakness in the lower extremity and no sensory deficit in the lower extremity. He diagnosed degenerative disc disease with annular tears and disc protrusions. With respect to causation, he stated as follows:

> Why this lady first developed degenerative disc disease at L4-5 we will never know now. But we are certain that it has been present since prior is 2005 and hence for a minimum of 15 years was repetitively traumatized by the nature of her work. Hence, the progression of that pathology observed on 6/25/10 lumbar MRI along with the associated right-sided disc protrusions are much more likely than not, causally related to the type of heavy work which she did over that period of time.

He opined that the only treatment that might alleviate the condition would be a decompression at L4-5 and an anterior and posterior fusion from L5 to S1. PX6.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the petitioner's repetitive activities constitute a repetitive trauma and an accidental injury arising out of and in the course of her employment. *Bellwood Nursing Home vs. Industrial Commission* (1987) 115 Ill. 2d. 524, 505 N.E. 2nd 1026, 106 Ill. Dec. 235. The Arbitrator finds that the date of accident to be April 22, 2010, the date in which the petitioner last worked for the respondent. *Oscar Meyer & Co. vs. Industrial Commission* (1988) 176 Ill. App. 3d. 607, 531 N.E. 2nd 174, 126 Ill. Dec. 41.

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

The issue is whether lifting the equivalent of 10 to 40 tons of steel per day for 18 years aggravated the degenerative disc disease in the petitioner's lumbar spine. Three physicians have rendered an opinion with respect to causation: Drs. Gierlachowski, Singh and Treister. Drs. Gierlachowski and Treister have opined that the petitioner's work-related activities aggravated the petitioner's pre-existing degenerative disc disease in her lumbar spine. Dr. Singh did not find causation.

The Arbitrator finds the opinions of Drs. Gierlachowski and Treister to be more persuasive than that of Dr. Singh. Dr. Gierlachowski has been the petitioner's treating physician since 1999. She has documented and noted the progress of the petitioner's low back problems throughout her last twelve years of employment with the respondent. She ordered testing and treatment and performed interval physical examinations showing the progression of the disease. Dr. Treister's report reveals a detailed understanding of each aspect of the petitioner's work including the size of the materials being lifted; the weight of the materials; the frequency that it had to be performed; and the biomechanics involved in performing her work. While he acknowledged that the reason why she had degenerative disc disease in the first place would never be known, the heavy work she had to perform for many years repetitively traumatized that degenerative condition.

Dr. Singh failed to demonstrate an understanding of the basic aspects of the petitioner's work. It does not appear that he understood that it was a repetitive trauma claim because his report reflects that there was "no acute interval event." The respondent did not provide him with a job description or the video that was taken of the machine operator's job, as flawed as that video might be. It is well settled under Illinois law that an expert's opinion is only as valid as the bases and reasons for the opinion. When there is no factual support for an expert's conclusions, his conclusions alone do not create a question of fact. *Wilson v. Bell Fuels, Inc.* (1991) 214 Ill App. 3rd 868, 158, Ill. Dec. 406, 574 N.E. 2nd 200. In that Dr. Singh was not provided with any information regarding the petitioner's job duties, little weight can be placed on his opinion. The Arbitrator, therefore, finds that the petitioner's current condition of ill-being is causally related to the repetitive work she performed in her job as a machine operator for the respondent.

K. What temporary benefits are in dispute?

The petitioner was taken off of work by Dr. Gierlachowski on April 22, 2010 and was kept off work through the date of her last examination of March 17, 2011, a period of 47 weeks. Her doctor indicated on March 17, 2011 that she did not expect her condition to improve from that point. Therefore, her condition was no longer temporary. The respondent did not seek an evaluation of the petitioner until August of 2011. Therefore, it is unrebutted that the petitioner was temporarily totally disabled during that period of time. The Arbitrator awards the petitioner 47 weeks of temporary total disability from April 23, 2010 through March 17, 2011.

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

The petitioner suffers from a central disc protrusion at L4-5 and annular tears at L4-5 and L5-S1. Drs. Gierlachowski, Kakol, Branovacki and Treister have all opined that the petitioner is not capable of returning to work. Dr. Lim has recommended surgery but the petitioner is reluctant to undergo the procedure because she has been warned the condition could worsen. Dr. Treister has recommended a two-level lumbar discectomy and fusion. Dr. Singh, on the other hand, finds that the petitioner sustained only a lumbar strain.

16IWCC0306

The Arbitrator finds the opinions of the petitioner's treating doctors and that of Dr. Treister to be more persuasive than that of Dr. Singh. The petitioner's lumbar radiculopathy is reflected not only in the findings of the MRIs but also in the treating doctors physical examinations, which all consistently show a positive straight leg raising indicative of neurological impingement. The petitioner credibly testified that she is capable of sitting, standing and walking only in 40-minute intervals. She continues to take prescription medication at the present time and undergoes interval physical therapy. The Arbitrator finds that the petitioner sustained the complete and permanent loss of 30% of a person as the whole.

16IWCC0306

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
10WC35396
SIGNATURE PAGE

L Thompson

Signature of Arbitrator

October 7, 2015
Date of Decision

OCT 8 - 2015

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeffrey Wernsman,
Petitioner,

vs. NO: 10 WC 40229

City of Bloomington,
Respondent.

ORDER

Motion to Supplement the Record having been filed by Petitioner herein, and due notice given, this matter came on for hearing before the Illinois Workers' Compensation Commission on April 11, 2016 in Peoria, Illinois.

Upon consideration of said Motion and a review of the record and file, the Commission is of the belief that Petitioner's Motion to Supplement the Record should be denied.

Petitioner's attorney represented that on January 29, 2015 Petitioner signed an Authorization to Disclose Health Information and Medical Records and sent the request to Advocate Medical Group. The above caption claims proceeded to trial before Arbitrator Erbacci on August 13, 2015. At the time of the Arbitration hearing, Petitioner's attorney moved to submit Petitioner's PX3, medical records from Advocate Medical Group for dates of service January 1, 2006 up to and including the present. The request to Advocate Medical Group specifically sought medical records included progress and physicians' notes from January 1, 2006 to January 29, 2015. Pursuant to their request, Petitioner's attorney represented that Petitioner's law office received 70 pages of medical records, including physician consultation notes from January 30, 2007 through March 5, 2014 which were submitted into the record as Petitioner's PX3 exhibit. At the conclusion of the Arbitration Hearing and specifically on page 73 of the Arbitration transcript, Arbitrator Erbacci expressly stated, "Proofs in this mater are closed". Additionally, the Arbitration transcript contains an authentication page signed by the attorneys in the above caption claim representing that the transcript is true and correct. An Arbitration decision was

issued by Arbitrator Erbacci on October 9, 2015. Both parties filed a Petition for Review of the Arbitrator's decision. A Return Date on Review was set for February 19, 2016 and oral arguments were scheduled for May 5, 2016.

At the April 11, 2016 Review Hearing, Petitioner's attorney represented that Advocate Medical Group did not provide the May 24, 2010 and July 19, 2010 progress/physician notes related to Petitioner's consultation and initial post-accident examination with Dr. Christopher Hughes, Petitioner's primary care provider. Petitioner's attorney first became aware of the absence of these records after the October 9, 2015 Arbitration decision was issued by Arbitrator Erbacci. On January 25, 2016, Petitioner's attorney contacted Advocate Medical Group and requested the missing records from May 24, 2010 and July 19, 2010 dates. Advocate Medical Group mailed the requested records to Petitioner's attorney and they were received by Petitioner's law firm on January 29, 2016 and were submitted into the April 11, 2016 Review Hearing record as Petitioner's Exhibit A. At the April 11, 2016 Review Hearing, Petitioner's attorney requested that Petitioner's Exhibit A, the May 24, 2010 and July 19, 2010 medical record be added to the record and be considered as part of the Review in the above caption matter.

The Commission finds that Section 19 (e) of the Illinois Workers' Compensation Act states as follows:

> "In all cases in which the hearing before the arbitrator is held after December 18, 1989, no additional evidence shall be introduced by the parties before the Commission on review of the decision of the Arbitrator."

The Commission further notes that the Illinois Appellate Court has held that the primary goal of statutory construction is to ascertain and give effect to the intent of the legislature and that is best evidenced by the clear and unambiguous language of the statute. See Modern Drop Forge v. Industrial Commission, 284 Ill. App. 3d 259 (1996). The Appellate Court further held that the legislative intent is determined by looking to the words of the statute since the legislature is presumed to have intended what it said. See Pluto v. Industrial Commission, 272 Ill. App.3d 722 (1995). Lastly, generally the words of a statute are given their plan and commonly understood meanings and only when the meanings of the statute are unclear will extrinsic aids to construction be employed. See King v. Industrial Commission, 301 Ill. App. 3d (1998).

With the Appellate Court's holding in mind and noting that Section 19(e) of the Illinois Workers' Compensation Act specifically uses the word "shall" in not allowing any additional evidence to be introduced by the parties before the Commission on review of the decision of the Arbitrator, the Commission applies the plain meaning of the words set forth by the Illinois legislature and in doing so it denies Petitioner's Motion to Supplement the record on review and to consider Petitioner's Exhibit A as part of the review of said case. The Commission further finds that the common misnomer that Section 19(e) only addresses "new" evidence is incorrect

and it should be noted that the plain language of the Act indicates no "additional" evidence shall be admitted on review.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Motion to Supplement the Record is hereby denied.

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

DATED: MAY 20 2016

MB/jm

R: 4/11/16

43

Mario Basurto

David L. Gore

Stephen Mathis

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

Eugene Buss,
Petitioner,
vs.

NO: 10 WC 40951

Buss Safety Environmental LLC,
Respondent,

16IWCC0347

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 22, 2015, is hereby affirmed and adopted.

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

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

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

DATED: MAY 23 2016
O050516
DLG/mw
045

David L. Gore

Mario Basurto

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUSS, EUGENE
Employee/Petitioner

Case# 10WC040951

16IWCC0347

BUSS SAFETY ENVIRONMENTAL LLC
Employer/Respondent

On 7/22/2015, 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 0.13% shall accrue from the date listed above to the day before the 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:

2119 CALIFF & HARPER PC
STEVE NELSON
506 15TH ST SUITE 600
MOLINE, IL 61285

2293 BROOKS LAW FIRM PC
JEFFREY D BEST
3725 BLACKHAWK RD
ROCK ISLAND, IL 61201

16IWCC0347

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

Eugene Buss
Employee/Petitioner

Case # **10** WC **40951**

v.

Buss Safety Environmental, LLC
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rock Island**, on **June 10, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 24, 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 not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**75,062.00**; the average weekly wage was $**1,443.50**.

On the date of accident alleged, Petitioner was **62** years of age, ***married*** with **0** dependent children.

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

ORDER

The Arbitrator finds that the Petitioner has failed to prove that an accident arising out of and in the course of his employment occurred on December 24, 2007 and further finds that the Petitioner failed to prove any current condition of ill-being which is causally related to the alleged accident of December 24, 2007. The Petitioner's claim for compensation is, therefore, denied.

No benefits are awarded herein.

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

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

Arbitrator Anthony C. Erbacci

July 21, 2015
Date

JUL 22 2015

16IWCC0347

FACTS:

On December 24, 2007, the Petitioner was employed by the Respondent as a safety consultant. The Petitioner testified that he was the Respondent's owner and sole employee. At the time of his alleged accident, the Petitioner was 62 years old, and he testified that he had been involved in the safety business for fourteen to fifteen years. The Petitioner testified that, as a safety consultant, his job duties included working with companies to develop safety programs, perform site inspections and help companies make corrections to insure compliance with current safety standards.

The Petitioner testified that on December 24, 2007 he was conducting an inspection and setting up a safety perimeter at a job site in East Moline, Illinois. The Petitioner did not testify or offer any other evidence as to the specific air temperature on that date but he estimated that the temperature was "in the teens." The Petitioner testified that while he was conducting the inspection and setting up the safety perimeter, he was outside on a roof for approximately fifteen minutes. He testified that he then began coughing and wheezing and experiencing chest congestion and tiredness. The Petitioner testified that he then sought treatment with Dr. Shnurman and was hospitalized for several days.

The Petitioner admitted that prior to December 24, 2007 he had been treated for asthma by Dr. Thomas Ade and Dr. Benjamin Shnurman. The Petitioner testified that he had been diagnosed with asthma several years prior to December of 2007 but he testified that, prior to December 24, 2007, he had ever been told by his physicians that he had COPD. The Petitioner also testified that he had undergone open heart surgery in April of 2007.

The medical records demonstrate that the Petitioner had respiratory complaints and treatment with Dr. Ade dating back to 2003 and that in December of 2005 Dr. Ade diagnosed the Petitioner with "acute bronchitis with aggravation of COPD". The Petitioner also treated with Dr. Shnurman who diagnosed the Petitioner with "COPD vs reactive airway disease" in August of 2006. Dr. Shnurman also referred the Petitioner to Dr. Enriquez who, in March of 2007, diagnosed the Petitioner with asthma/COPD.

On April 10, 2007, the Petitioner underwent a coronary artery bypass surgery performed by Dr. Jeffrey Veluz at Trinity Medical Center. Subsequent to the coronary artery bypass surgery, the Petitioner participated in cardiac rehab. At discharge from cardiac rehab, the Petitioner was advised to use caution in hot/humid weather or cold/windy weather. The Petitioner was further advised by the cardiac rehab nurse to limit outdoor activity when temperatures are greater than 80 degrees or lower than 40 degrees.

On August 30, 2007, Dr. Shnurman noted that the Petitioner complained of increased shortness of breath and coughing due to sinus drainage and congestion with yellowish dark phlegm. On October 11, 2007, the Petitioner was noted to have complaints of wheezing, increasing shortness of breath and difficulty breathing. It was also noted that the Petitioner's medications included Advair, albuterol, Benicar, clonidine, Mucinex, Norvasc, Spiriva, and Veramyst nasal spray. He was diagnosed with Asthma and COPD with exacerbation.

On December 13, 2007 the Petitioner was noted to have called Dr. Enriquez to report that he had increasing shortness of breath and had just finished his Prednisone.

Dr. Shnurman's records demonstrate that on December 14, 2007 the Petitioner complained of chest and sinus congestion which was noted to be "recurrent". On December 26, 2007 the Petitioner called and reported that he was still coughing up phlem and still felt very congested and very tired. On December 27, 2007 the Petitioner called Dr. Shnurman with complaints of extreme shortness of breath. It was noted that the Petitioner also reported that his symptoms "started after Prednisone was stopped." The Petitioner was directed to go to the emergency room.

In a letter report dated January 15, 2008, Dr. Enriquez noted that the Petitioner was under his care for "chronic obstructive pulmonary disease and asthma" and that those chronic pulmonary conditions are greatly affected by environmental factors, such as temperature extremes and inhaled pollutants. Dr. Enriquez further wrote that he advised the Petitioner to work only in temperatures between 40 – 80 degrees Fahrenheit, and to avoid exposure to dust and fumes to maintain his respiratory function.

In a letter report dated January 16, 2008, Dr. Shnurman noted that the Petitioner had been diagnosed with chronic COPD and asthma and he opined that the Petitioner should only work in temperatures between 40 and 80 degrees Fahrenheit and should avoid exposure to dust, fumes and other respiratory pollutants that may adversely affect him.

At the request of the Respondent, the Petitioner was examined on April 8, 2009 by Dr. Patrick Hartley. Dr. Hartley concluded that the Petitioner suffered from asthma and he opined that exposure to cold air did not cause or significantly worsen the Petitioner's underlying asthma. Dr. Hartley further opined that "exposure to cold temperature may cause an exacerbation of airway disease, but does not significantly worsen the underlying disease process in any permanent way."

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

It is axiomatic that the Petitioner bears the burden of proving all of the elements of his claim by a preponderance of the credible evidence. The Arbitrator finds that the Petitioner failed to meet that burden here.

The Petitioner alleges that on December 24, 2007, an accident occurred when he

16IWCC0347

began to experience coughing, wheezing, congestion and tiredness after working outside in cold temperatures. The Arbitrator notes that there is no evidence in the record which corroborates or supports the Petitioner's testimony and, in fact, the histories contained in the medical records tend to contradict the Petitioner's testimony. It is clear from the medical records that, contrary to the Petitioner's testimony, he had been diagnosed with asthma and COPD prior to the date of his alleged accident. The medical records demonstrate that the Petitioner had respiratory issues dating back to at least 2003 and that in December of 2005 Dr. Ade diagnosed the Petitioner with "acute bronchitis with aggravation of COPD". The medical records further demonstrate that in the weeks prior to the date of accident alleged by the Petitioner the Petitioner was complaining to his physicians of chest congestion, difficulty breathing and tiredness. There was no history of having been exposed to cold temperatures while working noted anywhere in any of the medical records that were admitted into the record.

Similarly, the Arbitrator notes that there is no medical opinion contained in any of the medical records admitted into the record that that the Petitioner's exposure to cold temperatures on December 24, 2007 aggravated or accelerated the Petitioner pre-existing conditions of asthma and COPD. In a letter report dated January 15, 2008, Dr. Enriquez indicated that the Petitioner was under his care for COPD and asthma and opined that the Petitioner should work only in temperatures between 40 and 80 degrees Fahrenheit. In a letter report dated January 16, 2008, Dr. Shnurman indicated that the Petitioner had been diagnosed with chronic COPD and asthma and he opined that the Petitioner should only work in temperatures between 40 and 80 degrees Fahrenheit. Neither Dr. Enriquez nor Dr. Shnurman rendered an opinion that the Petitioner's alleged exposure on December 24, 2007 aggravated or accelerated the Petitioner's preexisting conditions of COPD or asthma.

The Respondent's examining physician, Dr. Patrick Hartley, opined that the Petitioner's exposure to cold air did not cause or significantly worsen the Petitioner's underlying asthma. Dr. Hartley also stated that exposure to cold temperatures does not hasten the underlying disease process in any permanent way.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner has failed to prove that an accident arising out of and in the course of his employment occurred on December 24, 2007. The Arbitrator further finds that the Petitioner failed to prove any current condition of ill-being which is causally related to the alleged accident of December 24, 2007.

As the Arbitrator has found that the Petitioner failed to meet his burden of proof with regard to the issues of accident and causation, determination of the remaining issues is moot. The Petitioner's claim for compensation is denied and no benefits are awarded herein.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Zbigniew Kafara,

Petitioner,

vs. No. 10 WC 46601

16IWCC0310

Advanced Strobe Products, Inc.,
Jaroslaw Bijak, Milena Bijak, and
State Treasurer as Ex-Officio Custodian of the Injured Workers' Benefit Fund,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of employment relationship, accident, notice, statute of limitations, causal connection, medical expenses, prospective medical care, benefit rates, temporary disability, permanent disability, penalties and attorney fees, and being advised of the facts and law, affirms and adopts the Decisions of the Arbitrator, which are attached hereto and made a part hereof.

The Arbitrator filed two decisions captioned with the same case number, 10 WC 46601. One decision addressed the liability of Advanced Strobe Products, Inc., and the other decision addressed the liability of Jaroslaw Bijak, Milena Bijak and the Injured Workers' Benefit Fund to pay compensation to Petitioner. The Commission affirms and adopts both decisions.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decisions of the Arbitrator filed July 1, 2015, are hereby affirmed and adopted.

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

16IWCC0310

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.

MAY 11 2016

DATED:
o-04/21/2016
JDL/sk
44

Joshua D. Luskin

Marie Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KAFARA, ZBIGNIEW
Employee/Petitioner

Case# 10WC046601

16IWCC0310

MILENA BUJAK & JAROSLAW BIJAK ET AL
Employer/Respondent

On 7/1/2015, 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 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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CHICAGO, IL 60601

16IWCC0310

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ZBIGNIEW KAFARA
Employee/Petitioner

v.

MILENA BIJAK & JAROSLAW BIJAK, et.al,
Employer/Respondent

Case # 10 WC 46601

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **GEORGE ANDROS**, Arbitrator of the Commission, in the city of **WAUKEGAN**, on **05/19/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **10/06/2010**, Respondents ***were not*** operating under and subject to the provisions of the Act ***since the respondents were not statutory employers.***

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondents, ***Milena Bijak and Jaroslaw Bijak.***

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment, ***as there was no employment relationship between Petitioner and Respondents, Milena Bijak and Jaroslaw Bijak.***

Timely notice of this ***alleged*** accident ***wasnot*** given to Respondent, ***as there was no employment relationship between Petitioner and Respondents, Milena Bijak and Jaroslaw Bijak.***

Petitioner's current condition of ill-being ***is not*** causally related to the accident, ***as there is no accident for which Milena Bijak and Jaroslaw Bijak can be found liable.***

In the year preceding the injury, Petitioner earned $**8,660.00**; the average weekly wage was $**721.66**.

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

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services, ***as there was no employment relationship between Petitioner and Respondents, Milena Bijak and Jaroslaw Bijak.***

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

Respondent is entitled to a credit of **$5,000.00** under Section 8(j) of the Act.

ORDER

See attached Findings of Fact and Conclusions of Law incorporated here as though fully set forth herein.

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

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

#01 Signature of Arbitrator

06-29-15
Date

JUL 1 - 2015

FINDINGS OF FACT

1. The location of the accident was at the private, family home of the respondents, Milena and Jaro Bijak, 20 Mill Road Lake Forest, Lake County, Illinois.

2. Jaro Bijak is the CEO of Advanced Strobe Products, Inc., which makes strobe lamps and photography lights at 7227 W. Wilson in Harwood Heights, Illinois. There was no evidence presented that the home created any rent, income, revenue, gain or served any benefit to any business;

3. The petitioner responded to an ad in a newspaper. When petitioner met with Mr. Bijak's administrative assistant at Advanced Strobe, he was told to report to the Lake Forest home;

4. Petitioner went to the Lake Forest home the following Monday and began work. Tools for the work at the home were already present. Petitioner did not know who the provided the tools at the job. He also testified that he used his tools he brought to the job. He testified that he was an experienced carpenter;

5. Petitioner was paid an hourly rate of for his work. He started in July of 2010 working up until the time of the accident five days week and a half day on Saturday;

6. Petitioner was paid in cash and also by check every Friday by Milena Bijak. Petitioner identified and introduced into evidence copies of checks he received. (Petitioner's Exhibit 12) These were the payments he received. The checks were all made to "cash." The amounts on the check accurately stated what his earnings were which was his hourly rate multiplied by the hours worked. There was no evidence presented that any taxes were withheld from his payments. To the contrary, he was paid in full;

7. Petitioner negotiated the pay rate on his first date at the job. Milena Bijak took his photo. Mr. Bijak testified that the photo was taken since there were kids who lived at this home.

8. Petitioner testified that Jaro Bijak gave instructions of the task to be completed. Mr. Bijak and the petitioner both testified that he was given a task to do, but that the respondents did not give him instructions or describe how to do or complete the task. Petitioner was free to do the work as he saw fit;

9. A co-worker, Frank Kowalicz, testified through an interpreter. He was also paid an hourly rate for the time worked. One task he did was work with the petitioner to remove stone or bricks from the front of the house and clean the bricks. They were only told to remove and clean the bricks, but were not given any instructions on how to do the work. Mr. Kowalicz testified that he and petitioner

did not need instructions as to how to do the work. They used the tools they brought to the jobsite. They decided how to do the work with petitioner sliding the bricks to him off the scaffolding, the bricks were cleaned, and then were brought to the back yard. He also testified that once this work was done, he no longer worked at the site;

10. Mr. Bijak testified that after giving instruction as to the work that would be done, he left his home and went to work located in Harwood Heights. Petitioner also testified that during the months that he worked at the home, Mr. Bijak was rarely present. The testimony was Mr. Bijak frequently traveled;

11. At the time of the accident, he was cutting wood for a window installation. Petitioner testified that he did not need instruction on how to do the actual work since he was skilled carpenter. There was no testimony or evidence that either Mrs. Bijak or Mr. Bijak gave any instructions on how to do the work or what tools to use to complete the work;

12. The records of Lake Forest Hospital were admitted into evidence. (Petitioner's Exhibit 1) In those records, the history on page three was that plaintiff was self-employed. Petitioner confirmed that personal information about him on page seven which included his religion were accurate.;

13. Petitioner submitted photographs of jobsite which also depicted Milena Bijak's father. (Petitioner Exhibit 16).

14. No evidence was presented that petitioner's work was part of the Bijaks' business or that the Bijaks were in the business of construction or maintenance of buildings or any business benefit.

B. Was There An Employer-Employee Relationship between Zbigniew Kafara and Milena and Jaroslaw Bijak?

The arbitrator finds as follows:

1. The petitioner was an independent contractor and no employer/employee relationship existed between the petitioner and the respondents, Milena Bijak and Jaroslaw Bijak, to warrant the entry of an award in favor the petitioner and against Milena and Jaroslaw Bijak. An employment relationship is required for an award of benefits under the Act. *Roberson v. Industrial Commission*, 225 Ill.2d 159, 174 (2007). A number of factors are considered whether the employer may control the manner of the work; whether the employer withholds taxes and benefits; whether the employer dictates the schedule; whether the person is paid hourly; whether he may be discharged at will; whether the employer provides materials and equipment; and whether the person's work encompasses the alleged employer's general purpose. *Id.* at 200.

The petitioner has the burden of proof. The Bijaks did not control the work. Mr. Bijak told the petitioner what work was to be done, i.e. remove and clean brick or install a

window, but did not give any instructions on how to do the work, the method to employ or the tools to use to complete the task. The petitioner decided how to complete his work. After Mr. Bijak gave the work assignment, he then left for work, was rarely present and did not supervise the work. The Bijaks checked the work to see that it was actually what they wanted. The petitioner, even though paid hourly, was hired solely to do work on this project. No taxes or benefits were taken out of the payments to the petitioner. The presence and pictures of Mrs. Bijak's father indicate that the work was only for the home and that petitioner was only hired for that job. Further, the termination of cessation of Frank Kowalicz when the brick cleaning was completed supports the conclusion that this was an at-will relationship. The petitioner's work was not part of the respondents' business with Advanced Strobe Products, Inc. The petitioner stated that he was self-employed to his medical providers. All these factors make the petitioner an independent contractor and not an employee of the respondents.

2. Milena Bijak and Jaroslaw Bijak are/were not statutory employers. This case is unlike *Fefferman v. Industrial Commission*, 71 Ill.2d 325 (1978) and *Cropmate Company Industrial Commission*, 313 Ill.App.3d 290 (4th Dist. 2000). In both cases, the courts found that the work by the employee was to a building from which the employers derived a business benefit. In *Fefferman* and *Cropmate*, the work was on a building used for maintenance as part and parcel of a business which then required automatic application of the Act and finding each was a statutory employer. Here, no evidence was produced in this matter showing any revenue or business purpose or business benefit was derived from the work. Accordingly, Melina Bijak and Jaroslaw Bijak were not statutory employers. The Arbitrator finds as a matter of fact and law the Respondents named herein were homeowners without legal relationship of employee -employer to the Petitioner herein.

3. There is no evidence that the respondents, Milena Bijak and Jaro Bijak, were in the business of constructing or maintaining the building. There was no evidence that the home was utilized for a business purpose. Petitioner's claim against Milena Bijak and Jaroslaw Bijak is denied. This finding is supported by *White v. Industrial Commission*, 35 Ill.2d 293 (1966) and *Davis v. Industrial Commission*, 261 Ill.App.3d 849 (4th Dist. 1994).

Based upon the arbitrator's findings in this section, all other matters before this Arbitrator are moot. The Arbitrator denies any award of medical expenses temporary total disability, permanent award or prospective medical since the respondents, Milan Bijak and Jaroslaw Bijak have no liability for petitioner's claim.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KAFARA, ZBIGNIEW
Employee/Petitioner

Case# 10WC046601

ADVANCE STROBE PRODUCTS INC ET AL
Employer/Respondent

16IWCC0310

On 7/1/2015, 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 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2291 BELLAS & WACHOWSKI
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5353 LEWIS BRISBOIS BISGAARD/SMITH
JAMES B TOBIN
550 W ADAMS ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS 16IWCC0310

)SS.

COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ZBIGNIEW KAFARA
Employee/Petitioner

v.

ADVANCED STROBE PRODUCTS, INC., et al.
Employer/Respondent

Case # **10** WC **46601**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **GEORGE ANDROS**, Arbitrator of the Commission, in the city of **WAUKEGAN**, on **05/19/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **10/06/2010**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent, ***Advanced Strobe Products, Inc.***

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment, ***as there was no employment relationship between Petitioner and Respondent Advanced Strobe Products, Inc.***

Timely notice of this ***alleged*** accident ***was not*** given to Respondent, ***as there was no employment relationship between Petitioner and Respondent Advanced Strobe Products, Inc.***

Petitioner's current condition of ill-being ***is not*** causally related to the accident, ***as there is no accident for which Advanced Strobe Products, Inc. can be found liable.***

In the year preceding the injury, Petitioner earned $**8,660.00**; the average weekly wage was $**721.66**.

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

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

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

Respondent is entitled to a credit of $**3,150.00** under Section 8(j) of the Act.

ORDER

No benefits are payable under the Workers Compensation Act because no employee – employer relationship existed between the Petitioner and Advanced Strobe Products, Inc.

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.

George Andros

Signature of Arbitrator

Date 6/29/15

JUL 1 - 2015

INTRODUCTION – Relationship of the Parties

The petitioner, Mr. Zbigniew Kafara, alleges that he was injured on October 6, 2010, when he was performing activities at a residential address located at 20 Old Mill Road, in Lake Forest, Illinois. That home was owned by Mr. and Mrs. Bijak, who are also jointly-named as a Respondent in this matter.

Mr. Bijak is a 90% shareholder of a business entity, Advanced Strobe Products, Inc., which is also named as a Respondent in this matter.

This Decision will only address the disputed-issues as they pertain to the alleged employment relationship between Petitioner- Mr. Kafara, and Respondent- Advanced Strobe Products, Inc.

Accordingly, the Findings of Fact set forth below will only address those facts necessary to make a determination on whether an employment relationship existed between Petitioner and Respondent Advanced Strobe Products Inc., hereinafter referred to as "Advanced Strobe".

All other issues in this matter are dependent upon said determination.

FINDINGS OF FACT

The petitioner alleged that on October 6, 2010, he was injured while performing work at a residential address located at 20 Old Mill Road, in Lake Forest, Illinois. Mr. Bijak and his wife, jointly, are the owners of the residential property in Lake Forest.

Petitioner had been performing work at that address since as early as July 2010, which consisted mostly of cleaning and preserving bricks, and then some carpentry work. On the above date, he was performing window-framing and using a table-saw when his left hand was pulled into the saw, lacerating his fingers.

The Petitioner came to that position in Lake Forest after responding to an advertisement in the Polish newspaper "Dziennik Zwiazkowy". Petitioner claimed that the ad indicated workers were wanted, provided a contact address of 7227 W. Wilson with a phone number, and said "ask for Ilona". Petitioner testified that the ad also included the name "Advanced Strobe Products".

Respondent Advanced, Inc. is a business entity that manufactures light bulbs and strobe lamps for multiple purposes, for example on airplane wings or for camera flashes. This corporation is located at 7227 W. Wilson in Harwood Heights, Illinois. At the time of alleged injury, this corporation performed all of their business activities and manufacturing at this Harwood Heights location.

Petitioner testified that after seeing the name Advanced Strobe in the ad, he researched the company online. He testified that he became aware that the company manufactured lights. Petitioner confirmed that he personally never made any lights, nor did he ever observe anyone else making lights or

Petitioner testified that after seeing the name Advanced Strobe in the ad, he researched the company online. He testified that he became aware that the company manufactured lights. Petitioner confirmed that he personally never made any lights, nor did he ever observe anyone else making lights or performing any other similar manufacturing activity at the residence in Lake Forest. Similarly, he testified that in his research of the company, he did not see any mention of Advanced Strobe engaging in business activity involving brickwork nor carpentry, which was the nature of activities Petitioner was performing at the residence in Lake Forest.

Petitioner testified that he went to Advanced Strobe's location in Harwood Heights a total of three times, where he met with a woman named Ilona. Ilona is an employee of Advanced Strobe.

Mr. Bijak testified that Ilona was his assistant at Advanced Strobe for many years. Due to his traveling overseas, he stated that he often relied on her personally as well. She had even developed relationships with his family members, including taking his mother to doctor's appointments or helping with babysitting. He asked her to place the ad in the Polish newspaper because he knew she was already familiar with process of placing an ad in that newspaper.

The petitioner testified that the first time he went to Advanced Strobe in Harwood Heights was after seeing the advertisement in the newspaper. That would have been around July of 2010. At that time, he says he was told two workers were needed, so he returned for a second time shortly thereafter with a friend named Mr. Kowalicz. Mr. Kowalicz was called by petitioner to testify, which is discussed below in further detail.

Petitioner testified that both men were then sent to the Lake Forest residential address to meet with a Mr. Drozd. He stated that Ilona had given them the Lake Forest address on the back of her Advanced Strobe business card.

Mr. Bijak, who is the majority shareholder of Advanced Strobe, testified that Mr. Drozd is not an employee of Advanced Strobe. Both Mr. Bijak and petitioner testified that Mr. Drozd oversaw the remodeling work that was being performed at the Lake Forest residence. Mr Bijak testified that Mr. Drozd had the final say on whether the men were qualified to perform the work at the residence. If Mr. Drozd liked them then he would put them to work.

Petitioner testified that he negotiated his final pay rate at the house in Lake Forest. He testified that at that location Mrs. Bijak took his and Mr. Kowalicz's identification to make copies.

Advanced Strobe does not own the residence in Lake Forest at which the petitioner claims he was injured. Advanced Strobe neither directly nor indirectly receives any benefit from the Lake Forest residence. Advanced Strobe did own the table-saw on which the petitioner allegedly injured himself. That table saw had been borrowed from the company. However, Advanced Strobe did not own any of the other tools used in the home's remodeling. Advanced Strobe had no knowledge of from where the other tools and equipment came.

Between July and October, petitioner only presented to the residential address in Lake Forest where he performed brick work and carpentry. During that time, all witnesses (Mr. Bijak, Mr. Kowalicz, and the petitioner himself) testified that Mr. Bijak was rarely ever at the residence. He was traveling overseas.

Petitioner testified that the third and final time that petitioner ever went to Advanced Strobe in Harwood Heights, was some time after his October 2010 injury at the residence in Lake Forest. He did not go there to perform any manufacturing work, or work otherwise. Petitioner testified that he went there to notify Ilona that he needed more medical treatment and had no way to pay.

Mr. Bijak testified that he was overseas when Ilona called him asking what to do. Mr. Bijak stated that he acted out of compassion in what seemed to be an urgent situation and told Ilona to "help him". Ilona then paid for some medical treatment using the Advanced Strobe's credit card that she had in her possession.

Mr. Bijak testified that he did not become aware that any medical bills were paid for until the time of trial. He also testified that if business funds are ever used for expenses that are personal to him, then he would want to reimburse the company.

When petitioner called Mr. Kowalicz as a witness, Mr. Kowalicz offered testimony regarding the advertisement in the Polish newspaper that differed from what was offered by petitioner.

Mr. Kowalicz testified that it was he, Mr. Kowalicz, who found the ad. Mr. Kowalicz testified that the ad merely stated "construction workers needed" and provided a phone number. After calling the number, he received the Harwood Heights address where to appear and meet Ilona. He further testified that it was he who then contacted petitioner (whom he knew from past work experience and through family connection) and that he then took petitioner to the address in Harwood Heights.

According to Mr. Kowalicz the men appeared together at the Harwood Heights location only that one time. Mr. Kowalicz was specifically asked whether he thought Ilona hired him, to which he replied, "there was somebody else" and that she only gave them the Lake Forest address.

OVERVIEW OF RELEVANT EXHIBITS

Petitioner's Exhibit 1 is the medical records and bills of Northwestern Lake Forest Hospital. These are the emergency room records from the date of alleged accident.

On page three, the petitioner is noted as "self-employed" under the section for "employers information". The same occurs on a handwritten form found on page seven of this packet. Petitioner confirmed that the information on page seven, including his address, phone number (in 2010), and even his noted

religion, were accurate and was the information that he personally provided. However, the areas for "patient's company" and related details were all left blank.

Petitioner's Exhibit 2 is the medical records and bills of Illinois Bone & Joint Institute. Page 10 reflects the office visit of October 11, 2010, and includes a history that "patient is employed as a handyman who was up working in someone's home; whereupon he was utilizing a table saw which, unfortunately attacked his left hand..." The record indicates that he was accompanied at this visit by a family friend who performed translation.

The "Patient Registration Packet" found on page 33, noted his "Employer" as "Self" and "Occupation" as "Handyman". Petitioner testified that these details must have been in error although all other details in the records were accurate.

Petitioner's Exhibit 3 is the medical records and bills of Illinois Sports Medicine & Orthopedic Surgery Center. Once again on page seven, the "demographic" information includes all of petitioner's personal details, including what his religion was and even his son's name. Petitioner testified that those are details that he would have personally given to the provider. However, the entire sections for "employment" and "insurance" are left blank.

Petitioner's Exhibit 11 is the Ilona's Advanced Strobe business card, on which she wrote the Lake Forest residential address to where she directed the petitioner and Mr. Kowalicz after meeting them.

Petitioner's Exhibit 12 is a group of personal checks written from the account of "Jaro Bijak" and "Milena Bijak" at the Lake Forest residential address. Petitioner testified that these checks included payment to him for the work he performed at the residence. All checks were made payable to "cash."

Petitioner's Exhibit 16 is a compilation of photos that show the residence in Lake Forest, and the work being performed there. No manufacturing of lights is seen in the exhibit. No photos of Advanced Strobe in Harwood Heights are included in the exhibit.

Respondent – Advanced Strobe Products – Exhibit 1 is a sample of the standard paycheck that was issued to employees of their company. The check shows the payor as Advanced Strobe, not the Bijaks personally. This check also confirms that taxes are withheld and other deductions are made for employees of Advanced Strobe. The employee's name on that sample check, and other personal identifying information, has been redacted from it. This confirms that employees of Advanced Strobe are paid to them specifically, and not to "cash" as the petitioner was in the checks from the Bijak's personal account.

The Arbitrator Finds As Follows

B. Was there an employer-employee relationship?

The burden is on the petitioner to establish all elements of his claim by a preponderance of the evidence, including accident. The Arbitrator finds that the petitioner failed to prove that an employment relationship existed between him and the respondent Advanced Strobe Products, Inc.

The only nexus between the petitioner and Advanced Strobe directly was the meeting with Ilona at the business. This alone is insufficient to establish an employment relationship. The meeting could have just as easily occurred at a Starbucks, for example, and it would be clear to all that it does not mean he was being hired by Starbucks.

All other details must be examined.

The nature of Advanced Strobe's business is the manufacturing of lights. Petitioner stated that he never personally made lights, nor did he ever even observe others making lights. Petitioner also admitted that in his alleged research of the company, he did not see any aspect of the business to include brick work or carpentry. Petitioner confirmed that the work he did at the house was that of cleaning and preserving bricks, followed by carpentry. Consequently the Arbitrator finds that petitioner did not engage in any aspect of Advanced Strobe's business.

The Arbitrator finds that the testimony offered by petitioner and his witness Mr. Kowalicz, regarding the advertisement in the Polish newspaper and how they came to get work at the residence, to be conflicting. The testimony of Mr. Kowalicz is found to be more credible than that of petitioner.

Mr. Kowalicz testified that the ad asked for "construction workers" and he did not say that it named "Advanced Strobe Products" in it. When Mr. Kowalicz was asked whether he thought Ilona "hired" them, he replied that she only provided an address to them and the hiring was done by "someone else". Mr. Bijak testified that it was Mr. Drozd, who was overseeing the remodeling at the residence, who had the final say on hiring.

The Arbitrator finds that the decision as to whether the petitioner would get to work at the home, and thus the actual acts of "hiring", occurred away from the Advanced Strobe's location in Harwood Heights. Petitioner even testified that he made his agreement as to his pay rate while at the home located in Lake Forest, when he first presented there. Consequently the Arbitrator finds that Advanced Strobe did not hire the petitioner.

Petitioner was paid "To Cash" via personal checks issued by the Bijaks with the Lake Forest residential address listed therein. Petitioner's own Exhibit 12 was a copy of those personal checks. The Arbitrator finds that petitioner produced no evidence of being paid by Advanced Strobe. The especially evident based on the contrast of those checks to the ones typically issued by Advanced Strobe to its actual employees. (R-Advanced.Ex.1)

Advanced Strobe did not own, or have any interest in, the residence in Lake Forest. The Arbitrator finds that Advanced Strobe received no benefit from the remodeling done at the Lake Forest residence.

It is a well-settled principle that payment of any medical is not an admission of liability. Thus the Arbitrator finds it irrelevant to the question of liability that any of the petitioner's medical bills were paid by Advanced Strobe Products. It was done so altruistically in this case.

The Arbitrator has reviewed the medical exhibits and considered petitioner's related testimony. Petitioner confirmed that the personal information recorded in the records for multiple providers, including his religion, description of accident, contact information and so on, are all details that he personally provided. The petitioner then testified that the omission of Advanced Strobe Products, or any specific employer for the matter, must have been an error.

The Arbitrator notes that English is not the petitioner's primary language. He testified at trial through use of a translator. Accordingly, the Arbitrator does give some room for the details within records to vary slightly from the petitioner's direct testimony at trial. However, the Arbitrator finds petitioner to be totally unpersuasive in his assertion that *multiple* providers would make the exact same mistake by failing to note his employer, or worse still, in actually noting the petitioner was "self-employed". Consequently, the Arbitrator finds that despite his testimony at trial in 2015, when he presented for medical attention to multiple providers in 2010, petitioner did not actually believe he was employed by Advanced Strobe. He believed he was self-employed.

Had petitioner actually believed he worked for Advanced Strobe, then it would have been conveyed to the provider and recorded in any of these 2010 records.

Based on the evidence, as detailed above, the Arbitrator finds that the petitioner failed to meet his burden of proof on the disputed issue of whether an employment relationship existed.

Based on the Arbitrator's findings in this Section, all other aspects of this claim are moot. The Arbitrator specifically denies any award of medical expenses, temporary total disability, and prospective medical, finding that Respondent Advanced Strobe Products, Inc. has no liability for petitioner's claim of injury.

STATE OF ILLINOIS)	☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF SANGAMON)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JULIE NIHISER,

Petitioner,

16IWCC0343

vs. NO: 11 WC 07516

AIMCO/BETHESDA HOLDINGS,

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 temporary total disability, medical expenses, and permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

With regard to the issue of medical expenses, the Commission vacates the Arbitrator's award of medical expenses related to Petitioner's ADHD, including the January 29, 2014 office visit with Dr. Heimbrecht, at which time Petitioner complained of attention issues and was diagnosed with ADHD, the July 14, 2014 office visit with N.P. Jennifer Norton, the April 24, 2014 medication "retrieval fee" charge, and the prescription medication for ADHD. While Dr. Heimbrecht opined the morphine Petitioner was taking might cause concentration problems, a review of the record fails to indicate Dr. Heimbrecht or any other medical provider opined that Petitioner's ADHD or medication for same was causally connected to her December 28, 2010 work injury or to the pain medication prescribed for her December 28, 2010 work-related injury.

16IWCC0343

With regard to the issue of permanent partial disability, based upon a review of the record as a whole, the Commission modifies the Arbitrator's permanent partial disability award from 70% loss of use of the man as a whole under Section 8(d)2 to 45% loss of use of the left leg under Section 8(e) of the Act based upon the left knee injury, surgical repair, continuing left knee pain complaints, and testimony of Petitioner's treating physician, Dr. Heibrecht, indicating Petitioner is capable of returning to her prior occupation as an assistant apartment complex manger.

The Commission further finds Petitioner failed to prove she is entitled to an award of vocational rehabilitation or an award of permanent total disability. Dr. Heimbrecht, Petitioner's treating physician, testified on cross exam, after viewing the surveillance video of July 3, 2014, July 5, 2014 and July 22, 2014. The surveillance video depicts Petitioner engaged in shopping, exiting, entering, and driving a large sport utility, swinging back and forth on a porch swing while pushing off with both feet on the ground, carrying a young child on her hip, and walking around in flip flops without an ankle brace, all without outward signs of significant difficulty. Dr. Heimbrecht opined that based upon his review of the video surveillance that Petitioner should be able to show properties and guide individuals to different apartment units. Dr. Heimbrecht specifically testified that based upon his review of the videotape and job description of the assistant manager position, "she should be able to do the job you described." (RX1, PX3 at T 44-46). The Commission concludes that the record as a whole fails to indicate that Petitioner sustained a loss of earning capacity due to her left leg injury, as Petitioner presented no evidence she ever attempted to secure subsequent employment upon her release from care, and both her treating physician, Dr. Heimbrecht, and Respondent's Section 12 examiner, Dr. Milne, testified that Petitioner was capable of returning to work doing light office work. (PX12, T15-18). Dr. Heimbrecht specifically testified that the surveillance video changed his opinion that Petitioner was unable to ambulate due to her knee injury. Instead, he testified that Petitioner is capable of performing her prior job managing and maintaining a senior living apartment complex, including office work, walking to different units with prospective residents to show apartments and talk with them. Dr. Heimbrecht further testified that the surveillance video depicted a much more subtle inversion of Petitioner's left foot than observed during her office visits with him, and that her ambulation abilities were improved in the videos as compared to his observations in the office in the past and on the date of his deposition when he observed Petitioner. (PX3, T44-48,57).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 10, 2015, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable and necessary medical services as identified in Petitioner's Exhibit 16, as provided in §8(a) and §8.2 of the Act, excluding the medical expenses related to Petitioner's ADHD diagnosis and treatment as for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of

16IWCC0343

medical expenses related to Petitioner's ADHD diagnosis and treatment is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $286.32 per week for a period of 2 weeks, for the period of April 3, 2014 through April 16, 2014, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner $569.35 for mileage reimbursement under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $257.69 per week for a period of 96.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent partial disability to the extent of 45% loss of use of the left leg.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $26,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 20 2016
KWL/kmt
04/04/16
42

Ruth W. White

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0343

NIHISER, JULIE A
Employee/Petitioner

Case# 11WC007516

AIMCO/BETHESDA HOLDINGS INC
Employer/Respondent

On 7/1/2015, 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 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2205 FRANK H BYERS II LTD
160 W MAIN ST
DECATUR, IL 62523

2904 HENNESSY & ROACH PC
STEPHEN KLYCZEK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

16IWCC0343

Julie A. Nihiser
Employee/Petitioner

v.

Aimco/Bethesda Holdings, Inc.
Employer/Respondent

Case # 11 WC 07516

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on May 22, 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 Mileage Reimbursement

FINDINGS

On December 28, 2010, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $12,026.34; the average weekly wage was $429.48.

On the date of accident, Petitioner was 49 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00. Petitioner and Respondent stipulated that, with the exception of a two week period, TTD benefits were paid in full through July 14, 2014.

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 16, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $286.32 per week for two weeks commencing April 3, 2014, through April 16, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $257.69 per week for 350 weeks because the injuries sustained caused the 70% loss of use of the body as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall reimburse Petitioner the additional mileage expense of $569.35 (the total mileage expense of $881.96 less the credit of $312.61).

Respondent shall pay Petititioner compensation benefits that have accrued since July 15, 2014, and shall pay the remaining balance, if any, in weekly installments.

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

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

William R. Gallagher, Arbitrator

June 22, 2015
Date

JUL 1 - 2015

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 28, 2010. According to the Application, Petitioner fell while carrying some items in to Respondent's facility and sustained injuries to her left knee and both hands (Arbitrator's Exhibit 2). At trial, Petitioner and Respondent stipulated (among other things) that Petitioner sustained a work-related accident and that her current condition of ill-being was causally related to same (Arbitrator's Exhibit 1).

This case was previously tried in a 19(b) proceeding before Arbitrator Douglas McCarthy and his Decision was entered on September 4, 2013. In that Decision, Arbitrator McCarthy awarded medical bills and prospective medical treatment; temporary total disability benefits of 136 3/7 weeks commencing December 29, 2010, through August 9, 2013 (the date of trial) and 19(k) penalties of $8,670.00. Neither Petitioner nor Respondent filed a review of that Decision.

At trial, Petitioner claimed that Respondent was responsible for various medical and prescription bills which included $130.00 that Respondent was previously ordered to pay in the 19(b) Decision. Petitioner and Respondent further stipulated that temporary total disability benefits had been paid in full through July 14, 2014, with the exception of a period of two weeks, commencing April 3, through April 16, 2014, for which Respondent disputed liability. Petitioner also claimed entitlement to reimbursement for mileage expenses for visits with medical providers selected by Respondent (Arbitrator's Exhibit 1).

Petitioner testified that she worked for Respondent as an Apartment Manager at a facility called "The Woods" which was an apartment community for people 55 years of age and older. Petitioner stated that she worked as an Apartment Manager for the vast majority of her working career.

On December 28, 2010, Petitioner was in the process of carrying some items that were to be used for an event at the apartment complex when she fell on some ice. When Petitioner fell, she sustained an injury to her left knee as well as both of her hands.

Subsequent to the accident Petitioner was seen at Springfield Clinic by Dr. Dennis Heim, her primary care physician, on December 28, 2010, who authorized her to be off work and referred her to Dr. Kurt Heimbrecht, another physician with Springfield Clinic, who saw her on January 3, 2011. Because of Petitioner's left knee complaints, Dr. Heimbrecht referred Petitioner to Dr. Edmund Raycraft, an orthopedic surgeon (Petitioner's Exhibit 2).

Dr. Raycraft ordered an MRI/arthrogram and subsequently performed arthroscopic surgery on Petitioner's left knee on February 11, 2011 (Petitioner's Exhibit 4). From February 23, through June 8, 2011, Petitioner had physical therapy at St. Mary's Rehab Services and Athleticare (Petitioner's Exhibit 5).

Petitioner's left knee condition did not improve so she sought medical treatment from Dr. Kenneth Tuan, an orthopedic surgeon, on July 19, 2011. When Dr. Tuan saw Petitioner, she

complained of anterior pain and burning. Petitioner was using a cane and taking Aleve and Vicodin. Dr. Tuan imposed work/activity restrictions and ordered that Petitioner continue physical therapy (Petitioner's Exhibit 6). From July 28, through August 19, 2011, Petitioner received physical therapy at St. Mary's Rehab Services and Athleticare (Petitioner's Exhibit 5).

At the direction of Respondent, Petitioner was examined by Dr. Michael Milne, an orthopedic surgeon, on September 26, 2011. In connection with his examination of Petitioner, Dr. Milne reviewed medical records provided to him by Respondent. At that time, Petitioner complained of constant pain/swelling in the left knee and that her left foot turned inward with locking and catching. On clinical examination, Dr. Milne noted that Petitioner had tenderness over the patellar tendon, quadriceps atrophy and a left foot drop. He recommended Petitioner have an EMG/nerve conduction study to evaluate her peroneal nerve and imposed work/activity restrictions. He also opined that Petitioner may have temporarily exacerbated her right hip and knee symptoms because of her altered gait (Petitioner's Exhibit 11).

Petitioner was again seen by Dr. Tuan on October 10, 2011, and he ordered an EMG/nerve conduction study be performed. Dr. Tuan referred Petitioner to Dr. Susan Wu, who performed an EMG/nerve conduction study on October 28, 2011. This study was incomplete because Petitioner had difficulty tolerating the needle portion of the exam, but it was indicative of left tibial motor neuropathy (Petitioner's Exhibit 2).

Petitioner saw Dr. Tuan on October 31, 2011, and he ordered an AFO brace for her left leg. He was unable to explain why Petitioner had the left foot drop and suspected that she may have had a herniated disc. He ordered an MRI of the lumbar spine which was performed on November 15, 2011. It did not reveal any disc herniations (Petitioner's Exhibit 6).

Dr. Tuan referred Petitioner to Dr. Oliver Dold, a neurosurgeon, who evaluated Petitioner on November 30, 2011. Dr. Dold confirmed that Petitioner had a left foot drop but opined that spine surgery was not indicated. He subsequently reviewed the EMG/nerve conduction study and recommended that it be repeated in stages (Petitioner's Exhibit 2).

At Dr. Tuan's direction, Petitioner underwent a functional capacity evaluation (FCE) on December 19, 2011. Petitioner was determined to have physical and functional deficits in regard to prolonged walking, balancing, stair climbing, squatting, lifting in excess of 10 to 30 pounds and an inability to walk on ramps and uneven surfaces. Significant work restrictions were recommended, specifically, sit/stand at will, occasional walking, occasional lifting up to 30 pounds, occasional carrying up to 10 pounds, infrequent squatting and stair climbing and no ramp/uneven surface walking (Petitioner's Exhibit 8).

On December 30, 2011, Petitioner was again seen by Dr. Heimbrecht and he reviewed the FCE. At that time, Petitioner was taking hydrocodone-acetaminophen, but without significant relief. Dr. Heimbrecht changed her pain medication but, on that specific occasion, the name of it was redacted from his medical record. When Dr. Heimbrecht saw Petitioner on March 15, 2011, he prescribed acetaminophen-codeine and noted that this would be better than the 10 Aleve that Petitioner was taken on a daily basis (Petitioner's Exhibit 2).

At Respondent's request, the FCE was reviewed by Dr. Milne and, in a supplemental report dated April 26, 2012, he opined that the FCE was valid and that the work restrictions indicated therein were permanent. He stated that Petitioner should have an EMG/nerve conduction study performed to determine if there was a peroneal nerve injury, but that if she declined to undergo the test, she would be at MMI (Petitioner's Exhibit 11).

Dr. Tuan subsequently referred Petitioner to Dr. Edward Trudeau, who performed an EMG/nerve conduction study on June 19, 2012. The study was positive for moderately severe to severe peroneal neuropathy at/distal to the left fibular head (Petitioner's Exhibit 10).

At the direction of Respondent, Petitioner was again examined by Dr. Milne on June 28, 2012. In connection with his examination, Dr. Milne reviewed the EMG/nerve conduction study that had just been performed by Dr. Trudeau. He opined that Petitioner had a left peroneal nerve injury, left peroneal nerve entrapment and right hip pain, the latter symptom being attributable to her altered gait. He recommended evaluation by a peripheral nerve surgeon, Dr. Robert Hagan. If Petitioner elected not to proceed with surgery, he would find her to be at MMI but that she would require vocational retraining (Petitioner's Exhibit 11).

Dr. Hagan examined Petitioner on July 23, 2012, and, in connection with his examination of Petitioner, he reviewed medical records provided to him by Respondent. On clinical examination, he noted that Petitioner had a persistent left foot drop and that she had sustained a peroneal nerve injury. He recommended surgery which would consist of a decompression and neurolysis of the common peroneal nerve (Petitioner's Exhibit 13).

Dr. Heimbrecht continued to treat Petitioner's pain symptoms with prescribed medications. On August 24, 2012, he continued to prescribed acetaminophen-codeine as well as Kadian. When seen by Dr. Heimbrecht in January, 2013, Petitioner informed him that she made the decision to proceed with the surgery that had been recommended by Dr. Hagan (Petitioner's Exhibit 2).

Dr. Hagan saw Petitioner on April 30, 2013, and opined that peroneal nerve surgery was still appropriate. He performed this procedure on September 18, 2013. Petitioner was seen by Dr. Hagan subsequent to the surgery and, on April 1, 2014, Dr. Hagan opined that Petitioner could return to work without restrictions from the peroneal nerve standpoint and that Petitioner was at MMI (Petitioner's Exhibit 13). Based on the preceding, Respondent terminated payment of temporary total disability benefits.

Petitioner continued to be seen and treated by Dr. Heimbrecht and, when seen on January 29, 2014, he continued her pain medication and also, for the first time, made the diagnosis of ADHD. When Petitioner was seen by Dr. Heimbrecht on April 16, 2014, Dr. Heimbrecht noted that Petitioner had undergone two knee surgeries and that neither of them had helped her. Dr. Heimbrecht continued to prescribed acetaminophen-codeine, morphine sulfate and amphetamine-dextroamphetamine. Dr. Heimbrecht noted that Petitioner was unable to ambulate due to the knee injury which she needed to ice every two hours. He also opined that Petitioner could not work and that she should remained on sedating medications (Petitioner's Exhibit 2). Based on the preceding, Respondent reinstated Petitioner's temporary total disability benefits.

At the direction of Respondent, Petitioner was again examined by Dr. Milne on June 5, 2014. At that time, Dr. Milne specifically noted that Petitioner was taking a high daily dose of morphine. He opined that Petitioner could return to work as an apartment complex manager provided she could perform the job while taking the high dosage of pain medication. He also opined that Petitioner should have another EMG/nerve conduction study performed (Petitioner's Exhibit 11). Based on the preceding, Respondent terminated payment of temporary total disability benefits on July 14, 2014.

Dr. Milne referred Petitioner to Dr. Dan Phillips who performed an EMG/nerve conduction study sometime following Dr. Milne's June 5 examination of Petitioner (Dr. Phillips' report was not tendered into evidence). When Dr. Milne saw Petitioner again on July 24, 2014, he noted that he had discussed the diagnostic studies with Dr. Phillips and that Petitioner did not complete it because of her complaints of left leg pain (Petitioner's Exhibit 12; p 19).

Respondent obtained surveillance video of Petitioner on July 3, July 5 and July 22, 2014. A copy of the video was tendered into evidence at trial. In that video, Petitioner was observed driving a truck and walking without the use of a brace but with an altered gait (Respondent's Exhibit 1).

Dr. Heimbrecht was deposed on October 16, 2014, and his deposition testimony was received into evidence at trial. Dr. Heimbrecht testified that Petitioner's left leg condition including the left foot drop was causally related to the accident of December 28, 2010. Because of the change in Petitioner's gait, he also opined that Petitioner's right hip condition was also related to the accident of December 28, 2010 (Petitioner's Exhibit 3; pp 18, 25-26).

Dr. Heimbrecht also testified regarding the side effects that the medications he prescribed for Petitioner would have. The medications including Kadian (a morphine product) and the acetaminophen with codeine, could have had side effects which could include dizziness, concentration problems, constipation, fatigue and sedation. He also stated that Petitioner would have difficulties with focusing and forgetting what she reads. Dr. Heimbrecht opined that, because of the injury and necessary medications Petitioner was taking, that she was unable to work, that this was a permanent condition and that Petitioner was at MMI (Petitioner's Exhibit 3; pp 18, 25, 34-38).

On cross-examination, Dr. Heimbrecht stated that he diagnosed Petitioner with attention deficit disorder on January 29, 2014. Also, when cross-examined, Dr. Heimbrecht watched the surveillance video of Petitioner and, based upon his observation of Petitioner during that video, he opined that while Petitioner's medications would interfere with her ability to do mathematical computations that Petitioner would be able to do such things as show properties and guide people to places within an apartment complex (Petitioner's Exhibit 3; pp 40, 45-46).

Petitioner was subsequently seen by Dr. Heimbrecht's Physician's Assistant, on July 31, 2014, and Petitioner was also subsequently seen by Dr. John Di Mondo, a physician in that same office, on December 4, 2014, January 19 and February 20, 2015. Dr. Di Mondo also noted the diagnosis of ADHD and he continued to prescribe the same medications that Dr. Heimbrecht had previously prescribed, including the morphine sulfate (Petitioner's Exhibit 2A).

Dr. Milne was deposed on February 9, 2015, and his deposition testimony was received into evidence at trial. Dr. Milne also watched the surveillance video of Petitioner and he expressed some concern about Petitioner driving a vehicle while on medication but that she could return to work in an office setting. On cross-examination, Dr. Milne agreed that the morphine could cause the side effects of dizziness, concentration problems, constipation, fatigue and sedation as opined by Dr. Heimbrecht (Petitioner's Exhibit 12; pp 12-13, 17-18).

At trial, Petitioner testified that she still has significant complaints of pain in her left leg and knee as well as her right hip. Petitioner was wearing a knee brace which she stated that she wears virtually all of the time. Petitioner continues to take a significant amount of pain medication. Because of the medication Petitioner has been taking, she stated that she has persistent lapses of memory, her cognitive thinking is off, her reading comprehension is not what was previously, etc. Petitioner has not returned to work for Respondent or for any other employer.

Petitioner claimed to be entitled to reimbursement for mileage expenses incurred in connection medical examinations scheduled by Respondent. Petitioner tendered into evidence mileage logs which indicated a total mileage of 1,561 miles. The same log indicated that Respondent had paid Petitioner $312.61 for mileage expenses (Petitioner's Exhibit 18).

Conclusions of Law

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

Respondent is liable for all of the medical bills and prescription receipts tendered into evidence at trial.

Respondent shall pay or reimburse Petitioner for reasonable and necessary medical services as identified in Petitioner's Exhibit 16 as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

All of the medical bills and prescriptions were incurred by Petitioner as a result of the injury she sustained on December 28, 2010. Respondent has taken the position that it does not owe for prescriptions for Petitioner's attention deficit disorder on the basis that it was not causally related to the accident or medications Petitioner was taking. However, Dr. Heimbrecht opined that one of the side effects of Petitioner taking morphine was concentration problems and Respondent's Section 12 examiner, Dr. Milne agreed with same. Further, as noted herein, Petitioner and Respondent stipulated that Petitioner's current condition of ill-being was causally related to the accident.

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

The Arbitrator concludes that Petitioner is entitled to payment of two weeks of additional temporary total disability benefits, commencing April 3, through April 16, 2014.

In support of this conclusion the Arbitrator notes the following:

The release from Dr. Hagan for Petitioner to return to work was only in regard to her peroneal nerve surgery and not for her other conditions. This is obvious because Respondent reinstated payment of temporary total disability benefits to Petitioner when she was subsequently seen by Dr. Heimbrecht on April 16, 2014.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 70% loss of use of the body as a whole.

In support of this conclusion the Arbitrator notes the following:

Petitioner sustained a severe injury to her left lower extremity which resulted in significant work/activity restrictions being imposed on her. Further, because of Petitioner's ongoing pain symptoms, she continues to take prescribed pain medications including morphine.

Petitioner's use of pain medications has impacted her ability to work as well as her activities of daily living.

Upon reviewing the surveillance video, both Dr. Heimbrecht and Dr. Milne opined Petitioner could return to work at a sedentary office job; however, there was no testimony tendered from either an employment or vocational expert that there was or was not such a position that existed within Petitioner's work restrictions, subject to her age, education and employment history for which there was a reasonable stable labor market.

Based on the preceding, the Arbitrator finds that an award a permanent total disability is not supported by the evidence in the record.

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

The Arbitrator concludes that Respondent owes Petitioner reimbursement for mileage expense of $569.35.

In support of this conclusion the Arbitrator notes the following:

Petitioner's Exhibit 18 indicated that Petitioner incurred 1,561 miles. At the rate of .565 per mile the total mileage expense for which Petitioner is entitled to reimbursement is $881.96. Respondent paid Petitioner $312.61 meaning Petitioner is entitled to an additional reimbursement of $569.35.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patrick McCarey,

Petitioner,

16IWCC0313

vs.

NO: 11 WC 9178

State of Illinois – Central Management Services,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b-1) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of "the current amount of medical owed, and to whom it shall be paid," and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Findings of Fact and Conclusions of Law

1. This matter was arbitrated under §19(b)1 of the Act. The parties stipulated that Petitioner sustained a compensable accident/injury on December 12, 2010 and that proper notice was given. The specifics of Petitioner's injuries are not really relevant to the issues now before the Commission, but Petitioner suffered an injury to his back after slipping on ice shoveling snow while working as a stationary engineer for Respondent.

ГОЛОСОВ

2. Petitioner eventually had two surgeries on June 27, 2012 and October 24, 2014, respectively, involving the L3-4, L4-5, and L5-T1 levels of his spine.

3. After testimony, Petitioner submitted his exhibits. He then objected to Respondent's Exhibits A and B based on hearsay. Those exhibits purported to be records of payments made by Respondent's third-party administrator, Tristar. The Arbitrator indicated that the objection was well founded and that she would only admit the exhibits if a representative from Tristar testified to lay proper foundation; a follow up hearing was planned. After some further discussion, Petitioner withdrew his objection so that proofs could be closed at that time.

After arbitration, the Arbitrator awarded Petitioner 256&5/7 weeks of temporary total disability benefits, medical expenses of $177,853.91 to be paid "directly to Petitioner," gave Respondent unspecified credit for all medical expenses paid, gave Respondent credit of $257,058.91 for total disability benefits paid, and denied Petitioner's petition for penalties and fees. The Arbitrator broke down the medical award as $60,153.85 to Dr. Rinella's group, $3,570.21 to Functional Therapy Rehab, $15,535.00 to Dr. DiPasquo's group, $68,317.66 to Parkview Orthopedic Group, $29,515.40 to Silver Cross Hospital, and $761.01 for imaging tests. The Arbitrator did not explain further her medical award except to cite the corresponding exhibit. The Arbitrator also did not appear to explain the reasoning behind her language that the total medical award of $177,853.91 should be paid "directly to Petitioner."

The Commission does not believe we have enough reliable information to determine the initial issue on review, the amount of outstanding medical bills for which Respondent is liable. The Commission is not able to readily interpret Respondent's exhibits purporting to specify payments. For example, there is more than a $15,000 discrepancy between the $95,760.74 in "net incurred" medical bills and the presumably actual payment of $79,555.64. This discrepancy may reflect a lower negotiated rate, but we cannot infer that as a fact.

In addition, the Commission cannot possibly be able to provide specific monetary medical expenses that are currently due pursuant to the medical fee schedule or any contractual relationship between Respondent's insurance carrier(s) and the various medical providers. Because this claim was tried pursuant to §19(b-1) of the Act, and the issue of compensability is not at issue before the Commission, this matter must necessarily be remanded to the Arbitrator for further adjudication.

The Commission concludes that the parties, the insurers, and medical providers are in a much better position than the Commission to determine the precise amount of outstanding medical bills. Therefore, the Commission finds it appropriate for that issue to be adjudicated upon remand.

16IWCC0313

In Respondent's review, it seeks clarification of what exactly is due and to whom it should be paid. It does not challenge the legitimacy of the expenses awarded or its ultimate responsibility for any outstanding bills due. Section 8(a) of the Act provides in pertinent part: "If the employer does not dispute payment of first aid, medical, surgical, and hospital services, the employer shall make such payment to the provider on behalf of the employee." At this point the employer does not dispute its liability for the payment of medical bills; therefore, the Commission concludes that Respondent should pay any outstanding medical bills directly to the providers and not directly to Petitioner.

Accordingly, the Commission vacates the portion of the Decision of the Arbitrator which directs medical expenses to be paid directly to Petitioner. In addition, Commission remands the matter to the Arbitrator with instructions for the Arbitrator to determine the amount of medical bills that are currently outstanding and to order that any medical bills be paid by Respondent directly to the providers pursuant to the medical fee schedule.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,076.34 per week for a period of 256&5/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b-1) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

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

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

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

DATED: MAY 12 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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O-4/13/16
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19 (b-1) ARBITRATOR DECISION
CORRECTED

16IWCC0313

McCAREY, PATRICK Case# **11WC009178**
Employee/Petitioner

STATE OF ILLINOIS
Employer/Respondent

On 1/21/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

Unless a party does the following, this decision shall be entered as the decision of the Commission:

1) Files a Petition for Review within 30 days after receipt of this decision; and

2) Certifies that he or she has paid the court reporter $ 700.00 for the estimated cost of the arbitration transcript and attaches a copy of the check to the Petition; and
3) Perfects a review in accordance with the Act and Rules.

If the Commission reviews this award, interest of 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:

0391 HEALY SCANLON LAW FIRM
KEVIN VEUGELER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

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

4390 ASSISTANT ATTORNEY GENERAL
ERIN DOUGHTY
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

JAN 21 2016

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

16IWCC0313

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
19(b-1)

PATRICK MCCAREY
Employee/Petitioner
v.
STATE OF ILLINOIS
Employer/Respondent

Case # 11 WC 009178

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. Petitioner filed a *Petition for an Immediate Hearing Under Section 19(b-1) of the Act* on **September 3, 2015**. Respondent filed a *Response* on **September 16, 2015**. The Honorable **Robert Williams**, Arbitrator of the Commission, held a pretrial conference on **October 20, 2015** and Honorable **Maria S. Bocanegra** held a trial on **November 13, 2015**, in the city of **Chicago**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

CORRECTED FINDINGS

On the date of accident, **12/12/10**, 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 $**84,802.38**; the average weekly wage was $**1,630.82**.

On the date of accident, Petitioner was **57** 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 **$257,058.91** for temporary total disability benefits that have been paid.

CORRECTED ORDER

Respondent shall pay temporary total disability benefits in the amount of **$1,087.21/week** from **12/13/10** through **11/13/15**, representing **256-5/7**th weeks. Respondent shall be given a credit of **$257,058.91** for temporary total disability benefits that have been paid.

Respondent shall pay directly to Petitioner medical services of **$177,853.13**, as provided in Sections 8(a) and 8.2 of the Act. Against this award, Respondent shall be given a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Petitioner's petition for penalties and fees is hereby ***denied.***

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

RULES REGARDING APPEALS Unless a party 1) files a *Petition for Review* within 30 days after receipt of this decision; and 2) certifies that he or she has paid the court reporter an estimated cost of $**700.00** of the arbitration transcript and attaches a copy of the check to the *Petition*; and 3) perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

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

Signature of Arbitrator

1-20-2016
Date

JAN 21 2016

FINDINGS OF FACT

Patrick McCarey ("Petitioner") testified he has been employed with the State of Illinois ("Respondent") as a stationery engineer for the past seventeen years. In relevant part, he is responsible for maintaining and repairing heaters and chillers for Respondent's buildings, dealing with unplanned maintenance and working with a variety of tools both his own and of Respondent's. Petitioner testified that his job duties include lifting up to 100 lbs. prior to this employment, he was a stationary engineer for Sheraton hotel.

Petitioner testified on 12/12/10, he was shoveling snow at a Respondent facility for the blind. Prior to this date, Petitioner testified he did not have any problems with his back, had not received any treatment on his back and had never visited any physician for any injury to his back. It was not disputed or unrebutted that on that day, Petitioner slipped and fell down ice covered stairs in the courtyard of Respondent's building, falling backwards and landing on his low back while attempting to shovel snow. Petitioner testified that he noticed immediate low back pain. he said he noticed extreme, searing pain in the back and rear end, so intense he could hardly breathe. He noticed pain in the right buttock as well.

The following day, Petitioner sought treatment from his primary care physician, Dr. Raymond P. DiPasquo. Petitioner recalled he received medication, heat therapy and was taken off of work. Dr. DiPasquo that Petitioner complained of low back pain after slipping on snow while clearing a sidewalk when he twisted and landed on his buttocks. Dr. DiPasquo diagnosed low back pain, prescribed medication and instructed Petitioner to remain off work and return to his office in three days. Petitioner stated that at that time, he had pain from the rear to the thigh, that he could hardly walk, sit and was in extreme pain.

Petitioner returned as instructed to Dr. DiPasquo's office on 12/16/10. The doctor recommended Petitioner continue off work and Petitioner was instructed to begin a formal physical therapy program. Petitioner testified that he began physical therapy at Primary Health Physical Therapy. On 12/22/10, lumbar MRI showed central disc protrusion encroaching on the S1 nerve root at L5-S1, bulges at L3–L5 and mild bilateral neural foraminal narrowing. Petitioner testified that this was the first MRI of his low back he has ever had. On 12/29/10, Dr. DiPasquo diagnosed S1 nerve root compression from a L5-S1 disc herniation and prescribed continued physical therapy, off work, and medication.

On 1/6/11, Dr. DiPasquo again examined Petitioner and noted tenderness in the low back to right leg. Petitioner recalled he had spasm along the right side, same pain since the injury but that it started to go across to the right and down the thigh. Petitioner was referred to Dr. Anthony Rinella for a possible injection and instructed to continue off work. Petitioner testified he contacted Dr. Rinella's office and was referred to Dr. Faris Abusharif for an injection.

On 1/13/11, Petitioner was evaluated by Dr. Abusharif. Dr. Abusharif's notes from that visit indicate that Petitioner was complaining of low back pain radiating into the right buttock that was exacerbated by physical activity as a result of a work related injury on 12/12/10. Dr. Abusharif's examination revealed a positive straight leg raise on the right, positive right lumbar tenderness and decreased sensation to the right leg. Dr. Abusharif diagnosed lumbar radiculopathy with a central disc protrusion at L5-S1 resulting in S1 nerve root impingement. Dr. Abusharif performed an epidural injection at the L5-SI level. On 1/19/11, Dr. DiPasquo recommended Petitioner continue off work, prescribed medication and instructed Petitioner to return to Dr. Abusharif. On 1/27/11, Dr. Abusharif performed a second lumbar epidural steroid injection at L5-S1.

On 2/3/11, Petitioner followed up with Dr. DiPasquo for low back pain. Petitioner underwent a third epidural steroid injection at L5-S1 with Dr. Abusharif on 2/10/11. On 2/17/11, Dr. DiPasquo recommended Petitioner begin a regimen of work conditioning and instructed Petitioner to remain off work. On 3/4/11, Petitioner underwent a Functional Capacity Exam that indicated that Petitioner could not return back to work in his former employment, as he could not safely perform at the heavy work level.

On 3/9/11, Petitioner returned to Dr. DiPasquo complaining of numbness and tingling in his right leg. Dr. DiPasquo recommended Petitioner follow up with Dr. Abusharif and referred Petitioner to Dr. Anis Mikhail. On 3/14/11, Petitioner returned to Dr. Abusharif. Dr. Abusharif noted that Petitioner's pain had been reduced by about 75- 80% and discharged Petitioner from his care.

On 3/21/11, Petitioner was evaluated by Dr. Anis Mikhail. Dr. Mikhail's notes indicate that Petitioner was complaining of radiating pain to the right thigh and to the right foot that began on 12/12/10, when he slipped shoveling snow at work. Dr. Mikhail's history indicated that Petitioner had no prior complaints of low back pain. Dr. Mikhail reviewed Petitioner's MRI and diagnosed Petitioner with right lumbar radiculopathy from a L5 disc protrusion, prescribed a follow-up MRI, EMG and Medrol Dose Pak and instructed Petitioner off work.

On 4/1/11, an EMG indicated there was no active L5-S1 radiculopathy, though the findings may be consistent with prior radiculopathy. On 4/8/11, repeat lumbar MRI revealed mild to moderate right and mild left foraminal narrowing at the L5-S1 interspace caused by shallow right disc protrusion and hypertrophic facet arthropathy along with mild bilateral foraminal narrowing at L3-L5 due to bilateral disc bulging and facet arthropathy.

On 4/14/11, Dr. Mikhail recommended a L5-S1 discectomy. Petitioner testified that during this time, he felt the same as he had when the accident initially occurred but that he now had pain going down the leg. The surgery was not initially approved. In June and July 2011, Petitioner continued to await approval of surgery.

On 10/25/11, Petitioner was examined by Dr. Frank Phillips pursuant to §12 of the Act at the request of Respondent. Px4. The doctor believed Petitioner's injuries to be causally related to his work accident and recommended a selective nerve root block to be used both diagnostically and therapeutically. Petitioner returned to Dr. Mikhail on 12/12/11, again complaining of right lumbar radiculopathy. Dr. Mikhail agreed to prescribe a nerve root block as recommended Dr. Phillips and referred Petitioner to Dr. Bayran for same. On 2/6/12, Petitioner was evaluated by Dr. Bayran, who diagnosed low back pain and right sided radiculopathy secondary to disc protrusion at L5-S1 and recommended the selective nerve root block at L5-S1.

On 2/10/12, Petitioner underwent a right L5-S1 selective nerve root block by Dr. Bayran at Parkview Orthopaedics. Petitioner returned to Dr. Mikhail on 2/13/12, indicating that the nerve root block had alleviated only some of his pain. As a result, Dr. Mikhail recommended a L5-S1 mircodiscectomy and decompression. On 6/27/12, Petitioner underwent and Dr. Mikhail performed a right L5-S1 decompression laminotomy, foraminotomy, and partial discectomy for the stenosis with decompression for both exiting as well as traversing nerve roots as well as right L5-S1 mircodiscectomy.

On 7/9/12, Petitioner complained of residual leg pain with numbness and tingling, with the right leg giving out. Petitioner was instructed to begin a regimen of physical therapy. Petitioner called the doctor's office concerned with right leg radiculopathy.

On 8/6/12, Petitioner continued to complain of right sided radiculopathy of the right leg. Decreased sensation at the S1 distribution and mild weakness in the gastrocnemius was noted. MRI with gadolinium was

ordered to rule out residual/recurrent herniation and/or stenosis. Therapy was held and Petitioner was ordered off of work. Repeat MRI showed enhancing granulation tissue along the posterior, right lateral and right ventral aspect of the thecal sac with a mass effect on the S1 nerve root.

On 8/16/12, Petitioner returned to Dr. Mikhail's office complaining of pain down the right leg "as bad as before surgery." Examination revealed a positive straight leg raise on the right side and decreased sensation in the S1 distribution. Dr. Mikhail noted recent MRI may indicate a recurring herniated disc. Dr. Mikhail recommended to hold off re-doing the surgery and instead recommended an epidural steroid injection, additional medication and off work restrictions. Records show Petitioner continued physical therapy with Functional Therapy & Rehabilitation through August 2012. Px2.

On 9/17/12, Petitioner was evaluated by Dr. Bayran. Petitioner complained of continued numbness to the right foot without relief. Examination revealed decreased sensation to the right leg and a positive straight leg raise on the right. Dr. Bayran diagnosed Petitioner with a recurring disc herniation at L5-S1 and performed an epidural steroid injection. On 10/12/12, Petitioner followed up with Dr. Bayran who noted low back pain with right-sided radiculopathy status post recurrent disc herniation/granulation tissue at L5-S1.

On 10/15/12, Petitioner returned to Dr. Bayran for a follow-up after the second epidural steroid injection. Dr. Bayran noted low back pain, radiculopathy of the right leg along with a positive straight leg on the right. At that time, Dr. Bayran instructed Petitioner to return to Dr. Mikhail and prescribed Lyrica for Petitioner's nerve issues. On that same date, Petitioner also saw Dr. Mikhail, who noted they attempted to treat the "recurrent lumbar radiculopathy" nonsurgically and noted a positive straight leg raise on the right and low back pain. Dr. Mikhail recommended a revision surgery with fusion along with the previously prescribed Lyrica. On 11/6/12, Dr. DiPasquo referred Petitioner back to Dr. Rinella for a second opinion concerning surgery.

On 1/22/13, Petitioner was again evaluated by Dr. Frank Phillips (#2). The doctor noted that Petitioner's complaints had a neuropathic component to them. He recommended a CT myelogram to confirm whether there was any significant or severe foraminal stenosis, residual or recurrent, on the right at L5-S1. He advised Petitioner could not work in the interim until "the issue is resolved." Dr. Phillips also recommended a functional capacity evaluation. On 2/7/13, Dr. Mikhail noted right lumbar radiculopathy going down to the right big toe indicating the L5 distribution and altered sensation in the S1 distribution. Dr. Mikhail concurred with the recommendation for a CT myelogram.

CT myelogram revealed impingement of the right thecal sac, bilateral facet hypertrophy, marginal osteophyte on the left extending into the neural foramen at L5-S1 along with multi-level disc and facet disease. Dr. Mikhail reviewed the CT myelogram results with Petitioner and again recommended a revision surgery at L5-S1 with a decompression and fusion. On 3/13/13, Dr. Mikhail completed disability paperwork issued by Respondent on behalf of Petitioner indicating a continued recommendation for decompression and fusion and that Petitioner remain off of work. He estimated Petitioner would remain off of work until 8/4/13.

On 6/13/13, Petitioner first consulted with Dr. Rinella. The doctor noted Petitioner's work accident and resultant mircodiscectomy at L5-S1 without improvement of symptoms. Petitioner complained of bilateral leg pain and low back pain. Exam showed numbness throughout the anterior thigh, diminished sensation in the right L4 and L5 nerve root distribution without other sensory problems. Dr. Rinella reviewed 2012 MRI along with 2013 myelogram and recommended Petitioner undergo a L5-S1 fusion. Petitioner was instructed off work. Dr. Rinella wrote to Respondent requesting authorization for his surgical recommendation. On 6/28/13, Dr. Phillips issued an addendum IME report (#3). The doctor opined that the CT myelogram showed primarily scar tissue around L5-S1 and that fusion surgery would not help. The remainder of his opinions remained unchanged.

On 7/3/13, Dr. Rinella again recommended L5-S1 fusion surgery as well as a return to work with no lifting greater than 10 pounds, no bending and twisting. On 8/16/13, Dr. Rinella noted ongoing persistent foraminal stenosis at L5-S1 on the right and bilateral lower extremity radiculopathy increasing in severity and with new sided symptoms on the left. At that time, Dr. Rinella prescribed a new MRI and continued Petitioner's light duty restrictions. Petitioner was prescribed a lumbar brace while awaiting the surgical authorization. Petitioner received letters from Illinois Administrative & Regulatory Shared Services Center seeking updated medical disability notes indicating whether he was disabled. The last one noted to have been received was from 10/24/13.

In 2014, Dr. Rinella ordered new studies and revised his surgical recommendation from fusion to L4-5 laminectomy to address leg symptoms. Petitioner continued to remain off of work. On 1/23/14, MRI of the lumbar spine showed spondylitic changes most significant at L5-S1 along with diffuse bulge with facet arthropathy that encroaches upon the descending right S1 nerve root, essentially unchanged from previous exam.

On 5/5/14, Dr. Phillips issued another Section 12 report (#4). After conducting a records review only, he concluded that Petitioner continued to suffer from primarily neuropathic pain after surgery. He concurred with Dr. Rinella's recommendation for decompressive surgery at L4-5. He did not believe the need for this second surgery, however, was work related. The doctor concluded Petitioner was at maximum medical improvement for his work injury and treatment. On 7/19/14, Respondent's insurance carrier, Tristar, issued a letter to Petitioner indicating that temporary total benefits would be terminated effective 7/16/14 based on the report of Dr. Phillips. RxE.

On 8/25/14, EMG showed chronic L5 radiculopathy and absent H reflexes. On 9/9/14, Petitioner underwent a heart test at the Heart Care Center with Dr. Stella in connection with pre-operative lumbar surgical clearance. On 10/13/14, Petitioner underwent pre-operative clearance for surgery at Silver Cross Hospital. On 10/27/14, Petitioner underwent a laminectomy and spinal decompression at L3 through S1 at Silver Cross Hospital by Dr. Anthony Rinella. On 10/29/14 Petitioner was discharged following surgery with a final diagnosis of spinal stenosis at L3-S1. Petitioner had post-surgical follow-ups with Dr. Rinella on 11/12/14 and 12/12/14 and Petitioner was instructed to remain off work and prescribed medication.

On 1/21/15, Dr. Rinella indicated that Petitioner improving with complete resolution of left leg symptoms. Numbness in the right anterior thigh continued. He was released to light duty and prescribed work conditioning. On 2/25/15, Dr. Rinella indicated that work conditioning was prescribed but not approved and Dr. Rinella cautioned that the failure to complete a work conditioning program would aggravate Petitioner's symptoms. In March, Petitioner followed up with Dr. Rinella complaining of lingering symptoms. Work conditioning had still not been approved. Petitioner remained on a 15 pound lifting restriction.

On 4/1/15, Dr. Rinella indicated decreased sensation in the right leg and complaints of persistent decreased sensation on the right. Dr. Rinella diagnosed persistent right leg radiculopathy and recommended new MRI and EMG. The EMG noted a right sub acute to chronic L5 radiculopathy. On 4/16/15, Dr. Rinella recommended a CT scan and prescribed a Medrol Dosepak. Impression was status post L3-S1 laminectomy, lumbago and lumbar radiculopathy.

On 5/7/15, Dr. Rinella prescribed work conditioning and a functional capacity exam (FCE), and placed Petitioner on light duty restrictions of no lifting greater than 10 pounds. Petitioner underwent a pain management exam with Dr. Brown in July 2015. Petitioner followed up with Dr. Rinella's office in September 2015 and was advised to seek work conditioning, an FCE and medication management. At Petitioner's most recent exam in November 2015 with Dr. Rinella, the doctor again recommended an FCE. Petitioner testified that he was also referred to Dr. Anderson, a neurologist at Loyola Medical Center, for an evaluation of placement of a spinal cord stimulator.

Petitioner testified that at the time of hearing, he still had numbness and tingling down his right leg as well as difficulty lifting. Petitioner testified that he was paid Temporary Total Disability benefits up to and including July 16, 2015. Since that time, Respondent has not paid any benefits. Petitioner testified that he is very depressed, that he used to be very powerful man, that he cannot lift his granddaughter. Further, he does not do physical activities and has difficulty sleeping.

The parties took the evidence deposition of Dr. Rinella. At his evidence deposition, Dr. Rinella summarized his treatment and examinations of Petitioner. The doctor confirmed the presence of pathology verified by objective testing and consistent with Petitioner's then subjective complaints. Dr. Rinella opined that Petitioner's work accident led to the need for the continued treatment, current residual symptoms and that further limited Petitioner's ability to return to work. The doctor opined that all treatment, including charges, were reasonable, necessary and related to Petitioner's work accident. On cross-examination, Dr. Rinella discussed the cause for the need for additional surgery. Specifically, part of Petitioner's issue was foraminal stenosis due to lack of sufficient disc height from the original herniation and also from residual scaring from his initial surgery. The doctor opined that this was causing ongoing symptoms. Further, the loss of disc height may be due to degenerative changes, age related changes and/or the disc herniation from the work fall.

Respondent presented the testimony of Dr. Frank Phillips. RxC. Dr. Phillips testified he was not provided any of Dr. DiPasquo's medical records, the films for the 2010 MRI nor any EMG studies showing any abnormalities. He agreed he would want all relevant records to provide an opinion in this case and his opinion could change if additional records were available for review. Dr. Phillips testified that he reviewed the April 2011 MRI and that it failed to show any acute findings. He also reviewed the post-surgical MRI of August 2012 and noted scar tissue around the surgical site at L5-S1 but felt the MRI results were "unimpressive." According to Dr. Phillips' review of the medical records, Petitioner's right leg pain did not develop until after the first surgery. Dr. Phillips confirmed that Petitioner did not have any low back pain prior to 12/12/10, nor did he have any symptoms of degenerative changes in his low back prior to the date of the accident. Dr. Phillips concluded that Petitioner's current condition of ill-being was not casually related to his work accident.

CORRECTED CONCLUSIONS OF LAW

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

The Arbitrator, having considered the credible testimony of Petitioner and all available medical evidence and opinions, concludes that Petitioner's current condition of ill-being, namely the low back/lumbar spine injury and associated radiculopathies, is causally connected to his work accident of 12/12/10.

It is well settled that proof of prior good health and change immediately following and continuing after an injury may establish that an impaired condition was due to the injury. Here, a preponderance of evidence in the record demonstrated that Petitioner had no prior low back injuries, symptoms or treatment before his undisputed work accident. He testified he felt fine the morning of his work shift prior to slipping and falling. The Arbitrator finds Petitioner was in a state of good health before his work accident as it relates to his low back/lumbar spine. following his work accident, Petitioner began experiencing low back pain with associated right sided lumbar radiculopathy for which he appropriately and continued to treat through the date of hearing. As early as 2010 and 2011, MRI studies implicated an L5-S1 protrusion/herniation with associated S1 nerve root impingement as well as levels L3-L4 and L4-L5 for bulging and associated narrowing. Further evidence shows Petitioner attempted to treat the primary L5-S1level with conservative care by way of medication, epidural steroid injections and selective nerve root block and therapy. Upon failure of conservative care, surgery by way of right L5-S1 decompression laminotomy, foraminotomy, and partial discectomy for the stenosis with decompression for both exiting as well as traversing nerve roots as well as right L5-S1 microdiscectomy was performed. The surgery implicated not just the

disc at L5-S1 but also the lamina and foramen. The Arbitrator notes that up to this point in treatment, Respondent's doctor, Dr. Phillips, found causation between Petitioner's then current condition of ill-being and the work accident.

Following surgery, Petitioner continued to experience right-sided radiculopathy and low back pain. post-operative studies suggested recurrent or residual herniation and/or scarring/granulation at L5-S1. Revision surgery and possible fusion was recommended by both Drs. Mikhail and Rinella. The Arbitrator notes that Dr. Phillips' second exam identified similar concerns, recommending a myelogram and that noting that Petitioner could not work until his issues were resolved. Dr. Rinella noted the presence of bilateral radiculopathy and appropriately ordered a new MRI. based on new imaging studies, Dr. Rinella revised his surgical recommendations to exclude fusion. Dr. Phillips agreed with Dr. Rinella's revised surgical recommendation but concluded the new surgery would not be work related. Eventually, Petitioner underwent a laminectomy and spinal decompression at L3 through S1.

The Arbitrator finds that the preponderance of medical evidence and the credible opinions of Dr. Rinella demonstrate a failed first surgery necessitating a revision surgery as well as laminectomy at additional levels to address Petitioner's ongoing right-sided radiculopathy and newer left-sided leg pain. Dr. Rinella credibly testified and explained that Petitioner's low back and leg problems began with the work accident and continued through his last surgery. The doctor also explained that while Petitioner may have had some pre-existing lumbar conditions, those were probably aggravated with the work accident. To the extent that those were aggravated, the Arbitrator notes that it is well-settled that an employee need only show that some act of employment was a causative factor, not the sole or, principal cause, of his injury. The fact that the employee had a preexisting condition, even though the same result may not have occurred had the employee been in normal health, does not preclude a finding that the employment was a causative factor. The question is whether the evidence supports an inference that the accident aggravated or accelerated the process which led to the employee's current condition of ill-being. Here, there is sufficient evidence in the record to support a conclusion that Petitioner's current condition of ill-being, even if pre-existing to some degree, was aggravated as a result of the work accident.

The Arbitrator rejects the opinions of Dr. Phillips. In overruling Petitioner's *Ghere* objection to Dr. Phillips' opinions, the Arbitrator notes there was no surprise in Dr. Phillips' opinions through out his involvement, which primarily concentrated on causal connection between any lumbar conditions pre and post surgery to the work accident. Although those later opinions may differ from Petitioner's ultimate position at trial, those are not entirely new or surprising so as to warrant exclusion under *Ghere*. Despite Dr. Phillips' conclusions that Petitioner's condition is not work related, the Arbitrator rejects this opinion as it primarily relies on the assumption that the first surgery, which only addressed the L5-S1 level, was the appropriate and only level symptomatic from the work accident. the Arbitrator finds that Dr. Phillips' conclusion that the proposed second surgery to L4-L5 was not work related again is premised on the assumption that the L5-S1 level was the only symptomatic level. While there was scarring at that level following surgery, which likely accounted for the ongoing right sided radiculopathy, additional levels were also found to be spondylitic before the first surgery and certainly symptomatic after the first surgery resulting in left-sided radiculopathy as evidenced by Petitioner's complaints and post-operative studies. Thus, the onset of additional symptomatic levels are a sequela of the original injury.

Further, the Arbitrator rejects Dr. Phillips' conclusion during his testimony that Petitioner did not develop any right leg symptoms or difficulties until after the surgery. First, the following treatment records demonstrate a contrary conclusion: 1/6/11 Dr. DiPasquo – positive tenderness to right leg, 1/13/11 Dr. Abusharif – radiating right leg pain, 1/13/11 Dr. Abusharif – diagnosed lumbar radiculopathy, 1/19/11 Dr. DiPasquo – complaint of shooting pain in right leg, 2/3/11 Dr. DiPasquo – complaint of right leg ache, 3/9/11 Dr. DiPasquo – complaint of numbness and tingling in the right leg, 3/21/11 Dr. Mikhail – complaint of radiating pain in right thigh to right foot,4/4/11 Dr. Mikhail – complaint of right radiating leg pain, 12/12/11 Dr. Mikhail – complaint of right lumbar

radiculopathy symptoms. Further, even if a right leg abnormality developed after the first surgery, the Arbitrator could easily conclude that this development was a sequela of the original injury. This conclusion is supported by Dr. Phillips' testimony under cross-examination wherein he conceded as much. Second, Dr. Phillips' conclusion during his deposition regarding the right-sided complaints as not work related run contrary to his earlier written reports, which found causal connection up to the point of the recommended second surgery. for the foregoing reasons, the Arbitrator concludes that Petitioner's current condition of ill-being is causally related to his work 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?

Having found in favor of Petitioner on the issue of causal connection, the Arbitrator concludes that Petitioner's medical treatment to date has been both reasonable and necessary. At trial, Petitioner submitted the following medical expenses:

Px6 – Anthony Rinella/Illinois Spine & Scoliosis Center (6/26/13 – 11/6/15): $60,153.85
Px7 – Functional Therapy Rehabilitation (7/12/12 – 8/16/12): $3,570.21
Px8 – Raymond DiPasquo/Primary Health Associates (12/13/10 – 11/6/12): $15,535.00
Px9 – Neema Bayran/Parkview Orthopaedic Group (3/21/11 – 5/13/14): $68,317.66
Px10 – Radiologist & Nuclear Consultants (2/25/13): $761.01
Px13 – Silver Cross Hospital (10/27/14 – 10/29/14, 4/8/15): $29,515.40

Given the findings and conclusions concerning causal connection, the Arbitrator finds Respondent responsible for medical expenses by the above providers. Respondent shall pay directly to Petitioner medical services of **$177,853.13**, as provided in Sections 8(a) and 8.2 of the Act. Against this award, 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. See Ax1, Px6-10, Px13, RxA-B.

L. What temporary benefits are in dispute?

Petitioner testified that he was paid temporary total disability benefits up to and including 7/16/15 Given that the Arbitrator has found Petitioner's current condition of ill-being is causally related to his work accident, the Arbitrator further finds that Petitioner's current condition of ill-being has not yet reached a state of permanency. Petitioner testified that he continues to experience low back pain and right leg difficulties for which he is still treating. The Arbitrator finds that Respondent shall pay temporary total disability benefits in the amount of **$1,087.21/week** from **12/13/10** through **11/13/15**, representing **256-5/7**th weeks. Respondent shall be given a credit of **$257,058.91** for temporary total disability benefits that have been paid. RxA.

M. Should penalties or fees be imposed upon Respondent?

It is well-settled that a Respondent's good faith basis for disputing a claim will not subject it to an award of penalties and fees. The reliance on the opinions of a qualified §12 examiner may demonstrate a good faith denial of benefits. However, in order to rely on a §12 examiner, Respondent may not fail to provide relevant materials and simply accept a demonstratively flawed opinion. Here, Dr. Phillips relies on two bases for his opinion that Petitioner's back injury and need for surgery were not related to his work activities that are simply untrue. Dr. Phillips testified that the April 11, 2011 MRI failed to show any acute findings when in fact, the radiologist concludes findings of an L5-S1 disc protrusion.

16IWCC0313

Here, Petitioner seeks penalties and fees on the basis that Dr. Phillips, Respondent's Section 12 examiner, had flawed opinions on which Respondent may not rely. Dr. Phillips testified, in part, that the 2011 MRI failed to show acute findings. Petitioner argues the MRI in fact demonstrated a protrusion. It cannot be said Dr. Phillips' testimony is inherently flawed as Dr. Rinella conceded on cross examination that doctors may differ on interpretation of such studies. Further, the basis on which Petitioner's claim was denied had nothing to do with the 2011 MRI but rather Dr. Phillips' conclusion that Petitioner's myelogram following the first surgery did not demonstrate anything pathologically that would warrant further surgery. Dr. Phillips concluded that Petitioner had reached maximum medical improvement in so far as his work related treatment was concerned.

Based on the foregoing, the Arbitrator need not address Petitioner's additional arguments concerning the request for penalties and fees. Having concluded that Respondent had a good-faith and reasonable basis in which to dispute Petitioner's claim for additional compensation and treatment, Petitioner's petition for penalties and fees is hereby ***denied.***

Signature of Arbitrator

1-20-2016
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

Mary Jane Forney,
Petitioner,

vs.

NO: 11WC 11595

16IWCC0277

State of Illinois, Department of Human Services,
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 27, 2015, 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: MAY 2 - 2016
d041216
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

81MC60854

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FORNEY, MARY JANE
Employee/Petitioner

Case# **11WC011595**

ST OF IL DEPT OF HUMAN SVCS
Employer/Respondent

16IWCC0277

On 4/27/2015, 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 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2427 KANOSKI BRESNEY
THOMAS R EWICK
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

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

4993 ASSISTANT ATTORNEY GENERAL
AMY S OXLEY
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1745 CMS - RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

APR 27 2015

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

16IWCC0277

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

PERSONAL

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Mary Jane Forney
Employee/Petitioner

v.

State of Illinois, Dept. of Human Svcs.
Employer/Respondent

Case # 11 WC 11595

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on February 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. ☒ 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 _____

UNDERTIAL

16IWCC0277

FINDINGS

On October 25, 2010, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $68,446.00; the average weekly wage was $1,316.27.

On the date of accident, Petitioner was 61 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

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

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

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

William R. Gallagher, Arbitrator

April 21, 2015
Date

APR 27 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of October 25, 2010, and that Petitioner sustained repetitive trauma to the right and left hands/wrists and thumbs (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship.

Petitioner began working for Respondent in 2003 as a Public Service Administrator. Prior to being employed by Respondent, Petitioner worked at the Family Service Center of Sangamon County for approximately 23 years.

Petitioner testified that while working for Respondent, she was required to type/keyboard for four to six hours every day. Petitioner was not required to do any typing/keyboarding at all when she worked at the Family Service Center. Petitioner customarily worked Monday through Friday; however, Petitioner also stated that there were occasions in which she traveled outside the office to conduct inspections/evaluations of various state facilities. Petitioner testified that the keyboard was on a desk, not on a pull out tray. When Petitioner was keyboarding, she placed her wrists on a pad and reached upward to the keyboard. Petitioner also performed other clerical duties including filing and answering the telephone. Filing would generally take approximately two hours per day.

Petitioner testified that the amount of time she spent typing/keyboarding increased in 2010 because of the number of projects that the office was handling. Petitioner stated that the typing increased from approximately four hours per day to approximately six hours per day.

Petitioner stated that sometime in either 2009 or 2010, she started having symptoms of numbness, tingling and pain in both hands. The symptoms usually occurred after typing for about one hour or so. She also, on occasion, had the same symptoms when she was driving.

Petitioner initially sought medical treatment from Dr. Geoffrey Bland, her family physician, on August 20, 2010. At that time, Petitioner advised Dr. Bland that she had numbness/tingling in both hands associated with typing and driving. Dr. Bland referred Petitioner to Dr. Claude Fortin, a neurologist, for nerve conduction studies (Petitioner's Exhibit 2).

Petitioner was seen by Dr. Fortin on August 30, 2010, and he performed nerve conduction studies on that date which were positive for severe bilateral neuropathies of the median nerve and that surgery was indicated. Dr. Fortin's record also stated that "Optimizing diabetic control may be of some value as well." (Petitioner's Exhibit 3).

At trial, Petitioner testified that she was diagnosed with type II diabetes in 1978. Petitioner's medical records from Springfield Clinic were received into evidence at trial. During 2010 and 2011, Petitioner was treated by Dr. Lynn Speck who noted on several occasions that Petitioner's diabetes was not well controlled. Petitioner was also diagnosed with diabetic retinopathy (Petitioner's Exhibit 4). Petitioner also stated that she was a non-smoker and had never been diagnosed with any thyroid disorders.

On October 25, 2010 (the date of manifestation alleged in the Application) Petitioner completed an Employee's Notice of Injury wherein Petitioner reported a gradual onset of cramping, tingling and pain in the hands, arms, neck and shoulders. She noticed the symptoms while driving and keyboarding (Petitioner's Exhibit 1).

Dr. Bland subsequently referred Petitioner to Dr. Richard Brown, a plastic surgeon, who initially evaluated Petitioner on December 16, 2010. At that time, Petitioner advised Dr. Brown that she had bilateral hand symptoms for the preceding five years and that they were getting worse. She also informed Dr. Brown that she spent a lot of time on the computer typing that she had numbness in her index, long and ring fingers. She also complained of locking of both thumbs. Dr. Brown's diagnoses were bilateral carpal tunnel syndrome and bilateral trigger thumbs. He recommended Petitioner undergo both carpal tunnel and trigger thumb surgical release procedures (Petitioner's Exhibit 4).

At the direction of Respondent, Petitioner was examined by Dr. James Williams, an orthopedic surgeon, on April 13, 2011. In connection with his examination of Petitioner, Dr. Williams reviewed medical records provided to him by Respondent as well as information regarding Petitioner's job duties. Dr. Williams opined that Petitioner had bilateral carpal tunnel syndrome and that surgical release procedures were appropriate; however, he opined that the condition was not related to Petitioner's repetitive keyboarding. Dr. Williams further opined that the condition was related to Petitioner's uncontrolled diabetes, obesity and being female (Respondent's Exhibit 1).

Dr. Brown performed surgery on July 13, 2011, and the procedure consisted of a left endoscopic carpal tunnel release and release of the left trigger thumb (Petitioner's Exhibit 5). Dr. Brown performed surgery on August 5, 2011, and the procedure consisted of a right endoscopic carpal tunnel release and release of the right trigger thumb (Petitioner's Exhibit 6).

Dr. Brown authorized Petitioner to be off work following the surgeries and Petitioner did return to work on August 24, 2011. At trial, Petitioner and Respondent stipulated that Petitioner was disabled from July 13, 2011, through August 23, 2011, a period of six weeks.

Dr. Brown was deposed on November 10, 2014, and his deposition testimony was received into evidence at trial. Dr. Brown's testimony regarding his diagnoses and treatment of Petitioner's conditions was consistent with his medical records and that Petitioner had bilateral carpal tunnel syndrome and bilateral trigger thumbs which required surgeries (Petitioner's Exhibit 7; pp 5-13).

In regard to causality, Dr. Brown was asked a question which described Petitioner's work activities as well as the fact that Petitioner was a non-smoker and had no thyroid conditions. Dr. Brown testified that he could not say that Petitioner's work activities caused the bilateral carpal tunnel syndrome but that her typing in a "bad position" could aggravate it but that it was not "a causative factor." He also testified that Petitioner's work activities did not have anything to do with her bilateral trigger thumbs (Petitioner's Exhibit 7; pp 20-22).

On cross-examination, Dr. Brown agreed that Petitioner's uncontrolled diabetes could be a cause or aggravating factor of both the carpal tunnel syndrome and trigger thumb conditions. He also

agreed that Petitioner's obesity was a risk factor as well; however, he did not believe that Petitioner's post menopausal status was a major risk factor (Petitioner's Exhibit 7; pp 24-26).

Dr. Williams was deposed on November 20, 2014, and his deposition testimony was received into evidence at trial. Dr. Williams' testimony was consistent with his medical report and he reaffirmed the opinions contained therein. He specifically noted that Petitioner's typing was intermittent and that she performed other clerical activities in the course of a workday. He also stated that Petitioner's uncontrolled diabetes was the most significant risk factor for both carpal tunnel syndrome and trigger thumbs in addition to Petitioner's obesity and being female (Respondent's Exhibit 2; pp 14-17).

At trial, Petitioner testified that the symptoms of numbness and cold feeling improved in both of her hands. She stated that there are still times that she has symptoms of numbness/tingling in both hands as well as pain along the outer edge of the palm. When typing, she does notice tingling sensations in her fingers. When lifting heavier items, Petitioner generally uses both hands.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injury that manifested itself on October 25, 2010, and that her current condition of ill-being is not causally related to her work activities.

In support of this conclusion the Arbitrator notes the following:

Petitioner credibly testified in regard to the repetitive nature of her work activities. While the exact number of hours Petitioner was required to type/keyboard cannot be precisely determined, the evidence indicates that it was a minimum of four hours per day.

Both Petitioner's treating physician, Dr. Brown, and Respondent's Section 12 examiner, Dr. Williams, agreed that Petitioner had bilateral carpal tunnel syndrome and bilateral trigger thumb. They also agreed that the bilateral trigger thumb condition was not related to Petitioner's work activities.

The evidence is clear that Petitioner had other risk factors for carpal tunnel syndrome, in particular, uncontrolled diabetes, obesity, being a female and being post menopausal. The most significant of these risk factors was Petitioner's uncontrolled diabetes.

When Dr. Brown was deposed, he opined that there was a causal relationship between Petitioner's repetitive work activities and the bilateral carpal tunnel syndrome and stated that Petitioner's repetitive work activities did not cause the condition but typing in a "bad position" could aggravate it but that it was not "a causative factor." The Arbitrator finds Dr. Brown's opinion to be unclear and it is not a definitive medical opinion of causality.

Dr. Williams noted that Petitioner's typing was intermittent and that she performed other clerical tasks. Dr. Williams' opinion was that Petitioner's carpal tunnel syndrome was not work-related because it was related to Petitioner's other risk factors, primarily, Petitioner's uncontrolled diabetes.

The Arbitrator finds the opinion of Dr. Williams to be more persuasive than that of Dr. Brown.

In regard to disputed issues (J), (K) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

William R. Gallagher, Arbitrator

TOBACCOS.a

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Segneri,

Petitioner,

vs. NO: 11WC 16123

Pathway Health Services, Inc.

Respondent.

16IWCC0362

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 July 27, 2015 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.

16IWCC0362

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: MAY 2 6 2016
SJM/sj
o-5/5/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SEGNERI, ROBERT A
Employee/Petitioner

Case# 11WC016123

16IWCC0362

PATHWAY HEALTH SERVICES INC
Employer/Respondent

On 7/27/2015, 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 0.13% shall accrue from the date listed above to the day before the 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:

0529 GREG TUITE & ASSOC
119 N CHURCH ST
SUITE 407
ROCKFORD, IL 61101

2837 LAW OFFICE OF JOHN MARCINIAK
MATTHEW A WRIGLEY
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

16IWCC0362

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert A. Segneri
Employee/Petitioner

v.

Pathway Health Services, inc.
Employer/Respondent

Case # **11** WC **16123**

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 **George Andros**, Arbitrator of the Commission, in the city of **Rockford**, on **December 15, 2014 & June 19 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0362

FINDINGS

On **2/2/2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**70,184.50**; the average weekly wage was $**1403.89**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**Compensation has been paid at $935.83 a week since 2/2/2009 through the dates of hearing. Respondent is credited for all payments paid to date.**

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

ORDER

Respondent shall pay reasonable and necessary medical services of $118.90, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of $**935.83**/week for life, commencing **1/11/2013**, 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 Petitioner the disability benefits that have accrued from 2/2/2009 through , and shall pay the remainder of the award, if any, in weekly payments.

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

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

01 Arb George Andros
Signature of Arbitrator

July 20, 2015
Date

JUL 27 2015

FINDINGS OF FACTS 11 WC 16123

On February 2, 2009, Petitioner Robert Segneri was employed as a Nurse Consultant for the Respondent, Pathway Health Services, Inc. In addition to having his Registered Nurse license, he had additional experience with state and federal regulations of nursing homes. All of his experience had been in nursing homes or psychiatric units.

Both positions would require significant physical effort. Often in the psychiatric unit he would have to use non-violent restraint techniques to subdue the patient. In the nursing home positions he would assist with transfers of patients along with repositioning, toileting, obtaining monthly weights along with dietary issues. In addition, he would help feed residents and assist them with dressing and bathing. Mr. Segneri testified that he was right-hand dominant. He had no prior history of a right shoulder injury except for a one-month strain that had occurred approximately five years before the accident in question.

Petitioner injured his right shoulder on February 2, 2009, while assisting a CNA transfer a resident from a wheelchair to a cardiac chair. While attempting to set the resident down into the cardiac chair, Petitioner felt a sharp pain and a pop in his right shoulder. An MRI taken a few days later revealed a massive rotator cuff tear involving the entire supraspinatus and infraspinatus tendons, along with a degenerative SLAP tear and severe posterosuperal labral fraying with probable degenerative tearing. Mr. Segneri underwent a right rotator cuff repair along with a Mumford procedure on March 31, 2009. Dr. Whitehurst at Rockford Orthopedic Associates performed surgery. Shortly thereafter he began physical therapy. In the interim, he was released to sedentary, one-handed work, which the employer could not accommodate. He continued to receive TTD benefits.

On September 28, 2009, an MRI of the right shoulder revealed a large recurrent full-thickness rotator cuff tear, along with a fractured suture anchor, which had retracted. As a result of this pathology, Dr. Whitehurst recommended a repeat surgery. In response, Respondent had Mr. Segneri evaluated by Dr. Scott Sagerman on November 10, 2009. Dr. Sagerman agreed that the shoulder condition was related to the original work injury of February 2, 2009. He also agreed with the proposed surgery and postoperative rehabilitation plan.

Repeat surgery was performed by Dr. Whitehurst on December 29, 2009. Subsequently Mr. Segneri reinstituted a program of physical therapy.

Because of continuing pain during physical therapy an MRI was performed on the right shoulder on May 27, 2010. This showed a large recurrent full-thickness rotator cuff tear along with two suture anchor fragments displaced from the bone. In addition, there was severe suprascapularis tendonosis and a partial interstitial longitudinal tear.

Once again, Dr. Whitehurst recommended an arthroscopic revision. A bone density scan revealed normal bone mass. As before, Respondent sent Mr. Segneri to Dr. Sagerman for a Section 12 examination. He again indicated that the current pathology was related back to the original work injury in February 2009. He recommended an open repair as opposed to an arthroscopic procedure.

Dr. Whitehurst performed the third operation on September 16, 2010. This was: a revision rotator cuff repair with graft jacket augmentation; an arthroscopic subscapularis repair; and a mini open biceps tenodesis along with extensive arthroscopic debridement. Once again, Mr. Segneri embarked on a program of extensive physical therapy shortly after the surgery. This continued through March 21, 2011, when Dr. Whitehurst released Mr. Segneri from care. The doctor imposed a permanent restriction of no lifting over five pounds and no overhead work. He referred Mr. Segneri to his primary physician should he need further pain medication.

Mr. Segneri began seeing Dr. Fellers, his primary physician, on April 1, 2011. Dr. Fellers recommended a repeat MRI of the right shoulder on June 24, 2011. This continued to show a large recurrent rotator cuff tear. Mr. Segneri then sought a second opinion from Dr. John Orwin from the University of Wisconsin Hospital and Clinics on August 30, 2011. Dr. Orwin noted a number of positive objective findings. He noted numerous anchors in place in the humeral head. He did not believe another surgery would be of benefit, but recommended an EMG test along with his own review of the recent MRI. Mr. Segneri returned to Dr. Orwin on September 28, 2011 to discuss the test results. The only surgery Dr. Orwin would consider was a possible revision decompression and distal clavicle excision. He did not believe any further surgery on the rotator cuff would be beneficial. He also indicated that Mr. Segneri would not be able to return to his normal job as a nurse because of a lack of necessary strength.

Subsequently Mr. Segneri saw Dr. Nowak of Rockford Health Physicians who became his primary physician. Dr. Nowak provided on-going pain medication, including Tramadol, Flexeril, and eventually Norco. In addition, she attempted a glenohumeral joint injection into the shoulder on April 2, 2012. On July 10, 2012, she also recommended physical therapy at Rockford Orthopedic Associates, also, on July 10, 2012 for a period of 6 to 8 weeks. The therapy was terminated after only a few days because it was causing increased pain in the right shoulder. A January 10, 2014, MRI of the right shoulder, performed at the request of Dr. Nowak, revealed near-complete chronic disruption infraspinatus as well as a portion of supraspinatus tendon. The biceps tendon showed chronic atrophy and possibly a tear. In order to obtain a more definitive shoulder evaluation, the radiologist recommended an MRI arthrogram with contrast imaging or a repeat arthroscopy. Mr. Segneri declined the MRI and chose to continue with conservative care.

Subsequent to the release by Dr. Whitehurst on March 21, 2011, Petitioner was seen by two vocational counselors. He was initially seen at his attorney's request by Ms. Susan Entenberg CRC on May 3, 2011. The report of that visit was admitted into evidence as Petitioner's Exhibit 2. Ms. Entenberg confirmed that Mr. Segneri's past work was that of a Nurse Consultant and Director of Nursing along with that of a Registered Nurse. She did not believe that Mr. Segneri was capable of his past employment, but she did believe he was a candidate for rehabilitation. She indicated that he would need specific and targeted job placement efforts due to the fact that he would be competing with nurses who had Bachelors or Masters degrees while his degree was an Associates from a community college. She further indicated that if he could not obtain a sedentary position, his wages would be reduced to a range of between $9.96 and $13.89 an hour.

On January 11, 2012, Respondent arranged for a vocational evaluation by Mr. Eric Flanagan of Encore Unlimited. After the initial evaluation Mr. Flanagan helped Mr. Segneri edit his resume and provided 5 to 10 job leads a week. Mr. Segneri worked with Mr. Flanagan from January 11, 2012 through March 29, 2013. At that time, Petitioner received an email from Mr. Flanagan indicating that his file was to be closed. During the time that Mr. Segneri worked with Mr. Flanagan, he only had two interviews. One was a volunteer position with Habitat for Humanity. The other was with a nursing home called Bickford House. He was informed that the volunteer position was unsuitable due to the fact that he would have to do lifting and moving of objects. He was told that the Bickford position was not a fit for him.

Petitioner testified that he continued to look for work, including volunteer positions, after the file closure by Mr. Flanagan. As of the hearing date of December 15, 2014, he had not received any job offer. In the interim, Mr. Segneri was re-evaluated by Ms. Entenberg on December 27, 2012. That report was entered into evidence as Petitioner's Exhibit 3. Ms. Entenberg noted that Mr. Segneri was wearing a shoulder brace that had been prescribed by Rockford Orthopedic Associates in July 2012. He also felt that his range of motion had decreased and he could only lift the arm to a level parallel to the floor. He was also now taking Hydrocodone 10/325 mg. up to four times daily. He further indicated that he had been looking for nursing-related positions since April 2011. Ms. Entenberg modified her previous opinion and indicated that she did not believe Mr. Segneri to be a candidate for vocational rehabilitation nor did a stable labor marked exist for him. She based her opinion on the over 600 contacts made without success, including no success in obtaining volunteer work because of his limitations. Mr. Segneri had also completed a home-study electronic repair course while pursuing the rehabilitation efforts directed by Mr. Flanagan. He had also looked for jobs within the electronics field without success.

At the Arbitration hearing, Mr. Flanagan testified that he terminated case management services because he believed Mr. Segneri had the skills required and had been given the appropriate advice to be successful in a job search. He also gave an opinion that he believed Mr. Segenri was employable in an occupation that had been identified in a 2013 labor market survey. He identified certain of case management documents that were admitted into evidence. On insightful, well preparrd cross-examination, Mr. Flanagan admitted that the exhibits he identified did not include all of his reports. He also admitted that the exhibits did not contain any of the job search logs that documented the extent of Petitioner's job search. He did not have them in his possession at the hearing. Thus, he could not testify as to how many jobs Mr. Segneri had actually applied for. He admitted that Mr. Segneri did not receive any interviews for jobs during the time that he worked with him, nor had he received any job offers. Mr. Flanagan further agreed that labor market surveys were snapshots in time and that any jobs identified in the survey could be gone the next day. He further admitted that he did not personally contact any of the employers identified in the labor market survey in an attempt to set up an interview with Mr. Segneri. In fact, he had not attempted to set up any interviews during the time that he provided rehabilitation service. He did not believe that to be part of the role of a vocational case manger. Mr. Flanagan agreed that his vocational service consisted of monitoring a job search and providing up to ten job leads a week for Mr. Segneri. These leads were obtained via computer searches and there was no direct contact with any of the employers. This is deemed sub par by the Arbtrator given Rule 7110 and the National Tea case plus its progeny.

Subsequent to the hearing, Ms. Entenberg was presented with the testimony of Mr. Flanagan and rehabilitation reports prepared by Encore. After reviewing these materials, Ms. Entenberg prepared a third report on June 8, 2015. That report was entered into evidence as Petitioner's Exhibit 9. In it, Ms. Entenberg noted that Mr. Flanagan had terminated his services in March 2013 because he believed Mr. Segneri had the skills needed to be successful in a job search. She noted that Mr. Segneri had been attempting to find a nursing-related position since April 2011 and had not been successful. She noted that Mr. Flanagan had not attempted to contact any employers or establish informational interviews for Mr. Segneri, which could pave the way for a job opportunity. Further, she noted he did not attempt to prescreen employers for potential positions within Mr. Segneri's restrictions, educational level and skill set. She indicated such activities are often utilized in job placement, both for professional and non-professional candidates.

Ms. Entenberg also addressed the labor market survey. She specifically stated that a labor market survey is not a predictor of a specific individual being hired for a position.

This CRC added the following:

> "In Mr. Segneri's situation, his age, his AAS degree and needing to compete with BSN and MSN candidates and his restrictions to his dominant arm are strong contributing factors in obtaining a nursing-related job. A robust job search, as identified in the number of years and hundreds of contacts, is more of an indicator of a specific individual being hired for the position."

She further reiterated that her opinion rendered in January 10, 2013, remained the same, that being that Mr. Segneri had performed a diligent and an exhaustive job search with no success and, therefore, was no longer a candidate for rehabilitation and that a stable labor market did not exist for him.

CONCLUSIONS OF LAW

In regard to (J) HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, the Arbitrator finds the following facts:

Having stipulated that the petitioner's condition of ill-being as causally related to the injury of February 2, 2009, the Arbitrator finds that the submitted charges of $118.90 from Rockford Health Physicians are causally related to the injury. These charges related to treatment rendered by Dr. Nowak, claimant's primary physician. Dr. Nowak is responsible for prescribing pain medication to Mr. Segneri for his shoulder pain. Based on this, the Arbitrator awards $118.90 in medical expenses under 8A subject to the workers' compensation fee schedule.

In regard to (L) WHAT IS THE NATURE AND EXTENT OF THE INJURY, the Arbitrator finds the following facts:

With regard to nature and extent, the Arbitrator incorporates the findings previously noted above. In addition, the Arbitrator notes that the parties both submitted additional evidence with regard to Petitioner's ability to return to work. Petitioner has proven by a preponderance of the evidence that he is entitled to a finding of permanent total disability under the odd-lot theory. An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify the payment of wages to him. A.M.T.C. of Illinois v. Industrial Comm'n, 77 Ill.2d 482, 397 N.E.2d 804 (1979). The Supreme Court has stressed, however, that the employee need not be reduced to total physical incapacity before a permanent disability award may be granted. Ceco Corp v. Industrial Comm'n, 95 Ill.2d 278, 447 N.E.2d 842 (1983). Rather, the employee must show that he is unable to perform services except those that are so limited in quantity, dependability, or quality that there is no reasonably stable market for them. Alano v. Industrial Comm'n, 282 Ill. App 3d 531, 668 N.E.2d 21 (1996).

The Claimant ordinary satisfies his burden of proving that he falls into the odd lot category in one of two ways: (1) by showing diligent but unsuccessful attempts to find work, or (2) by showing that because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market. Once the claimant establishes that he falls into the odd-lot category, the burden shifts to the employer to prove that the claimant is employable in a stable labor market and that such a market exists.

Clearly the Petitioner has met his burden on either prong of the odd-lot test. He has made a diligent work search both before the retention of Mr. Flanagan, during the 15 months that he worked with Mr. Flannigan, and in the 1¾ years after Mr. Flanagan closed his file. In addition to this diligent work search, Petitioner offered three reports from Ms. Susan Entenberg, a certified rehabilitation counselor. In her first report, Ms. Entenberg indicated that Mr. Segneri would be a candidate for vocational rehabilitation. She indicated that the market would be extremely limited and that the job search should be targeted to a few specific jobs. In her second and third reports, Ms. Entenberg indicated that the Petitioner was no longer a candidate for rehabilitation and that a stable labor market did not exist for him. She based this opinion primarily upon the extensive job search made by Mr. Segneri and the fact that he had not received any interview or job offers while performing that search.

Clearly the burden has shifted to the Respondent to show, by a preponderance of the evidence, that: (1) Petitioner is employable in a stable labor market and (2) that such a market exists. The first prong requires that Claimant be employable in a stable labor market. At the outset, the Arbitrator notes that Mr. Flanagan admitted that he did not have his complete file and that the exhibits offered did not contain all of the reports generated. In addition, he admitted that he did not have any of the job search logs that documented the jobs that Petitioner looked for or the results of these contacts. He did state that Mr. Segneri contacted at least 20 employers a week. Mr. Flanagan also agreed that Petitioner did not receive any interviews or job offer while they worked together. Finally, Mr. Flanagan made no effort to contact any employers in an attempt to open the door for Mr. Segneri to be employed. Based upon the extremely limited nature of Mr. Flanagan's effort, the Arbitrator assigns little weight to his opinion that Petitioner is employable in a stable labor market.

Respondent also apparently relies on two labor market surveys. The most recent survey was performed on March 21, 2013, which is the day after Flanagan's last meeting with Mr. Segneri. While this report shows that some, but not all, of the business were hiring, it does not demonstrate that Petitioner could actually perform the work with his existing restrictions, the shoulder brace, and the use of narcotic medications. In other words, the report lacks sufficient detail to prove that Mr. Segneri has the physical capabilities and the vocational background to perform the work. For example, the job at "Access2Care" indicates an available position as a "Medical Call Center Supervisor."

However, showing the oversimplification of a rather general labor market sampling, in actuality, there is no evidence anywhere that Petitioner has any experience in a call center and could perform the job. Therefore, the Arbitrator finds that Respondent has not proven that Claimant is capable of gainful employment in a readily stable job market.

Even assuming that Petitioner could actually perform the jobs identified in the survey, Respondent has not proven that such a market exists. The survey which seems to a minimalistic sampling of some job postings - only lists 13 jobs. This is less than the number of jobs that Petitioner contacted during one week of his job search. Clearly this sampling , couched as a "survey"does not constitute a statistically significant sample size to define the labor market.

Mr. Flanagan admitted he did not know the size of the sedentary labor market in the Rockford area. If Respondent had offered evidence of a monthly, or even a quarterly survey, the Arbitrator may have found some merit to its argument. But to rely on 13 jobs when Petitioner has contacted hundreds without success does not meet the required proof of a stable market that is currently available to Petitioner.

There was never any indication of Petitioner making an unsatisfactory search. In fact, Respondent's exhibit 10 shows a number of negative replies to jobs he had applied for in the medical field. The Arbitrator agrees with Ms. Entenberg's statement that the failure to obtain a job during a "robust" search that lasted for many years outweighed the probative value of a limited labor market survey. If there was a stable market available for Mr. Segneri, it must be assumed he would have been offered a job.

Therefore, the Arbitrator finds that Respondent via Encore has not met its burden;

Moreover, Mr. Segneri has proved by a preponderance of the evidence that he is permanently and totally disabled on an odd-lot basis.

The Arbitrator further finds that Petitioner became permanently and totally disabled on January 11, 2013, the day following the report from the second evaluation by CRC Entenberg and approximately 22 months after he began his job search.

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

Kent Burdine,

Petitioner,

vs.

NO: 11 WC 18897

University of Illinois at Chicago,

16IWCC0334

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 8, 2015 is hereby affirmed and adopted.

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

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

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

No bond or summons required for State of Illinois cases.

DATED: MAY 17 2016

MB/mam
o:4/21/16
43

Mario Basurto

David L. Gore

Joshua D. Luskin

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

BURDINE, KENT
Employee/Petitioner

Case# **11WC018897**

16IWCC0334

UNIVERSITY OF ILLINOIS AT CHICAGO
Employer/Respondent

On 8/28/2015, 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 0.20% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2208 CAPRON & AVGERINOS PC
STEPHEN SMALLING
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CHICAGO, IL 60603

1408 HEYL ROYSTER VOELKER & ALLEN
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ROCKFORD, IL 61101

0902 UNIVERSITY OF IL/CLAIMS MGMT
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CHICAGO, IL 60612

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

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

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

AUG 28 2015

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

16IWCC0334

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)

Kent Burdine
Employee/Petitioner

v.

University of Illinois at Chicago
Employer/Respondent

Case # **11** WC **018897**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **07-02-15**. 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. ☒ 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 _____

16IWCC0334

FINDINGS

On the date of accident, **04-02-11**, 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 $**36,428.08**; the average weekly wage was $**700.54**.

On the date of accident, Petitioner was **44** 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 $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

- Respondent to pay for all reasonable and necessary charges incurred with a surgical evaluation of Petitioner's right shoulder to assess his current need for surgery or other viable treatment options.

- Respondent shall pay all reasonable and necessary medical services to the Petitioner as contained in Petitioner's Exhibit 5 pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

- Respondent shall pay Petitioner temporary total disability benefits of $467.03 per week for 221 2/7 weeks commencing April 6, 2011 through July 2, 2015 as provided in Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

08-26-15
Date

ICArbDec19(b)

AUG 28 2015

ADDENDUM

KENT BURDINE V. UNIVERSITY OF ILLINOIS AT CHICAGO
I.C. NO.: 11 WC 018897

FINDINGS OF FACT

The Petitioner had been employed by the Respondent for over 20 years as a Transporter I in the patient transport department. He testified his primary duties involved assisting patients in and out of wheelchairs, beds and gurneys and moving them throughout the hospital. The Transporter's job duties are detailed in the job description contained in Respondent's Exhibit 3.

The Petitioner is right handed and testified that immediately prior to the subject accident, he had no medical conditions or restrictions which precluded him from performing his job duties with the Respondent. The Petitioner was obligated to report to University Health Services whenever an absence of three days or more was necessitated. (P.X. 1) Petitioner was involved in a motor vehicle accident in 2005 wherein he injured his low back and a diagnosis of tendonitis in the right shoulder was noted. Over the next three years he treated with Dr. Labanauskus primarily for the low back condition with no active treatment to the shoulder. (R.X. 8) On May 14, 2008, he was released to return to work with no restrictions attributable to his back or shoulder. (P.X. 1) The Petitioner testified that from May 14, 2008 through the date of the alleged accident, April 2, 2011 he sustained no injuries nor received treatment for any conditions related to his right arm or shoulder.

Petitioner testified that on April 2, 2011, he began to develop a sharp pain in his right shoulder after performing his usual and customary job duties for the Respondent. April 2nd was a Saturday and Petitioner testified he could not get in to see his family physician, Dr. Henry Lin until April 5, 2011. On that date, he presented with pain in the right shoulder with a history of

having pushed a patient and hurt his right shoulder on April 2, 2011. (P.X. 2) Dr. Lin diagnosed a strain of the right shoulder and prescribed medications.

Petitioner testified he was off work for the remainder of the week and returned on April 11, 2011. On that date, he notified the Respondent of the incident and completed the first report of injury/illness identified as Respondent's Exhibit 1. His supervisor, Grady Wheaton, Sr. completed a first report of injury on the same date identified as Respondent Exhibit 2. These documents contain histories that the Petitioner injured his right shoulder at work on April 2 but do not contain details surrounding the alleged accident.

On April 14, 2011, Petitioner was again examined by Dr. Lin with noted persistence of pain in the right shoulder as a result of which he was referred to an orthopedic specialist Dr. Pye.

On April 28, 2011, the Petitioner was first examined by Dr. Harold Pye who diagnosed a rotator cuff tear and arm strain and removed him from work through May 15, 2011. (P.X. 3) He prescribed a course of manual therapy and medications. On June 1, 2011, an MRI was performed of Petitioner's right shoulder revealing a full thickness tear of the distal supraspinatus at the humeral attachment. It is noted that the Petitioner had not undergone therapy to that point as he was waiting for approval from the Respondent. It was also noted he was probably going to need surgery. Given the positive finding on the MRI, Dr. Pye referred the Petitioner to Dr. Brash for a surgical consultation on June 6, 2011. Petitioner testified that he never received authorization to see Dr. Brash and has not undergone the surgery recommended by his treating physicians.

At the request of the Respondent, the Petitioner was examined by Dr. Jay Pomerance on October 25, 2011. Dr. Pomerance opined that the Petitioner's rotator cuff condition was degenerative in nature and there did not appear to be any specific work injury or single event that

arose out of the course of his employment. It was further noted the medical records documented shoulder complaints dating back many years and he was at risk for developing this condition due to his morbid obesity and diabetes. (R.X. 4)

At the direction of Petitioner's counsel, Petitioner was examined by Dr. Shane Nho on September 25, 2012. The history related was that the Petitioner noticed pain in his shoulder a couple of hours following the lifting of a patient from a hospital bed to a cart together with complaints of stiffness and achiness. After reviewing the ime report of Dr. Pomerance, Dr. Nho concurred that the Petitioner faced a number of risk factors for a torn rotator cuff including his work, diabetes and obesity however he was relatively young for a rotator cuff tear and that his occupation certainly could have contributed to it. (P.X. 4, x2)

Given the denial of the workers' compensation claim by the Respondent, Petitioner sought disability and medical benefits through State Universities Retirement System of Illinois which paid him approximately $1,000.00 per month through May of 2014 when the benefits were suspended. The Petitioner did receive unrelated medical care through that Retirement System but has not undergone the recommended surgery. In conjunction with receipt of those benefits, he was periodically examined by Dr. Rajneesh Salwan who continues to opine that he is completely disabled due to his right shoulder condition. (P.X. 6) The Petitioner testified that he has never returned to work since April 6, 2011, has sustained no other injuries to his right shoulder since April of 2011 and desires to undergo the surgery recommended by Dr. Pye.

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

The Petitioner testified that he was employed by the Respondent for over 20 years as a patient transporter. Medical records dating back to 2003 reveal he had no injuries or medical conditions for which he received treatment to his right shoulder. While a diagnosis of right shoulder tendonitis was noted by Dr. Labanauskus in 2005 when he treated Petitioner for a low back issue, his records reflect no treatment was rendered to the shoulder. (R.X. 8) Petitioner testified he had no treatment or medical conditions relative to his right shoulder between May 14, 2008, when tendinitis is noted in the shoulder, and the date of the accident.

Petitioner testified that on April 2, 2011, he was performing his regular job duties which required the moving of patients from wheelchairs to beds and other medical apparatus throughout his entire work day. Petitioner would lift patients weighing anywhere from 150 to 500 pounds. Grady Wheaton, Jr., the assistant director of materials management testified that a medical transporter would lift on average 50 to 75 pounds every day and it would not be unusual to move patients that weighed in excess of that amount up to 250 pounds. He did testify that it was rare that a patient would have to be moved who weighed in excess of 500 pounds. The job description tendered as Respondent Exhibit 2 addresses the general lifting requirements of the job and acknowledges that in an effort to minimize back strains, a properly sized lumbar belt or support will be provided to the transporter as part of their uniform.

Petitioner testified that towards the end of his work day on April 2, 2011, he began to experience pain in his right shoulder. The history contained in his physician's records immediately following the accident corroborate his testimony that he experienced pain after pushing a patient on April 2, 2011 per Dr. Lin's notes. (P.X. 2, 4/5/11 note) The arbitrator further acknowledges that the Petitioner had been seen in January and March of that year with no complaints of shoulder pain or symptoms noted therein. (P.X. 2)

The Petitioner timely reported the shoulder complaints to his supervisor which were documented in Respondent's Exhibits 1 and 2. Respondent's Health Service concurred that his shoulder condition necessitated the imposition of restrictions at that time. (P.X. 1)

There is no evidence that the Petitioner sustained any trauma or injuries to his right shoulder other than as described on April 2, 2011. For the foregoing reasons, the Arbitrator finds that an accident occurred that arose out of and in the course of Petitioner's employment by the Respondent.

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

Dr. Pomerance examined the Petitioner at the direction of the Respondent on October 25, 2011. (R.X. 4) He notes that the Petitioner reported on onset of right shoulder pain while at work but did not describe a specific incident of trauma. It was noted the symptoms arose on a weekend wherein the Petitioner worked on Saturday, April 2, 2011. Dr. Pomerance opined that the rotator cuff perforation identified in the MRI was degenerative in nature based upon the fact that there was no specific work injury or a single event and the medical records documented shoulder complaints dating back many years. He further noted that the Type III acromiom present in the Petitioner as well as an acromial spur have been associated with the development of degenerative rotator cuff tears.

Dr. Shane Nho, Petitioner's IME physician, conceded that the Petitioner's right shoulder condition could be related to something other than his work as a transporter given those factors enumerated by Dr. Pomerance. However, according to Dr. Nho's observation of the appearance of the tear on the MRI, it did not appear to be a degenerative type rotator cuff tear as alluded to by Dr. Pomerance. (P.X. 4, pg. 31-32) Dr. Nho testified that a diagnosis of right shoulder tendonitis, such as noted three years prior to the subject accident, was distinct from the diagnosis

of a torn rotator cuff. Dr. Nho further acknowledged that he had the opportunity to review the records of Dr. Lin and Dr. Pye, both of which contained a history that the Petitioner had noticed pain in his shoulder after performing his job duties with the Respondent on April 2, 2011. From personal knowledge, Dr. Nho acknowledged that a transporter lifts, pulls and pushes heavy patients throughout their work day and that if the Petitioner developed pain within hours of leaving his job, the timeframe would be consistent with his opinion as to causation. (P.X. 4, pg. 35)

Based on the foregoing, the arbitrator finds the opinions of Dr. Nho more credible than those of Dr. Pomerance. In so finding, the arbitrator acknowledges that Dr. Nho did not have the opportunity to review a description of the job as provided by the Respondent but concludes it does not negatively impact on his opinions. The doctor is intimately involved with the job duties of a medical transporter having working side by side with them in a hospital setting. Contrary to Dr. Pomerance's assertion, the evidence established that Petitioner had not in fact suffered from shoulder complaints for many years prior to the accident. The previous note of shoulder tendinitis was rendered at the time he was treating for a low back condition and there is no evidence his shoulder necessitated treatment or restricted him in any fashion prior to the subject accident. There is no evidence Petitioner experienced shoulder symptoms in the three year period preceding the onset of symptoms following the performance of his job duties with the Respondent on April 2, 2011. The arbitrator further finds the testimony of the Petitioner to be credible and the lack of a specific incident as alluded to by Dr. Pomerance is not a prerequisite to finding that the work activities performed by the Petitioner on April 2, 2011 were sufficient to be a cause of the shoulder condition necessitating the surgical recommendation. There is no

evidence contained in the record that the Petitioner sustained any further trauma to his right shoulder subsequent to the accident in question.

For the foregoing reasons, the arbitrator finds that the Petitioner's current condition of ill-being is causally connected to the injury.

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

The medical evidence has established that the Petitioner suffers from a torn rotator cuff in his right shoulder. He was examined by his family physician Dr. Lin (P.X. 2) who referred him to Dr. Harold Pye, an orthopedic physician. (P.X. 3) Dr. Pye in turn prescribed physical therapy and ultimately a referral to Dr. Brash for a surgical consultation. The surgical consultation was not authorized by the Respondent. Dr. Pomerance, Respondent's independent medical examiner, opined that standard and customary treatment for rotator cuff perforation is initially non-surgical with structured therapy and judicious use of subacromial steroid injections. If non-operative management fails to resolve the symptoms, then surgery would be necessitated. (R.X. 4) Dr. Nho, Petitioner's examining physician, concurred that a trial subacromial cortisone injection was indicated given his failure to respond to oral anti-inflammatories and therapy. No physician has opined that the treatment received to date was unnecessary or unreasonable.

Petitioner's Exhibit 5 consists of medical expenses incurred with his treatment for the subject injuries. The arbitrator finds these charges were reasonable and necessary to treat the subject injuries.

Based on the foregoing, Respondent shall pay to the Petitioner all reasonable and necessary medical charges as contained in Petitioner's Exhibit 5 pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

In support of the Arbitrator's decision relating to ("K"), is Petitioner entitled to prospective medical care, the Arbitrator finds the following facts:

The medical evidence has established that the Petitioner sustained a torn rotator cuff in his right shoulder. At the time his initial treatment was terminated, Petitioner had a recommendation for a surgical evaluation to be performed by Dr. Brash. Respondent's independent medical examiner, Dr. Pomerance and Petitioner's independent examiner Dr. Nho both concurred that surgery is the next viable treatment following an unsuccessful course of conservative treatment consisting of therapy and injections.

Having found that the Petitioner's current condition of ill-being is causally related to the subject injury, the arbitrator hereby orders the Respondent to pay for all reasonable and necessary charges incurred with a surgical evaluation of Petitioner's right shoulder to assess his current need for surgery or other viable treatment options given the length of time which has transpired since his last examination.

In support of the Arbitrator's decision relating to ("L"), what temporary benefits are in dispute, the Arbitrator finds the following facts:

Following the subject accident, the Petitioner was examined by Dr. Henry Lin who in turn referred the Petitioner to Dr. Harold Pye. Both of these physicians restricted the Petitioner from returning to his regular duties with the Respondent. (P.Xs. 2, 3)

In accordance with the Respondent's procedures, the Petitioner was examined by University Health Services on April 11, 2011. The examining physician in turn imposed restrictions and modified duty which was not accommodated by the Respondent. (P.X. 1)

Petitioner testified that he has not returned to work since April 6, 2011. Petitioner did receive non-occupational benefits pursuant to the State University's Retirement System necessitating periodic evaluations by Dr. Rajneesh Salwan to confirm his inability to return to work. As of September 5, 2014, the Petitioner remained off work under Dr. Salwan's recommendation and was deemed to be disabled in accordance with that State University's Retirement program. Grady Wheaton Jr, the head of the Transport Department appeared on behalf of the Respondent but offered no testimony that a light duty position was extended to the Petitioner nor that he has returned to work in any capacity since April 6, 2011. The medical evidence has further established that the Petitioner has yet to reach maximum medical improvement and pursuant to Interstate Scaffolding, is deemed to be temporarily totally disabled under the Act.

For the foregoing reasons, Respondent shall pay Petitioner temporary total disability benefits of $467.03 per week for 221 2/7 weeks commencing April 6, 2011 through July 2, 2015 as provided in Section 8(a) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Luis Villegas,

Petitioner,

vs.

NO: 11 WC 24989

16IWCC0335

Kelley's Truck Center and Illinois State Treasurer as Ex-Officio Custodian of the Injured Workers' Benefit Fund,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 9, 2014, 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.

16IWCC0335

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $23,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
TJT:yl
o 5/10/16
51

MAY 17 2016

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VILLEGAS, LUIS
Employee/Petitioner

Case# **11WC024989**

KELLEY'S TRUCK CENTER AND ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

16IWCC0335

On 12/9/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

0206 GAINES & GAINES
GEORGE L GAINES
PO BOX 6345
EVANSTON, IL 60202

0000 KELLEY'S TRUCK CENTER
4825 W LAKE ST
MELROSE PARK, IL 60160

4928 ASSISTANT ATTORNEY GENERAL
RAFAL DOBEK
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

16IWCC0335

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

LUIS VILLEGAS
Employee/Petitioner

Case #11 WC 24989

v.

KELLEY'S TRUCK CENTER AND
ILLINOIS STATE TREASURER
AS EX-OFFICIO CUSTODIAN OF THE
INJURED WORKERS' BENEFIT FUND
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on November 17, 2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☒ Was there an employee-employer relationship?

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

D. ☒ What was the date of the accident?

E. ☒ Was timely notice of the accident given to the respondent?

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

G. ☒ What were the petitioner's earnings?

H. ☒ What was the petitioner's age at the time of the accident?

I. ☒ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☒ TPD ☒ Maintenance ☒ TTD?

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

M. ☒ Should penalties or fees be imposed upon the respondent?

N. ☒ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- This claim was on file for more than three years when it appeared on the November 2, 2014, status call and received a trial date of November 17, 2014. Respondent Kelley's Truck Center failed to appear by its officers or a representative at the status call or on November 17, 2014. The petitioner presented evidence of a notice on August 21, 2014, of the November 7, 2014, hearing date, time and location to respondent Kelley's Truck Center to their last known address at 4825 W Lake Street, Melrose Park, IL 60160 via regular and certified U.S. Mail.

- The petitioner received certified records from NCCI revealing no workers' compensation insurance coverage for respondent Kelley's Truck Center from January 28, 2011, through February 26, 2013.

- Respondent Injured Workers' Benefit Fund Illinois through the State Treasurer, the *ex-officio* custodian of the Injured Workers' Benefit Fund, was represented by the Illinois Attorney General's office.

- Respondent Kelley's Truck Center did not appear or request a continuance and the petitioner moved to proceed *ex parte* against respondent Kelley's Truck Center, which was granted.

- The petitioner testified that he received $514.00 per week from the respondent Kelley's Truck Center for three months after his injury, totalling $6,682.00.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $400.00/week for 29-1/7 weeks, from February 24, 2011, through September 15, 2011, which is the period of temporary total disability for which compensation is payable.

- The respondent shall pay the petitioner the sum of $360.00/week for a further period of 50.6 weeks, as provided in Section 8(e) of the Act, because the injuries sustained

caused the permanent partial disability to petitioner to the extent of 20% loss of use of his right arm.

- The respondent shall pay the petitioner compensation that has accrued from February 23, 2011, through November 17, 2014, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner for his right arm through September 15, 2011, was reasonable and necessary and is awarded. The medical care rendered the petitioner for his right arm after September 15, 2011, was not related to his work injury on February 23, 2011, and is denied. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- An award is hereby entered against the Injured Workers' Benefit Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of respondent-employer to pay the benefits due and owing the petitioner. The respondent Kelley's Truck Center shall reimburse the Injured Workers' Benefit Fund for any compensation obligations that are paid to the petitioner from the Injured Workers' Benefit Fund.

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

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

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

Robert E. Williams

Signature of Arbitrator

December 9, 2014

Date

DEC 9 - 2014

FINDINGS OF FACTS:

On February 23, 2011, the petitioner sought emergency care at Elmhurst Memorial Hospital for right arm pain. The physician's diagnosis was a biceps muscle strain. The petitioner was allowed to return to work with restrictions. X-rays of his elbow and humerus were normal. Dr. Vitale saw the petitioner on March 1st and found a retracted right biceps cephalad and a normal right shoulder and wrist. His diagnosis was ruptured right biceps. Dr. Tu's impression after his evaluation of the petitioner on March 3rd was a rupture of tendons of biceps. He released the petitioner to restricted work. An MRI on March 9th revealed a complete tear of the distal biceps tendon and retraction. On March 18th, Dr. Tu performed a right distal biceps reattachment. Physical therapy was started on March 31st.

On April 21st, Dr. Tu released the petitioner to restricted work. The petitioner followed up periodically with Dr. Tu and continued physical therapy and home exercises through September 14, 2011. On September 15th, Dr. Tu noted that the petitioner had no deficits, 5/5 supination and flexion and 0-135 ROM. He released the petitioner for work without restrictions.

The petitioner saw Dr. Singh on December 12th for right arm pain. An x-ray of his right shoulder showed degenerative changes in his AC joint and cortical irregularity, associated lytic/lucent lesions and a large homogeneous bone density in his right proximal humerus. A CT on February 8, 2012, showed findings consistent with chronic osteomyelitis within the proximal humeral diaphysis. An MRI on February 24th revealed a partial supraspinatus tear, a benign appearing cortical defect in the proximal humeral

diaphysis and mild acromioclavicular joint osteoarthritis. On March 6th and May 8th, the assessment at Cook County Hospital was chronic osteomyelitis.

FINDING REGARDING WHETHER RESPONDENT KELLEY'S TRUCK CENTER WAS OPERATING UNDER AND SUBJECT TO THE WORKERS' COMPENSATION ACT:

Based upon the evidence presented, the respondent Kelley's Truck Center was operating under and subject to the provision of Section 3, paragraph 15 of the Workers' Compensation Act. Respondent Kelley's Truck Center was a towing operation and utilized power-driven tools, hoists and other equipment.

FINDING REGARDING WHETHER THERE WAS AN EMPLOYER/EMPLOYEE RELATIONSHIP BETWEEN THE PARTIES:

An employer/employee relationship existed between the petitioner and the respondent Kelley's Truck Center on February 23, 2011. The petitioner testified that he was employed as a diesel mechanic by respondent Kelley's Truck Center. He worked forty hours/five days a week from 8 a.m. to 5 p.m. repairing trucks and buses. His supervisor was Mohammed, who assigned him written daily tasks with the amount of time required for completion of the task.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner proved that he sustained an accident on February 23, 2011, arising out of and in the course of his employment with the respondent Kelley's Truck Center. Mohammed ordered the petitioner to empty a garbage container on February 23, 2011. The petitioner felt pain in his right arm and heard popping sounds when he lifted the container over his head.

FINDINGS REGARDING WHETHER TIMELY NOTICE WAS GIVEN TO THE RESPONDENT:

The petitioner's supervisor, Mohammed, was notified of his injury immediately on February 23, 2011. The respondent Kelley's Truck Center received timely notice of the petitioner's injury.

FINDING REGARDING THE AMOUNT OF WAGES:

Based on the petitioner's testimony, the petitioner earned $15 per hour and worked forty hours per week during his three months of employment. His average weekly wage was $600.00.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for his right biceps tendon rupture through September 15, 2011, was reasonable and necessary and is awarded. The medical care rendered the petitioner for his right arm after September 15, 2011, was not related to his work injury on February 23, 2011, and is denied. The petitioner's right shoulder was normal when evaluated on March 1, 2011. Moreover, there were no deficits or difficulties with supination, flexion or range of motion when he was discharged on September 15, 2011. The treatment the petitioner received from Dr. Singh and at Cook County Hospital was for the chronic osteomyelitis in his right shoulder. His chronic osteomyelitis was not related to the rupture of his right biceps tendons on February 23, 2011.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that his current condition of ill-being with his right biceps tendons is causally related to the work injury. The petitioner failed to prove that his current condition of ill-being with the

chronic osteomyelitis in his right arm is causally related to the work injury. The petitioner's right shoulder was normal when Dr. Vitale evaluated him on March 1, 2011. Moreover, the petitioner had no deficits, 5/5 supination and flexion and 0-135 range of motion on September 15, 2011, and was released to unrestricted work.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

On April 21, 2011, the petitioner was released to restricted work but was not accommodated by respondent Kelley's Truck Center. He was released to unrestricted work on September 15, 2011. The petitioner was temporarily totally disabled from February 24, 2011, through the date of his release to unrestricted work by Dr. Tu on September 15, 2011. The respondent Kelley's Truck Center shall pay the petitioner temporary total disability benefits of $400.00/week for 29-1/7 weeks, from February 24, 2011, through September 15, 2011, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner failed to prove that he is obviously incapable of employment or that he cannot perform any services except those which are so limited in quantity, dependability or quality that there is no reasonably stable labor market for them. The petitioner can perform some form of employment without seriously endangering his health or life, but failed to prove that he conducted a genuine and diligent search for employment.

The petitioner's handwritten job-search log indicates that he conducted a job search after his release to unrestricted work on September 15, 2011, through July 30, 2012. The petitioner's job log of 75 to 100 employers for that period reveals only a

perfunctory effort and is not a convincing job search effort. His efforts were not focused on employers seeking workers and there is no evidence of the position sought or of any qualifications or physical requirements. The petitioner did not conduct a genuine job search. There are employment opportunities available to the petitioner. The employment opportunities available to the petitioner are not limited and there is a reasonably stable labor market for him.

The petitioner complains that he can't do the duties of a labor mechanic and that his arm hurts with twisting movements and overhead lifting. The respondent Kelley's Truck Center shall pay the petitioner the sum of $360.00/week for a further period of 50.6 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 20% loss of use of his right arm.

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ABEL PONCE,	)	
	)	
Petitioner	)	
	)	
	)	No. 11WC 35631
	)	
	)	
CLASSIC PARTY RENTALS	)	
	)	
Respondent.	)	

ORDER

This matter comes before the Commission on a petition for attorney fees filed by the DePaolo, Zadeikis & Gore Firm (Mark A. DePaolo, formerly of Kenneth P. Gore, Ltd. law firm) for legal services rendered to Abel Ponce by Attorney DePaolo commencing September 15, 2011 through July 31, 2013. Lulay Law Offices substituted in as successor attorneys on July 31, 2013. On March 17, 2015 Lulay Law Offices presented and the arbitrator approved a settlement contract resulting in a fee of $4,487.58. Hearing on the distribution of the fee was reserved to a later date and due notice was given. Having reviewed the complete hearing transcript and the pleadings filed on behalf of both parties the Commission equally apportions the attorney fees in this matter between Mark DePaolo and successor attorneys, Lulay Law Offices, for the reasons that follow.

In the Affidavit filed by Attorney DePaolo, signed and sworn March 17, 2015 he purports to "conservatively" reconstruct 10.55 hours of time spent in the preparation and prosecution of petitioner Ponce's case against respondent Classic Party Rentals. At hearing Attorney DePaolo was extensively examined by his counsel and cross-examined by respondent Attorney Lulay. The Commission notes that Attorney DePaolo was frustrated in his ability to move the case forward by a delay in arbitrator reassignment after Arbitrator Brian Cronin recused himself from the case due to being related to a partner in the law firm that represented respondent in the underlying case. The matter was eventually assigned to Arbitrator Lynette Thompson-Smith.

Attorney Lulay defends against the fee petition asserting that no value or benefit inured to petitioner Ponce as the result of Attorney DePaolo's representation and that therefore his fee petition is without merit. Nevertheless, by June 7, 2013 Attorney DePaolo had moved the matter forward to the point where respondent's counsel in the underlying matter wrote to Attorney DePaolo soliciting a settlement demand in hopes of resolving the claim.

Lulay Law Offices filed their substitution of attorneys and undertook professional responsibility for the file on July 31, 2013. The underlying case was settled 20 months later on March 17, 2015.

Having carefully reviewed the pleadings, the transcript of hearing on the fee petition conducted April 20, 2015, and the exhibits admitted into evidence, it appears that Attorney DePaolo and Attorney Lulay spent approximately the same amount of time in the matter.

IT IS THEREFORE ORDERED BY THE COMMISSION that Lulay Law Offices shall pay to DePaolo, Zedeikis & Gore the sum of $2,243.79 representing half of the attorney fees received in this matter.

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

DATED: MAY 2 7 2016
SM/msb
44

Stephen J. Mathis

Maria Basurto

David L. Gore

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eugene Lippold,
Petitioner,

vs.
Eugene Lippold Construction Co.,
Respondent,

NO: 11 WC 40276

16IWCC0304

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 8, 2015 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 $16,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 6 – 2016

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:4/7/16
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LIPPOLD, EUGENE
Employee/Petitioner

Case# 11WC040276

16IWCC0304

EUGENE LIPPOLD CONSTRUCTION CO
Employer/Respondent

On 9/8/2015, 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 0.27% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICES
LESLIE COLLINS
PO BOX 99
EAST ALTON, IL 62024

1337 KNELL LAW LLC
MATT BREWER
504 FAYETTE ST
PEORIA, IL 61603

16IWCC0304

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

EUGENE LIPPOLD,
Employee/Petitioner

v.

EUGENE LIPPOLD CONSTRUCTION,CO.,
Employer/Respondent

Case # 11 WC 40276

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **7/28/15**. 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 _____

FINDINGS

On **6/8/11**, 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 as it relates to his right and left hand ***is*** causally related to the accident. Petitioner's current condition of ill-being as it relates to his cervical spine ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**106,600.00**; the average weekly wage was $**2,050.00**.

On the date of accident, Petitioner was **71** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**00.00**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

Petitioner's claim for temporary total disability benefits is denied.

Respondent shall pay reasonable and necessary medical services related to petitioner's right hand and left hand from 6/8/11 through 7/28/15, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner permanent partial disability benefits of $669.64/week for 24.6 weeks, because the injuries sustained caused the 2% loss of the right hand, and 10% loss of the left hand, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

8/24/15
Date

ICArbDec p. 2

SEP 8 - 2015

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 71 year old owner of Lippold Construction, sustained an accidental injury that arose out of and in the course of his employment with Lippold Construction on 6/8/11. A dispute exists as to whether or not petitioner sustained an accidental injury to his cervical spine that arose out of and in the course of his employment by respondent on 6/8/11. Respondent stipulates the petitioner sustained an injury to his right and left hand.

Prior to petitioner's injury on 6/8/11 petitioner underwent some treatment for his cervical spine. On 11/18/08 petitioner presented to Dr. Williams with complaints of bilateral shoulder pain, left worse than right. He stated that he had had injections into the left shoulder two years ago and they provided a significant amount of relief. He also had three injections into the left shoulder recently. X-rays of the left shoulder showed a type III acromion, AC joint arthritis, and mild amount of arthritis of the glenohumeral joint. Three views of the cervical spine showed significant degenerative changes at the each level, worst at C5 – C6. Also noted was a very large interior osteophyte. On 12/3/08 petitioner was assessed with left shoulder pain with chronic rotator cuff tear involving at least the supraspinatus and part of the infraspinatus, and significant AC joint arthritis. On the right side, he also had a rotator cuff arthropathy, long-standing. A left shoulder arthroscopy was recommended.

Following his left shoulder arthroscopy, petitioner presented to Dr. Maender on 1/5/09. He stated that immediately after surgery his pain was much better. On 9/9/09 petitioner reported to Dr. Williams complaints of pain in the axial cervical spine, and between his shoulder blades, as well as occasional pain in his upper extremities. X-rays of the cervical spine showed degenerative changes throughout the cervical spine, and a rather large osteophyte at C4 – C5. Petitioner was assessed with chronic axial neck pain, questionable cervical radiculopathy, and cervical spondylosis. On 9/21/09 petitioner underwent an MRI of the cervical spine for complaints of neck pain radiating to the shoulder, and for headaches. The impression was degenerative changes with canal stenosis most prominent at C3 – C4. Findings were also suggestive of postoperative changes at C5 – C6, and fusion or non-segmentation of C6-C7. On 10/6/09 petitioner returned to Dr. Williams. Petitioner reported that he had a shoulder arthroscopy in early 2009, after which he had tremendous improvement in his pain. He complained of occasional numbness and tingling in his hands and occasional pain down the upper extremities. Dr. Williams assessed chronic axial neck pain, C3 – C4 spinal stenosis, C3 – C4, and C4 – C5 degenerative disc disease. He noted questionable cervical myelopathy.

On 6/8/11 petitioner slipped and fell down steps. He testified that when he was falling he twisted his body to avoid hitting his head on a truck that was in front of him. Petitioner stated he fell on the ground and rolled on the rocks.

After the accident petitioner presented to the emergency room at a Carlinville Area Hospital. He gave a history of missing the last step and falling into the rocks. He complained of left forearm/wrist pain and a laceration to his right palm. An examination revealed a jagged laceration in petitioner's right palm. The laceration and petitioner's right palm was sutured with 6 stitches. Petitioner also sustained a fracture to the left distal radius and ulnar styloid. A splint was applied to petitioner's left wrist. Petitioner was given a prescription for Vicodin and discharged from care. No complaints were made regarding his head or neck.

On 6/10/11 petitioner presented to Dr. Wolters for his left hand injury. Dr. Wolters assessed a left wrist fracture involving the radius and ulna. On 6/15/11 Dr. Wolters assessed a left closed distal radial and ulnar styloid fracture with some dorsal angulation. Dr. Wolters recommended conservative measures. He continued petitioner in his current splint for two more weeks. Petitioner continued to follow up with Dr. Wolters.

On 7/13/11 petitioner presented to Dr. Gary, his chiropractor. Petitioner admitted that he had treated with Dr. Gary for his lumbar and cervical spine prior to 6/8/11. Petitioner reported that his low back hurt mainly on the right side due to a fall. He also complained of neck pain and rated it as 6/10, bilaterally. Petitioner told Dr. Gary that he did not feel right from his left temple to his right occipital area. He complained of frontal headaches. He gave a history of falling down 2 to 3 steps that had wet lime on them. He stated that he fell forward and fractured his wrist. He rated his right lumbar pain as a 5/10. Dr. Gray performed some ultrasound to petitioner's left and right cervical area, mainly the right.

On 7/15/11 Dr. Gray noted that petitioner's right posterolateral cervical area appeared mildly swollen with increased pain on palpation of C4-C5, C5-C6, and C6-C7, and the facet areas. Petitioner reported trapezius pain mainly on the right from the occipital area to the right shoulders. On 7/18/11 petitioner reported that his headaches were persisting with visual differences. Dr. Gray referred petitioner to his family physician. Petitioner reported that his right neck was more sore than his left neck. On 7/20/11 petitioner stated that the soreness in his cervical spine persisted. He reported no improvement in his condition. On 7/27/11 petitioner told Dr. Gray that his head was not feeling right since the accident. He also reported some right cervical soreness. The pain in his cervical spine remained unchanged.

On 8/2/11 petitioner underwent an MRI of his cervical spine for neck pain and hand pain. Petitioner reported that he fell 5 weeks ago. The impression was mild worsening of severe left neural foramina stenosis at

C4–C5 since the previous exam on 9/21/09. Otherwise, the impression was stable mild central spinal canal stenosis at C3–C4. Petitioner also underwent x-rays of the cervical spine that revealed advanced cervical facet arthropathy and advanced degenerative changes, predominantly at C5–C6, and C6–C7. A fusion at C6–C7 was also noted, as well as a large bridging osteophyte at C5–C6 anteriorly.

On 8/5/11 petitioner told Dr. Gray that he felt his head was slowly getting worse. Dr. Gray again advised petitioner to see his primary care physician. Petitioner stated that his cervical pain was relatively constant. On 8/8/11 Dr. Williams assessed chronic axial neck pain, acute exacerbation of chronic axial neck pain, right upper extremity radicular symptoms, C3-C4 moderate canal stenosis, C4–C5 moderate to severe bilateral foraminal stenosis, and cervical degenerative disc disease at multi-levels, as the result of a fall eight weeks ago.

On 8/19/11 petitioner underwent a brain MRI for his frontal and occipital headaches. There were no acute intracranial abnormalities noted. Also noted was a small vessel disease.

On 9/9/11 petitioner underwent an EMG of the upper extremities secondary to pain and parathesias that he has had in his neck since a fall that occurred in June. He gave a history of walking up some steps, slipping and falling with his arms outstretched. He reported that since that time he had been complaining of neck pain and shooting pain in the right upper extremity. Petitioner stated that his arm pain comes on when he does any type of cervical neck range of motion. The impression was evidence of a subacute right upper extremity C5–C6 cervical radiculopathy, and chronic bilateral upper extremity C5 and C7 cervical radiculopathy. These findings were consistent with cervical spinal stenosis. Evidence of a severe right upper extremity median and ulnar neuropathy, consistent with a severe large fiber generalized polyneuropathy, and consistent with the petitioner's history of diabetes, was noted.

On 9/20/11 petitioner followed up with Dr. Wolters for his left wrist. He reported that he was about 50% better. He reported constant pain in the wrist and some weakness and tingling in the wrist. Dr. Wolters recommended occupational therapy.

On 9/23/11 petitioner returned to Dr. Williams. Dr. Williams was of the opinion that petitioner had multilevel degenerative changes in the cervical spine. He also noted that petitioner had cervical spinal stenosis that was moderate at C3–C4. He noted that the pain in petitioner's right upper extremity was consistent with cervical radiculopathy, but also carpal tunnel syndrome. He noted that petitioner had a laceration as a result of the fall, right at the area of the carpal tunnel on the right. Dr. Williams stated that both a carpal tunnel syndrome and cervical radiculopathy could be causing his symptoms. He noted that petitioner's multi-level degenerative changes with the disc herniation present at C3–C4 resulted in spinal stenosis. He also noted that since petitioner

has been an insulin-dependent diabetic since 1976, peripheral diabetic neuropathy must be entertained. Dr. Williams ordered occupational therapy for petitioner's carpal tunnel.

On 11/1/11 petitioner returned for follow-up of his left wrist with Dr. Wolters. He stated that he was still painful. He stated that he was wearing his brace intermittently. He denied any numbness or tingling. Petitioner had about 40° of dorsiflexion and palmar flexion of the left wrist, mild tenderness over the TFCC, minimal tenderness over the radius and ulna distally, and a congenital deformity of his hand on the left side. Dr. Wolters recommended continued conservative therapy including occupational therapy.

On 11/11/11 petitioner presented to Dr. Williams for his axial neck pain. Dr. Williams assessed cervical spondylosis and moderate cervical spinal stenosis. He was of the opinion that he could not explain petitioner's atypical symptoms in the head. He also did not feel that the cervical stenosis was severe enough that it would cause headaches. Dr. Williams did not note any acute findings on the cervical MRI, but noted that they all appeared to be age related degenerative changes. He referred petitioner to a neurologist. Petitioner continued to follow up with Dr. Williams for his cervical spine.

Petitioner followed up with Dr. Gray on 14 occasions through 11/21/11. Dr. Gray continued to treat petitioner's cervical spine. On 8/19/11 petitioner's range of motion had improved and his pain level had decreased slightly. On 8/29/11 petitioner related that his neck felt stiff. He continued to complain of ear and eye pressure, as well as lumbar spine pain. On 9/14/11 Dr. Gray assessed chronic cervical strain. On 10/5/11 petitioner's cervical pain was reduced to a 4/5 on a scale of 10. Petitioner's ear and eye pain and pressure continued. On 10/17/11 petitioner continued with cervical facet area pain on the right at C4-C5 and C5-C6. On 11/21/11 Dr. Gary advised petitioner to see his doctor regarding further treatment of his right cervical area. Dr. Gray was of the opinion that petitioner had reached maximum medical improvement as far as chiropractic care was concerned.

On 11/3/11 petitioner presented to Dr. Richard Bass for complaints of ear pressure, ringing in the ears, and unstableness. Petitioner gave a history of going down some steps and slipping on a slippery pavement and hitting his head on a rock and twisting his body in June 2011. Petitioner reported that he hit the back of his head on the rocks. He stated that he needed stitches in his right hand and had a fractured wrist on the left side. Petitioner complained of discomfort and pressure in his ears, pressure in his temples, pressure in his forehead, a neck ache, and shoulder aches since the time of the accident. Dr. Bass noted that petitioner had a long-standing history of hearing loss, and told him he developed tinnitus bilaterally after the accident. Dr. Bass examined petitioner and his impression was referred otalgia to the muscle spasms in his neck from his trauma.

On 11/22/11 petitioner presented to Dr. Richard Katz for a Section 12 examination, at the request of the respondent. Petitioner gave a history of the descending some steps, slipping and falling forward during a business meeting in Alton, Illinois. He stated that he fell forward, but then twisted backwards striking the back of his head on some rocks. He had left wrist pain and a right wrist laceration. Radiographs confirmed left distal radial and ulnar fractures. Petitioner's present issues included neck pain 24 hours a day, at a severity of 9 on a scale of 10. With respect to his left wrist fracture, petitioner reported that there was a full fracture that was now healing. Dr. Katz noted that in petitioner's past medical history he had chronic axial neck pain. Following a record review, physical examination and neurological examination Dr. Katz's impression was that petitioner's primary diagnosis was early Parkinson's disease. He was also the opinion that petitioner had diffuse and marked stenosis and degeneration in his neck and low back, that were old. He did not believe that petitioner had significant radiculopathy or spinal stenosis. He indicated that he was against surgery for petitioner's neck as it would be multi-level, complex, and high risk. He indicated that petitioner did not wish to undergo any surgery. Dr. Katz was of the opinion that petitioner's EMG/NCS results complicate the picture since petitioner had a diffuse peripheral neuropathy which had likely worsened significantly since the pre-fall EMG of 3/14/06. Dr. Katz was of the opinion that this was likely the main contributor to petitioner's focal neuropathies. Dr. Katz opined that the diagnosis of ulnar and median neuropathy were complicated by petitioner's diffuse peripheral neuropathy, but he did not believe that these were related to the fall. Dr. Katz opined that the wrist fracture had mostly healed, and the small ulnar styloid fragment would continue to heal with time. He opined that petitioner had reached MMI with regards to this. Dr. Katz had no explanation for petitioner's visual disturbances, and suggested that petitioner undergo an ophthalmological evaluation. Dr. Katz believed petitioner had reached MMI with regards to the fall. He did not believe petitioner should return to heavy machinery operation, with the primary reason being his suspected Parkinson's disease.

On 12/15/11 petitioner underwent CT scan of the brain. It was compared to a CT scan of the brain done 12/11/09. Nothing acute was noted. Mild atrophy in white matter ischemic changes were noted.

On 12/19/11 petitioner presented to Dr. Omar, at the SIU Neurology Clinic. On his intake form petitioner stated that he last worked on 6/15/11 after breaking his left wrist, getting six stitches in his right hand, and sustaining neck and back pain. Petitioner reported that on 6/15/11 he missed a step, fell down the steps, and fell to the ground. His chief problems were identified as his neck, head and hands.

On 12/29/11 petitioner presented to Dr. Williams and stated that after being recently discharged from Memorial Medical Center on 12/19/11 he fell between two cars and sustained an injury to his right hand that

was diagnosed as a fracture of the fifth metacarpal. This injury is unrelated to petitioner's work accident. Petitioner treated for this injury with Dr. Williams.

On 1/31/12 petitioner followed up with Dr. Omar. Petitioner stated that he fell and hit the back of his head, and twisted his neck and shoulder and upper extremities in July 2011. He stated that ever since then he has been having severe neck pain and stiffness, as well occipital headaches radiating to the sides of the head. Dr. Omar was of the opinion that the left neuroforaminal stenosis which was severe on C4–C5 and C3–C4, and spinal canal stenosis, were unchanged from a prior exam. He noted that the left neuroforaminal stenosis at C4 – C5 was more pronounced. Dr. Omar was of the opinion that petitioner's neck pain seemed to be consistent with cervical radiculopathy, and perhaps related to a soft tissue injury related to the fall, as well as occipital neuralgia and muscle stiffness. Dr. Omar started petitioner on gabapentin.

On 2/27/12 petitioner returned to Dr. Omar for follow-up of his neck pain radiating to the head. Petitioner reported significant improvement in his pain. Dr. Omar was of the opinion that petitioner may want to consider the option of an occipital nerve block.

On 4/24/12 petitioner followed up with Dr. Omar for his bilateral occipital neuralgia, and cervical radiculopathy. Petitioner reported that he was significantly improved after undergoing a bilateral greater submittal nerve block two weeks ago.

On 3/8/13 petitioner underwent an MRI of the cervical spine. It was compared to an MRI done on 8/2/11. The impression was moderate to severe degenerative central spinal canal stenosis at C3–C4 from endplate osteophyte in combination with thickening of the ligamentum flavum. Moderate to severe degenerative right neural foramina stenosis was noted. On 3/18/13 petitioner followed up with Dr. Williams. Having failed conservative treatment, Dr. Williams discussed with petitioner an anterior cervical discectomy and fusion at C3–C4.

On 4/18/13 petitioner underwent an anterior cervical discectomy and fusion at C3–C4. This procedure was performed by Dr. Williams. Petitioner's postoperative diagnosis was C3–C4 severe cervical spinal stenosis; C3–C4 severe degenerative disc disease; C3–C4 disc herniation; chronic axial neck pain; cervicogenic headaches; chronic cervical radiculopathy; and cervical spondylosis. Petitioner followed-up postoperatively with Dr. Williams. This postoperative treatment included physical therapy. Petitioner treated with Dr. Williams through 10/4/13. At that time petitioner was doing fine, and did not have any complaints in regards to the cervical spine.

On 10/8/13 the evidence deposition of Dr. Williams was taken on behalf of petitioner. Dr. Williams is an orthopedic surgeon. Dr. Williams opined that he told petitioner that his symptoms like headaches, pressure, visual changes were a result of his cervical spine and the stenosis that was present. During the deposition Mr. Galanti, petitioner's attorney, stipulated that petitioner's visual changes were not related to the injury on 6/8/11. Dr. Williams opined that none of his records indicate that he made any recommendations to hold petitioner off from work for any period of time. Dr. Williams opined that assuming the fall described by petitioner actually occurred on 6/8/11 in that manner he described, that his neck issues appeared to be the result of the fall. Dr. Williams opined that petitioner was probably nearing maximal medical improvement with respect to the cervical spine on the date of his deposition.

On cross-examination Dr. Williams opined that petitioner's cervical spine was in a better condition when he saw him on 10/4/13 that it was when he first saw him back in 2011. He also opined that there did not seem to be any anticipated permanent disability to petitioner's cervical neck as a result of the surgery performed. Dr. Williams opined that petitioner's ability to function with respect to the movement of his neck, increased significantly after the surgery. Dr. Williams opined that he had never taken petitioner off work. Dr. Williams opined that petitioner's C3–C4 severe cervical spinal stenosis could've preexisted his accident on 6/8/11. He further opined that petitioner's C3–C4 severe degenerative disc disease did preexist the injury on 6/8/11. Dr. Williams opined that his causal connection between petitioner's neck condition and the injury on 6/8/11 was based in part on the assumption that petitioner did not have any neck complaints predating the injury on 6/8/11. He further opined that if petitioner had cervical complaints, chronic neck pain, and radiculopathy, chronic axial pain, headaches, and spinal stenosis prior to the injury that could change his causal connection opinion. Dr. Williams opined that after seeing petitioner on 11/11/11 he did not treat petitioner again until 2013. He was of the opinion that if during this period petitioner was doing any activity that had increased complaints to his neck, those activities could have aggravated his neck to the point where he saw him in 2013. Dr. Williams opined that the cervical MRI taken after the accident did not show any acute findings. Dr. Williams opined that cervical spondylosis is a progressive disease that on its own could worsen to the point that one could have complaints of cervical radiculopathy that could lead to the need for surgery without trauma. Dr. Williams was also of the opinion that if someone smokes and has a diagnosis of spondylosis, that can lead to the point where he would perform the surgery he did, absent trauma. Dr. Williams was under the impression that petitioner's cervical complaints started immediately after the injury on 6/8/11. He opined that if petitioner's cervical complaints started a month after the accident that it is possible that it is less likely that the accident aggravated petitioner's preexisting cervical condition.

On 3/26/14 petitioner underwent an MRI of the cervical spine. The impression included postoperative changes at C3–C4; residual canal and foraminal stenosis, improved since preoperative exam; remaining degenerative changes stable when compared to the previous studies. On 4/25/14 petitioner followed up with Dr. Williams for his axial neck pain and headaches. Dr. Williams was of the opinion that the MRI did not reveal any more compression of the nerves. He did not believe petitioner's headaches were cervicogenic in nature. He also noted that it is atypical to have vision problems or nosebleeds due to the cervical spine.

On 4/30/14 petitioner was seen by Dr. O'Brien regarding complaints of headaches. He stated that his spine surgeon told him that his headaches were not related to his neck. Dr. O'Brien assessed cervicalgia and chronic tension type headaches. On 5/19/14 petitioner returned to Dr. O'Brien for ongoing headaches and neck pain. He related that the pain was present since he fell on 6/8/11 and hit his head after falling. Petitioner told Dr. O'Brien that he was suing for millions as he had not been able to work during this time and it had cost his company this much money. Dr. O'Brien's assessment remained the same.

An MRI of the cervical spine performed 12/30/14 showed no substantial changes from the prior study performed on 3/26/14.

On 1/6/15 the evidence deposition of Dr. Katz was taken on behalf of respondent. Dr. Katz has certifications by the American Board of Physical Medicine and Rehabilitation, the American Board of Independent Medical Examiners, and the American Board of Electrodiagnostic Medicine. His primary specialty is physical medicine and rehabilitation. Dr. Katz was of the opinion that petitioner had a chronic history of neck pain that had been worked up in 1999 with an MRI that showed degenerative changes as well as possible congenital fusion. Dr. Katz was of the opinion that the EMG study he reviewed was over diagnosed. Dr. Katz was of the opinion that petitioner was 71 years old when he examined him and had developed chronic stenoses of the neck, both of the exiting nerve root area, as well as central canal stenosis that the EMG examiner attributed to acute radiculopathy secondary to an injury. He opined that the EMG examiner attributing these findings to acute radiculopathy secondary to an injury was an overstretch. Dr. Katz opined that on his 2009 MRI petitioner had significant findings in terms of canal stenosis, that on the August 2011 MRI showed mild worsening, of both the spinal stenosis and foraminal stenosis. Dr. Katz attributed this to the effects of aging. He opined that one would only treat these conditions if they reached the point that petitioner was so symptomatic that they required surgical intervention. Dr. Katz opined that the findings on the August 2011 cervical spine MRI were chronic, degenerative changes that had worsened with time, and were not from an acute onset. Dr. Katz was of the opinion that petitioner's numbness in his 1st, 2nd and 3rd digits on his right hand were most likely related to his carpal tunnel syndrome. Dr. Katz opined that petitioner had nonspecific

cervical pain associated with chronic degenerated changes. He further opined that petitioner may have had a superimposed soft tissue injury from banging his head and neck subsequent to the fall in late spring of 2011. He did not feel that petitioner developed an acute radiculopathy secondary to the late spring 2011 fall. Dr. Katz opined that it's possible that petitioner's soft tissue injury of the neck and/or low back would have resolved in a number of weeks and that he would of been back to his baseline chronic neck pain and chronic low back pain. He opined that he saw nothing in petitioner's history, his medical records, or physical examination that would suggest a long-term issue that was caused by the fall with respect to his cervical spine. He opined that petitioner only sustained a short-term exacerbation of his pre-existing neck and low back pain. Dr. Katz further opined that the eventual surgery to petitioner's cervical spine was not performed as a result of the fall.

On cross-examination Dr. Katz opined that petitioner's fall did not cause an acute and/or chronic radiculopathy. Dr. Katz opined that in many patients with chronic pain, that pain continues to get worse over time.

Currently petitioner has complaints of minor scars on his right hand. He stated that he still has pain in his right hand but just lives with it. He reported difficulty writing with his right hand. Petitioner testified that his left wrist fracture healed without complications. With respect to his neck petitioner testified that he cannot twist his neck like he should. He testified that he takes 2 to 4 Tylenol a day for headaches and pressure on his eyes and ears. Petitioner testified that he cannot operate a pickup truck and can only drive about 45 minutes before his back hurts.

Petitioner testified that before the injury he had roughly 10 employees employed by Lippold Construction. During that period petitioner received a weekly payroll check, in the form of the salary, that he collected whether or not he worked. After the accident, petitioner did not have any employees because he sold his company to GP Materials. Petitioner testified that he did not work at all after the accident. He testified that he did not issue himself a paycheck because the company was sold, and there was no money going in or out of the operation. Petitioner testified that his business shutdown on 6/8/11.

Petitioner admitted that neither Dr. Williams, Dr. Gray, nor Dr. Wolters took him off work or ever placed restrictions on him. He testified that his restrictions were self-imposed. Petitioner admitted that he had cervical and low back problems, for which he treated before the accident. Petitioner admitted that he had an accident to his neck before the injury on 6/8/11 when he fell coming out of a Cracker Barrel.

Denise Davis, adjuster for Americasafe Risk Services, was called as a witness on behalf of respondent. Davis is currently a senior field case manager, and before that was a field case manager for Americasafe Risk

Services. She testified that she handled petitioner's case in 2011. Davis testified that she had a conversation with petitioner in an audio recording on 8/30/11 regarding his wages. She testified that petitioner told her that as an owner of the company he gave himself a salary that was not contingent on anything. She testified that petitioner told her it was a guaranteed wage that he received weekly. He stated that the number of hours he worked or what profits came in did not matter. Davis testified that she talked to petitioner many times after the recorded message. In those conversations petitioner said he was doing sales. Davis testified that petitioner never asked for any temporary total disability benefits during the audio recording. She admitted that in subsequent phone calls between the two there were calls for temporary total disability. Davis admitted that she had never received any off work slips or light duty slips from petitioner/respondent. Davis testified that she received the original claim on 8/25/11.

Petitioner testified that he treated with Dr. Williams until January 2012, and then did not see Dr. Williams until 2013. Petitioner testified that when he stopped seeing Dr. Williams in January 2012, up to that point, Dr. Williams had never made any surgical recommendation with respect to his cervical spine.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

The parties stipulate that petitioner's current condition of ill-being as it relates to his left and right hands is causally related to the injury on 6/8/11. A dispute exists as to whether or not petitioner's current condition of ill-being as it relates to his cervical spine is causally related to the injury on 6/8/11.

Contrary to petitioner's claim that he had no treatment for his cervical spine prior to 6/8/11, the credible medical records show petitioner had undergone treatment for his cervical spine prior to 6/8/11. X-rays of the cervical spine on 11/18/08 showed significant degenerative changes at each level, worse at C5-C6. Also noted was a very large interior osteophyte at C4-C5. On 9/9/09 petitioner complained of pain in the axial cervical spine. X-rays of cervical spine at this time were unchanged from 11/18/08. He was assessed with chronic axial neck pain, questionable cervical radiculopathy, and cervical spondylosis. An MRI of the cervical spine was performed on 9/21/09 due to radiating neck pain complaints. The impression was degenerative changes with canal stenosis most prominent at C3-C4, post operative changes at C5-C6, and fusion or non-segmentation of C6-C7. On 10/6/09 petitioner complained of radiating pain down the upper extremity. Dr. Williams assessed chronic axial neck pain, spinal stenosis from C3-C5, and degenerative disk disease. Questionable cervical myelopathy was also noted. Prior to 6/8/11 petitioner also treated with Dr. Gary, a chiropractor, for his cervical spine condition.

On 6/8/11 petitioner slipped and fell down some steps. At trial he testified that when he was falling he twisted his body to avoid hitting his head on the truck that was in front of him. However, after the injury

petitioner presented to Carlinville Area Hospital and gave an accident history of missing the last step and falling into the rocks. He complained of left forearm/wrist pain and a laceration to the right palm. Petitioner made no mention of any cervical complaints.

On 6/10/11 and 6/15/11 petitioner treated with Dr. Wolters for his left hand injury. Again, he made no complaints regarding his cervical spine.

Following the injury, petitioner's first complaint regarding his cervical spine was made to Dr. Gary, his chiropractor, on 7/13/11. He reported that his low back hurt mainly on the right side due to a fall. He also complained of neck pain, bilaterally, and rated it at a 6/10. He did not specifically state that his neck pain was related to the fall. He also complained of frontal headaches after falling forward and fracturing his wrist. Petitioner continued to complain of, and treat for, persistent soreness in his cervical spine, right worse than left.

On 8/2/11 petitioner underwent an MRI of the cervical spine. The impression was mild worsening of his severe left neural foramina stenosis at C4-C5 since 9/21/09. Otherwise, the impression was stable mild central spinal canal stenosis at C3-C4. X-rays of the cervical spine revealed advanced cervical facet arthropathy and advanced degenerative changes, predominantly at C5-C7. The fusion at C6-C7 was noted as well as a large bridging osteophyte at C5-C6 anteriorly. Dr. Williams opined that this MRI did not show any acute findings, and opined that cervical spondylosis is a progressive disease that on its own could worsen to the point that one could have complaints of cervical radiculopathy that could lead to the need for surgery without trauma.

Petitioner presented to Dr. Williams on 8/8/11 and gave him a history of cervical complaints starting immediately after the injury on 6/8/11. He did not mention any cervical complaints prior to 6/8/11. The arbitrator finds that the credible medical records do not support such a finding. The arbitrator finds the credible medical records support a finding that petitioner had cervical complaints prior to the accident and that following the accident he made no mention of any cervical complaints until over a month after the accident, when he presented to Dr. Gary, whom he had previously treated with for his preexisting cervical complaints. Based on the fact that petitioner's cervical complaints are not recorded until over one month after the accident Dr. Williams opined that it is possible that it is less likely that the accident aggravated petitioner's preexisting cervical condition.

Petitioner returned to Dr. Williams for his axial neck pain on 11/11/11. Dr. Williams did not note any acute findings on the cervical MRI, and noted that all the changes appeared to be age related degenerative changes. On 11/21/11 Dr. Gary opined that petitioner had reached maximum medical improvement as far as chiropractic care for the cervical spine was concerned.

On 11/22/11 petitioner was examined by Dr. Katz at the request of the respondent. Petitioner gave a history of slipping and falling down some stairs on 6/8/11, falling forward, and then twisting backwards striking the back of his head on some rocks. Based on this accident history Dr. Katz opined that petitioner may have sustained a soft tissue injury to his cervical spine that would have resolved in a couple of weeks. The arbitrator does not give much weight to this opinion based on the fact that this accident history is entirely inconsistent with the accident history given most contemporaneous to the accident, and the fact that petitioner did not voice any complaints regarding his cervical spine until over one month after the injury.

Dr. Katz opined that petitioner has a chronic history of neck pain, and following the injury on 6/8/11 no acute findings were noted. Dr. Katz attributed petitioner's current condition of ill-being as it relates to his cervical spine, to his chronic degenerative changes that worsened over time, and were not from an acute onset.

The arbitrator finds it significant that petitioner admitted that he had cervical and low back problems, and treatment for these conditions before the accident. Petitioner also admitted that he had an accident to his neck before the injury on 6/8/11 when he fell coming out of a Cracker Barrel.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being as it relates to his cervical spine is causally related to the injury on 6/8/11. However, based on the parties stipulation, the arbitrator finds the petitioner's current condition of ill-being as it relates to his right hand and left hand is causally related to the injury he sustained on 6/8/11.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being as it relates to his cervical spine is causally related to the injury on 6/8/11, the arbitrator finds that all treatment to petitioner's cervical spine following the injury on 6/8/11 was not reasonable or necessary to cure or relieve petitioner from the effects of the injury on 6/8/11.

However, based on the parties stipulation, the arbitrator finds the petitioner's current condition of ill-being as it relates to his right hand and left hand is causally related to the injury he sustained on 6/8/11, the arbitrator finds all medical treatment petitioner received for his right hand and left hand was reasonable and necessary to cure or relieve petitioner from the effects of the injury on 6/8/11.

Respondent shall pay reasonable and necessary medical services related to petitioner's right hand and left hand from 6/8/11 through 7/28/15, as provided in Sections 8(a) and 8.2 of the Act.

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

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner is claiming temporary total disability benefits from 6/9/11 through 10/8/13. However, the petitioner testified that he was never taken off work by any of his providers. Petitioner admitted that neither Dr. Williams, Dr. Gray, nor Dr. Wolters took him off work or ever placed restrictions on him. He testified that his restrictions were self-imposed.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that he was temporarily totally disabled from 6/9/11 through 10/8/13. Therefore, the arbitrator finds the petitioner's claim for temporary total disability benefits is denied.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

As a result of the injury on 6/8/11 petitioner sustained a jagged laceration to his right palm that was sutured with 6 stitches. He also sustained a fracture to the left distal radius and ulnar styloid. He was given a splint for his left wrist.

Petitioner treated with Dr. Wolters for his hand injuries. On 6/15/11 Dr. Wolters assessed a left closed distal radial and ulnar styloid fracture with some dorsal angulation. Dr. Wolters recommended conservative measures.

On 9/20/11 petitioner followed-up with Dr. Wolters for his left wrist. He reported that it was about 50% better. He reported constant pain in the wrist and some weakness and tingling in the wrist. Dr. Wolters recommended a course of occupational therapy.

On 11/1/11 petitioner returned to Dr. Wolters for his left wrist. He stated that it was still painful. He noted that he was wearing his brace intermittently. He denied any numbness or tingling. Petitioner had about 40 degrees of dorsiflexion and palmar flexion of the left wrist, mild tenderness over the TFCC, minimal tenderness over the radius and ulna distally, and a congenital deformity of his hand on the left side. Dr. Wolters again recommended continued conservative therapy including occupational therapy. Petitioner had no further visits with Dr. Wolters.

Petitioner testified that he has minor scars on his right hand and some pain in his right hand. He reported difficulty writing with his right hand. He stated that his left wrist fracture healed without complications.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner sustained a 2% loss of use of the right hand, and 10% loss of use of the left hand, pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tequila Smith,

Petitioner,

vs. NO: 11WC 44525

Schneider Logistics,

16IWCC0278

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 30, 2015, 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.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
o042716
CJD/jrc
049

MAY 2 - 2016

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

1 81WC00S2T8

Mark W Wilson

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

SMITH, TEQUILA
Employee/Petitioner

Case# 11WC044525

SCHNEIDER LOGISTICS
Employer/Respondent

16IWCC0278

On 6/30/2015, 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 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1357 RATHBUN CSEVENYAK & KOZOL
LUIS J MAGANA
3260 EXCUTIVE DR
JOLIET, IL 60431

0075 POWER & CRONIN LTD
RORY McCANN
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

16IWCC0278

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

STSC03WI81

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

Tequila Smith
Employee/Petitioner

v.

Schneider Logistics
Employer/Respondent

Case # **11** WC **44525**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **New Lenox**, on **March 10, 2015, March 17, 2015** and **June 16, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] 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

16IWCC0278

FINDINGS

16IWCC0278

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

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

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

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

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

In the year preceding the injury, Petitioner earned $26,932.73; the average weekly wage was $538.65.

On the date of accident, Petitioner was 45 years of age, *single* with no dependent children.

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

Respondent shall be given a credit of $6,343.10 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $6,343.10. *See* AX1.

Respondent is entitled to a credit under Section 8(j) of the Act and the parties stipulate that Petitioner will recognize Respondent's Section 8(j) credit upon proof of payment made under an employer sponsored group plan. *See* AX1.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $359.10/week for 21 & 6/7th weeks, commencing May 10, 2011 through October 9, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from May 10, 2011 through March 17, 2015, and shall pay the remainder of the award, if any, in weekly payments.

As stipulated by the parties, Respondent shall receive credit of $6,343.10 for temporary total disability benefits paid and for any additional hours paid while Petitioner worked as reflected in Respondent's Exhibit 12 as agreed by the parties as reflected in Respondent's Exhibit 12 as agreed by the parties. *See* AX1 & RX12.

Medical Benefits

Respondent shall pay reasonable and necessary medical services as reflected in Petitioner's Exhibits that remain unpaid for treatment through October 9, 2011 as indicated to be reasonable and necessary by Dr. Gleason pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall receive a credit, if any, as agreed by the parties. Petitioner's claim for payment of medical bills after October 9, 2011 and as indicated by Dr. Gleason to be unreasonable or unnecessary is denied.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator denies Petitioner's claim for prospective medical care in the form of a revision fusion surgery at L5-S1 as prescribed by Dr. Siemionow.

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

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

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

Signature of Arbitrator

June 19, 2015
Date

ICArbDec19(b) p.3

JUN 30 2015

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

Tequila Smith
Employee/Petitioner

v.

Schneider Logistics
Employer/Respondent

Case # **11** WC **44525**

Consolidated cases: **N/A**

16IWCC0278

FINDINGS OF FACT

The issues in dispute are causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement[1] to temporary total disability benefits from May 10, 2011 through March 17, 2015, and whether she is entitled to prospective medical care in the form of a fusion surgery as ordered by Dr. Siemionow. Arbitrator's Exhibit[2] ("AX") 1.

Background

Petitioner testified that she worked for Respondent since July 24, 2005 through May 10, 2011. She was a full time fork lift driver. Petitioner testified that her duties were to pick up pallets and move them from one location to another with a fork lift at a large warehouse facility. She operated the fork lift during 10-hour shifts and remained in the fork lift except for breaks and lunch. Petitioner testified that she never had any low back problems, injuries, or medical treatment before May 10, 2011. She has not worked since that date.

On cross examination, Petitioner testified that she previously worked at Walmart and sustained an injury to her wrist in August of 2006 or so. She was also employed with Respondent at that time and received medical treatment from Dr. Cohen. After two years of treatment, Petitioner testified that she was released with restrictions and she underwent a functional capacity evaluation.

Respondent offered a functional capacity evaluation report into evidence for Petitioner's results from April 30, 2008. RX2. Petitioner had a work-related injury in August of 2006 and underwent a proximal row carpectomy. *Id.* At the time, she was employed in a medium physical demand level job. *Id.* The evaluating physical therapist recommended four weeks of work conditioning and she was released back to heavy level work "per subjective rating by [Petitioner]." *Id.* Petitioner's efforts during testing were consistent. *Id.* Petitioner was released by her then-treating physician, Dr. Michael Cohen, to full duty work on August 4, 2008. RX3.

On cross examination, Petitioner testified that between July 2006 and 2008 there were times that she was working for Respondent and receiving checks while off work for her Walmart injury, but she explained that she had to use her vacation time while working for Respondent because she had a cast. Petitioner testified that she was not sure that she could work for Respondent while she was in therapy for her injury with Walmart.

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[1] Respondent stipulated that Petitioner is entitled to temporary total disability benefits on May 11, 2011 and commencing May 16, 2011 through September 13, 2011. AX1.

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

Petitioner also acknowledged on cross examination that she has high blood pressure and high cholesterol, which are unrelated to her injury in 2011. Petitioner did not recall reporting pain in the front of her legs previously to another doctor. RX2 at 2.

Respondent offered certain medical records of Dr. Ahsan into evidence. RX9. On January 23, 2009, Petitioner saw Dr. Ahsan for a general medical evaluation and follow up on some labs. *Id.* She reported "...feeling well, but states that the front of her lower extremities started hurting after being the new chol medications[.]" *Id.* The hydrochlorothiazide prescribed for hypertension was discontinued and replaced with a different medication. *Id.*

16IWCC0278

May 10, 2011

On May 10, 2011, Petitioner was operating a fork lift and "slotting" which is when you receive items off the truck and create labels for them. Petitioner testified that someone on the fork lift was pulling pallets out because the dock was jam packed. Petitioner was on her feet labeling. Another fork lift driver hit pallets and the cart hit Petitioner after which she hit the floor. She described that her left side hit the floor. Petitioner testified that she was in pain in her left hip. Petitioner reported the injury and then sought medical attention. The operations manager called the ambulance and Petitioner was taken to the Provena St. Joseph Medical Center emergency room.

Medical Treatment

The emergency room records reflect Petitioner's report of left-sided hip pain occurring after an accident at work when a coworker was moving pallets which hit another stack of pallets falling into her cart and pushing her down onto the ground. PX5 at 14-18. She underwent x-rays which were negative for fracture and was given a Toradol injection. *Id.* The emergency room physician ordered Ibuprofen 600mg, Tylenol with Codeine #3, and diagnosed with a left hip contusion. *Id.* She was directed to follow up with Dr. Azeem Ahsan. *Id.*

Petitioner testified that she then saw Dr. Ahsan, her primary care physician, on May 12, 2011. She explained that she reported left hip pain that radiated down to the knee and that she started feeling pain in her low back, which she had never experienced before her accident at work.

Dr. Ahsan's records reflect Petitioner's report that she was "hit by cart at work, fork lift hit pallets which hit her cart which knocked her down left ankle was twsted (sic) and fell on left hip , braced self with left arm.shoulder when falling. went to ER, was off yesterday and was to return to work today light duty with pain pills Needle sharp pain radiates from hip to knee when walking unable to perform duties of driving fork lift today. Pain in left hip when walking and when sitting on forklift also had sharp pains radiating from left hip to left knee." PX4 at 7-11. Dr. Ahsan noted that Petitioner's x-rays were all negative for fracture, diagnosed left hip pain, added Norco and Flexeril prescriptions for pain, and restricted her from driving or operating machinery. *Id.*

Petitioner returned to Dr. Ahsan on May 16, 2011 reporting "continued pain in left lumbar area and states she isn't ready for going to work although she is bored at home." PX4 at 12-16. Dr. Ahsan ordered a lumbar MRI and kept Petitioner off work relating to pain in the lumbar/hip area. *Id.* On May 23, 2011, Dr. Ahsan noted that Petitioner was still waiting for approval of the lumbar MRI and that she had continued pain. PX4 at 17-23. He kept her off work. *Id.*

Petitioner underwent lumbar x-rays on May 26, 2011. PX4 at 34-35; RX4. The interpreting radiologist noted minimal arthritic change of the lumbar spine and no radiographic evidence of an acute bony abnormality. *Id.*

She also underwent the recommended lumbar MRI on June 20, 2011. PX3 at 15-16; RX5. The interpreting radiologist noted a mild right-sided disc bulge at L5-S1 with associated mild right lateral recess stenosis and no evidence for significant spinal stenosis or foraminal stenosis. *Id.*

Petitioner returned to Dr. Ahsan on June 23, 2011. PX4 at 24-28; RX6. His medical records reflect that he referred her to an "ortho", kept her off work, and refilled her Norco prescription. *Id.*

Petitioner testified that Dr. Ahsan referred her to Dr. Sharma and a doctor at Parkview Orthopedics. Petitioner testified that the doctor at Parkview Orthopedics did not examine her low back, and that her low back symptoms worsened. On cross examination, Petitioner could not recall how she came to see Dr. Farrell. She testified that she has not seen anyone herself and explained that there had to be a referral. On re-direct examination, Petitioner recalled that Dr. Farrell was referred by Dr. Ahsan.

The Parkview Orthopaedic Group records reflect that Petitioner saw Dr. William Farrell for the first time on June 28, 2011. PX3 at 11-14; PX11. At this time, Petitioner reported that she was injured at work falling "directly on her left low back and left hip area." *Id.* On examination, Dr. Farrell noted tenderness to palpation over the sacroiliac area and left lateral buttock region without spasm, an unremarkable straight leg raise, and normal hip range of motion. *Id.* He diagnosed Petitioner with a low back contusion, added a Celebrex prescription, and referred her to Dr. Sharma or Dr. Patel, pain management physicians in his group, for an epidural injection. *Id.* Dr. Farrell also placed Petitioner on light duty with sedentary restrictions. *Id.*

Petitioner saw Dr. Sharma on July 1, 2011. PX2 at 7-10, 28-30. She reported the injury at work involving pallets and that she "hit the concrete on my left side." *Id.* Petitioner testified that she then received low back injections, which temporarily relieved her symptoms and that Dr. Sharma kept her off work. Dr. Sharma's records reveal back pain and joint stiffness on examination. *Id.* Dr. Sharma diagnosed Petitioner with low back pain and lumbar radiculopathy, and ordered a transforaminal epidural injection at left L4-L5 level in one week. *Id.*

On July 8, 2011, Dr. Sharma administered the recommended injection. PX2 at 31-34. When she returned on July 26, 2011, Petitioner reported no relief with the injection. PX2 at 35-38. Dr. Sharma recommended and administered a diagnostic medial nerve branch block of the S1-S3 nerves. *Id.* On August 10, 2011, Petitioner reported no change in her symptoms with a worsening of pain for a short time after the nerve block. PX2 at 39-41. Dr. Sharma prescribed Voltaren gel and instructed her to complete a pain diary over the next month. *Id.*

On August 30, 2011, Petitioner returned to Dr. Farrell who prescribed a TENS unit and released her to work five hours per day. PX3 at 8; PX11.

When Petitioner saw Dr. Sharma for pain management on September 7, 2011, she reported pain increasing with activities. PX2 at 42-44; PX11. Dr. Sharma ordered a lumbar discogram with post-discogram CT scan and Keflex. *Id.*

First Section 12 Examination & Supplemental Report – Dr. Gleason

On September 13, 2011, Petitioner submitted to a medical evaluation with Dr. Thomas Gleason at Respondent's request. RX1 (Dep. Exh. 2). Petitioner testified that she reported the accident and her symptoms, which she testified were the same ones she reported to everyone else. The report reflects that Dr. Gleason took a history

from Petitioner, examined her, reviewed various treating medical records, and rendered opinions regarding her physical condition. *Id.*

Specifically, Dr. Gleason noted Petitioner's report that on May 10, 2011 she was at work and pushed by her cart causing her to fall backwards off a stack of pallets landing on her left hip area. *Id.* Petitioner reported no low back or left hip problems before her incident at work. *Id.* She also reported left buttock and lateral upper pelvic pain. *Id.* Dr. Gleason noted that Petitioner's June 20, 2011 lumbar MRI report revealed no evidence of significant spinal stenosis or foraminal stenosis and a mild right-sided disc bulge at L5-S1 with associated mild right lateral recess stenosis. *Id.*

Dr. Gleason diagnosed left pelvic pain with a positive left Fabere test, diminished range of motion of the left hip secondary to pain, and local tenderness over the left upper, outer pelvic area. *Id.* With regard to her lumbar spine, Dr. Gleason opined that Petitioner's condition as noted in her lumbar MRI was not casually related to her accident at work. *Id.* He indicated that she did not require any further epidural steroid injections. *Id.* However, he also indicated that the lumbar back pain and radiculopathy noted by Dr. Ahsan, Dr. Sharma and Dr. Farrell were accurate relating to the bulging disc. *Id.*

Dr. Gleason noted no signs of symptom magnification or exaggeration at the time of his examination. *Id.* He opined that Petitioner could return to full duty work without restrictions, should consider weight loss, and that she should follow up with an orthopedist for a possible pelvic MRI. *Id.* Dr. Gleason opined that Petitioner's left hip condition was causally related to her accident at work. *Id.*

Thereafter, Dr. Gleason provided a supplemental report dated October 9, 2011 at which time he placed Petitioner at maximum medical improvement. RX1 (Dep. Exh. 3). He noted his review of a pelvic MRI scan of September 30, 2011 which was negative. *Id.* Dr. Gleason also noted Petitioner's reported history at the time of her MRI that she had persistent left-sided low back and right buttock pain following her fall at work. *Id.*

Continued Medical Treatment

On September 20, 2011, Petitioner returned to Dr. Farrell. PX3 at 6; PX11; RX7. He noted that she underwent an evaluation with Dr. Gleason, but did not yet have the report. *Id.* He also noted Petitioner's report of the following:

> She is still experiencing pain in the low back. There is no referred pattern. Dr. Sharma, the pain management physician that I referred her to, suggested a possible discogram. He is awaiting approval from the insurance carrier on that. Therefore at this point I would defer her to his care and treatment along with Dr. Ahsan, her primary physician. I will basically see her back as needed. No medication was dispensed by me today. She will continue the same work status as she has to date. She did not have questions relative to these recommendations. We will therefore see her only as needed."

Id.

Petitioner testified that Dr. Sharma then referred her to Dr. George DePhillips for an evaluation. Dr. DePhillips' initial evaluation note is addressed to Dr. Sharma thanking him for the referral. PX2 at 20-21.

Dr. DePhillips' records show that Petitioner had an initial evaluation on October 12, 2011. *Id.* He noted Petitioner's report of persistent left buttock and left-sided lower back pain with occasional mild pain radiating

into the posterior thigh and knee since her accident at work. *Id.* He noted that her neurological examination was unremarkable, she had a negative bilateral straight leg raise test, and she showed no Waddell signs or exaggerated tenderness to palpation. *Id.* Dr. DePhillips recommended a lumbar discogram to determine if she had an annular tear at L5-S1 and noted his explanation to Petitioner of a differential diagnosis of pain including discogenic, facet mediated, SI dysfunction, and myofascial pain. *Id.*

Petitioner returned to Dr. Sharma on October 5, 2011 and November 2, 2011 at which time he noted that she had an IME, but the report was not yet available. PX2 at 45-50. He diagnosed Petitioner with lumbar discogenic pain and reiterated his recommendation for a discogram. *Id.* Dr. Sharma also placed Petitioner on adjusted work restrictions with no lifting over 20 pounds, repetitive bending, twisting, or fork lift riding. *Id.*

Dr. Sharma then performed the recommended discogram from L3-S1 on December 1, 2011. PX6 at 27-30. When Petitioner returned on December 12, 2011 and January 13, 2012, she reported a worsening of pain thereafter for a short time. PX6 at 31-36. Dr. Sharma found that the discogram showed an L5-S1 annular tear and he referred Petitioner for a neurosurgical evaluation. *Id.*

Petitioner testified that she returned to see Dr. DePhillips and he recommended lumbar surgery, but Petitioner testified that she was unsure about the surgery and wanted to find other options. Dr. DePhillips' records reflect Petitioner's report that she had recently returned to work of 4-5 hour shifts, which aggravated her pain significantly to the point that she was unable to return and she was sent home by her supervisor. PX8 at 3. Dr. DePhillips recommended a discectomy and fusion. *Id.* Petitioner returned to Dr. Sharma on February 13, 2012 at which time he noted her desire to avoid surgery if possible and ordered a functional capacity evaluation. PX6 at 37-39.

Petitioner testified that she underwent a functional capacity evaluation to see what she could and could not handle before she underwent surgery. The functional capacity evaluation was performed at ATI on February 20, 2012. PX6 at 51-57. The evaluating physical therapist noted that Petitioner's position with Respondent was in the medium physical demand level and that she tested at the light physical demand level. *Id.* He also noted that the results were deemed conditionally valid based on Petitioner's efforts. *Id.*

Petitioner returned to Dr. Sharma on March 12, 2012 at which time he reviewed her functional capacity evaluation results. PX6 at 40-42. Dr. Sharma noted that Petitioner's functional capacity evaluation results were valid and he released her consistent with those results with a light duty limitation with no lifting over 25 pounds. *Id.* He again referred Petitioner to a neurosurgeon for evaluation after the functional capacity evaluation. *Id.*

Petitioner testified that she then sought a second opinion with Dr. Lorenz as referred by Dr. Sharma and that she stopped seeing Dr. DePhillips at this time. Dr. Sharma's records do not reflect a specific referral to Dr. Lorenz. Petitioner completed a patient assessment on March 22, 2012 in which she noted that Dr. Stronger and her then-current attorney referred her to Hinsdale Orthopaedics. RX8; *see also* PX14(a) at 30-31.

The medical records reflect that Petitioner initially saw Dr. Mark Lorenz on March 22, 2012. PX13 at 34-35. Petitioner testified that she reported worsened low back symptoms that radiated down her legs. However, Dr. Lorenz specifically noted the following history:

> This is a 45-year-old pleasant female who gives a history of working for Schneider Logistics on May 10, 2011, where she was hit by a forklift at work. She sustained a back injury that caused her back pain and leg pain. She has gone through a long course of conservative care including injections, medication. She

has failed conservative care. She is now here for a surgical consultation. States her back pain ranges from a 6-10. She is not able to sit more than 5 minutes. Walking is about an hour where she gets increasing back pain. She gets pain radiating to her left hamstring which stops at her knee.

Id. Dr. Lorenz reviewed Petitioner's June 20, 2011 MRI noting desiccation of discs at L5-S1 with a right-sided disk bulge and right lateral recess stenosis and posterior annular fissure. *Id.* On examination, he noted pain on forward flexion to about 75 degrees and lumbar extension and mildly positive straight leg raising. *Id.* Dr. Lorenz recommended a posterior spinal fusion at L5-S1. *Id.* He kept her off work and noted that she would continue with pain management. *Id.*

Petitioner testified that at this time she decided to go ahead and have the surgery.

Petitioner returned to Dr. DePhillips on April 26, 2012 at which time he noted that she would like to proceed with surgery. PX8 at 2. He reiterated his recommendation for an anterior lumbar interbody fusion surgery. *Id.* Petitioner testified that this was the last time she saw Dr. DePhillips.

Second Section 12 Examination, AMA Guides Impairment Rating, & Addendum Report – Dr. Gleason

On May 29, 2012, Petitioner submitted to a second medical evaluation with Dr. Gleason at Respondent's request. RX1 (Dep. Exh. 4). Dr. Gleason took additional history from Petitioner, examined her, reviewed various treating medical records, rendered opinions regarding her physical condition, and provided an AMA Guides impairment rating. *Id.*

Dr. Gleason noted his review of Petitioner's discogram and prior diagnostic study reports. *Id.* He noted no objective findings on physical examination related to the low back and pelvis and diagnosed Petitioner with left low back pain based only on Petitioner's subjective complaints. *Id.* Dr. Gleason opined that Petitioner was at maximum medical improvement and that she could return to work per her functional capacity evaluation results. *Id.* He disagreed with Dr. Lorenz's recommendation for surgery and further opined that discograms of normal discs were unwarranted and inappropriate. *Id.* Dr. Gleason also calculated a 1% impairment rating for Petitioner using the AMA Guides, 6th Edition. *Id.*

On June 10, 2012, Dr. Gleason issued an addendum report indicating that if Petitioner's job description was at the medium level, then her release per the functional capacity evaluation at the light level would causally be related to her work injury. RX1 (Dep. Exh. 5).

Continued Medical Treatment

Petitioner then returned to Dr. Lorenz on September 24, 2012. PX13 at 31-33. He noted that her surgery had not yet been approved and that she had increased left leg radiculopathy. *Id.* Petitioner reported that she would like to work limited duty, and Dr. Lorenz released her back to work for a maximum of four hours per day, 20 hours per week with no lifting over 20 pounds. *Id.*

Petitioner then underwent surgery on November 9, 2012 with Dr. Lorenz. PX12 at 68-75. Dr. Lorenz and his co-surgeons, Drs. Fronczak and Sullivan, authored operative reports. *Id.* Pre- and post-operatively, Dr. Lorenz diagnosed Petitioner with L5-S1 disk protrusion with annular repair, first mobile segment, L5-S1. PX12 at 68-69. The procedures he noted were as follows: (1) L5-S1 discectomy; (2) L5-S1 interbody fusion; (3) L5-S1 cage

insertion 9 mm cage; (4) L5-S1 posterior fusion; (5) L5-S1 segmental fixation with pedicle screws and rods; (6) iliac crest bone graft harvest; (7) demineralized bone matrix implantation; (8) stem cell allograft transplant including thawing and washing; and (9) intraoperative x-rays interpreted by both surgeons. *Id.*

Pre- and post-operatively, Dr. Fronczak diagnosed Petitioner with L5-S1 lumbar spondylosis with axial instability (discogenic back pain) and left S1 radiculopathy secondary to above. PX12 at 70-72. The procedures he noted were as follows: (1) a 360° spinal fusion (Wiltse approach); (2) L5-S1 laminotomy, foraminotomy, nerve root decompression and discectomy; (3) L5-S1 posterolateral spinal fusion; (4) L5-S1 posterior segmental spinal instrumentation (Orthofix polyaxial screws and Isola rods); (5) L5-S1 transforaminal lumbar interbody fusion (Orthofix PEEK cages); (6) autograft, left iliac crest bone graft with reconstruction through a separate incision; (7) fat graft x1 through separate skin incision; (8) autograft, Osiris and Trinity (bone stem cells); (9) allograft, DBM putty and sponge (Bacterin); (10) intraoperative x-ray interpretation x2; and (11) continuous intraoperative SSEP and EMG monitoring with individual pedicle screw stimulation x4. *Id.* No measurement was noted by any of the surgeons of the size of the herniated disc. PX12 at 68-75.

Petitioner testified that her symptoms were temporarily relieved, but after the surgery she was still having back pain. She could not drink or eat anything cold. She also had difficulty with cold because it aggravated her symptoms. Petitioner continued to see Dr. Lorenz initially after the surgery and underwent physical therapy, which she testified did not help. Petitioner testified that her symptoms worsened approximately two weeks during therapy. Petitioner testified that one of the therapists put her elbow in the center of her back where the screws were and that caused excruciating pain. Petitioner testified that she reported this to Dr. Lorenz and he stopped the therapy. Petitioner testified that her low back symptoms did not completely resolve after her surgery.

In correspondence dated November 27, 2012, the workers' compensation insurance carrier denied Petitioner's request for payment of the L5-S1 surgery. RX10.

The medical records reflect that Petitioner returned to Dr. Lorenz for follow up on December 13, 2012. PX13 at 14-16. She reported improvement in her leg pain and overall improvement after the surgery. *Id.* On January 21, 2013, Dr. Lorenz discontinued Petitioner's use of her brace and ordered physical therapy. PX13 at 11-13. She reported generally increased pain at a level of 5-6/10, but pain at a level of 9-10/10 at that visit. *Id.*

On March 4, 2013, Petitioner reported making very slow progress in physical therapy and significant discomfort in her left buttock consistent with the graft donor site. PX13 at 8-10. Dr. Lorenz ordered continued physical therapy and kept Petitioner off work. *Id.* As of April 15, 2013, Petitioner reported that physical therapy helped ease her pain, but continued pain over the left buttock consistent with the donor graft site. PX13 at 5-7. Dr. Lorenz ordered continued physical therapy and a final visit in 4-6 weeks. *Id.*

Petitioner continued to undergo pain management with Dr. Sharma while receiving treatment from Dr. Lorenz. PX9.

On May 13, 2013 Petitioner underwent a second functional capacity evaluation at ATI. PX7; PX10 at 37-43. The results of this functional capacity evaluation were deemed conditionally valid by the evaluating physical therapist and released her to sedentary-to-light physical demand level work. *Id.* Petitioner testified that she did not return to work thereafter.

Petitioner saw Dr. Lorenz on May 29, 2013. PX13 at 2-4. He noted that her functional capacity evaluation results were conditionally valid, but he imposed permanent sedentary restrictions with no lifting desk-to-chair over 20 pounds, occasionally. *Id.*

Petitioner saw Dr. Sharma on June 25, 2013 reporting stiffness after prolonged sitting or standing with paraverterbal muscle spasm and worsened pain with extension and twisting movements. PX9 at 56-58. He recommended work restrictions consistent with those imposed by her orthopedic surgeon (Dr. Lorenz). PX9.

Deposition Testimony – Dr. Lorenz

On April 1, 2014, Petitioner called Dr. Lorenz as a witness and he gave testimony at an evidence deposition. PX14(a). Dr. Lorenz is a board-certified orthopedic surgeon. PX14(a) at 4-5. He testified about his medical treatment of Petitioner's condition. PX14(a).

Dr. Lorenz testified that he understood that Petitioner's injury occurred when she was struck by a forklift. PX14(a) at 6-7. He noted her reports of back and leg pain. PX14(a) at 11. Dr. Lorenz also noted his review of Petitioner's lumbar x-rays and MRI performed on June 20, 2011, which showed a torn disk at L5-S1 with an annular fissure, and the discogram that he later ordered. PX14(a) at 8-9. He reviewed no other diagnostic tests or prior medical records. PX14(a) at 13, 29. On examination at her first visit on March 22, 2012, Dr. Lorenz noted a "somewhat positive straight leg raising, primarily on the left side, and it was near full extension." PX14(a) at 11-12. He indicated that this meant that "the nerve is a bit irritated on that day on that side." PX14(a) at 12-13.

Dr. Lorenz testified that he reviewed her functional capacity evaluation of May 15, 2013. PX14(a) at 21-23. He acknowledged that Petitioner's functional capacity evaluation results were deemed conditionally valid, which he understood that would show "that the patient demonstrated some inconsistencies throughout the examination, and a conditional eval suggests that the patient may have motion fear, fear of movement, fear of exacerbation, so it suggests that the patient should be able to do slightly more, if that fear was gone, than what the FCE shows." PX14(a) at 23. He agreed that Petitioner could do sedentary to light duty work per the functional capacity evaluation results. *Id.* Dr. Lorenz also testified that Petitioner reported a decrease in her pain symptoms after surgery, which he considered to be a success. PX14(a) at 25-26.

On cross examination, Dr. Lorenz acknowledged that he did not see Petitioner until 10 months after her accident at work, but he maintained that Petitioner's "history matches completely with the mechanics that she described and so does her treatment record." PX14(a) at 33-35. Dr. Lorenz also testified that he remembered that Petitioner shifting around after five minutes when he first evaluated her on March 22, 2012 and, thus, he had no problem reconciling her report to him that she could not sit more than five minutes compared to her patient assessment report of pain only arising from sitting for long periods on hard surfaces. PX14(a) at 35-36.

With regard to the desiccation of disks at L5-S1 shown in her June 20, 2011 MRI, Dr. Lorenz acknowledged that Petitioner probably would have had some graying of the disks and some loss pre-existing her accident at work. PX14(a) at 37-38. He testified that the annular fissure "probably occurred when she got struck by that vehicle, by the forklift." PX14(a) at 38. Dr. Lorenz denied that the use of the word "fissure" by radiologists and orthopedic surgeons referred to a chronic condition versus using the work "tear", which he testified were the same. PX14(a) at 38-39. Dr. Lorenz testified that annular fissures or tears are "always the result of a traumatic event" which in Petitioner's case stemmed from getting hit by a forklift. PX14(a) at 39-40. On cross

examination, Dr. Lorenz also testified that Petitioner's mildly positive straight leg raise finding was "from the inflammatory process." PX14(a) at 41-42.

With regard to the herniation noted in his intraoperative report, Dr. Lorenz testified that the herniation was small. PX14(a) at 42. When asked about a precise measurement and whether the herniation was a couple of millimeters, Dr. Lorenz responded "No. Ask the radiologist. He can measure it out. It depend where they cut through the disk, if it's the top or the bottom." *Id.* He testified that the herniation sizes are not typically charted and that "they wouldn't be because they're clinically irrelevant. I've seen people with really severe pain and severe sciatica with small herniations, and I've seen people who have bigger herniations with little complaints." PX14(a) at 43.

With regard to the usefulness and safety of discography, Dr. Lorenz testified that "There's no controversy among spine surgeons. A discogram is a well accepted test, is accepted by the North American Spine Society, is accepted by evidence-based medicine, and it is useful at times as a particular data point. There's no doubt about that at all, no controversy about that particular statement." PX14(a) at 50.

Continued Medical Treatment

Petitioner testified that Dr. Sharma then referred her to Dr. Siemionow, a surgeon. Dr. Sharma's records do not reflect a referral to Dr. Siemionow.

On June 2, 2014, Petitioner saw Dr. Krzysztof Siemionow. PX15 at 19-23. Petitioner testified that she had pain like pins shooting through her left leg and back as well as numbness in her leg at the time of this visit. Dr. Siemionow noted Petitioner's report that "...some of her symptoms certainly did improve after surgery, however, new symptoms developed which are different in character, quality, and in nature and in a similar location after surgery. They are slowly but progressively intensifying. She reports that she specifically remembers that these symptoms were brought on approximately 3-4 months after surgery. While she was in physical therapy she was asked to perform a certain set of exercises which exacerbated the pain and brought on this new type and character of pain in a similar distribution." *Id.* Dr. Siemionow ordered a CT scan and MRI of the lumbar spine noting that he was concerned about a non-union at L5-S1. *Id.* He diagnosed her with psuedoarthrosis and status post L5-S1 fusion and kept her off work. *Id.*

Petitioner underwent the recommended CT scan on June 24, 2014. PX15 at 13-15. The interpreting radiologist found no appreciable change compared with the previous study of May 22, 2013. *Id.*

Petitioner returned to Dr. Siemionow on July 30, 2014 at which time he reviewed her CT scan and noted that one of the screws on the left side was close to violating the end plate of L5, but was still in the bone. PX15 at 11. He noted no evidence of bony union in the intervertebral space at L5-S1 and that her overall picture was consistent with psuedoarthrosis at L5-S1. *Id.* He recommended a revision surgery to remove the case and insert new pedicle instrumentation. *Id.*

Since the recommendation for surgery, Petitioner has returned to Dr. Siemionow on several occasions. PX15-PX16. On September 5, 2014, Dr. Siemionow's office sent another request for approval of the recommended surgery. PX15 at 7-9.

Deposition Testimony – Dr. Gleason

On November 18, 2014, Respondent called Dr. Gleason as a witness and he gave testimony at an evidence deposition. RX1. Dr. Gleason is a board-certified orthopedic surgeon. RX1 at 3-6. He testified about his medical evaluations of Petitioner, review of records, and rendered opinions about her medical condition and its relation, if any, to her accident at work. *See generally* RX1.

Dr. Gleason testified that Petitioner had pre-existing degeneration in her pelvis and sacroiliac joint as of the time of his first examination of her. RX1 at 12-13. He explained that, because of the positive left Fabere test suggesting sacroiliitis, these conditions were aggravated by her accident at work. *Id.* Regarding his October 9, 2011 report, Dr. Gleason testified that it was his opinion that Petitioner had reached maximum medical improvement. RX1 at 13-14.

Dr. Gleason also testified about his second examination of Petitioner on May 29, 2012. RX1 at 14-15. He found no objective findings on physical examination, although Petitioner reported subjective complaints in the low back and posterior mid thigh area. RX1 at 16.

Dr. Gleason believed that Petitioner was receiving excessive medical treatment to the low back. *Id.* RX1 at 17-18. He also wholly disagreed with any statement that discograms were beneficial, and testified that according to Dr. Eugene Caragee from Stanford the editor of the Spine Journal, the literature well demonstrated that discograms are unreliable and can actually promote and accelerate degenerative disease. RX1 at 18-19.

Dr. Gleason concluded that Petitioner was capable of returning to light duty work based on her valid functional capacity evaluation results. RX1 at 17, 19-20. He also disagreed with Dr. Lorenz's recommendation for a low back fusion. RX1 at 20-21. He explained that Petitioner had no evidence of radiculopathy and that she had left-sided and low back complaints while her MRI showed a mild right-sided disc bulge. *Id.* Dr. Gleason also explained that a fusion would not improve Petitioner's axial back pain particularly given the absence of positive objective findings at the time of his second examination and her withdrawing to even gentle palpation and touch over the lumbar spine and left lower para-lumbar area, "suggesting magnification or possibly exaggeration." *Id.*

Dr. Gleason also testified that he has been trained and is certified since 2011 by the American Board of Independent Examiners to render impairment ratings according to the AMA Guides. RX1 at 21-22. He determined that Petitioner had a 1% impairment rating. RX1 at 22.

Dr. Gleason further testified about his June 10, 2012 report. RX1 at 22-23. He indicated that it was his opinion at this time that Petitioner could perform light duty work per her functional capacity evaluation results and that if her job duties fell within these restrictions she could return to work full duty. *Id.* Dr. Gleason testified that Petitioner's "restrictions would then causally be related to the work injury based upon the review of records history as well as physical and examination processes." *Id.* However, Dr. Gleason was tendered a copy of Petitioner's functional capacity evaluation results, which he noted was deemed conditionally valid based on testing consistencies and inconsistencies. RX1 at 24-25.

In addition, Dr. Gleason was given additional treating medical records from Dr. Siemionow to review. RX1 at 25-31. He testified that Dr. Siemionow's diagnoses and the additional treating information did not change his opinions; specifically that the fusion performed by Dr. Lorenz did not improve Petitioner's condition, was not recommended, and that he did not recommend any further treatment. RX1 at 31-32, 35. On cross examination, Dr. Gleason testified regarding Dr. Siemionow's diagnosis of pseudoarthrosis; he explained that in light of the

fact that Petitioner had a fusion and the radiologist did not note any shift in positioning of lucency or loosening of the screws, those facts suggested that Petitioner had a stable situation. RX1 at 37.

Continued Medical Treatment

As of January 14, 2015 and February 23, 2015, Dr. Siemionow has kept Petitioner off work pending approval of her revision surgery. PX15 at 3-5; PX16.

In a letter dated February 24, 2015, Dr. Ahsan's office provided a narrative letter indicating that Petitioner was under their care since her accident at work and that her condition had deteriorated. PX17. The letter indicates that Petitioner could not walk without a walker, that she was unable to bend, kneel, climb stairs, or twist, and that she had a permanent restriction of no lifting over 10 pounds. *Id.* Petitioner was also noted to be unable to stand or sit for long periods of time and that her medication made her sleepy and drowsy making it unsafe for her to drive and that her legs give out causing frequent falls. *Id.*

Additional Information

Petitioner testified that she wants to undergo the recommended surgery. She cannot live like this. Petitioner testified that her life is restricted. She explained that she cannot walk half the time, her legs give out, she has fallen several times, and has bruises on her thighs when she's fallen out of bed or in the bathroom. Petitioner testified that she walks with a walker as ordered by Dr. Ahsan. Petitioner also testified that she cannot drive anymore because her legs give out.

On re-direct examination, Petitioner testified that the leg symptoms she had previously were not like what she has now. Prior to this accident, Petitioner testified that she has not fallen due to leg pain.

Petitioner also testified that she has not been pain-free since her accident. She last saw Dr. Ahsan on March 9, 2015 and continues to have pain. She testified that she underwent an ultrasound and found out that she had a blood clot in her legs and she was placed on blood thinners. Her next appointment is scheduled for March 23, 2015. Petitioner testified that she wishes to undergo the surgery recommended by Dr. Siemionow.

ISSUES AND CONCLUSIONS

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

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

The Arbitrator finds that Petitioner's current condition of ill-being in the left hip and lumbar spine is causally related to her accident at work on May 10, 2011 through October 9, 2011. In so concluding, the Arbitrator finds several facts to be significant.

Petitioner had no complaints or medical treatment relative to the left hip or low back before her accident at work. She reported symptoms in these areas within days of the accident to the emergency room physician and continuing thereafter to her own physicians, Dr. Ahsan, Dr. Sharma and Dr. Farrell. These physicians noted some objective findings during these first months correlating Petitioner's reported symptoms to the left hip and left low back. Petitioner reported symptoms stemming from the low back with any radiating symptoms into the buttocks and leg, localized to the left side.

Petitioner's report of injury at the emergency room was that, through a short chain of events, a forklift driven by a co-worker hit her cart pushing her down onto the ground. She reported a similar mechanism of injury to Dr. Ahsan two days after her accident explaining that she was "hit by cart at work, fork lift hit pallets which hit her cart which knocked her down left ankle was twsted (sic) and fell on left hip , braced self with left arm.shoulder when falling. went to ER...." Petitioner's testimony at trial describing the accident is corroborated by these early reports of injury; that is, that another fork lift driver hit pallets and/or her cart which hit her and caused her to fall on the floor hitting her left side.

Petitioner then underwent a lumbar MRI on June 20, 2011. Contrary to the localization by Petitioner of symptoms on the left, the MRI showed a mild disc bulge at L5-S1 on the right side with associated mild right lateral recess stenosis. The MRI showed no evidence of significant spinal stenosis or foraminal stenosis. When Petitioner saw her first orthopedic surgeon, Dr. Farrell, on June 28, 2011 he noted tenderness to palpation over the sacroiliac area and left—not right—lateral buttock. He also noted no spasms, normal hip range of motion, and an unremarkable straight leg raise. Dr. Farrell diagnosed a low back contusion and referred Petitioner to one of two pain management physicians in his group. Petitioner saw Dr. Sharma for pain management.

Shortly thereafter, Respondent sent Petitioner for a medical evaluation pursuant to Section 12 with Dr. Gleason on September 13, 2011. Dr. Gleason's report is somewhat confusing, but with regard to her lumbar spine, he opined that Petitioner's condition as noted in her lumbar MRI report—a mild right-sided disc bulge at L5-S1, etc.—was not casually related to her accident at work. With regard to her left hip, he sought a pelvic CT scan before reaching an opinion. After reviewing Petitioner's pelvic CT scan, he opined on October 9, 2011 that Petitioner was at maximum medical improvement with regard to both her low back and left hip.

Petitioner returned to Dr. Farrell on September 20, 2011 and he released her from care. At this visit, over four months after her accident at work, Dr. Farrell noted that she continued to report low back pain, but he noted no referred pattern or radiculopathy. Dr. Farrell did not make any surgical or further treatment recommendations

from an orthopedic perspective and deferred her ongoing care to Dr. Sharma his colleague at Parkview for pain management.

Petitioner then saw another orthopedic surgeon, Dr. DePhillips, on October 12, 2011. She reported persistent left buttock and left-sided lower back pain with occasional mild pain radiating into the posterior thigh and knee since her accident at work. Petitioner's neurological examination was unremarkable. She had a negative bilateral straight leg raise test. Petitioner discontinued seeing Dr. DePhillips and turned to Dr. Lorenz, her third orthopedic surgeon.

When Petitioner saw Dr. Lorenz for the first time on March 22, 2012, more than 10 months after her accident, she reported left sided symptoms. Her physical examination produced a "mildly positive" straight leg raise and Dr. Lorenz understood that Petitioner was hit by a fork lift in her accident at work. Dr. Lorenz opined that Petitioner's condition was related to her accident at work and recommended discography and surgery for the right sided disc bulge. The opinions offered at trial regarding the relatedness, if any, of Petitioner's ongoing low back condition to her accident at work come from Respondent's Section 12 examiner, Dr. Gleason, and Petitioner's former and current orthopedic surgeons, Drs. Lorenz and Siemionow. In consideration of the record as a whole, the Arbitrator finds the opinions of Dr. Gleason to be persuasive because they are based on objective medical and clinically-noted evidence and a more complete understanding of Petitioner's medical history than the opinions of Drs. Lorenz or Siemionow.

Moreover, while accident is not in dispute, the mechanism of injury understood by each physician is important in determining the persuasiveness of his opinions and, concordantly, the extent of causal connection in this case. Also important is the extent of medical information available to each physician, as the context in which each physician renders his opinion bears of the persuasiveness of each. It is well-established in workers' compensation cases that physicians base their diagnoses, treatment recommendations, and opinions, at least in part, on the patient's history. By extension, "[e]xpert opinions must be supported by facts and are only as valid as the facts underlying them." *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at 36 (3rd Dist. 2014) (citing *Gross v. Ill. Workers' Comp. Comm'n*, 2011 IL App (4th) 100615WC at 16-17 (4th Dist. 2011) (quoting *In re Joseph S.*, 339 Ill. App. 3d 599, 607 (1st Dist. 2003))). Further, such opinions are "only as valid as the reasons for the opinion." *Gross*, (citing *Kleiss v. Cassida*, 297 Ill. App. 3d 165, 174 (4th Dist. 1998)). Given the evidence in this record, the Arbitrator finds the opinions of Dr. Gleason to be persuasive and supported by the treatment plan recommended by Petitioner's first orthopedic surgeon; that is, to seek pain management care for her ongoing complaints. The Arbitrator finds the opinions of Petitioner's treating physicians, Dr. Lorenz and Dr. Siemionow, to be unpersuasive.

Dr. Lorenz steadfastly maintained that Petitioner's low back condition was directly related to Petitioner's accident at work. However, Dr. Lorenz's understanding of the mechanism of injury (i.e., being hit directly by a fork lift) is significantly different from the reported mechanism of injury as reflected in Petitioner's other treating medical records prior to March 22, 2012 (i.e., that a fork lift hit pallets and/or her cart which caused her to fall on her left side on the ground).

Dr. Lorenz also had an inadequate understanding of Petitioner's medical history during the 10 months of treatment after her accident before seeing him for the first time. While he could certainly diagnose and treat Petitioner based on the information available to him, his opinions in the context of that period of treatment are unconvincing. Dr. Lorenz admitted that he had no prior treating medical records at his disposal other than Petitioner's discogram, MRI and x-rays. Given that Petitioner's symptoms were limited to the left side for 10 months—and the equivocal findings on examination by Dr. Sharma, Dr. Farrell and Dr. DePhillips

substantiating any radiculopathy—Dr. Lorenz's assertion that Petitioner's left-sided complaints after her accident at work were related to a small right-sided disc bulge is wholly unpersuasive.

Additionally, it is notable in considering Petitioner's extensive orthopedic care that Petitioner's first orthopedic surgeon, Dr. Farrell, did not recommend any further orthopedic treatment or surgery to address her low back complaints. Her second orthopedic surgeon, Dr. DePhillips, recommended further conservative care and surgery during which time Petitioner continued to report left sided symptoms. Petitioner chose to discontinue treatment with Dr. DePhillips and sought out Dr. Lorenz. However, neither Dr. DePhillips, nor later, Dr. Lorenz, were able to explain how Petitioner's accident, described initially as a left-sided impact and with corresponding left-sided symptoms, would result in a right-sided mild disc bulge or why this bulge could be a likely pain generator.

The record does establish that Petitioner had no low back condition or medical treatment to the low back or left hip before her accident at work, but the connection between her right-sided disc bulge and wholly left-sided symptoms are unclear. While Petitioner's low back condition improved only slightly with conservative treatment from the time of her accident until she saw Dr. Lorenz, it is notable that two orthopedic surgeons, Dr. Farrell and Dr. Gleason, recommended only minimal conservative treatment given her symptoms and no surgery given her lack of radiculopathy in the first ten months after her accident. The question is whether Petitioner met her burden of proof under the Act establishing causal connection between a left hip and left-sided low back condition such that she requires a revision surgery to address Dr. Lorenz's prior treatment of a small right-sided disc bulge. Based on a preponderance of the evidence, the Arbitrator finds that Petitioner has established causal connection between her low back and left hip condition through the date of Dr. Gleason's addendum report of October 9, 2011 and that the opinions of Dr. Gleason in this case are persuasive.

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

Respondent argues as a threshold issue that Petitioner exceeded her allotted choices of physicians and that it is not liable for certain claimed medical bills. The Arbitrator views the evidence differently and finds that Petitioner did not exceed her allotted choices of physicians.

Section 8(a) of the Act provides that an employer is liable to pay for two chains of medical services as selected by the employee with exception of first aid and emergency treatment. 820 ILCS 305/8(a) (LEXIS 2008). More specifically, Section 8(a) states in pertinent part:

> [T]he employer's liability to pay for ... medical services selected by the employee shall be limited to:
>
> (1) all first aid and emergency treatment; plus
> (2) all medical, surgical and hospital services provided by the physician, surgeon or hospital initially chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said initial service provider or any subsequent service provider of medical services in the chain of referrals from said initial service provider; plus
> (3) all medical, surgical and hospital services provided by any second physician, surgeon or hospital subsequently chosen by the employee or by any other physician, consultant, expert, institution or other provider of services

> recommended by said second service provider or any subsequent provider of medical services in the chain of referrals from said second service provider.

Id. Petitioner initially went to St. Joseph's emergency room for treatment. This emergency treatment does not constitute a choice made by Petitioner pursuant to Section 8(a) of the Act. Petitioner then saw Dr. Ahsan for treatment. The medical records reflect that she was specifically referred to him by the St. Joseph's emergency room staff. Petitioner's treatment with Dr. Ahsan does not constitute a choice of physician. Thereafter, Dr. Ahsan referred Petitioner to an "ortho".

Petitioner first saw Dr. Farrell at Parkview Orthopaedics. He evaluated Petitioner and made orthopedic recommendations. The medical records reflect that Dr. Farrell referred Petitioner to Dr. Sharma or Dr. Patel, pain management physicians at Parkview Orthopedics, after he reviewed her MRI and diagnosed a low back contusion. Before releasing her from his care, Dr. Farrell referred Petitioner back to Dr. Sharma for ongoing pain management care. Thus, treatment by these physicians fall within the chain of referrals from the emergency room and Dr. Ahsan and do not constitute a choice pursuant to Section 8(a).

Petitioner then saw a second orthopedic surgeon, Dr. DePhillips. Dr. DePhillips' medical records reflect that Petitioner was referred to him by Dr. Sharma. Thus, Petitioner's medical treatment with Dr. DePhillips does not constitute a choice pursuant to Section 8(a).

Thereafter, Petitioner saw a third orthopedic surgeon, Dr. Lorenz at Hinsdale Orthopaedics. The medical records submitted do not reflect any referral or corroborate Petitioner's testimony that she saw him after a referral. To the contrary, the records reflect Petitioner's own handwritten statements that Dr. Stronger—an unknown physician to the medical treatment rendered in this case—and her then-current attorney referred her to Dr. Lorenz or Hinsdale Orthopaedics. Thus, Petitioner's medical treatment with Dr. Lorenz constitutes her first choice of physician.

Petitioner also saw a fourth orthopedic surgeon, Dr. Siemionow. There is no reference in any of the medical records referring Petitioner to Dr. Siemionow from an allowable chain of referral. Thus, Petitioner's medical treatment with Dr. Siemionow constitutes her second choice of physician. Based on all of the foregoing, the Arbitrator finds that Petitioner has not exceeded her allowable choices.

Respondent also disputes Petitioner's claim that it is liable for certain medical bills after Dr. Gleason's addendum report dated October 9, 2011 asserting that such treatment was not for causally related conditions, which has been addressed above, and that it was not reasonable or necessary.

As noted in the causal connection analysis above, the Arbitrator finds that Petitioner has established causal connection between her left hip and low back conditions and her accident at work through October 9, 2011 based on the opinions of Respondent's Section 12 examiner, Dr. Gleason. Accordingly, the Arbitrator finds that the medical bills submitted into evidence by Petitioner that remain unpaid for treatment through October 9, 2011 as indicated to be reasonable and necessary by Dr. Gleason are to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit, if any, as agreed by the parties. Petitioner's claim for payment of medical bills after October 9, 2011 and as indicated by Dr. Gleason to be unreasonable or unnecessary is denied.

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

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to her accident at work through October 9, 2011 based on the opinions of Dr. Gleason. Accordingly, and in consideration of the record as a whole, the Arbitrator denies the recommended prospective medical care in the form of a revision fusion surgery at L5-S1 as prescribed by Dr. Siemionow.

In support of the Arbitrator's decision relating to Issue (L), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at *28 (opinion filed June 26, 2014); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003).

In light of the causal connection analysis explained above, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits beginning May 10, 2011 through October 9, 2011. In this case, the record reflects that Petitioner was undergoing active medical treatment and placed off work or on light duty restrictions by Drs. Sharma, Farrell, DePhillips, Lorenz, and Siemionow as it related to her left hip and low back conditions during this period of time. However, Respondent presented evidence that Petitioner was able to work, and did in fact work, during some portion of the claimed temporary total disability period in a document entitled "Time Detail" for Petitioner's worked hours from May 10, 2011 through December 9, 2012. RX12. The parties agreed at the hearing that Respondent would be entitled to credit for periods that Petitioner worked during the claimed temporary total disability period and she does not claim entitlement to temporary partial disability benefits. AX1.

In light of the foregoing, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from May 10, 2011 through October 9, 2011. Respondent shall receive a credit for hours paid while Petitioner worked as reflected in Respondent's Exhibit 12 as agreed by the parties.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Walter Barber,

Petitioner,

16IWCC0312

vs. NO: 11 WC 46763

L&M Super Vac,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Arbitrator found that Petitioner proved a compensable accident on November 23, 2011 which caused a current condition of ill being of his left shoulder and proper notice was provided. She awarded Petitioner 175 weeks of temporary total disability benefits, all current medical expenses, and ordered Respondent to authorize and pay for prospective treatment recommended by Dr. Mall and Dr. King. The Commission agrees with the determinations of the Arbitrator in finding accident and causal connection as well as the determination of proper temporary total disability benefits and affirms those aspects of the Decision of the Arbitrator.

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Findings of Fact and Conclusions of Law

1. Petitioner injured his left shoulder at work on November 23, 2011 after tossing a bag of trash unto the flatbed of a truck.

2. The medical records indicate Petitioner presented to the emergency department of Memorial Hospital on November 27th. X-rays of the shoulder and chest were unremarkable. The clinical impression was tendinitis of the left shoulder. He was released to work in two days, earlier if he felt better. He was not to perform heavy lifting until cleared by his doctor, with whom he had an appointment the following Friday.

3. On December 5, 2011, Petitioner presented to Weimer for evaluation of his shoulder injury. Dr. Weimer's impression was likely labral pathology and possible SLAP lesion. He wanted an MR arthrogram, but Petitioner wanted to file a Workers' Compensation claim first. Petitioner was released to light duty with 5-pound left arm lifting limit.

4. Dr. Weimer prescribed conservative treatment including physical therapy and injections, On March 15, 2012, Petitioner returned to Dr. Weimer and indicated he thought the last injection helped somewhat with range of motion but did not really think it helped the pain. In looking at the mechanism of injury, Dr. Weimer thought Petitioner suffered a small partial rotator cuff tear that was symptomatic. He indicated Petitioner had failed conservative treatment, recommended surgery, and kept Petitioner off work until further notice.

5. On May 13, 2012, Petitioner had a medical examination performed by Dr. King at the direction of Respondent, pursuant to Section 12 of the Act. Dr. King opined that The mechanism of injury Petitioner reported could either cause the shoulder pathology Petitioner exhibited or significantly aggravate an underlying condition. He recommended arthroscopic evaluation of the labrum, addressing subacromial space issues, and possible rotator cuff tear repair and biceps tenodesis.

6. On July 24, 2012, Dr. Weimer performed shoulder arthroscopy with arthroscopic repair of a partial thickness rotator cuff tear, subacromial decompression, and debridement of bursal surface rotator cuff tendonosis for subacromial impingement and partial tear of the rotator cuff.

7. Dr. Weimer continued to supervise Petitioner's post-operative care. On December 19, 2012, Dr. Weimer responded to an inquiry from Petitioner's lawyer. He noted Petitioner's post-operative progress was complicated by adhesive capsulitis. Dr. Weimer recommended additional physical therapy which was subject to a utilization review. He was unable to contact the utilization review doctor and the physical therapy was denied.

Dr. Weimer noted that Petitioner was not able to return to work and needed additional physical therapy.

8. On January 13, 2013, Petitioner had a second section 12 medical examination performed by Dr. King, at the request of Respondent. He noted that Dr. Weimer performed arthroscopic surgery to repair the partial rotator cuff tear, subacromial decompression, and debridement of bursal surface rotator cuff tendinosis. Petitioner still had pain and an injection after surgery temporarily relieve all symptoms. Petitioner indicated he was told he needed to strengthen the shoulder to resolve the pain. After his examination, Dr. King diagnosed impingement syndrome, AC joint arthritis, biceps tensynovitis, and a labral tear. He felt the labral pathology was related to Petitioner's accident. He recommended AC resection, evaluation and possible repair of the labrum, and biceps tenodesis.

9. On January 23, 2013, Petitioner returned to Dr. Weimer who indicated that during surgery he spent a lot of time looking for a labral and/or long biceps tendon tear but did not find any. He had also re-reviewed the numerous photographs taking during surgery which also had shown no such pathology. He noted that Petitioner had another Section 12 medical examination and the doctor recommended additional surgery including resection of the AC joint as well as possible labral repair and a biceps tenodesis. Dr. Weimer thought such surgery was not indicated. He continued to believe Petitioner's pain was secondary to adhesive capsulitis, which he had for some time. They were unable to have additional physical therapy approved. He again recommended additional physical therapy, and a new MRI. He administered an injection. If such treatment was not successful he would recommend an arthroscopic capsulotomy.

10. On January 2, 2014, Dr. Weimer noted the new MRI showed significant fluid around the long biceps tendon, which he thought indicated a tear. He administered a diagnostic injection, which corroborated the tear. He recommended surgical bicep repair and capsulotomy. He again refuted the radiologist's interpretation of a labral tear noting he observed that exact location during surgery.

11. On January 28, 2014, Dr. Weimer performed shoulder arthroscopy with distal clavicle excision, posterior capsulotomy, subacromial adhesiolysis, open subpectoral biceps tenodesis, and debridement of rotator cuff for adhesive capsulitis, partial tear of the long biceps tendon, subacromial adhesions, AC joint osteoarthritis, and bursal surface rotator cuff tendonosis.

12. Petitioner continued treating conservatively with physical therapy and injections. By May 12, 2014, Dr. Weimer noted Petitioner would continue with a home exercise program only. He released Petitioner with significant lifting restrictions. However, Dr. Weimer noted that six months post surgery Petitioner would not need restrictions and

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released him prn and to full duty as of July 28, 2014. Petitioner testified Dr, Weimer would not see him after he released him to full-duty work.

13. On September 3, 2014, Petitioner presented to Dr. Mall for a second opinion regarding his left shoulder. In his intake form he indicated he heard about Dr. Mall from his lawyer. Petitioner had two previous surgeries after initially injuring his shoulder in 2011. Dr. Mall examined Petitioner, viewed MRIs, and reviewed arthroscopic photos taken during surgery.

14. Dr. Mall diagnosed AC joint arthrosis and posterior labral flattening/Kim lesion, which he indicated was suggested in the surgical photos, but were often missed. He also noted that the photos did not show the surgeon palpating the superior labrum and therefore there could easily be a tear which was not identified. He administered therapeutic/diagnostic injections. If a possible series of injections did not provide lasting relief he would recommend surgery. He restricted Petitioner to 10-pound lifting from floor to waist, 5-pound lifting above the waist, and no reaching overhead.

15. On September 15, 2014, Petitioner had another section 12 medical examination at Respondent's request, this time by Dr. Rotman. After his examination and review of the medical records, Dr. Rotman believed that Petitioner's pathology was relatively minor. He thought that biceps and clavicle resections were not really indicated in the first place but he understood why Dr. Weimer performed those procedures after the section 12 examinations and because the procedures were fairly benign.

16. Dr. Rotman opined that currently there was no major problem with Petitioner's shoulder and no further treatment was indicated. The only injury he could relate to the mechanism of injury was the minimal rotator cuff lesion. The other pathology would not be related to the alleged accident. Petitioner was at maximum medical improvement and could return to work at full duty per the recommendation of Dr. Weimer.

17. On September, 19, 2014, Petitioner presented to Dr. King, on his own volition, seeking another opinion regarding prospective treatment for his left shoulder. Petitioner reported he had the same pain as he did prior to treatment with Dr. Weimer. He also reported he saw Dr. Rotman, who after consultation with Dr. Weimer, opined that Petitioner did not need any additional treatment. Petitioner also saw Dr. Mall who recommended additional arthroscopic surgery. Dr. King examined Petitioner again. He recommended additional arthroscopic evaluation to assess Petitioner's AC joint, evaluate the labrum, and possible biceps tenodesis revision. He opined that the need for this surgery was caused by the work injury.

The Arbitrator awarded all medical expenses incurred to date as well the recommended prospective treatment. In doing so she found that Petitioner did not exceed his two choices of

doctors as prescribed under Section 8(a) of the Act. She agreed with Petitioner's statement that he was referred to Dr. Weimer by the Memorial Hospital Emergency Department and therefore that referral did not comprise a selection of physicians under the Act.

The Commission concedes that there is a reference in the emergency department records that Petitioner was to "f/u Weimer." However, the emergency department records also show that Petitioner was seen prior to his already scheduled Friday appointment with "his doctor."

Therefore, the Commission concludes that Dr. Weimer was "his doctor" prior to his visit to the Memorial Hospital Emergency Department. Consequently, the choice of Dr. Weimer was his first choice and Dr. Mall was his second choice. The record is clear that when Petitioner saw Dr. King for his "second" second opinion in January of 2014, that decision was his and his alone and not due to any direction from Respondent. Therefore, his choice to return to Dr. King became his third choice, which would be outside the purview of the Workers' Compensation Act and is thus not compensable. Accordingly, the Commission vacates the award of medical expenses incurred from the treatment/evaluation performed by Dr. King.

However, the fact that the Commission finds that Dr. King was Petitioner's third choice of doctors only precludes Respondent's responsibility under the Act to pay for the treatment he provided. It does not preclude the Commission from considering his treatment notes in arriving at our decision. In effect his treatment note becomes a Section 12 medical examination report solicited by Petitioner. In this matter, the Commission finds his opinions persuasive and finds the combination of his and Dr. Mall's opinions more persuasive that those of Dr. Weimer and Dr. Rotman. Therefore, the Commission affirms the Decision of the Arbitrator ordering Respondent to authorize and pay for prospective treatment they recommend.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $324.45 per week for a period of 175 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses specified in Petitioner's Exhibit 1 pursuant to §8(a) of the Act and subject to the applicable medical fee schedule under §8.2 of the Act, except those relating to any treatment rendered by Dr. King. The Arbitrator's award of Dr. King's medical bills is vacated

IT IS FURTHER ORDERED BY THE COMMISION that Respondent authorize and pay for prospective medical treatment for his left shoulder condition prescribed by Dr. Mall.

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16IWCC0312

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 12 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-4/13/16
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Under the Weather

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

16IWCC0312

BARBER, WALTER
Employee/Petitioner

Case# **11WC046763**

L&M SUPER VAC
Employer/Respondent

On 6/19/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0000 EVANS BLASI LAW OFFICE
PETER BLASI
1512 JOHNSON RD
GRANITE CITY, IL 62040

2965 KEEFE CAMPBELL BIERY & ASSOC
TIMOTHY J O'GORMAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

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

16IWCC0312

- ☐ 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)

Walter Barber
Employee/Petitioner

v.

Case # **11** WC **46763**

Consolidated cases: N/A

L&M Super Vac,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **April 23, 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 Petitioner's choice of physicians

FINDINGS

16IWCC0312

On **11/23/11**, 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 the accident ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$25,307.10**; the average weekly wage was **$486.68**.

On the date of accident, Petitioner was **29** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$46,489.05** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$46,489.05**.

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 $324.45/week for 175 weeks, commencing December 7, 2011 through April 23, 2015, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services as set forth in PX 1, as provided in Sections 8(a) and 8.2 of the Act and subject to the Medical Fee Schedule. Respondent shall receive credit for any medical bills previously paid.

Respondent shall authorize and pay for the treatment recommended by Dr. Mall and Dr. King as provided in Section 8(a) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of 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.

Mary Lindsey
Signature of Arbitrator

June 19, 2015
Date

ICArbDec p. 2

JUN 19 2015

Walter Barber v. L & M Super Vac, 11 WC 46763 (19 (b))

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

According to the medical records Petitioner initially sought medical treatment from Memorial Hospital Emergency room on 11/27/11. Petitioner reported pain in the chest and left arm pain. Petitioner was noted to have experienced nausea and vomiting. Petitioner reported that he "does a lot of heavy lifting" and had pain for 1 week. EKG's and x-rays of the left arm were read as normal. Petitioner was advised to perform no heavy lifting or repetitive use of the left arm until he followed up with orthopedic Dr. Donald Weimer. (PX. 2)

Petitioner was next seen by Dr. Donald Weimer on 12/5/11. Petitioner gave Dr. Weimer a history of injuring his left shoulder at work on 11/23/11 throwing trash bags 8 feet high into the back of a sweeper truck. Petitioner described swinging trash bags from his side and noting immediate onset of pain. Petitioner reported constant anterior deep pain, swelling, bone to bone rubbing, numbness, popping, loss of motion and difficulty elevating the shoulder. Dr. Weimer's impression was that there was likely labral pathology and ordered an MR Arthrogram for further evaluation. Petitioner was placed on restrictions of no pushing, pulling or lifting greater than 5 pounds and no overhead reaching or climbing. Petitioner was directed to follow up with Dr. Weimer after the MR Arthrogram was done. (PX. 4).

Dr. Weimer placed Petitioner completely off-work on 12/7/11 pending the approval of worker's compensation approving the MR Arthrogram of the left shoulder. (PX. 4)

Petitioner underwent an MR Arthrogram on 2/7/12 at MidAmerica Imaging. The radiologist reported finding a posterior labral tear, a shallow and small partial thickness bursal surface tear or fraying of the posterior supraspinatus tendon insertion, effusion and mild thickening of the subacromial subdeltoid bursa and Lateral down sloping of the acromion. Fluid was noted by the radiologist to be found in a cleft at the base of the posterior labrum (PX. 3).

Dr. Weimer saw Petitioner on 2/13/12 to review the MR Arthrogram. Dr. Weimer was skeptical about the presence of the labral tear read by the radiologist. Dr. Weimer notes that Petitioner's complaints were localized to the mid deltoid region while abducting the arm. Dr. Weimer noted finding impingement at the anterolateral edge of the acromion and tendinosis at the posterior supraspinatus. Dr. Weimer injected a local anesthetic into the subacromial space and Petitioner reported 85%-90% improvement in pain, but still reported popping. Dr. Weimer felt that Petitioner's problem was likely impingement with the bursal surface tendinosis. Dr. Weimer ordered two weeks of physical therapy to see if Petitioner responded. Dr. Weimer kept Petitioner off work until the next scheduled visit. (PX. 4).

Petitioner attended Physical therapy at Belleville Memorial Hospital. Petitioner reported too much pain to continue with program. (PX. 7).

Petitioner returned to see Dr. Weimer on 2/27/12 reporting that he was unable to complete the therapy because it caused him too much pain. Petitioner was noted of reporting localized pain in the anterior aspect of the shoulder and for there to be swelling present. Dr. Weimer found Petitioner to be tender along the biciptal sheath. Dr. Weimer's impression was bicipital tendinitis and recommend an injection. Dr. Weimer ordered additional physical therapy. Petitioner was kept off work by Dr. Weimer. (PX. 4).

Petitioner returned to physical therapy at Belleville Memorial Hospital. (PX. 7).

Dr. Weimer saw Petitioner again on 3/15/12. Petitioner reported that the injection into the biceps helped but that he was still very painful and experienced popping and a catching sensation in his joint. Petitioner reported that at times the pain was so intense he would cry. Dr. Weimer noted swelling and tenderness anteriorly and over the biceps tendon. Dr. Weimer noted that the MRI read by the radiologist did note a posterior labral tear and a possible small partial thickness bursal-sided tear at the posterior supraspinatus with the latter accounting for his symptoms. Dr. Weimer opined that the history given by Petitioner, swinging the trash bags, probably resulted in the small partial tear. Dr. Weimer recommended proceeding with a left shoulder arthroscopy with a possible repair of the posterior labrum and decompression and repair of the partial thickness bursal-sided tear at the posterior supraspinatus tendon. A possible biceps tenodesis was also considered by Dr. Weimer if a significant tear was found in the long biceps tendon at the time of the arthroscopy. Petitioner agreed to proceed with the surgery and Dr. Weimer sought approval from worker's Compensation to schedule. Dr. Weimer kept Petitioner off-work until further notice. (PX. 4).

Petitioner was sent to Orthopedic Surgeon Dr. David J. King by the Respondent for a Section 12 examination on 5/31/2012. (P.6 exhibit 2). Dr. King is a board certified orthopedic surgeon, licensed to practice in Illinois and Missouri. Dr. King took a history from Petitioner. Petitioner reported to Dr. King that he works driving a sweeper truck and that he has had left shoulder pain since injuring it on 11/23/11 lifting large bags into the air above his head. Dr. King noted that the history reported to him by Petitioner was similar to the prior records he reviewed. Dr. King noted that Petitioner did have a muscle strain in 2004-2005, but that it recovered quickly. Dr. King noted that there were no medical records to indicate prior treatment. Dr. Kings' physical exam revealed positive O'Brien testing, discomfort and weakness with thumbs on abduction testing, positive Neer and Hawkings impingement test and Tenderness over the bicipital groove. Dr. King noted no pain in the AC joint. Dr. King noted that the 2/7/11 MRI arthrogram revealed a posterior labral tear, small partial-thickness bursal sided rotator cuff tear supraspinatus, effusion and mild thickening of the subacromial deltoid bursa and a down slopping acromion. Dr. King opined that Petitioner suffered a labral tear and possible partial thickness rotator cuff tear based upon the claimed injury from 11/23/11. Dr. King opined that the mechanism of throwing trash bags or lifting them above the head could create this pathology. Dr. King noted there are no medical records to suggest the injury was pre-existing and Petitioner was working full-duty up until the time of the injury. Dr. King opined that conservative measures have failed and that the surgery proposed by Dr. Weimer was warranted. Dr. King recommended evaluation and repair of the labrum, address the subacromial space issues and a possible repair of the rotator cuff and biceps. Dr. King opined that the treatment to date was reasonable and the surgery and need for surgery were related to Petitioner's work injury. Dr. King did not feel Petitioner was at maximum medical improvement, but felt Petitioner could return to work with restrictions of no lifting over 25 lbs. overhead.

Petitioner underwent left shoulder arthroscopic surgery performed by Dr. Weimer on 7/24/12 at the Belleville Surgical Center. Dr. Weimer notes that the arthroscope was inserted posteriorly and that the biceps and labrum were intact. Dr. Weimer performed a bursectomy, he noted impingement and performed a subacromial decompression. Dr. Weimer also repaired a small partial thickness bursal-sided tear of the posterior supraspinatus. (PX. 4).

Petitioner followed up with Dr. Weimer on 8/1/12, 8/16/12, 10/4/12, 11/28/12. Dr. Weimer ordered Physical therapy and kept Petitioner off work. Dr. Weimer noted on December 19, 2012 that some of the physical therapy he had ordered had been denied by Workers' Compensation and that Petitioner's recovery was complicated by frozen shoulder (adhesive capsulitis). Dr. Weimer opined that further

physical therapy was necessary for Petitioner due the complications and weakness he was experiencing. Dr. Weimer notes that it would be unsafe for Petitioner to return to work. (PX. 4).

Petitioner was sent back to Orthopedic Surgeon Dr. David J. King by the Respondent for a Section 12 examination on 1/10/2013. (PX.6 exhibit 3). Dr. King reports that Petitioner complained of anterior – based pain pointing over the bicipital groove and A.C. joint. Petitioner reported to Dr. King that he was continually being told the he simply needed to strengthen the shoulder and his pain would go away. Dr. King notes that Petitioner's anterior pain complaints were exactly the same as before surgery. Dr. King's physical exam revealed decreased range of motion, rotator cuff strength diminished and significant pain with palpitation of the biceps over the bicipital groove. Dr. King noted severe pain with O'Brien testing and a positive Yergason's test. Pain was also noted at the A.C. joint with palpitation and cross body adduction. Dr. King's assessment was Impingement syndrome of the left shoulder, arthritis of the A.C. joint, biceps tenosynovitis and a sprain/SLAP tear. Dr. King indicated that he reviewed the surgical records and notes from Dr. Weimer. Dr. King noted that Petitioner continues to have pain in similar areas as were prior identified in May of 2012. Dr. King opined that he believes the pathology is not pre-existing and is directly related to the 11/23/11 work injury. Dr. King recommended a revision arthroscopy with a.c. resection, evaluation and possible labral repair and a biceps tenodesis. Dr. King opined that he believed these procedures would address Petitioner's symptoms and allow him to get back to full duty work. Dr. King opined that Petitioner was not at MMI. Dr. King gave restrictions of no lifting/carrying more than 20 lbs. to chest level or lifting/carrying more than 5 lbs. overhead with the left arm.

Petitioner was next seen by Dr. Weimer on 1/23/13. Dr. Weimer noted that Petitioner was 26 weeks out from his arthroscopic repair. Dr. Weimer noted that he saw no pathology of the labrum or biceps tendon at the time of surgery. Petitioner reported to Dr. Weimer that he continues to experience anterior shoulder pain and that it is worse at night when he lays on his side. Dr. Weimer notes that since he last saw Petitioner he was seen by another surgeon for an IME who recommended an additional surgery that would include resection of the AC joint, as well as a labral repair and biceps tenodesis. On examination Petitioner was found to be tender at the coracoid process and the anterior inferior joint capsule. Petitioner was also found to have some discomfort over the long biceps tendon. Dr. Weimer opined that Petitioner still showed evidence of adhesive capsulitis and he felt the untreated adhesive capsulitis was responsible for Petitioner's ongoing symptoms. Dr. Weimer noted that Petitioner had been dealing with the condition for some time now because workers' compensation would not approve additional physical therapy. Dr. Weimer also notes that workers' compensation would only approve the surgery recommended by their IME physician instead. Dr. Weimer disagreed with the recommendation for additional surgery. Dr. Weimer gave Petitioner another shot to address the adhesive capsulitis and further recommended the additional therapy to focus on elevation and internal rotation. Dr. Weimer additionally opined that the lack of motion was now causing subcoracoid impingement and that if physical therapy and injections did not allow him to regain his range of motion that an arthroscopic capsulotomy would be recommended. Dr. Weimer also recommended that another MR Arthrogram be performed before undergoing another surgery. Petitioner was kept off-work. (PX. 4).

Dr. Weimer next saw Petitioner on 2/28/13. Petitioner was noted to have returned to physical therapy and showing improvement with his range of motion, but still experiencing pain. Dr. Weimer recommended further physical therapy to focus on internal rotation. Petitioner was kept off-work. (PX. 4).

Dr. Weimer next saw Petitioner on 12/19/13 where it was noted that the MR Arthrorgram was ordered following the entry of the Illinois Insurance Guarantee Fund.

Petitioner underwent an MR Arthrogram on 12/26/13 at MidAmerica Imaging. The radiologist reported finding a "small persistent posterior labral tear located along the articular surface at or near the labrocartilaginous junction, and mild supraspinatus tenodinosis with fraying along the bursal surface and minimal effusion of the subacromial-subdeltoid bursa suggesting bursitis, The biceps long head tendon was found by the radiologist to be "intact." (PX. 3).

Petitioner returned to see Dr. Weimer on January 2, 2014. Dr. Weimer notes that in his review of the MR Arthrogram he found significant fluid around the long biceps tendon in the bicipital groove. Dr. Weimer notes that Petitioner's complaints are primarily of anterior pain. Dr. Weimer found Petitioner to be tender along the long biceps tendon in the bicipital groove. Petitioner was noted as having pain with lifting and internal rotation behind his back. Petitioner's internal rotation was noted as still somewhat limited due to the adhesive capsulitis. Petitioner was noted as having pain with resisted supination and no pain with resisted abduction and Dr. Weimer opined that those findings were consistent with symptomology from the long biceps tendon. Dr. Weimer further opines that he believed the fluid shown represents a tear of the biceps tendon. Dr. Weimer notes that his previous arthroscopy did not show a tear of the intraarticular portion of the long biceps tendon, but he believes now there is a tear in the bicipital groove. To test the presence of pathology in the biceps, Dr .Weimer administered a shot of anesthetic into the biceps sheath and Petitioner's pain reportedly resolved. Dr. Weimer noted that the radiologist again noted the tear of the posterior labrum, but Dr. Weimer noted that his arthroscopy in 2012 did not show the existence of a tear and he believes Petitioner's continuing pain in that area was related to the frozen shoulder. Dr. Weimer sought approval for a left shoulder arthroscopy and open subpectoral biceps tenodesis and a posterior capsulotomy. Petitioner was kept off-work. (PX. 4).

Petitioner underwent an arthroscopic distal clavicle excision, arthroscopic posterior capsulotomy, arthroscopic subacromial adhesiolysis, arthroscopic debridement of bursal surface rotator cuff tendonosis and an open biceps tendon repair surgery performed by Dr. Weimer on 1/28/14 at the Belleville Surgical Center. Dr. Weimer notes that the superior, inferior, anterior and posterior labrum were found to be intact. (PX. 4).

Petitioner returned for physical therapy at Memorial Hospital. (PX. 7).

Dr. Weimer saw Petitioner on 2/5/14 where additional physical therapy was recommended. Dr. Weimer noted that Petitioner was off-work until further notice. Petitioner returned to see Dr. Weimer on 2/13/14 where he was noted as still having restricted motion. Dr. Weimer saw Petitioner on 3/3/14. Petitioner reported to Dr. Weimer that he felt the pain was worse than before he had surgery and located both anteriorly and posteriorly. Dr. Weimer believed that a lot of the pain was coming from the subcoracoid impingement of the scapular wining. Dr. Weimer recommended that he work with the physical therapist and was given tramadol for pain. Dr. Weimer increased Petitioner's physical therapy with the goal of increasing strength up to 5 pounds. Petitioner was instructed to return in 5 weeks. (PX. 4).

Petitioner returned to see Dr. Weimer on 4/14/14. Petitioner is noted as still not being able to work and complaining of a lot of weakness and deep pain in the joint with lifting. Petitioner reported to Dr. Weimer that he did not get much relief from the cortisone injection given back in February. Dr. Weimer felt that Petitioner was doing well with his range of motion, but that Petitioner's main problem was weakness. Dr. Weimer prescribed Tramadol with Tylenol for pain and recommended 4 more weeks of therapy and stretching with 4 pound Thera-Bands. Dr. Weimer kept Petitioner off-work. (PX. 4).

Petitioner was last seen for Physical Therapy on 5/9/14 at Belleville memorial hospital. The Physical therapist on that date noted that Petitioner continued to have shoulder pain on a 4-5/10 scale and experienced tightness 1 hour after therapy. Petitioner reported that he was continuing to take pain

medications for his symptoms. Petitioner was found by the physical therapist to be unable to progress to lifting 2 lbs. The long term goals of physical therapy were noted to have been "unmet." Petitioner also reported continued "deep sensation of pain in the left shoulder, upper arm and periscapular area. The physical therapist noted a catch when the arm was rotated at approximately 110 degrees. (PX. 7).

Dr. Weimer last saw Petitioner on 5/12/14. Dr. Weimer noted that Petitioner was 15 weeks post-surgery. It is noted that Petitioner is up to a "1-pound weight with strengthening." Dr. Weimer recommends that Petitioner continue with just a home exercise program to regain his internal rotation. Petitioner was released to return to work with restrictions of no pushing, pulling or lifting greater than 10 lbs. with the left arm to the waist, 5 lbs. with the left arm to chest level and 2lbs with the left arm overhead. Dr. Weimer indicated that he would see Petitioner "as needed" and at 6 months post—op Petitioner would not need as restriction. (PX. 4).

Dr. Weimer's notes show that Petitioner called Dr. Weimer's office on 6/30/14 reporting superior stabbing pain with elevation above chest. The notes show that Petitioner reported that it "feels like his clavicle is stabbing into shoulder." Dr. Weimer's office noted that an authorization for a repeat MRI would be sought from workers' comp. (PX. 4).

Dr. Weimer's office notes from 7/1/14 show that workers' compensation denied further treatment and indicated its intent to pursue another IME. (PX. 4).

Petitioner testified that Petitioner was released by Dr. Weimer to return to work on July 28, 2014. (PX 4)

Per the order of Dr. Weimer, Petitioner underwent an MRI on 8/5/2014 at MidAmerica Imaging. The radiologist reported finding rotator cuff tendinosis and peritendinitis without discrete tear, small effusion of the subacromial-subdeltoid bursa, chronic posterior labral tear and a prior biceps tenodesis. (PX 3)

Dr. Mall examined Petitioner on 9/3/14. Dr. Mall took a history of an injury occurring back in 2011 when Petitioner was slinging an 80 pound trash bag in front of a bar. Petitioner reported that he had two shoulder surgeries in the past but continued to experience pain. Petitioner reported to Dr. Mall that his shoulder felt unstable and he described anterior and posterolateral pain going into the elbow. Petitioner advised Dr. Mall that his pain was the same or more as it was before the surgery. Dr. Mall found that Petitioner had pain anteriorly, pain reaching behind his back, tightness as well as pain posterior, superior and anterior in location. Dr. Mall's examination revealed point tenderness over the AC joint, mild pain with impingement testing, and pain with a posterior directed force in the supine positon with the arm adducted. Dr. Mall reproduced a small click or clunk posteriorly. Petitioner was noted as having pain with cross-body adduction at the AC joint. Dr. Mall reviewed x-rays which were read as normal. Dr. Mall reviewed MRI films from August 2014 where he notes irregularity of the posterior labrum. Dr. Mall reviewed the arthroscopic photos from the 7/24/12 and 1/28/14 surgeries. Dr. Mall opined that the photos from both demonstrate the presence of a labral peel back or Kim-Type lesion of the posterior labrum. Dr. Mall diagnosed Petitioner as having AC joint arthrosis and posterior labral flattening/Kim lesion. Dr. Mall recommended proceeding with diagnostic injections into the shoulder to isolate the major component of Petitioner's pain. Dr. Mall noted that on examination Petitioner did have some issues with the posterior labrum. Dr. Mall also felt the AC joint was a major component. Dr. Mall injected lidocaine into the AC joint and Petitioner's pain improved significantly, but Petitioner continued to have pain with posterior directed force and load shifting. Dr. Mall next injected lidocaine into the glenohumeral joint and this resolved the remaining aspects of Petitioner's pain complaints. Dr. Mall administered cortisone injections into the AC joint to relieve discomfort. Dr. Mall recommended that Petitioner take anti-inflammatory medication and continue with physical therapy to regain the rest of his rotator cuff strength

and range of motion of the shoulder. Dr. Mall opined that if Petitioner's pain continued he would recommend an AC joint resection and posterior labral repair. Dr. Mall noted

> "Again, even when there is not a clear labral chondral disassociation, this can be a problem for patients. This so-called Kim lesion of the posterior labrum and is well documented in the medical literature. This is something that often times is missed and can respond well to posterior labral repair in which a larger bumper is created posteriorly for the patient."

Dr. Mall opined that Petitioner's symptoms following the work-related injury have not been resolved with the two prior surgeries. Dr. Mall opined that Petitioner's current symptoms and the necessity for future treatment are connected to his work injury that occurred while slinging trash. Dr. Mall opined that the treatment Petitioner received to date was medically necessary and required. Dr. Mall recommend Petitioner return to see him in 3-4 weeks and gave work restrictions of no lifting over 10 pounds or 5 pounds over head. No reaching overhead/overhead work and no pushing pulling over 5 pounds. Petitioner was also advised to primarily perform only one-handed work and avoid constant repetitive use of the left arm. (PX. 5).

Petitioner was examined by Dr. Mitchell Rotman at the request of the Respondent for another Section 12 examination. (RX 1). Petitioner gave a history of injuring his left shoulder slinging trash bags at work on 11/23/11. Petitioner complained of loss of motion, constant pain and instability in the arm. Dr. Rotman notes that Petitioner had two surgeries including a rotator cuff repair and biceps tenodeises, but no labrum repair. Dr. Rotman noted that he reviewed the medical records and arthroscopic photos from Dr. Weimer along with MR Arthrograms from 2012 and 2013 and the 2014 MRI. Dr. Rotman noted that the photos from 2012 and 2014 depicted no tears of the posterior labrum. Dr. Rotman described that be observed "irregularities" of the posterior labrum, but that he felt those represented a congenital variant rather than something related to an injury. Dr. Rotman opined that there was a little elevation of the posterior labral lesion, which would have appeared as a tear on an MRI. Dr. Rotman reviewed the MRI's and opined that the posterior irregularities correlated with the photographs. Dr. Rotman's examined Petitioner and found Petitioner complaints to be "nonspecific." Although pain was noted with O'Brien testing, Dr. Rotman found the test to be negative. Dr. Rotman was not able to demonstrate a click. Dr. Rotman opined that there was no evidence of a labral tear and that Petitioner's injury amounted to an "extremely minor rotator cuff lesion" and "secondary impingement." Dr. Rotman believes that Petitioner should have been back to work full duty in 3 months following the first surgery and that the second surgery was unnecessary. Dr. Rotman disagrees with the need for further surgery recommended or treatment as recommended by Dr. King and Dr. Mall. Dr. Rotman opined that Petitioner is at MMI and capable of returning to work without restrictions.

Petitioner returned to see Dr. King on 9/19/14. Dr. King noted in his history the past evaluations he performed on Petitioner, surgery by Dr. Weimer and Petitioner's recent Section 12 examination with Dr. Rottenman. Dr. King notes that Petitioner had sought treatment from Dr. Nathan Mall on September 3, 2014 and that Dr. Mall had, like him, recommended further arthroscopic intervention to address acromioclavicular joint arthrosis and a possible labral tear. Dr. King notes that Dr. Mall placed restrictions on Petitioner and recommended additional injections and physical therapy. Petitioner reported to Dr. King that his pain was the same as it was prior to treating with Dr. Weimer. Dr. King's physical exam of Petitioner revealed pain at the acromioclavicular joint with cross body adduction, pain with proximal biceps testing and pain with O'Brien testing and load shifting. Dr. King's assessment was left shoulder residual pain due to acromioclavicular joint arthorosis, left shoulder residual proximal biceps pain and left shoulder possible labral tear. Dr. King recommendations remained the same. Dr. King believes additional arthroscopic evaluation is warranted to assess the acromioclavicular joint and possible

revision biceps tenodesis and possible labrum repair. Dr. King opined that the need for this intervention is directly related to the work injury of 11/23/11. (PX. 6, exhibit 4).

Petitioner returned to see Dr. King on 1/8/15. Petitioner is noted as having ongoing pain in his left shoulder in the posterior region. Petitioner reported shoulder instability. Petitioner is noted to have been doing home exercises, but under no other treatment or therapy. Dr. King noted the treatment history by Dr. Weimer and most recent surgery of 1/20/14. Dr. King notes that he reviewed MRI Arthrograms and arthroscopic images from Dr. Weimer's 1/20/14 surgery. Physical exam of Petitioner revealed pain with posterior direct force and load and shift, a positive O'Brien test, pain with apprehension testing, tenderness over the acromioclavicular joint and pain with cross-body adduction. Decreased pain is noted along the biceps tendon. Dr. King's assessment was left shoulder residual pain at the level of the acromoclavicular joint, left shoulder improved, pain in the proximal biceps and left shoulder pain continued secondary to posterior labral tear. Dr. King opines that Petitioner continues to have symptoms consistent with a posterior labral tear. Dr. King notes that the two surgeries performed by Dr. Weimer have not resolved his symptoms. Dr. King opined that he continues to believe that it is reasonable to consider additional surgical intervention with Dr. Mall specifically related to the posterior labral pathology shown on the MRI arthorgrams and the arthroscopic images. Dr. King opined that the posterior labral pathology is related to the primary work injury. (PX. 6, exhibit 5).

Dr. King was deposed on February 23, 2015. Dr. King testified that he was initially hired by the Respondent's attorney to perform a section 12 examination on Petitioner back in May of 2012. Dr. King testified that when he first examined Petitioner tested positive with O'Brien testing which was consistent with a labrum tear. (PX. 6, pp 7-8). Dr. King testified that he felt the labral pathology was related to the work injury. (PX. 6, p. 11). Dr. King found positive O'Brien testing every time he examined Petitioner. (PX.6 p10, p12 and p14). Dr. King opined that he believes the pain Petitioner continues to experience is from the labral tear not addressed in Dr. Weimer's surgeries. (PX. 6, p. 15). Dr. King identifies the labral pathology in the MRI as well as the arthroscopic images. (PX. 6, p. 15). Dr. King testified that the treatment and surgery proposed by Dr. Mall is reasonable and medically necessary. (PX. 6, p. 16). Dr. King testified that the restrictions given by Dr. Mall were reasonable and related to the work injury. (PX. 6, p. 16).

Petitioner's case proceeded to arbitration on April 23, 2015. Two witnesses testified at the hearing: Petitioner and Keith Kannewurf.

Petitioner testified that he worked for Respondent in 2011. Petitioner testified that he had worked there for about a year before his injury on 11/23/11. Petitioner was responsible for cleaning parking lots, blowing out corners/sidewalks and dumping garbage cans. Petitioner testified that he would have to sling garbage cans/bags back and forth to throw them 7-8 feet up into the back of a sweeper truck. Petitioner testified that he worked 6-7 days per week and that most of his routes were in MO, but L & M was based in Illinois. Petitioner worked from 9:00 pm to 7:00 am. Petitioner testified that for a brief period in the summer he worked for two other companies where he was required to pass a physical. Petitioner testified that he returned to work for the Respondent in September 2011.

Petitioner testified that on the day of the accident he was cleaning the parking lot of a bar located at a strip mall in Missouri. Petitioner testified that one trash can was real heavy with liquid so he tilted the can over and slid the bag out before moving it back and forth to get it up 8 feet into the back of the truck. Petitioner testified that he felt real sharp pains in his left shoulder. Petitioner testified that he called his supervisor, Keith, that night to tell him what happened. Petitioner testified that Keith advised him to take

it easy and to see what happens because he may have just pulled something. Petitioner testified that he kept working that night and for 3-4 days following the injury.

Petitioner testified after a few days he could not take it anymore and was throwing up due to the sharp pains. Petitioner thought he was having a heart attack. Petitioner testified that he also had a conversation with Mike, Keith's dad, the owner of the company. Petitioner testified that he told Mike that he needed medical attention and Mike told him that he would pay for it all out-of-pocket and not to put it under workers' comp because it would raise his insurance.

Petitioner testified that he spoke with Mike and Keith again after the hospital visit on 11/27/11 and told him he needed to see a specialist. Petitioner testified that Mike gave him $250.00 to go see Dr. Weimer because he didn't want the insurance to go up.

Petitioner testified that after the visit with Dr. Weimer on 12/5/11 he spoke with Mike and Keith again about the work restrictions and the MRI ordered by Dr. Weimer. Petitioner testified that Mike and Keith told him they would save a little money and pay cash for the MRI because they didn't want it under work comp. Petitioner testified that he gave it a few days but grew concerned he wasn't getting anywhere, so he hired an attorney. Petitioner testified that he was fired by the Respondent after he hired an attorney. Petitioner testified that Keith asked him why he hired an attorney because he thought they had it under control.

Petitioner testified that there was a delay in treatment for the frozen shoulder because the physical therapy ordered by Dr. Weimer was not timely authorized.

Petitioner testified that his treatment and TTD benefits were discontinued following notice of the insurance company's bankruptcy.

Petitioner testified that the last time he saw Dr. Weimer was 5/12/14. Petitioner testified that he tried to go back and see Dr. Weimer but nothing was approved.

Petitioner testified that Petitioner was released by Dr. Weimer to return to work on July 28, 2014.

Petitioner testified that he went to get another opinion and treatment from orthopedic surgeon Dr. Nathan Mall on the recommendation of a friend and after he spoke with his attorney.

Petitioner testified that he received no TTD or medical benefits since being released by Dr. Weimer. Petitioner testified that Dr. Mall is his choice of treating physician and that he would like to pursue treatment based upon Dr. Mall's recommendations.

Petitioner testified that he continues to have difficulty with stiffness, sharp pain and weakness. Petitioner described having difficulty picking up anything causing sharp pain, trying to sleep and putting pressure on that side was sleeping. Petitioner testified that he cannot work, his highest level of education is high school and always worked with his hands.

Petitioner testified that he does not do "any side work with tree trimming" nor had he "helped a neighbor out with trimming trees prior to getting hurt." Petitioner testified that he has attempted to return to work since Dr. Weimer release him just mowing but it's been really horrible. Petitioner testified that he was experiencing sharp pains during questioning.

Keith Kannewuf testified that he was the Manager of L & M when Plaintiff was injured in November 2011. Mr. Kannewuf testified that he was the owner's son and had worked there for 18 years before opening his own street sweeping business. Mr. Kannewuf testified that he had a conversation with

Petitioner about his left shoulder injury and that Petitioner told him that "he wasn't sure if he hurt it at work or cutting this tree down." Mr. Kannewuf testified that he needed him as an employee and knew Petitioner didn't have insurance. Mr. Kannewuf testified that he told Petitioner to go to a doctor and offered to keep him on light duty while he took care of his arm. Mr. Kannewuf did not recall the date the conversation took place. Mr. Kannewuf testified that after Petitioner went to the doctor, Petitioner told him about the rotator cuff injury. Mr. Kannewuf testified that a "few days later" a lawyer called me asking questions. Mr. Kannewuf testified that he called Petitioner and asked "what's going on with the lawyer" and according to Mr. Kannewuf Petitioner responded that he believed he hurt himself at work, and after that "pretty much quit." Mr. Kannewuf testified that he does not remember the date of the conversation with Petitioner but thought "a month possibly." Mr. Kannewuf testified that part of Petitioner's job did involve lifting trash bags 25-35 pounds. Mr. Kannewurf testified that he was initially told by Petitioner that the injury might have occurred at work. Mr. Kannewurf testified that he knew within 45 days of 11/23/11 that Petitioner claimed he was injured at work. Mr. Kannewurf has no medical training. Mr. Kannewurf was not present and doesn't know how heavy the bag was that Petitioner lifted. Mr. Kannewurf does not recall getting a phone call from Petitioner. Mr. Kannewurf was unaware of whether Petitioner was at times paid in cash. Mr. Kannewurf lent Petitioner a chainsaw but was not present when Petitioner allegedly used it at home. Mr. Kannewurf has no knowledge of whether Petitioner has a side business cutting trees. Mr. Kannewurf testified that he is not aware of whether Petitioner sought immediate medical attention following the alleged tree trimming incident. Mr. Kannewurf testified that he does not recall the date but "would assume" it was in November. Mr. Kannewurf testified that Petitioner drove a large street sweeper truck across state lines but was unaware of whether it was required that the driver was CDL licensed or that DOT stickers were on the vehicle. Mr. Kannewuf testified that he sold Petitioner a car and that Petitioner "still owes him money."Mr. Kennewuf testified that he never received a phone call from Petitioner and there were no comments on the route sheet Petitioner turned in at the end of his shift. Mr. Kennewuf testified that it was possible that Petitioner may have sent a text about the shoulder being injured on the job. Mr. Kannewuf testified that he did not bring with him copies of the route sheets nor did he give them to his attorney.

Petitioner testified that he has never been employed as a tree trimmer. Petitioner testified that he borrowed a chainsaw but that it was in August or September of 2011. Petitioner testified that he did not use the chainsaw. Petitioner testified that he was not injured removing the tree limb from his yard. Petitioner testified that he worked for Respondent full duty and without complaints until the injury of 11/23/11. Petitioner testified that when he was fired he was told not to "come back on the property" and that they were not going to give him his last pay check.

The Arbitrator concludes:

C. Did an accident occur on 11/23/11 that arose out of and in the course of Petitioner's employment by Respondent?

Petitioner sustained an accident on 11/23/11 that arose out of and in the course of his employment with Respondent. The Arbitrator finds Petitioner to be credible and the medical records to show that Petitioner was consistent in reporting how the injury occurred. The Arbitrator did not find Mr. Kannewurf's testimony credible. The Arbitrator takes exception to the fact that Mr. Kannewurf's admitted that Petitioner told him that the injury could have occurred tree trimming or at work. The Arbitrator notes that Mr. Kannewurf admits to not being present for the alleged tree trimming incident or having any other knowledge about it besides alleged conversations with Petitioner. The Arbitrator further finds that Mr. Kannewurf was unable to provide anything more than guesses as to when the alleged conversations with Plaintiff took place or when the tree branch incident actually occurred. The Arbitrator found credible

Petitioner's testimony that the alleged tree limb incident at his home occurred in August or September 2011. The Arbitrator takes notice that Petitioner would have then worked weeks/months lifting heavy bags before the 11/23/11 injury date. The Arbitrator notes that there are no medical records, including Respondent's section 12 exam, addressing alleged tree trimming as a potential cause. The Arbitrator notes that Mr. Kannewurf failed to produce at hearing evidence of the alleged blank day sheet or texts, despite admitting to be in his possession, to support his testimony. Mr. Kannewurf's testimony that "he knows" Petitioner owes him money regarding a car sale demonstrated an obvious bias he has towards Petitioner.

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

Timely notice was given. The Arbitrator finds Petitioner's testimony that Mr. Kannewurf was told about the injury the night of the accident credible. The Arbitrator further acknowledges that Mr. Kannewurf even admitted that he may have received a text from Petitioner about the injury occurring at work and knew within a couple of days after Petitioner saw Dr. Weimer for the first time. Mr. Kannewurf also testified to speaking with Petitioner's attorney and being asked questions within a few days after seeing Dr. Weimer for the first time on December 5, 2011. The Arbitrator also notes that Petitioner signed his Application for Adjustment of Claim on November 30, 2011 alleging an accident on 11/23/11 (approximately). A copy of the document was mailed to Respondent on December 6, 2011. (see AX 2)

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

Petitioner's current condition of ill-being is causally related to the injury/accident. This conclusion is based upon Petitioner's credible testimony, the medical records, a chain of events, and the opinions of Dr. King and Dr. Mall. The Arbitrator finds that Dr. King and Dr. Mall's opinions are more persuasive. The Arbitrator notes that all the physicians involved in the case from Petitioner's treating physicians, Dr. Weimer and Dr. Mall to Respondent's two Section 12 examiners, Dr. King and Dr. Rottman, agree that the mechanism of injury, slinging/throwing trash bags overhead was directly responsible for Petitioner's initial complaints and need for at least the first surgery. Dr. Rottman disagrees as to the need for the second surgery and opined that Petitioner was really capable of returning to work three months after the first surgery. The Arbitrator takes exception to this opinion finding it unsupported in the medical records since the records show that Petitioner struggled with pain and range of motion issues due to a frozen shoulder. The Arbitrator takes notice of the fact that the Respondent's delay in treatment in both timely authorizing additional physical therapy and then the bankruptcy stay, confounded Petitioner's condition. The Arbitrator also notes that Dr. Weimer, although he missed it in the first MRI and surgery, performed a biceps tendon repair as part of the second surgery and Petitioner's complaints improved in that area following the procedure. Therefore the Arbitrator finds more persuasive the opinions of Dr. Weimer, Dr. King and Dr. Mall that the conditions treated by Dr. Weimer through July 28, 2014 were causally related to the injury of November 23, 2011.

The Arbitrator also finds more persuasive the opinions of the Dr. King, Dr. Mall and the two reviewing radiologists concerning the labrum tear, need for further treatment and the causality of continuing complaints. The Arbitrator finds Petitioner credible regarding his ongoing complaints and further notes that when Dr. Weimer released Petitioner he had not been seen by him for months since Respondent would not authorize additional visits or treatment. As of June 30, 2014 Petitioner was still reporting ongoing pain and symptoms. Dr. Weimer wished to have another MRI performed. Workers' compensation denied any further treatment indicating it was going to schedule an independent medical examination. Dr. Weimer then released Petitioner on July 28, 2014. That Petitioner was released from the doctor's care at that time does not mean he was at medical maximum improvement, especially given the circumstances surrounding the release – ie., despite Petitioner's complaints, the workers' compensation

carrier wasn't going to approve any further treatment. Petitioner nonetheless underwent an MRI per Dr. Weimer's order. Petitioner then established care with Dr. Mall. The Arbitrator takes notice of the fact that Petitioner on his last P.T. visit was still only lifting 1 lb. weights, reporting significant pain and that the physical therapist had marked that the goals of therapy were "unmet." The Arbitrator notes that from the beginning Respondent's first Section 12 examiner, Dr. King, diagnosed both clinically and by film, the presence of a labrum tear and had been able to reproduce corresponding symptoms such as pain and clicking. With the exception of Dr. Rottman, all O'Brien testing has been positive to date. The Arbitrator notes that although Dr. Weimer had reviewed the labrum arthroscopically, the Arbitrator finds more persuasive the opinion of Dr. Mall specifically his opinion that the type of lesion suspected and seen, a Kim-Lesion, is something that is "often time missed and can respond well to posterior labral repair." The Arbitrator also takes notice of the fact Dr. Mall was able to elicit and relieve pain he attributes to the torn labrum. The Arbitrator further notes that Respondent's first Section 12 examiner Dr. King who most recently saw Petitioner was likewise able to elicit pain that Dr. King attributes ongoing symptom to the presence of a labrum tear. Both Dr. Mall and Dr. King who reviewed the photos from the arthroscopic procedures see a problem with labrum which the attribute to Petitioner's ongoing complaints. Both King and Mall agree Petitioner cannot return to work without restrictions and is not at MMI. The Arbitrator acknowledges the fact that Dr. Weimer initially missed the biceps tear and only later repaired it in the second procedure. The Arbitrator has found that reasonable minds can differ in both diagnosis and approach and further acknowledges the procedure contemplated by Dr. Mall and Dr. King would be a minimally invasive arthroscopic procedure. The Arbitrator acknowledges that Petitioner's condition is complicated and has been confounded by delays in treatment. Therefore, the Arbitrator finds that Petitioner ongoing complaints are causally related to the 11/23/11 work injury, Petitioner has not reached maximum medical improvement.

J. Were 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 medical services received through present were reasonable and medically necessary to cure or alieve the effects of the work related injury sustained on November 23, 2011. The Arbitrator finds the opinions of Dr. Weimer, Dr. Mall and Dr. King persuasive on the issue. Respondent is to pay Petitioner a total of $76,260.56 minus any credit/previously paid amount subject to the fee schedule. Respondent shall authorize treatment recommended by Dr. Mall and Dr. King.

K. What temporary benefits are in dispute (TTD)?

The Arbitrator finds that Petitioner has not reached maximum medical improvement. The Arbitrator found Petitioner to be credible that he was fired and did not quit. The Arbitrator notes that Dr. Weimer took Petitioner completely off work starting December 7, 2011 and Petitioner has not returned to work. Petitioner is entitled to TTD from 12/7/11-4/23/15 less any amount previously paid. Respondent did not dispute the dates of TTD. (AX 1)

O. Did Petitioner exceed his 2nd choice of doctor?

Petitioner did not exceed his choice of two physicians by seeking treatment with Dr. Mall. Petitioner was referred to Dr. Weimer by the emergency room at Memorial Hospital. Emergency room visits and referrals do not count as a choice of doctor. Dr. Mall is Petitioner's 1st choice. Dr. King was a Section 12 examiner who the Respondent sent Petitioner to on the first two occasions. Dr. King is Petitioner's second choice when he returned to see him on his own in September of 2014.

****

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

Todd M. Kryger,
Petitioner,
vs. NO: 12 WC 08970

University of Chicago,
Respondent,

16IWCC0349

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 22, 2015, is hereby affirmed and adopted.

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

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

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

DATED: MAY 23 2016
o051216
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KRYGER, TODD M
Employee/Petitioner

Case# 12WC008970

16IWCC0349

UNIVERSITY OF CHICAGO
Employer/Respondent

On 9/22/2015, 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 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
JOSHUA E RUDOLFI
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

2461 NYHAN BAMBRICK KINZIE & LOWRY
ELIZABETH COPPOLETTI
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

16IWCC0349

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

Todd M. Kryger
Employee/Petitioner

v.

University of Chicago
Employer/Respondent

Case # 12 WC 08970

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **March 13, 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 _____

16IWCC0349

FINDINGS

On **6/25/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**36,400.00**; the average weekly wage was $**700.00**.

On the date of accident, Petitioner was **40** 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 $**11,622.13** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**11,622.13**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$15,663.00 to Illinois Bone and Joint Institute, $1,344.28 to Midwest Orthopedics at Rush, $1,204.00 to Open MRI of Chicago, $24,725.00 to Oak Park Medical Center, $350.00 to Peterson Surgical Center, $15,624.90 to Cigna, and $8,817.35 to EQMD**, as provided in **Sections 8(a) and 8.2 of the Act.**

Respondent shall pay Petitioner **temporary total disability benefits of $466.67/week for 79 weeks, commencing 6/27/2011 through 11/27/2011 and 4/25/2012 through 5/28/2013**, as provided in **Section 8(b) of the Act.**

Respondent shall pay Petitioner **permanent partial disability benefits** of **$420.00/week for 50 weeks,** because the injuries sustained caused the **10% loss of the person as a whole** regarding the left shoulder injury, as provided in **Section 8(d)2 of the Act.** Respondent shall pay Petitioner **permanent partial disability benefits of $420.00/week for 6.325 weeks,** because the injuries sustained caused the **2.5% loss of the Left Arm**, as provided in **Section 8(e) of the Act.**

Respondent shall pay Petitioner the compensation benefits that have accrued from 6/25/2011 through March 13, 2015, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

September 22, 2015
Date

SEP 22 2015

STATEMENT OF FACTS

Petitioner worked for Respondent as an actor from March 2011 through June 2011, playing the role of Porgy in Respondent's production of "Porgy and Bess". Petitioner testified that the character of Porgy is disabled and Petitioner spent most of the performances sitting on his left hip and dragging himself across the stage with his arms. On June 25, 2011, Petitioner was dragging himself across the stage in the middle of the second act when he felt a pop and pain in his left upper arm. Petitioner reported the injury to the stage manager, Ms. Sara Gammage. Respondent stipulated to accident and notice at the close of prrofs. (Arb. Ex. #1)

On June 27, 2011, Respondent sent Petitioner to the University of Chicago Hospital, at which time he complained of pain to his left arm (shoulder pain) and was taken off work. The U of C Hospital records are incomplete. The records from U of C Occupational Medicine show that Petitioner gave a history of a pop and pain in his left elbow on 6/25/11. Now the pain was worse and radiates up the arm to the patient's neck and below the elbow to his hand. The current diagnosis at Occ Med was elbow pain and Petitioner was released to modified duty. (Pet. Ex. #2, Res. Ex. #4) An MRI of the left elbow, performed on July 5, 2011, was interpreted as essentially normal. Petitioner was referred by the University of Chicago to Midwest Orthopedics at Rush. (Pet. Ex. #3)

On July 8, 2011, the Petitioner saw Dr. Mark Cohen at Midwest Orthopedics at Rush. Dr. Cohen noted that the Petitioner felt a pop on June 25, 2011 while acting and noted pain in the Petitioner's left elbow radiating to the biceps on exam. Dr. Cohen recommended a review of the left elbow MRI, formal physical therapy and ordered the Petitioner on light duty. The Petitioner was unable to return to work at that time. (Pet. Ex. #3)

A review of the left elbow MRI on July 11, 2011 by Dr. Cohen's practice group indicated a possible partial tear of the distal biceps insertion. Petitioner had physical therapy performed at Midwest Orthopedics at Rush from July 11, 2011 through September 1, 2011. Petitioner followed up with Dr. Cohen on August 3, 2011 and physical therapy and light duty restrictions were continued. Petitioner reported to physical therapy on

August 31, 2011 at which time he complained of shoulder pain and a mid left humerus bruise was noted. The Petitioner was referred to Dr. Brian Cole for a shoulder consultation. (Pet. Ex. #3)

Petitioner saw Dr. Brian Cole on September 12, 2011 and it was noted that Petitioner had a history of a left arm injury at work and noted pain in his left elbow and shoulder. Dr. Cole recommended an MRI of the left shoulder and continued Petitioner on light duty. The left shoulder MRI of September 12, 2011 revealed a partial thickness tear of the distal supraspinatus tendon and a possible split tear of the biceps tendon. (Pet. Ex. #3)

Petitioner followed up with Dr. Cole on September 19, 2011 and physical therapy was recommended along with light duty. Petitioner underwent physical therapy at Midwest Orthopedics at Rush from October 5, 2011 through November 23, 2011. Petitioner followed up with Dr. Cole on November 7, 2011, at which time he was instructed to finish physical therapy to address left arm weakness and then he would then be released and could return to work. Petitioner testified that the physical therapy lessened his left arm symptoms. The final PT note of November 23, 2011shows that the patient stated that overall his shoulder felt much better, with a slight pulling sensation as if he overworked his pec. He is able to sleep on his left side and do his ADL's. He has not yet returned to weightlifting and will do so gradually. (Pet. Ex. #3, Res. Ex. #2)

Petitioner testified that, in February of 2012, he called the Respondent's workers' compensation insurance carrier to request further treatment for his left shoulder injury. Petitioner was sent for an independent medical evaluation with Dr. Scott Sagerman on February 15, 2012. Dr. Sagerman opined that Petitioner had a possible labral tear, should consider an injection, should not consider surgery at that time and was able to work light duty. Dr. Sagerman could not confirm a causal relationship between Petitioner's left shoulder condition and his work injury. (Res. Ex. #11)

Petitioner sought a second opinion with Dr. Ronald Silver of Illinois Bone and Joint Institute on April 25, 2012. Dr. Silver noted Petitioner's work accident as the mechanism of injury, diagnosed the Petitioner with rotator cuff impingement, performed an injection to the Petitioner's left shoulder and took the Petitioner off

work. Petitioner followed up with Dr. Silver on May 9, 2012 and reported temporary relief from the previous injection. Dr. Silver read the MRIs and recommended surgery for Petitioner's shoulder. Dr. Silver drafted a letter dated June 6, 2012 to Mr. Ed Eno at CCMSI stating that Petitioner required surgery and that the need for that surgery is causally related to the work accident. Petitioner next saw Dr. Silver on June 28, 2012 and surgery was again recommended and the Petitioner continued off work. (Pet. Ex. 4)

Petitioner had left shoulder surgery performed on July 25, 2012 at Peterson Surgical Center and was continued off work. (Pet. Ex. #5) Petitioner followed up with Dr. Silver on August 3, 2012, was recommended for physical therapy, and continued off work. (Pet. Ex. #4) Petitioner had physical therapy performed at Oak Park Medical Center from August 7, 2012 through May 20, 2013. (Pet. Ex. #7) Petitioner followed up with Dr. Silver on August 31, 2012, October 5, 2012, November 9, 2012, December 14, 2012, February 8, 2013 and April 12, 2013, being continued off work and prescribed further physical therapy at each visit. (Pet. Ex. 4)

Petitioner saw Dr. Silver on May 28, 2013 and was discharged. It was noted that Petitioner would have continued issues with over-the-shoulder activities. (Pet. Ex. #4)

Petitioner testified credibly that prior to his undisputed work accident he had never had medical issues with his left arm, elbow and shoulder. Petitioner testified that, as of the date of trial, he has shoulder pain. He limits some of his activities due to concerns about the shoulder. He still performs home exercises and takes Aleve to treat his continued shoulder pain. Petitioner testified that some of his medical bills have not been paid to his knowledge. Petitioner's medical bills exhibit was Number 1.

Respondent tendered the evidence deposition of Dr. Scott Sagerman, taken on January 8, 2013. (Res. Ex. #8) Dr. Sagerman testified that, on examination, Petitioner had decreased range of motion in his left shoulder and had a positive impingement sign, positive supraspinatus test and a positive cross-arm test. Dr. Sagerman testified that he reviewed the left shoulder MRI and interpreted it to show a possible labrum tear. Dr. Sagerman recommended possible physical therapy, but not surgery, to help Petitioner. Dr. Sagerman testified that he could not confirm a causal relationship between Petitioner's left shoulder condition and the work injury.

Petitioner tendered the evidence deposition of Dr. Ronald Silver, taken on December 5, 2012. (Pet. Ex. #8) Dr. Silver testified that the Petitioner's mechanism of injury (Petitioner's dragging his body across a stage with his arms) is a competent cause of damage to the rotator cuff. He further testified that the mechanism of injury, in conjunction with the Petitioner's absence of injury prior to the work accident and the Petitioner's objective MRI, physical examination findings and surgical findings led him to his causal connection opinion.

CONCLUSIONS OF LAW

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

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

The Arbitrator Finds that Petitioner's left shoulder and left elbow/distal biceps tendon conditions are causally related to the injury, based upon the credible testimony of Petitioner, the medical records and the opinion of Dr. Silver.

Dr. Sagerman could not support a causal connection between the injury and Petitioner's left shoulder condition because of the absence of shoulder complaints until they arose spontaneously 2 months after the accident. This opinion is not persuasive, given Petitioner's testimony, the chart from U of C Hospital which states that the arrival complaint is shoulder pain and the patient is seen for left arm injury, the U of C Occupational Medicine chart stating that Petitioner's pain radiated up from his elbow to his neck (and down from the elbow to the hand). Dr. Silver's opinion that the shoulder condition is due to the injury, based upon the mechanism of injury, the MRI and surgical findings, the physical exam of the patient and the absence of prior shoulder injuries, is credible, persuasive and most comports with the evidence adduced.

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

Based upon the Arbitrator's finding regarding causal connection above, the Arbitrator awards Petitioner the claimed medical bills, totaling $67,728.53, finding the services to be reasonable, necessary and causally related to the injury. The award of medical expenses is according to §8(a) and §8.2 of the Act. Respondent is entitled to a credit for all bills paid.

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

Based upon the Arbitrator's finding regarding causal connection above, the Arbitrator finds that Petitioner was temporarily and totally disabled from work from June 27, 2011 through November 27, 2011 and from the date of the first visit with Dr. Silver (April 25, 2012) through May 28, 2013, a period of 79 weeks.

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

The Arbitrator finds that Petitioner sustained a sprained left elbow/biceps tendon (with a possible tear of the tendon) and a partial thickness rotator cuff tear with aggravation of impingement syndrome in the left shoulder, necessitating an arthroscopic surgery to debride the tear and remedy the impingement.

The Arbitrator finds that Petitioner sustained the 10% loss of use of a person as a whole regarding the shoulder injury and 2-1/2 % loss of use of the left arm regarding the elbow/biceps injury as a result of the accidental injuries sustained on June 25, 2011.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FRANK MOY,

Petitioner,

16IWCC0288

vs.

NO: 12 WC 21649

BON TON FOOD SERVICE,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Decision of the Arbitrator addressed the reasonableness and necessity of the medical treatment Petitioner received; the causal connection between Petitioner's present condition and the claimed injury; temporary total disability; the prospective medical care suggested by Dr. Tu; and penalties and fees. The Commission leaves undisturbed the findings of the Decision of the Arbitrator concerning all the above-mentioned issues save temporary total disability.

The Commission vacates the 93-5/7 weeks of temporary total disability benefits the Decision of the Arbitrator conferred to Petitioner, finding Petitioner declined an offer made by George Christie, Respondent's president, to become Respondent's dispatcher. There is credible evidence of the offer being made on February 3, 2012, only two days after Petitioner's February 1, 2012, accident and that offer being immediately declined.

Both Petitioner and Mr. Christie testified concerning the circumstances surrounding the job offer. Petitioner testified that he personally handed a copy of his work restrictions to Annette Reynolds, Respondent's office manager. The work restrictions precluded Petitioner from lifting more than 10 pounds, no pushing or pulling more than 10 pounds and no work-related driving. Petitioner testified that he never received any communication from Respondent that it was willing to employ him in a position consistent with his work restrictions. On cross-examination, Petitioner acknowledged Mr. Christie did offer him the dispatcher position but testified it would become his when the current dispatcher retired. Petitioner indicated that this position was a clerical position. Mr. Christie's testimony gives no indication that the job offer was premised on Respondent's then-current dispatcher retiring. Both Petitioner and Mr. Christie testified to the dispatcher position being clerical in nature.

The Commission, in weighing Petitioner's testimony against Mr. Christie, finds Mr. Christie more credible. In addition to the conflicting testimony noted in the paragraph above, Petitioner made several other statements that are either inconsistent with the medical record or, in the Commission's estimation, improbable. Petitioner testified to deferring a decision on the job offer until he either obtained a release from Concentra Medical Center or a job description. Prior to making that statement, Petitioner had already testified to having been to Concentra Medical Center and to have been given modified work restrictions. The timeline indicates Petitioner knew of his work restrictions at the time he met with Mr. Christie and Ms. Reynolds on February 3, 2012. The Commission finds it unlikely that Petitioner, a driver for Respondent for 17½ years at the time of the accident, would need to be provided with a job description for the dispatcher position to know what the responsibilities of that position would be. Petitioner also testified to bringing up the dispatcher position with either Ms. Reynolds or Mr. Christie and being rebuffed by Mr. Christie whenever he did so. Petitioner did not testify as to what Ms. Reynolds' response was when he brought the position up with her. In either case, the Commission is skeptical these conversations ever occurred. The Commission recalls Mr. Christie's testimony of him offering the dispatcher position to Petitioner prior to February 3, 2012. Mr. Christie demonstrated interest in Petitioner having the dispatcher position is at odds with Petitioner's testimony of being spurned by Mr. Christie.

The Commission, again, vacates the awarded temporary total disability benefits but leaves the other issues decided in the Decision of the Arbitrator undisturbed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the awarded temporary total disability benefits as conferred in the Decision of the Arbitrator is vacated. The vacating of this award, as provided in §19(b) of the Act, in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses incurred under §8(a) of the Act. Respondent shall hold Petitioner harmless of all medical bills paid by its group health insurance provider.

16IWCC0288

IT IS FURTHER ORDERED BY THE COMMISSION THAT Respondent pay the reasonable and necessary costs for the left arthroscopic partial lateral menisectomy as is recommended by Dr. Tu.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 4 - 2016
KWL/mav
O: 03/08/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

16IWCC0288

MOY, FRANK
Employee/Petitioner

Case# 12WC021649

BON TON FOOD SERVICE
Employer/Respondent

On 7/1/2015, 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 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2194 STROM & ASSOCIATES LTD
LINDSEY S STROM
180 N LASALLE ST SUITE 2510
CHICAGO, IL 60601

1739 STONE & JOHNSON CHTD
PATRICK DUFFY
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60602

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

16IWCC0288

FRANK MOY
Employee/Petitioner

Case #12 WC 21649

v.

BON TON FOOD SERVICE
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on June 18, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☒ Maintenance ☒ TTD?

L. ☐ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☐ Prospective medical care?

FINDINGS

- On February 1, 2012, the respondent was operating under and subject to the provisions of the Act.

- On this date, an employee-employer relationship existed between the petitioner and respondent.

- On this date, the petitioner sustained injuries that arose out of and in the course of employment.

- Timely notice of this accident was given to the respondent.

- In the year preceding the injury, the petitioner earned $32,899.31; the average weekly wage was $632.68.

- At the time of injury, the petitioner was 55 years of age, single with no children under 18.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $421.79/week for 93-5/7 weeks, from February 2, 2012, through November 18, 2013, which is the period of temporary total disability for which compensation is payable.

- The medical care rendered the petitioner for his left knee was reasonable and necessary and is awarded. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- The petitioner is entitled to have from the respondent the reasonable and necessary cost for a left arthroscopic partial lateral meniscectomy.

- The petitioner's request for penalties and fees is denied.

- In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of 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.

Robert E. Williams

Signature of Arbitrator

July 1, 2015

Date

JUL 1 - 2015

FINDINGS OF FACTS:

The petitioner, a truck driver, felt a pop in his left knee as he climbed into his truck on February 1, 2012. He received medical care at Concentra with Dr. Israel on February 3rd for complaints of pain in the medial aspect of his left knee and the posterior aspect of his left leg. The clinical examination of his left leg revealed mild knee effusion and medial joint line tenderness. X-rays of his left leg and knee were negative for fractures or a dislocation. The petitioner was provided a neoprene knee brace and prescribed physical therapy, icing, medication, activity restrictions and no work-related driving. On February 7th, the petitioner reported moderate and sharp left knee and leg pain that was localized on the medial and lateral aspect of his knee and the posterior aspect of his leg. Tenderness at the medial and lateral joint lines and slight tenderness over the gastrocnemius muscle was noted. On February 14th, he reported continued left knee and leg pain exacerbated by active flexion and extension of his knee with intermittent clicking along the lateral border of the patella. Pursuant to Dr. Israel's referral, the petitioner saw Dr. Kevin Tu at Occspecialists on February 20th and reported some improvement with range of motion, partial giving way episodes and difficulty with squatting activities. Dr. Tu noted medial joint line tenderness, mild lateral joint line tenderness and tenderness with circumduction maneuvers. Dr. Tu recommended pushing, pulling and lifting restrictions of ten pounds and no kneeling or squatting. An MRI on March 2nd revealed a partial tear of the posterior cruciate ligament, a grade I sprain of the medial collateral ligament and a tear in the anterior horn of the lateral meniscus.

On March 5th, Dr. Tu opined that the MRI showed a sprain or partial tear of the PCL, a partial tear of the MCL and an anterior horn tear of the lateral meniscus. Dr. Tu

recommended continued physical therapy and work restrictions of no lifting, pushing or pulling greater than ten pounds, no kneeling or squatting activities and no walking or standing longer than tolerated. The petitioner reported continued difficulty with partial giving-way episodes in squatting activities and localized pain in the medial and lateral aspects of his left knee to Dr. Tu on March 26th. Dr. Tu gave the petitioner a cortisone injection into his left knee and continued the prior activity restrictions.

Pursuant to Section 12 of the Act, Dr. Levin evaluated the petitioner on April 3rd and opined that the MRI showed a very minimal grade I sprain of his medial collateral ligament and an intact menisci and posterior cruciate ligament. The doctor found that the petitioner had no effusion and full extension and flexion of his knee. He noted the petitioner's reports of tenderness over the lateral facet of his patella, his anteriomedial, posteromedial and lateral joint lines, his medial and lateral tibial plateaus and his lateral and medial femoral condyles. Further Dr. Levin opined that the petitioner had excellent stability in his left knee and that his whole knee complaints did not correlate with the objective findings and diagnostic studies.

On May 7th, Dr. Tu noted that the petitioner had some mild temporary relief with the cortisone injection and that he had mechanical symptoms with partial giving-way episodes, difficulty squatting and localized pain over both the left medial and lateral joint lines. Dr. Tu recommended a left arthroscopic partial lateral meniscectomy.

The petitioner complains of continued left knee pain and limited range of motion. He would like to have the surgery recommended by Dr. Tu.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for his left knee was reasonable and necessary and is awarded.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that his current condition of ill-being with his left knee is causally related to the work injury. The petitioner complains of medial and lateral joint line tenderness and whole knee pain. The diagnostic findings of sprain or partial tear of the PCL, a partial tear of the MCL, and an anterior horn tear of the lateral meniscus support the petitioner's complaints of whole knee pain.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The petitioner was off work due to his work injury and the recommendation of his doctor from February 2, 2012, through November 18, 2013. The respondent shall pay the petitioner temporary total disability benefits of $421.79/week for 93-5/7 weeks, from February 2, 2012, through November 18, 2013, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner proved that the left arthroscopic partial lateral meniscectomy recommended by Dr. Tu is reasonable medical care necessary to relieve the effects of the work injury. There is no utilization review and Dr. Tu recommended an arthroscopic meniscectomy. The petitioner is entitled to have from the respondent the reasonable and necessary cost for a left arthroscopic partial lateral meniscectomy.

FINDING REGARDING PENALTIES AND FEES:

The petitioner failed to prove that he is entitled to penalties and attorney's fees. The respondent's reliance on the specific and reliable findings and opinions of Dr. Levin was not unreasonable or vexatious. The petitioner's request for penalties and fees is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jorge Crespo,
Petitioner,
vs.
Capital Wholesale Meat d/b/a
Fontanini Italian Meats & Sausage,
Respondent,

NO: 12 WC 21819

16IWCC0316

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 permanent partial disability, causal connection, medical, the evidentiary ruling admission of Respondent's Exhibit No. 1, 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 9, 2015 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 $7,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 12 2016

Marie Basurto

David L. Gore

Stephen Mathis

MB/mam
o:4/14/16
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CRESPO, JORGE
Employee/Petitioner

Case# **12WC021819**

16IWCC0316

CAPITAL WHOLESALE MEAT D/B/A FONTANINI ITALIAN MEATS & SAUSAGE
Employer/Respondent

On 9/9/2015, 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 0.27% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON
JOHN POWERS
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0532 HOLECEK & ASSOCIATES
BAMALI ROY-MOHANTY
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

16IWCC0316

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JORGE CRESPO
Employee/Petitioner

Case # **12 WC 21819**

v.

Consolidated cases: **None**

CAPITAL WHOLESALE MEAT d/b/a
FONTANINI ITALIAN MEATS & SAUSAGE
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 **June 30, 2015 and August 24, 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. X Other **evidentiary ruling regarding RX 1**

FINDINGS

16IWCC0316

On **06/12/2012**, 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 headache and neck condition of ill-being *is* causally related to the accident. For the reasons stated in the attached decision, the Arbitrator finds that Petitioner failed to establish causation as to the subarachnoid cyst documented on CT scan and as to the need for a laryngoscopy and tooth extractions.

In the year preceding the injury, Petitioner earned $**31,737.16**; the average weekly wage was $**610.33**.

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

Petitioner ***has in part*** received 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 $**925.34 (medical as indicated below)** for other benefits, for a total credit of $**925.34**.

Respondent is entitled to a credit of $**925.34** under Section 8(j) of the Act.

ORDER

- Respondent shall pay the following reasonable and necessary medical expenses, as provided in Sections 8(a) and 8.2 of the Act: 1) Adventist LaGrange Memorial Hospital Emergency Room, 6/12/12, $1,835.50; 2) Loyola University Medical Center, 7/2/12 – 7/25/12, therapy, $772.33; 3) Loyola University Medical Center, 7/9/12, cervical spine X-rays, $214.60; and 4) Stroger Hospital, 7/31/12, $627.00. See the attached decision for further details concerning the Arbitrator's medical award.

- Respondent shall pay Petitioner temporary total disability benefits of $**406.89**/week for **3-1/7** weeks, commencing **06/13/2012** through **07/04/2012**, as provided in Section 8(b) of the Act.

- Respondent shall pay Petitioner permanent partial disability benefits of $**366.20**/week for **10** weeks, because the injuries sustained caused the **2%** 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.

Molly C Mason

Signature of Arbitrator

9/9/15

Date

SEP 9 - 2015

Jorge Crespo v. Capital Wholesale Meats,
d/b/a Fontanini Italian Meats & Sausage
12 WC 21819

16IWCC0316

Arbitrator's Findings of Fact

Petitioner testified he began working for Respondent more than a year before his disputed accident of June 12, 2012. He worked in the office as a shipping and receiving clerk.

Petitioner denied having headaches or jaw pain prior to the accident.

Petitioner testified he is 6 feet, 1 inch tall. He weighs 215 pounds.

Petitioner testified he was working in Respondent's office on June 12, 2012 when he noticed a delivery driver angrily asking when his order would be ready. Petitioner pulled the paperwork concerning this order. A "docker," Jose Macedo Hernandez [hereafter "Macedo"], then came into the office. Petitioner testified that Macedo worked at the same facility and acted as a liaison between the office and warehouse. He described Macedo as "in good shape," about 5 feet, 8 or 9 inches tall and weighing about 180 pounds.

Petitioner testified that, after Macedo entered the office, Macedo aggressively grabbed the paperwork out of his hands and left. Macedo later returned to the office, at which point he was "ballistically angry." Petitioner was working inside his cubicle. Macedo started using profanity, saying he was not going to perform his assignment. Petitioner testified that Macedo then grabbed his left arm. Petitioner stood up. Macedo then hit Petitioner in the face, striking the right side of Petitioner's chin with his left hand in an "upper cut" motion.

Petitioner testified that a supervisor and two workers then came to the office and grabbed Macedo. A security guard escorted Petitioner to the office of Nancy Quintero, Respondent's human resources manager. Police were called to the scene.

Petitioner testified that, after Macedo struck him, he became dizzy and felt pain in his head, neck and the right side of his jaw. An ambulance arrived and paramedics transported Petitioner to the Emergency Room at Adventist LaGrange Memorial Hospital.

The Emergency Room records (PX 1) reflect that Petitioner arrived at about 12:28 PM and reported being involved in an employment-related accident at about 11:10 AM. Dr. Zerth examined Petitioner at about 12:39 PM, noting that Petitioner "presents to ER via EMS after he was hit in right jaw by co-worker." Dr. Zerth noted that Petitioner complained of "achy" pain in the right jaw and some dizziness but denied losing consciousness. The doctor also noted that Petitioner denied nausea/vomiting, headaches or vision changes. He indicated that Petitioner felt as if his teeth were lining up normally. On examination, the doctor noted "moderate pain to angle of right mandible" and a 0.5 centimeter laceration on the inside of Petitioner's right

lower lip. He indicated that Petitioner's teeth appeared normal. Panorex tomogram X-rays showed no evidence of acute fracture or dislocation.

At discharge, Dr. Zerth directed Petitioner to remain off work for the rest of his shift and then resume full duty. He prescribed Norco for pain and referred Petitioner to occupational health medicine for follow-up care "if needed."

Petitioner testified his brother picked him up from the hospital. He delivered the hospital paperwork to Respondent.

Petitioner saw Dr. Miller at Loyola the following day, June 13, 2012. Dr. Miller noted that Petitioner complained of 10/10 right-sided jaw and neck pain secondary to being hit in the jaw by a co-worker the previous day. According to Dr. Miller, Petitioner described his head as having been "whiplashed" with the blow. The doctor noted that Petitioner was taking Norco per the Emergency Room prescription. He diagnosed jaw pain/contusion and cervical strain. He described Petitioner's neurological examination as normal. He prescribed Naproxen and a dental evaluation. He recommended that Petitioner return in about a week. PX 2.

Petitioner returned to Loyola on June 19, 2012. On this occasion, he saw Dr. Judge. The doctor noted that Petitioner complained of dizziness, 9/10 headaches, neck pain, jaw pain and "difficulty concentrating" after getting struck at work. He also noted that Petitioner had been taking Naproxen since the previous Wednesday. On examination, Dr. Judge noted some photophobia and a decreased range of neck motion. He diagnosed a head injury, "with likely post-concussive syndrome," a cervical strain and a jaw contusion. He prescribed Tramadol and a head CT scan and indicated Petitioner should rest and return after undergoing the scan. PX 2, pp. 15-16 of 226.

The scan, performed with contrast on June 19, 2012 showed a dense collection of cerebral spinal fluid in the posterior aspect of the posterior fossa. The radiologist indicated this could be due to an arachnoid cyst or mega cistern magna. He indicated that the finding was "of doubtful clinical significance in either case." He saw no evidence of an acute intracranial injury or skull fracture. PX 2, p. 17 of 226.

Petitioner returned to Loyola on June 21, 2012 and again saw Dr. Judge. The doctor noted that Petitioner complained of persistent headaches "with slow sense and tiredness," as well as some jaw soreness. He discussed the CT scan results with Petitioner and recommended Petitioner see a neurosurgeon to further assess the possibility of a subarachnoid cyst. He described Petitioner's neurological examination as unchanged. He noted some right-sided jaw tenderness and a reduced range of cervical spine motion on examination. He recommended physical therapy. PX 2, pp. 21-22 of 226.

On July 2, 2012, Petitioner underwent an initial physical therapy evaluation at Loyola. The evaluating therapist recorded a consistent account of the June 12, 2012 incident, noting that Petitioner "reports being punched with an 'uppercut' motion in lower R jaw 6/12/12." The

therapist indicated that Petitioner complained of pain in his head, neck and right jaw, as well as some dizziness and difficulty concentrating. The therapist recommended a course of therapy and home exercises. Petitioner continued attending therapy thereafter through July 25, 2012. PX 2, pp. 60-226.

Petitioner saw Dr. Judge again on July 3, 2012, with the doctor recording the following complaints:

> "Re-check 3 weeks after attack at work. Pain in the neck is ongoing. Bilateral and both anterior and posterior. Also after resting and when he opens his eyes he will feel out of balance. Feels like he is about to fall. Feels like jaw still hurts when he eats or opens the jaw. Voices feel like they are echoing. Also feels like difficulty swallowing and with ongoing soreness at the base of the neck anteriorly and has a sensation of something stuck [in] the throat. Concentration is difficult as well, not back to normal. Head feels heavy all the time. Hot weather makes the symptoms worse."

On examination, Dr. Judge noted no facial tenderness or swelling, a reduced range of cervical spine motion and "some pain with masseter contractions" on the right side of the jaw. He recommended that Petitioner see Dr. Bier-Laning, an otolaryngologist, and a neurologist.

Petitioner returned to Loyola on July 9, 2012 and saw Dr. Anderson, a neurosurgeon. Dr. Anderson described Petitioner as a "victim of altercation during which he was struck in the jaw." He indicated that Petitioner reported a "whiplash-like head motion" after getting struck. He noted that Petitioner complained of headaches and neck pain. He reviewed the CT scan.

Dr. Anderson noted no abnormalities on neurologic examination. He described Petitioner's swallowing as normal. He diagnosed "post-concussive headache without neurologic syndrome" and recommended that Petitioner be treated with non-steroidal anti-inflammatories rather than opioid medications. PX 2, pp. 35-37 of 226.

Petitioner saw Dr. Bier-Laning at Loyola on July 17, 2012. The doctor noted that Petitioner reported experiencing "multiple problems," including headaches, right ear and jaw pain, difficulty swallowing and neck pain/stiffness, since being struck in the jaw at work on June 12, 2012. The doctor also noted that Petitioner complained of "heartburn that has been a problem for some time." On examination, she noted diffuse tenderness in the neck, partly in the right TMJ area. She performed a fiberoptic laryngscopy, noting no lesions. She diagnosed right TMJ dysfunction, "per pt history starting after being struck in R jaw," and dysphagia (difficulty swallowing), which she viewed as "likely secondary to GERD." With respect to the latter, she recommended various dietary and behavior modifications. PX 2, 48-53 of 226.

On July 24, 2012, Petitioner sought treatment at the Emergency Room at Stroger Hospital. The records reflect that Petitioner complained of headaches as well as neck and jaw pain of about a month's duration. The Emergency Room physician prescribed pain medication. PX 3.

Petitioner returned to the Emergency Room at Stroger Hospital on July 31, 2012, with Dr. Decker noting a history of the altercation and complaints of persistent head, neck and jaw pain. Dr. Decker indicated Petitioner had previously undergone care at Loyola but changed to Stroger due to losing his insurance. On examination, Dr. Decker noted a full but painful cervical spine range of motion. He prescribed a trial of Methocarbamal and recommended that Petitioner see an oral surgeon. PX 4.

It appears Petitioner saw a dentist, Dr. MacLeod, at Loyola on August 16 or 17, 2012 but the Loyola records (PX 2) do not contain any treatment note dictated by Dr. MacLeod.

On August 17, 2012, Petitioner saw Dr. Tran, a family practitioner, at Stroger Hospital. Dr. Tran noted that Petitioner was transferring care from Loyola "due to loss of job from altercation at work." She also noted that Petitioner had been struck in the right jaw at work on June 12, 2012. She indicated Petitioner had taken Norco and Naproxen for two months after the incident and had stopped taking these medications a month earlier. She indicated Petitioner was currently complaining of neck stiffness, right-sided TMJ pain with mouth opening, and constant head pressure accompanied by intermittent dizziness. She noted that Petitioner was currently taking Methocarbamol. On examination, she noted "right lower molar dental caries – part of tooth missing" and "no TMJ crepitus." She diagnosed muscle spasms of the head and/or neck. She prescribed Methocarbamol along with rest, ice, heat and stretching exercises. She recommended that Petitioner go to the oral surgery clinic for tooth extraction. PX 5.

On September 17, 2012, Petitioner saw Dr. Babzuk, a dentist, at Stroger Hospital's oral surgery clinic. The doctor noted that Petitioner complained of pain in the "right lower quadrant." On examination, he described tooth #30 as showing "gross decay." He extracted the tooth. PX 7.

On September 24, 2012, Petitioner saw George Panos, M.D. at the same oral surgery clinic. The doctor noted a chief complaint of pain and sensitivity coming from tooth #18 with no associated dysphonia, dysphasia, dyspnea or facial swelling. On examination, the doctor noted that tooth #18 was "cariously decayed." He extracted the tooth. PX 6.

Petitioner testified that his medical bills remain unpaid except for the amounts his group carrier paid.

Petitioner testified he still experiences jaw pain, neck pain and stiffness and severe headaches. He experiences the headaches approximately three times per week. The

headaches last until he takes medication. He currently takes only over the counter pain medication.

Petitioner testified that running and weather extremes aggravate his headaches. He can run for only one lap or so. He feels as if the back of his head is moving when he runs. He experiences neck pain two to three times weekly. His neck stiffness can persist for six to eight hours. When he chews something hard, he feels jaw pain.

Petitioner testified he did not work from June 13, 2012 through July 4, 2012. He did not return to work immediately after the accident because he was "in bad shape." He had no job to return to because Respondent terminated him. After being terminated, he applied for and received unemployment benefits. He worked as a warehouse manager between August 2013 and May 2014. He stopped working in May 2014 because his job was eliminated. He later worked for a temporary agency but his assignment ended in June 2015. He is not currently working.

Under cross-examination, Petitioner testified he was aware that Macedo worked at Respondent through a temporary agency. Macedo used profanity before striking him. Macedo came into his office twice. When Macedo first came in, he grabbed paperwork out of Petitioner's hands and walked out. It was after Macedo came back into the office that the altercation occurred.

Petitioner testified that, after the altercation, he notified Nancy Quintero. Quintero took an oral statement from him as to how the altercation came about. Petitioner denied telling Quintero that Macedo gave him a dirty look. Petitioner denied telling Macedo "go f*** your mom."

Petitioner testified a Village of McCook police officer came to Respondent's office after the altercation. Petitioner denied giving this officer a verbal account of the altercation.

Petitioner testified he requested a copy of the police report. He received the report about two weeks after the altercation. He identified RX 1 as the report. He denied saying "what the f*** are you looking at?" to Macedo before the altercation. He reiterated that he did not talk with the police officer on the day of the altercation.

Petitioner testified that, as of the altercation, he worked from 11 AM to 8 PM, Monday through Friday.

Petitioner testified that, in order to gain access to Respondent's office after he arrived at work each morning, he had to be cleared by a officer and walk through a "check" door before collecting his hat, hair cover and uniform.

Petitioner testified that Respondent terminated him on the day of the altercation, June 12, 2012. He received termination-related paperwork while he was at the hospital that day.

Petitioner acknowledged his teeth were extracted due to decay. He still has symptoms but has not undergone any treatment since 2012.

On redirect, Petitioner denied putting his finger on Macedo's chest. He was not present when the police officer took Macedo's statement. The police officer physically examined him but did not take any written statement from him. Macedo was performing work for Respondent before the altercation. Macedo worked for Respondent for an entire year before the altercation.

No witnesses testified on behalf of Respondent. Respondent offered into evidence a Village of McCook Police Department report dated June 12, 2012 (RX 1) concerning the altercation. At the hearing, the Arbitrator overruled Petitioner's hearsay objection and admitted the report in its entirety. At the continued hearing, held on August 24, 2015, Petitioner renewed his objection, with the Arbitrator indicating that both parties should address the admissibility of the report in their proposed decisions. See further below.

At the continued hearing, Petitioner offered into evidence records produced by Respondent in response to a subpoena. The records include a service agreement dated May 1998 running between Respondent and Total Staffing Solutions and a letter and affidavit dated August 19, 2015 from Vicki Sladowski, Respondent's human resources representative, indicating Respondent has no employment records concerning Jose Macedo Hernandez. PX 12.

Arbitrator's Evidentiary Ruling Concerning Admissibility of Police Report (RX 1)

At the initial hearing, the Arbitrator overruled Petitioner's hearsay objection and admitted the police report (RX 1) into evidence in its entirety. At the continued hearing, Petitioner renewed his objection and specifically argued that the report contained "double hearsay" in that the reporting officer recorded Nancy Quintero's recitation of a statement supposedly provided by an identified eyewitness.

The Arbitrator, having had an opportunity to review RX 1 and consider the parties' renewed arguments, revises her previous ruling and rejects the fourth paragraph of the second page of RX 1 so as to exclude the reporting officer's account of what Nancy Quintero purportedly told him. The remainder of RX 1 is admitted.

The Arbitrator notes, however, that she would still have found in Petitioner's favor on the issue of accident had she considered RX 1 in its entirety and taken Quintero's purported statement at face value. According to the reporting officer, Quintero told him there was an "independent witness" to the altercation who wished to provide no information other than that Petitioner and Macedo were "mutual combatants." This scenario does not contradict Petitioner's sworn testimony that the dispute had a work origin. Nor does it necessarily conflict with Petitioner's sworn testimony that Macedo threw the first punch.

Arbitrator's Credibility Assessment

Petitioner's account of the altercation was detailed and believable. Also credible was Petitioner's denial of any pre-altercation head or jaw problems. That denial is consistent with the treatment records, which describe Petitioner's medical history as significant only for seasonal allergies and hernia surgery.

Petitioner gave inconsistent responses when asked whether the reporting police officer took a statement from him. On redirect, Petitioner acknowledged that this officer examined him. This correlates with the officer's statement that he observed a small cut on the inside of Petitioner's right cheek, as well as facial swelling.

Overall, the Arbitrator found Petitioner credible.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident arising out and in the course of his employment on June 12, 2012?

The Arbitrator finds in Petitioner's favor on the issue of accident. In reliance on Petitioner's credible testimony, the Arbitrator finds that the altercation had its origin in work and that Petitioner was not the aggressor.

Respondent principally argues that accident should be denied because the alleged aggressor, Macedo, was not its employee at the time of the altercation. The Arbitrator notes that Respondent's own exhibit, RX 1, lists Respondent as Macedo's employer. Moreover, there is no case law suggesting that an injury arising out of a work-related dispute would not be compensable if the aggressor was on loan to the employer. Finally, Petitioner credibly testified that Macedo worked as a "docker" or "go to person" at Respondent's premises. Under Illinois law, that testimony establishes Macedo was a borrowed employee.

Respondent also argues that accident should be denied because there is no evidence indicating the dispute between Petitioner and Macedo had its origins in work. To the contrary, Petitioner credibly testified that, immediately prior to the accident, he saw a driver expressing anger about a delayed order, only to have Macedo, a "go-between," enter his office, grab paperwork relating to the order out of his hands, leave, later re-enter the office and start swearing about how he was "not going to do this job." RX 1 suggests there was personal animosity between the two men but it does not directly contradict Petitioner's testimony that emotions escalated due to a perceived delay in processing an order.

Finally, Respondent argues that accident should be denied because, based on RX 1, Petitioner placed his index finger on Macedo's chest and started swearing at Macedo before Macedo threw a punch. Respondent views Petitioner as the aggressor. The Arbitrator views

the evidence differently and accepts Petitioner's credible testimony that he did not touch Macedo's chest before Macedo hit him. The Arbitrator also notes that the "totality of circumstances" must be considered in determining which party is the aggressor, under Ford Motor Company v. Industrial Commission, 78 Ill.2d 260 (1980). According to Petitioner, it was Macedo who came into his workspace and made the first contact when he aggressively grabbed paperwork out of Petitioner's hands.

Did Petitioner establish a causal connection between the accident and any claimed current condition of ill-being?

The Arbitrator finds that Petitioner established causation as to a jaw and head/neck injury that required conservative care and that remained symptomatic as of the hearing. In so finding, the Arbitrator relies on the consistent histories in the treatment records, the causation-related comments of the Emergency Room physician, Dr. Judge and Dr. Anderson and Petitioner's credible denial of any pre-altercation headaches or jaw pain.

The Arbitrator finds that Petitioner did not establish causation as to the need for a laryngyscopy and tooth extractions. See further below. The Arbitrator also finds that Petitioner did not establish causation as to the subarachnoid cyst seen on his head CT scan. The radiologist who reviewed this scan characterized the cyst as "of doubtful clinical significance."

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from June 13, 2012, the day after the altercation, through July 4, 2012. Arb Exh 1. Respondent disputes this claim, in reliance on its accident defense and the Emergency Room records.

The Arbitrator has previously found in Petitioner's favor on the issue of accident. In considering the issue of temporary total disability, the Arbitrator acknowledges that, on June 12, 2012, the Emergency Room physician indicated Petitioner could resume full duty the following day. PX 1. However, Dr. Judge of Loyola, who began treating Petitioner the day after the altercation, instructed Petitioner to remain off work from June 12 through July 4, 2012 (see the last two pages in PX 2), citing diagnoses of a concussion and head injury.

In reliance on Dr. Judge's examination findings and diagnoses, the Arbitrator finds that Petitioner was temporarily totally disabled from June 13, 2012 through July 4, 2012, a period of 3 1/7 weeks.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims medical expenses relating to the initial Emergency Room visit (PX 8) as well as follow-up care rendered at Loyola and Stroger Hospitals.

As a preliminary matter, the Arbitrator notes she rejected a claimed $37.00 bill from Suburban Radiologists (PX 9), after sustaining Respondent's foundational objection based on lack of certification.

Based on the foregoing accident- and causation-related findings, the Arbitrator awards the following medical expenses, subject to the fee schedule: 1) LaGrange Memorial Hospital, Emergency Room, 6/12/12, $1,835.80 (PX 8); and 2) Loyola University Medical Center, $772.33 (unpaid balance for physical therapy performed in July 2012) and $214.60 (unpaid balance for cervical spine X-rays performed on July 9, 2012.

The Arbitrator finds the treatment underlying the June 19, 2012 $2,273.20 bill from Loyola University Medical Center to be reasonable, necessary and related to the accident but notes that the bill shows a $0 balance. PX 10.

The Arbitrator declines to award the $128.07 balance relating to the laryngoscopy performed at Loyola on July 17, 2012 because there is no evidence linking Petitioner's reported swallowing difficulty to the June 12, 2012 accident. Dr. Bier-Laning, the otolaryngologist who evaluated Petitioner on July 17, 2012, attributed Petitioner's swallowing problem to GERD and recommended Petitioner change his diet.

The Arbitrator turns to the claimed Stroger Hospital bills. PX 11.

The Arbitrator awards the Stroger Hospital bill of $627.00 relating to Emergency Room services provided on July 31, 2012. The Arbitrator finds it reasonable for Petitioner to have sought follow-up care for his persistent head and neck pain on that date. The Emergency Room records document a history of the altercation and reflect Petitioner could no longer seek care at Loyola due to losing his insurance. PX 4.

The Arbitrator declines to award the Stroger Hospital bills of $422.00 and $176.00 (PX 11) because those bills relate to dental examinations and/or extractions of decayed teeth performed in August 2012. There is no evidence linking the need for the extractions to the June 12, 2012 accident.

What is the nature and extent of the injury?

This is a post-amendatory case, since Petitioner's accident occurred after September 1, 2011. The Arbitrator thus turns to Section 8.1b of the Act for guidance in determining permanency. That section sets forth various factors to be considered, with no single factor predominating over another. The first factor, i.e., AMA impairment rating, is not relevant since neither party offered such a rating. The Arbitrator views the next two factors, Petitioner's occupation (shipping/receiving clerk) and age at the time of the occurrence (45) as not significant in terms of resolving permanency. As for the next factor, future earning capacity, there is no evidence suggesting that the injuries affected Petitioner's earning power. With respect to the last factor, "evidence of disability corroborated by the treating medical records,"

the Arbitrator notes the diagnosis of post-concussive syndrome, which was confirmed by Dr. Anderson, a neurosurgeon affiliated with Loyola University Medical Center. The Arbitrator also notes that several physicians documented right jaw tenderness and a reduced range of cervical spine motion.

The Arbitrator, having considered all of the foregoing, along with Petitioner's credible testimony concerning his persistent complaints, finds that Petitioner is permanently partially disabled to the extent of 2% loss of use of the person as a whole under Section 8(d)2 of the Act, equivalent to 10 weeks of benefits.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCHENRY)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bradley Calucci,

Petitioner,

16IWCC0300

vs. NO: 12 WC 29838

Safelite Auto Glass,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, two doctor rule, video 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 26, 2015, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 6 - 2016
KWL/vf
O-3/8/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

16IWCC0300

CALUCCI, BRADLEY
Employee/Petitioner

Case# 12WC029838

SAFELITE AUTO GLASS
Employer/Respondent

On 2/26/2015, 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 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0247 HANNIGAN & BOTHA, LTD
RICHARD D HANNIGAN
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

2542 BRYCE DOWNEY & LENKOV LLC
EDWARD JORDAN
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF MCHENRY)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 19(b)

16IWCC0300

BRADLEY CALUCCI ,
Employee/Petitioner

v.

SAFELITE AUTO GLASS ,
Employer/Respondent

Case # 12 WC 29838

Consolidated cases: NONE .

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Joann M. Fratianni**, Arbitrator of the Commission, in the city of **Woodstock**, on **January 15, 2015** and **February 5, 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: Did Petitioner exceed his two choices of chain of referrals of physicians?

FINDINGS

On the date of accident, **April 10, 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 **$37,398.40**; the average weekly wage was **$719.20**.

On the date of accident, Petitioner was **32** years of age, ***married*** with **two** dependent children.

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

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

Respondent shall be given a credit of $ **41,297.74** for TTD, $ **0.00** for TPD, $ **0.00** for maintenance, and $ **0.00** for other benefits, for a total credit of $ **41,297.74**.

Respondent is entitled to a credit of $ **125.00** under Section 8(j) of the Act, and under Section 8(a) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$479.47**/week for **146-6/7** weeks, commencing **April 11, 2012** through **April 17, 2012**, and **April 20, 2012** through **February 5, 2015**, as provided in Section **8(b)** of the Act.

Respondent shall pay reasonable and necessary medical services to Petitioner of **$21,234.16**, pursuant to the medical fee schedule or the negotiated rate, whichever is less, as provided in Sections **8(a)** and **8.2** of the Act.

Respondent is ordered to authorize, approve and pay for the prospective medical care and treatment as prescribed by Dr. Hall in the form of radiofrequency nerve ablation and medial branch neurotomies to the right arm and shoulder areas. This order shall include payment of all medical expenses incurred for such treatment as well as all periods of temporary total disability so incurred.

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 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 JOANN M. FRATIANNI

February 20, 2015
Date

ICArbDec19(b)

FEB 2 6 2015

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

Petitioner works for Respondent as an auto glass installer. Petitioner sustained a work related injury on April 10, 2012, while squatting down and picking up a windshield. He turned his head to the left and experienced a pop on the right side of his neck, along with pain into his right shoulder.

Petitioner first sought medical care for this injury on April 11, 2012 at the Northern Illinois Medical Center Occupational Health Clinic. A history was recorded of lifting a windshield that weighed around 60 pounds and while lifting he twisted his neck towards the left and experienced a pop in the lower region of the neck. Petitioner was diagnosed with an acute cervical strain and was prescribed an MRI. (Px3)

Petitioner underwent the MRI on May 2, 2012. This revealed straightening of the normal lordosis of the cervical spine indicating paraspinal muscle spasm. A subtle diffuse posterior disc bulge was noted at C5-C6 without central canal or neuroforaminal stenosis. (Px3) Following this MRI, the clinic referred Petitioner to see Dr. Chen.

Petitioner saw Dr. Chen on May 15, 2012 and Dr. Grindstaff of the same office on June 12, 2012. Dr. Grindstaff diagnosed posttraumatic spine disease, radiculopathy, and an ulnar neuropathy. Dr. Grindstaff prescribed intravenous steroids in the form of Solu-Medrol infusions that were administered to Petitioner over a period of three days. (Px2) Petitioner testified that following this treatment, he experienced severe pain and heat in both knees, hips, elbows, wrists and ankles. He reported to the emergency room at Northern Illinois Medical Center on July 1, 2012 for these symptoms. On July 3, 2012, Dr. Grindstaff noted that Petitioner did not respond to oral steroids and was given a trial of Solu-Medrol, experiencing some side effects. Petitioner felt no issues after the first infusion, but subsequent infusions caused severe pain and heat in both knees, hips, elbows, wrists and ankles. Those symptoms did improve somewhat since the last infusion, but Petitioner was having trouble walking due to pain in his joints. (Px2)

Dr. Hall testified by evidence deposition that the intravenous steroids treatment was an acceptable method for an acute cervical strain with paresthesia in the right fourth and fifth fingers. (Px11) Dr. Hall testified that Petitioner informed him that he fell three times due to diffuse pain in both knees. Dr. Hall did prescribe a right knee MRI that was performed on August 13, 2012. This revealed low to intermediate grade chondromalacia of the patella and a tiny Baker's cyst. Dr. Hall prescribed conservative care including physical therapy. Petitioner testified this therapy provided no relief of his symptoms.

Petitioner saw Dr. Kornblatt on September 27, 2012. This was at the request of the Respondent. Dr. Kornblatt noted the treatment with intravenous steroids and the history of joint swelling and falling at home three times injuring the right knee. Dr. Kornblatt was of the opinion that the right knee injury was due to the falls at home. If he fell due to complications from steroid treatment for the neck was a question of credibility to Dr. Kornblatt. If he fell due to complications from the steroid treatments then there would be in his opinion a causal connection and Petitioner would benefit from physical therapy.

Petitioner testified that he underwent physical therapy following the Dr. Kornblatt examination, but experienced no relief of his symptoms.

Dr. Hall testified that on November 21, 2012, he prescribed surgery to the right knee. Surgery took place on January 17, 2013 in the form of an arthroscopic debridement and chondroplasty of the patella and medial femoral condyle. (Px11) Post surgery, Dr. Hall also turned his attention to the neck and right shoulder injuries.

On February 4, 2013, Dr. Hall, prescribed right knee physical therapy. On February 25, 2013, Dr. Hall prescribed therapy to the neck and right shoulder areas. While in physical therapy, Petitioner voiced complaints of neck pain with pins and needles symptoms into his 4th and 5th right fingers along with stabbing pain from the elbow to the hand. Petitioner also complained of neck stiffness and difficulty sleeping along with difficulty in lifting with his right upper extremity. (Px11)

Dr. Hall testified that on April 25, 2013, he continued to note persistent neck discomfort located along the right paraspinal muscles that radiated to the trapezius, shoulder, elbow and forearm, along with numbness and tingling to the ring and little fingers. Dr. Hall discharged Petitioner from further physical therapy and treatment to his right knee at that time. (Px11)

On May 2, 2013, Dr. Hall noted Petitioner had reservations concerning epidural steroid injections, based on his prior experiences with the steroid infusions. Dr. Hall at that time elected not to prescribe the epidural steroid injections, but prescribed Cymbalta. Dr. Hall later discontinued the Cymbalta due to hallucination side effects. (Px11)

On June 14, 2013, Dr. Ryon Hennessy saw Petitioner. This was also at the request of Respondent. Dr. Hennessy called into question the appropriateness of Dr. Grindstaff's treatment of Solu-Medrol infusions, but felt this was not malpractice. Dr. Hennessy also reviewed records of treatment of Dr. Hall through February 18, 2013 and noted the impingement sign of the right shoulder to be slightly positive. Dr. Hennessy felt that if there was a diagnosis of cervical radiculopathy, it was not supported by objective findings. Dr. Hennessy did note that a pop in the neck at the time of the injury and that mechanism of injury was a potential cause for cervical radiculopathy, and the radiculopathy down through the 4th and 5th digits would correlate with the C8 dermatome that was later found on an EMG. Dr. Hennessy also felt the persistent right shoulder pain was not related to the April 10, 2012 accident. Dr. Hennessy agreed the symptoms of the neck and right shoulder as conveyed to various medical providers were consistent throughout treatment. Dr. Hennessy also admitted there was no history of such symptoms prior to April 10, 2012. Dr. Hennessy concluded that Petitioner could work full duty with no restrictions concerning his right knee, but with a 25 pound lifting restriction as it pertains to his cervical spine. (Rx1)

On August 28, 2013, Dr. Hall prescribed a right shoulder MRI. This was performed on October 3, 2013 and revealed a subchondral bone lesion in the superior medial aspect of the humeral head that may be related to a prior impaction injury. Dr. Hall reviewed this MRI on October 10, 2013 and felt it did not show any evidence of a rotator cuff tear. Dr. Hall prescribed surgery in the form of a right shoulder arthroscopy, anterior acromioplasty and distal, claviculectomy, to be performed within the next two months. Dr. Hall still feels this surgery would be appropriate, reasonable and related to Petitioner's injury of April 10, 2012. (Px6)

Petitioner saw Dr. Matthew Ross on April 3, 2014. This was at the request of his own attorney. Dr. Ross testified by evidence deposition (Px7) that he recorded a history of injury, reviewed medical records of treatment and reviewed the opinions of Dr. Hennessy. Based on his review of the cervical MRI, Dr. Ross felt it did not reveal where the pain generator was located. However, because the pain was worse with right side bending and rotation as well as tenderness over the right lower cervical facet joint, that raised the possibility the neck pain is facet mediated. Dr. Ross felt this was related to the work injury. Dr. Ross felt a diagnostic facet joint block from C6 through T1 on the right side would be appropriate. If that provided temporary relief of the pain when the joints are anesthetized, then Petitioner would be a candidate for radiofrequency medial branch neurotomy. Dr. Ross felt Petitioner required a 25 pound weight restriction and felt the radiofrequency medial branch neurotomy should be performed prior to right shoulder surgery, as it may provide pain relief, making the right shoulder surgery unnecessary. Dr. Ross testified that if the facet joint injections provided symptom relief, Petitioner would require up to a series of three radiofrequency injections. (Px7)

On January 12, 2015, Dr. Hall agreed the facet joint injections would be appropriate, but also felt the right shoulder surgery would also be appropriate. Petitioner underwent the right cervical facet joint injections as prescribed by Dr. Hall. When seen on December 9, 2014, Petitioner reported excellent results from those blocks but the pain later returned.

Respondent introduced into evidence surveillance videos showing Petitioner riding a motorcycle on two different occasions. There are medical restrictions in evidence before this Arbitrator that would prohibit this activity. It does not appear that any physician reviewed these videos. Petitioner testified that prior to this accident, he rode his motorcycle all the time. After the accident, he has ridden it twice, both for "memorial rides" in honor of his brother who was killed in a motorcycle accident. The Arbitrator finds the video surveillance in this matter to be not persuasive as to Petitioner's medical limitations.

Whether a causal connection exists between a Petitioner's condition of ill-being and his employment is a factual issue to be decided by the Commission, *Tower Automotive v. Illinois Workers' Compensation Comm'n,* 407 Ill.App.3d 427, 943 N.E.2d 153 (1st Dist. 2011). A Petitioner need only prove that some act or phase of his employment was a causative factor in the ensuing injury, *Vogel v. Industrial Comm'n,* 354 Ill.App.3d 780, 821 N.E.2d 807 (2005).

The Arbitrator finds it persuasive that there is no evidence that Petitioner suffered any neck and right shoulder symptoms prior to April 10, 2012. The medical providers and Section 12 examining physicians all agree that Petitioner's symptoms have been consistent since the date of accident of April 10, 2012. In this case, the chain of events that followed April 10, 2012 indicate that Petitioner was able to perform his job with no lost time or complaints prior to that date, but was unable to perform such work with consistent symptoms post injury which continue to the present time.

There appears to be no evidence or opinions concerning malingering or exaggeration of symptoms, and all physicians who have testified in this matter or who have treated Petitioner feel the symptoms are real.

Based upon the above, the Arbitrator finds the current condition of ill-being to the neck, right shoulder and upper extremity and right knee to be causally related to the accidental injury of April 10, 2012.

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

Petitioner introduced into evidence the following medical charges that were incurred after the accident of April 10, 2012 (Px10):

Centegra Hospital	$3,382.18
Centegra Physician Care	$1,410.00
Centegra Physician Care – ER	$1,317.00
Dr. Robert Hall	$ 884.00
Health Benefits Pain Management – IPN	$9,380.88
Illinois Physician Network – MRI	$3,415.50
Lake/McHenry Pathology	$ 13.80
Open Advanced MRI	$1,210.00
Out of Pocket Medical Expenses	$ 220.80

These charges total $21,234.16.

See findings of this Arbitrator in "F" above.

Based upon said findings, the Arbitrator further finds the above charges represent reasonable and necessary medical care and treatment that is causally related to this accidental injury and further finds Respondent to be liable to Petitioner for same, subject to the provisions of the medical fee schedule as created by the Act.

K. Is Petitioner entitled to any prospective medical care?

See findings of this Arbitrator in "F" above.

Based upon said findings, the Arbitrator further finds the approach suggested by Dr. Ross to be the most logical medical care and treatment at the present time. While Petitioner may ultimately require right shoulder surgery, this Arbitrator feels that such surgery at this time would be premature. This opinion is based upon the opinions of Dr. Ross that the neck findings could be causing the right shoulder pain and the facet blocks may be proof of this as they temporarily relieved the symptoms to the right side of the neck and radicular pain.

Based upon the above, the Arbitrator finds that the radiofrequency nerve ablation procedure should be administered. Dr. Ross felt that three such procedures may be necessary. Should this alleviate the pain symptoms, then right shoulder surgery may not be necessary. This approach appears to be reasonable and necessary to treat the current condition of ill-being and this Arbitrator so finds.

Based upon the above, the Arbitrator orders Respondent to authorize and pay for the prescribed radiofrequency nerve ablation procedures, including all periods of temporary total disability and additional medical treatment resulting from same.

L. What temporary benefits are in dispute?

See findings of this Arbitrator in "F" above.

Petitioner has yet to reach maximum medical improvement and has been off work or on light duty medical restrictions since this accident, which includes a 25 pound weight restriction.

Based upon said findings, the Arbitrator finds that Petitioner as a result of this accidental injury was temporarily and totally disabled from work commencing April 11, 2012 through April 17, 2012, and from April 20, 2012 through February 5, 2015, and is entitled to receive temporary total disability benefits from Respondent for these periods of time.

M. Should penalties or fees be imposed upon Respondent?

See findings of this Arbitrator in "F" above.

Based upon said findings, the Arbitrator does find that Respondent had a good faith basis to rely upon the opinions of Dr. Hennessy and his opinions of causation and medical care.

Based upon said findings, all claims made by Petitioner for penalties and attorneys fees in this matter are hereby denied.

O. Did Petitioner exceed his two choices of chain of referrals of physicians?

See findings of this Arbitrator in "F" above.

Petitioner testified he was sent to Northern Illinois Medical Center Occupational Health by his employer. This clinic later referred Petitioner to see Dr. Chen and Dr. Grindstaff at Centegra Physicians Care.

Petitioner first saw Dr. Hall on July 19, 2012. The Arbitrator finds under these circumstances that Dr. Hall is the first choice of physician for Petitioner in this matter. Dr. Ross was a Section 12 examining physician and is not a treating physician in this case.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wayne Lange,
Petitioner,
Vs.

16IWCC0326

NO: 12 WC 29993

United States Infrastructure,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent partial disability, penalties and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 2, 2015, is hereby affirmed and adopted.

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

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

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

DATED: MAY 13 2016
KWL/vf
O-5/9/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

16IWCC0326

LANGE, WAYNE
Employee/Petitioner

Case# 12WC029993

UNITED STATES INFRASTRUCTURE
Employer/Respondent

On 3/2/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the 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:

3098 MICHAEL NICHOLSON
7111 W HIGGINS AVE
CHICAGO, IL 60656

1596 MEACHUM STARCK & BOYLE
STEVEN SCHUETZ
225 W WASHINGTON ST SUITE 1400
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

16IWCC0326

Wayne Lange
Employee/Petitioner

v.

United States Infrastructure
Employer/Respondent

Case # 12 WC 29993

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 Molly C. Mason, Arbitrator of the Commission, in the city of Chicago, on January 30, 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 with regard to Petitioner's right knee?
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 with regard to his right knee?
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

16IWCC0326

FINDINGS

On the date of accident, June 23, 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.

Accident vis-à-vis the right hip is not in dispute. T. 4-5. Arb Exh 1. The parties agreed to defer all issues insofar as the low back is concerned. T. 8-9. The Arbitrator makes no findings as to the lower back. For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner lacked credibility as to certain issues and failed to prove accident with respect to his right knee.

Timely notice of this accident was given to Respondent.

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner lacked credibility as to certain issues and failed to prove a causal connection between his June 23, 2012 work accident and his current claimed right knee condition of ill-being.

In the year preceding the injury, Petitioner earned **$42,195.92**; the average weekly wage was **$811.46**.

On the date of accident, Petitioner was 49 years of age, **married** with **0** dependent children.

ORDER

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner lacked credibility as to certain issues and failed to prove accident and causation as to his current claimed right knee condition of ill-being. Based on these findings, the Arbitrator denies Petitioner's claim for prospective right knee surgery. The Arbitrator views the remaining disputed issue of penalties/fees as moot.

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

3/2/15
Date

ICArbDec19(b)

MAR 2 - 2015

Wayne Lange v. United States Infrastructure
12 WC 29993

Arbitrator's Summary of Dispute

There is no dispute that Petitioner injured his right hip in a work accident on June 23, 2012. As of the January 30, 2015 hearing, temporary total disability benefits were current (Arb Exh 1) and Respondent was paying the medical expenses relating to the right hip. T. 5.

Petitioner also claims right knee and lower back conditions of ill-being stemming from the same accident. Shortly before the hearing, Respondent agreed to authorize a lumbar spine MRI. T. 7. At the hearing, the parties agreed to defer all other issues with respect to the lumbar spine. The hearing was held for the sole purpose of determining whether Petitioner established accident and causation as to a right knee condition of ill-being and, if so, whether he is entitled to prospective right knee surgery and penalties/fees based on the denial of this surgery. Petitioner claimed no incurred right knee medical expenses at the hearing. Arb Exh 1. T. 5-6.

Arbitrator's Findings of Fact

Petitioner testified he was born on March 6, 1963. T. 13. He began working for Respondent about 2 ½ years before his accident of June 23, 2012. As of that date, he worked as an underground utility locator technician. T. 13-14. His duties included locating underground gas mains and providing gas, electric, telephone and cable services. T. 14.

Petitioner acknowledged undergoing right knee surgery, consisting of an ACL replacement, at Alexian Brothers Medical Center in 2002 or 2003. He underwent this surgery after injuring his right knee in a fight. He participated in physical therapy after this surgery and followed his surgeon's recommendations. His right knee was "fine" before his undisputed accident of June 23, 2012. His job with Respondent involved constant kneeling and climbing and he "never had any problems" performing these activities. He denied taking any time off from Respondent due to right knee pain prior to the accident. T. 43-44.

Petitioner testified he received an "emergency call-out" work assignment on June 23, 2012. He clocked in, from home, at 12:30 PM and drove to the call-out location in Hickory Hills. T. 14. A tenant met him there, showed him the basement door of the building and told him what had happened. Petitioner then went back to his truck and gathered his work equipment. By that time, a Commonwealth Edison employee had arrived at the scene. Petitioner told this employee that the building's meters were in the basement. The employee began gathering his equipment. T. 15.

Petitioner testified that, as soon as he began descending the stairs into the basement, the carpeting came loose and "shot out," causing him to lose his footing and fall. He landed on his right side and slid down the stairs on that side. He believed he fell down about fifteen

stairs. When he reached the bottom, he landed on his knees and then fell forward, smashing his head into a concrete surface. T. 15.

Petitioner testified that, immediately after falling, he realized his right knee was injured. When he tried to get to his feet, his right knee throbbed. He felt as if he had bruised the knee. He also felt pain in his back and hip. The Commonwealth Edison employee asked him if he wanted an ambulance. Petitioner testified he declined this offer because he "didn't think it was that big of a deal." He thought he had simply bruised his butt and sprained his knee. T. 17. He remained at the building and continued working. T. 17. He noticed swelling in his knee as time went by. T. 17-18. At about 1:35 PM, he radioed his supervisor, Brian Pierce, and told him he had fallen. Pierce asked him if he wanted to go to a clinic and he said no. T. 21. Pierce also told him he had to complete and submit an accident report, via E-mail. T. 21. Petitioner testified he completed the job at about 1:50 or 2:00 PM and went home. After he got home, he filled out the report, which he received via an E-mail sent to his company account. T. 18, 21. The report consisted of two pages. He testified he completed the first page while the second page was to be filled out by his supervisor. T. 24. On the first page, he indicated he had injured his knee, back and hip. He also checked a box indicating he was declining medical treatment at that time but was not waiving the right to seek care later on. T. 26. He was never asked to manually sign this form. The instructions on the website indicated that, once he clicked "send," in order to transmit the completed form, he was "electronically signing" the statement. T. 24, 27.

The Arbitrator sustained Respondent's foundational objection to PX 2. T. 19, 23. PX 2 was marked as a rejected exhibit. The Arbitrator will re-visit this ruling later in this decision.

Petitioner testified he also completed a "JUL [Joint Utility Locators]IE," or job, ticket concerning the work he performed at the site. T. 26. No job ticket is in evidence.

Petitioner testified he was "in a lot of pain" during the afternoon of June 23, 2012. The pain was primarily in his knee. T. 28. He had a "big bruise on [his] hip" and his "back and knee were swollen and red." T. 28.

Petitioner acknowledged he did not seek treatment until eleven days after the accident. At that point, he radioed his supervisor, Brian Pierce, and told him he could barely walk anymore. Pierce directed him to meet him at the WorkRight Clinic in an hour. Pierce arrived at the clinic shortly after Petitioner. Petitioner testified that Pierce brought a copy of the completed accident report with him. Pierce registered Petitioner and directed Petitioner to provide the clinic personnel with the report. It was after he did this that Petitioner saw a doctor. T. 28-30.

Petitioner testified that, at his first visit to WorkRight, he complained that he could hardly walk and that his knee was swollen and painful. He also indicated he bruised his hip and back when he fell. T. 34.

Petitioner testified that the first doctor he saw at WorkRight was Dr. Ramsey. Petitioner further testified he underwent X-rays of his hip, knee and lower back at Dr. Ramsey's direction. T. 30.

The WorkRight Occupational Clinic records reflect that Petitioner saw Dr. Ramsey for an initial visit on July 3, 2012, with the doctor recording the following history:

> "Patient states while at work on 6/23/12, he was walking down stairs and he slipped on a rug that was not tacked down. He did the splits and fell, landing on his right hip mainly. He has been in pain ever since but continued to work. Patient was sent to WorkRight by his employer for evaluation and treatment."

Dr. Ramsey noted that Petitioner complained of 5/10 pain "in his lower back and right hip area." He also noted that Petitioner felt as if his right hip was "getting out of socket." He indicated that Petitioner denied any radiation of pain to his lower extremities.

Dr. Ramsey noted that Petitioner had undergone a right anterior cruciate ligament repair in 2002.

Dr. Ramsey described Petitioner's gait as antalgic. On lumbar spine examination, he noted a moderately restricted range of motion, discomfort with flexion and extension and tenderness to palpation of the sacral region, more on the right. On right hip examination, he noted a significantly restricted range of motion, pain with all hip movements and tenderness to palpation in the greater trochanter area.

There is no indication that Dr. Ramsey examined either of Petitioner's knees.

Dr. Ramsey noted there were "no hematomas or ecchymosis present."

Dr. Ramsey ordered X-rays of the lumbar spine, pelvis and right hip. There is no indication he ordered any knee X-rays. The itemized clinic bill lists X-ray charges only for the lumbar spine, pelvis and hip.

Dr. Ramsey diagnosed contusions and sprains of the hip and back. He provided Petitioner with a TLSO lumbar support and crutches. He instructed Petitioner to use the crutches when walking and limit weight bearing on his right leg. He indicated he planned to order a right hip MRI once he obtained insurance approval. He dispensed Daypro and Toradol and released Petitioner to sitting work only. He instructed Petitioner to return on July 9, 2012. PX 3.

Petitioner underwent a right hip MRI on the morning of July 11, 2012. The interpreting radiologist noted mildly advanced osteoarthritic changes and probable superimposed changes o

avascular necrosis. He indicated it would be difficult to entirely exclude post-traumatic changes. PX 2.

The WorkRight records reflect that, following the initial visit with Dr. Ramsey, Petitioner saw Dr. Patel on July 11, 2012, shortly after undergoing the right hip MRI. Dr. Patel noted that Petitioner complained of a lot of pain in his right hip and stiffness in the base of his lower back. He indicated Petitioner was walking with crutches and that his gait was antalgic but he did not note any knee or leg complaints. He indicated he examined Petitioner's lumbar spine and right hip. He discussed the MRI results with Petitioner. He prescribed physical therapy and Voltaren and released Petitioner to light duty. He instructed Petitioner to continue using the crutches, perform range of motion exercises and return on July 16, 2012. PX 2.

Petitioner also saw Dr. Shah on July 11, 2012. Petitioner testified that Dr. Shah had been his personal care physician for about a year prior to July 11, 2012. T. 36. The doctor noted a history of a fall at work two and a half weeks earlier. He also noted that Petitioner complained of pain in his lateral right hip, right groin area and right thigh secondary to this fall. He indicated that Petitioner denied lower back pain and radiating pain.

Dr. Shah described Petitioner as 74 inches tall and weighing 308 pounds. He noted a past history of arthritis.

On extremity examination, Dr. Shah noted no edema and normal sensation.

Dr. Shah assessed Petitioner as having hip pain. He prescribed Norco and recommended an orthopedic consultation. PX 7.

On July 16, 2012, Dr. Ramsey of WorkRight prescribed Vicodin and released Petitioner to sitting work. PX 3.

Petitioner testified that Dr. Shah referred him to Dr. Gokhale, an orthopedic surgeon affiliated with M & M Orthopedics. T. 37.

Records from M & M Orthopedics reflect that Petitioner first saw Dr. Gokhale on July 17, 2012. The note of that date sets forth the following history:

> "R hip – fell down a flight of stairs on 6-23-12; went to the doctor on 7-3-12; pain from lateral/posterior right hip across almost to groin, sometimes down the leg a little; no previous tx; had X-rays taken (lumbar and right hip – has films) and right hip MRI . . . on 7-11-12 (has CD and report); PT is to start tomorrow; not working at this time – PCP told patient not to put pressure on – patient states he has crutches in the car (did not use in the office today) but prefers to use a cane (has been using in the right hand); taking Celebrex for a few years since right knee sx a few years ago; WC

doctor gave patient Toradol and Hydrocodone – does not take at the same time as Celebrex."

Dr. Gokhale described Petitioner as complaining of "groin pain as well as a lateral pain." He indicated that Petitioner reported being unable to properly lift his leg out of bed.

On initial examination, Dr. Gokhale noted tenderness deep in the groin, no particular tenderness over the greater trochanter, worsening of pain with log roll, a positive Stinchfield test, flexion only to 90 degrees and internal/external rotation to about 10 to 20 degrees before complaining of significant pain.

After examining Petitioner and reviewing the MRI and X-rays, Dr. Gokhale diagnosed a "right hip osteoarthritis exacerbation." He described Petitioner as "clearly worse after falling down the stairs" and "exacerbat[ing] an underlying problem." He recommended a fluoroscopic-guided hip injection. He instructed Petitioner to delay therapy until after undergoing this injection. He directed Petitioner to continue taking Celebrex and return in one month. He took Petitioner off work. PX 5.

Petitioner testified that, when he first went to M & M Orthopedics, he was experiencing pain, primarily in his knee, and could hardly walk. Petitioner also testified he reported his knee pain to the providers at M & M. T. 37-38.

Under cross-examination, Petitioner acknowledged completing and signing a three-page history form at M & M Orthopedics on July 17, 2012. T. 56-57. The first page of this form reflects that Petitioner wrote "right hip" in response to a query asking him to list the complaints he wanted a physician to evaluate. PX 5.

Petitioner saw Dr. Shah again on July 25, 2012, with the doctor noting that Petitioner had seen an orthopedic surgeon who recommended a hip injection. Dr. Shah diagnosed a hip sprain. He directed Petitioner to discontinue Vicodin and start Norco. PX 7.

Petitioner returned to WorkRight on August 10, 2012 and again saw Dr. Ramsey. No examination findings are noted. The records merely state that Dr. Ramsey released Petitioner to "sitting work only." PX 2.

Petitioner testified he underwent the fluoroscopic hip injection that Dr. Gokhale recommended. It appears he underwent this injection on August 13, 2012 but no records concerning the injection are in evidence.

Petitioner underwent an initial physical therapy evaluation at WorkRight on August 16, 2012. The evaluating therapist noted that Petitioner complained of 5/10 pain in his lower back, right hip and groin area. On examination, the therapist noted no swelling or edema of the lumbar spine or right hip area and pain with moving the right hip in all directions. He

recommended that Petitioner engage in therapy, perform home exercises and follow up as necessary. PX 3.

Petitioner attended additional therapy sessions on August 20 and 23, 2012. On both of these dates, Petitioner denied any improvement. The therapist noted that Petitioner's right hip pain increased with rotation and ambulation. He documented tenderness to palpation of the greater trochanteric area of the right hip, groin and right lumbar spine. He recommended additional therapy. The last WorkRight note in evidence is the therapy note of August 23, 2012. PX 3.

Petitioner returned to M & M Orthopedics on August 28, 2012 and again saw Dr. Gokhale. The doctor noted that Petitioner had undergone the recommended injection, as well as some therapy, but described his symptoms as worse. He also noted that Petitioner had run out of Hydrocodone and was taking Aleve. He indicated Petitioner was using a cane in his right hand. He suggested Petitioner hold the cane in his left hand instead. He described Petitioner as "limping quite a bit" and being unable to tolerate his level of pain.

On re-examination, Dr. Gokhale noted a positive Stinchfield test, worsening of pain with log roll and tenderness in the groin and laterally. He obtained a weight-bearing X-ray of the hip. He interpreted the film as showing "near bone-on-bone configuration with subchondral cyst formation and osteophytes." He again commented that the work injury exacerbated an underlying problem. He recommended that Petitioner see his partner, Dr. Lieber, for consideration of a total hip arthroplasty. He indicated that Petitioner was very much in agreement with this plan. He continued to keep Petitioner off work. PX 5.

On August 30, 2012, Petitioner filed an Application for Adjustment of Claim alleging a right hip injury of June 23, 2012 stemming from a fall down stairs.

Petitioner first saw Dr. Lieber on September 19, 2012. Dr. Lieber noted that Petitioner fell down a flight of stairs at work on June 23, 2012, "sustaining injury to his right hip." He also noted that Petitioner had derived no relief from the injection or medication.

On initial examination, Dr. Lieber noted "decreased range of motion of the right hip secondary to pain." There is no indication he examined either of Petitioner's knees.

After reviewing the MRI and X-rays, Dr. Lieber scheduled Petitioner for a right total hip replacement. He directed Petitioner to remain off work. PX 5.

On October 15, 2012, Petitioner saw Lauren Smith, a certified physician's assistant affiliated with M & M Orthopedics [hereafter "Smith"], for a pre-operative visit. Smith noted that Petitioner was using a cane and having trouble with his gait on the right side. On examination, she noted a decreased range of motion in the right hip, tenderness to palpation over the lateral hip, strong EHL, dorsiflexion, plantarflexion, quadriceps and hamstring muscle testing and a "full range of motion of the knee and ankle without any complaints." She

prescribed OxyContin and Norco for post-operative pain management and advised Petitioner to stop smoking. She continued to keep Petitioner off work. PX 5.

Dr. Lieber performed a right total hip replacement on October 23, 2012.

On November 2, 2012, Petitioner saw Dr. Shah and indicated he was in a lot of pain postoperatively. Dr. Shah increased his Norco dosage and refilled his Celebrex. PX 7.

Petitioner saw Smith on November 5, 2012. Smith noted that Petitioner was able to walk with a cane and complained of significant post-operative pain, for which he was taking alternating doses of Percocet and Norco. On examination, Smith noted 5/5 knee flexion and extension, an obviously decreased range of right hip motion and a positive Trendelenburg sign on the right side, which she described as "to be expected." She recommended home therapy visits and continued cane usage. She refilled the Norco and gave Petitioner a new prescription for Percocet. PX 5.

On November 7, 2012, Smith noted that Petitioner had called the office concerning his pain medication. She indicated she did not feel comfortable giving Petitioner any more narcotics since he already had Norco, Percocet and Oxycontin in his possession. PX 5. Two days later, Smith declined Petitioner's telephone request for an Oxycontin refill. On November 20, 2012, Smith called Petitioner and informed him that, per Dr. Lieber, no more refills would be given and that he could take over the counter Motrin or Tylenol. PX 5.

Petitioner returned to Smith for a six-week post-operative visit on December 3, 2012. Smith noted that Petitioner reported a little improvement but was still using a cane. On examination, she noted 4-/5 quadriceps and hamstring strength with flexion and extension of the knee, weak hip flexion and pain with range of motion of the right hip. She told Petitioner he needed to wean off all narcotic pain medication. She provided Petitioner with a limited supply of Norco, to be used only during therapy, and instructed Petitioner to discontinue the Percocet and OxyContin, start therapy and continue taking Celebrex. PX 5.

Petitioner testified he "constantly" complained of right knee pain to Dr. Lieber's physician's assistant and the therapist after he began therapy following the October 23, 2012 hip replacement. T. 46.

Petitioner underwent an initial physical therapy evaluation at M & M Orthopedics on December 27, 2012. The evaluating therapist, Deborah Mahalski, P.T. [hereafter "Mahalski"], noted a history of the work accident and subsequent care.

Mahalski noted that Petitioner complained of pain in his knee and groin along with constant right hip pain, worse with weight bearing. [This is the first treatment note specifically mentioning knee pain.]

Mahalski noted that Petitioner was using a straight cane that was, in her estimation, "just a little too short." She also noted that Petitioner's gait was abnormal even with the cane. She concluded that the cane was providing insufficient support, noting that Petitioner is a "very large man." She recommended Petitioner use one crutch instead. After Petitioner tried this, she noted an improved heel-toe gait.

Mahalski indicated that Petitioner had "lost much muscle mass" since his accident. She documented "great atrophy." She recommended continued therapy. PX 5.

Petitioner continued undergoing therapy with Mahalski thereafter. On January 11, 2013, Mahalski noted that Petitioner was still using a cane. She again instructed him to switch to a single crutch. PX 5.

On January 14, 2013, Smith instructed Petitioner to "be aggressive with physical therapy" and also perform home exercises. PX 5.

On January 15, 2013, Mahalski noted that Petitioner reported taking Ibuprofen due to having right hip pain all weekend. She also noted a complaint of knee soreness. She again recommended that Petitioner use crutches to walk. Two days later, she noted that Petitioner was still complaining of right hip and knee soreness. She provided Petitioner with crutches and instructed him how to use them. On January 18, 2013 she noted that Petitioner reported reduced hip soreness secondary to crutch usage. PX 5.

On January 24, 2013, Mahalski noted that Petitioner reported improvement of his right hip and groin pain but described his knee as "still very painful." She indicated that Petitioner rated his right knee pain at 5-6/10 when at rest and at 9/10 with weight bearing. She noted that Petitioner required rest breaks between exercises due to knee pain. The following day, she noted that Petitioner complained of increased hip soreness after slipping (but not falling) on ice.

On January 29, 2013, Mahalski noted that Petitioner told her that sometimes his right knee was actually bothering him more than his hip. She also noted that Petitioner was experiencing great difficulty sleeping due to pain. PX 5.

On February 1, 2013, Mahalski noted that Petitioner's right knee pain was "essentially unchanged" and that he was still experiencing pain in the right lateral hip and groin. PX 5.

On February 7, 2013, Mahalski noted that Petitioner described his knee as "more problematic and painful" than his hip. PX 5. On February 25, 2013, Mahalski noted she had received a message indicating that no further therapy would be authorized.

Petitioner returned to Dr. Shah on March 11, 2013 and requested a prescription for a right knee MRI. Dr. Shah noted that Petitioner was undergoing therapy and had been experiencing right knee pain for a "few months." He also noted that the pain was "worse with

movement" and that Petitioner frequently felt as if his right knee was giving out. Dr. Shah refilled the Celebrex prescription and instructed Petitioner to return in four weeks. PX 7.

On March 22, 2013, Petitioner underwent a physical therapy evaluation by a different M & M Orthopedics therapist, Tracy Bugielski, P.T. In her initial history, Bugielski noted that Petitioner reported injuring his right knee as well as his back and right hip in his work fall but stated that his knee pain had "never been examined by the doctor or treated." Bugielski also noted that Petitioner had purchased and was using knee braces. She further indicated that Petitioner reported developing plantar fasciitis in his right foot secondary to his poor gait pattern from hip and knee pain. She noted that Petitioner reported he began attending a gym daily after February 8, 2013 in order to perform upper body strengthening along with as much lower body strengthening as he could tolerate.

On initial examination, Bugielski noted visual edema around the right knee, an antalgic gait and pain to palpation along the medial joint line, medial and lateral tibial plateau and medial and lateral collateral ligaments. PX 5.

Subsequent therapy notes, authored by both Mahalski and Bugielski, also document complaints of right knee pain. PX 5.

Petitioner underwent a right knee MRI on March 28, 2013. The MRI report lists Dr. Shah as the prescribing physician. The MRI, performed with and without contrast, showed evidence of the previous ACL reconstruction surgery, intact medial and lateral menisci, "DJD/OA and severe chondromalacia patella" and a Baker's cyst. PX 4.

Petitioner testified he decided to seek a second opinion concerning his right knee. T. 47. He saw Dr. Evans, an orthopedic surgeon affiliated with Loyola, on April 2, 2013. Petitioner testified that, as of this date, both of his knees were extremely swollen and he could barely kneel or stand. T. 47.

On April 2, 2013, Dr. Evans noted that Petitioner reported having had right knee pain "since a fall last year." He also noted that Petitioner had previously undergone a right knee ACL reconstruction in 2004 and right total hip replacement after the 2012 fall.

On initial right knee examination, Dr. Evans noted crepitus with active extension, a 1+ effusion, tenderness around the medial and lateral patellofemoral joint, fairly discrete tenderness over the medial joint line and pain and popping with McMurray's testing.

Dr. Evans interpreted the right knee MRI as showing an "intact ACL graft, which appears appropriately placed" and a signal change in the medial meniscus. He saw no clear evidence of a meniscal tear but noted the MRI was open and of limited quality.

Dr. Evans diagnosed "post-traumatic arthritis with possible medial meniscus tear." He injected the right knee with Kenalog. He prescribed Voltaren and physical therapy. He directed Petitioner to return in six weeks. PX 8.

On April 5, 2013, Dr. Shah noted that Petitioner was following up with an orthopedic surgeon at Loyola. He refilled the Celebrex prescription. PX 7.

On April 15, 2013, Petitioner returned to M & M Orthopedics and saw both Dr. Lieber and his assistant, Lauren Smith, PA-C. Smith noted that Petitioner was deriving some benefit from therapy and had undergone a right knee MRI. On right knee examination, Smith noted tenderness to palpation over the medial and lateral joint lines, tenderness on the posteromedial popliteal fossa, no acute effusion or swelling, no increased warmth, a positive patellofemoral joint grind test, no signs of instability and negative Lachman and McMurray tests. Smith indicated that Dr. Lieber examined Petitioner and concluded the right knee was "nonsurgical at this time." According to Smith, Dr. Lieber felt the knee problem could be managed via injections. Petitioner was instructed to continue aggressive work-related conditioning and to return to light duty, at ground level only, with no aggressive stooping or bending. PX 5.

On April 17, May 8 and May 10, 2013, Bugielski noted that Petitioner was still complaining of significant right knee pain during therapy. PX 5.

Petitioner returned to Dr. Evans on May 14, 2013. The doctor noted that Petitioner reported some improvement following the injection but was complaining of a locking sensation in his right knee. He indicated the next step would be for Petitioner to undergo an arthroscopic evaluation with partial meniscectomy and evaluation of the previous ACL graft. He stated that, based on his discussion with Petitioner, "this does appear to be related to his work-related fall." PX 8.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Primus on June 21, 2013. [In his report of the same date, Dr. Primus rendered opinions concerning both the right hip and the right knee. The Arbitrator addresses only the knee-related opinions.]

On examination of Petitioner's right knee, Dr. Primus noted a limited range of motion and tenderness to palpation along the medial and lateral joint lines and a positive McMurray's. Dr. Primus obtained right knee X-rays. He interpreted the films as showing arthrosis with moderate joint space narrowing, particularly in the medial compartment, along with "residual calcification of the previous ACL tunnel placement."

Dr. Primus found no correlation between the work fall and Petitioner's right knee condition. Dr. Primus described Petitioner as "not very specific" as to whether he injured his right knee when he fell. He indicated that, based on the records he reviewed, the first treatment note to mention right knee pain was dated March 11, 2013. He also indicated that it

would be reasonable for Petitioner to undergo conservative care for his right knee pain but did not link the need for this care to the work fall. RX 2.

On June 24, 2013, Petitioner returned to Dr. Shah and expressed concern about joint metalosis. Petitioner also complained of persistent right knee pain of a few months' duration. He indicated he was not deriving benefit from physical therapy. Dr. Shah recommended serum cobalt level testing. PX 7.

On June 27, 2013, Dr. Shah noted that Petitioner's cobalt level was high. He recommended repeat testing in three months. PX 7.

On July 23, 2013, Petitioner filed a 19(b) petition and a petition for penalties/fees alleging, inter alia, that Respondent had improperly refused to authorize a right knee surgery recommended by Dr. Evans. PX 1.

Petitioner was admitted to Good Samaritan Hospital on April 15, 2014 with numerous diagnoses, including metal toxicity and "loose right total hip replacement." Dr. Lieber performed a revision of the previous right total hip replacement on April 16, 2014. T. 46. Petitioner saw a consultant, Dr. Thukral, the same day, with this doctor noting that Petitioner had previously undergone radiation therapy to the right hip "for HO [heterotopic ossification] prophylaxis after initial right hip replacement." Dr. Thukral recommended against additional radiation treatment to the hip, so as to avoid side effects and secondary malignancies. Petitioner developed atrial fibrillation and acute blood loss anemia postoperatively and underwent a cardiac work-up. In a discharge summary dated April 17, 2014, Dr. Shah indicated that Petitioner became "very agitated" following the surgery and left the hospital against medical advice. PX 6.

Petitioner testified his right knee got worse after the second right hip surgery. He also began experiencing excruciating pain in his right buttock. T. 46.

On May 20, 2014, Dr. Shah noted that Petitioner was asking for pain medication. He referred Petitioner to pain management. PX 7.

Petitioner returned to Dr. Evans on November 20, 2014. The doctor's treatment note of that date is not in evidence. [See below for a summary of the doctor's testimony concerning the November 20, 2014 visit]. Bilateral knee X-rays taken on November 20, 2014 showed post-surgical changes in the right knee, consistent with the prior ACL surgery, and "mild arthritic changes" in both knees. PX 8.

Dr. Evans testified by way of evidence deposition on December 4, 2014. Dr. Evans is a fellowship-trained, board certified orthopedic surgeon who specializes in sports medicine. PX 9 at 5-6. He testified he performs about 300 surgeries per year. About half of these surgeries involve the knee. He regularly sees patients with traumatic knee injuries. PX 9 at 7-9.

Dr. Evans testified he first saw Petitioner on April 2, 2013. On that date, Petitioner told him he had undergone a right knee ACL reconstruction in 2004 and a right total hip replacement in 2012, after a work fall. Petitioner also told him he had been experiencing right knee pain since this fall and had noticed an increase in this pain during the preceding few months. PX 9 at 9-11.

Dr. Evans testified he reviewed the right knee MRI report and images. He found the MRI to be of poor quality. He interpreted it as showing that the ACL graft was intact. It also showed a signal change in the medial meniscus without clear evidence of a tear. PX 9 at 12-13.

Based in part on Petitioner's history that he had no right knee pain before the work fall and began experiencing right knee pain after the fall, Dr. Evans opined that the fall was an exacerbation that resulted in symptoms. PX 9 at 15.

Dr. Evans testified he administered a right knee injection on April 2, 2013. This injection provided only temporary relief. Petitioner was still symptomatic at the next visit, on May 14, 2013, so he recommended a right knee arthroscopy. PX 9 at 16. He next saw Petitioner on November 20, 2014, at which time he injected both knees and again recommended a right knee arthroscopy. PX 9 at 18.

Dr. Evans testified he did not recall having a telephone conversation with Dr. Papilion. He doubts he would have told this doctor that Petitioner's right knee condition was not related to the work accident because he said that such a relationship existed several times in his notes. PX 9 at 22-23.

Dr. Evans testified that, based on the history Petitioner provided, it is likely that the work fall aggravated an underlying right knee arthritic condition and caused symptoms. Whether or not the fall also caused a meniscal tear is difficult to say but it is possible. PX 9 at 25.

Dr. Evans testified that a painful joint can become more painful with activity.

Dr. Evans indicated he could not comment on Petitioner's gait because he never documented Petitioner's gait in his notes. PX 9 at 28.

After reviewing a couple of the physical therapy notes, Dr. Evans testified that therapists take "a different approach" than physicians but that the therapist's findings seemed consistent with his. PX 9 at 29.

Dr. Evans acknowledged he never reviewed Dr. Shah's or Dr. Lieber's records. All of his opinions are based on Petitioner's history, his examination findings and the MRI. PX 9 at 30-31.

Under cross-examination, Dr. Evans confirmed he saw Petitioner three times. He has no independent recollection of Petitioner. PX 9 at 32. Apart from the right knee MRI and the

physical therapy notes he looked at during direct examination, he reviewed no other treatment records. PX 9 at 33,42. The MRI was open. Open MRIs are typically of poorer quality than closed MRIs. It could be that Petitioner has a meniscal tear but there is no clear evidence of this. PX 9 at 34. Petitioner's records reflect he is 6 feet, 3 inches tall and weighs 325 pounds. They also reflect a BMI of 40.62, which means Petitioner is obese. PX 9 at 36-37. It is possible that Petitioner's arthritis is age-related or related to his previous right knee surgery. PX 9 at 38. Age and usage can affect cartilage wear. Obesity is a definite factor in degenerative knee arthritis. Diabetes can also affect the progress of arthritis. He is not aware that Petitioner has been diagnosed with Type 2 diabetes. PX 9 at 41. Petitioner's history is one factor he relied on in addressing causation. If the history is faulty, his opinion could change. He has not talked with Petitioner's attorney. PX 9 at 43. He did not see Petitioner between May 14, 2013 and November 20, 2014. PX 9 at 44. His notes do not reflect that any physician referred Petitioner to him. PX 9 at 45. He reiterated he has no recollection of talking with Dr. Papilion. PX 9 at 46.

On redirect, Dr. Evans testified his opinions did not change between May 14, 2013 and November 20, 2014. PX 9 at 46. There is nothing that would cause him to change the treatment plan he has for Petitioner. PX 9 at 46-47. If Petitioner's history changed, that could cause him to change his opinion but no one has provided him with a different history. PX 9 at 47. He believes that an arthroscopy would relieve some of Petitioner's symptoms, including "locking" of the knee, but Petitioner could still have pain postoperatively. He can clean up but not eliminate that arthritis. PX 9 at 47-48. If it turns out that Petitioner does have a meniscal tear, he could repair that tear. PX 9 at 48. Because Petitioner has arthritis, it is possible he would need additional surgery later on but he is very young to consider a knee replacement. PX 9 at 48. It is reasonable to believe he will require a knee replacement at some point. PX 9 at 49. A sensation of "giving way" in the knee could result from ligamentous instability or from knee pain associated with quadriceps inhibition. PX 9 at 49. In Petitioner's case, his knee could be giving way because of his patellar arthritis. PX 9 at 50. Petitioner's large size makes it more likely that he will have arthritis. PX 9 at 51. The work fall exacerbated Petitioner's pre-existing right knee arthritis. PX 9 at 52. The treatment he is recommending is reasonable and necessary. PX 9 at 52.

Under re-cross, Dr. Evans reiterated that Petitioner is more likely to have arthritis than someone who is less heavy, regardless of any fall. PX 9 at 52.

On further redirect, Dr. Evans testified he has not reviewed any IME reports. PX 9 at 53.

Dr. Papilion, Respondent's utilization reviewer, testified by way of evidence deposition on December 9, 2014. Dr. Papilion is a fellowship-trained, board certified orthopedic surgeon. He devotes more than 90% of his practice to knee and shoulder surgery, split about 50/50. RX 3 at 7. He has performed utilization reviews for more than five years. He performs about three to five such reviews per month. RX 3 at 7. He relies on URAC standards in performing these reviews. RX 3 at 8.

Dr. Papilion identified Papilion Dep Exhibit 1 as a utilization review report he wrote on July 5, 2013 in Petitioner's case. He identified Papilion Dep Exhibit 2 as an addendum he issued after reviewing an MRI and additional records. As part of his review, he considered Dr. Evans' notes and Dr. Primus's report. RX 3 at 12. He spoke with Dr. Evans via telephone on August 15, 2013. During that conversation, Dr. Evans told him he did not know when Petitioner first began experiencing right knee symptoms or whether the right knee condition was related to the work accident. RX 3 at 13.

Dr. Papilion testified that, in his report, he found the proposed right knee surgery to be not medically necessary. He relied on the ODG guidelines in making this finding. RX 3 at 18. Those guidelines "spell out that arthroscopic surgery of the knee for osteoarthritis is not recommended." He also relied on a large study performed in 2013 that concluded that arthroscopy was not superior to supervised exercise alone after a non-traumatic degenerative medial meniscus tear in older patients. RX 3 at 19. In Petitioner's case, there is no conclusive evidence that Petitioner has a meniscal tear. RX 3 at 20.

Under cross-examination, Dr. Papilion acknowledged he does not know Petitioner and never examined Petitioner. RX 3 at 24-25. He never saw any accident report completed by Petitioner. RX 3 at 25. It is his opinion, based on the MRI, the treater's and IME's examination findings and the ODG guidelines, that the proposed right knee surgery is not indicated. RX 3 at 26-27.

Dr. Papilion testified he does not know how much he received for the utilization report he issued in Petitioner's case. He suspects he received under $100. RX 3 at 27. He does not know how much he will receive for deposition time. RX 3 at 28. He does not receive a regular salary as a utilization reviewer. He is paid for the time he spends on reviewing records and generating reports. RX 3 at 28. All of the utilization review requests he receives are from insurers. RX 3 at 28-29. He has performed about 250 knee arthroscopies per year during his surgical career. RX 3 at 29. A person who falls down a long flight of stairs can injure his knee. RX 3 at 30. He has not read Dr. Evans' deposition. He does not know that Dr. Evans testified the fall aggravated an underlying condition. RX 3 at 30-31. He does not dispute the right knee MRI findings. RX 3 at 31. He does not have the notes he made concerning his conversation with Dr. Evans. He is aware that Dr. Evans commented on causation in his notes. RX 3 at 33. It is his understanding that Dr. Evans is proposing an arthroscopy to see whether a meniscal tear exists. RX 3 at 34. It is not the standard of care to perform an exploratory arthroscopy where an MRI is available and where X-rays document arthritis. RX 3 at 34. He did not review any records from M & M. RX 3 at 35. He does not disagree with the injection Dr. Evans administered. RX 3 at 35. A traumatic knee injury does not typically first become symptomatic nine months after the trauma. RX 3 at 38. Even if he were to consider PX 1A, the accident report, he would not change his causation opinion. RX 3 at 41. He did not review any records predating the work fall. RX 3 at 41.

On redirect, Dr. Papilion testified that none of the questions he was asked under cross-examination caused him to change the opinions he rendered on direct examination. RX 3 at 42.

Dr. Primus testified by way of evidence deposition on December 23, 2014.

Dr. Primus is a fellowship-trained, board certified orthopedic surgeon. He obtained board certification in 2010. RX 2 at 5. Primus Dep Exh 1. About 20% of his patients present with knee complaints. He performs five to ten knee surgeries per week. RX 2 at 7.

Dr. Primus testified he examined Petitioner's right hip, back and right knee. [As noted previously, the Arbitrator summarizes only those opinions relating to the disputed right knee condition.] Petitioner presented with "right knee pain secondary to moderate arthrosis." Petitioner walked with an antalgic gait. RX 2 at 11. He exhibited a restricted range of right knee motion (110 degrees versus 135 degrees on the left). RX 2 at 12. He also complained of right knee pain with certain provocative maneuvers. RX 2 at 12.

Dr. Primus testified he obtained X-rays, including X-rays of the right knee. Those X-rays showed bone spurs, ossifications and loose bodies, "representing a chronic pre-existing degenerative condition of the knee," along with "evidence of residual calcification of the previous ACL tunnel placement, correlating with his prior history of ACL reconstruction." RX 2 at 14.

Dr. Primus testified he reviewed a number of treatment records, including physical therapy notes. Of those records, Dr. Shah's note of March 11, 2013 was the first note to mention the right knee. RX 2 at 18.

Based on Petitioner's history and his records review, Dr. Primus attributed Petitioner's right knee complaints to his "pre-existing arthritis and chronic condition." RX 2 at 19.

Dr. Primus testified he did not ascertain a history whereby Petitioner complained of his right knee at the time of his work fall. RX 2 at 20.

Under cross-examination, Dr. Primus acknowledged he did not have available information concerning the amount he billed for examining Petitioner. RX 2 at 23. He conducts approximately two IMEs per week. He cannot say what percentage of his examinations are for Liberty Mutual. RX 2 at 25. Of the IMEs he performs, about 90% are for defendants. He treats 150 to 200 patients per week. Some of these patients are treating for work injuries. RX 2 at 25. His IME charges can range from $900 to $1500, depending on the size of the chart and the body parts examined. RX 2 at 26. He charges $750 to $1200 per hour for deposition time. RX 2 at 26.

Dr. Primus acknowledged he saw no records other than those referenced in his report. He is aware there are other records he did not see. RX 2 at 27. He did not note anything about Petitioner that caused him to suspect Petitioner was untruthful. RX 2 at 28. He did not review Dr. Evans' records or deposition testimony. RX 2 at 29. He did not review any accident report. RX 2 at 30. If, in fact, Petitioner reported a right knee injury at the outset, that would not

prompt him to alter his opinions. RX 2 at 30. He did not review any records predating the work fall. RX 2 at 31. He would not have expected Petitioner to exhibit an altered gait due to the work fall. He attributes Petitioner's altered gait to his right hip surgery and consequent restricted motion, not the work fall. RX 2 at 31-32. He believes Petitioner was experiencing right knee pain at the time of his examination but Petitioner "wasn't sure when [this] pain" started. RX 2 at 32. Petitioner had undergone a right knee ACL reconstruction in the past and had moderate arthritis. RX 2 at 32. His right knee examination findings correlated with this degree of arthritis. RX 2 at 32-33. A fall could certainly aggravate a pre-existing arthritic condition but, in this case, there is no evidence that the work fall did in fact aggravate Petitioner's right knee. RX 2 at 34, 61. There is no evidence in the post-accident records of a right knee acute injury or aggravation. RX 2 at 34. Petitioner told him he had been experiencing right knee pain for a long time. He did not ask Petitioner what he meant by the term "long time." RX 2 at 37.

Dr. Primus testified he reviewed 29 notes concerning the physical therapy Petitioner underwent from late December 2012 to May 2013. He is aware that those notes document complaints relative to the right knee. RX 2 at 40.

Dr. Primus testified he is unsure of the decision-making process that led to the right hip surgery. RX 2 at 41-45. He has some serious concerns about whether the total hip arthroplasty was the correct procedure. RX 2 at 45.

Dr. Primus testified he did not lead Petitioner through the history. He allowed Petitioner to talk freely. Petitioner told him he was unsure of when his right knee pain began. RX 2 at 47.

Dr. Primus testified that Petitioner's right knee arthritis is significant. The X-ray shows chondromalacia and "you don't typically see chondromalacia on [an] X-ray." RX 2 at 48.

Dr. Primus testified Dr. Shah's note of March 11, 2013, recommending a right knee MRI, makes no sense because he described his examination as "unremarkable." RX 2 at 50.

Dr. Primus testified that arthritic knee pain can cause giving way or buckling of the knee. RX 2 at 56.

Dr. Primus testified it is very unlikely for a patient to sustain an acute injury to a body part and not develop symptoms within 24 to 48 hours of that injury. RX 2 at 58.

Dr. Primus acknowledged he used the term "mild trauma" to refer to the fall down stairs when he commented on Petitioner's right hip MRI. RX 2 at 66, 74.

On redirect, Dr. Primus testified that nothing raised during cross-examination prompted him to change his opinion that the work fall did not cause or aggravate Petitioner's right knee condition. RX 2 at 78-79.

Petitioner testified he has not undergone the right knee arthroscopy that Dr. Evans recommended. It is his understanding that this surgery would not be done to cure his arthritis but rather to remove a piece of material that is floating around in his knee. T. 49.

Petitioner testified he is still experiencing a lot of right knee pain, especially with stair usage. T. 51. Sometimes his right knee pops and burns. Sometimes, when he is in the process of sitting, the knee will lock and he will have to manually pull on his leg "to make it finish popping." T. 52-53.

Under cross-examination, Petitioner testified he has been truthful with his doctors because he wants to make sure they understand his complaints. T. 55. When he first went to M & M Orthopedics, on July 17, 2012, he completed an intake form. This form contained a question asking him to list his complaints. He responded with only one complaint, i.e., his right hip. T. 57.

No Respondent witnesses testified at the hearing.

Arbitrator's Credibility Assessment

The Arbitrator finds not credible Petitioner's testimony that he injured his right knee at the time of the fall and that his right knee was his primary problem when he first sought treatment. Also not credible is Petitioner's testimony that he underwent right knee X-rays at his first doctor's visit. All of this testimony is at odds with the records from WorkRight and M & M Orthopedics. It is also at odds with the history form Petitioner completed when he first went to M & M Orthopedics. It is also inconsistent with the Application for Adjustment of Claim. The first treatment note that specifically mentions knee pain is dated December 27, 2012. This note was written more than six months after the accident and more than two months after Dr. Lieber's physician's assistant documented a full range of knee motion.

The Arbitrator is also troubled by Petitioner's testimony that he had no right knee problems before the work accident. When Dr. Gokhale, a physician of Petitioner's selection, first saw Petitioner, he noted that Petitioner had been taking Celebrex for a few years in connection with his previous right ACL reconstruction.

Arbitrator's Conclusions of Law

<u>Did Petitioner establish accident vis-à-vis his right knee? Did Petitioner establish a causal connection between his accident of June 23, 2012 and his current right knee condition of ill-being?</u>

The Arbitrator finds that Petitioner failed to prove accident and causation vis-à-vis his right knee. In so finding, the Arbitrator relies largely on the foregoing credibility assessment. The Arbitrator assigns little weight to the causation opinions voiced by Petitioner's current knee

treater, Dr. Evans, because Dr. Evans relied on Petitioner's history that he had no right knee pain before he fell and began experiencing right knee pain after he fell. That history is not supported by the treatment records. Dr. Evans acknowledged he did not review those records. He also acknowledged his opinions could change if Petitioner's history was faulty. He further acknowledged that, even if the history was accurate, he could not clearly draw a link between the work fall and the suspected meniscal tear. He would only say that such a link was a possibility.

In analyzing causation, the Arbitrator has considered an alternate theory, i.e., that the undisputed right hip condition gave rise to a gait abnormality that, over time, resulted in right knee pain. This might have been a viable theory but it is not the theory Petitioner advanced. Nor did Dr. Evans hinge his opinions on an assumption of an altered gait. In fact, he admitted he made no notes concerning Petitioner's gait. PX 9 at 28. Thus, the opinion testimony does not support the theory.

The Arbitrator sustained Respondent's foundational objection to PX 2 [the two-page accident report] but notes she would reach the same conclusions as to accident and causation even if she had considered that exhibit. PX 2 would still have to be balanced against the treatment records created during the six months following the accident. None of those records reflect complaints relative to the right knee. Additionally, Petitioner's testimony that it fell to his supervisor to complete the second page of PX 2 is inconsistent with the document. Both pages of PX 2 are labeled as employee, not supervisor, statements.

The Arbitrator, having found that Petitioner lacked credibility on a number of vital issues and failed to prove accident and causation with respect to his right knee, denies Petitioner's claim for prospective right knee surgery. The Arbitrator views the remaining disputed issue of penalties/fees as moot but also notes the Appellate Court has held there is no statutory authority for finding an employer liable for penalties and fees for delaying the authorization of medical care. Hollywood Casino-Aurora, Inc. v. IWCC, 2012 Ill.App. (2d) 110426WC.

STATE OF ILLINOIS)	☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
) SS.		☐ Rate Adjustment Fund (§8(g))
COUNTY OF KANE)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rosalinda Villagomez,
Petitioner,
vs.

AJR Filtration, Inc.,
Respondent.

16IWCC0301
NO: 12 WC 30402

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 29, 2015 is hereby affirmed and adopted.

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

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

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

DATED: MAY 6 - 2016
KWL/vf
O-3/8/16
42

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0301

VILLAGOMEZ, ROSALINDA
Employee/Petitioner

Case# 12WC030402

AJR FILTRATION INC
Employer/Respondent

On 4/29/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0059 BAUM RUFFOLO & MARZAL LTD
HENRY C SZESNY
33 N LASALLE ST SUITE 1710
CHICAGO, IL 60602

1408 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONACCI
120 W STATE ST PO BOX 1288
ROCKFORD, IL 61105

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

16IWCC0301

ROSALINDA VILLAGOMEZ
Employee/Petitioner

Case # 12 WC 30402

v.

Consolidated cases: _____

AJR FILTRATION, INC.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maria S. Bocanegra**, Arbitrator of the Commission, in the city of **Geneva**, on **03/11/2015**. 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 : Accident, Notice, Causal connection, Medical – causal connection, Reasonableness and necessity, TTD and Nature and extent.

16IWCC0301

FINDINGS

On **07/27/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**13,156.00**; the average weekly wage was $**253.00**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services, but the medical services were causally unrelated to any alleged work accident.

Respondent is not liable for any unpaid 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

Denial of benefits

Because an accident did not occur that arose out of and in the course of employment, and because there is no causal connection, all benefits are denied.

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

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

Signature of Arbitrator

4/29/15
Date

APR 29 2015

BACKGROUND

Rosalinda Villagomez ("Petitioner") filed her application for adjustment of claim alleging injuries occurring while under the employ of AJR Filtration Inc. ("Respondent"). On or about 3/3/15, Petitioner presented her notice of motion and order requesting to proceed to hearing before former Arbitrator Luskin, or any Arbitrator sitting in his stead, in Geneva, Illinois. Ax2. The parties completed a request for hearing form and proceeded to trial on all issues on 3/11/15 in Geneva, Illinois. At trial, the parties stipulated that on 7/27/12 both Petitioner and Respondent were operating under the Illinois Workers' Compensation Act and their relationship was one of employee and employer. Further, the parties agreed that Petitioner's earnings in the year preceding her alleged injury were $13,156.00 and that her average weekly wage was $253.00. The disputed issues at trial were accident, notice, causal connection, liability for unpaid medical bills, entitlement to temporary total disability (TTD), nature and extent of the injury and other issues, including accident, notice, causal connection, medical – causal connection, reasonableness and necessity, TTD and nature and extent. Ax1. Arbitrator Bocanegra, who on 3/11/15 was assigned to cover former Arbitrator Luskin's trial day as Arbitrator Luskin had then been recently appointed to Commissioner for the Illinois Workers' Compensation Commission, heard the instant matter by agreement of the parties. Arbitrator Bocanegra issued the decision that follows.

FINDINGS OF FACT

Petitioner testified, via Spanish interpreter/translator Joseph Bonura, that she began working for the Respondent around 2007 as a machine operator and was so on 8/15/12. Petitioner described the machine as "closed up" and that "it closes them and they were used in a hospital." She stated the machine is a higher position and boxes of pieces are brought over, she grabs one and puts in the filling that is then pressed very tight, that one presses the material even and sews the edge. She testified the machine has a lever go back and repeated times; she is "doing this, doing this like this." She stated she lifted and pulled this lever. Petitioner testified she did these 10 hours per day, producing 260-269 pieces. On her last week of work she testified she produced around 420, which she stated was less than normal due to the problem in her arms. On cross, she clarified that she sewed 1 pound boots that had four openings, 2 of which were about 2-3 inches long and the other 2 were about 5 inches long. She stated the machine was operated by a foot pedal and she guided the boots thru the machine. She testified that both the boots and the machine are on a table. She agreed that she took a boot of out a cart located next to her, sewed it, then placed it into another cart in front of her were boots were completed.

She testified that on 7/27/12, she complained of problems in her wrists, arms, her shoulder and back. She reported it several times and asked John, owner, to change her to a different machine. She recalled the conversations took place in February 2012 and later. On 8/15/12, Petitioner stated she reported again her problems as she felt the pain in her arm, elbow, hand and fingers strongly. She described feeling pains "here" and "inside here," "this part here," and "this part there." She said she began to work and sleep bandaged up for her hands.

Petitioner stated her first visit was to Dr. Shah on 7/30/12 at VNA where she told a lady about the problem in her hands, her shoulder and that she wanted a refill of thyroid medication. She testified her visit was prompted by pain in her left hand, right shoulder, elbow and hands, more on the right.

Under cross examination, Petitioner admitted that the medical boots weighed approximately one pound when the sewing was completed. She also agreed that the sewing machine was operated by a foot pedal. Petitioner would sew the openings on the boots shut with the sewing machine. Two of the openings were approximately 2.5 inches in length, and two openings were approximately 5 inches in length. Petitioner guided the boots through the sewing machine with her hands. The boots were on a table, as was the sewing machine. When the sewing was complete, Petitioner would place the completed boot into a cart located in front of her. Petitioner was seated the entire time she was performing her work duties.

Petitioner testified that as of the date of trial, she feels pain and discomfort in her arm that the pain doesn't change and continues in her shoulder and runs to her back. She stated that the pain does not disappear from her shoulder, her elbow and her hands. She continues to work for her new employer in splints while Dr. Fink awaits surgical authorization for her shoulder. She stated the pain wakes her ever day and gets worse from her current work. She applies cream and patches mostly in the shoulder and neck. Petitioner raised her arm to demonstrate but did not describe much. She stated she still has trouble with internal rotation of the shoulder and that it is the same pain she reported to the VNA. Petitioner testified that following her surgeries performed by Dr. Fink, she did not improve

Testimony of Celeste Cruz

Celeste Cruz ("Cruz") testified on behalf of Petitioner. She testified she worked for the Respondent for approximately seven years performing the same work as the Petitioner. She last worked for the Respondent on 9/07/12, claiming she was terminated because she did not "reach the numbers." She was not happy about being terminated and is still not happy about it, according to her testimony on cross-examination. She claimed that the job-duties video did not show the correct speed at which the employees worked and did not illustrate the same amount of force. She indicated she used force in an up-and-down motion with her right hand.

Testimony of Andre Lima

Andre Lima ("Lima") testified on behalf of the Respondent. He is currently a production manager for the Respondent but was a supervisor in July of 2012. He was a direct supervisor of Petitioner from 2010 through 2011. He testified that he has firsthand knowledge of the job duties of the sewers at the Respondent.

Lima testified that the Petitioner's job duties required her to sew medical boots. He confirmed that the medical boots weighed approximately one pound when sewing was completed. Another individual would bring a cart of boots to Petitioner that needed to be sewn. The other worker would place the cart to the right of the Petitioner. When the boots were brought to Petitioner, they would have already been filled with stuffing. There were four areas on the boots that needed to be sewn by Petitioner. Two of those holes were 2.5 inches in length, and two others were 5 inches in length. Those areas would be pinched together by the Petitioner with her hands and guided into the sewing machine. They were then sewn together by the sewing machine. The sewing machine was operated by a foot pedal. There was a "back-tack" lever on the machine which allowed the sewing machine to sew backwards. The Petitioner would utilize this lever with her right hand to sew backwards. Petitioner would utilize scissors to cut the thread which the machine had just sewn into the boot. When the sewing was complete,

the Petitioner would push the boot into an empty cart located in front of her table. Another individual would remove the carts full of completed boots from the Petitioner's work area.

Lima confirmed that the Petitioner's work duties did not require her to lift more than one pound. She worked from 6:00 a.m. to 2:30 p.m. and usually worked five days per week during the time period in question. She was allowed two 10-minute breaks and 30 minutes for a lunch break during her shift. Lima testified the Petitioner was to sew 460 to 520 boots per shift. He testified the job duties did not require forceful gripping or grasping with the upper extremities or awkward positions of the hands, wrists, or arms. He said there was no lifting over the shoulder level and no forceful pushing or pulling with the upper extremities. He did not recall Petitioner wearing braces while working. Lima testified that he reviewed the job duties video and that he believed it accurately and fairly showed Petitioner's job duties and job activities.

Job Video

The Arbitrator personally reviewed the job-duties video and evaluated the pace of the work being completed. Rx6. There are two occasions on the video in which the worker performs sewing on a boot from start to finish. On the first occasion, the worker grabs a boot at 54 seconds into the video. She completes the sewing activities on the boot 1 minute 41 seconds into the video. It took the worker 47 seconds to complete the sewing on the boot. On the second occasion, the worker grabs the boot 1 minute 41 seconds into the video and completes the sewing activities at 2 minutes 33 seconds into the video. It took the worker 52 seconds to complete the sewing activities on this boot. Averaging those two occasions, it took the worker approximately 50 seconds to complete the sewing activities per boot. Regarding the forces involved, the Arbitrator notes that the worker in the video is guiding the boot through the sewing machine, as the sewing machine pulls the boot along as it is sewing. Minimal force is observed.

Medical Treatment & Evidence

On 7/31/12, Petitioner sought medical treatment at VNA Health Care. Px8. Records indicate Petitioner was treating for hypothyroidism and a reaction she had to an increase in her thyroid medication. The medical records note she was complaining of right arm pain at that time, but her right arm was never examined, and she received no diagnosis with respect to her right arm. Petitioner admitted on cross-examination to having been diagnosed with hypothyroidism since 2003. Petitioner agreed that she had been experiencing symptoms for one year prior to July 2012.

On 8/02/12 Petitioner follows up with VNA, complaining of right arm pain. Initially, the medical notes from 8/02/12 indicate that the Petitioner had been experiencing this right arm pain for six days, but later in the records, it is noted that the Petitioner had right arm and hand pain on and off for a year, which became worse a week prior. Petitioner denied numbness, tingling, or weakness at that time. The Petitioner was diagnosed with right elbow lateral epicondylitis and was provided a brace and nonsteroidal anti-inflammatory drugs. She was also provided a light-duty work slip for the first time. (Petitioner's Exhibit No. 1.) There were no complaints noted regarding the Petitioner's left upper extremity or right shoulder.

On 8/18/12, VNA saw Petitioner for arm pain and diagnosed right elbow lateral epicondylitis. Medicine and therapy was prescribed.

On 8/23/12, Petitioner began therapy with Fullerton Drake. Px5. Initial treatment notes indicate Petitioner performed repetitive work with her hands. Treatment continued through 5/5/14 with much of the same notations noted throughout.

On 9/20/12, EMG with Dr. Kiang revealed mild right and moderate-to-severe left carpal tunnel syndrome. Px10. On 9/26/12, Petitioner was first seen by Dr. Fink of Goldcoast Orthopedics complaining of pain in her right shoulder, bilateral hands, and bilateral elbows. Px3. Dr. Fink recommended carpal tunnel release surgery. He recommended Petitioner to remain off work. Petitioner continued to follow-up with Dr. Fink.

On 1/17/13, Dr. Anderson performed a utilization review at the request of the Respondent. Only the first six visits of physical therapy were noted to be reasonable and necessary after physical therapy began on 8/23/12. In addition, Dr. Anderson noted that Official Disability Guidelines outline that the TENS unit, paraffin wax bath, and ultrasound were not reasonable or necessary. The medical records did not document clinical response to the treatment, including specific and sustained functional benefit prior to the purchase or date of service.

On 1/19/13, Dr. Gerber noted that the Petitioner reached maximum medical improvement in physical therapy at that time. On 10/3/13, Dr. Fink performed and Petitioner underwent a right carpal tunnel release. Petitioner returned to Fullerton Drake for post operative therapy. Petitioner testified that none of her surgery helped.

On 6/18/13, Dr. Palacci performed an independent medical examination at the request of the Petitioner. Px2. Petitioner advised Dr. Palacci her job duties required repetitive flexion and extension of the wrist and elbows. Dr. Palacci obtained a history that Petitioner handled over 400 compression boots daily, each weighing a few pounds. Petitioner advised that she would feed the boots into a sewing machine ten hours per day, six days per week. Dr. Palacci opined that Petitioner's bilateral carpal tunnel syndrome was directly aggravated and/or caused by work duties as a machine operator/sewer as a result of repetitive hand and wrist use. Dr. Palacci felt that carpal tunnel release surgery was reasonable. Petitioner agreed Dr. Palacci did not note any complaints of right shoulder pain.

On 1/17/14 MRI of the cervical spine showed 3 to 4 mm left paracentral disc herniation with mild posterior and left-sided spinal stenosis at C4–C5, a 3 to 4 mm posterior disc herniation with central stenosis, and mild bilateral neuroforaminal narrowing at C5–C6 and C6–C7. Px3. The MRI of the right shoulder showed intact rotator cuff with mild rotator cuff tendinitis and/or bursitis involving the distal supraspinatus tendon.

On 1/31/14, Dr. Fink performed and Petitioner underwent a left carpal tunnel release surgery. Petitioner returned to Fullerton Drake for post-operative therapy. Petitioner testified that her surgery did not improve her.

On 3/25/14, Dr. Palacci performed a supplemental records review. She reviewed Dr. Fink's additional records as well as MRIs of the right shoulder and cervical spine. Dr. Palacci concluded that Petitioner's repetitive work duties aggravated a previously asymptomatic wrist condition, based on Petitioner's description of job duties.

On 4/1/14, Dr. Palacci testified via evidence deposition. Dr. Palacci noted her opinions were based on Petitioner's description of her job. She did not review a written analysis of Petitioner's job or a job-duties video. The doctor did not know the amount of repetition, and did not know how Petitioner would hold or maneuver her hands. Dr. Palacci admitted Petitioner has non-occupational risk factors for carpal tunnel syndrome, including age, female sex, weight, and body mass index. Petitioner's thyroid disease is a known co-morbidity that can be associated with bilateral carpal tunnel involvement, but there is typically clinical improvement or resolution of the carpal tunnel syndrome following thyroid replacement. Dr. Palacci also confirmed Petitioner's cervical spine was degenerative. Dr. Palacci noted Petitioner did not complain of any shoulder pain. Dr. Palacci felt Petitioner could return to full-duty work.

On 4/16/14, Petitioner was released to full duty by Dr. Fink. She testified she found other work shortly thereafter. She testified that after she began at her new job, she started to feel the same pains and that she went back to Dr. Fink to tell him.

Contrary to Petitioner's testimony, on 4/30/14 Dr. Fink noted Petitioner's carpal tunnel symptoms were greatly improved with surgery, but she was now complaining of persistent right shoulder pain. He administered a right shoulder injection. Dr. Fink felt Petitioner may require right shoulder surgery if there was no improvement. He provided work restrictions of no lifting over 15 pounds, no over-the-shoulder work with the right hand, no lifting above the waist, no repetitive pulling or pushing.

On 5/05/14, Petitioner was placed at MMI by therapists. At trial, Petitioner admitted that she is no longer receiving medical treatment for her carpal tunnel symptoms.

On 8/20/14, Dr. Fink provided a second right shoulder injection. Petitioner allegedly was still complaining of right shoulder pain. Petitioner testified that she returned to work for a temporary agency in August of 2014. She worked for this temporary agency on and off for approximate three months.

On 10/08/14, Dr. Fink testified via evidence deposition. Px3. According to Dr. Fink, Petitioner provided a history of injuring herself at work on 7/27/12 while doing repetitive use of her hands, working for five years performing repetitive, heavy, fast-paced work on a heavy machine. He acknowledged he did not know what kind of machine Petitioner worked on.
Dr. Fink felt Petitioner's bilateral carpal tunnel syndrome problems related to Petitioner's repetitive work duties. He based this partially on the fact that Petitioner claimed she was lifting heavy packages. He admitted that Petitioner did not give him much information about the physical requirements of her position, that he did not have information about the positions of her upper extremities, the movements of her upper extremities, the posture, or anything else that was required as part of her job duties, that he never reviewed a written job-duties analysis or job-duties video. He was not aware of the forces involved or the weights involved in her work. He did not recall Petitioner describing any awkward or unusual positions or movements required in her job. He admitted he would not consider a sewing machine operator to be heavy work. He did not know what products Petitioner worked with. He did not know the quantity of pieces Petitioner worked with. Dr. Fink did not review any other medical records besides the EMG.

Regarding Petitioner's right shoulder, Dr. Fink testified that Petitioner's work activity contributed to her right shoulder problem. The spur in the right shoulder itself was not caused by an injury, per Dr. Fink, as spurs can be developmental. He testified Petitioner was restored to

full, functional use following the carpal tunnel release surgeries. Dr. Fink last treated Petitioner on 2/11/15. Petitioner continued to complain about right shoulder pain and right shoulder arthroscopy with Neer acromioplasty was recommended.

On 10/30/12, Dr. Pomerance performed a Section 12 exam. Rx1. He drafted two reports and prepared a supplemental report. In his 10/30/12 report, he noted Petitioner's subjective complaints appeared to be greater than the objective findings. Pomerance also reviewed the job-duties video and the job physical-demand analysis from Genex. Rx3. Based on his physical examination, the history obtained from Petitioner, his review of the records, job-duties video, and the job physical-demand analysis, Dr. Pomerance concluded that the Petitioner's bilateral hand and wrist conditions were not causally related to her work duties for the Respondent. He based his opinion on the fact that the written job analysis and the job-duties video did not contain any activities which would be known to cause, aggravated or accelerated a diagnosis of carpal tunnel syndrome. He further noted that Petitioner has numerous risk factors for the development of carpal tunnel syndrome. These included her age, female gender, menopause status, body mass index, and her thyroid condition. He disagreed with Dr. Palacci's claim that patients who have hypothyroidism and are treated with thyroid-replacement medication will have resolved carpal tunnel syndrome as blatantly false. He did not believe any right shoulder condition causally connected to her work.

CONCLUSIONS OF LAW

ISSUE (C), (O) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
ISSUE (F), (O) Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator carefully observed and listened to Petitioner's testimony. Her testimony along with her treatment records, supports the Arbitrator's notation that Petitioner is alleging accident based on a repetitive trauma theory. While it is true that repetitive trauma has been found to qualify as an "accident" in accordance with the Illinois Workers' Compensation Act, it is not merely sufficient to assert that one sustained an accident through repetitive trauma without proving the elements thereof. That is, one can not merely state that they performed a number of tasks by hand and then conclude that they have proven that they sustained an accident via repetitive trauma. It is true that one does not need to show the number of repetitions that an employee performs doing a particular task in the course of a shift in order for that employee to have proven that he sustained a repetitive trauma injury. It is also not required that the employee prove, with any degree of preciseness, the amount of force or pressure that might be required of an individual's hand or upper extremities when performing the activities of his work in order for it to be compensable as repetitive trauma. However, an employee under the Act must prove that the trauma to which they were exposed was indeed "repetitive." That is, the employee must prove that they were engaged in the activity for a sufficient period during the course of the day, or for a sufficient number of times during the course of a day, for it to be considered repetitive. *Phillips v. Casino Queen*, 06 WC 41573, 10 IWCC 1086 (Nov. 3, 2010).

The Arbitrator has carefully reviewed and analyzed Petitioner's testimony, the testimony of all witnesses and having reviewed all medical evidence, concludes that Petitioner failed to

prove by a preponderance of the evidence that she sustained an accident arising out of and in the course of her employment with Respondent.

Petitioner's testimony regarding her job duties and in describing the machine she worked on was vague, ambiguous, confusing and therefore unpersuasive. Petitioner was provided multiple and ample opportunities to describe her job activities in relation to her alleged injured body parts and Petitioner failed to adequately describe those duties or activities, often using phrases like "this," "here," or "there." To the extent Petitioner did describe a certain job movement, for example moving a machine lever "up and down," she failed to describe what arm(s), hand(s), elbow(s) or finger(s), if any, were involved in that job activity and how, if at all, that movement caused pain and if so, what type of pain. In another description, Petitioner merely stated she sewed boots and pressed things together. There was no description of what body parts were involved and what pain, if any, she felt while performing these activities. It is unclear whether one activity or all activities were alleged to have led to Petitioner's repetitive trauma. Based on the insufficient information provided in Petitioner's testimony, it is unclear what Petitioner's job activities were and which ones caused the repetitive trauma alleged. Because Petitioner's testimony is vague, the Arbitrator cannot conclude her testimony is persuasive on the issue of accident.

Moreover, none of Petitioner's testimony, however descriptive, is corroborated or consistent with any of her treating medical records. For example, her light duty slip from VNA fails to describe any specific work-related movement or activity. Px1. Additional records from VNA in September 2012 fail to mention any particular job duty, activity or movement similar to what Petitioner testified to. Px4. The only mention is that Petitioner worked on a "machine" at work and that "her pain in the arm gets worse." Again, in the Arbitrator's view this statement fails to provide any description of what part of Petitioner's work on a machine led to an accident. In July 2012, VNA records only mention thyroid medication and right arm pain, which is contrary to Petitioner's testimony that she went to VNA in July 2012 to report her work accident. Besides VNA records, Fullerton Drake records described using hands repetitively and experiencing a sudden and severe onset of right hand and wrist pain. This conclusory statement fails to document any specific job activity or movement and references body parts different than VNA. Px5. To the extent that the Fullerton Drake description describes something, it is not consistent with Petitioner's testimony.

In addition, Dr. Palacci only described flexing and extending wrists and that Petitioner feed boots into a machine. Px2. Dr. Palacci concluded that Petitioner's self-reported job description and amount of repetition caused her symptoms. However, the Arbitrator is not persuaded by this conclusion as the description noted by Dr. Palacci is not clear other than Petitioner stated she fed boots through a machine to be sewn. On cross, Dr. Palacci agreed she did not know how exactly Petitioner was required to hold or maneuver her hands while performing her work. Again, to the extent Dr. Palacci's records describe a job activity, it is not consistent with any of Petitioner's testimony.

Similarly, Dr. Fink testified that Petitioner was injured after "doing repetitive use of her hands," doing "repetitive heavy, fast-paced work on heavy machine." He also wrote that she injured herself "while doing repetitive use of her hands," and that she was doing "repetitive, heavy, fast-paced work on heavy machine." Px3. In the Arbitrator's view, this description fails to describe Petitioner's job activities, any body part(s), any particular movements, body mechanics or any quantitative or qualitative description of work. Dr. Fink admitted he had no

idea what kind of machine Petitioner worked with and only knew she was a machine operator. He based his opinions on the fact that Petitioner claimed she was lifting heavy packages. Dr. Fink admitted he would not consider a sewing machine operator to be heavy work. He did not know what products Petitioner worked with. He did not know the quantity of pieces Petitioner worked with. Dr. Fink admitted that Petitioner did not give him much information about the physical requirements of her position. He admitted he did not have information about the positions of her upper extremities, the movements of her upper extremities, the posture, or anything else that was required as part of her job duties. He was not aware of the forces involved or the weights involved in Petitioner's work. Unfortunately, Dr. Fink's conclusory description that Petitioner's work was repetitive is insufficient to aid Petitioner in meeting her burden.

The Arbitrator concludes that Dr. Pomerance's opinions are most credible regarding a lack of nexus between Petitioner's job duties and any accident and/or resultant carpal tunnel syndrome. Dr. Pomerance reviewed the job-duties video and the job physical-demand analysis from Genex. Dr. Pomerance is the only physician who reviewed the video and the analysis. Based on his physical examination, the history obtained from Petitioner, his review of the records, the job-duties video and the job physical-demand analysis, Dr. Pomerance reasonably concluded that the Petitioner's bilateral hand and wrist conditions were not causally related to her work duties for the Respondent. He based his opinion on the fact that the written job analysis and the job-duties video did not contain any activities which would be known to cause, aggravate, or accelerate a diagnosis of carpal tunnel syndrome. Based on his review of the video and written analysis, Dr. Pomerance is the only physician who was aware of the amount of repetition, the position of Petitioner's upper extremities, and the forces involved in Petitioner's position as a sewer. He further noted that Petitioner has numerous risk factors for the development of carpal tunnel syndrome. These included her age, female gender, menopause status, body mass index, and her thyroid condition.

The Arbitrator finds that the job video is the most credible and accurate representation of Petitioner's job duties, based on the fact that Petitioner, on cross, agreed the positioning and movement as ultimately contained in the video, on the fact that Lima credibly described Petitioner's job, which also matched the video. In adopting the job duties video as an accurate depiction of Petitioner's true job activities, the Arbitrator again notes that Petitioner's testimony was vague and ambiguous and further, that Petitioner's treating doctors' understanding of her job activities lacked serious detail.

Based on the foregoing, the Arbitrator concludes that Petitioner failed to prove she sustained an accident arising out of and in the course of her employment with Respondent and therefore that any of her bilateral carpal tunnel conditions, right shoulder and right elbow conditions are causally related to any accident.

ISSUE (E), (O) ***Was timely notice of the accident given to Respondent?***
ISSUE (J), (O) ***Were 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), (O) ***What temporary benefits are in dispute?***
ISSUE (L), (O) ***What is the nature and extent of the injury?***

Because an accident did not occur that arose out of and in the course of employment, and because there is no causal connection, all other benefits are denied as moot.

ARBITRATOR SIGNATURE **DATE** 4/29/15

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Paul McAdon,

Petitioner,

vs. NO: 12 WC 42753

Millennium Knickerbocker Hotel,

16IWCC0339

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on Remand by Order of the Circuit Court of Cook County, Judge Robert Lopez Cepero presiding, wherein the Commission's Decision and Opinion on Review filed 5/16/14 (14 IWCC 366) was "... affirmed as it relates to accident and reversed and remanded for further determination on the issues of causal connection of McAdon's back injury and entitlement to TTD benefits." Pursuant to the Remand Order and having considered the entire record, the Commission modifies the decision of the Arbitrator to find that Petitioner failed to prove that his current condition of ill-being with respect to his low back is causally related to the accident on 11/12/12 and that Petitioner is entitled to temporary total disability benefits from 1/1/3 through 4/24/13, for a period of 16-2/7 weeks, all other aspects of the Arbitrator's decision affirmed and adopted, for the reasons set forth below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

I. HISTORY OF THE CASE

Respondent appealed the §19(b) Decision of Arbitrator Milton Black filed on 6/10/13 finding that Petitioner proved he sustained accidental injuries arising out of and in the course of his employment on 11/12/12 and that Petitioner's current conditions of ill-being relative to his right shoulder and low back were causally related to said accident. Specifically, the arbitrator found that "Petitioner testified credibly that his right shoulder injury and his low back injury

were as the result of the claimed accident." (Arb.Dec., p.7). As a result, the arbitrator found that Petitioner was temporarily totally disabled from 1/1/13 through 4/24/13, for a period of 16-2/7 weeks, that Petitioner was entitled to $803.74 for necessary medical expenses under §8(a) of the WC Act, that Petitioner was entitled to prospective medical treatment in the form of right shoulder surgery recommended by Dr. Yenni, and that Petitioner was entitled to penalties in the amount of $3,420.00 as provided in §19(l) of the Act. (Arb.Dec., pp.2,7-9).

The Commission on Review modified the decision of the Arbitrator to find that Petitioner was entitled to TTD from 2/14/13 through 4/24/13, for a period of 14-2/7 [sic] weeks. All else was otherwise affirmed and adopted.

The matter was subsequently appealed to the Circuit Court of Cook County. In his remand order, Judge Cepero noted that the Arbitrator "... found that McAdon testified credibly that his right shoulder injury and his low back injury were the result of the claimed accident. The Arbitrator explained McAdon's testimony was corroborated by the medical records and is consistent with the sequence of events." (Circuit Court Order, p.6). However, Judge Cepero noted that "... nowhere in the Arbitrator's decision is there mention of these medical records that corroborate McAdon's testimony regarding his low back. The only facts contained in the decision relating to the back are McAdon's testimony that he injured his back. The only mention of a medical opinion regarding the back is Dr. Barker's opinion that McAdon's back injury was not caused by his work accident. The Commission similarly failed to put forth any facts regarding the causal connection between the back injury and the November 12, 2012 accident." (Circuit Court Order, p.6). As a result, Judge Cepero stated that "... the Court cannot assess whether the Commission's decision is against the manifest weight of the evidence on that issue. Further, the Court is not permitted to weight the evidence or make its own inferences from the evidence. Therefore, the Commission's decision is reversed as it relates to the causal connection of McAdon's current condition of ill-being of his back. The Commission is ordered to specifically address the issue of causal connection as it relates to McAdon's back, articulating the bases and the facts relied on for any determination it makes on this matter." (Circuit Court Order, p.6).

Furthermore, Judge Cepero noted that in awarding TTD the Arbitrator indicated that the dispositive inquiry is whether the medical condition had stabilized, citing *Interstate Scaffolding*, 236 Ill.2d 132. (Circuit Court Order, p.7). Judge Cepero pointed out that in modifying the Arbitrator's TTD award (starting TTD on 2/14/13 instead of 1/1/13), the Commission "... distinguished this case from *Interstate Scaffolding*, explaining that in *Interstate*, the claimant was not capable of performing the full duties of his job ... [while] McAdon [in the present case] was still able to perform his job full duty." (Circuit Court Order, p.7). Judge Cepero went on to state that "[t]he Court is not clear on why the Commission decided to begin TTD benefits on February 14, 2013... [and] if McAdon was not at MMI as of the February 14, 2013 date, the Court is unsure how, absent some intervening event that is not in the record, McAdon was at MMI between January 1, 2013 and February 14, 2013. Similarly, if McAdon was capable of performing the full duties of his employment, and was therefore not temporarily totally disabled while working for the Employer, what made him temporarily totally disabled as of January 1, 2013 or February 14, 2013?" (Circuit Court Order, p.7).

16IWCC0339

II. FINDINGS OF FACT

Petitioner, a 49 year old "director of rooms and revenue" testified at the hearing held on 4/24/13 that on the date of the accident, 11/12/12, he was employed by the Millennium Knickerbocker Hotel in Chicago. (T.12-14). He noted that he lives in Durham, North Carolina and was allowed to travel between his home and Chicago on a bi-weekly basis and otherwise work remotely from Durham. (T.13-14).

Petitioner agreed that he started working for Hotel Knickerbocker in Chicago in March of 2012 and that the last day he worked there was 12/31/12. (T.40-41). He noted that on 11/8 or 11/9/12 he had a one-on-one meeting with the general manager of the hotel, Jim Gould, at which time he was informed that his employment would be ending on 12/31/12 because "... the corporate office did not like the fact that [he] was working from Durham." (T.41-42).

On 11/12/12, Petitioner was preparing rooms for approximately 20 Millennium employees, including the president and a few vice-presidents of the company, as part of a "huge sales event." (T.15-16). During the course of inspecting rooms for the event, Petitioner and Respondent's executive housekeeper, Rosa Guzman, were walking down the stairwell when Petitioner "... slammed into this junction box. It spun me around... I think it was more like a spin-around and then jump onto the landing, and I ended up hitting my back onto the wall behind me from that landing. (T.17-25). He noted that "[i]t was right in the center of my back." (T.25). Petitioner testified that his right shoulder hit the electrical box at the time of the incident. (T.147). He stated that afterwards he "... almost thought immediately that I dislocated my shoulder. That was the pain I was feeling, and I just sensed that I didn't want to really move. I just kind of stayed there ... (T.25-26).

Petitioner testified that he had not suffered any injuries to his right shoulder prior to the incident in question. (T.34). However, he did acknowledge that he had a problem with his back prior to 11/12/12. (T.34). Petitioner testified that he had "... had back problems for quite some time; and [his] doctor at Triangle Orthopaedics, [they] finally worked it out where [he] ha[s]n't had a back issue for almost two years; and about a week after this accident, [his] back started bothering [him] again for the first time in a long time, so [he] simply set up an appointment with [the doctor] so that he could take a look at it." (T.35). He agreed that this "intervention' consisted of medication. (T.35-36). When asked whether he was having any back pain at the time of trial, Petitioner responded: "No, I'm feeling pretty good." (T.62). When asked if he may have last taken narcotic medication for his back in July of 2012, Petitioner responded: "I'm not sure. I perhaps may have. I'm not sure." (T.64).

Ms. Guzman, Respondent's head housekeeper, testified that on the date in question she and Petitioner were descending a back stairwell to inspect rooms on another floor. (T.73). She noted that Petitioner was ahead of her and that she could not actually see him at the time of the incident. (T.73-74). She testified that she "... just heard him say like 'ouch' and, as [she] went back down where he was, he was at the end of the step; and [she] told him, what happened? You strained your leg? [She] thought he slipped on the step. He said, no, I hit my shoulder. As he said that, [she] look[ed] and there was an electrical box there." (T.74). Ms. Guzman noted that following the incident Petitioner "... stood there at the bottom of the steps saying that he hurt his

16IWCC0339

shoulder. He said, what do I do? Seriously, [she] said, are you okay? He said, it's hurting me. [She] said, let's go to HR and file a report." (T.78).

Lisa Shields, Respondent's human resources manager, testified that on 11/12/12 Petitioner reported a work injury to her. (T.103). The report Ms. Shields completed was admitted at PX9. This report notes that Petitioner was "coming down back stairwell. Junction box & rammed into it. Right shoulder. Felt that it popped out. Can lift from front. South stairwell by 28 rooms, on 9th floor. Walking fast. Pick up speed. Fell back. Hit on electrical down & did not see & was too close to wall." (PX9).

Petitioner testified that after he reported the incident to Ms. Shields he was directed to Concentra Medical Center. (T.26-27). He noted that he treated at this facility in Chicago from 11/12/12 until 11/19/12, including doctor visits and physical therapy. (T.28). He indicated that he would have no reason to disagree with these records. (T.28).

In a Concentra Medical Center office note dated 11/12/12 it was recorded that Petitioner "complains about his Shoulder which he injured on 11/12/2012." (PX1). This report goes on to indicate that "Patient states: 'Trotting down the stairwell and jammed my shoulder into a metal junction box.'" (PX1). Under "History of Present Illness" it was recorded that "[t]he patient states that he hit the box sticking out of wall with his right shoulder. C/O pain outer aspect of the shoulder alond [sic] with burning sensation. The patient grades the pain Intensity Level at : 5/10. The pain did not radiate. Denies paresthesias, numbness, sensory loss, or loss of strength." (PX1). X-rays of the right shoulder were negative, and he was diagnosed with a shoulder strain/contusion. (PX1). He was prescribed Ibuprofen 600 mg and scheduled for therapy 3 times per week for 1 to 2 weeks. (PX1). He was also given a restriction of modified activity of no lifting over 5 lbs, no pushing/pulling over 10 lbs. of force, and no reaching above shoulders. (PX1). A handwritten history recorded at this facility on 11/12/12 noted "49 yom presents [with] R shoulder injury. Pt coming down stairs and hit his shoulder on a junction box sticking out from the wall." (PX1).

Petitioner returned to Concentra on 11/15/12 for therapy initial evaluation. (PX1). Once again, it was recorded that Petitioner injured his shoulder on 11/12/12 and that he was trotting down the stairwell when he jammed his shoulder into a metal junction box. (PX1). Under mechanism of injury, it was noted that "Patient reports that he banged his shoulder into a fuse box." (PX1). The patient's examination at that time was found to be consistent with a diagnosis of right shoulder strain. (PX1). It was also noted that Petitioner could return to work on 11/15/12 with restrictions of no lifting over 5 lbs., no pushing and/or pulling over 10 lbs. of force and no reaching above shoulders. (PX1).

Petitioner returned to Concentra on 11/19/12 at which time it was noted that Petitioner had been working within the duty restrictions, and that he had reached a plateau in physical therapy with no further improvement. (PX1). It was recorded that "[t]he pain is located on right shoulder. The pain is described as severe and aching. The pain did not radiate. The symptoms are exacerbated by movement or raising arms overhead... Denies paresthesias, numbness, sensory loss, or loss of strength." (PX1). Petitioner was given restrictions of no lifting over 15 lbs., no pushing/pulling over 20 lbs. of force and no reaching above shoulders. (PX1). Petitioner

16IWCC0339

was diagnosed with a shoulder contusion and an MRI of the right shoulder was requested "because of likely derangement." (PX1).

Thereafter, Petitioner commenced treatment in Durham on 11/28/12 extending through 2/14/13. (T.28).

In a Concentra Medical Center (Durham) office note dated 11/28/12 it was recorded that Petitioner injured his arm on 11/12/12 while working for Millennium Knickerbocker Hotel. (PX2). This record shows that "Patient states: 'I jammed my right shoulder into metal junction box. Injured my right shoulder." (PX2). It was noted that Petitioner "... has been working their regular duty. Patient has been taking their medications [with] slight improvement. The pain did not radiate. Denies paresthesias, sensory loss, snapping, clicking, popping, swelling, redness and bruising. Patient states, 'In general I am fine but when I move in a certain way the pain goes from a 1 to a 10.'" (PX2). Petitioner was diagnosed with a right shoulder contusion/strain. (PX2). Petitioner was allowed to engage in "[r]egular activity", noting that "Patient states he is hotel director and works a 'desk job.' States he is not required to reach overhead, lift, pull, or push. Therefore, he can work his regular work duties." (PX2).

Petitioner underwent an MRI of the right shoulder in North Carolina on 12/10/12. (T.29).

In a report dated 12/11/12, Triangle Orthopaedic Associates physician assistant Leonilde Alves noted that Petitioner "... has been having back pain flare. He states he did really well for a year and a half with the pain flare starting around November 2012. [H]e states it has been going on for the past 3 weeks or so. Unfortunately to make things worse he injured his right shoulder at work. He hit metal junction box about a month ago and now is followed by Concentra for his right shoulder. He is very worried about that... He denies any radicular symptoms..." (PX3). The impression was "1. Chronic nonspecific axial mechanical lower back pain with MRI 10/10 showing left lumbar scoliosis with some subtle retrolistheis of L2 on L3, L5 on S1. Borderline mild central canal stenosis L1-2 comparison was made with previous x-rays/MRI from 10/07, retrolisthesis L2 on L3 and L4 on L5 is more conspicuous on examination. Abutment of descending S1 space at T12-L1 level, which is new[;] 2. Right shoulder pain, work related injury, hit metal junction box 11/12 at work but that is followed under WC." (PX3).

When asked whether he provided a history of back pain to Triangle Orthopaedics when he saw them after the accident Petitioner responded: "I had been seeing them for a long time. They had everything on record, so I didn't have to give them any history." (T.65).

Petitioner visited Concentra (Durham) again on 12/12/12 at which time it was recorded that "[t]he patient still has significant burning pain in the right shoulder with most planes of motion. He has had an MRI. He is working regular duty as he had a desk job. He had a significant flare of low back pain along with his shoulder injury and just started some prednisone for that. He has not started PT yet."(PX2). The assessment on that date was rotator cuff tear/strain and probably labral tear. (PX2). Petitioner was allowed to engage in regular activity but was not released from care at that time. (PX2). In a separate "Physician Work Activity Status Report" dated 12/12/12 it was noted that Petitioner could return to regular duty on that date. (PX2).

Petitioner returned to Triangle Orthopaedic Associates on 12/17/12 at which time physician assistant Alves noted that the patient "... is here concerned about his right shoulder. His right shoulder is under WC so I explained to him that I am not going to discuss the MRI results with him or any kind of treatment option or diagnosis as a matter of fact since he is followed by Concentra for his right shoulder problems under WC... I am happy to refer him to Dr. Mallon to address his [right shoulder] concerns but he understands that since this is a WC case he needs to have WC authorize his visit first. As for his back, which is what I am addressing today he continues to have localized pain ..." (PX3).

An initial physical therapy report dated 12/19/12 recorded the same history of injury on 11/12/12 when Petitioner jammed his right shoulder into a metal junction box. (PX2). It was noted that he had been referred for therapy with a medical diagnosis of right shoulder suprapinatus tear. (PX2).

In a Concentra (Durham) "Progress Note" dated 12/19/12, it was recorded that Petitioner "...feels the pattern of symptoms is no better. Patient has been working modified duty. Patient has been taking their medications and has not noted any improvement. Patient has had physical therapy and does not feel better. The pain is located on anterior aspect of the right shoulder. Stopped PT due to MRI findings suggesting partial supraspinatus tear and possible labral tear. Arthrogram was recommended." (PX2). Petitioner was placed on modified duty and referred to Orthopedics for further evaluation. (PX2).

A separate "Physician Work Activity Status Report" dated 12/19/12 indicated that Petitioner could return to work on that date with restrictions of no lifting over 10 lbs., no pushing and/or pulling over 10 lbs. of force, no reaching above shoulders, unable to use impact tool with right arm and/or hand, unable to use power tool with right arm and/or hand, and limited use of right arm. (PX2).

Petitioner noted that he subsequently treated with orthopedic surgeon Dr. Lawrence J. Yenni from 1/14/13 to 2/14/13. (T.30).

In an office note dated 1/14/13, Dr. Yenni indicated that Petitioner was being seen for a right shoulder injury "... which he sustained on 11/12/2012 when he struck the shoulder on the junction box coming down the stairwell. It struck him hard enough that he lost balance. He did not fall completely to the ground. Since that time, he has complained of pain mainly over the anterosuperior aspect of the shoulder. He denies significant radiating pain..." (PX4). Dr. Yenni recommended MRI with contrast arthrogram and Petitioner was allowed to work on 1/14/13 with restrictions of no lifting over 10 lbs., no pushing and/or pulling over 10 lbs. of force and no reaching above shoulders. (PX4).

Petitioner noted that the MRI was performed at Durham Regional Hospital on 2/13/13. (T.31). This report is attached at PX5. Petitioner testified that when he returned to see Dr. Yenni thereafter the latter recommended surgery after determining that physical therapy would not do any good. (T.32).

In an office note dated 2/14/13, Dr. Yenni noted that the MRI "... shows degenerative changes at the AC joint as well as the glenohumeral joint. He has got a superior labrum tear, predominantly of posterior component. No cuff tear is noted." (PX4). Dr. Yenni indicated that he discussed treatment options with Petitioner and that "[h]e wants to proceed with surgery. We will get him set up at his convenience. It should be noted that he is currently not working, but it is not that he is unwilling to work in the sense that I am not allowing him to work due to limitation on his shoulder. He was released today with restrictions ..." (PX4). In a "Physician Work Activity Status Report" dated 2/14/13 it was noted that Petitioner could return to work on that date with restrictions of no lifting over 10 lbs., no pushing and/or pulling over 10 lbs. of force, no reaching above shoulders. (PX4).

When asked whether the doctors at Concentra imposed any restrictions or took him off work during the course of his treatment, Petitioner responded: "It really varied. At one point, I had no restrictions; and it was primarily because I have a desk job for the most part and that I could do 99 percent of my job because most of it was right at the computer and that's where I was comfortable with this injury." (T.28).

Petitioner testified that he continued to work for Respondent following the incident through 12/31/12 at which time he was let go. (T.32-33). He indicated that no doctor has released him for full duty since 1/1/13 through the date of hearing. (T.33). He also noted that he has not returned to work for any firm since 1/1/13. (T.33).

Petitioner testified that he has "absolutely" looked for work since he last worked for Respondent, and that he has filed for and is receiving unemployment benefits. (T.63). He agreed that if his former job as director of rooms and revenue was available today he would be able to physically do it. (T.64). When asked if that's been the case since the date of the accident until trial, Petitioner responded: "Absolutely." (T.64).

On cross, Petitioner disagreed that his job did not require him to lift anything, noting that when he's in the field he would have to help guests with such things as luggage, getting in and out of a vehicle or assisting in moving a delivery when a houseman was on break. (T.37-38). However, he then acknowledged that physical lifting was not a requirement for his job as director of rooms and revenue. (T.39). He also agreed that when he went to Concentra on 11/28/12 he stated that as a hotel director he works a desk job and is not required to reach overhead, lift, pull or push, and that he could work his regular duties. (T.39).

At the request of Respondent, Petitioner was examined by Dr. Joseph U. Barker on 4/10/13. (T.63). Petitioner agreed that he did not report any back pain to Dr. Barker at that time. (T.63).

In a report dated 4/10/13, Dr. Barker stated that he thought that Petitioner's diagnosis of superior labral tear and possible adhesive capsulitis "...is due to the injury he incurred at work. I do think that the mechanism is appropriate as he did take a direct jolt as he describes and directed to the front of the shoulder which could cause shifting of the shoulder and tearing of the labrum as well as inflammation in the shoulder. I do think, to a reasonable degree of medical certainty, in light of the alleged mechanism of the accident that the findings of the MRI could be caused by

16IWCC0339

this. I do not think he is at full duty or maximum medical improvement at the current time. I do think he needs further treatment for his shoulder." (RX1). However, Dr. Barker noted that Petitioner "... did not mention any back pain to me and in reviewing the notes there is only one mention of back pain. If he does complain of back pain I do not think it is related to the work injury to any reasonable degree of certainty." (RX1). Dr. Barker recommended an injection and physical therapy, noting that if Petitioner did not get significant, long-term relief from this treatment "... then I would consider a right shoulder arthroscopy, labral debridement, open long head of biceps tenodesis, and subacromial decompression." (RX1). In the meantime, Dr. Barker "... would give [Petitioner] work restrictions consistent with not lifting over 10 pounds or pulling over 10 pounds, and no overhead activities." (RX1).

III. CONCLUSIONS OF LAW

The issues on remand are a) is Petitioner's present condition of ill-being with respect to his low back causally related to the accident on 11/12/12, and b) what amount of compensation is due for temporary total disability?

A) Causation

Petitioner testified that on the date of the accident he was walking down the stairwell to check on the status of rooms when he "... slammed into this junction box. It spun me around... I think it was more like a spin-around and then jump onto the landing, and I ended up hitting my back onto the wall behind me from that landing. (T.17-25). He noted that "[i]t was right in the center of my back." (T.25). Petitioner testified that his right shoulder hit the electrical box at the time of the incident. (T.147). He stated that afterwards he "... almost thought immediately that I dislocated my shoulder. That was the pain I was feeling, and I just sensed that I didn't want to really move. I just kind of stayed there ... (T.25-26).

The Commission notes that other than the above testimony, the record contains no references to a history of injury on the date in question involving the lower back. Indeed, neither the incident report completed by Ms. Shields, Respondent's human resources manager, nor any of the initial treating records from Concentra Medical Center dated 11/12/12, 11/15/12 or 11/19/12 reference any injury other than to the right arm occasioned by Petitioner running into a metal junction box. (PX9; PX1). In fact, it was not until Petitioner returned home to North Carolina one month later that the first mention of any back complaints can be found.

Furthermore, the evidence shows that Petitioner had a pre-existing history of lower back problems. Along these lines, Petitioner testified that he had "... had back problems for quite some time; and [his] doctor at Triangle Orthopaedics (in Durham), [they] finally worked it out where [he] ha[d]n't had a back issue for almost two years; and about a week after this accident, [his] back started bothering [him] again for the first time in a long time..." (T.35).

When back complaints are finally noted in the record, no reference is made linking those back symptoms to the accident in question. Instead, these records would appear to reflect a chronic condition that had recently flared. Along these lines, in a report dated 12/11/12, Triangle Orthopaedic Associates physician assistant Leonilde Alves noted that Petitioner "... has been

16IWCC0339

having back pain flare. He states he did really well for a year and a half with the pain flare starting around November 2012. [H]e states it has been going on for the past 3 weeks or so. Unfortunately to make things worse he injured his right shoulder at work. He hit metal junction box about a month ago and now is followed by Concentra for his right shoulder..." (PX3). The impression was "1. Chronic nonspecific axial mechanical lower back pain with MRI 10/10 showing left lumbar scoliosis with some subtle retrolistheis of L2 on L3, L5 on S1. Borderline mild central canal stenosis L1-2 comparison was made with previous x-rays/MRI from 10/07, retrolisthesis L2 on L3 and L4 on L5 is more conspicuous on examination. Abutment of descending S1 space at T12-L1 level, which is new[;] 2. Right shoulder pain, work related injury, hit metal junction box 11/12 at work but that is followed under WC." (PX3). This note would seem to indicate that Petitioner's chronic back condition was separate and distinct from the documented work injury involving his right shoulder.

Therefore, based on the above, and the record taken as a whole, the Commission finds that Petitioner failed to prove by a preponderance of the credible evidence that his current condition of ill-being with respect to his lower back is causally related to the accident on 11/12/12.

B) ~~T-T-D~~

The record shows that following the accident on 11/12/12 Petitioner continued to work his regular duties for Respondent until he was let go on 12/31/12. When asked whether the doctors at Concentra imposed any restrictions or took him off work during the course of his treatment, Petitioner responded: "It really varied. At one point, I had no restrictions; and it was primarily because I have a desk job for the most part and that I could do 99 percent of my job because most of it was right at the computer and that's where I was comfortable with this injury." (T.28).

A "Physician Work Activity Status Report" dated 12/19/12, or prior to the termination of his employment, shows that Petitioner was allowed to return to work on that date with restrictions of no lifting over 10 lbs., no pushing and/or pulling over 10 lbs. of force, no reaching above shoulders, unable to use impact tool with right arm and/or hand, unable to use power tool with right arm and/or hand, and limited use of right arm. (PX2).

After his termination, Petitioner began treatment with Dr. Yenni on 1/14/13. (T.30). In an office note on that date Dr. Yenni allowed Petitioner to work with restrictions of no lifting over 10 lbs., no pushing and/or pulling over 10 lbs. of force and no reaching above shoulders. (PX4).

In an office note dated 2/14/13, Dr. Yenni noted that he discussed treatment options with Petitioner and that "[h]e wants to proceed with surgery. We will get him set up at his convenience. It should be noted that he is currently not working, but it is not that he is unwilling to work in the sense that I am not allowing him to work due to limitation on his shoulder. He was released today with restrictions ..." (PX4). In a "Physician Work Activity Status Report" on that date it was noted that Petitioner could return to work with restrictions of no lifting over 10 lbs., no pushing and/or pulling over 10 lbs. of force, no reaching above shoulders. (PX4).

Petitioner testified that no doctor has released him for full duty since 1/1/13 through the date of hearing. (T.33). He also noted that he has not returned to work for any firm since 1/1/13.

(T.33). However, Petitioner testified that he has "absolutely" looked for employment since his termination by Respondent, and that he has filed for and is receiving unemployment benefits. (T.63). He also agreed that if his former job as director of rooms and revenue was available today he would be able to physically do it. (T.64). When asked if that's been the case since the date of the accident until trial, Petitioner responded: "Absolutely." (T.64).

Based upon the above, and the record taken as a whole, the Commission finds that Petitioner was temporarily totally disabled from 1/1/13 through 4/24/13, for a period of 16-2/7 weeks. In support of this holding, the Commission specifically finds that Petitioner's condition has yet to stabilize or reach maximum medical improvement ("MMI") given Petitioner's ongoing complaints and recommended surgery relative to his right shoulder. Furthermore, Petitioner has consistently been placed on work restrictions by his various physicians, and was only able to continue in his prior position given the sedentary nature of the job. Petitioner also credibly testified that he has looked for work within his restrictions since the termination of his employment without success, and that he is currently on unemployment.

Therefore, upon further consideration, and in response to the circuit court order on remand, the Commission modifies the decision of the Arbitrator to find that Petitioner failed to prove by a preponderance of the credible evidence that his current condition of ill-being with respect to his low back is causally related to the accident on 11/12/12. Furthermore, the Commission finds that Petitioner proved that he was entitled to temporary total disability benefits from 1/1/3 through 4/24/13, for a period of 16-2/7 weeks, based on Petitioner's restrictions and ongoing treatment relative to his right shoulder during this time and his credible testimony that he had looked for work without success.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 6/10/13 is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $993.59 per week for a period of 16-2/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $803.74 for medical expenses and prospective medical treatment in the more of right shoulder surgery as recommended by Dr. Yenni under §8(a)and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $3,420.00 pursuant to §19(l) of the Act without further delay.

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

16IWCC0339

without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 19 2016

o: 3/21/16
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

Jeffrey Wittenborn,

Petitioner,

vs.

NO: 12 WC 43885

16IWCC0285

Randolph County Road Dist. #1 ,

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 medical, causal connection, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 23, 2015, 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.

16IWCC0285

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: MAY 4 - 2016
o040716
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WITTENBORN, JEFFREY
Employee/Petitioner

Case# 12WC043885

16IWCC0285

RANDOLPH COUNTY ROAD DIST 1
Employer/Respondent

On 9/23/2015, 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 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH LAW OFFICES
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

3150 JAMES KELLY LAW FIRM
4801 N PROSPECT RD
SUITE 832
PEORIA HEIGHTS, IL 61616

16IWCC0285

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

Jeffrey Wittenborn
Employee/Petitioner

v.

Randolph County Road Dist. 1
Employer/Respondent

Case # 12 WC 43885

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 **Collinsville**, on **July 29, 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 **January 27,2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**39,767.48**; the average weekly wage was $**828.49**.

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

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

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

Respondent is entitled to a general credit for any medical bills paid by its group health insurance carrier for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay the following reasonable and necessary medical services contained in Petitioner's Group Exhibit 1, as provided in Section 8(a) and 8.2 of the Act and pursuant to the Medical Fee Schedule: Dr. Walls (3/25/10 and 4/9/10 visits) - $150.00; Imaging Center at Wolf Creek (3/31/10) - $1208.00; Sparta Community Hospital (4/9/10) - $171.00; Dugan Radiology Associates (4/9/10) - $44.00. Respondent shall be given a credit for any medical bills that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving the credit, as provided in Section 8(j) of the Act.

Respondent shall pay permanent partial disability benefits in the amount of **$497.09/week** for a period of **25 weeks**, which represents **5% loss of use of the body as a whole** as provided in Section 8(d)(2) of the Act.

Respondent shall pay Petitioner compensation that has accrued between 1/27/10 and 7/29/15 and shall pay the remainder of the award, if any, in weekly installments.

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

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

Henry Kinsey
Signature of Arbitrator

September 19, 2015
Date

SEP 23 2015

Jeffrey Wittenborn v. Randolph County Road Dist. 1, Case # 12 WC 43885

FINDINGS OF FACT AND CONCLUSIONS OF LAW

At the time of arbitration the disputed issues were causal connections, medical bills, and the nature and extent of any injury. Mr. Delbert Renner was present at trial as Respondent's representative. Petitioner was the sole witness testifying at the hearing.

The Arbitrator finds:

Petitioner was involved in an undisputed accident on January 27, 2010 while working for Respondent. Petitioner, a laborer for Respondent, fell off a truck and caught himself with his left hand. Petitioner timely reported the accident but continued working and did not seek any medical treatment for almost two months. He then presented to his family doctor, Dr. Walls.

While difficult to read, it appears that Dr. Walls noted on March 25, 2010 that Petitioner was having trouble sleeping and was symptomatic in his left shoulder and neck. There is a reference to "off truck."(PX 3)

On March 31, 2010 Petitioner underwent an MRI of his cervical spine as ordered by Dr. Walls. According to the history contained in the report, Petitioner had fallen off a truck and pulled his arm and was complaining of neck and shoulder pain as well as headaches. The MRI report showed a hydrated compressive left paramedian C6-7 disc protrusion with a small extruded component resulting in left ventral lateral cord flattening and severe left C-6 nerve root foramen stenosis due to uncovertebral joint spurring. (PX 4)

Due to complaints of pain, Dr. Walls ordered right AC joint x-rays with stress views on April 9, 2010. That same day Petitioner underwent same. According to the report, Petitioner had a history of "chronic left-sided superior shoulder pain related to injury three months ago." The findings suggested low-grade acromioclavicular separation on the left side. (PX 5)

On April 12, 2010 Petitioner underwent right AC joint x-rays with stress views at Sparta Community Hospital due to "chronic left-sided superior shoulder pain related to injury three months ago." The radiologist's findings suggested low-grade acromioclavicular separation on the left side. (PX 5)

Petitioner presented to the office of Dr. Chris M. Murry, a chiropractor, on November 29, 2010 complaining of moderate neck pain bilaterally and moderate restricted neck motion bilaterally. Petitioner also reported moderate neck muscle spasms on both sides, as well as moderate shoulder pain bilaterally, moderate pain between the shoulder blades and moderate mid back muscle spasms. Petitioner underwent chiropractic manipulation to his cervical and thoracic regions. (PX 6)

Petitioner returned to see Dr. Murry on February 21, 2011 reporting similar complaints as in November of 2010. Similar treatment was provided. (PX 6)

Petitioner again underwent chiropractic manipulation on March 4, 2011, August 22, 2011, and August 29, 2011. (PX 6)

On September 7, 2011 Petitioner presented to Dr. Robert Ryan Reiss regarding cervical, upper thoracic, left trapezius/superior scapula, right trapezius/superior scapula, right mid thoracic, mid thoracic, left mid thoracic, left thoracolumbar junction and right thoracolumbar discomfort that started several years earlier. According to the doctor's notes, the pain started gradually and since then had worsened. "The symptoms began unknown." Sleeping, sitting and standing increased his pain and anti-inflammatories decreased his symptoms. Petitioner was diagnosed with cervical segmental dysfunction, cervicalgia, thoracic segmental dysfunction, thoracalgia, myofascitis, lumbar segmental dysfunction, and lumbalgia. Trigger point massage was recommended. Petitioner filled out various patient histories and oswestry questionnaires which indicated he was able to perform activities of daily living and work since his work accident. (PX 7)

Petitioner underwent physical therapy at Sparta Community Hospital on December 29, 2011 and January 4 and 5, 2012. Petitioner's diagnosis remained neck and shoulder pain. When seen on December 29, 2013 the therapist noted that Petitioner had gotten in at 5:00 a.m. after clearing roads of snow. As of January 5, 2012 Petitioner was reporting he was some better but still had tingling in his right upper extremity and hands, although better. He continued to have some left shoulder pain and neck pain "that is aggravated by different work tasks." Therapy was to be discontinued unless a new order was given. (RX 9)

Dr. Reiss again provided trigger point massage and chiropractic treatment to Petitioner on April 20, 2012. (PX 7)

On September 21, 2012 Petitioner was seen at Murphysboro Health Center for left shoulder and neck pain. Petitioner reported that his neck and shoulder were getting worse. He reported a history of trauma on the left shoulder and "new pain in neck." Petitioner was diagnosed with left neck/shoulder pain and disc herniation. Physical therapy was prescribed and a script for Tylenol 4 was given. Petitioner presented to Dr. Smith on September 21, 2012 with continued complaints of left shoulder and neck pain. (PX8, Murphysboro Health Center 9/21/12). Dr. Smith noted that Petitioner's left shoulder and neck symptoms were "getting worse," and that Petitioner had a history of trauma to the left shoulder. *Id.* He also indicated that Petitioner had developed pain in his neck when attempting to turn his head. *Id.* Dr. Smith's diagnosis was left neck/shoulder pain, as well as a disc herniation. *Id.* X-rays were ordered. (PX 8)

Petitioner underwent physical therapy at Sparta Physical Therapy and Sports Medicine commencing November 15, 2012 through December 29, 2012. At the time of his last visit Petitioner reported feeling some better. He still had some tingling in his right upper extremity and hands but less than he had before he began therapy. He also still had some superior left

shoulder pain and neck pain that was felt, by him, to be aggravated by different work tasks. Petitioner was discharged from therapy pending a new order. (PX 9)

On December 15, 2012 Petitioner signed his Application for Adjustment of Claim in this matter. (AX 2)

On January 11, 2013 Petitioner underwent an MRI of his cervical spine due to complaints of neck pain. The report indicates varying degrees of neural foraminal narrowing which was severe at C5/6 on the left and moderate at C3/4 on the left and at C5/6 on the right. There was also moderate narrowing at C4/5 on the left and at C6/7 bilaterally. Multiple disc osteophyte complexes were present without significant spinal canal narrowing, multilevel disc dessication without significant disc height loss was noted and, finally, some findings suggested some form of chronic sinusitis. (PX 10)

On February 4, 2013 Dr. Todd Smith ordered an x-ray of Petitioner's left shoulder due to pain complaints. (PX 5)

Petitioner underwent left shoulder x-rays at Sparta Community Hospital on February 8, 2013. The x-rays were negative for evidence of any acute bony fracture. No "appreciable" spurring of the acromioclavicular joint was noted. (PX 5)

Due to Petitioner's shoulder pain, Dr. Smith ordered additional studies and on February 18, 2013 Petitioner underwent bilateral acromioclavicular joint x-rays with and without weight bearing due to "chronic injury to left acromioclavicular joint related to pulling injury three years ago." No evidence of acromioclavicular joint instability on the current study was noted. (PX 5)

On February 26, 2013 Petitioner underwent an MRI of his left shoulder due to pain. The impression was: supraspinatus tendinopathy with a rim rent tear at its anterior most attachment; infraspinatus and subscapularis with mild tendinopathy; and mild degenerative changes of the acromioclavicular joint. (PX 10)

On March 13, 2013 Petitioner presented to the office of Dr. David Raskas with the chief complaint of neck pain, ringing in his ears, and numbness in his hands and arms. Petitioner reported having had an accident on January 27, 2010 when he was removing some debris from the top of his truck, climbing up to free the debris, missed a step on the way back down, and hung from the tow bar with his left arm sustaining his entire weight. He was eventually able to maneuver back into his cab and had no function of his shoulder or arm. Petitioner stated he could not even draw it into 15 degrees of abduction. The doctor noted, "After months of inactivity, rest, and observation, his pain and range of motion in his arm and shoulder returned." Petitioner was concerned that his upper neck pain and numbness and tingling in his fingers had not changed since the accident. His arm function had returned but Petitioner noticed left upper trapezius pain, left AC pain, and numbness and tingling in his hand and arm since April or May of 2012 and a constant tenderness to touch of the neck, anterior and posterior shoulder since December of

2012. Petitioner complained of weakness in his grip strength but no gross or fine motor abnormalities. Petitioner reported pain with twisting, stress, night, fatigue, work activities, and activities requiring turning his head in a lateral rotation as when driving. While Petitioner could drive, walk, climb stairs, engage in housework, sit, perform yard work, work at his job, stand, and get dressed, they were "halted and slow" secondary to pain. Petitioner reported being highly sleep disturbed. Dr. Raskas performed a physical examination and reviewed Petitioner's radiographs, including the 2010 MRI and 2013 MRI. He felt the 2013 findings were not markedly worse than the 2010 findings. Dr. Raskas was most concerned by Petitioner's numbness and dense heavy feeling that extended from his elbows to his hands and which Petitioner reported came on after driving. He did not feel those symptoms were related to the cervical spine findings; rather, he felt they were more likely related to a peripheral neuropathic process for which he recommended a nerve conduction study. He also felt some of Petitioner's neck pain that radiated into his left shoulder could be related to some of the foraminal stenosis at C5/6 and C3/4 and he recommended a nerve root block at C4. "The need for the [recommended] testing is directly related to the patient's work injury." Petitioner was allowed to continue working full duty. (PX 11)

Petitioner underwent electrodiagnostic studies on March 20, 2013 and they were interpreted as normal. (PX 11)

On March 21, 2013 Petitioner underwent a left C4 selective nerve root injection with Dr. Hurford. Dr. Hurford noted that Petitioner was referred for:

> [N]umbness and tingling and pain in the left and right upper extremities primarily distal to the shoulder. His symptoms began in January of 2010 after he slipped and hung with the left upper extremity from his truck. He is a 50-year old right-hand dominant gentleman who is having more left-sided greater than right-sided symptoms particularly with the arms elevated. He has difficulty sleeping at night and his principle complaint is numbness and tingling. Traction has helped to some degree but symptoms persist. He denies any significant neck symptoms but does report shoulder pain. (PX12, Dr. Hurford, 3/20/13).
>
> Dr. Hurford performed bilateral Electrodiagnostic studies including F-wave studies of the median and ulnar nerves and monopolar needle study, as well as the left cervical paraspinals. *Id.* No Electrodiagnostic evidence of a peripheral nerve entrapment, brachial plexopathy or cervical radiculopathy was detected. *Id.* Dr. Hurford advised Petitioner to follow up with Dr. Raskas. *Id.*

Petitioner also underwent a selective nerve root injection under fluoroscopic guidance to the left at C4, which was performed by Dr. Hurford on March 21, 2013. (PX12, Dr. Hurford, 3/21/13). It was noted that Petitioner's pain rating prior to the injection was 3 out of 10, and his post-injection pain rating was a 2 out of 10. (PX 11, 12)

Thereafter, Petitioner followed up with Dr. Raskas on April 5, 2013 reporting some neck pain relief with the injection but ongoing pain in the posterior trapezius area in his shoulder which he especially noticed with forward elevation and flexion when he drove. Petitioner was still experiencing pain in the posterior trapezius area in the shoulder, which occurred when holding the shoulder in forward elevation and forward flexion like when he drives. (PX11, Dr. Raskas, 4/5/13). Dr. Raskas stated, "Certainly the trauma that he sustained would have been an injury to his shoulder. His neural examination is otherwise unchanged. I would really like to get a person to evaluate his shoulder. I am recommending that he be referred for evaluation by a shoulder specialist. I will see him back after he is evaluated by an orthopedic shoulder specialist." *Id.* Petitioner was given no work restrictions, and a referral was made to Dr. George Paletta. *Id.*

At the request of Respondent Petitioner underwent an examination pursuant to Section 12 with Dr. Frank Petkovich on April 15, 2013. A written report followed. Petitioner described his job to the doctor as "driving a dump truck and also doing physical work such as shoveling rock and pushing snow." Petitioner also described his work accident explaining that he was coming down from the roof of his truck when his left foot slipped and his right arm slipped (trying to hold himself up) and he was hanging only by his left arm. He noticed immediate pain in his left shoulder area but kept working although he notified his supervisor. Petitioner did not seek any immediate medical treatment believing the condition would improve on its own. Petitioner did keep working and noticed residual discomfort in his left shoulder area and left side of his neck. Petitioner then sought treatment which he summarized for the doctor noting that during the entire time he kept working his regular job but kept feeling pain. Petitioner further told the doctor that in light of his persistent pain he spoke with his employer who did not feel Petitioner's condition was related to his work activity. Petitioner then retained legal counsel and began treating with various doctors, including Dr. Raskas. (RX 2, pp. 1-3)

Dr. Petkovich noted that Petitioner's primary complaints were in his left shoulder area and the left side of his neck along with persistent headaches. He acknowledged some neck pain in the past as well as bilateral shoulder pain but felt the shoulder and neck pain were worse since the work accident. Dr. Petkovich reviewed outside radiographic studies and reviewed a voluminous outside set of medical records. He diagnosed Petitioner with a cervical strain, degenerative disc disease at C4-5, C5-6, and C6-7, a left shoulder strain, and a left shoulder rotator cuff tendinitis at the insertion of the supraspinatus tendon. He felt the strains occurred at the time of the accident and that Petitioner may have had some exacerbation of his pre-existing degenerative shoulder and neck conditions but there was no aggravation or acceleration of those conditions as a result of the accident. With regard to medical care and treatment, he felt the initial visit and follow-up exam with Dr. Walls was reasonable and necessary as well as the cervical spine and shoulder x-rays and MRI studies. He also felt the physical therapy was appropriate. He did not think any further treatment was reasonable or necessary. He further felt Petitioner could continue working without restrictions especially since he had been doing so. He also did not feel that any further treatment was necessary as a result of the accident nor did he feel Petitioner had sustained any permanent impairment. (RX 2, pp. 3-6)

On May 8, 2013, Petitioner presented to Dr. George Paletta upon referral from Dr. Raskas. Dr. Paletta took the following history:

> This is the first visit for this 50 year old right hand dominant white male who presents for evaluation of a chief complaint of left shoulder pain. He presents for consultation at the request of Dr. Raskas. Jeff works as a road maintenance specialist for Randolph County Road District I in Illinois. He has been in that capacity for over twenty-two years. He has a history of injury dating back to 1-27-10. At that time he suffered a traumatic injury while getting down off the top of a dump truck. He slipped and fell from the top of a dump truck. He estimates that the top of the dump truck is about nine (9) feet up. As he fell he caught himself with his left arm. He describes the arm being forced into full extension and having to sustain the entire weight of his body as he fell. He had immediate pain in the shoulder and had an inability to raise the left arm. He had pain at night. Eventually he underwent a series of evaluations that included MRI of the neck as well as the shoulder. The MRI documented some cervical disc problems. At one point a recommendation was made for surgery of the cervical spine. However he underwent nonsurgical treatment including an injection. Overall things seemed to improve somewhat but he still had continued complaints of left shoulder pain as well as numbness into his forearm and into his left hand and fingers. He also gets similar symptoms bilaterally involving the right side. None of these symptoms were present prior to this fall. He denies any prior history of significant neck injury or shoulder injury preceding the incident of 1-27-10. (PX14, Dr. George Paletta, 5/8/13).

On physical exam, it was noted that Petitioner experienced mild pain at the end ranges of motion in his left shoulder, and also had positive Neer and Hawkins impingement signs. *Id.* Mild discomfort on resisted supraspinatus testing was also noted. *Id.*

Dr. Paletta also reviewed several MRI scans of the left shoulder, as well as MRI scans of the cervical spine from 3-31-10 and 1-11-13. Dr. Paletta interpreted the scans as follows:

> The MRI scans of the cervical spine demonstrate multilevel cervical disc disease. In addition there was a significant disc space narrowing at C3-4 and C5-6. There was evidence of multiple disc osteophyte complexes. There was multilevel disc desiccation. These are by report of the MRI scan from 1-11-13.
>
> I personally reviewed the MRI scan of the left shoulder. This was completed at Cedar Court Imaging on 2-26-13. It is a well done study of diagnostic quality. It demonstrates a small tear involving the anterior aspect of the supraspinatus. This appears to be consistent with a Rembrandt [sic] tear. It suggests a high grade partial but incomplete or non full thickness tear. The remainder of the study is unremarkable with the exception of degenerative changes of the AC joint. *Id.*

Dr. Paletta's impressions were cervical degenerative disc disease and a rim-rent tear supraspinatus tendon of the left shoulder. *Id.* An ultrasound of the left shoulder was

recommended in order to further delineate the rotator cuff tear. Dr. Paletta indicated that if the tear was high grade partial or a small full thickness tear, Petitioner might benefit from rotator cuff repair surgery. *Id.* With regard to the interplay between cervical spine and shoulder symptoms, Dr. Paletta noted:

> I do think there is a component of the symptoms emanating from the cervical spine but he has been under the care of a neck specialist and I would defer to the neck specialist with regard to any symptoms originating from the neck or requiring treatment. *Id.*

Petitioner underwent the ultrasound of his left shoulder on May 21, 2013, and returned to Dr. Paletta on May 24, 2013 to discuss the results of same. Dr. Paletta noted:

> The ultrasound demonstrates a moderate sized partial thickness tear of the posterior rotator cuff. This is consistent with the findings noted in the MRI scan. This appears to be a moderate grade tear involving approximately 50% of the thickness of the cuff. There is no full thickness tear noted. No other abnormalities noted. Biceps tendon is appropriately positioned within the bicipital groove. Subscapularis is noted to be intact. No fluid in the subacromial space. (PX14, Dr. Paletta, 5/24/13).

Dr. Paletta's impression and plan were as follows:

> The ultrasound certainly demonstrates findings consistent with the clinical suspicion of a partial tear of the supraspinatus. It involves approximately 50% of the thickness of the cuff. If the cervical spine specialist caring for Mr. Wittenborn does not feel there is any additional treatment directed to the spine then I would recommend he consider arthroscopy with partial rotator cuff repair versus debridement. We will contact the patient by telephone to discuss the results. If the patient does not want to pursue surgical treatment the other option would be to consider an ultrasound or fluoroscopically guided injection of the glenohumeral joint. Intraarticular injection should be performed by Dr. Helen Blake under ultrasound guidance. The patient would then be placed on a dose pack followed by a couple of weeks of Naprosyn. He would do a month's worth of rehabilitation. If at that point he is not improved at all then his only option would be to consider surgical treatment. *Id.*

On August 10, 2013 Dr. Petkovich issued an addendum report after reviewing additional records for Respondent, including those of Dr. Paletta and Dr. Raskas. His earlier opinions remained unchanged. (RX 3)

The deposition of Dr. Petkovich was taken on August 13, 2013. (RX 1) Dr. Petkovich diagnosed Petitioner with a cervical strain, degenerative disc disease at C4-5, C5-6 and C6-7, as well as a left shoulder strain and left shoulder rotator cuff tendinitis at the insertion of the supraspinatus tendon. (RX1, p. 26, RX2, p. 5) He opined that Petitioner's cervical strain and left shoulder strain occurred at the time of the incident on January 27, 2010. (RX1, p. 26-27; RX2, p. 5) Dr.

Petkovich believed that Petitioner suffered from pre-existing cervical disc disease as well as rotator cuff tendinitis which were present prior to January 27, 2010. *Id.* He opined that the January 27, 2010 work-related incident "may have caused some exacerbation of the pre-existing degenerative conditions in his cervical spine and his left shoulder that were present prior to January 27, 2010; however, I do not believe that the incident on January 27, 2010 caused an aggravation or acceleration of the pre-existing conditions in his cervical spine and his left shoulder that were present prior to January 27, 2010." (RX1, p. 27) He defined an "exacerbation" as a temporary phenomenon, and an "aggravation" as a concept that "has some permanency attributed with it that will not resolve." (*Id.* at 28)

On cross-examination, Dr. Petkovich acknowledged that he reviewed no medical records prior to January 27, 2010 documenting any complaints of neck or left shoulder pain. (RX1, p. 42-43) He confirmed that no MRI of the cervical spine or left shoulder had ever been recommended or performed prior to January 27, 2010. (*Id.* at 45) Dr. Petkovich testified that he agreed with Dr. Paletta and the radiologist's interpretation of Petitioner's left shoulder ultrasound, and confirmed that same revealed a partial tear of the supraspinatus at the insertion into the proximal humerus. *Id.* at 46-47. Dr. Petkovich confirmed that the tear could not be dated from simply reviewing the ultrasound or MRI. (*Id.* at 47) Dr. Petkovich was asked if Petitioner's symptoms ever returned to the pre-January 27, 2010 status after his accident and the doctor reiterated that Petitioner had acknowledged both cervical and bilateral shoulder pain prior to the accident. He also acknowledged that Petitioner told him his neck and left shoulder symptoms were worse after the January accident and he had no reason not to believe what Petitioner said. (*Id.* at 48-51). He also went on to explain that degenerative conditions can wax and wane over time. (*Id.* at 52)

Petitioner returned to Dr. Raskas on August 30, 2013 after the evaluation with Dr. Paletta. (PX11, Dr. Raskas, 8/30/13). Dr. Raskas indicated: "I have read through Dr. Paletta's evaluation and spoken with Jeff. It appears that he has a partial rotator cuff tear. He has symptoms in his neck at times. He gets numbness in his hands when he drives but he does not get consistent radiating symptoms out of his neck, down his arms into his hands. He gets pain in his shoulder that is brought on by shoulder motion." *Id.* His assessment was as follows: "At this point, while he does have some mechanical neck pain, I have suggested some topical anti-inflammatory, anti-muscle spasm type medication. Beyond that, I do think it is safe for him to proceed with operative treatment of his shoulder provided that Dr. Paletta believes it is indicated. There is nothing from a cervical spine standpoint that would preclude him from having surgery. I will reevaluate the patient after he completes his treatment with Dr. Paletta. He can continue working regular duties from the standpoint of his neck." *Id.*

Dr. Paletta was deposed on April 3, 2014, and his testimony was received into evidence as Petitioner's Exhibit 20. (PX 20). Dr. Paletta testified that he is a board certified orthopedic surgeon who is fellowship trained in and subspecializes in sports medicine, and whose practice is confined to caring for injuries of the shoulder, elbow, upper extremity and knee. (PX 20, p. 4). Dr. Paletta estimated that he performs approximately 300-350 surgeries annually. (*Id.* at 5) When asked to describe his referral source, Dr. Paletta testified: "I see patients from a wide variety of sources. I see patients from primary care physicians. I see patients from other orthopedists. I see patients on referral from physical therapists. I see patients on referral from employers, from attorneys, from adjusters and case managers, and I see a large number of

patients on self-referral either by word-of-mouth or through other patients." (*Id.* at 6) He also confirmed that he performs independent medical examinations for various employers in the course of his practice. (*Id.* at 7) Dr. Paletta explained that in this case, Petitioner was referred to him by Dr. Raskas, an orthopedic spine specialist, because "patients with shoulder pain—the etiology or the cause of their shoulder pain can sometimes be from the neck and sometimes can be from the shoulder. So sometimes there's overlap, and I'll refer a patient to a spine specialist or he'll refer a patient to me." (*Id.* at 8-9)

Dr. Paletta testified that he took a history of injury from Petitioner, and confirmed that Petitioner recalled no previous injury to the neck or shoulder prior to January 27, 2010. (*Id.* at 11) Based on the history given to him by Petitioner, the mechanism of injury that he reported, his prior history of a lack of complaints of shoulder problems, physical exam findings, and the results of the MRIs he reviewed, Dr. Paletta confirmed his diagnoses of cervical degenerative disc disease and a rim-rent tear of the supraspinatus tendon of the left shoulder. (*Id.* at 15) He confirmed that he would defer to Dr. Raskas with regard to any treatment recommendation or causation opinion of Petitioner's cervical spine. (*Id.* at 15-16)

With regard to causation, Dr. Paletta testified that it was his opinion within a reasonable degree of medical certainty that the January 27, 2010 injury contributed to or caused the partial-thickness rotator cuff tear in Petitioner's left shoulder. (*Id.* at 17) When asked whether the mechanism of injury that Petitioner reported was consistent with his pathology, Dr. Paletta explained:

> You can see a rotator cuff tear from a distraction injury. This gentleman weighs 220 pounds, and he basically took the entire force of his body on his left shoulder with the arm in distraction, and that is certainly a mechanism that can cause a partial-thickness or a full-thickness tear of the rotator cuff, in his case a partial-thickness tear. (*Id.* at 18)

The following exchange also took place on direct examination:

Q: Is it also significant to your causation opinion in this case that he reported no prior problems of significance with regard to his cervical spine or left shoulder?
A: Yes, it is.
Q: And why is that?
A: Well, he was asymptomatic up until the time of this traumatic episode. He had a distinct mechanism of injury to the shoulder with immediate onset of pain, subsequent persistent pain, and an MRI scan and ultrasound that showed partial-thickness tear of the rotator cuff. So even if one were to make the case that that partial-thickness tear of the rotator cuff preexisted this fall, it was entirely asymptomatic and didn't become symptomatic until after this incident. (*Id.* at 18-19)

When asked whether he agreed or disagreed with Dr. Petkovich's opinion that the January 27, 2010 injury caused an exacerbation of a pre-existing degenerative condition in Petitioner's

cervical spine and left shoulder, but that the incident did not cause an aggravation or acceleration of the left shoulder condition, Dr. Paletta explained:

> I disagree with that. Well, again, the only condition that could be identified as preexisting would have been the arthritis of the AC joint, but that was not Mr. Wittenborn's source of pain. He was completely asymptomatic with no pain, no complaints, prior to this incident. And again, as I testified to, if somebody wanted to make the case that that partial-thickness rotator cuff tear preexisted, A, there's no way to prove that, and B, it was clearly asymptomatic but then became symptomatic after the incident. And that's why I disagree with him. There's no history that this patient had any preexisting condition that caused him problems prior to the incident. (*Id.* at 23-24)

On cross-examination, the following exchange took place:

Q: What I'm getting at, doctor, is that if he received treatment and then went back to work, didn't receive treatment for a year, would that change your opinions?

A: Only if there was documentation that his symptoms had completely resolved and he was back to normal. (*Id.* at 34)

Dr. Paletta also confirmed that he sees patients "all the time" in his practice who simply go about their daily life in the hopes that their condition improves before seeking medical care and treatment, and testified specifically:

> There are several reasons for that. Sometimes patients just hope or think that their condition will resolve on its own. Other times, the level of disability or pain or dysfunction is not significant enough that it greatly influences their life, but over a long period of time, they realize that in fact it is impacting them significantly. And sometimes it's just an issue of not having access, to be honest with you. But those are the major factors and—that oftentimes delay patients from seeking treatment, even though they have an ongoing painful condition. (*Id.* at 42-43)

On further cross-examination Dr. Paletta admitted that he had not seen Petitioner until 3 ½ years after the accident and that the physicians in proximity to the accident would be in a better position to address causation. Dr. Paletta also indicated he did not review any treatment records from 2010 to 2013. Dr. Paletta also agreed with Dr. Petkovich that you can have a degenerative rotator cuff tear. Dr. Paletta indicated that a degenerative rotator cuff tear can become symptomatic with or without a traumatic event. Dr. Paletta indicated that degenerative tears can occur over time. He also indicated that the symptoms could wax and wane. Dr. Paletta did not know Petitioner's activities outside of work other than that he was a smoker and was a road worker. Dr. Paletta admitted he did not review medical records from Sparta Hospital or Dr. Murray. Dr. Paletta admitted that reviewing those records could be helpful to a causation opinion. Dr. Paletta also indicated a literal reading of Dr. Raskas' records could be interpreted that Petitioner's symptoms waxed and waned over time post-accident.

On May 19, 2014, Petitioner returned to Dr. Paletta for re-evaluation with continued complaints of left shoulder pain. (PX14, Dr. Paletta, 5/19/14). It was noted that Petitioner's workers' compensation claim had been denied and he presented for follow up through his private insurance. *Id.* Dr. Paletta indicated: "When I saw him last he was having some ongoing cervical issues but those are apparently status quo and there is no indication for any surgical treatment of the neck. He states at this point they are going to 'just let that go.' He is frustrated by the ongoing symptoms in his shoulder. He notes discomfort with overhead activities. There has been no intervening injury or trauma. Overall the shoulder just has not gotten better." *(Id)*

Dr. Paletta stated: "At this point he remains symptomatic. Options are to consider a repeat injection and physical therapy versus surgical treatment. Given the limited response to the injection and therapy in the past and the persistence of his symptoms I would recommend he consider arthroscopy with rotator cuff debridement versus repair as well as subacromial decompression." *(Id.)*

On May 27, 2014, Petitioner underwent a left shoulder arthroscopy with extensive debridement of the superior labrum, subacromial bursa and subacromial space, as well as an arthroscopic assisted rotator cuff repair. (PX16, Frontenac Surgery & Spine Care Center, 5/27/14) Intraoperative findings included evidence of significant fraying and unstable parrot beak fragment of the anterior and superior labrum. *Id.* Petitioner was kept off work following the surgery.

Petitioner continued to follow up with Dr. Paletta following surgery, who recommended a postoperative course of physical therapy, as well as restrictions of no lifting more than one pound from floor to chest level, and no lifting above chest level. (PX14, Dr. Paletta, 6/9/14, 8/27/14)

On October 8, 2014, Petitioner returned to Dr. Paletta for one final follow-up visit. Dr. Paletta noted that Petitioner had returned to some weightlifting activities, but noted soreness when attempting a bench press. (PX14, Dr. Paletta, 10/8/14) Dr. Paletta noted:

> Overall he is doing well at this point. He has minimal rotational losses. He still has some mild discomfort on heavy lifting activities and still has a little bit of endurance loss. This is not uncommon at 4 ½ months after surgery. At this point in time, he can increase activities as tolerated and requires no specific restrictions or limitations with regard to the shoulder. I explained to him that subjectively it typically takes between six and twelve months before patients feel like they are truly back to 100%. However, at this point he requires no restrictions or limitations.
>
> Of note, he does have a cervical spine issue for which he has been seen by Dr. Raskus [sic]. Dr. Raskus [sic] recommended that the shoulder be dealt with first. At this point, I think it is reasonable for him to return to Dr. Raskus [sic] and resume treatment for any cervical issues. The shoulder should not stand in the way of any additional treatment that Dr. Raskus [sic] would recommend for the shoulder. As such, I am referring him back to Dr. Raskus [sic] for reevaluation and treatment of his cervical spine issue. In my opinion, he is at maximum

> medical improvement and does not require additional follow up or formal treatment for the shoulder. He can continue to increase his activities as tolerated. (*Id.*)

Following his release from Dr. Paletta, Petitioner returned to Dr. Raskas with continued complaints of neck pain. (PX11, Dr. Raskas, 10/17/14). Dr. Raskas noted the following:

> Mr. Wittenborn returns to the office today. We have not seen him since August of 2013. Since that time he underwent a rotator cuff repair of his left shoulder. This was performed on May 27, 2014 by Dr. Paletta. He tells me he was released from care one week ago. He presents to our office today complaining of diffuse neck pain. This pain is situated on both sides of the neck. He does have some pain which radiates over the top of his left shoulder. He tells me he is unable to distinguish whether this could be coming from the neck or the shoulder itself. He denies parascapular pain. He denies radiating arm pain. His biggest complaint is of bilateral hand numbness. The numbness seems to involve the hand in its entirety. It involves all fingers. He tells me this numbness is constant. It does seem to worsen slightly with driving. However it is not alleviated with any change of position of his hands or his neck.

X-rays revealed narrowing changes at C5-6 and C6-7 with anterior osteophytes, as well as spondylolisthesis at C4-5 on flexion/extension and at C3-4. *Id.* Spondylolisthesis at both C3-4 and C4-5 was also noted. Dr. Raskas recommended a new cervical spine MRI and a new EMG/ nerve conduction study in order to differentiate whether Petitioner's symptoms were cervical or represented a peripheral neuropathic process. (*Id*)

Petitioner underwent repeat nerve conduction studies on November 3, 2014, which were performed by Dr. Andrew Wayne, a physical medicine and rehabilitation specialist. (PX11, Dr. Wayne, 11/3/14) Dr. Wayne noted that Petitioner had been injured on 1/27/10 after falling from a truck and developing neck pain, as well as episodic numbness and tingling in his bilateral upper extremities, as well as radiating pain over to the top of his left shoulder. (*Id.*) It was indicated that Petitioner had recently undergone a rotator cuff repair to his left shoulder on 5/27/14, and that he had previously experienced temporary relief from his cervical spine pain after undergoing selective nerve blocks. (*Id.*) On physical exam, Dr. Wayne noted limited range of motion in Petitioner's cervical spine upon flexion, extension, and bilateral rotation, as well as diminished sensation to light touch in the bilateral upper extremities from the mid forearm down to the fingertips. (*Id.*) Nerve conduction studies revealed the following:

> Nerve conduction study reveals moderately delayed left median motor distal latency with a small amplitude. The right median motor distal latency and amplitude are normal. The bilateral ulnar and motor distal latencies reveal mild delay on the right but normal latency on the left with mild to moderately small motor ulnar amplitudes on the right but normal ulnar amplitudes on the left with the exception of slight drop in amplitude across the left elbow. In addition, there is a mild bilateral ulnar and motor slowing across the elbows but normal ulnar velocities across the forearms. The ulnar sensory peak latencies and amplitudes

> are normal. The median sensory peak latencies are mildly delayed with slightly small amplitudes. The radial sensory responses are normal. (*Id.*)

Dr. Wayne's impression following the nerve conduction study was:

> [N]eck pain with bilateral upper extremity tingling and numbness in a gentleman who is status post neck injury occurring on 1/27/10. His Electrodiagnostic study reveals the following: 1. There is no evidence for an acute or chronic right or left cervical radiculopathy. 2. He has a moderate left focal median sensory-motor neuropathy at the wrist, and a mild right sensory only median focal neuropathy at the wrist. 3. He has a very mild bilateral focal ulnar neuropathy at the elbows. 4. There is no evidence for peripheral neuropathy based on the study performed. (*Id.*)

Following the repeat nerve conduction study and cervical MRI scan, Petitioner returned to Dr. Raskas on January 16, 2015 with continued complaints of neck pain and tingling in his hands. (PX11, 1/16/15). Dr. Raskas stated the following upon review of the MRI:

> While his MRI does show disc herniations at C3-4 and he has some foraminal encroachment bilaterally at C5-6, I think given the EMG findings I would not recommend any treatment at this time. The patient can continue on with activities as tolerated and I will reevaluate him on an as needed basis only should he has [sic] trouble in the future. Of course this would be causally connected to the problems that he has had in these areas in the last four years and this is something he needs to consider going forward should he develop recurrence of some of the neck and radiation arm pain that he had in the past. I will reevaluate him on an as needed basis. He is released from my care without restrictions. (PX11, Dr. Raskas, 1/16/15)

Petitioner was evaluated again by Dr. Petkovich on February 23, 2015. (RX3) Dr. Petkovich re-affirmed his opinions with regard to Petitioner's diagnosis and causation, and issued an AMA impairment rating. (*Id.* at 6-7)

Dr. Petkovich was deposed for a second time on June 11, 2015. (RX4) He again re-affirmed his opinions with regard to diagnosis and causation. He confirmed that he has not performed spine surgery in over three (3) years, and performs only a limited number of orthopedic surgical procedures. (RX4, p. 37-38) He estimated that he last performed a rotator cuff repair four (4) years prior to his deposition. (*Id.* at 39) When confronted with Dr. Paletta's testimony that the only condition which could be identified as pre-existing in Petitioner's shoulder would be the AC joint, which was not the source of Petitioner's pain, and asked if he agreed, Dr. Petkovich testified, "No. I believe that Mr.—again, Mr. Wittenborn had degenerative arthritic changes in his left shoulder, as we have discussed, and he also had degeneration at the insertion of the rotator cuff with tearing of the rotator cuff as a degenerative tear. So I think that's what the MRI indicated that that's what Dr. Paletta's operative report indicates." (*Id.* at 50) When asked if the degenerative changes in Petitioner's left shoulder caused him any symptoms prior to January 27, 2010, Dr. Petkovich testified, "I don't remember exactly what his symptoms were prior to the—

prior to January 27, 2010 with regard to his left shoulder, but I'm sure with his history that he had some pain in his shoulder with those radiographic findings." (*Id.* at 51) He further testified that just because someone doesn't see a physician doesn't mean they aren't in pain. (*Id.* at 53) When asked if he had received any medical records documenting any complaints to his neck or left shoulder prior to January 27, 2010, Dr. Petkovich responded, "I don't remember specifically the records, Mr. Rich. I don't have all of his records memorized." (*Id.* at 52) Dr. Petkovich agreed that the surgery performed by Dr. Paletta was appropriate and reasonable.

Petitioner's case proceeded to arbitration on July 29, 2015.

Petitioner testified that on January 27, 2010, he was a forty-eight (48) year old road maintenance worker for Respondent. and at the time of trial, had been employed in that capacity for over twenty-four (24) years. He testified that he performs various tasks involving heavy manual labor, including patching holes in the roadways, grading roads, hauling rocks on the roads, pushing show, and trimming trees. Petitioner testified, and it was stipulated to by the parties, that on January 27, 2010, he sustained accidental injuries in the course of his employment when he fell off a truck and caught himself with his left hand. He confirmed that he later notified his employer, Mr. Renner, that he had been injured.

Following the incident, Petitioner sought medical care and treatment with his primary care physician, Dr. Walls, on March 25, 2010. (PX3). When asked at trial to explain why he waited to seek medical care and treatment until two (2) months after his injury, he indicated that he believed it would heal up on his own. When his symptoms did not resolve, he sought medical care and treatment. Petitioner testified that after seeing Dr. Walls he ultimately came under the care of Dr. Raskas who performed shoulder surgery.

Petitioner testified that he did not sustain any additional injuries or accidents to his left shoulder or neck following the January 27, 2010 injury, and that his pain never went away prior to undergoing surgery with Dr. Paletta. Petitioner explained that he experienced "horrific pain" at the time of the accident. It was terrible and he went in to work but Delbert (Renner) let him work "light duty so to speak" and he thought if he waited long enough it would heal up. He acknowledged that the pain did subside a lot from what first occurred but it never completely went away.

Petitioner acknowledged that he continued to work regularly duty for Respondent up until the time of surgery. Petitioner confirmed that he lifts weights as a hobby, and attempted to engage in this activity after his injury on January 27, 2010, but stopped because it didn't feel right. He testified that he resumed his weightlifting regimen after undergoing surgery with Dr. Paletta and engaging in physical therapy. Petitioner also testified that prior to January 27, 2010 he did not experience any pain or symptoms in his neck and left shoulder which required him to seek medical care and treatment.

Petitioner denied ever engaging in any cliff jumping.

Petitioner testified that he has improved following surgery with Dr. Paletta. Despite this improvement, however, he testified to continued soreness in the anterior portion of his left

shoulder which becomes irritated with activity, as well as loss of range of motion and loss of strength. He also confirmed that he takes Tylenol 4 several times per month on an as needed basis, and Flexeril on a daily basis. Petitioner confirmed that while he is able to satisfactorily perform his job, he still experiences loss of strength in his left hand which he notices when shoveling. He indicated that his hobby of weightlifting has been affected, and specifically he can't get his hand far back enough to grab the barbell when he's doing squats without forcing it. He can get it there but he has to go under and then twist to get his hand back so he can grab it with his other one. Petitioner testified that he has difficulty sleeping on his left shoulder. He has also observed that his left shoulder appears to be physically drawn up higher than his right shoulder.

On cross-examination Petitioner acknowledged that his job requires him to lift, shovel, reach up and trim limbs on trees, haul limbs, and perform manual labor. He also patched holes and shoveled asphalt. He acknowledged being honest with Dr. Petkovich regarding how he felt before and after the accident. He denied having problems in both of his shoulders before the accident. He also denied that his symptoms waxed and waned after the accident. When asked if he had any right arm problems post-accident, he couldn't honestly say. He acknowledged that he worked hard for a living and would both go to bed aching and wake up aching even before the accident. Petitioner testified at length regarding his weightlifting regimen both before the accident and since his surgery. He can essentially do everything he did before the accident except for squats.

On redirect examination Petitioner was asked if he had any pain or symptoms in his left shoulder and neck before his accident and he responded, "Not that bad." While he never sought medical treatment for those symptoms he acknowledged using Tylenol and rest at times.

The Arbitrator concludes:

In support of the Arbitrator's Decision relating to F: "Is Petitioner's current condition of ill-being causally related to the injury?"

Petitioner failed to prove a causal connection between his current condition of ill-being in his neck and left shoulder and his accident of January 27, 2010. In so concluding the Arbitrator bases her determination on the following.

After the accident Petitioner continued to work. He saw Dr. Walls on one occasion two months post-accident and underwent a shoulder x-ray. He then continued to work and underwent no further treatment for seven months. When Petitioner did present for treatment in late November of 2010 he complained of bilateral shoulder pain, neck pain, mid back pain, and thoracic back spasms and pain. He made no reference to the accident. Petitioner continued working and underwent no further treatment for three months. He then saw the chiropractor once and underwent no further treatment for two months at which point he again returned to his chiropractor and then he underwent no further treatment for five months. Again, he worked during this time. Petitioner then presented to Dr. Reiss over a year and a half after the accident regarding a multitude of physical complaints which he told the doctor had begun "several years earlier" with gradually increasing pain which had since worsened. "The symptoms began unknown." (PX 7) Thereafter Petitioner underwent some physical therapy and the therapist noted

that Petitioner was experiencing some ongoing left shoulder pain and neck pain "aggravated by different work tasks." There is then another gap in treatment between January and April of 2012 at which point Petitioner returned to Dr. Reiss for another trigger point massage and chiropractic treatment followed by a gap in treatment of five months. At that time Petitioner reported to Murphysboro Health Center with a history of trauma to his left shoulder and "new pain in neck" stemming from attempting to turn his head. (PX 8) When seen by the therapist in late 2012 Petitioner was reporting his pain complaints were being triggered by different work tasks. Petitioner then filed his Application herein.

After doing so, Petitioner presented to Dr. Raskas reporting his work accident of January 27, 2010 and stating that after the accident he had absolutely no function in his shoulder or arm. The doctor noted that after months of inactivity, rest, and observation his pain and range of motion in his arm and shoulder "returned." Petitioner was also concerned because his upper neck pain and numbness and tingling in his fingers had not changed since the accident.

While Petitioner suffered an undisputed accident, Petitioner's symptoms were not severe enough to warrant much medical treatment immediately after the accident nor did Petitioner miss any work because of the accident until four years later. His job was physically demanding and active. Petitioner also did not receive any medical treatment until two months after the accident. The Arbitrator also notes a significant difference in the histories provided by Petitioner to the various doctors before and after the filing of his claim herein. Prior thereto, the histories given to the various providers contained little or no reference to the accident. After signing his Application herein the histories contained specific references to the accident but (and this also goes to causation) incomplete summaries as to his treatment and gaps in treatment. The medical records pre-dating the filing of his claim herein also contain references to work activities aggravating Petitioner's shoulder. Thus, there may have been two components to Petitioner's claim – his work accident and his ongoing work duties. Indeed, Petitioner told Dr. Petkovich that he did continue to work after the accident, spoke to his employer about his work activities bothering his shoulder, and this led to his filing of his claim. However, no treating physician rendered a causal opinion regarding the interplay of these two potential causes. Ie., neither Dr. Raskas nor Dr. Paletta opined that Petitioner's accident combined with his ongoing work duties were a cause of his condition and need for treatment nor did they testify that regardless of his ongoing work duties that may have aggravated both conditions, his accident of January 27, 2010 remained a cause of his ongoing difficulties. Neither doctor reviewed Petitioner's earlier treatment records. Neither doctor considered that Petitioner had problems with his neck and shoulder before the accident (as Petitioner clearly acknowledged on cross-examination and redirect examination, as well as in some of the medical records). Petitioner's history to Dr. Raskas about the numbness and tingling in his fingers isn't corroborated by the actual medical records.

Dr. Paletta essentially agreed with all of Dr. Petkovich's opinions and diagnoses but differed on the aggravation theory because Dr. Paletta was under the assumption Petitioner was asymptomatic prior to the accident. Petitioner admitted to being symptomatic prior to the accident both to Dr. Petkovich and to his own treating physicians. The September 7, 2011 record indicates that Petitioner's cervical and scapular discomfort "started years ago." Petitioner further explained that "the pain started gradually and since then has gotten worse. The symptoms began

unknown." Petitioner's history contained in his own treating doctor's record of September 7, 2011 supports exactly the opinion Dr. Petkovich described. Dr. Paletta's opinion is flawed in that Petitioner admitted on re-direct examination that his symptoms after the accident were "not as bad" as before the accident. Petitioner told Dr. Petkovich that he had pre-existing problems and Petitioner admitted at arbitration that he was being truthful with Dr. Petkovich about his prior symptoms. Petitioner's own medical records confirmed pre-existing problems. Therefore, Dr. Paletta's opinion is not based on the facts and is flawed.

Dr. Paletta did not see Petitioner until four years after the accident and had limited information regarding Petitioner's pre and post-accident care and symptoms. Dr. Petkovich performed an IME and examined all of the pre and post-accident records and diagnostic films. Dr. Petkovich was in the best position of the physicians to render a causation opinion. Dr. Petkovich testified that Petitioner had a cervical sprain, cervical degenerative disc disease and a shoulder sprain. Dr. Petkovich testified that Petitioner's cervical and shoulder sprains resolved within weeks of the accident. Dr. Petkovich indicated that any aggravation of Petitioner's degenerative disc disease was a temporary exacerbation that had resolved. Dr. Petkovich gave a credible opinion that Petitioner's need for surgery was reasonable but not causally related to the work accident given that Petitioner had symptoms pre and post-accident that waxed and waned and Petitioner did not miss any time from work or require surgery until four years later. Dr. Petkovich also addressed the stress caused by being a regular weight lifter for many years consistent with Petitioner's arbitration testimony.

Dr. Raskas did not testify nor did Dr. Reiss, one of Petitioner's early treating physicians to whom Petitioner made no specific mention of his work accident.

Additionally, Petitioner had both right-sided and left-sided complaints which do not support Petitioner's symptoms emanating from the work accident. That there were no medical records suggesting prior treatment to Petitioner's neck and shoulder does not negate a finding that Petitioner had pre-existing conditions in both. Petitioner acknowledged as much while testifying. Furthermore, Dr. Petkovich credibly explained that one can have pre-existing pain regardless of whether one seeks medical treatment. Petitioner also had a significant hobby of weight lifting that Dr. Paletta was not even aware of when he gave his opinions. Petitioner testified at length regarding the repetitive movements he performed both pre and post-accident involving his upper extremities. Dr. Paletta's own history indicates Petitioner's symptoms were activity related and caused when Petitioner would raise his arms, which would be consistent with the activities he described at arbitration while weight lifting. Petitioner also described having symptoms driving his personal automobile.

Also, Petitioner had a number of symptoms in his fingers, wrist and elbow that were not addressed by his treating physicians' opinions. Petitioner had EMG findings consistent with focal neuropathies of both wrists and elbows resulting in tingling bilaterally. Petitioner's EMG findings were negative for cervical radiculopathy, which supports Petitioner had symptoms not related to a left handed injury while working. Dr. Paletta also admitted that he did not review any of the medical records. Dr. Petkovich did review the medical records that show Petitioner had right and left handed symptoms after the accident and that Petitioner had the slow onset of symptoms that started years before the alleged accident. After Petitioner's shoulder surgery and

after the documented diagnostic tests confirming no cervical radiculopathy, Petitioner still had numbness and tingling in his hands and arms that was unexplained by his treating physicians.

Based upon all the credible medical evidence, the Arbitrator finds that Petitioner suffered a cervical strain, shoulder strain and a temporary aggravation of his cervical degenerative disc disease. Petitioner failed to prove a causal connection between his work accident and his complaints after April of 2010. Petitioner failed to prove that his shoulder surgery was causally related to the work accident.

In support of the Arbitrator's Decision relating to J: "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?"

The Arbitrator incorporates her findings with regard to causal connection herein. Based on the credible medical evidence, Petitioner is entitled to all of the medical bills consistent with Dr. Petkovich's opinion including the diagnostic tests, initial doctor visits and conservative care. Petitioner is not entitled to any medical bills other than those outlined in Dr. Petkovich's IME and consistent with his opinions. These would include the following: Dr. Walls (3/25/10 and 4/9/10 visits) - $150.00; Imaging Center at Wolf Creek (3/31/10) - $1208.00; Sparta Community Hospital (4/9/10) - $171.00; Dugan Radiology Associates (4/9/10) - $44.00. While Dr. Petkovich felt that physical therapy was appropriate, the Arbitrator notes that the therapy Petitioner underwent from November of 2012 through January of 2013 was for bilateral shoulder complaints Petitioner associated with work duties, not his accident. Consistent with her causation opinion, the Arbitrator declines to award that bill.

In support of the Arbitrator's Decision relating to L: "What is the nature and extent of the injury?"

The Arbitrator incorporates her findings with regard to causal connection and medical herein. Based on the credible medical evidence, Petitioner suffered a cervical strain, shoulder strain and temporary aggravation of degenerative cervical disc disease. Petitioner did not miss any work due to the work accident until years after the accident. The medical records established that Petitioner had pre-accident symptoms to his neck and shoulders. Petitioner's post-accident symptoms waxed and waned as reflected by significant gaps in treatment and varying complaints. Petitioner's conditions causally related to the work accident included strains and an aggravation of his underlying cervical degenerative condition. While Petitioner suggested that his employer allowed him to work "light duty so to speak" he didn't provide any details or time frame. Medical records, including the physical therapy records, suggest Petitioner was working regular duty and often engaged in more physically demanding tasks than driving a truck. Thus, how long this "light duty" or just what it exactly involved wasn't really addressed by Petitioner. Whatever it was, Petitioner essentially worked his job with no lost time until he underwent surgery. No physician ever felt he needed work restrictions despite his complaints. Based on the Petitioner's ability to continue to work full duty, the lack of need for any traumatic care after the

accident, and Dr. Petkovich's persuasive testimony and opinions, it appears Petitioner had minimal disability as a result of the work accident. Accordingly, Petitioner is entitled to 5% of a person as a whole for his permanent disability pursuant to Section 8(d)2.

****

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eric Burroughs,

Petitioner,

vs. NO: 13 WC 1648

Ford Motor Company,

16IWCC0352

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

The Commission corrects page 3 of the decision of the Arbitrator to show that Petitioner's condition of ill-being is not causally related to the accident on 11/28/12 so as to be consistent with the causation finding contained in the body of the decision at page 7.

Furthermore, the Commission notes an apparent inconsistency at p.7 of the Arbitrator's decision with respect to Petitioner's credibility. Along these lines, the Arbitrator determined that Petitioner's "... testimony regarding the date, time and nature of accident is credible" only to note two paragraphs later that "Petitioner has greatly exaggerated his work duties...". (Arb.Dec., p.7). The Commission clarifies this holding to find that while the record contains sufficient evidence to support a finding that Petitioner sustained accidental injuries arising out of and in the course of his employment on 11/28/12, the Commission does not find Petitioner's testimony to be credible with respect to his claim that he would install canisters 600 times a day, given that at a rate of one canister ever 2 to 2-1/2 minutes it would require 20 hours plus a day to achieve such a level of production. As a result, the Commission finds that Petitioner failed to prove that his current condition of ill-being is causally related to the accident on 11/28/12.

16IWCC0352

Finally, the Commission vacates the Arbitrator's permanency award of 2% person-as-a-whole pursuant to §8(d)2 given that the matter appears to have proceeded to trial pursuant to §19(b) of the Act and nature and extent of the injury was not at issue as evidenced by the Request for Hearing. (Arb.Ex.#1). Furthermore, given the Arbitrator's determination that Petitioner failed to prove that his current condition of ill-being is causally related to accident in question, a permanency award is not appropriate under the circumstances.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 1/23/15, with the above corrections, is hereby affirmed and adopted, and Petitioner's claim for compensation is hereby denied.

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

DATED: MAY 26 2016
o:4/11/16
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BURROUGHS, ERIC
Employee/Petitioner

Case# **13WC001648**

FORD MOTOR COMPANY
Employer/Respondent

16IWCC0352

On 1/23/2015, 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 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2356 DONALD W FOHRMAN & ASSOC LTD
ADAM J SCHOLL
101 W GRAND AVE SUITE 500
CHICAGO, IL 60610

0075 POWER & CRONIN LTD
WILLIAM P DEWYER
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

16IWCC0352

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

Eric Burroughs
Employee/Petitioner

Case # **13 WC 01648**

v.

Consolidated cases:

Ford Motor Company
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the **Honorable Ketki Steffen**, Arbitrator of the Commission, in the city of **Chicago**, on **November 5, 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 11/28/2012, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, the Petitioner ***did*** sustain 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, the Petitioner earned $17,295.93; the average weekly wage was $640.59.

On the date of accident, Petitioner was 44 years of age, ***single*** with 2 children under 18.

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 $ under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner the sum of 2% person as a whole, 10 weeks of compensation, at the PPD rate of $384.35 pursuant to 8(d)(2) of the Act as the Petitioner sustained injury to the extent of 2% person as a whole.

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

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

Ketki Steffen
Signature of Arbitrator

1/22/15
Date

ICArbDec p. 2

JAN 23 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ERIC BURROUGHS	)	
	)	
Petitioner	)	
	)	
vs.	)	Case No.: 13 WC 1648
	)	
FORD MOTOR COMPANY	)	
	)	
Respondent	)	

FACTUAL SUMMARY

Petitioner, Eric Burroughs, was 44 years old on the date of the alleged work incident. He had started work for Respondent, Ford Motor Company, in April 26, 2012 and relocated from Michigan to Chicago, Illinois for that purpose. Initially Petitioner worked on the engine line at the plant till November, 2012.

On November 28, 2012 he was working on installing carbon canisters. The Petitioner had been in this assignment for a very short period of time. Per the incident report that was partially handwritten by the Petitioner, he had been in this particular assignment for approximately three days prior to his injury. (RX9) (PX1) (It should be noted that PX1 is missing the second page of the document which indicates that the Petitioner wrote that he had only been on the carbon canister line for only 3 days.) Petitioner describes his assignment as repetitive installation of the canisters to the undercarriage of automobiles. The canisters were the size of a shoe box and weighed 4-5 lbs. Petitioner testified that the car undercarriages were suspended overhead and moved along a track. While the car was moving, petitioner would reach overhead and install the carbon canister into the undercarriage using a screw gun to fasten the canister. The canisters would also be connected to two hoses and the whole install required fastening six screws using multiple screw guns. Petitioner estimated that he did this activity 600 times a day and that that the entire process required two to two and a half minutes per car.

Petitioner alleges that this repetitive motion/work after his transfer from the engine line into the carbon canister install line caused him to suffer neck and back pain. Petitioner claims that he had no pre-existing medical issues with his back and neck prior to this accident. He acknowledged that he had a strain playing basketball and had a report of back pain injury while working at Ford in Michigan. (RX6) Contrary to the accident Report Petitioner testifies that he had been working in the canister install line for approximately twelve days.

Petitioner incident report with the medical clinic states that he complained of sharp pain in his neck and back from reaching to install carbon canisters. (PX1) Petitioner was seen by Mary Brown, RN who offered him Ibuprofen and then assessed him fit to work. (RX6) Petitioner testified that he returned back to work as directed.

KSS

On November 30, 2014, petitioner returned to the company medical clinic on a couple of occasions with complains of back pain. Tamara Montgomery, a registered nurse, diagnosed Petitioner with a strain and returned him to work. (RX6)

Petitioner continued to work on the carbon canister line until late December and was then transferred to the seat installation line. The job involved lifting the seats with a hoist and fitting the seat in the grooves and fastening the same with a screw gun. Petitioner stated that the activity of installing seats aggravated his lower back. In late December, the company shut down for the holidays and Petitioner returned home to Michigan.

On January 7, 2013 Petitioner was seen by his personal physician, Dr. Crawford. He reported pain in both elbows with pain worse from his left elbow down to his fingers. (RX5) Dr. Crawford referred petitioner to an orthopedic physician and recommended no lifting, twisting, pushing or pulling. (RX5)

Petitioner returned to Ford on January 8, 2013 and presented the note from Dr. Crawford. The Visit Summary Report of the company clinic indicated that petitioner elbows and back hurt from constant pulling, installing canisters by reaching and pushing hose and clips in place. (RX6) The report indicated that the onset of the condition occurred on December 12, 2012. (RX6) An Injury/Accident report was also filled out for a date of accident of December 12, 2012, (PX2,RX10) Petitioner was instructed by Tamara Montgomery, RN to return to work with the restrictions set forth by Dr. Crawford and to return to see the physician. (RX6)

On January 9, 2013, a Visit Summary Report was filled out by the company medical clinic by Patricia Lewis. The report explained that petitioner's case was changed to personal since there was no information submitted that an injury occurred on December 12, 2012. (RX6) An hour or so thereafter, the company medical clinic filled out a second Visit Summary Report which detailed that the petitioner called to clarify that his elbow pain was associated with claimed injury of November 28, 2012 when he reported his low back and neck pain. (RX6)

On January 10, 2013, petitioner returned to the company medical clinic. The Visit Summary Report indicated that petitioner informed them that his elbow issues were from performing the carbon canister job in the Chassis Department. (PX6) Petitioner was given restricted work to take to LRO. (PX6) Petitioner testified that the respondent would not accommodate his restrictions after the company doctor determined his medical issues to be of personal nature and he thereafter was off of work.

On January 17, 2013, Petitioner sought medical care with a physician in the Chicago area, Krishna Chunduri, M.D. Dr. Chunduri is a board certified physician in pain management and anesthesiology. (PX4,PX6,p.5) Petitioner reported pain in his neck radiating down his left arm to his fingers and pain in his right upper extremity from his elbow to his hand, as well as low back pain. (PX4) Petitioner explained to Dr. Chunduri his job activities which included working overhead with a screw gun and about installing seats. (Id.) Petitioner stated that his neck pain was constant but that his upper extremity symptoms and low back pain would come and go with exertion. (Id.) Dr. Chunduri diagnosed petitioner with cervicalgia with bilateral radiculitis and lumbago. (Id.) After conducting a physical examination, Dr. Chunduri felt that petitioner's symptoms and diagnoses were work related. (Id.) Dr. Chunduri recommended an MRI of the cervical spine, medications and physical therapy. (Id.)

Petitioner underwent an MRI of his cervical spine on January 29, 2013. The MRI revealed spondylosis changes superimposed on congenital cervical spinal stenosis. (PX4,RX2)

Petitioner returned to Dr. Chunduri on January 31, 2013. Petitioner reported that he had started physical therapy and that he continued to experience both neck and back pain. (PX4) Petitioner stated that his neck pain was worse and his radiated down both of his upper extremities. (Id.) Dr. Chunduri reviewed the MRI results and determined that petitioner had mild to moderate compression of the nerves at the level of C5-6. (PX5,p.13) Since petitioner continued to have pain in his neck as well as paresthesias, Dr. Chunduri recommended an epidural steroid injection to treat the irritation. (PX5,p.13) Dr. Chunduri further indicated that petitioner was to be off from work. (PX4)

Dr. Chunduri treated Petitioner conservatively with epidural injections and Petitioner underwent an MRI of lumbar spine and the EMG on March 21, 2013. Petitioner received temporary but complete relief from the epidural shots. The MRI revealed multi-level annular disc bulging. (RX3) The EMG confirmed a left C6 radiculopathy. (RX4) Dr. Chunduri's impression was C5-6 disc herniation with left radiculitis and lumbar spondylosis and facet syndrome. (PX4) Dr. Chunduri's opinion was that petitioner needed to be evaluated by a spine surgeon with regard to his neck. (PX5,p.23) With regard to his lower back, Dr. Chunduri recommended a diagnostic medical branch block. (Id.)

Petitioner testified that his last visit with Dr. Chunduri was on June 6, 2013. He did not follow up with the spine surgeon due to lack of health insurance and/or authorization because the respondent would not authorize medical care and he had no health insurance.

On November 27, 2013, petitioner was seen by respondent's medical examiner, Jay Levin, M.D. pursuant to Section 12 of the Act. Petitioner provided Dr. Levin a detailed history of his job including the carbon canister assembly and the installation of seats. (RX1,p.8) Dr. Levin examined petitioner and performed a medical record review. He reviewed Petitioner's medical records, MRI and imaging studies and examined the Petitioner. Dr. Levin opined that Petitioner did not sustain any acute injury to his cervical and lumbar spine acutely from the occurrence of November 28, 2012. He further noted that based on the mechanism of the injury, the pre-existing complains to the cervical and lumbar spine, the degenerative changes at multiple levels as evidenced by the MRI and the physical examination findings, Petitioner's condition was not causally connected to his work and he was capable of returning to full duty work as a line worker., . (RX1,P. 35 and RX1, attached exhibit to Deposition)

In December , 2013, Petitioner was evaluated by orthopedic physician, Rakesh Patel, M.D. of the University of Michigan Health Systems. Petitioner's chief complaint was neck pain greater than lower back pain. (PX7) Dr. Patel's impressions were multilevel degenerative changes of the cervical spine, most marked at C5-6. (Id.) As to the lumbar spine, no impingement was appreciated. (Id.) Dr. Patel's impressions were that petitioner's signs, symptoms and radiographic findings were consistent with cervical spondylosis and muscular in origin. (Id.) Dr. Patel thought the numbness and tingling in his small finger was associated with a cubital tunnel syndrome. (Id.) Dr. Patel recommended physical therapy for cervical range of motion and a referral to an orthopedic hand surgeon to evaluate the elbow for cubital tunnel syndrome. (Id.)

Petitioner testified that he has not seen any physicians since Dr. Patel nor obtained any further therapies or treatment.

KSS

FINDINGS/ANALYSIS

In support of the Arbitrator's Decision relating to *(C) did an accident occur that arose out of and in the course of petitioner's employment by respondent* and *(F) is petitioner's current condition of ill-being causally related to the injury*, the Arbitrator finds the following:

The Petitioner claims that the repetitive motion of installing the carbon canister position caused him to suffer back and neck injuries. The written incident report is dated 11/28/12 and Petitioner testified that his job duties involved fastening shoebox-sized canister with two hoses to the undercarriage of a car with using screw gun. Petitioner testified that said assembly took two to two-and-a-half minutes per car and was performed over 600 times per shift. Petitioner's accident or pain from this assembly work is documented and his testimony regarding the date, time and nature of accident is credible. Based on that, the Arbitrator finds that the Petitioner suffered an accident arising out of and in the course of his employment at Respondent on November 28, 2012. Dr. Rukesh Patel does not give a clear causal connection opinion but rather makes a finding of multilevel degenerative changes. (PX&)

In regards to the causal connection, the Arbitrator finds that Petitioner's current condition is not causally related to his initial work accident of duties from November-December, 2012. Specifically, Petitioner claims his current neck and back pain stem from his repetitive work activities of installing the carbon canisters and that he still continues to suffer neck and back pain from this accident. The Arbitrator has evaluated the opinions of the treating pain management doctor, Dr. Chunduri as well as the opinion of IME, Dr. Levin and is persuaded by the opinion of Dr. Livin for the following reasons. The Arbitrator acknowledges that Petitioner was seen and evaluated by Dr. Patel but Dr. Patel failed to provide any opinion as to causal connection but simply diagnosed Petitioner with multilevel degenerative changes. He notes no acute causes for the Petitioner's current condition.

Dr. Levin is an orthopedic doctor with expertise in evaluating Petitioner's neck and back complains. He conducted a thorough review along with physical examination. His opinion is supported by the imaging findings that show degenerative changes at several levels. There is no acute injury and even under the best case scenario, Petitioner was in the carbon canister assembly line work for a very short duration. Petitioner has greatly exaggerated his work duties in that a 2 to 2 and ½ minute install of canisters, 600 times a day would require 20 plus hours a day. Petitioner's shift is at best, 10 hr, including breaks. The length, nature and duration of Petitioner's job duties support Dr. Levin's opinion on causal connection. Additionally, Petitioner does have prior neck and back pain history and although the history is from 15 years ago, the MRI findings of degenerative condition at several levels, discounts Petitioner's opinion. Lastly, the fact that Petitioner was able to transition to car seat installation duties and was able to continue to work till the holiday break shows that his discomfort/pain due to the work duties was minor and or temporary. The Arbitrator is not convinced in assessing Petitioner testimony and Dr. Chunduri's findings that the current subjective complaints stem from the non acute work incident.

KSS

In support of the Arbitrator's Decision relating to (K), *What temporary total disability benefits are due?* the Arbitrator finds the following:

Petitioner is seeking TTD benefits from January 10, 2012 through November 5, 2014 at the rate of $427.06 per week for 95 weeks. Petitioner worked from respondent till January 9, 2013. He had light work restrictions from Dr. Chunduri for some time and then Dr. Chunduri completely took him off work. Based on the causal connection findings and supported by the opinion of Dr. Levin, the Arbitrator finds that the Petitioner's claim for TTD is denied. Additionally, The Arbitrator notes that per the Petitioner's own testimony he worked both after his initial claim of injury of November 18, 2012 and a subsequent report of December 12, 2012. The Petitioner did not attempt to return to any form of gainful employed and based upon the findings regarding the medical benefits and the lack of testimony regarding Petitioner's initial disablement or any restrictions, the Arbitrator declines to award any interim TTD benefits.

In support of the Arbitrator's Decision relating to *(J) Were the medical services provided to the Petitioner reasonable and necessary? Had Respondent paid all appropriate charges for all reasonable and necessary medical services*, the Arbitrator finds the following:

The Arbitrator declines to award the requested medical bills based on a finding that Petitioner's current condition and treatment is not causally connected to his work accident.

The Petitioner, according to his testimony, sought additional medical care and treatment at the Plant Medical Department and was noted to undergo initial care and treatment and worked with accommodation by his employer. The Arbitrator notes that the medical bills being offered into evidence from Dr. Chunduri were of a conservative nature and do not relate to any specific injury to Petitioner's cervical spine, back, or arms. The Arbitrator notes that the diagnostic studies most notably indicate disc bulges at multiple levels without any herniation with the epidural steroid injections not at the level as noted at the C5-6 protrusion level. Based upon the expert testimony of Dr. Levin, a board certified orthopedic surgeon, the Arbitrator finds that the medical charges and billing there from were not reasonable or necessarily related to cure the effects of the alleged accidental injury and therefore the Arbitrator declines to award same.

In support of the Arbitrator's Decision relating to *(M) Should penalties and fees be imposed upon respondent*, the Arbitrator finds the following:

Petitioner request for penalties and fees is denied as there is a finding of no causal connection and Respondent has a reasonable basis, based on well founded medical opinion of Dr. Levin for denying Petitioner's claim. The Arbitrator is persuaded by the Independent Medical Evaluation report of Dr. Levin from November 27, 2013 and his supplemental report of January 7, 2014. The Evidence deposition testimony of August 12, 2014 gives the Respondent a good faith basis with which to deny this claim based upon the lack of information and treatment and the Arbitrator declines to award any penalties or attorney's fees pursuant to Section 16 or 19(k) of the Act.

Kelli Steffen
Signature of Arbitrator

1/22/15
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dale Halstead,

Petitioner,

16IWCC0338

vs.

NO: 13 WC 03136

Caterpillar, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, liability for medical expenses, and the nature and extent of the injury and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below on the issue of causal connection with respect to the right shoulder and otherwise affirms and adopts the Decision of the Arbitrator which is attached hereto and made a part hereof. We note that Respondent accepted liability for Petitioner's left shoulder injury but sought a reduction of the corresponding award. After considering all of the evidence, we hereby affirm the Arbitrator's award of 10% of the person as a whole pursuant to §8(d)2 for the left shoulder injury. For the reasons set forth below, we find that Petitioner failed to prove that his condition of ill-being in his right shoulder is causally related to his employment by Respondent on May 6, 2012.

Petitioner was 52-years-old on the alleged date of accident. He was employed in a sedentary management position. Petitioner had preexisting bilateral shoulder conditions with a substantial history of right shoulder treatment, including an arthroscopy with a subacromial decompression and debridement of the rotator cuff in 1997. He underwent additional surgery in 1999 to address posterior instability, and subsequently participated in a functional capacity evaluation resulting in his permanent transfer to a management position at Respondent's Aurora facility.

From May 2, 2012 through May 6, 2012 Petitioner did not work his usual sedentary

office position at Respondent's Aurora facility. Instead, he operated a friction welding machine at Respondent's Joliet facility. The reassignment was precipitated by a pending labor strike; management employees were trained to fill labor jobs on a contingency basis. As a result of the work stoppage, Petitioner filled the position of friction welding machine operator beginning on May 2, 2012. On February 1, 2013, Petitioner filed a worker's compensation claim alleging that he sustained injuries to both shoulders arising out of and in the course of his employment by Respondent on May 6, 2012. Petitioner did not allege a specific occurrence, but that his work in the friction welder position over the course of five days caused repetitive trauma injuries to both shoulders. Respondent accepted liability for left shoulder treatment but denied Petitioner's claim with respect to the right shoulder.

On May 9, 2012, Petitioner completed an incident report stating "Shoulder (left) started to hurt several days earlier. On 5/8 upon waking the pain was strong so I called my supervisor. On 5/9 he sent me to medical." There is no evidence that Petitioner made any complaints during his training period or while performing the contingency assignment. Petitioner was examined at Respondent's medical clinic on May 9, 2012. Petitioner reported left greater than right bilateral shoulder pain after performing shoulder-level work. Dr. Roggenkamp diagnosed a flare-up of Petitioner's chronic condition and allowed Petitioner to return to his regular sedentary position at the Aurora facility. Petitioner reported to Dr. Roggenkamp that his surgeon had not allowed him to do any factory work. The records show that in June of 2010 Petitioner's surgeon, Dr. Evans, restricted Petitioner from performing overhead work or lifting heavy weights. These restrictions were reviewed by Dr. Neu at Respondent's clinic as recently as September of 2011.

Petitioner returned to Respondent's clinic on May 11, 2012 and reported to Dr. Neu that his right shoulder was "settling down nicely," although his left shoulder continued to be painful and interfere with his sleep. According to Dr. Neu's notes, Petitioner expressed concern that he "pulled something loose" and wanted further evaluation for the left shoulder, which Respondent ultimately approved. On May 14, 2012, Petitioner returned to Dr. Neu at Respondent's clinic and reported that his right shoulder had returned to its longstanding baseline, a "low level of occasional discomfort."

On July 3, 2012, Petitioner returned to his prior surgeon, Dr. Evans, "for a follow-up of his left shoulder after a reinjury." Dr. Evans noted he last saw Petitioner in June of 2010. He noted that Petitioner works in management, but that as a result of a strike Petitioner was asked to do floor work once again: "He did overhead work for several days and following the overhead work began having problems with both shoulders once again. He notes pain along the lateral side of his left arm, and some right shoulder pain as well." Dr. Evans referred Petitioner to physical therapy for his left shoulder. On July 5, 2012 Petitioner began left shoulder physical therapy at Physical Therapy Plus. The records show that Petitioner reported having to do an assignment in Joliet with overhead activities, despite restrictions for his shoulder. He reported that he was only able to do the job for a short time because he had pain throughout the left shoulder that interfered with his job performance. The records show that the physical therapy evaluation and recommendations pertained to the left shoulder only.

In August of 2012, during a physical therapy session, Petitioner identified a palpable lump that had recently appeared on his right deltoid. The therapist noted that Petitioner did not

report any injury associated with the appearance of the mass. On September 18, 2012, Dr. Evans referred Petitioner for an MRI to evaluate the right deltoid and Respondent denied right shoulder treatment under workers' compensation. Petitioner continued treatment for his left shoulder on an authorized basis and underwent left shoulder surgery by Dr. Evans on January 4, 2013. A right shoulder MR arthrogram was eventually performed on January 29, 2013 at Silver Cross Hospital. The results do not mention the right deltoid mass but indicate partial thickness supraspinatus and infraspinatus tendon tears in the right shoulder. We note that the records of Dr. Evans are absent any further mention of the right deltoid mass that instigated the right shoulder examination and treatment.

On June 13, 2013, Dr. Evans wrote a causation letter relating the condition of both of Petitioner's shoulders to injuries sustained as a result of work duties. Dr. Evans wrote: "On several occasions he has related to me that both shoulder injuries are referable to the heavy and repetitive lifting required for his work. In addition, after his left shoulder surgery his right shoulder has been required to handle a heavier load of work. As a result, even though there is not a clear incident to link his shoulder pain to his work, I do think that his right shoulder symptoms and the treatment I have recommended are referable to his work." Dr. Evans performed right shoulder surgery on June 26, 2013. The post-operative diagnosis was "right shoulder degenerative appearing superior labral and biceps anchor tear without evidence of rotator cuff tear or impingement."

Dr. Evans testified via deposition on January 13, 2014 and reiterated his causal connection opinion, although he acknowledged it was based solely on Petitioner's history of performing heavy lifting and overhead work in the Joliet factory. Dr. Evans thought it was "reasonable to consider [Petitioner's] work related incident as if not causative, definitely exacerbating his symptoms" and he further specified that "repetitive overhead lifting would be the main cause." Cross-examination revealed that Dr. Evans had incomplete and inaccurate knowledge of Petitioner's work history and activities. Dr. Evans was not aware that Petitioner held the labor position for only five days before he reported injuries and returned to sedentary office work on the orders of Respondent's physician. Dr. Evans did not review any records corresponding to the treatment at Respondent's medical clinic between May 9, 2012 and July 3, 2012. Furthermore, Dr. Evans was not aware that Petitioner completed an incident report only with respect to the left shoulder, or that although Petitioner initially reported some increased right shoulder pain he later reported a return to his baseline level of right shoulder discomfort after resuming sedentary office work. Indeed, the causation letter written by Dr. Evans shows that Dr. Evans believed that Petitioner had been required to handle heavy work duties with his right arm even after left shoulder surgery in January of 2013, where in fact Petitioner returned to his regular office work after May 9, 2012. We further note that Dr. Evans acknowledged the right shoulder MRI was ordered for further evaluation of Petitioner's right upper arm mass.

At hearing, Petitioner testified that the friction welding position required shoulder-level work. He admitted there was actually no overhead activity, but he testified that he was required to push and pull forcefully with his left arm and lift heavy weights without assistance. We note that Petitioner's testimony was not corroborated by that of Mr. Tammen or Ms. Allen. Mr. Tammen and Ms. Allen were both very familiar with the performance of the friction welder job duties and testified credibly. We acknowledge Petitioner's testimony that functional lift assist

16IWCC0338

equipment was not available to him, but his testimony was contradicted by the testimony of Mr. Tammen and Ms. Allen. Furthermore, although an ergonomic report from 2008 indicates that workers were observed manually lifting rather than using assistive devices due to "time and space" concerns, by 2012 lifting guidelines had changed and manual lifting of heavy weights was no longer accepted. Petitioner testified that as a manager he was very familiar with all lifting guidelines and safe lifting practices.

After considering all of the evidence, we conclude that nothing in the record, not even Petitioner's own testimony, established the basis of fact upon which Dr. Evans relied, and therefore the causal opinion of Dr. Evans with respect to the right shoulder is not persuasive. We find that Petitioner's right shoulder treatment, precipitated by the appearance of an unrelated right deltoid mass, bears no credible causal relation to Petitioner's employment by Respondent on May 6, 2012. We further question the credibility of Petitioner's testimony that he performed forceful pushing and pulling with his right arm, while his left hand merely worked the switches on a pendant controller. This is plainly inconsistent with Petitioner's medical records and his incident report of May 9, 2012 alleging a left shoulder injury as a result of strenuous left arm work. In conclusion, we find that Petitioner failed to establish a causal connection between his right shoulder condition and his employment by Respondent on May 6, 2012.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award of permanent partial disability and medical expenses as related to Petitioner's right shoulder is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $695.78 per week for a period of 50 weeks, for the reason that the injuries Petitioner sustained to his left arm caused the 10% loss of the person as a whole, as provided in §8(d)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 $34,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 18 2016
RWW/plv
o-03/23/16
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0338

HALSTEAD, DALE
Employee/Petitioner

Case# 13WC003136

CATERPILLAR (AURORA)
Employer/Respondent

On 5/26/2015, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0190 PETER F FERRACUTI & ASSOCIATES
JENNIFER L KIESEWETTER
110 E MAIN ST
OTTAWA, IL 61350

2851 CATERPILLAR INC
ELIZABETH C LeBARON
PO BOX 348
AURORA, IL 60507

16IWCC0338

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dale Halstead
Employee/Petitioner

v.

Caterpillar (Aurora)
Employer/Respondent

Case # **13** WC **3136**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **New Lenox**, on **March 6, 2015**. After reviewing all of the evidence presented, the undersigned Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On May 6, 2012, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $64,809.68; the average weekly wage was $1,246.34.

On the date of accident, Petitioner was 52 years of age, *married* with no dependent children.

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

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

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

Respondent is entitled to a credit of $37,904.66 under Section 8(j) of the Act. *See* AX1.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has established a causal connection between his bilateral shoulder condition and his accident at work on May 6, 2012.

Medical Benefits

Respondent shall pay reasonable and necessary medical services and out-of-pocket expenses reflected in Petitioner's Exhibit 1, totaling $114,388.52, that remain unpaid pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $37,904.66 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. *See* AX1.

Permanent Partial Disability: Person as a whole (Right Shoulder)

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 75 weeks, because the injuries sustained caused the 15% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Permanent Partial Disability: Person as a whole (Left Shoulder)

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

May 18, 2015
Date

MAY 26 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Dale Halstead
Employee/Petitioner

v.

Caterpillar (Aurora)
Employer/Respondent

Case # **13** WC **3136**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues[1] in dispute at this hearing include causal connection with regard to Petitioner's right shoulder condition, Respondent's liability for certain unpaid medical bills relating to the right shoulder, and the nature and extent of Petitioner's injury. Arbitrator's Exhibit[2] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Petitioner testified that he is currently a manufacturing engineer for Respondent Caterpillar and held that title on May 6, 2012. However, on May 6, 2012, he was performing different work for Caterpillar in the factory due to contract negotiations. He was placed in the Joliet factory and was friction welding tubes.

Prior to May 2012, Petitioner did have prior injuries and medical treatment to both shoulders. Dr. Velagapudi performed surgery on Petitioner on March 18, 1997 for right shoulder impingement in the form of a right shoulder arthroscopic procedure with subacromial decompression and debridement of the rotator cuff. RX2 at 121. On January 7, 1999, he underwent additional surgical intervention on his right shoulder performed by Dr. James Boscardin for posterior instability of the right shoulder including the placement of anchors. RX2 at 75.

A functional capacity evaluation completed on October 8, 1999 indicated a valid representation of his work abilities and placed him at the medium level with precautions for avoiding prolonged unsupported reaching with the right arm and avoidance of sudden, forceful push/pull activities. RX2 at 87. The Caterpillar Medical Department Records also contain voluminous notes regarding updated restrictions which result in his transfer to this management position. RX2 at 49-59.

Petitioner was seen in the Caterpillar Medical Department on May 13, 2008 at which time his physical restrictions were discontinued by Dr. Roggenkamp, but the discontinuation appears to be related to his continuation in the management position. Dr. Roggenkamp noted at that time that Petitioner had not been to Caterpillar Medical Department since 2004. RX2 at 5.

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[1] The parties stipulated that causal connection and medical bills were not in dispute with regard to Petitioner's left shoulder, and that temporary total disability benefits were not an issue. AX1. Petitioner testified that he received either temporary total disability or management pay continuation from Respondent for any periods that he was off work undergoing medical care. Tr. at 37.

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

On April 29, 2010, Petitioner underwent a left shoulder arthroscopy for left shoulder impingement with partial thickness undersurface supraspinatus tear. He was discharged in June 2010. PX5. On June 7, 2010, he returned to Caterpillar Medical Department and was returned to his regular job at the time as a manufacturing engineer and it was noted that he can totally avoid physical work. RX2 at 156.

As a manufacturing engineer, Petitioner testified that he is in charge of setting up processes to build the structures that Caterpillar builds in the Aurora plant. He has a two pound weight limit. The friction welding job is more physically demanding than his engineering job. Petitioner testified that prior to May of 2012, he had never performed friction welding. He started that factory job within a few days of May 6, 2012.

Petitioner's prior medical treatment is also reflected in the Silver Cross Hospital and Loyola University Medical Center records. PX2, PX5-PX8. At the time of this accident, Petitioner testified that he was already on restrictions and had been performing the manufacturing engineer position based upon prior shoulder restrictions which were placed on him in 1999. He was promoted to management in about 2006. Petitioner is right-hand dominant.

Friction Welding

Petitioner testified that friction welding tubes is taking a tube of various lengths between 2-5 feet with different diameters and friction welding the eye on the end of the tube. He stated that it would require taking the tube with various lifting devices and lift it out of a carrel brought to the work site, hooking a magnet to it, and then having to lift it, put it in place, and load it into the friction welding machine, which has already been loaded with the eyes. Petitioner explained that the eyes weigh about 45-50 pounds and he would have to load them. After this is done, he would perform the process with the machine, unload the machine, and go on to the next part.

Petitioner testified that Respondent provided a semi-automatic stationary lifting device called a manipulation machine. He testified that this machine was down much of the time that he was there and that the range that he had did not involve the use of the manipulator so he would have to reach into the bottoms of the tubs, lift the eyes out, put them on a piece of plywood, stretch across the tub, and put them in position on the machine. He performed this job the first week of May 2012.

Petitioner testified that the tubs were approximately 3-3 ½ feet tall to the best of his recollection. As he would load, he explained that he would be reaching into the bottom of the tub. This would require him to bend over and reach down to lift the eye onto the plywood, take it from the plywood, and load it into the machine.

Petitioner further testified that he would have to reach about 2 ½ feet into the machine to load the eye into the mechanical part of the machine. He explained that the other part of the process would be loading the tube with the use of a magnet. This would be performed by hooking the magnet to the tube and lifting the tube to a certain level. It also required positioning the tube into the machine and loading it into the carriages that hold it. Petitioner estimated that the hand-held magnet would be about 5-6 feet high depending on one's height. Petitioner testified that he is 5'6 tall.

At the time that he was performing this job, Petitioner worked 12 hours per day. He could not recall a definitive number as to how many times he would perform the process he described, but he estimated that it would be multiple times per hour.

16IWCC0338

Regarding the friction welding process, Petitioner reviewed Respondent's Exhibit 5, which is a description of the friction welding job that he was performing at the time of the injury. He testified that it was not him pictured in the photographs, but that the description is accurate and that picture number 5 demonstrates loading the cylinder with the magnet that he described. Petitioner testified that he was not familiar with the procedure performed in picture number 6, which appeared to be either measuring or the use of a lifting device with which he was not familiar. Petitioner also testified that he is right handed so the hoist would be operated with his left hand. He testified that the manipulation of loading the part would be with his right arm pretty much in the matter shown by the worker in the photograph. Petitioner explained that he would use his left hand for not only operating the hoist but also for lifting the eyes out of the tub and for the set up process.

Petitioner explained that his particular job, at present, is to set up work for Respondent. Thus, he explained that he is aware of what work is considered to be overhead work. Petitioner testified that the set up process for this machine would meet that definition because it required work at the shoulder level, but with his arms extending forward. Petitioner also described reaching at 90 degrees about 2-2½ feet into the machine to perform the process and that the set up process required changing the eyes, which was performed daily, sometimes even hourly, depending on the work orders. On cross-examination, Petitioner testified that he is also familiar with safe lifting due to his position as a manufacturing engineer.

Petitioner testified that he would have used the pendant control in his left hand and done the manipulation in his right hand since he is right handed. He testified that the manipulator was present in the area of the job to use to lift the eyes, but that it was non-functional part of the time. Petitioner also testified that he would have been lifting the eyes manually, by hand, from the tub. He explained that this is how he was trained to lift the eyes. Petitioner further identified that in photograph number 2 of Respondent's ergonomic worksite evaluation, the worker was lifting the eyes by hand. *See* RX5.

Accident

Petitioner testified that on or about May 6, 2012 he noticed that his shoulders were getting sore in performing the job and he had a conversation with his shop floor supervisor. Petitioner remembered that he called him on the phone while he was driving to work and that he told him that both shoulders felt inflamed that day.

Petitioner did not recall when he last had shoulder treatment prior to May 2012, but he did recall that he was not having any problem performing his manufacturing engineer job duties. The Caterpillar Medical Department records contain multiple records regarding his prior bilateral shoulder conditions. The last note prior to his accident on May 6, 2012 was from March 31, 2009 at which time Petitioner was hoping to have his restrictions removed so that he could return to the floor as a welder. Dr. Neu noted that he had good arc of his shoulders, but did have crepitus. They agreed on his restrictions. RX2 at 50.

Petitioner completed portions of an incident report dated May 9, 2012. RX2 at 1. The incident report describes left shoulder pain and indicates that the Petitioner felt that the machine required too much heavy push pull with arms elevated due to his prior shoulder injuries. Id.

Medical Treatment

16IWCC0338

On May 9, 2012, he reported to Caterpillar Medical Department. Petitioner testified that he noticed soreness in his shoulders and difficulty sleeping due to soreness at that time. He was prescribed therapy and returned to his normal position for Respondent.

Petitioner was also assessed by a nurse in Respondent's Medical Department and an initial nursing assessment dated May 9, 2012 noted Petitioner's complaints of pain in both shoulders with pain on the left being greater than pain on the right. RX2 at 2-3. Petitioner reported his prior surgeries to the shoulders and noted that he was working above shoulder level all day. Id. Petitioner completed a pain diagram on May 9, 2012 describing sharp pain to his left shoulder, aching pain to his right shoulder, and an arthritic pain in his low back. Id. Petitioner then saw Dr. Neu in Respondent's Medical Department for an evaluation. RX2 at 5.

On May 11, 2012, Dr. Neu noted that Petitioner's right shoulder was settling down, but that he continued to have concerns about his left shoulder difficulty. RX2 at 4-6. Dr. Neu recommended continued restrictions and a safety evaluation at Joliet. Id.

Petitioner returned to Dr. Neu on May 14, 2012 reporting that his right shoulder was back to baseline and that his left shoulder was still causing lack of sleep and other complaints. Id. Dr. Neu referred Petitioner to Loyola. Id.

On July 3, 2012, Petitioner presented to Dr. Douglas Evans, treating orthopedic surgeon at Loyola University Medical Center, with complaints of re-injury of his shoulders. PX6 at 184-208. Specifically, Dr. Evans noted the following:

> I last saw him in June of 2010. He works in Management for the Caterpillar Company. They are undergoing a strike and as a result he was asked to do floor work once again. He did overhead work for several days and following the overhead work began having problems with both shoulders once again. He notes pain along the lateral side of his left arm. He does have some right shoulder pain as well. He has difficulty with overhead activity and reaching behind him.

Id. Dr. Evans noted evidence of subacromial decompressions bilaterally with x-rays and diagnosed bilateral shoulder pain with a re-injury at work in May of this year with symptoms most consistent with impingment on the left and possible impingement on the right as well. Id. He recommended work restrictions as well as physical therapy. PX5-PX8. Concurrently, Petitioner continued to follow up with Dr. Neu in Respondent's Medical Department. RX2.

As referred by Dr. Neu, Petitioner underwent a left shoulder MRI on August 17, 2012. PX4. The interpreting radiologist noted the following: mild to moderate tendinosis involving the mid-to-posterior insertional fibers of the supraspinitus tendon and anterior insertional fibers of the infraspinatus tendon without tear, an intact biceps tendon, mild subacromial/subdeltoid bursitis, and mild acromioclavicular degenerative joint disease. *Id.*

Petitioner returned to Dr. Evans on September 18, 2012. PX5 at 209-230. Dr. Evans noted that Petitioner's physical therapy was stopped after Dr. Neu read the MRI of the left shoulder. Id. Petitioner also reported pain in the right shoulder and a mass was noted. Id. Dr. Evans noted that the left shoulder MRI revealed tendinopathy versus a partial thickness tear on the supraspinatus. Id. He diagnosed left shoulder impingement

16IWCC0338

with rotator cuff tendinopathy and recommended an MRI of the right shoulder to evaluate the deltoid mass. Id. Dr. Evans administered a subacromial injection to the left shoulder. Id.

On October 9, 2012, Dr. Evans again requested a right shoulder MRI. PX5 at 231-253. Petitioner reported continued left shoulder pain and pain in the mass in the right shoulder. Id. He further stated that since the left shoulder had not responded to therapy, injection, and anti-inflammatories, he was recommending surgical intervention. Id.

Petitioner underwent the right shoulder MRI at Silver Cross Hospital on October 27, 2012. PX2 at 146. The interpreting radiologist noted the following: (1) an intact rotator cuff; (2) surgical changes noted at the glenoid; (3) no enhancing mass; and (4) mild degenerative changes of the acromioclavicular joint causing moderate impression on the supraspinitus myotendinous junction may contribute to the clinical syndrome of external impingement. *Id.*

On January 4, 2013, Petitioner underwent left shoulder arthroscopy performed by Dr. Evans. PX5 at 54-55. Pre-operatively, Dr. Evans diagnosed left shoulder impingement with possible superior labral tear. Id. He performed an arthroscopic debridement of the superior and anterior labrum, as well as subacromial bursa, arthoscopic superior labral repair, arthroscopic subacromial bursectomy. Id. Post-operatively, Dr. Evans diagnosed Petitioner with left shoulder mild bursitis with superior labral tear. Id.

Petitioner returned to Dr. Evans on January 8, 2013 and underwent injections in his right shoulder. PX5 at 254-277. Dr. Evans also diagnosed a partial thickness rotator cuff tear in the right shoulder and recommended physical therapy for both shoulders. Id. He then recommended an MR arthrogram for the right shoulder since only an MRI was performed. Id. Petitioner began physical therapy at ATI Physical Therapy. PX9.

On January 29, 2013, Petitioner underwent an MR arthrogram of the right shoulder. PX2 at 103-106. The interpreting radiologist noted no evidence of partial or full thickness right rotator cuff tear. Id. However, in comparison with Petitioner's October 27, 2012 MRI, he noted the following: (1) findings consistent with a new anterosuperior labral tear extending from 12-3 o'clock and a previous posterioinferior labral repair with no evidence of a re-tear; (2) low grade partial thickness tears of the supraspinitus and infraspinatus tendons; (3) stable mild acromioclavicular osteoarthritis; and (4) moderately thickened middle and inferior glenohumeral ligaments indicating remote injury. Id. Petitioner also underwent a right shoulder injection. PX2 at 98, PX5-PX8.

Petitioner returned to Dr. Evans on February 5, 2013. PX5 at 278-296. Petitioner reported that the left shoulder was progressing well, but that he had continued problems with the right shoulder. Id. Dr. Evans reviewed Petitioner's MR arthrogram noting dye leakage around the superior labrum as well as low grade partial thickness tears of the supraspinatus and infraspinatus tendons. Id. He diagnosed status post left shoulder labral repair and a right shoulder partial thickness supraspinitus repair. Id. He recommended continued physical therapy for both shoulders. Id.

On April 2, 2013, Petitioner reported that he was doing well in physical therapy and had returned to full duty work, but had continuing pain in the right shoulder and inability to do right shoulder physical therapy because of scheduling and insurance issues. PX7 at 48-49. Dr. Evans recommended continued physical therapy focusing more on the right shoulder. Id. Beginning April 9, 2013, Petitioner had physical therapy performed at Silver Cross Hospital. PX2.

16IWCC0338

On May 21, 2013, Petitioner reported to Dr. Evans that the left shoulder continued to improve, but the right shoulder was not making progress. PX7 at 46-47. He also reported that he was discharged from physical therapy due to lack of progression. Id. Dr. Evans recommended continued exercises with regard to the left shoulder and surgical intervention of the right shoulder. Id.

On June 13, 2013, Dr. Evans authored a narrative letter in which he noted Petitioner's reports that his bilateral shoulder injuries were referable to the heavy and repetitive lifting he was required to perform at work. PX3 (Dep. Exh. 2). Dr. Evans also noted that Petitioner was required to handle a heavier load of work with his right shoulder after he had left shoulder surgery. Id. He stated, "[a]s a result, even though there is not a clear incident to link his shoulder pain to his work, I do think that his right shoulder symptoms and the treatment I have recommended are referable to his work." Id.

On June 26, 2013, Petitioner underwent right shoulder surgery performed by Dr. Evans at Loyola University Medical Center. PX7 at 84-85. Pre-operatively, Dr. Evans diagnosed right shoulder superior labral tear with possible impingement or rotator cuff tear. Id. He performed a right shoulder arthroscopy with debridement of the superior, anterior and posterior labrum, a biceps tenotomy with open subpectoral biceps tenodesis, and subacromial bursectomy. Id. Post-operatively, Dr. Evans diagnosed right shoulder degenerative appearing superior labral and biceps anchor tear without evidence of rotator cuff tear or impingement. Id.

Petitioner returned to Silver Cross Hospital for physical therapy beginning on July 2, 2013. PX2. On August 6, 2013, Petitioner returned to Dr. Evans with reports that he was doing well in physical therapy with minimal pain. PX7 at 40-41. His pre-operative pain was improved or gone. Id. Dr. Evans recommended continued physical therapy with strengthening. Id.

On October 1, 2013, Petitioner saw Dr. Evans for the last time. PX7 at 205-210. He reported that he was doing well with physical therapy and was back at work full duty. Id. He also reported that his pre-operative pain was gone. Id. Dr. Evans released Petitioner from care. Id.

Petitioner then returned to Dr. Neu at the Caterpillar Medical Department on October 4, 2013. He continued him in his management position and indicated that he should follow up with the Medical Department before any manual work in the future. RX2 at 11.

Dr. Evans – Deposition Testimony

Petitioner called Dr. Evans as a witness and he have testimony at an evidence deposition taken on January 13, 2014. PX3. Dr. Evans is a board-certified orthopedic surgeon. PX3 at 4; PX3 (Dep. Exh. 1). Dr. Evans testified about the medical treatment he rendered to Petitioner and offered opinions about Petitioner's bilateral shoulder condition. *See generally* PX3. Dr. Evans testified that Petitioner was a prior patient of his in 2010. PX3 at 4.

Dr. Evans testified consistent with his narrative letter that Petitioner's shoulder injuries were related to his work and work injury around the date of May 2012 based on the information Petitioner provided to him as well as based on the description of his job duties and the symptoms that Petitioner was having. PX3 at 11-12. Specifically, he explained that it was Petitioner's repetitive overhead lifting activities at work that were the main cause. PX3 at 12-13.

On cross examination, Dr. Evans testified that he did not have any of the medical records from Caterpillar when he saw Petitioner in 2012. PX3 at 15-16, 17. He acknowledged that Petitioner had been diagnosed with multidirectional instability of the right shoulder as early as 1997 and that he did not review Petitioner's functional capacity evaluation from 1999 releasing Petitioner with multiple restrictions. PX3 at 16-17.

Dr. Evans testified that he understood from Petitioner that he was performing more manual labor when he first saw him on July 3, 2012, but otherwise Petitioner's job was in management in a sedentary-type role. PX3 at 17-18. He acknowledged that he did not know whether Petitioner started the manual-type labor on May 2, 2012 and concluded those duties on May 8, 2012, he did not have any ergonomic evaluation or job description regarding Petitioner's duties from May 2-8, 2012 available for review, and he did not know if Petitioner had a hoist available for use during this period of time. PX3 at 18-20.

Dr. Evans also understood that Petitioner's complaints were related to repetitive physical duties at work. PX3 at 19. He testified that if Petitioner was not performing overhead activities during this period of time, it could be significant to his causal connection opinion. PX3 at 20. Dr. Evans did not think that the operation of a hoist by pushing buttons between waist and shoulder height would cause or aggravate a right shoulder condition. PX3 at 20-21.

Dr. Evans further testified that if the job duties required considerable pushing or pulling above shoulder level for an entire shift, that those types of job duties are the kind of overhead activities that he would expect to exacerbate the condition. PX3 at 21. If Petitioner was not performing pushing and pulling activities above shoulder height, that could impact his opinion given regarding causation. PX3 at 22.

Dr. Neu – Deposition Testimony

Respondent called Dr. Neu as a witness and he have testimony at an evidence deposition taken on September 9, 2014. RX1. Dr. Neu testified that he has been employed by Respondent for over 38 years and is currently the Area Medical Director. RX1 at 4. He is board-certified in occupational medicine. RX1 at 4-5. Dr. Neu also testified that he evaluates injuries to determine if they are work-related under OSHA. RX1 at 7.

Dr. Neu had evaluated Petitioner after his 1997 right shoulder injury and after his left shoulder surgeries. RX1 at 9-11. As of September 19, 2011, Petitioner had work restrictions including no lifting/pushing/pulling over 40 pounds, and no overhead work. RX1 at 11.

Dr. Neu testified that he determined that Petitioner's May 6, 2012 injury was work-related for OSHA reporting purposes. RX1 at 16. He explained that when Petitioner first came in he indicated that he had chronic trouble with both shoulders but that his focus as clearly on the left. Id. Dr. Neu further testified that it was Dr. Roggenkamp who examined Petitioner on May 9, 2012 and assessed Petitioner to have had a flare-up of chronic left shoulder pain with a history of multidirectional instability. RX1 at 16, 19. He testified that there was no work within the restrictions provided by Dr. Roggenkamp for the contingency work force assignments. RX1 at 19.

Dr. Neu first saw Petitioner following the May 6, 2012 injury on May 11, 2012. RX1 at 19-20. He testified that Petitioner reported improvement in his right shoulder but that his left shoulder continued to hurt him and he had difficulty sleeping. RX1 at 20. Dr. Neu further testified that he received an ergonomic work site evaluation

dated April 23, 2008 following his request for a safety evaluation from Joliet from Mr. Shiring for the job of the friction weld machine operator. RX1 at 20-21. The safety evaluation indicated that the 2008 evaluation was done prior to the current formal lifting rules and that the parts on the job were now lifted by manipulator in 2012 and not by hand but that the remainder of the job was the same. RX1 at 21.

Dr. Neu testified that on September 19, 2012 Petitioner reported that he had pain in his right arm when he lifted his arm and that he had a bump in his right shoulder that "he noticed it last night and he did not know why it appeared." RX1 at 28. According to Dr. Neu, Petitioner reported that he found the lump while undergoing physical therapy, but Petitioner did not report that he injured himself in physical therapy. RX1 at 28-29.

Ultimately, Dr. Neu testified that it was his opinion that Petitioner's right shoulder was not aggravated by nor injured by the work activities between May 1, 2012 and May 6, 2012 because Petitioner was merely operating the hoist buttons with his right hand and that the parts for the position were lifted by a manipulator. RX1 at 31-32. Dr. Neu testified that in reaching this opinion he relied on Petitioner's report to him that his right shoulder pain was back at baseline by May 12, 2012 and the understanding that there was no overhead work with his machine with the right arm. RX1 at 32-33.

On cross examination, Dr. Neu testified that he was not aware whether the particular job was still being performed at the Joliet plant as of the date of the deposition. RX1 at 36. It was Dr. Neu's understanding that the pushing and reaching of the part reflected in the photographs along with the job description were done by the hand that was not operating the hoist. RX1 at 36-40.

James Tammen

Respondent called James Tammen ("Mr. Tammen") as a witness. He testified that he has been employed by Respondent for approximately 21 years and is currently working for Respondent in Sumpter, South Carolina as a supplier development engineer. Mr. Tammen testified that his position in 2012 was as a lead operations supervisor and he operated the friction welder for approximately one year prior to becoming a supervisor. Mr. Tammen testified that his role during the contingency would have been to greet Petitioner and go over the training paperwork, but that the actual union employee would train him. However, Mr. Tammen testified that he would have been present as supervisor when Petitioner reported to work for his contingency assignment in May of 2012.

Mr. Tammen testified that the training period was roughly two weeks and it would be fair to say that he observed Petitioner 20-25% of the time. He testified that he would have had to submit documentation regarding Petitioner's training which included the standard work for the job. Mr. Tammen testified that, at no time during his training, did Petitioner tell him that he had a shoulder condition or request a medical evaluation.

Mr. Tammen identified Respondent's Exhibit 5, an ergonomic work site evaluation and document from Dr. Neu dated April 23, 2008. RX5. He testified that it does accurately describe the friction welder position as it was operated in 2012 except for the picture of the individual reaching inside of the tub. He testified that the difference is that anything over 35 pounds requires a lifting device and that this particular device would be a magnet that picks up such items out of the tub. Mr. Tammen explained that there would only be three parts that the operator could pick up by hand because these weighed six pounds. With regard to moving eyes, Mr. Tammen testified that the procedure would be to use the magnet to pick the eye up out of the tub and to use the manipulator to move the part over to place the eye into the fixture and into the machine.

Mr. Tammen described the manipulator as an air-powered tool with two grips that the operator would operate using two levers with buttons. He explained that this would require minimal force to operate and that the six-way crane has a magnet attached that is pulled by cables and would be operated by a pendant. Typically, Mr. Tammen explained that the operator would have one hand on the pendant and use the other hand to steady the load he was handling. Mr. Tammen estimated that the pendant hung around chest level and the operator's other hand would be located below shoulder height handling the piece or magnet itself. He is just under 6' tall. Mr. Tammen testified that the highest the operator's hand would be located was with loading and unloading the part; approximately at shoulder height as shown in pictures 4, 5, and 7 of Respondent's Exhibit 5. RX5. In an eight hour shift, the operator would perform 1-2 set-ups and approximately 4-8 parts would be run an hour depending on the part. During a 12 hour shift, the operator would get a 30 minute lunch and three 15 minute breaks.

According to Mr. Tammen, the only manual work that would be done with setup would involve bolts that weigh maybe 1-2 pounds, and anything heavy would be lifted with a lifting device. He testified that at this station, no heavy lifting, use of force, overhead work, or pushing/pulling was required. He testified that if the manipulator was down, either he or another supervisor would have been notified and it would have been called in to get fixed. Mr. Tammen explained that the use of the manipulator would have been included in the training because it was part of "standard" work. He also testified that he would have been disciplined if he did not report a work injury that was reported to him or follow proper procedure.

On cross-examination, Mr. Tammen testified that he performed the friction weld position in the same area that Petitioner performed it, and that the setup would have been the same including everything located at the same height. However, he acknowledged that he has seen a worker doing that job without the use of a manipulator and that worker was written up. Mr. Tammen also acknowledged that the manipulators do break down, but the turnaround time for repair would have been 1-2 hours with the maintenance department even during the strike.

With regard to Petitioner's claimed condition in the shoulders, Mr. Tammen testified that the first time he was ever contacted about this was in May of 2014. He testified that if he saw a contingency worker not using a manipulator, that contingency worker would have been disciplined just as a union employee would have been disciplined.

Joy Allen

Respondent called Joy Allen ("Ms. Allen") as a witness. She testified that she is employed at Respondent's Joliet facility for approximately eight years, currently as a senior Engineer. In 2012, she was working as a process engineer.

Ms. Allen explained that as a process engineer she would control the quality and the parameters for the friction welding operation. She would have been working on the shop floor at the friction welders during the contingency period in May 2012 and she operated a friction welder. Ms. Allen testified that she would have participated in the training as well.

Ms. Allen recalled meeting Mr. Halstead during the contingency training and making sure he understood the process. She testified that she worked from 5:00 a.m. to 5:00 p.m. during the contingency and overlapped with all shifts. She operated the friction welder during the contingency and is familiar with the process. Ms. Allen

testified that the position of a friction welder does not involve any heavy pushing/pulling, heavy lifting, or overhead work.

She explained that the eye would be moved with the use of a pneumatic manipulator and the bar would be lifted with a magnet attached to an overhead hoist. She testified that it does not require any forceful pushing or pulling, just getting it into position. The hoist is operated by a pendant which, according to Ms. Allen, would be operated at a comfortable level for the operator between waist and chest height. Ms. Allen explained that the hand not used to operate the hoist would be used to keep the part in control and would be on the cylinder or bar that it is lifting. She testified that the movement of the bar would not require any force.

Ms. Allen also testified that there was no overhead work at the friction welder. The highest she would raise or lower her arm would be whatever height the pendant hung depending on operator's comfort level. The other arm would be chest height and she testified that you would have to lift it over that to get it out of the machine, so approximately shoulder height.

With regard to setting up the friction welder, Ms. Allen testified that there is no lifting or overhead work involved in the set up changing at the machine. The only lifting would include parts weighing about four pounds. Ms. Allen did not recall any problems with the manipulator at the friction weld station during the first week of May. She explained that there were only three parts that were supposed to be lifted by hand so the machine would be down if the manipulator was down. The "standard" work would give instructions on how to lift everything.

Ms. Allen testified that she did have an opportunity to observe Petitioner operating the friction welder during the first week of May 2012. She did not remember if he was working outside of standard work. However, she testified that if any employee during contingency were not following standard work she would have corrected it and told them they had to follow standard work process.

On cross-examination, Ms. Allen testified that if Petitioner were working third shift during the contingency she would have only overlapped with his shift for two hours. She did not recall which shift he was working. She was both supervising and operating the friction weld machine during the contingency.

She further testified that she could not comment on whether or not there were parts that were lifted by hand at the friction weld station that should not have been lifted that way. Ms. Allen explained that she did not observe anyone lifting anything by hand that they were not supposed to lift by hand. However, she had previously observed operators lifting the eyes out of the tub.

Ms. Allen testified that prior to hearing she had never seen the ergonomic evaluation or photographs in Respondent's Exhibit 5. After reviewing it, she testified she was shocked that the evaluation allowed for the lifting of eyes by hand although a manipulator was available. Ms. Allen testified that she is not trained in ergonomics, but testified that the pictures describe her recollection of the job.
When asked if the job in 2012 differed from the April 23, 2008 ergonomic evaluation, Ms. Allen testified that she did not recall it requiring any force needed to get the rod into the fixture. She testified that the eyes were not hand lifted and the manipulator was instructed to be used in the standard work. Ms. Allen performed the job only about four months during contingency.

Diane Moncrief

Respondent called Diane Moncrief ("Ms. Moncrief") as a witness. Ms. Moncrief is employed by Respondent as a workers' compensation adjuster and disability benefits supervisor and has been so employed for about eight years. She has worked for Respondent for about 15 years.

Ms. Moncrief testified that safety checklists are not retained by Respondent after the contingency plan is concluded.

With regard to Respondent's Exhibit 5, Ms. Moncrief testified that individual photographed has had several claims and she knows that he is left-handed. She explained that the document was authored by Mr. Shiring, who is now in Texas, but at the time was employed by Respondent as the ergonomics specialist. This job evaluation was performed in April of 2008 and she testified that the job has not changed.

Additional Information

Regarding his current condition, Petitioner testified that following his May 2012 injuries and treatment he has to be very careful in his daily life not to reinjure his shoulders again. He testified that he has to get help with things he normally would not have gotten help with and he no longer bow hunts.

ISSUES AND CONCLUSIONS

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

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

The parties stipulated that Petitioner's left shoulder condition is causally related to his injury at work. AX1. The nature and extent of that injury is addressed below. The causal connection issue relates to Petitioner's right shoulder condition.

The Arbitrator finds that Petitioner's current condition of ill-being in the right shoulder is causally related to the injury sustained at work on May 6, 2012. In so concluding, the Arbitrator relies on the credible testimony of Petitioner which is corroborated by contemporaneous medical records, certain testimony of Respondent's witnesses, and the opinions of Petitioner's treating physician, Dr. Evans.

To recover in a preexisting condition case, a claimant need only establish a causal connection between his work-related injury and claimed current condition of ill-being by showing that his injury aggravated or accelerated the preexisting disease. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 204-206, (2003) (*citing Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d 30, 36-37 (1982) (an accidental injury will be deemed compensable if it can be shown that the employment was also a causative factor)). It has long been held that an employer takes its employees as it finds them. *Sisbro*, 207 Ill. 2d at 205 (*citing Baggett v. Industrial Commission*, 201 Ill.2d 187, 199 (2003)). As in this case, even where an employee has a pre-existing condition that renders him more vulnerable to an injury, "recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor." *See Sisbro*, 207 Ill. 2d at 205 (*citing Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d at 36; *Williams v. Industrial Commission*, 85 Ill. 2d 117, 122 (1981); *County of Cook v. Industrial Commission*, 69 Ill. 2d 10, 18 (1977)).

The evidence is clear that Petitioner had prior bilateral shoulder conditions requiring surgeries before the accident at work on May 6, 2012. The medical records reflect that Petitioner immediately reported bilateral shoulder conditions, albeit greater on the left, when he saw Respondent's onsite physician, Dr. Neu, and Respondent's nursing staff in the Medical Department. He continued to report such symptoms until he was released to full duty by Dr. Evans. Petitioner's testimony at the hearing was consistent with these medical records.

In addition, Petitioner's testimony regarding the physical activities in which he was engaged as a friction welder is corroborated, in part, by the testimony of Respondent's witnesses and Respondent's Exhibit 5. Petitioner testified that the friction weld position required repetitive overhead work, pushing and pulling above shoulder level, and lifting of eyes from a bin that weighed considerably more than a few pounds. There is discord between the testimony of Petitioner, Mr. Tammen, and Ms. Allen about the relative location of the parts being maneuvered, the pendant's length in relation to the body of the operator, whether pushing or pulling parts required any force, and whether overhead work was required. With regard to one of these activities, the evidence clearly establishes that the 2008 ergonomic study and "standard" work required by Respondent were regularly not followed by friction weld operators. Ms. Allen confirmed that she had observed other operators

lifting eyes out of bins, which falls outside of Respondent's "standard" work process. Respondent's Exhibit 5 even shows an operator lifting eyes from a bin, an activity which Mr. Tammen denied occurred. While both Mr. Tammen and Ms. Allen testified that there was no overhead or strenuous work involved in the friction weld position, Petitioner explained otherwise.

The Arbitrator infers from the medical records that Petitioner's bilateral shoulder condition was deteriorated given his injuries before May 6, 2012. He had permanent work restrictions that were accommodated in his sedentary job as a manufacturing engineer. However, Petitioner testified that that the friction weld operator work aggravated his bilateral shoulder condition with specificity as to the work activities causing him bilateral shoulder pain, and contemporaneous medical records from Respondent's Medical Department corroborate his testimony.

Petitioner also completed an incident report on May 9, 2012 noting left shoulder pain and his feeling that the friction weld machine required too much heavy push pull with his arms elevated. Respondent's own Medical Department records of the same date note Petitioner's report of soreness in his shoulders and difficulty sleeping due to soreness. The initial nursing assessment noted Petitioner's complaints of pain in both shoulders, left greater than right, and Dr. Neu saw Petitioner on this date as well. As of May 11, 2012, Respondent's own medical director, Dr. Neu, noted that Petitioner's right shoulder was settling down, but he continued to have concerns about his left shoulder.

The Arbitrator finds Petitioner's testimony to be credible. His testimony is consistent with contemporaneous reports to Respondent's own medical personnel and the incident report as well as his ongoing reports to his own treating physician, Dr. Evans, and Respondent's medical director, Dr. Neu, throughout his treatment. It is reasonable to conclude that the position of the friction weld operator required pushing and pulling to load the parts onto the machine at or above Petitioner's shoulder level and requiring the use of both arms for various activities to which Petitioner testified at trial and as described to Dr. Evans, and beyond that anticipated by the 2008 ergonomic study or standard work orders. The Arbitrator further finds the opinions of Dr. Evans to be more persuasive than those of Dr. Neu in this case.

Based on all of the foregoing, the Arbitrator finds that Petitioner's bilateral shoulder condition of ill-being is causally related the work accident he sustained on May 6, 2012.

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

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

As explained more fully above, causal connection is not disputed with regard to Petitioner's left shoulder

condition and the Arbitrator finds that Petitioner's right shoulder condition is causally related to his accident at work relying on Petitioner's credible testimony as well as the opinions of his treating physician, Dr. Evans. The medical bills submitted into evidence are for the reasonable and necessary medical treatment rendered to Petitioner to address his bilateral shoulder condition.

Thus, the Arbitrator awards these medical bills incurred by Petitioner as reflected in Petitioner's Exhibit 1 that remain unpaid to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

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

First, the Arbitrator notes that no report was offered pursuant to Section 8.1b subsection (a) of the Act delineating Petitioner's level of impairment. Thus, the Arbitrator assigns no weight to this factor.

Second, the evidence established that Petitioner was employed as a manufacturing engineer at the time of the accident, but he was performing work as a friction weld operator under a contingency work plan as instructed by Respondent during a strike. Petitioner was able to return to work in his manufacturing engineer position. The Arbitrator also finds Petitioner's testimony regarding his duties at work on the date of accident to be

credible and corroborated by the testimony of Respondent's witnesses with regard to some work performed outside of "standard" work procedures as required by Respondent. Thus, the Arbitrator assigns significant weight to this factor.

Third, the parties stipulated that Petitioner was 52 years old on the date of accident. This evidence is uncontroverted and, thus, the Arbitrator assigns it significant weight.

Fourth, while there is evidence reflecting Petitioner's physical capabilities (i.e., Petitioner's own testimony, the treating medical records, etc.) no evidence was introduced regarding Petitioner's future earning capacity as a result. Moreover, Petitioner testified that he returned to work full duty for Respondent. Thus, no weight is assigned to this factor as there is no evidence of any impact on Petitioner's future earning capacity as a result of his injury.

Fifth, the Arbitrator notes that Petitioner had previously had surgery to both shoulders before his accident at work and that Petitioner's injury to the left shoulder is undisputed. With regard to the left shoulder, Petitioner underwent conservative medical treatment to the left shoulder followed by surgery including an arthroscopic debridement of the superior and anterior labrum, as well as subacromial bursa, arthoscopic superior labral repair, arthroscopic subacromial bursectomy. Dr. Evans diagnosed Petitioner with left shoulder mild bursitis with superior labral tear.

With regard to the right shoulder, the treating medical records reflect that Petitioner sustained an aggravating injury to the right shoulder also requiring surgical intervention. Dr. Evans performed a right shoulder arthroscopy with debridement of the superior, anterior and posterior labrum, a biceps tenotomy with open subpectoral biceps tenodesis, and subacromial bursectomy. Petitioner was diagnosed with a right shoulder degenerative appearing superior labral and biceps anchor tear without evidence of rotator cuff tear or impingement. Petitioner is right-hand dominant.

Petitioner continued with post-operative physical therapy after both surgeries and followed up with his orthopaedic surgeon, Dr. Evans, until he was released to return to work as a manufacturing engineer. Petitioner credibly testified that after his release back to full duty work he has had to be very careful in his daily life not to reinjure his shoulders and that he needs help with things he normally would not have needed before his accident. Petitioner also testified that he no longer engages in the recreational activity of bow hunting. In view of all of the foregoing, the Arbitrator finds that there is credible evidence of ongoing disability as reflected in the treating medical records corroborating Petitioner's testimony of debilitating injuries to both shoulders as a result of his accident at work with some continuing symptomatology in both shoulders. Given the entirety of the record, the Arbitrator assigns significant weight to this factor.

Based on all of the foregoing and in consideration of the factors enumerated in Section 8.1b, which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the man as a whole pursuant to Section 8(d)2 for the injury to his (dominant) right shoulder and 10% loss of use of the man as a whole pursuant to Section 8(d)2 for the injury to his (non-dominant) left shoulder.

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

Carter K. Webb,
Petitioner,

vs.
Decatur Conference Center and Hotel,
Respondent,

NO: 13 WC 05433

16IWCC0305

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 26, 2015 is hereby affirmed and adopted.

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1.00. 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: MAY 6 – 2016

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:4/7/16
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WEBB, CARTER K
Employee/Petitioner

Case# **13WC005433**

16IWCC0305

DECATUR CONFERENCE CENTER AND HOTEL
Employer/Respondent

On 5/26/2015, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0834 KANOSKI BRESNEY
CHARLES N EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

2593 GANAN & SHAPIRO PC
MELINDA M ROWE-SULLIVAN
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

16IWCC0305

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

CARTER K. WEBB
Employee/Petitioner

Case # 13 WC 005433

v.

Consolidated cases: _____

DECATUR CONFERENCE CENTER AND HOTEL
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 Dearing**, Arbitrator of the Commission, in the city of **Springfield**, on **March 24, 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 the date of accident, October 16, 2012, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$22,222.72**; the average weekly wage was **$427.36.**

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

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

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

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

Respondent is entitled to a credit in an amount **to be determined without a credit waiver** under Section 8(j) of the Act.

ORDER

Because Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent on October 16, 2012, claim is denied. All benefits are denied.

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

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

Arbitrator Molly Dearing

May 7, 2015
Date

MAY 26 2015

16IWCC0305

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CARTER K. WEBB
Employee/Petitioner

v. Case # 13 WC 005433

DECATUR CONFERENCE CENTER AND HOTEL
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of his accident, Petitioner was forty-two years of age and employed by Respondent as a maintenance technician. He had been so employed since February 2008. Petitioner testified that his position as a maintenance technician requires him to perform repairs, paint, move furniture, and perform other maintenance-related duties. He testified that at the time of his accident, he was secondarily employed by Clifton Moving, where he also performed lifting and moving job tasks.

Petitioner testified that, on October 16, 2012, he was working for Respondent on the fourth floor moving television armoires. He testified that the large size of the armoires required he rock the armoire back and forth to tip it back onto the dolly and that when doing so, he felt an immediate strain and burning sensation down his left side. While he believed it to be a pulled muscle, Petitioner testified that it did not resolve and progressed into a steady burning sensation until he noticed the protrusion from his abdomen. Petitioner described the armoire he was moving at the time he was injured as large, and "kind of a creamish white colored armoire. It's the only ones they have got out there that has like the dome. It's got - the top of it is domed up." He also stated that his accident occurred near the middle are of the fourth floor.

Petitioner testified that he first reported his injury to Andrew Crisler on November 3, 2012. Petitioner confirmed that his signature appeared at the bottom of page 2 of the Incident Report. He testified that he was "pretty sure" that the accident occurred on October 16, 2012, but stated that, when completing the report with Mr. Crisler, "I was unsure of the date because it was just shortly, I guess after - I am not sure. It's been awhile, but yeah, reported it, but it was - it wasn't filled out I don't think until the 3rd, I believe." Petitioner stated that "[o]n the exact time I know where it happened", but he denied being unable to recall giving Mr. Crisler information regarding to whom the accident was first reported on November 3, 2012. Petitioner testified that he was truthful with Mr. Crisler when he reported the accident, and when he discussed the information contained in the Incident Report.

Petitioner testified that in October 2012, he assisted Tom Kaigley in moving his personal belongings as well as a couch, end tables, chairs, and a small kitchen table to Mr. Kaigley's apartment.

On November 5, 2012, Petitioner presented to the Decatur Memorial Hospital Emergency Room where he reported a gradual onset of symptoms one week prior to arrival. The history of present illness notes Petitioner as the historian, and he indicated he sustained an "injury lifting furniture 1 week ago thinks has hernia, also vomiting diarrhea 1 day". He reported that he was experiencing aching, sharp pain in his lower left quadrant that was exacerbated by movement and a cough. The "Triage Note" reflects an onset of abdominal pain two weeks prior, with left groin pain and swelling, nausea and vomiting/diarrhea that day. Petitioner was diagnosed with a hernia and acute gastroenteritis, and he was instructed to follow-up with Dr. Steven Weber. PX 2.

On November 8, 2012, Petitioner presented to Dr. Robert Braco at Decatur Memorial Hospital Corporate Health and complained of pain in his left groin area after moving furniture. Petitioner described an onset of three weeks prior with the soreness for more that week. An injury date was noted to be October 16, 2012. Petitioner described his pain as fairly localized, not spreading into the abdomen or affecting his appetite/digestion. Petitioner was diagnosed with a left inguinal hernia and "observation after event at work". Dr. Braco recommended surgical repair of the hernia and he placed weight lifting restrictions on Petitioner for daily work tasks through November 30, 2012. PX 1.

On November 12, 2012, Petitioner presented to Dr. Steven Weber and reported bulging and discomfort in the left inguinal area for one month after lifting with increased symptoms over the prior two weeks. Dr. Weber noted that Petitioner had previously undergone a right inguinal hernia repair twelve years ago with Dr. Bailey. Dr. Weber recommended Petitioner undergo left inguinal hernia repair with mesh, which was performed on November 28, 2012. PX 3.

Petitioner returned to Dr. Weber post-operatively, at which time he complained of some pressure in the left testicle along with some swelling, though he denied pain. Dr. Weber noted that Petitioner was doing well following the left inguinal hernia repair with mild swelling of the left testicle, but no evidence of a hernia. Petitioner was instructed to return on an as-needed basis, and he was allowed to return to work the following day with no lifting more than ten pounds for three weeks. PX 3.

Petitioner returned to Dr. Braco on December 12, 2012, at which time it was noted that Petitioner had undergone a hernia repair on November 28, 2012 that had progressively healed without difficulty. Dr. Braco further noted that Petitioner was driving and walking normally, and was not taking any pain medications. Petitioner reported working full-time on limited duty in maintenance and that he was performing job tasks that did not involve lifting. Dr. Braco diagnosed Petitioner with a repaired left inguinal hernia and "observation after event at work, 10/16/12". Dr. Braco recommended lifting restrictions through December 30, 2012, after which he was allowed to return to full duty. PX 1.

Petitioner testified that he has not sought additional medical treatment since January 2013 relative to his hernia and he denied having any current appointments. Petitioner acknowledged that he had previously suffered a hernia on his right side that was surgically repaired. He testified that he was truthful with the emergency room personnel when he sought treatment at Decatur Memorial Hospital, at Decatur Memorial Hospital Occupational Health, and with Dr. Weber.

Petitioner testified that he presently experiences some tightness and pressure in his affected area with strenuous lifting. Petitioner testified that he has returned to work since being released in

December 2012. He denied filing any other workers' compensation claims against Respondent, and he denied having any similar prior problems in his groin prior to his date of accident.

Andrew Crisler testified at Arbitration on behalf of Respondent. Mr. Crisler is employed as the Director of Security for Respondent and he has worked for Respondent for eleven years. He testified that he is familiar with the Petitioner in his capacity as a maintenance technician and that he is familiar with the Incident Report regarding Petitioner's claim. Mr. Crisler testified that his signature appears at the bottom of page 1, and that he completed the Incident Report on November 3, 2012 at 5:30 p.m. with Petitioner. Mr. Crisler testified that the Report was completed based upon information that was provided to him by Petitioner.

Mr. Crisler testified that Petitioner was unable to ascertain a specific date on which the alleged lifting incident occurred, and initially reported to him an accident date of the end of September or beginning of October. Mr. Crisler stated that the timeframe of "End of September '12 - October 4, '12" enumerated on page 2 of the Incident Report was taken from Petitioner's history, but was later changed for a reason unbeknownst to him. Mr. Crisler testified that Petitioner was unable to give him an exact location of where his alleged accident occurred, but instead reported that it happened somewhere on the fourth floor. Mr. Crisler testified that Petitioner also supplied the history enumerated in the section entitled "To whom was the accident first reported" on page 2 of the Report.

Mr. Crisler testified that November 3, 2012 was the date in which he was made aware that Petitioner was claiming that he was injured at work while moving furniture. He stated that as the director of security, he had opportunities to observe maintenance technicians, including Petitioner, while he worked at the facility in October of 2012. He acknowledged that he would not observe them on a regular basis, but he would instead see other employees in passing as he patrolled the facility. Mr. Crisler testified that Petitioner worked regularly up until he reported the accident on November 3, 2012 and that he would have occasion to pass Petitioner when he saw him at the facility in October 2012. Mr. Crisler did not recall Petitioner reporting any pain complaints in his abdominal area to him prior to November 3, 2012.

Tom Kaigley testified at Arbitration on behalf of Respondent. Mr. Kaigley is employed as the maintenance supervisor for Respondent and he has been so employed for sixteen and a half years. Mr. Kaigley was Petitioner's direct supervisor in October 2012 and on his alleged date of accident of October 16, 2012. Mr. Kaigley testified that he became aware of Petitioner's alleged accident on November 3, 2012 when Petitioner contacted Mr. Crisler to complete an Incident Report. Mr. Kaigley testified that Petitioner worked regularly up through the date he reported the accident on November 3, 2012. As Petitioner's direct supervisor, Mr. Kaigley had opportunities to observe Petitioner in the performance of his work duties in October 2012, and he testified that Petitioner did not appear to be injured at that time nor did he complain of any pain prior to reporting his accident on November 3, 2012. Mr. Kaigley acknowledged that he does not work alongside Petitioner throughout the workday and that most of Petitioner's job tasks are completed away from his direct supervision.

Mr. Kaigley prepared a statement admitted as Respondent's Exhibit 3 as part of the investigation of Petitioner's workers' compensation claim, and he testified that his signature appears in that statement. Mr. Kaigley testified that on October 28, 2012, Petitioner assisted him in moving his personal belongings and furniture from one apartment to another. He indicated that the items

transferred were the contents of a one-bedroom apartment. Mr. Kaigley testified that moving the large furniture took approximately two hours and that carts were used to effectuate the move. Mr. Kaigley testified on October 28, 2012, Petitioner did not report any difficulty in moving the furniture on that date.

Jody Stinebring testified at Arbitration on behalf of Respondent. She is employed by Respondent as the property operations manager and human resources director. Ms. Stinebring testified that she is familiar with Petitioner, and she testified that Respondent's Exhibit 2 is a true and accurate copy of Petitioner's personnel file with Respondent. Ms. Stinebring testified that on October 12, 2012, she asked Petitioner to assist her in moving two pieces of furniture, including a buffet and a table, from Respondent's facility to her home. At that time, she stated that Petitioner did not appear to be injured nor did he complain of any pain. Ms. Stinebring testified that as the human resources director, she has the opportunity to meander through the facility in order to observe other employees and converse with them, and she acknowledged that she does not work side-by-side Petitioner in the performance of his duties.

Petitioner's personnel file maintained by Respondent was admitted into evidence. The Incident Report reflects that it was completed on November 3, 2012 by Andrew Crisler. Page 1 of the Report indicates the "Location of Incident" as being the "Exact location unknown other than fourth floor somewhere." The narrative portion of Report indicates that on November 3, 2012 at approximately 5:30 p.m., Mr. Crisler was advised of an injury that maintenance technician, Keith Webb, had sustained approximately four weeks prior. Petitioner reported that while moving furniture on the fourth floor, he pulled something in his left groin area, and that Petitioner stated the pain had progressively worsened. The "Date and Time of Incident" was "Unknown" and the "End of Sept. '12 – 1st week Oct. '12" was stricken. The Report reflects that Petitioner was "Not exactly sure" to whom the accident was first reported and that Petitioner reported witnesses to the accident. Page 3 of the Incident Report identifies the "Date of Injury/Illness" to be "Sept. '12 – Oct. '12," and that the time of the occurrence "Cannot Be Determined." Petitioner's signature appears on page 2 of the Report. RX 2.

A written statement of Tom Kaigley was admitted into evidence. Therein, Mr. Kaigley states that on Sunday, October 28, 2012, Petitioner helped him move furniture from one apartment to another for approximately two hours, and that Mr. Kaigley paid Petitioner for his assistance. Mr. Kaigley further states that he noted no physical difficulties with Petitioner at that time. RX 3.

CONCLUSIONS OF LAW

In regard to disputed issue (C), the Arbitrator finds that Petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accident that arose out of and in the course of his employment with Respondent on October 16, 2012. In so concluding, the Arbitrator notes that Petitioner's claim essentially rests upon his testimony at the time of trial that he sustained an injury while lifting furniture on the alleged date of accident. However, Petitioner's testimony is not supported by record. The Arbitrator notes that Petitioner's testimony that he is "pretty sure" that he injured himself on October 16, 2012 is inconsistent with the information he provided to Mr. Crisler, as testified to by Mr. Crisler and reflected in the Incident Report signed by Petitioner, which initially notes an accident date of "End of Sept. '12 – 1st week of Oct. '12" that was stricken and then changed to "unknown". RX 2. The Arbitrator questions how Petitioner was able to recall at Arbitration the exact date, mechanism of injury, and details concerning the armoire he was moving

at the time of his alleged injury, including its color and shape, approximately two and a half years after the accident, yet was unable to do so when he reported the accident to Mr. Crisler on November 3, 2012 merely two weeks following the date of accident.

Moreover, Petitioner's treating medical records of Decatur Memorial Hospital on November 5, 2012 reflect that Petitioner reported an onset of abdominal pain one week prior (PX 2), which does not temporally correspond with his alleged accident date of October 16, 2012 and instead more accurately aligns with his lifting activities performed for Mr. Kaigley on October 28, 2012. Petitioner's alleged work accident is also suspect in light of the notations in Petitioner's treating medical records that reflect a general history of moving furniture (PX 1, 2, 3), which, in light of the totality of the testimony, is not unique to Petitioner's job duties for Respondent, but was also a task that Petitioner performed temporally proximate to his date of accident for Mr. Kaigley, Ms. Stinebring, and in his secondary employment with Clifton Moving.

Furthermore, the Arbitrator finds the temporal disparity of approximately three weeks between Petitioner's alleged work accident of October 16, 2012 and his first date of treatment on November 5, 2012 indicative of a lack of a work accident. Petitioner worked full duty during that three-week period of time without voicing any abdominal or groin complaints to his direct supervisor or human resource manager, or seeking medical treatment. The Arbitrator questions how Petitioner was capable of moving furniture for Mr. Kaigley for two hours on October 28, 2012 if he was indeed experiencing sharp abdominal pain exacerbated by movement since his alleged date of accident, as he so reported at the Emergency Room on November 5, 2012. PX 2. The Arbitrator finds the aforementioned evidence calls into question the existence of a work accident on the date alleged.

Based upon the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner failed to prove by a preponderance of the credible evidence that he sustained an accident that arose out of and in the course of his employment with Respondent on October 16, 2012. All benefits are denied. The remaining issues of causal connection, medical benefits, temporary total disability benefits, and the nature and extent of the injury are rendered moot, and the Arbitrator accordingly does not make any conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Poe,

Petitioner,

16IWCC0344

vs. NO: 13 WC 6619

Mette's Cabinet Corner,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 20, 2015, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 2 0 2016
KWL/vf
O-5/16/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

16IWCC0344

POE, ROBERT A
Employee/Petitioner

Case# 13WC006619

METTE'S CABINET CORNER
Employer/Respondent

On 8/20/2015, 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 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2427 KANOSKI BRESNEY LAW FIRM
THOMAS R EWICK
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

0734 HEYL ROYSTER VOELKER & ALLEN
JOE GUYETTE
102 E MAIN ST SUITE 300
URBANA, IL 61801

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)

16IWCC0344

Robert Poe
Employee/Petitioner

v.

Mette's Cabinet Corner
Employer/Respondent

Case # **13** WC **6619**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **June 24, 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, **2/7/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**37,441.56**; the average weekly wage was $**720.03**.

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

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

Respondent shall be given a credit of $**17,286.86** 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's unpaid medical bills listed in Petitioner's Exhibit No. 13 directly to the providers consistent with the Medical Fee Schedule established by the Commission for necessary medical services, as provided in Section 8(a) and 8.2 of the Act.

Petitioner is awarded prospective medical care recommended by Dr. Timothy VanFleet, including a fusion at the L4-5 and either lumbar decompression or laminotomies at the L3-4 level with a possible fusion.

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

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

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

Edward Lee
Signature of Arbitrator

8/14/15
Date

ICArbDec19(b)

AUG 20 2015

16IWCC0344

FINDINGS OF FACT

Petitioner, Robert Poe, is 64 years old and had been employed by Respondent, Mette's Cabinet Corner, since 2001. Respondent manufactures cabinets and countertops. Petitioner testified that prior to February 7, 2012, he never had a physician recommend an MRI, CT scan, physical therapy, injections, or surgery for his lower back. Prior to that date, he never experienced any pain, numbness or tingling in his legs.

Petitioner testified that in November 2011, he treated with Dr. Gapsis at Bonutti Clinic after he picked something up at work and twisted his back. Petitioner's Exhibit No. 14 is Petitioner's records for his treatment in November 2011 with Dr. Gapsis. On November 16, 2011, Petitioner presented to Dr. Gapsis, indicating he was having low back pain after turning a cabinet at work earlier in the day. He reported no leg pain, weakness, numbness or tingling. He was tender to palpation of the left side of the lower back. Straight leg raise testing was negative. An x-ray showed lumbar spondylosis, disk space narrowing at L5-S1 and facet arthropathy at L5-S1. He was diagnosed with a back strain, prescribed Skelaxin, told to alternate heat and ice therapy, and taken off of work for two days. He was seen by Dr. Gapsis on November 18, 2011, and he reported left-sided back pain but no radiating pain into the buttocks or legs. He was kept off of work. He returned on November 21, 2011, reporting he was 50% better. He was last seen by Dr. Gapsis on November 28, 2011, reporting no pain for 3 days. Dr. Gapsis returned him to work with no restrictions and released him on an as needed basis. (Px. 14)

Petitioner testified that on February 7, 2012, he and a coworker were moving a slab of solid surface countertop to the CNC machine. He was walking backwards, carrying the slab, which weighed 160 to 165 pounds. His heel caught on a power cord, causing him to lose his balance and fall backwards. He noted that he landed hard on the concrete floor on his tail section and the slab caught his finger. Afterwards, he noticed his legs were jerky. He stated that Don Mette, one of the owners, took him to Bonutti Clinic, where he arrived about 30 minutes after the accident.

Following the accident, Petitioner was seen at Bonutti Clinic by Dr. Karl Rudert, an occupational medicine physician, complaining of pain to his left hip, buttocks, and lower back. He denied any numbness or tingling down his legs. Dr. Rudert ordered x-rays of the hip and low back, which he did not interpret as showing any fractures but rather significant degenerative changes at the L4-5 and L5-S1 levels. Dr. Rudert took Petitioner off of work and recommended an MRI evaluation if no improvement. He recommended conservative care and prescribed Ultracet for pain and Flexeril for spasms. (Px. 1)

Petitioner testified that later that night, he could not urinate. The next day, he called Dr. Rudert's office, and Dr. Rudert Rudert referred him for an MRI of his lower back. An MRI performed that day at St. Anthony's Memorial Hospital showed an acute central compression fracture of the L4 vertebral body resulting in approximately 40% loss of height. No retropulsion or paravertebral hematoma was noted. It also documented lumbar spondylosis, moderated to marked central spinal canal stenosis at L4-5 to due to facet athropathy, broad disk bulge and

minimal L4 anterolisthesis, mild broad posterior disk at L5-S1, and compression of bilateral L4 and left L5 nerve roots with the narrowed foramina. (Px. 2; Px. 3)

On February 22, 2012, Petitioner was seen by Dr. Josue Gabriel, an orthopedic surgeon at Bonutti Orthopedic Services, upon referral by Dr. Rudert. Dr. Gabriel diagnoses included radiculopathy and paresthesias in the left buttock and posterolateral thigh as well as pain in the left dorsum of his foot, with no symptoms in the right lower extremity, an acute L4 compression fracture, spinal stenosis at the L4-5 and L3-4, spondylolisthesis at L4-5, and bulging disc protrusions at the L4-5 and L5-S1, worse at the L4-5 especially on the left side with compression of the bilateral nerve roots worse on the left. Dr. Gabriel discussed trying either epidural injections or a Medrol Dosepak for the radiculopathy. He also recommended a brace for the L4 fracture and referred him to Dr. Lee for an evaluation of trigger finger. (Px. 1)

On March 12, 2012, Petitioner saw Dr. Frank Lee for his left long finger trigger finger. Dr. Lee recommended proceeding with a trigger finger release due to the likely temporary effects of an injection in a diabetic trigger finger. (Px. 1)

On April 3, 2012, Petitioner had a CT of the lumbar spine performed at St. Anthon's Memorial Hospital. The radiologist interpreted it to show a comminuted fracture of the L4 vertebra involving the vertebral body with more loss of height of the vertebra since the MRI from February 8, 2012. It also showed a narrowing of the central canal at the L3-4 and L4-5, impinging the dural sac, multilevel degenerative disease, and narrowing of the neural foramina at the L4-5 and L5-S1. (Px. 4)

On April 30, 2012, Petitioner presented to Dr. Joseph Ritchie at Orthopedic Specialists at the request of Respondent for a Section 12 examination for an evaluation of his left trigger finger. Dr. Ritchie diagnosed post-traumatic trigger finger of the left middle finger. He indicated that he did not see any reason the L4 fracture was not caused from the work injury but he was not asked to evaluate that. He recommended an injection for the trigger finger before surgery was contemplated. (Px. 9)

On May 15, 2012, Dr. Gabriel noted Petitioner's low back pain was improving but he continued to have some left lower extremity symptoms. He recommended that Petitioner remain off of work, undergo a bone scan, start physical therapy, and start a trial of epidural injections into the lumbosacral spine for his stenosis and disc protrusions to see if they would improve his left leg symptoms. (Px. 1)

On May 17, 2012, Petitioner started physical and aquatic therapy at Biomax Rehabilitation Services. During the initial evaluation on May 17, 2012, it was noted that Petitioner had left lower extremity radicular symptoms. On May 31, 2012, he reported he was able to walk 1.5 miles before he started hurting and had to stop because of pain in the left low back and into the left lower leg. (Px. 8)

On June 8, 2012, Petitioner underwent a bone scan which demonstrated increased uptake in the lower lumbar spine at the L4 vertebra consistent with the previously diagnosed fracture as well as degenerative changes in the remainder of the spine. (Px. 5)

On June 27, 2012, Dr. Gabriel recommended Petitioner undergo an epidural steroid injection to see if it would alleviate his symptoms in the left lower extremity due to is moderate to severe stenosis at the L4-5 and mild at L4-4, nueral foraminal stenosis and lateral recess at L5-S1 with spondylolisthesis at L4-5. (Px. 1)

On July 3, 2012, Petitioner reported to his therapist that he was still getting a flare up of the nerve in his left leg with walking more than one mile. On July 18, 2012, he began a work hardening program. (Px. 8)

On July 9, 2012, Dr. Lee reviewed the report of Dr. Ritchie and recommended an injection followed by surgery if there was no improvement with the injection. He performed an injection of Celestone. (Px. 1)

On July 11, 2012, Petitioner presented to Dr. Brian Ogan, of the Illinois Spine & Pain Center, upon referral from Dr. Gabriel. Dr. Ogan recorded Petitioner was experiencing low back pain and left lower extremity radiating pain secondary to a February 7, 2012 work injury. Dr. Ogan's straight leg raise testing was positive on the left at 45 degrees and negative on the right. Performed. Dr. Ogan commented that the mechanism of injury and MRI findings were consistent for lumbar nerve root irritation on the left at L4-5 and L5-S1 levels. (Px. 6, p. 35) Dr. Ogan recommended proceeding with a series of lumbar epidural steroid injections. (Px. 6, p. 36) On July 12, 2012, Dr. Ogan performed a left L4-5, left L5-S1 transforaminal epidural steroid injection. (Px. 6, p. 23)

On August 8, 2012, Petitioner reported to Dr. Gabriel that the epidural performed on July 12, 2012 helped somewhat. Dr. Gabriel indicated his spinal exam revealed a kyphotic posture and 15 degree ROM. Dr. Gabriel noted Petitioner was electing to try another epidural injection to see if it would help his left lower extremity symptoms prior to surgical intervention in the form of a decompression and laminectomy of the L4-5, L3-4, and L5-S1 levels, with a possible fusion at the L4-5 level for spondylolisthesis. (Px. 1)

On August 13, 2012, Petitioner returned to Dr. Ogan, who recorded Petitioner reported 50% improvement following his previous epidural steroid injection. Physical examination indicated he had positive straight leg raise at 45 degrees on the left and a negative straight leg test on the right. (Px. 6, pp. 32-33) On September 4, 2012, Dr. Ogan performed a left L4-5, left L5-S1 transforaminal epidural steroid injection with fluoroscopic guidance.

Petitioner testified that injections Dr. Organ performed helped somewhat, meaning about 50 percent.

On August 15, 2012, Dr. Lee performed a left long trigger finger release under local sedation. On August 27, 2012, Dr. Lee found Petitioner was at MMI for his trigger finger and released him on an as needed basis. (Px. 1)

According to the work conditioning note of September 21, 2012, Petitioner was able to complete work safely in the medium physical demand level. On September 26, 2012, the occupational therapist noted that Petitioner had met his maximum benefit and recommended that he continue with a home exercise program and follow up with his physician. (Px. 8)

On September 24, 2012, Petitioner was seen by Dr. Gabriel, noting he was walking a mile in the morning and evening. Dr. Gabriel diagnoses included L4 compression fracture with interval healing, comminution and retropulsion of burst-type fracture which appeared stable, radiculopathty and paresthesias, in the left buttock and left lower extremity as well as pain in the left dorsum of the foot, moderate to severe spinal stenosis at the L4-5 and mild at L3-4 and neuroforaminal stenosis and lateral recess at L5-S1, worse on the left. Dr. Gabriel noted the was some moderate improvement of the left lower extremity radiculopathy and paresthesias, but Petitioner was still having occasional symptoms. Dr. Gabriel performed a left L4-5 and L5-S1 transforaminal injection, which helped some of Petitioner's symptoms in the left buttock and left leg but not all the way in the left foot. Dr. Gabriel recommended facet block/RFA to the left L3-4, L4-5 and L5-S1 and put physical therapy on hold. Dr. Gabriel returned Petitioner to sedentary duty with restrictions of no lifting over 5-10 pounds along with no prolonged stooping, twisting, or bending. (Px. 2)

Petitioner testified that following the February 7, 2012 work accident, he kept off of work and paid TTD up through an independent medical examination with Dr. Soriano on October 17, 2012. He testified that when he saw Dr. Soriano on October 17, 2012, he was still having symptoms in his left leg. After that exam, his TTD benefits were terminated and he went back to work. He did not continue to treat with Dr. Gabriel because work comp did not authorize further treatment. He also noted that Bonutti Clinic let Dr. Gabriel go, and Dr. Gabriel moved to Ohio.

Petitioner testified that in June 2013, he saw Dr. Opilka, his family physician, and asked for a referral for a second opinion. He noted that Dr. Opilka ~~referred~~ mentioned Dr. VanFleet and a doctor in St. Louis. He testified that his attorney referred him to Dr. Timothy VanFleet, who he saw on October 14, 2014. He noted that following his exam with Dr. VanFleet, Respondent referred him again to Dr. Soriano. He denied telling Dr. Soriano that he was only having pain in his left buttock and left thigh 2 to 3 times a month.

Respondent introduced into evidence two office visits Petitioner had with his family physician on September 11, 2012 and on December 31, 2012. On September 11, 2012, Petitioner presented to Dr. Opilka with an earache. On December 31, 2012, Petitioner was seen by Dr. Opilka for cold symptoms, lab work, and medication management for his hypertension, hyperlipidemia, and diabetes. He did not complain of back or leg pain on these dates. (Rx. 4)

Petitioner's Exhibit No. 10 is a June 11, 2013, office note of Dr. Opilka. On that day, Petitioner presented to Dr. Opilka, indicating work comp was not approving further work up at the time and that he would like to be referred. Petitioner complained of left lower back pain which radiated to the left posterior thigh, left calf, and left foot. He characterized it as intermittent, moderate in intensity, sharp and stabbing. He noted that he began 16 months prior when he fell backwards while carrying a 165-pound slab at work. Associated symptoms were stiffness, radicular left leg pain and numbness in the left foot. Dr. Opilka diagnosed low back pain and recommended a referral for a second opinion. (Px. 10)

Petitioner testified that he walks every evening. He walks 1 to 2 miles, but it has got to the point where he cannot walk 2 miles. Sometimes at work, he has pain so he will sit down. If he lifts something the wrong way, he will have pain in his lower back and a sharp pain going

down the outside of his left thigh and into his left calf and the inside of his left foot. He did not have these symptoms prior to February 7, 2012.

On cross examination, Petitioner noted he was prescribed a brace in 2011 and the pain in 2011 was worse than he experiences today. He noted that after he saw Dr. Soriano in 2012, he returned to work in the wood shop. He assembles cabinets. It is a fairly heavy job. When he gets ready to lift a heavy cabinet, he asks for help. He did not need help with lifting a cabinet prior to the work accident. He was able to till his garden this year, but he has not been able to split firewood since the accident. After he was seen by Dr. Soriano in October 2012, he saw his family physician for other conditions.

On redirect examination, Petitioner noted that he had not been prescribed a back brace prior to his accident of February 7, 2012. The back brace he was referring to on cross examination was prescribed by Dr. Gabriel after the February 7, 2012 work accident. When he was comparing his symptoms between now and 2011 on cross examination, he was confused and did not understand he was being asked to compare his symptoms prior to the work accident. He was comparing his symptoms on cross examination from right after the accident and now. He testified that in 2011, he did not have any pain down his leg.

Dr. VanFleet's Section 12 Exam

Petitioner presented to Dr. Timothy VanFleet at the Orthopedic Center of Illinois, on October 14, 2014 at the request of his attorney. Dr. VanFleet authored a report, which is marked as Petitioner's Exhibit No. 11. Dr. VanFleet testified that he is board certified in orthopedic surgery and specializes in spinal surgery. Dr. VanFleet reviewed Petitioner's medical records and took a history from him concerning the February 7, 2012 accident. Dr. VanFleet reviewed Petitioner's records from November 2011, and noted he did not see any notations of radicular complaints or symptoms in either lower extremity. Dr. VanFleet testified that the February 8, 2012 MRI did not show any evidence of compression of the spinal canal but demonstrated some spinal stenosis at the L4-5 level and an L4 fracture. He observed that on February 22, 2012, Dr. Gabriel diagnosed Petitioner with radiculopathy and parasthesias and posterolateral thigh pain as well as pain in the left dorsum of his foot. No symptoms were noted in the right lower extremity. (Px. 12, pp. 6-15)

Dr. VanFleet testified that when he saw Petitioner in October 2014, Petitioner reported some difficulty when he was upright and indicated he could not stand or walk very well for a long duration because he would get pain into his buttocks and down his legs. (Px. 12, pp. 6-11) Dr. VanFleet noted his physical examination in October 2014 was essentially normal other than Petitioner had a little limitation in terms of his extension of lumbar spine, which was consistent with spinal stenosis. (Px. 12, pp. 12-13) Dr. VanFleet performed x-rays at his office, which demonstrated an L4 compression deformity with overall loss of body height of approximately 20%, spondylolisthesis at the L4-5 and multi-level lumbar degenerative disc disease with decreased disc space height diffusely. (Px. 11)

Dr. VanFleet testified Petitioner's current diagnosis is a healed L4 fracture, lumbar spondylolisthesis, and lumbar spinal stenosis. Spondylolisthesis refers to a forward shifting of

one vertebra on top of another, and spinal stenosis refers to narrowing within the spinal canal. Dr. VanFleet noted Petitioner sustained an L4 fracture as a result of the February 7, 2012 work accident. Dr. VanFleet noted the spondylolisthesis and spinal stenosis were preexisting but were aggravated following the fall and compression fracture. He noted in his report that Petitioner's spinal canal was changed somewhat by the compression fracture and certainly the resultant neural foraminal narrowing would increase as well because of the loss of height in the anterior column and middle columns due to the loss of the overall disc space height at each level. (Px. 11) Dr. VanFleet testified that his opinion that the spondylolisthesis and spinal stenosis were aggravated by the work accident is based upon his experience in terms of how patients with spinal stenosis and spondylolisthesis react to injuries and also upon the alignment change that would have taken place with the L4 fracture, which would adversely affect the spinal stenosis. He explained that because of the alterations in the actual morphology of the vertebral body with a fracture the dimension of the spinal canal will be changed. A compression fracture will change the way a spinal canal is actually aligned, and a change in the alignment of the spine can change the overall configuration of the rest of the spine as well. (Px. 12, pp. 20-23)

Dr. VanFleet testified that Petitioner's treatment to date has been reasonable and necessary. He believes Petitioner needs a fusion at the L4-5 and noted one can consider a fusion at the L3-4 or just doing a decompression at the L3-4. The purpose of the fusion is to address the instability with the spondylolisthesis, and he noted that the L3-4 level needs to be addressed by opening up the spinal canal as well. Dr. VanFleet also noted that Petitioner remains symptomatic when he is on his feet. He explained that a lot of people with spinal stenosis will have a reasonably normal physical examination, but when they try to stand up and walk they develop claudication because when they are in an upright position, the spinal canal becomes more compressed as a result of being upright. Dr. VanFleet testified the surgery he is recommending is necessitated by the aggravation of spondylolisthesis and spinal stenosis caused by the work injury, reasoning he was asymptomatic prior to the injury but has been symptomatic since. (Px. 12 pp. 23-25)

On cross-examination, Dr. VanFleet noted while spondylolisthesis could be a source of back pain and spinal stenosis is generally consistent with pain into the legs, Petitioner was only diagnosed with a back sprain in November 2011. (Px. 12, pp. 26-27) Dr. VanFleet noted that generally people with spinal stenosis are fine as long as they are sitting down and acknowledged Petitioner's symptoms seem to be controlled by sitting down or taking a rest. Most of the time when he performs an operation for spinal stenosis it is a quality of life issue because the patient cannot be on his or her feet to do anything long enough to get anything done. Dr. VanFleet was asked on cross-examination whether he was familiar with the success rates for a two-level lumbar fusion in a 63 year old patient, and he responded that he is because he does these surgeries all of the time. For spinal stenosis, the actual success rate of lower extremity symptoms is very high. For establishing a solid fusion it is also very high. He noted that when you look at a group of patients, if you are doing a spinal fusion for neurogenic claudication, it is very high in the 80th percentile. (Px. 12, pp. 30-36)

Dr. Soriano's Section 12 Exams

On October 17, 2012, Petitioner was seen by Dr. Morris Soriano, at the request of the Respondent, for a section 12 exam. Dr. Soriano diagnosed Petitioner with a healed L4

compression fracture with no retropulsion. Dr. Soriano opined the compression fracture was causally related to the work injury of February 7, 2012. He stated Petitioner's left leg and left foot numbness and tingling were not present during his exam of October 17, 2012 and therefore would not have any relationship to the L4 burst fracture since his neurological examination was negative. Dr. Soriano recommended no further treatment, although he noted Petitioner could wear a corset brace when he returned to work and should obtain help with heavy lifting. Dr. Soriano believed Petitioner was at maximum medical improvement. (Rx. 1)

On October 10, 2014, Dr. Soriano saw Petitioner for a second section 12 exam at the request of Respondent's attorney. Dr. Soriano diagnosed Petitioner with multi-level degenerative disc disease, mild to moderate spinal stenosis, and facet disease, none of which were objectively aggravated as a result of the February 7, 2012 work accident. Dr. Soriano indicated that the chance of success from a two level fusion, for an individual over 63 years old, is less than 50%. He opined Petitioner's back completely healed and his neurological status was completely intact. (Rx. 2)

Dr. Soriano testified in an evidence deposition, noting he is a neurosurgeon and performs spinal surgeries. He reviewed Petitioner's medical records and the MRI and CAT scan reports. Dr. Soriano testified that when he first saw Petitioner, Petitioner rated his pain at between 0 and 3. Petitioner noted he was not taking any pain medication. Petitioner indicated he could garden, wash dishes, and vacuum, but could not mow his lawn. Dr. Soriano stated that retropulsion occurs where there is a fracture of the bone in the posterior part of the cortex causes a piece of bone to go backwards into the spinal canal and cause compression in either the nerve root or dural sac. Dr. Soriano stated there was no retropulsion present in Petitioner's case. Dr. Soriano noted his physical examination was normal. He diagnosed Petitioner with a healed compression fracture and believed Petitioner was capable of going back to his regular work. He did not believe Petitioner was in need of further treatment. (Rx. 3, pp. 5-16)

Dr. Soriano testified that when he saw Petitioner a second time on December 16, 2014, Petitioner told him he was walking 2 to 3 miles per day when the weather was reasonable and that his left lower back pain would ease up when he sat down or relaxed. His pain seemed to be worse when working, exerting himself, or bending. Petitioner told Dr. Soriano that he was still having some good and some bad days and that 2 to 3 times per month his pain would radiate into his left buttocks and thigh but would resolve after he sat down and rubbed his thigh. He was taking 0 to 4 Aleve per day. His exam findings were essentially normal. He did not find Petitioner's complaints in 2014 were causally related to the work accident of February 2012. Dr. Soriano does not agree that the February 2012 work accident resulted in a change in the sagittal balance. Dr. Soriano does not believe surgery is warranted because Petitioner's spine is not unstable. (Rx. 3, pp. 17-26)

On cross-examination, Dr. Soriano stated that prior to seeing Petitioner the first time, he was informed by Petitioner's case nurse manager that Dr. Gabriel had mentioned surgery but was trying to avoid it. (Rx. 3, p. 28) Dr. Soriano agreed that Petitioner was not diagnosed by Dr. Gapsis in November 2011 with radiculopathy. (Rx. 3, p. 30) Dr. Soriano acknowledged he did not detect any positive Waddell's signs with Petitioner. (Rx. 3, p. 30) Dr. Soriano noted that a person can have degenerative changes, such as stenosis or spondylolisthesis, and be asymptomatic. It is possible that trauma to the lower back which leads to a compression fracture

could aggravate those degenerative changes or make them symptomatic, although he does not believe that is the case here because there was no retropulsion. (Rx. 3, pp. 34-35)

CONCLUSIONS OF LAW

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

The Arbitrator adopts his findings of fact and incorporates them herein by this reference.

Both sides agree that on February 7, 2012, Petitioner sustained an accident which arose out of an in the course of his employment. On that day, Petitioner was carrying a countertop slab which weighed between 160 and 165 pounds, when he tripped on a cord and fell backwards onto a concrete floor landing on his tail bone. He testified that in November 2011, he had treated for low back pain on 4 occasions, but did not have left leg symptoms and was released to full duty work on November 28, 2011. He was working full duty at the time of the accident. He noted that after the February 7, 2012 work accident he subsequently developed left leg symptoms, which still persist.

The Arbitrator finds Petitioner to be a credible witness, as he appeared candid and forthright in his testimony and demeanor at arbitration. Further, his testimony is corroborated by the medical records which document a change in his relatively asymptomatic condition following the work accident.

The records are devoid of any type of radicular complaints in Petitioner's lower extremity prior to the work accident. Prior to the February 7, 2012 accident, Petitioner had never undergone or had a physician recommend any type of significant treatment for his lower back or leg pain, including injections, surgical consultation, physical therapy, work conditioning, MRI's, or CT scans. Following his work accident, Petitioner has had physical and aquatic therapy, epidural injections, work hardening, and was prescribed a back brace.

It is also noteworthy that when he saw Dr. Gapsis in November 2011, straight leg raise testing was negative and there were no complaints of left leg numbness, tingling or pain in November 2011. (Px. 14) However, when Petitioner first presented to Dr. Gabriel on February 22, 2011, two weeks after the work accident, he completed a history of injury form, circling numbness and tingling in the legs under the review of symptoms. Dr. Gabriel diagnosed radiculopathy and paresthesias in the left buttock and posterolateral thigh as well as pain the left dorsum of the foot, with no symptoms in the right lower extremity. (Px. 1) Dr. Ogan, during his exams of July 11, 2012, and August 13, 2012, recorded a positive straight leg raise test on the left, negative on the right. (Px. 6)

It is well settled that "[a]bsence of proof of ill-being of an employee prior to the time of the injury, coupled with a change immediately following the injury continuing thereafter, is competent as tending to establish that the impaired condition was due to the injury." *Burrell v. Industrial Com'n*, 171 Ill.App.3d 723, 729, 525 N.E.2d 935, 940 (1st Dist. 1988); *See also International Harvester v. Industrial Comm'n*, 93 Ill.2d 59, 63-64, 442 N.E.2d 908, 911 (1982)

("A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury.").

Respondent asserts Petitioner has not treated for his back since Dr. Soriano found him to be at maximum medical improvement in October 2012. This does not mean, however, that Petitioner has been asymptomatic. In fact, the medical records document Dr. Gabriel that as of September 24, 2012, one month prior to Dr. Soriano's first exam, Petitioner was still having symptoms in his left leg and had not been released from care by Dr. Gabriel. In fact, Dr. Gabriel had recently mentioned surgery but recommended trying facet blocks to address radiculopathty. Further, Petitioner's did seek a referral for a second opinion for his back and leg pain from his family physician in June 2013. (Px. 10) Petitioner testified that he did not continue to treat with Dr. Gabriel after Dr. Soriano's first because further treatment was not authorized by work comp. It was be contrary to the purposes of the Act to allow Respondent to deny treatment and then use the inability of Petitioner to obtain treatment at his expense as evidence that he was not longer symptomatic. Petitioner credibly testified that he still has symptoms in his left leg.

The Arbitrator relies upon and finds more persuasive the causal connection opinions of Dr. VanFleet than those of Dr. Soriano. Dr. VanFleet noted the spondylolisthesis and spinal stenosis were preexisting but were aggravated following the fall and compression fracture. He based his opinion on his experience with how patients with spinal stenosis and spondylolisthesis react to injuries and also upon the alignment change that would have taken place with the L4 fracture, which would adversely affect the spinal stenosis. He explained that because of the alterations in the actual morphology of the vertebral body with a fracture the dimension of the spinal canal will be changed. A compression fracture will change the way a spinal canal is actually aligned, and a change in the alignment of the spine can change the overall configuration of the rest of the spine as well. (Px. 12, pp. 20-23) Dr. VanFleet also reasoned that Petitioner was asymptomatic prior to the injury but has been symptomatic since. (Px. 12 pp. 23-25)

An employer takes the employee as he or she is. If a preexisting condition is aggravated, exacerbated by an accidental injury, the employee is entitled to benefits. *Rock Road Construction Co. v. Industrial Comm'n*, 37 Ill.2d 123, 127, 227 N.E.2d 65, 67-68 (1967); *Illinois Valley Irrigation, Inc. v. Industrial Comm'n*, 66 Ill.2d 234, 362 N.E2d 339 (1977). The accidental injury need not be the sole causative factor, or even the primary causative factor; instead, it is sufficient if the accident was a causative factor resulting in the condition of ill-being. *Rock Road Construction Co. v. Industrial Comm'n*, 37 Ill.2d 123, 127, 227 N.E. 2d 65 (1967).

While Petitioner's spondylolisthesis and spinal stenosis are degenerative, pre-existing conditions, the preponderance of the evidence shows these conditions were aggravated by the work accident and resulting L4 compression fracture.

For the forgoing reasons, the Arbitrator finds Petitioner's current condition of ill-being of his lumbar spine is causally related to the injury sustained on February 7, 2012.

With respect to Petitioner's left long finger, Dr. Ritchie, Respondent's examiner, diagnosed Petitioner with post-traumatic trigger finger as a result of the work accident and recommended an injection prior to surgery. (Px. 9) Dr. Lee attempted an injection, but

performed a trigger finger release after the injection did not provide significant relief. (Px. 1) As such, the Arbitrator also finds Petitioner's current condition of ill-being of the left long finger is causally related to the work injury.

With respect to issue (J), were the medical services that were provided to Petitioner reasonable and necessary and has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

The Arbitrator adopts his findings of fact and conclusions of law contained above.

The Arbitrator finds the medical services rendered to Petitioner have been reasonable and necessary as a result of the February 7, 2012 work injury. Accordingly, Respondent shall pay Petitioner's unpaid medical bills listed in Petitioner's Exhibit No. 13 directly to the providers consistent with the Medical Fee Schedule established by the Commission for necessary medical services, as provided in Section 8(a) and 8.2 of the Act.

With respect to issue (K), is Petitioner entitled to any prospective medical care, the Arbitrator finds as follows:

The Arbitrator adopts his findings of fact and conclusions of law contained above with respect to causal connection

The Arbitrator finds the opinions of Dr. VanFleeet regarding prospective medical care more persuasive than those of Dr. Soriano. The Arbitrator also bases his decision with respect to future medical care on the medical records, which clearly document Petitioner was still consistently and actively treating for radiculopathy at the time Dr. Soriano found him to be at maximum medical improvement in October 2012.

Dr. Soriano noted in his first report that Petitioner was not reporting left leg numbness or tingling when he saw him. Petitioner testified that when he first saw Dr. Soriano, he was still having symptoms in his left leg. His testimony is corroborated by the medical records which consistently document left-sided radiculopathy.

On August 8, 2012, Dr. Gabriel noted Petitioner was electing to try another epidural injection prior to surgical intervention. Dr. Gabriel referenced a decompression and laminectomy of the L4-5, L3-4, and L5-S1, with a possible fusion at the L4-5. (Px. 1) On September 24, 2012, Dr. Gabriel continued to diagnose radiculopathy and paresthesias and referred Petitioner for facet blocks. (Px. 1) This is within one month of Dr. Soriano's examination. The records at this time clearly contradict Dr. Soriano's statement that Petitioner was not having left leg symptoms during this time. The medical records refute Dr. Soriano's opinion that Petitioner was at maximum medical improvement in October 2012, as no doctor had indicated Petitioner was at maximum medical improvement. He was still under Dr. Gabriel's care, who was recommending the facet blocks before proceeding with surgery.

The medical records demonstrate Petitioner was been compliant with his treatment. He attended all of his doctor's appointments before his benefits were terminated and the appointments no longer authorized following Dr. Soriano's examination. He consistently attended his appointments at Biomax Rehabilitation Services, participating in physical and aquatic therapy followed by work conditioning. Despite his efforts, as of September 21, 2012, he was only able to achieve functioning at a medium physical demand level and according to the therapist had reached his maximum benefit from work hardening. (Px. 8)

Dr. Soriano testified a fusion can be done following a compression fracture to stabilize the spine if there has been shown to be a progression of kyphosis or a collapse of the vertebral body. (Rx. 3, p. 12) However, he claimed on cross examination that Dr. VanFleet was the only doctor to mention kyphosis. (R. 3, p. 44) The records reflect Dr. Gabriel explicitly noted a kyphotic posture during his exam on August 8, 2012. (Px. 1)

Dr. VanFleet credibly testified Petitioner needs a fusion at the L4-5 level and either a fusion or decompression at the L3-4. Dr. VanFleet explained that a fusion is designed to address the instability caused by the spondylolisthesis, and the L3-4 level needs to be addressed by opening up the spinal canal as well. Dr. VanFleet also explained that Petitioner remains symptomatic when he is on his feet, noting a lot of people with spinal stenosis will have a reasonably normal physical examination, but when they try to stand up and walk they develop claudication because standing in an upright position causes the spinal canal to become more compressed. Dr. VanFleet testified the surgery he is recommending is necessitated by the aggravation of the spondylolisthesis and spinal stenosis caused by the work injury. He observed Petitioner was asymptomatic prior to the injury but has been symptomatic after it. (Px. 12 pp. 23-25) Dr. VanFleet was asked on cross-examination whether he was familiar with the success rates for a two-level lumbar fusion in a 63 year old patient. He noted that he is familiar with the success rate because he does these surgeries all of the time. For spinal stenosis, the actual success rate of lower extremity symptoms is very high. For establishing a solid fusion it is also very high. The success rate for doing a spinal fusion for neurogenic claudication is very high, in the 80th percentile. (Px. 12, pp.30-36)

For the foregoing reasons, Petitioner is awarded prospective medical care recommended by Dr. Timothy VanFleet, including a fusion at the L4-5 and either lumbar decompression or laminotomies at the L3-4 level with a possible fusion.

13 WC 7365
Page 1

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☐ 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

Roger Jenkins,

Petitioner,

vs. NO: 13 WC 7365

ABF Freight Systems,

Respondent.

16IWCC0279

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, extent of temporary total disability, medical expenses and prospective medical care and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Arbitrator's Decision finding that although Petitioner may have sustained accidental cervical injuries arising out of and in the course of his employment on December 4, 2012, he failed to prove that a causal relationship exists for his current condition of ill-being for his cervical condition. The Commission affirms the Arbitrator's finding that Petitioner failed to prove that a causal relationship exists for his current condition of ill-being for his left knee. The Commission denies Petitioner's claim for compensation, medical expenses and prospective medical care.

Petitioner, a 57 year old truck driver, testified that on December 4, 2012, he was working for Respondent and proceeding northbound on I-57 to Chicago. Petitioner drove over a large bump in the highway. Petitioner testified, "I was thrown forward and then backwards and immediately felt pain in my neck and tingling in my arms and hands." This incident took place just north of mile marker 327 on I-57. Petitioner submitted a DVD video of the bump on I-57 while driving a vehicle and this was admitted into evidence as Px8. Respondent submitted a DVD video of the same bump on I-57 taken by an investigator while driving a vehicle on January 20, 2013 and this was admitted into evidence as Rx4. The Arbitrator found that while the disturbance seen on the videos could not be characterized as extremely violent, the footage from both videos would appear to support Petitioner's claim that the damaged portion of the roadway existed and that the sudden dip and shaking of a vehicle traveling over that section, particularly a fully loaded tandem (two-trailer) tractor trailer, was entirely capable of thrusting an individual forward and then backward in his seat, creating a whiplash effect, no matter how many times Petitioner had traveled that particular spot.

The Commission has viewed both DVD videos Px8 and Rx4 and notes there is definitely a jostling that occurs inside the vehicles. SafeWorks Illinois Dr. Fletcher opined, "I believe his work activities aggravated his pre-existing condition." However, Dr. Fletcher had not viewed either video. In his report, §12 Dr. Graf opined causal connection for Petitioner's neck condition, but he had not seen either video at that time. In his deposition, §12 Dr. Graf was shown DVD video Rx4 and opined that there would not be any force to create a condition such as Petitioner suffers from currently if he were traveling down that section of highway. §12 Dr. Zelby opined no causal connection, based on his viewing of the DVD video Rx4, opining that that there was not enough force for Petitioner to have sustained a whiplash injury. The Commission strongly notes that Petitioner provided no doctor's opinion that the force of the bump could have caused a whiplash injury which aggravated his preexisting cervical condition. Therefore, the Commission finds that Petitioner has not met his burden of proof regarding his cervical claim.

Regarding his left knee, Petitioner testified that later on December 4, 2012, while unhooking and re-hooking his second set in the Chicago Heights terminal yard, he stepped into a pothole and twisted his left knee. Petitioner had prior left knee problems. In April 2005 he had left knee arthroscopic surgery. While working for Respondent in December 2010, Petitioner injured his left knee and underwent conservative treatment at that time consisting of physical therapy and injections. Petitioner testified that from 2010 to 2012, he had no significant treatment for his left knee. The medical records indicate that a left knee MRI done on June 7, 2011 showed a tear affecting the body and the posterior horn of the lateral meniscus perhaps degenerative type and a minor tear affecting the medial meniscus could not be excluded, as well as osteoarthritis of left knee joint and joint effusion. Petitioner received a Synvisc injection on June 21, 2011 and reported walking better on July 26, 2011. A left knee MRI done on January 4, 2013 showed: 1) tear of the medial meniscus with Grade II to III cartilage thinning and joint space narrowing; 2) tear of the posterior lateral meniscus with Grade II cartilage thinning; 3) Grade III to IV patellofemoral articular cartilage thinning and mild osteoarthritis. Petitioner

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16IWCC0279

sought no further treatment for his left knee since his last visit with Dr. Li on March 7, 2013. §12 Dr. Raab opined that Petitioner sustained a temporary aggravation of his preexisting arthritic condition in his left knee as a result of the incident of stepping in a pothole on December 4, 2012. The Arbitrator agreed with §12 Dr. Raab's opinion that Petitioner's current left knee condition is related more to his underlying degenerative arthritis and is no longer causally related to the work injury on December 4, 2012. The Commission affirms this finding. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove a causal relationship exists between the accidents of December 4, 2012 and Petitioner's condition of ill-being for his cervical spine and left knee, his claim for compensation, medical expenses and prospective medical care is hereby denied.

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

DATED: MAY 2 - 2016
MB/maw
o03/17/16
43

Mario Basurto

Stephen J. Mathis

David L. Gore

1810028.2

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

JENKINS, ROGER
Employee/Petitioner

Case# **13WC007365**

ABF FREIGHT SYSTEMS
Employer/Respondent

16IWCC0279

On 7/13/2015, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0222 GOLDBERG WEISMAN & CAIRO LTD
DONN LaHAIE
ONE E WACKER DR SUITE 3900
CHICAGO, IL 60601

2965 KEEFE CAMPBELL BIERY & ASSOC
TIMOTHY J O'GORMAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

16IWCC0279

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

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

Roger Jenkins,
Employee/Petitioner

v.

ABF Freight Systems,
Employer/Respondent

Case # **13** WC **7365**

Consolidated cases: **none**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **New Lenox**, on **5/11/15**. 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. ☒ 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 **Respondent's request for a finding under §25.5 of the Act.**

16IWCC0279

FINDINGS

On the date of accident, **12/4/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being with respect to his cervical condition ***is*** causally related to the accident, but that Petitioner's current condition of ill-being with respect to his left knee condition ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**53,447.16**; the average weekly wage was $**1,027.83**.

On the date of accident, Petitioner was **57** years of age, ***single*** with **no** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $685.22 per week for 105-6/7 weeks, commencing 5/1/13 through 5/11/15, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 12/5/12 through 5/11/15, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services of $9,312.60, as provided in Sections 8(a) and 8.2 of the Act.

Petitioner is entitled to prospective medical care and treatment in the form of a C3-C7 cervical laminoplasty as prescribed by Dr. Singh, and Respondent shall be liable for the reasonable and necessary medical expenses associated therewith pursuant to Section 8(a) and the fee schedule provisions of Section 8.2 of the Act.

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

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

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

Signature of Arbitrator

7/7/15
Date

ICArbDec19(b)

JUL 13 2015

15WC00101

STATEMENT OF FACTS:

Petitioner testified that he has been employed as a union truck driver for approximately 37 years, most recently with Respondent as a utility truck driver. Typically, he would drive a semi tractor attached to tandem (dual) trailers. His duties included hauling freight from Respondent's terminal in Champaign, Illinois to Respondent's terminal in Chicago Heights, Illinois. He would sometimes make that trip twice in one day. After arriving at either terminal, Petitioner would unhook the trailer he was hauling and then attach a new trailer. Petitioner would then haul the newly attached trailer back to the other terminal. Petitioner traveled Interstate 57 between terminals.

On December 4, 2012, Petitioner was driving northbound on Interstate 57 from Champaign to Chicago Heights. He was driving a 2007 Sterling semi truck with shock absorbers, seatbelts, and an air ride seat. He testified that ideally the freight would be loaded evenly so that the load was balanced. Petitioner stated that any time the trailer is loaded heavier to the front or rear it rides differently. He noted that although he did not know precisely how the freight was loaded on the date of accident, the reaction was greater at the time of the alleged accident.

Petitioner testified that between mile marker 327 and 328, he drove over a bridge which he knows to be a rough stretch, especially just north of the bridge. Petitioner and witness Ray Griest both testified that as vehicles travel northbound in the right hand lane over the bridge in question, there is a bump or significant dip in the road. Petitioner testified that when he drove over this stretch of road on December 4, 2012, his head was thrown forwards and immediately felt pain in his neck and tingling in his hands. He indicated that he had driven over this bump many times before, but the condition of roadway had continued to deteriorate. He noted that he had also felt pain at other times during that day. Petitioner testified that the State later placed a diamond shaped warning sign near the bump until they could fix it. However, he noted that despite the State's attempts to fix the problem, the bump is still there.

Former UPS road driver Raymond Griest testified that before his retirement he drove a double or tandem trailer similar to Petitioner's to and from Chicago along I57. He indicated that he and Petitioner were friends and that they had talked about the case on and off, including the condition of the road. Mr. Griest testified that he was not with Petitioner when he was injured, but that he was familiar with the mile stretch of highway on I57 between markers 327 and 328. He noted that the stretch of roadway is known for its bump, which he said was challenging to truck drivers. Mr. Griest also indicated that heavily loaded trailers result in more bounce, and while he was aware of the bump he wouldn't say you were prepared for it when you hit it.

Following the incident Petitioner continued to finish his shift and took an additional run from Champaign to Chicago Heights. Later that day (in the morning), while at the Chicago Heights terminal, Petitioner also stepped into a pothole, injuring his left knee. He testified that he previously injured his left knee and received an injection in 2010, but that he had not received any significant treatment for same from that time up to the date of the alleged accident on December 4, 2012. Petitioner indicated that after being told in the South Chicago port that he could only report accidents to his home terminal, he subsequently reported both of his injuries to his supervisor Dave Bowers at the Champaign terminal on the date of the alleged accident.

Later that same day, Petitioner sought treatment at SafeWorks Occupational Health with Dr. David J. Fletcher and Dr. James Blatzer. (PX2, PX5). Petitioner was directed to this provider by Respondent. Petitioner complained of neck pain along with bilateral upper extremity tingling and numbness. He rated his pain as 5/10. (PX2, PX5). The radiology impression was "cervical strain, both upper extremities paresthesias and left knee

hyperextension." (PX2, PX5). Petitioner admitted that he had left knee surgery in 2005 and a left knee injection in 2010.

Petitioner returned to SafeWorks for a follow up on December 11, 2012. (PX2. PX5). On that date, he rated his pain a 3/10. Examination impressions were left knee strain, neck strain, and bilateral extremity radicular symptoms. (PX2, PX5). Petitioner was given a plan to do physical therapy and continued to work without restrictions. (PX2, PX5). He continued to work until May 1, 2013. (PX2, PX5).

On January 4, 2013, Petitioner completed an MRI of both his left knee and cervical spine. (PX5). The MRI of the left knee was interpreted as revealing 1) a tear of the medial meniscus with Grade II to III cartilage thinning and joint space narrowing, 2) a tear of the posterior lateral meniscus with Grade II cartilage thinning and 3) Grade III to IV patellofemoral articular cartilage thinning and mild osteoarthritis. (PX5). The MRI of the cervical spine on that date was interpreted as revealing 1) a large right sided C6-7 herniation compressing the right side of the cord and the right C7 root, 2) malalignment and a broad herniation at C3-4 producing moderate cord compression and 3) bulging at C5-6 producing moderate cord compression. (PX5). Petitioner continued to do physical therapy 2-3 times per week and work without restrictions. (PX2).

On January 10, 2013, Petitioner was referred by Dr. Fletcher to Dr. Lawrence Li regarding his knee. (PX3). Dr. Li diagnosed Petitioner with left knee underling arthritis with medial and lateral meniscus tears. (PX3). Petitioner was to follow up with Dr. Li in 4 weeks. (PX3). Petitioner returned to Dr. Li on February 7, 2013 for follow up at which time it was noted that his symptoms were better, with continued anterior knee pain but improved medial pain with corticosteroid injection. (PX3).

On February 14, 2013, Petitioner visited Dr. Carl N. Graf at the request of Respondent for purposes of a §12 examination. (PX6). In a "Spine Patient History Questionnaire" filled out at that time Petitioner noted that he had been experiencing symptoms in his neck and arms since December 4, 2012 when he "hit rough bump snapping neck forward then back" at "M.M. 327 I-57 Peotone, IL." (PX6). Following physical examination, Dr. Graf opined that the diagnosis was consistent with significant cervical myelopathy. (PX6). Dr. Graf recommended consultation with an orthopedic spine specialist or neurosurgical spine specialist and opined that Petitioner was unable to work in any capacity. (PX6). Dr. Graf also noted in his initial report that "... it appears that Mr. Jenkins' condition is causally related to the injury in question." (PX6).

At the time of his deposition on October 11, 2013, Dr. Graf was shown a video filmed of the roadway Petitioner alleged traveled on the date of the accident – the same tape that was eventually admitted into evidence as RX4. (RX1, pp.19-20). Dr. Graff noted that "[o]verall it appears to be a pretty smooth ride and I don't see much motion in the mater on either of the video loop segments." (RX1, p.20). Based on this video, Dr. Graff opined that traveling down this stretch of highway would not result in enough force to create Petitioner's current cervical condition. (RX1, p.20). Dr. Graf noted that "[b]ased upon the mechanism seen here [in the video], this is certainly different than the mechanism which was described to me and as described in the medical records. I don't see forces which would generate the head snapping back and forth if this is truly the segment of road where this occurred, so that would change my opinions." (RX1, p.21). When asked whether Petitioner was predisposed to developing a cervical spine condition due to his size (450 pounds), Dr. Graf noted that he would consider an individual's weight more in terms of lumbar problems and would not come to that conclusion based on weight alone. (RX1, pp.23-24).

On March 7, 2013 Petitioner returned to Dr. Li for a recheck of his left knee. At that time Dr. Li noted that Petitioner's symptoms were the same from his last visit on February 7, 2013 and that he was progressing slowly with therapy. (PX3). Dr. Li's diagnosis at that time was left knee osteoarthritis and meniscus tear. (PX3). Dr.

Li also noted that Petitioner was to follow up with Dr. Fletcher to determine work status. (PX3). Petitioner testified that he has not required follow up treatment for his knee since that time.

On May 1, 2013, Dr. Fletcher restricted Petitioner from work and has not released him to work, pending surgery, up to the date of hearing. (PX1, PX2).

On May 6, 2013, Petitioner saw orthopedic surgeon Dr. Kern Singh. (PX5). In his report at that time Dr. Singh recorded that "... on 12/03/13 [sic], when he was working [as] a truck driver for Arkansas Best Freight, he hit a depression in the highway and his head went down and snapped back, going at approximately 62 miles an hour driving speed. He states he had instant neck pain and tingling and numbness down both arms. He comes in today stating that his pain persists in the axial neck and radiates into both shoulders, with numbness, tingling, and pain down both arms into the hands. Both arms are equal, and his arms are worse than his neck. He has at this time only done physical therapy with traction. He has been off work since last Wednesday." (PX5). Dr. Singh ordered a CT myelogram of Petitioner's cervical spine which occurred on June 4, 2013. (PX4). The CT myelogram revealed degenerative changes throughout the cervical spine including moderate to severe spinal stenosis at C3-4 and C6-7, mild spinal stenosis at C4-5 and moderate stenosis at C5-6. (PX4). Dr. Singh ultimately recommended a C3-C7 cervical laminoplasty for Petitioner's severe spinal cord compression. (PX5).

On February 11, 2013 Petitioner visited board certified orthopedic surgeon Dr. David J. Raab at the request of Respondent for purposes of a §12 examination relative to his left knee. (RX3). Dr. Raab testified by way of evidence deposition on September 29, 2014. (RX3). The Arbitrator notes that it appears no representative for Petitioner appeared or cross examined Dr. Raab at that time. (RX3). Upon questioning by defense counsel, Dr. Raab indicated that following his examination and review of the records his impression was that Petitioner suffered from degenerative arthritis to the left knee and possible medial and lateral meniscal tears to the left knee. (RX3, p.17). Dr. Raab testified that "... if there was an injury to the knee, it's a temporary aggravation of his preexisting arthritis. It's clear he has arthritis that predates the work related injury." (RX3, p.18). Dr. Raab went on to state that "... some of the treatment is reasonable, but continuing treatment is for the arthritis in his knee and not causally related to the work-related injury that he sustained on that particular date. He does have intermittent complaints of pain. It gets better and worse. It's my opinion again that these are secondary to the progression of the degenerative arthritis in his knee and the natural history of the degenerative arthritis and not causally related to his work-related injury of December 4, 2012." (RX3, p.19).

On May 8, 2013 Petitioner visited board certified neurosurgeon Dr. Andrew Zelby at the request of Respondent for purposes of a §12 examination relative to his cervical spine. (RX2). Dr. Zelby testified by way of evidence deposition on January 15, 2014. (RX2). Dr. Zelby viewed the video eventually admitted into evidence at RX4 and opined that "... there was no identifiable road condition or other abnormality that would result in his cervical condition or his symptoms. I thought that it was quite likely that a number of his symptoms were related to his cervical spondylosis and myelopathy... Based on the lack of movement seen in the water in the video, it is medically inconceivable that his condition resulted from his driving across this segment of highway. There would be no force applied to the spine based on the video I reviewed which would cause any type of injury to the cervical spine." (RX2, p.14). However, when asked whether a whiplash injury could have caused Petitioner's symptoms, Dr. Zelby testified that he "... suppose[d] [that] it's possible that it took a preexisting condition and caused it to become symptomatic, with a true whiplash, sure." (RX1, p.15). Dr. Zelby also noted that Petitioner's weight was of no practical significance in relation to his cervical condition given that his "...weight really isn't loading his cervical spine. It's loading his thoracic and his lumbar spine, but it's not really loading his cervical spine biomechanically." (RX1, p.15).

Currently, Petitioner notices that he has constant ringing in his ears, pain in his shoulders, difficulty raising his arms, lack of body strength and a lack of balance. He stated that he is still awaiting surgery on his neck.

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:

Petitioner testified that between mile marker 327 and 328, he drove over a bridge which he knows to be a rough stretch, especially just north of the bridge. Petitioner and witness Ray Griest both testified that as vehicles travel northbound in the right hand lane over the bridge in question, there is a large bump or dip in the road. Petitioner testified that when he drove over this stretch of road on December 4, 2012, his head was thrown forwards, after which he experienced pain in his neck and tingling in his hands and arms.

Respondent submitted into evidence video footage from inside a vehicle driven an investigator hired by Respondent over the stretch of road in question. (RX4). Petitioner also submitted into evidence his own video footage from inside a vehicle driving over the same stretch of highway. (PX8). The Arbitrator viewed both videos and notes that neither could be considered scientific in terms of its methodology. Indeed, it would not be a stretch to say that each video was produced from a particular perspective and with a preconceived end result in mind. In any event, the Arbitrator notes that the footage in each video would appear to substantiate Petitioner's claim to the extent that a rough patch of highway did in fact exist in the right lane between the 327 and 328 mile markers traveling north on Interstate 57 where the pavement gives way to a concrete overpass. Specifically, the videos show that most of the mile-long expanse in question appears to have been relatively recently repaved, with the asphalt appearing smooth and uniformly black, uninterrupted by any signs of damage or repair until after the vehicles pass beneath another highway and come up the slight rise of a bridge, where the unblemished asphalt pavement abruptly stops and a lighter, and presumably older expanse of concrete roadway begins. Once on this part of the highway, both vehicles are seen to suddenly dip and shake as they travel over rougher, less pristine pavement that stands in sharp contrast to the smooth expanse leading up to it. In addition, both videos show, at some point, a container half-filled with liquid sitting on the dash board of the respective vehicles, with the container in RX4 sitting on some sort of cross-hatched fabric or material that could, for all we know, have had some adhesive qualities that served to keep the bottle upright – hence the Arbitrator's earlier comments about the unscientific methodologies used. Be that as it may, the Arbitrator notes that when each vehicle travels over this rougher patch of highway, the vehicles as well as the containers are noticeably jostled, with the container in PX8 actually falling over as a result of the rough terrain. And while the disturbance could not be characterized as extremely violent, the footage from both videos would appear to support Petitioner's claim that the damaged portion of roadway existed and that the sudden dip and shaking of a vehicle traveling over that section, particularly a fully-loaded tandem tractor trailer, was entirely capable of thrusting an individual forward and then backward in his seat, creating a whiplash effect, no matter how many times he had traveled that particular spot.

Furthermore, with respect to the Petitioner's claim that he subsequently twisted his left knee when he stepped in a pothole while unhooking his trailer in the Champaign terminal, the photos submitted into evidence at RX8 appear to show a gravel yard outside a terminal that is pockmarked by large depressions or potholes. While Petitioner testified that he previously injured his knee and received treatment for same in 2010, he credibly testified that he continued to work and neither sought nor received any significant treatment for his left knee during the period leading up to the date of the alleged accident two years later.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the credible evidence that he sustained accidental injuries arising out of and in the course of his employment on December 4, 2012.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's uncontroverted testimony was that he gave notice of his work accidents to his supervisor, Dave Bowers, on the date of the injury. Mr. Bowers was not called to testify by either party, and Respondent otherwise submitted no evidence to contradict Petitioner's testimony along these lines.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner gave proper and timely notice of the injury to Respondent pursuant to §6(c) of the Act. Furthermore, Respondent failed to show that it was somehow prejudiced by any possible defect in said notice.

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

It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 204-206, 797 N.E.2d 665, ___, 278 Ill.Dec. 70, ___ (2003); citing *Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d 30, 36-37, 65 Ill. Dec. 6, 440 N.E.2d 861 (1982); *Caradco Window & Door v. Industrial Comm'n*, 86 Ill. 2d 92, 99, 56 Ill. Dec. 1, 427 N.E.2d 81 (1981); *Azzarelli Construction Co. v. Industrial Comm'n*, 84 Ill. 2d 262, 266, 49 Ill. Dec. 702, 418 N.E.2d 722 (1981); *Fitrro v. Industrial Comm'n*, 377 Ill. 532, 537, 37 N.E.2d 161 (1941).

It is axiomatic that employers take their employees as they find them. *Baggett v. Industrial Comm'n, 201 Ill. 2d187, 199, 266 Ill. Dec. 836, 775 N.E.2d 908 (2002).* "When workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment." *General Electric Co. v. Industrial Comm'n*, 89 Ill. 2d 432, 434, 60 Ill. Dec. 629, 433 N.E.2d 671 (1982). Thus, even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d at 36; *Williams v. Industrial Comm'n*, 85 Ill. 2d 117, 122, 51 Ill. Dec. 685, 421 N.E.2d 193 (1981); *County of Cook v. Industrial Comm'n*, 69 Ill. 2d 10, 18, 12 Ill. Dec. 716, 370 N.E.2d 520 (1977); *Town of Cicero v. Industrial Comm'n*, 404 Ill. 487, 89 N.E.2d 354 (1949) (It is a well-settled rule that where an employee, in the performance of his duties and as a result thereof, is suddenly disabled, an accidental injury is sustained even though the result would not have obtained had the employee been in normal health). Accidental injury need not be the sole causative factor, or even the primary causative factor, as long as it was a causative factor in the resulting condition of ill-being. *Rock Road Construction Co. v. Industrial Comm'n*, 37 Ill. 2d 123, 127, 227 N.E.2d 65 (1967).

In the present case, Petitioner testified that on December 4, 2012 he was driving a tandem semi which was heavily loaded when he struck uneven and rough pavement just beyond the bridge near mile markers 327-328 on Northbound I 57. He noted that as a result of the incident he was thrown forwards and felt immediate pain in his neck and numbness in his extremities. Later that day, Petitioner testified that he twisted his left knee when he stepped in a pothole while unhooking his rig. There is no evidence to suggest that Petitioner was

suffering from any pain relative to either his neck or left knee prior to the incidents in question. However, diagnostic testing did subsequently reveal degenerative changes in Petitioner's cervical spine, evidencing a pre-existing condition. In addition, Petitioner acknowledged that he had previously injured his left knee in 2010, at which time he received injections. However, there is no evidence to show that Petitioner sought or received treatment for either his cervical spine or left knee during the period leading up to the date of the accident.

On February 11, 2013 Petitioner visited board certified orthopedic surgeon Dr. David J. Raab at the request of Respondent for purposes of a §12 examination relative to his left knee. (RX3). Dr. Raab testified by way of evidence deposition on September 29, 2014. (RX3). The Arbitrator notes that it appears no representative for Petitioner appeared or cross examined Dr. Raab at that time. (RX3). Upon questioning by defense counsel, Dr. Raab indicated that following his examination and review of the records his impression was that Petitioner suffered from degenerative arthritis to the left knee and possible medial and lateral meniscal tears to the left knee. (RX3, p.17). Dr. Raab testified that "... if there was an injury to the knee, it's a temporary aggravation of his preexisting arthritis. It's clear he has arthritis that predates the work related injury." (RX3, p.18). Dr. Raab went on to state that "... some of the treatment is reasonable, but continuing treatment is for the arthritis in his knee and not causally related to the work-related injury that he sustained on that particular date. He does have intermittent complaints of pain. It gets better and worse. It's my opinion again that these are secondary to the progression of the degenerative arthritis in his knee and the natural history of the degenerative arthritis and not causally related to his work-related injury of December 4, 2012." (RX3, p.19).

On February 14, 2013 Petitioner visited board certified orthopedic surgeon Dr. Carl Graf at the request of Respondent for purposes of a §12 examination relative to his cervical spine. (PX6, RX1). Dr. Graf issued a report dated February 14, 2013 (PX6) and later testified by way of evidence deposition on October 11, 2013 (RX1). In his initial report, Dr. Graf noted that Petitioner's diagnosis was consistent with significant cervical myelopathy and that "... it appears that Mr. Jenkins' condition is causally related to the injury in question." (PX6). At the time of his deposition, Dr. Graf was shown a video filmed of the roadway Petitioner alleged traveled on the date of the accident – the same tape that was eventually admitted into evidence as RX4. (RX1, pp.19-20). Dr. Graff noted that "[o]verall it appears to be a pretty smooth ride and I don't see much motion in the mater on either of the video loop segments." (RX1, p.20). Based on this video, Dr. Graff opined that traveling down this stretch of highway would not result in enough force to create Petitioner's current cervical condition. (RX1, p.20). Dr. Graf noted that "[b]ased upon the mechanism seen here [in the video], this is certainly different than the mechanism which was described to me and as described in the medical records. I don't see forces which would generate the head snapping back and forth if this is truly the segment of road where this occurred, so that would change my opinions." (RX1, p.21). When asked whether Petitioner was predisposed to developing a cervical spine condition due to his size (450 pounds), Dr. Graf noted that he would consider an individual's weight more in terms of lumbar problems and would not come to that conclusion based on weight alone. (RX1, pp.23-24).

On May 8, 2013 Petitioner visited board certified neurosurgeon Dr. Andrew Zelby at the request of Respondent for purposes of a §12 examination relative to his cervical spine. (RX2). Dr. Zelby also viewed the video eventually admitted into evidence at RX4 and opined that "... there was no identifiable road condition or other abnormality that would result in his cervical condition or his symptoms. I thought that it was quite likely that a number of his symptoms were related to his cervical spondylosis and myelopathy... Based on the lack of movement seen in the water in the video, it is medically inconceivable that his condition resulted from his driving across this segment of highway. There would be no force applied to the spine based on the video I reviewed which would cause any type of injury to the cervical spine." (RX2, p.14). However, when asked whether a whiplash injury could have caused Petitioner's symptoms, Dr. Zelby testified that he "... suppose[d] [that] it's possible that it took a preexisting condition and caused it to become symptomatic, with a true

whiplash, sure." (RX1, p.15). Dr. Zelby also noted that Petitioner's weight was of no practical significance in relation to his cervical condition given that his "... weight really isn't loading his cervical spine. It's loading his thoracic and his lumbar spine, but it's not really loading his cervical spine biomechanically." (RX1, p.15).

Based on the above, it would appear that Petitioner suffered from pre-existing conditions relative to both his cervical spine and left knee. However, the evidence also shows that Petitioner had never sought treatment with respect to his neck prior to the accident in question, and that he had last received treatment for his left knee approximately two (2) years earlier. Furthermore, as previously determined, Petitioner credibly testified that on the date in question he was traveling over a rough patch of roadway when he was suddenly thrust forward and then backwards in his seat, resulting in a whiplash-like effect, followed by the immediate onset of pain in his neck and numbness down his arms. He reported the incident and sought treatment on the date of the accident. He provided a consistent history to his care-givers of driving over a rough patch of highway and being jostled in his seat -- the same history Dr. Graf initially relied upon to opine that Petitioner's current cervical condition was causally related to the incident in question. Indeed, it was not until Dr. Graf viewed the video produced by Respondent's investigator that he questioned whether the stretch of highway depicted even included such a rough patch. Likewise, Dr. Zelby based his opinion entirely on Respondent's video. However, as previously noted, the Arbitrator viewed both videos and found that the stretch of highway did in fact contain a dip or damaged portion that was quite capable of resulting in the sudden jostling and/or shaking of an individual riding in a fully-loaded tandem tractor trailer, creating a whiplash-type action that even Dr. Zelby conceded would be capable of aggravating Petitioner's pre-existing cervical condition. As a result, the Arbitrator finds that the accident in question aggravated or accelerated Petitioner's preexisting cervical condition so as to be considered a contributing cause of his injury, pursuant to *Sisbro*, supra.

Furthermore, Dr. Raab opined that Petitioner sustained a temporary aggravation of his pre-existing arthritic condition in his left knee condition as a result the incident of stepping in a pothole on December 4, 2012. For his part, following therapy and in spite of diagnostic testing that was interpreted as revealing underling arthritis with possible medial and lateral meniscus tears, Petitioner has sought no further treatment for his left knee since last visiting Dr. Li on March 7, 2013. As a result, the Arbitrator is inclined to agree with Dr. Raab's opinion that Petitioner's current left knee condition is related more to his underlying degenerative arthritis and is no longer causally related to the work injury on December 4, 2012.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the credible evidence that his current condition of ill-being relative to his cervical spine is causally related to the accident on December 4, 2012, but that Petitioner failed to prove that his current condition of ill-being relative to his left knee condition is causally related to said accident.

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

Petitioner submitted into evidence outstanding medical bills from Rush University Medical Center ($4,534.35), Affiliated Radiologists ($14.55), Prescription Partners ($2,280.89), and SafeWorks Illinois ($2,304.81). (PX7).

Based on the above, and the record taken as a whole, as well as the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner is entitled to

reasonable and necessary medical expenses totaling $9,312.60 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

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

A CT myelogram of the cervical spine performed on June 4, 2013 revealed degenerative changes throughout the cervical spine including moderate to severe spinal stenosis at C3-4 and C6-7, mild spinal stenosis at C4-5 and moderate stenosis at C5-6. (PX4). As a result, Dr. Singh recommended a C3-C7 cervical laminoplasty for Petitioner's severe spinal cord compression. (PX5).

When asked whether Petitioner needed surgery, Dr. Zelby, who examined Petitioner at the request of Respondent, testified that "... my first recommendation was a better MRI, and it was my suspicion based on the MRI I saw that he was probably going to need surgery, but I think the MRI that he had was inadequate to make a definite surgical opinion. Based on the fact that he appeared to have some myelopathic symptoms, he had some myelopathic findings on exam, and a poor quality MRI that suggested the possibility of spinal cord compression, with a better MRI I wouldn't have been surprised if I would've recommended surgery." (RX1, p.17).

Based on the above, and the record taken as a whole, as well as the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner is entitled to prospective medical treatment in the form of a C3-C7 cervical laminoplasty as recommended by Dr. Singh, and Respondent shall be liable for the reasonable and necessary medical expenses associated therewith pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

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

On May 1, 2013, Dr. Fletcher restricted Petitioner from work and has not released him to work, pending surgery, up to the date of hearing. (PX1, PX2).

Based on the above, and the record taken as a whole, as well as the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner was temporarily totally disabled from May 1, 2013 through May 11, 2015, the date of arbitration, for a period of 105-6/7 weeks.

WITH RESPECT TO ISSUE (O), RESPONDENT'S REQUEST FOR A FINDING UNDER §25.5 OF THE ACT, THE ARBITRATOR FINDS AS FOLLOWS:

At the commencement of trial, and as reflected on the Request for Hearing form (Arb.Ex.#1), counsel for Respondent requested a "determination under Section 25.5", the statutory provision of the Workers' Compensation Act that deals with allegations of fraud.

The Arbitrator notes that §25.5 sets forth certain unlawful acts and the penalties associated therewith, and mandates the establishment by the Department of Insurance of a fraud and insurance non-compliance unit "... responsible for investigating incidences of fraud and insurance non-compliance pursuant to this Section... It shall be the duty of the fraud and non-compliance unit to determine the identity of insurance carriers, employers, employees, or other persons or entities who have violated the fraud and non-compliance provisions

16IWCC0279

of this Section. The fraud and insurance non-compliance unit shall report violations of the fraud and insurance non-compliance provisions of this Section to the Special Prosecutions Bureau of the Criminal Division of the Office of the Attorney General or to the State's Attorney of the county in which the offense allegedly occurred, either of whom has the authority to prosecute violations under this Section." 820 ILCS 305/25.5(c).

The statute goes on to provide that "[a]ny person may report allegations of insurance non-compliance and fraud pursuant to this Section to the Department of Insurance's fraud and insurance non-compliance unit whose duty it shall be to investigate the report. The unit shall notify the Commission of reports of non-compliance. Any person reporting an allegation of insurance non-compliance or fraud against either an employee or employer under this Section must identify himself... Any person who intentionally makes a false report under this Section to the fraud and insurance non-compliance unit is guilty of a Class A misdemeanor." 820 ILCS 305/25.5(d).

Furthermore, the statute expressly provides that "[i]t is unlawful for any employer, insurance carrier, service adjustment company, third party administrator, self-insured, or similar entity to file or threaten to file a report of fraud against an employee because of the exercise by the employee of the rights and remedies granted to the employee by this Act." 820 ILCS 305/25.5(e).

The Arbitrator notes that "[i]t is important to remember that worker's compensation is a statutory remedy and the Workers' Compensation Commission, as an administrative agency, is without general or common law powers." *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission*, 236 Ill.2d 132, 145, 923 N.E.2d 266, ___, 337 Ill.Dec. 707, ___ (2010); See *Flynn v. Industrial Commission*, 211 Ill.2d 546, 553, 813 N.E.2d 119, 286 Ill.Dec. 62, (2004); *Cassens Transport Co. v. Industrial Commission*, 218 Ill.2d 519, 525, 844 N.E.2d 414, 300 Ill.Dec. 416 (2006). Accordingly, any action taken by the Commission must be specifically authorized by statute. Citing *Cassens Transport Co.*, 218 Ill.2d at 525.

Along these lines, the Arbitrator notes that the above statute clearly sets forth the procedure for the reporting of allegations of fraud – namely, to the Department of Insurance's fraud and insurance non-compliance unit which in turn is entrusted with the task of investigating and reporting violations of the fraud and insurance non-compliance provisions of the Act to the Special Prosecutions Bureau of the Criminal Division of the Office of the Attorney General or to the appropriate State's Attorney office in the county where the violation allegedly occurred. Nowhere in the statute does it provide for the determination of fraud by the Workers' Compensation Commission, either at the arbitration or the review levels. As a result, since the Commission has not been specifically granted the power to make any determination as to alleged fraud, the Arbitrator has no authority to make any such a finding. Indeed, one might interpret Respondent's demand for such a finding as an attempt to intimidate Petitioner and dissuade him from pursuing his rights under the Act, an activity that is equally prohibited under §25.5, and a determination the statute similarly refrains from expressly authorizing the Commission to make.

Therefore, based on the above, Respondent's request for a determination under §25.5 is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Erdin Salmani,

Petitioner,

vs. NO. 13 WC 08209

3600 N. Lake Shore Dr. Condo Association,

16IWCC0363

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Order of the Arbitrator filed October 29, 2015 is hereby affirmed and adopted.

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

No bond is required for 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: MAY 26 2016

Stephen J. Mathis

Mario Basurto

David L. Gore

SJM/sj
o-5/12/2016
44

16IWCC0363

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF MOTION AND ORDER

ATTENTION. You must attach the motion to this notice. If the motion is not attached, this form may not be processed.
Upon filing of a motion before a Commissioner on review, the moving party is responsible for payment for preparation of the transcript.

Erdin Selmani
Employee/Petitioner

v. **3600 Condominium Association**
Employer/Respondent

Case # 13 WC 08209

FILED
2015 SEP 29 PM 2:43
ILLINOIS WORKERS' COMPENSATION COMMISSION

TO: Power & Cronin/Attn: Andrew M. Luther
900 Commerce Dr. - Ste 300
Oak Brook, IL 60523

On **October 2, 2015**, at **2:00** PM ☐, or as soon thereafter as possible, I shall appear before the Honorable **Lynette T. Smith**, or any arbitrator or commissioner appearing in his or her place at **100 W.Randolph St., Chicago**, Illinois, and present the attached motion for:

___ Change of venue (#3072)
___ Consolidation of cases (#3071) (list case#)
___ Dismissal of attorney (#3052)
___ Dismissal of review (#3085)
___ Fees under Section 16 (#1600)
___ Fees under Section 16a (#1645)
___ Hearing under Sect.19(b) (#1902)
___ Penalties under Sect. 19(k) (#1911)
___ Penalties under Sect. 19(l) (#1912)
✔ Reinstatement of case (#3074)
___ Request for hearing (#R33)
___ Withdrawal of attorney (#3073)
___ Other (explain) _____

Signature Petitioner ___x___ Respondent ___

Caroline Watson #0592
Attorney's name and IC code # (please print) [1]

Pomper & Goodman
Name of law firm, if applicable

111 W. Washington St., Ste1000
Street address

Chicago, IL 60602
City, State, Zip code

(312) 236-2977 cwatson@pomperlaw.com
Telephone number E-mail address

ORDER

The motion is set for hearing on _____

_____ _____
Signature of arbitrator or commissioner Date

ORDER

The motion is ___ Granted ___ Withdrawn ___ Continued to _____
___ Denied ___ Dismissed ___ Set for trial (date certain) on _____

_____ 10-29-15
Signature of arbitrator or commissioner Date

16IWCC0363

PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.

I, Myra Gonzalez, affirm that I delivered ____ mailed with proper postage ✔

in the city of Chicago, Illinois a copy of this form

at 5:00 PM ☒ on 9/8/2015 to each party at the address(es) listed below.

Power & Cronin/Attn: Andrew M. Luther
900 Commerce Dr. - Ste 300
Oak Brook, IL 60523

M. Gonzalez
Signature of person completing *Proof of Service*

Signed and sworn to before me on _____

Notary

[1] The Workers' Compensation Commission assigns code numbers to attorneys who regularly practice before it. To obtain or look up a code number, contact the Information Unit in Chicago or any of the downstate offices at the telephone numbers listed on this form.

STATE OF ILLINOIS)
) SS.
COUNTY OF ST. CLAIR)

☐ 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

DANIEL R. HOPKINS,

Petitioner,

vs. NO: 13 WC 9207

SNAP-ON-TOOLS,

16IWCC0280

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, permanent partial disability, and §8(j) credit, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the award for permanent partial disability. Applying the five factors in §8.1b(b), we find that:

(i) There was no American Medical Association Impairment report so we give that no weight.

(ii) At the time of Petitioner's injury on January 18, 2013, he worked for Respondent as a "Franchise Developer" under 50-pound restrictions that existed due to a previous fusion surgery. After his post-accident lumber fusion surgery on September 5, 2013, Petitioner was ultimately released to full duty work under the same 50-pound restrictions that he had previously. Although Petitioner testified that when he returned to work, he was no longer a "Franchise Developer" but instead was a "Techno Sales Rep," we find that Petitioner failed to prove that this change in position was required as a result of his work injury. We give this factor no weight.

(iii) Petitioner was 50 years old at the time of the accident and will have to live with his ongoing symptoms longer than an older worker. The Commission gives this factor

IBIA0880

some weight.

(iv) Although Petitioner testified that he is now earning $400 less per pay period since returning to work as a "Techno Sales Rep" instead of his previous job as a "Franchise Developer," as we noted in (ii) above, Petitioner failed to prove that this change in position was required by his accident or due to any new restrictions. We find that Petitioner has not suffered an accident-related diminishment in his future earning capacity and give no weight to this factor.

(v) Regarding "evidence of disability corroborated by the treating medical records," Petitioner testified that he has muscle pain in his back "all the time" and he can't do anything for a long period of time. The last medical record from Dr. Kennedy on April 24, 2014, indicates that Petitioner noted increased pain with walking for any distance and had some reduced range of motion but that Petitioner was overall improved compared to his pre-operative condition. As mentioned above, Petitioner was released to the same 50-pound restrictions that he had previously. We find that Petitioner's testimony is corroborated by the last medical record and we give some weight to Petitioner's continuing evidence of disability.

Based on the above, the Commission finds that Petitioner is permanently partially disabled to the extent of 12.5% of the person as a whole.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $902.03 per week for a period of 27-6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act, with Respondent receiving a credit of $20,392.89 for short-term and long-term disability benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 62.50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 12.5% loss use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $123,015.39 for medical expenses under §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of $28,882.63 under §8(j) of the Act for medical benefits that have been paid; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

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

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: MAY 3 - 2016

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 4/12/16
49

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Made in Malaysia

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOPKINS, DANIEL R
Employee/Petitioner

Case# **13WC009207**

SNAP-ON-TOOLS
Employer/Respondent

16IWCC0280

On 4/2/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the 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:

1413 BRAD L BADGLEY PC
26 PUBLIC SQUARE
BELLEVILLE, IL 62220

4942 LEAHY WRIGHT & ASSOC LLC
KEVIN LEAHY
10805 SUNSET OFFICE DR #306
ST LOUIS, MO 63127

16IWCC0280

STATE OF ILLINOIS)
)SS.
COUNTY OF ST. CLAIR)

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

08BC30178

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DANIEL R. HOPKINS
Employee/Petitioner

v.

SNAP-ON-TOOLS
Employer/Respondent

Case # 13 WC 009207

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Belleville**, on **November 21, 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 _____

16IWCC0280

FINDINGS

On **January 18, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$70,358.70**; the average weekly wage was **$1,353.05**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$20,392.89** for other benefits, for a total credit of **$20,392.89**.

Respondent is entitled to a credit of **$28,882.63** for medical payments made under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $902.03 per week for 27 6/7 weeks, commencing September 5, 2013 through March 18, 2014 as provided in Section 8(b) of the Act. Respondent shall be given credit of $20,392.89 for STD and LTD benefits paid.

Respondent shall pay reasonable and necessary medical services of $123,015.39, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $28,882.63 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.

Pursuant to the factors set forth in §8.1b(b) of the Act, which the Arbitrator specifically addresses herein below, Respondent shall pay Petitioner permanent partial disability benefits of $712.55 per week for 112.5 weeks, because the injuries sustained caused the 22.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

3/23/15
Date

ICArbDec p. 2

APR 2 - 2015

16IWCC0280

BACKGROUND

Prior to beginning his employment with Respondent, Petitioner was a member of the Collinsville Police Department for 19 years. During the course of his employment with the Police Department Petitioner suffered a back injury in 2004. As a result of the injury he underwent fusion surgery at the L4-5 and L5-S1 levels. Petitioner was ultimately granted a line of duty disability pension. He was released at maximum medical improvement in 2006. At that point he had a 50 pound lifting restriction with only occasional bending, twisting or stooping. He underwent no treatment for his low back between 2006 and January 18, 2013.

FINDINGS OF FACT

Petitioner went to work Respondent in 2009 as a franchise developer. His duties required Petitioner to would work with the individual franchisees helping to start up their businesses. He would ride with them on their sales calls for 3 to 5 weeks. Petitioner worked from his home and would travel throughout the country to wherever the franchisees were located. When close enough to home, he would work with the franchisees during the week and return to his home on the weekends.

On January 18, 2013 Petitioner was working with a franchisee in the Indianapolis Indiana area. He was injured on the last day of the work week. As was his custom, Petitioner dropped his personal vehicle before beginning the work day in a location near the last planned stop of the day. He would then ride along with the franchisee for the entirety of the workday and pick up his personal vehicle once the day's stops were complete. The last stop of the day on January 18, 2013 was Hobbs Automotive. Petitioner and the franchisee with whom he was working arrived at Hobbs between 330 and 4:30 PM on that Friday. There were two parking lots at Hobbs automotive. There was a parking lot in front which was open to the general public and a back lot which is fenced in and not accessible to the public. When they returned to Hobbs that afternoon they parked the Snap-On tool truck in the rear gated lot, 20 to 30 yards from the rear entrance to the business. As Petitioner was walking toward the rear entrance he stepped on a snow and sleet covered piece of 2 x 4 lumber. This caused him to slip and struggle to retain his balance. Petitioner caught himself before he actually fell. He wrenched, but did not strike his back. He experienced immediate onset of low back and leg pain. Petitioner testified that the franchisee was in front of him at the time and did not see him slip. Petitioner also indicated that it was his custom to carry his tool catalog into each stop. He was able to complete the last stop of the day with the franchisee. Thereafter, he returned to his personal vehicle and made the drive back home to the St. Louis area.

In the days and weeks that followed the accident Petitioner's symptoms got progressively worse. Eventually he made and appointment with Dr. Kennedy. He was familiar with Dr. Kennedy, having had treated with him previously for the 2004 back injury. Petitioner's first visit with Dr. Kennedy following the date of accident was February 12, 2013. A CT scan of the lumbar spine with contrast performed on February 26, 2013 showed a large posterior disc herniation L3–4 resulting in severe canal stenosis. (PX 2) On September 5, 2013 Petitioner underwent a lumbar decompression and fusion at L3–4. (PX 1, p.13) Postoperatively Petitioner developed a hematoma in the groin area which ultimately resolved.

Dr. Kennedy testified that the very large herniated disc at L3–4 which he operated on was a new injury to a new site. The area which was previously operated on "did not have any issues so that was not involved in his current pain condition." (PX1, pp. 11–12) it was Dr. Kennedy's opinion that the herniated disc at L3-4 was causally related to Petitioner wrenching his back when he slipped on the 2 x 4. Dr. Kennedy indicated that the herniated disc at L3–4 was not related to the prior surgery and would not have occurred absent a significant trauma. (P X1, p. 17) On January 28, 2014 Dr. Kennedy released Petitioner to return to work only for the purpose of participating in training. Later, on March 19, 2014 Petitioner was released to light duty. His last visit with Dr. Kennedy was April 24, 2014 at which point he was released with permanent restrictions.

Dr. Robert Backer examined Petitioner on April 25, 2013 at Respondent's request pursuant to § 12. Dr. Backer agreed that Petitioner required surgery. He did not address the specific procedure performed by Dr. Kennedy. He did not feel, however that the condition of Petitioner's lumbar spine was causally related to the accident. Instead, Dr. Backer testified that Petitioner suffered from "adjacent segment" disease as a result of the prior two level fusion. He indicated that this condition could have been aggravated by normal activities of daily living. Dr. Backer did agree, however that based upon the treatment and history, the January 18, 2013 accident brought Petitioner to seek medical attention. (RX2, pp. 40 – 41)

The parties agreed that Petitioner incurred $123,015.39 in medical expenses as a result of the treatment necessitated by the accident. Respondent however disputes their liability for medical expenses based on the issues of accident and causation. The parties further agree that Respondent is entitled to a credit of $28,882.63 pursuant to §8 (j).

The parties agree that Petitioner was temporarily and totally disabled for the period of September 5, 2013 through March 18, 2014 a period of 27 6/7 weeks. It was stipulated that Petitioner's average weekly wage was

$1,353.05. At the corresponding temporary total disability rate of $902.03, the temporary total disability due would be $25,127.94.

The parties also agreed that Petitioner was paid $23,605 (gross) in short-term disability benefits (STD) and $3,697.23 in long-term disability benefits (LTD). Petitioner agrees with Respondent's claimed credit of $3,697.23 for long term disability payments. With respect to the short term disability benefits Petitioner claims that Respondent is only entitled to credit for $16,695.66 as that was the net amount received by Petitioner(JX1). The unrefuted testimony of Petitioner shows that while on short term disability he received bi-weekly checks in the gross amount of $1,820.00 from which he netted $1,285.27 after taxes were withheld.

CONCLUSIONS OF LAW

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

At the time of injury Petitioner was clearly in the course of his employment. In addition, the parking lot in which Petitioner and the franchisee had parked the Snap-On tools truck was a private fenced lot behind Hobbs automotive. The area in which Petitioner slipped was not an area open to the public. Petitioner sustained his injury when he slipped on a 2 x 4 which was hidden from view by snow and wrenched his back. Petitioner's testimony in this regard was forthright and credible. Based upon forgoing, the Arbitrator finds Petitioner did sustain an accident which arose out of and in the course of his employment.

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

Both Dr. Kennedy and Dr. Backer agreed that surgical treatment for Petitioner was reasonable and necessary given his condition of ill-being. Dr. Kennedy testified that the condition of ill-being which brought Petitioner to seek treatment following the January 18, 2013 accident was a new injury to a new part of the body. The treatment was unrelated to Petitioner's prior two level lumbar fusion. Dr. Kennedy pointed out that during the surgical procedure his observation of the prior surgery site indicated there were no untoward findings with respect to those levels. It was his opinion that when Petitioner wrenched his back on January 18 that trauma led to the herniated disc which he treated in September 2013. (PX1, pp.11-12, 17) Dr. Backer on the other hand indicated that although the incident led Petitioner to seek treatment, the pre-existing condition was such that any activities of normal daily living could have resulted in the need for treatment. (RX2, pp.24, 40-41) It is clear from the evidence that there was no herniated disc present at the L3-4 level in 2006. Further, the Petitioner had

no significant symptoms in his low back and did not require any medical treatment for the low back between 2006 and the date of accident. The Arbitrator finds Dr. Kennedy's testimony to be more persuasive.

Based upon the foregoing the Arbitrator finds the condition of ill-being of Petitioner's lumbar spine which necessitated surgical intervention on September 5, 2013 is causally related to the accident he sustained on January 13, 2013.

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

Both Dr. Kennedy and Dr. Backer agreed that the Petitioner required surgery to treat his condition. There is no evidence in the record to refute that the procedure recommended by Dr. Kennedy and accepted by Petitioner was both reasonable and necessary. Further, the parties stipulated that Petitioner incurred $123,015.39 in medical expenses related to his low back condition. Respondent disputes responsibility for these medical expenses based upon the issues of accident and causation only. Having previously found Petitioner sustained an accident which arose out of and in the course of his employment and that his current condition of ill-being was causally related to the accident, the Arbitrator finds that the medical services provided to Petitioner were reasonable and necessary and Respondent shall pay those expenses pursuant to the fee schedule.

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

The parties agreed that Petitioner's period of temporary total incapacity began on September 5, 2013 and ran through March 18, 2014, a total of 27 6/7 weeks. Based on Petitioner's average weekly wage of $1,353.05, his TTD rate is $902.03 and the temporary total disability benefits due are $25,127.84.

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a franchise developer at the time of the accident. He was able to return to work for Respondent as a techno-sales representative following his surgery with essentially the same

restrictions on his activities that he had prior to the accident. The Arbitrator notes that now, although Petitioner is able to tolerate the duties, his employment causes his symptoms to increase through the course of the work day and he has difficulty sitting for long periods of time. The Arbitrator therefore gives some weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of the accident. Because Petitioner will have to suffer from his ongoing symptoms longer than an older worker the Arbitrator gives some weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner has returned to work for Respondent with no diminution in earning capacity indicated in the record. The Arbitrator therefore gives little weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner's complaints are consistent with the medical records of the treating physician. Petitioner now has three adjacent levels of his lumbar spine fused. He continues to suffer ongoing symptoms of pain and reduced range of motion. The Arbitrator therefore gives great weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 22.5% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

Issue (N): Is Respondent due any credit?

During the period of time Petitioner was off work he received short term and long term disability benefits. The parties agreed he received long term disability benefits in the amount of $3,697.23. Respondent claimed that Petitioner received $23,605.00 in short term disability benefits however, that figure did not take into consideration taxes and other deductions. Petitioner testified he received net after tax payments, of $16,695.66. His testimony was unrefuted. Although this claim arose after the 2011 amendments to the Act, the Legislature in those amendments did modify the calculation method for TPD benefits under §8(a), but did not address the computation of credit under §8(j). As a matter of Statutory construction the Arbitrator presumes that if the Legislature had intended to modify the method of calculating §8(j) credit they would have done so. Therefor the Arbitrator finds Respondent only entitled to §8(j) credit for the net STD benefits paid pursuant to *Navistar Int'l Transp. Corp. v. Industrial Comm'n*, 315 Ill. App. 3d 1197, 734 N.E.2d 900 (2000). When the net

amount of STD payments is added to the agreed sum for LTD payments, this results in a total of $20,392.89 for which Respondent is entitled to a credit pursuant to §8(j) of the Act against the temporary total disability benefits awarded.

Respondent disputed its obligation to pay Petitioner's medical expenses, again based on the issues of accident and causal connection. Many of Petitioner's medical expenses were, however paid by his health insurance carrier, Optum. This coverage was provided by Respondent. Optum paid $28,882.63 for which they have asserted a lien. Respondent shall be given a credit of $28,882.63 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, and shall further hold Petitioner harmless from the claimed lien of Optum.

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

Vickie Reichardt,

Petitioner,

16IWCC0314

vs. NO: 13 WC 14430

Sodexho,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 12, 2015, 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.

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

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

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

DATED: MAY 12 2016
o4/27/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

JOINDOCS

Wade M Wilson

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

16IWCC0314

REICHARDT, VICKIE
Employee/Petitioner

Case# 13WC014430

SODEXHO
Employer/Respondent

On 6/12/2015, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5122 PORRO NIERMANN & PETERSEN
MICHELLE D PORRO
821 W GALENDA BLVD
AURORA, IL 60506

1832 KLAUKE LAW GROUP LLC
MARK DINOS
10 N MARTINGALE RD SUITE 400
SCHAUMBURG, IL 60173

STATE OF ILLINOIS)
)SS
COUNTY OF LA SALLE)

16IWCC0314

☐ 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)

Vickie Reichardt
Employee/Petitioner

v.

Sodexo
Employer/Respondent

Case # **13** WC **14430**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Ottawa**, on **May 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

16IWCC0314

On the date of accident, **9/8/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's cervical and right shoulder condition ***are*** causally related to the accident.

Petitioner's carpal and cubital tunnel condition ***are not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**19,240.00**; the average weekly wage was $**370.00**.

On the date of accident, Petitioner was **45** 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 $**34,175.62** for TTD, $**0** for TPD, $**0** for maintenance, and $**2,200.00** for other benefits, for a total credit of $.

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

ORDER

Respondent shall pay all reasonable and necessary medical services related to Petitioner's cervical and shoulder condition, subject to the Fee Schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any related expenses it has already paid. Any expenses for treatment of Petitioner's carpal or cubital tunnel syndrome are found unrelated and therefore denied.

Respondent shall pay Petitioner temporary total disability benefits of $246.66/week for 130-4/7 weeks, commencing 9/15/10 through 3/25/13, as provided in Section 8(b) of the Act. Petitioner's claim for TTD beyond 3/25/13 is denied.

Petitioner's claim for prospective medical care is denied.

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

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

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

Signature of Arbitrator

6/11/15
Date

JUN 12 2015

16IWCC0314

FINDINGS OF FACT

This claim arises out of an undisputed accident sustained by the Petitioner on September 8, 2010 while working as a head cook for the Respondent. The Application for Adjustment of Claim indicates the Petitioner is claiming injuries to her neck, right shoulder, arm and hand. At trial, the parties disputed the following issues: 1) causation, 2) TTD, 3) medical expenses, and 4) prospective medical care.

On the date of the injury, September 8, 2010, Petitioner was a 45-year old employee of the Respondent, Sodexo. Petitioner testified she worked as a cook at Plainfield North High School and had been employed for about five years. Her work duties include putting away boxes of food that were delivered, to rotate the stock, and things of that nature. On the date of the accident, Petitioner testified she was putting boxes of apples on shelf. One case of apples fell and struck her in the chin. She estimated the box weighed between 55 and 60 pounds. Petitioner testified she reported the accident to her supervisor Jodi.

Petitioner came under the care of Dr. Thomas McGivney at Castle Orthopedics in September 2010. (PX B.) She reported pain in her neck, right shoulder and both arms. She underwent a cervical MRI on September 24, 2010 which revealed a herniated disc at C5-6 and slight protrusions at C3-4 and C4-5. Id.

Petitioner came under the care of Dr. Bathina at Aurora Pain Clinic in October 2010. (PX C). She underwent a right shoulder MRI on October 21, 2010, which revealed degenerative changes. Id.

On January 19, 2011, Petitioner underwent an anterior cervical microdiskectomy, allograft arthrodesis, and plating at C5-6 and C6-7 to address her cervical condition. The procedure was performed by Dr. McGivney at Rush Copley Medical Center. (PX H).

On March 23, 2011, Dr. McGivney opined Petitioner had a solid cervical fusion after reviewing updated x-rays of the cervical spine. (PX B)

On May 24, 2011, Petitioner underwent a Functional Capacity Evaluation at WCS Rehabilitation. (RX 5). The evaluation showed Petitioner gave an inconsistent effort. Id. Nonetheless, the results of the FCE showed Petitioner was capable of working at a medium duty work capacity.

On June 6, 2011, Dr. McGivney released Petitioner from care and placed her at MMI. He opined Petitioner could return to work consistent with the work restrictions of the FCE. (RX 4)

On June 24, 2011, Petitioner began treating with Dr. Saleem at Castle Orthopedics for her right shoulder. (PX B). Dr. Saleem reviewed an MRI of the shoulder which had evidence of a rotator cuff tear.

On July 18, 2011, Petitioner was seen by Dr. Shane Nho for an Independent Medical Examination of the right shoulder. (RX 1). Dr. Nho opined Petitioner that he had reason to believe Petitioner's right shoulder condition was related to the work accident. Furthermore she had not reached maximum medical improvement. He recommended a lidocaine injection to the right shoulder prior to surgical intervention. Id.

On August 3, 2011, Petitioner underwent right shoulder arthroscopic rotator cuff repair with Dr. Saleem (PX B) All indications were that Petitioner tolerated the procedure well.

On November 2, 2011, Petitioner came under the care of Dr. Michael Caron. (PX E). At that time Petitioner complained of constant hand swelling and numbness at her right hand. She reported that she initially sustained an injury on September 8, 2010 at work and injured her shoulder and felt a "pop". At that time she had numbness and tingling into both hands. A cervical MRI was recommended.

On November 8, 2011, Petitioner had an additional Cervical MRI at Edwards Hospital. (PX F) The MRI showed hardware fusion from C5-7 that appeared stable without evidence of postsurgical complications.

On December 19, 2011, Petitioner returned to Dr. Caron who saw no additional problems at the surgical sight. (PX F).

On December 22, 2011, Dr. Saleem released Petitioner to work with 10-pound lifting restrictions. He also placed Petitioner at MMI, noting her symptoms resolved. (RX 3)

On January 30, 2012, Petitioner was seen for an Independent Medical Examination by Dr. Paul Papierski relative to cubital tunnel and carpal tunnel symptoms. (RX 2) Dr. Papierksi opined the cubital tunnel was not related. He further opined the carpal tunnel may have been related to her work activities, but she also had several other contributing factors including her age, weight and gender. Id. Petitioner testified she did not recall seeing Dr. Papierski for an IME.

On May 17, 2012, Petitioner underwent right carpal tunnel release at Castle Surgicenter. (PX B). She subsequently underwent left carpal tunnel release in June, 2012.

On July 18, 2012, Petitioner returned to Dr. Caron. (PX F). She had complaints of worsening pain in the neck. Pain medications were prescribed at that time.

Petitioner saw Dr. Caron again on August 29, 2012. Id. At that time he recommended Petitioner undergo anterior cervical fusion at C4-5.

On September 14, 2012, Petitioner was seen by Dr. Babak Lami for an Independent Medical Evaluation relative to her neck and shoulder complaints. (RX 6). Dr. Lami opined Petitioner was not a surgical candidate. She had normal orthopedic and neurologic examination of the spine. Her previous cervical surgery had healed nicely. Specifically, he stated, "I cannot support any surgery for her cervical spine. I cannot support any cervical epidural injection due to the lack of radiculopathy not can I support and facet injections due to her clinical presentation and lack of correspondence to facet symptoms." Id. He could, however, support a trial for occipital nerve blocks to reduce some of Petitioner's headaches. He opined Petitioner was capable or working at a medium duty capacity. Id.

On November 1, 2012, Petitioner underwent medial branch nerve blocks at C2-3, C4, C5 and C6.

On February 11, 2013, Petitioner was seen for a follow up Independent Medical Evaluation with Dr. Lami. (RX 7) Petitioner reported the injections provided temporary relief for a short period of time. This was inconsistent with Dr. Bathina's reports, according to Dr. Lami, which indicated Petitioner had reported complete resolution of the pain. Id. Again, Dr. Lami opined Petitioner was not a surgical candidate and could return to work in medium duty capacity.

16IWCC0314

Petitioner retuned to Dr. Bathina on April 2, 2013. (PX C) He indicated he would prescribed Petitioner only three additional months of opioids and opined Petitioner needed radiofrequency denervation of the facet joints. Id.

Petitioner testified that she spoke with an insurance adjuster some time in March, 2013, wherein the adjuster advised Petitioner to contact the Respondent via Eloise Sopka for available light duty work. On March 4, 2013, Ms. Eloise Sopka, General Manager for Sodexo, authored a letter to Petitioner advising her of the availability of work within her restrictions. (RX 8). Ms. Sopka testified that letter was sent via UPS. (RX 10) The letter was returned to Respondent with a note on the envelope indicating "Receiver did not want, refused delivery." Ms. Sopka testified she had a conversation with Petitioner on or about March 21 or 22 wherein she confirmed Petitioner's mailing address, but did not discuss the availability of work within the Petitioner's restrictions. (RX 10). She subsequently authored an additional letter on March 22, 2013, and it was mailed to Petitioner's address via Certified Mail through the US Post Office. (RX 9). Petitioner testified she never received either letter sent by Ms. Sopka, but has received other documents from the Respondent regarding insurance and retirement.

Petitioner further testified that she was advised by Ms. Sopka to contact either Marcus or Donna at the Respondent since Ms. Sopka was retiring. Petitioner testified that she left messages for both Marcus and Donna and did not receive any return phone calls from either of these people.

The parties agreed Petitioner was paid TTD benefits from September 9, 2010 through March 25, 2013.

On March 12, 2014, Dr. Ali authored an off work note indicating Petitioner should remain off work until after she underwent cervical surgery. (PX N)

On July 23, 2014, Petitioner underwent an MRI of the cervical spine. (PX K). It revealed a small stable central disc protrusion at C3-4; a stable slightly larger central disc protrusion at C4-5 with some inferior extrusion without absolute canal stenosis or deformity of the nerve roots; and some facet arthritis most severe on the left C2-3 through C4-5.

On September 15, 2014, Dr. Caron evaluated Petitioner again. (PX K) After reviewing the MRI, he opined Petitioner required a C4 through T1 anterior cervical decompression and reconstruction due to an incomplete fusion at C5-6 and definite non-union at C6-7. Id.

On February 26, 2015, Dr. Lami evaluated Petitioner for a third time for an additional Independent Medical Examination. (RX 11). At the conclusion of that exam, Dr. Lami opined Petitioner was still not a candidate for any surgical intervention and she could work consistent with the duties of a cook. Id. He opined, based on his review of the July MRI, Petitioner has a solid fusion at C5-6 and likely solid fusion at C6-7. Id. Petitioner testified she recalled seeing Dr. Lami for all three IME evaluations.

Petitioner testified that she is seeking authorization for treatment recommended by Dr. Caron.

CONCLUSIONS OF LAW

1. With regard to the issue of causation relating to the Petitioner's neck and shoulder condition, the Arbitrator finds that the Petitioner has met her burden of proof . However, the Arbitrator further finds on this issue that the Petitioner has failed to meet her burden of proof on the question of whether the Petitioner's carpal and cubital tunnel condition are related to her September 8, 2010 accident. In support of this finding the Arbitrator relies on both the testimony and the medical evidence presented at trial. The testimony and the medical evidence all indicate the Petitioner experienced pain to her neck and her right shoulder soon after the undisputed accident on September 8, 2010. In fact Respondent's IME doctors do not dispute the question of causality with respect to the Petitioner's neck and right shoulder. Based on these facts, the Arbitrator concludes that the Petitioner's neck and right shoulder condition are related to her September 8, 2010 accident.

As for the Petitioner's carpal and cubital tunnel conditions, there is no evidence indicating any causal relationship between these conditions and the Petitioner's September 8, 2010 accident. Although Respondent's IME, Dr. Papierski indicates that Petitioner's carpal tunnel symptoms may have been related to the Petitioner's work activities, he weakens that opinion by adding that the Petitioner has several other contributing factors. Furthermore, there is no evidence that the Petitioner's job was sufficiently repetitive in nature to support a repetitive trauma theory of causation. There was also no evidence indicating the Petitioner's carpal and cubital tunnel syndrome were caused by a traumatic incident. Given the lack of evidence on this issue, the Arbitrator concludes that the Petitioner's carpal and cubital tunnel syndrome are not related to her accident from September 8, 2010.

2. Based on the Arbitrator's conclusions with regard to the issue of causation, the Arbitrator finds that the Petitioner's medical treatment thus far related to her neck and shoulder condition was both reasonable and necessary to alleviate her work-related conditions. As such, the Arbitrator awards any and all medical expenses related to treatment for the Petitioner's neck and shoulder condition, subject to the fee schedule and in accordance with Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit for any related medical expenses it has paid thus far. Furthermore, in accordance with the Arbitrator's findings above, the Petitioner's claim for medical expenses related to her carpal and cubital tunnel syndrome is denied.

3. With regard to the issue of TTD, the Arbitrator finds that the Petitioner has met her burden of proving her entitlement of TTD fromSeptember 15, 2010 through the March 25, 2013. The Arbitrator denies the Petitioner's claim for ongoing TTD beyond March 25, 2013. This finding is based on the testimony and the medical evidence presented at trial. Petitioner's lack of credibility is a major factor in deciding this issue. The Arbitrator finds persuasive the opinions of Dr. Lami, who indicated the Petitioner had reached MMI status as of February, 2013 and could return to medium duty work in accordance with Petitioner's FCE. Soon after that IME, the Respondent claims it had light duty work available for the Petitioner, but Petitioner claims that she was not aware of this. The Arbitrator finds incredible the Petitioner's claim that she was not aware of any light duty work being offered to her by Respondent, given the fact that the Petitioner testified she was told by an insurance adjuster to contact the Respondent regarding light duty work in March, 2013. And when Respondent attempted to send Petitioner a letter regarding the available light duty work via UPS, the evidence indicates that the correspondence was refused by the intended

16IWCC0314

recipient – who presumably was the Petitioner. Respondent attempted a second time to send a letter offering light duty work to the Petitioner via US mail, but Petitioner claims she never received that second letter. Again, the Arbitrator finds this claim incredible based on the Petitioner's testimony that she has received other correspondence from Respondent relating to insurance and retirement. Based on these facts, the Arbitrator concludes that the Respondent attempted a good faith effort to offer the Petitioner work within her restrictions and the Petitioner made no effort to attempt to return work within her restrictions. As such Petitioner is not entitled to TTD beyond March 25, 2013, the date when she would reasonably have received the Respondent's second offer of light duty work.

4. Based on the findings above, the Petitioner's request for prospective medical care is denied. The Arbitrator finds persuasive the opinions of Dr. Lami on this issue. Dr. Lami specifically notes that the Petitioner had reached MMI status and was not in need of further surgical intervention for her cervical condition. Petitioner's treating physician, Dr. Caron recommended that the Petitioner undergo surgery due to an incomplete fusion at C5-6 and definite non-union at C6-7. However, in reviewing the records, other than Dr. Caron's comments, there does not appear to be medical evidence indicating a non-union or that the Petitioner was having any complications with the prior surgery. The Arbitrator finds it telling that the Petitioner did not return to her original surgeon, Dr. McGivney when she continued to have complaints in her neck following her fusion surgery and after Dr. McGiveny had placed the Petitioner at maximium medical improvement for her cervical condition. Given these facts, the Petitioner's request for surgery in accordance with Dr. Caron's recommendations is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Peter Potocky

Petitioner,

vs. NO. 13 WC 15772

B&R Insurance Partners, D/B/A Globe Taxi,

16IWCC0360

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the parties herein and proper notice given, the Commission, after considering the issues of medical expenses, permanent disability, causal connection 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 5, 2015 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.

16IWCC0360

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 26 2016
SJM/sj
o-5/19/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

POTOCKY, PETER
Employee/Petitioner

Case# 13WC015772

16IWCC0360

B&R INS PARTNERS D/B/A GLOBE TAXI
Employer/Respondent

On 8/5/2015, 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 0.16% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4129 WOLFE LAW PC
KENNETH WOLFE
200 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

0507 RUSIN & MACIOROWSKI LTD
KISA P STHANKIYA
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

16IWCC0360

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

PETER POTOCKY
Employee/Petitioner

v.

B&R INS. PARTNERS, D/B/A GLOBE TAXI
Employer/Respondent

Case # **13** WC **15772**

An *Application for Adjustment 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 **2/4/15**. 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **3/28/13**, 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 $**26,425.00**; the average weekly wage was $**508.17**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**2,516.95** for TTD, $**0** for TPD, $**0** for maintenance, and $**3,049.00** for other benefits, for a total credit of $**5,565.95**.

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 **$338.78week** for **16-3/7 weeks**, commencing **April 17, 2013 through August 9, 2013**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**2,516.95** for TTD, $**0** for TPD, $**0** for maintenance, and $**3,049.00** for other benefits, for a total credit of $**5,565.95**.

Respondent shall pay to the Petitioner reasonable and necessary medical services, pursuant to the medical fee schedule, of **$2,880.00 for MRI Lincoln Imaging, $1,710.00 for MRI of Chicago, and $75.00 for Rush University Medical Center**, as provided in Sections 8(a) and 8.2 of the Act. Respondent is entitled to a credit for all bills paid.

Respondent shall pay Petitioner permanent partial disability benefits of **$304.90/week** for **50 weeks**, because the injuries sustained caused the **10%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

August 5, 2015
Date

AUG 5 – 2015

FINDINGS OF FACT

At trial, Petitioner amended the Application for Adjustment of Claim to name the Respondent as "B and R Insurance Partners LLC d/b/a Globe Taxi." The Amended Application was admitted as Arbitrator's Exhibit 3 and an Order allowing the amendment of the Application will be entered with this Decision.

Peter Potocky ("Petitioner") began working as a taxi driver for B &R Insurance d/b/a Globe Taxi ("Respondent") in January of 2013. Petitioner testified that he worked 12 hour days for the Respondent driving a taxi and lifting luggage for passengers.

The Parties stipulated that Petitioner sustained accidental injuries which arose out of and in the course of Petitioner's employment by Respondent on March 28, 2013. Petitioner was involved in a motor vehicle accident in which the driver of the other vehicle T-boned the passenger side of the taxi Petitioner was operating. Petitioner was driving about 25 MPH on in the left lane on Randolph Street in Chicago and the car that struck his cab turned left from the right lane and struck the right side of the cab. Petitioner testified that he hit his head and was bleeding from his lower jaw. He broke two teeth, one later removed, had pain in his jaws, very painful lower back and legs, tingling in his legs, and had a hard time breathing. Petitioner could not get out of his cab and was removed by paramedics, put in a cervical collar, and taken by ambulance to Rush University Medical Center.

At Rush, Petitioner complained of headache, dizziness, and pain all over his back, down his legs, right shoulder, neck, and jaw. Petitioner received a tetanus shot, pain medication and x-rays were taken of his back. A CT scan of the cervical spine was recommended.

Petitioner next saw his family physician, Dr. Mysliwiec, on April 4th, 2013. Petitioner complained of terrible headaches and vomiting a few times, pain in his low back, neck, shoulder, elbow, knee and legs. Dr. Mysliwiec recommended an MRI of Petitioner's brain, physical therapy, and provided a prescription for pain medication.(PetEx. 2)

Petitioner attempted to return to work on April 5th. He worked until April 16th. Petitioner testified that he noticed that he became stiff while driving and the pain did not go away and was too severe to drive. He surrendered his chauffeur license on April 17th and has not returned to work since.

Petitioner underwent an MRI of his brain on April 8th at the Lincoln Imaging Center. He was still complaining of headaches. He returned to see Dr. Mysliwiec on April 9, 2013 still complaining of headaches, pain in his neck, lower back, and legs and difficulty sleeping due to the pain. Dr. Mysliwiec prescribed medication and recommended Petitioner stop working. Petitioner continued physical therapy. Petitioner returned to Dr. Mysliwiec on April 12th and his complaints remained the same. On April 19th, Petitioner complained to Dr. Mysliwiec of a lack of concentration and being anxious. He still had headaches, lower back and leg pain, and neck pain. He continued with physical therapy and pain medication. Petitioner saw Dr. Mysliwiec on May 10th and although Petitioner was having less spasm and pain in his low back, he had pain down both legs. Treatment remained the same except that he was referred to, Dr. Michel Malek, an orthopedic doctor, and another MRI was recommended. Dr. Mysliwiec had him remain off work. (PetEx. 2)

Petitioner underwent an MRI of his lumbar spine at MRI of Chicago on May 14, 2013. The MRI showed spinal stenosis at L3-4 and L4-5 with subtle disc bulge at L3-4 and moderate to severe bulge at L4-5. Also noted was a subtle disc bulge at L2-3 abutting the thecal sac. The impression was listed as lumbar spondylosis. (PetEx. 5)

Petitioner saw Dr. Malek on May 28, 2013. Dr. Malek recommended an EMG and an injection to Petitioner's back. Petitioner did not undergo the injection, as he testified he is afraid of injections.

Petitioner returned to Dr. Mysliwiec on June 3, 2013. She adjusted Petitioner's medication, continued the muscle relaxants, Ibuprofen, and physical therapy. Petitioner testified that he attended physical therapy approximately 2 times per week and worked on his upper body, lower back, and legs. Petitioner once again saw Dr. Mysliwiec on August 9, 2013. He testified that his neck had improved but he was still having the same complaints as previous visits. Dr. Mysliwiec did not know what other treatment she could provide and discharged him from her care in regards to his work accident. Petitioner continued taking his medications.

On October 21, 2013, at the request of the Respondent, the Petitioner was examined by Dr. Avi Bernstein. Dr. Bernstein originally diagnosed Petitioner with low back pain radiating into both legs and noted that the MRI showed prior surgery at the L4-5 level. He opined that the motor vehicle accident aggravated Petitioner's prior low back condition and agreed with the recommendation for an epidural steroid injection. After reviewing two additional medical notes of Dr. Mysliwiec, on March 15, 2014, Dr. Bernstein amended his earlier report to say that he did not think the accident caused a significant aggravation and that if it did the Petitioner would have reached MMI 6-12 weeks after the accident. (ResExs. 6 & 7)

Petitioner testified that he returned to Dr. Mysliwiec on January 14, 2014 due to increasing pain. He still complained of headaches and pain in his lower back. Petitioner's last treatment for his injuries was with Dr. Mysliwiec in of May 2014. He continues to take Ibuprofen and Extra Strength Excedrin for his back pain.

Petitioner, at his own request, was examined by Dr. David Robertson on March 18, 2014. Dr. Robertson examined Petitioner and diagnosed him with degenerative disc disease worse at L4-5 with radicular pain into both legs. His report indicates that Petitioner was asymptomatic before the motor vehicle accident and opined that the accident caused an aggravation of his condition. He further opined that the Petitioner was unable to perform heavy physical activity or sit for prolonged periods and his prognosis was guarded. (PetEx. 7)

Petitioner took the deposition of Dr. Anita Mysliwiec on January 23, 2014. Dr. Mysliwiec is board certified in internal medicine and has been Petitioner's family physician since approximately 2008. Dr. Mysliwiec testified that the first time she saw Petitioner after the accident was April 4, 2013 with complaints of headaches, dizziness, and pain in his neck, left shoulder, elbow, and ankle, low back pain radiating to both legs and tooth pain. She further testified that she recommended pain control, physical therapy, and an MRI of his brain. She stated that it was not in her chart but "usually we recommend patient to stay off work" and later testified that it is usually her assistant who writes off work notes for her patients. Dr. Mysliwiec testified that she saw Petitioner again on April 9th, 12th, and 19th with similar pain complaints and added complaints of difficulty sleeping, anxiety, dizziness on and off, and lack of concentration. She reported that on exam he had upper trapezius tenderness, paraspinal muscle spasm, and tenderness in the lumbosacral area. Dr. Mysliwiec testified that her assessment was anxiety, dizziness, headache, insomnia, lower back pain with left sciatica, and neck pain. She recommended anti-anxiety medication, Xanax, Motrin, Flexeril to relax his muscles, and continued physical therapy which Petitioner reported was helping. Dr. Mysliwiec also testified that although she did not write it down she discussed with Petitioner about not working due to the fact that he was experiencing dizziness and taking certain medications. At the May 13th visit with Petitioner, Dr. Mysliwiec noted limited forward bending and tenderness in Petitioner's neck and referred him for an orthopedic evaluation and ordered an MRI of his lumbar spine. Dr. Mysliwiec reported that the May 14, 2013 MRI showed osteoarthritic changes, lumbar spondylosis, and multiple level disc herniations. She recommended that Petitioner not drive when taking his

medications, Norco and Xanax, as they may affect his dizziness. Dr. Mysliwiec testified she saw Petitioner again on June 18th and August 9th with similar complaints of headaches, low back pain radiating to the legs, and neck pain and she continued his medications and physical therapy. According to Dr. Mysliwiec, Petitioner's orthopedic doctor recommended an epidural injection, however the Petitioner was reluctant due to fear. Petitioner was discharged from her care, as she did not expect any further improvement but she never released him to return to work. Petitioner returned to see Dr. Mysliwiec on January 14, 2014 and she reported he still exhibited tightness in his neck, tenderness in the lumbar region, and could not bend forward and she recommended continued pain control. Dr. Mysliwiec testified that she did not treat the Petitioner for his low back, neck or for headaches prior to his motor vehicle accident. On cross-examination, after being presented with two office notes containing notations of a diagnosis of lumbago and treatment for low back pain with Ibuprofen, Dr. Mysliwiec clarified that she was aware of his prior back surgery but did not recall the back pain complaints because it was "never a main complaint coming here to the office." (PetEx. 3)

The chart note of September 24, 2012 shows Petioner had complaints of stiffness in the groin area on both sides, LBP worse with prolonged sitting, the pain radiates to both sides. The chart note of January 11, 2013 states that Petitioner has chronic LBP, had surgical repair before. (ResEx. 5)

Dr. Mysliwiec further testified that she knows Petitioner's back pain was aggravated after the accident because afterward he was very uncomfortable but before he "had his lower back pain like anybody else can have back pain." Dr. Mysliwiec's final opinion was that the Petitioner has lower back pain, paravertebral spasm, neck pain, upper back pain, and headaches that all are disabling and permanent in nature and are causally connected to the motor vehicle accident. She would give work restrictions of no heavy lifting, not more than 20 pounds, no prolonged sitting of more than two hours at a time, since August 2013. According to her testimony, these opinions and restrictions are based in part on her observations and examinations of the Petitioner in that his complaints were never as significant before the accident as they were afterward. (PetEx. 3)

On March 27, 2014, Petitioner took the deposition of Dr. David Robertson, board certified orthopedic surgeon. Dr. Robertson performed a §12 examination of the Petitioner on March 18, 2014 at the request Of Petitioner's attorney. He testified that he reviewed the records and deposition transcript of Dr. Mysliwiec, emergency records of Rush University, MRI reports of the brain and lumbar spine, and the IME report of Dr. Avi Bernstein. Dr. Robertson took a consistent history of a motor vehicle accident in which the Petitioner's taxi was broadsided on the passenger side and Petitioner was thrown against the left driver's door, striking his head on the window. At the time of the exam Petitioner still had complaints of moderate low back pain radiating down both legs. Dr. Robertson noted that the Petitioner had an increased lumbar lordosis, which he testified could be due to trauma, and mild lumbar scoliosis. Dr. Robertson testified that he was aware of Petitioner's prior back surgery and episodes of back pain prior to the accident as reported by the Petitioner and contained within Dr. Mysliwiec's notes. Dr. Robertson further testified that it would be typical for someone with degenerative disc disease and prior back surgery to have episodic pain and intermittent radicular symptoms. His diagnosis was aggravated degenerative disc disease and he thought that it would be "difficult, if not impossible" for the Petitioner to continue his duties as a cab driver which could include prolonged sitting and lifting luggage in and out of the cab. He further stated that the Petitioner's condition is permanent and progressive. (PetEx. 7)

Respondent took the deposition of their §12 examining physician, Dr. Avi Bernstein, board certified orthopedic surgeon on October 7, 2014. Dr. Bernstein first examined Petitioner on October 21, 2013. He testified that at the time of the exam the Petitioner complained of low back pain radiating down both legs to his feet and that this pain was worsened with prolonged sitting. Dr. Bernstein noted that Petitioner had a normal gait and straight leg raise test. Dr. Bernstein testified that at the time of his first report he felt that the Petitioner's underlying preexisting condition could have been aggravated by the accident causing him to become symptomatic. He

further opined that at that time he felt the treatment to date had been appropriate and that it would be reasonable to try an epidural steroid injection. He disagreed with Dr. Malek's recommendation for surgical intervention and felt that the Petitioner could return to work as a cab driver after completing treatment. As evident in his testimony, his opinion of Petitioner's return to work was based partially on his belief that as a cab driver Petitioner would be in a seated position and would not need to bend, lift, or twist. However, on cross-examination, Dr. Bernstein also testified that prolonged sitting is not in a person's best interest if they have back issues and that prolonged sitting can increase back pain by increasing the pressure in the discs. Dr. Bernstein created an addendum to his October report in March of 2014 after reviewing two additional medical notes of Dr. Mysliwiec. (ResEx. 7) He testified that the records consisted of basically two entries noting low back pain radiating to the legs made before the work related accident. He further testified that it is not unusual for patients to have some degree of pain following disc surgery and that it is varies with the patient. Due to these two additional office notes between 2008 and 2013, Dr. Bernstein changed his opinion and felt that Petitioner's current complaints were similar to those before the accident, that Petitioner did not require any further treatment, and could return to his job. Dr. Bernstein also felt that Petitioner's refusal to undergo injections showed that his pain was not severe but on cross, also testified that a person's fear "can get in the way of their best interests through all phases of life." (ResEx. 8)

Petitioner currently experiences headaches 2 to 3 times per week, has a stiff neck, pain in his lower back and both legs to the ankles. Petitioner testified that he had prior low back surgery in 2002 consisting of a discectomy at L4-L5. He initially had some pain on and off which was alleviated with ibuprofen but eventually got better. After the accident of March 28, 2013, Petitioner stated the pain was more than he had before and became so severe that he could not work. The pain increases with prolonged sitting and he finds it difficult to lift items due to the pain in his back going down his legs. Petitioner applied for and received Social Security Disability benefits starting September 2013 and currently holds a CDL license that he is currently unable to use, due to lack of a physical exam.

CONCLUSIONS OF LAW

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

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

The Arbitrator finds that Petitioner's present condition of ill-being (low back and lower extremity radicular pain, secondary to an aggravation of a post L4-5 discectomy lumbar spine with degenerative disc disease) is causally related to the injury, based upon the credible testimony of Petitioner, the medical records and the persuasive opinions of Drs. Mysliwiec and Robertson.

Dr. Bernstein originally thought that Petitioner's low back could have been aggravated by the accident, but then changed his mind after reviewing the Dr. Mysliwiec charts of September 24, 2012 and January 11, 2013. Dr. Bernstein's opinion is not persuasive in this case.

Even though Dr. Mysliwiec testified on direct that she did not treat Petitioner for low back complaints before the accident and she obviously did treat him for Lumbago in September of 2012 and January of 2013, her causal connection opinion regarding Petitioner's low back condition being aggravated by the accident is persuasive in

this case. This error in testimony is not found to be an act of intentional deception. One would expect a person of Petitioner's habitus, age and surgical history to have off and on back pain. The back pain complaints became more severe and constant after the accident. The accident permanently aggravated Petitioner's low back condition.

The headache and neck complaints are found to be not causally related, given Petitioner's hypertension condition and the lack of documented treatment of the cervical spine.

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, AND WITH RESPECT TO ISSUE (N) IS RESPONDENT DUE ANY CREDIT , THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner claimed three bills at the time of trial: $2,880.00 from MRI Lincoln Imaging (Brain MRI); $1,710.00 from MRI of Chicago LLC (Lumbar MRI); and $75.00 from Rush University Medical Group (EKG at the ER) These bills are found to be reasonable and necessary to cure or relieve the effects of the injury and they are awarded. Respondent is entitled to a credit if they have paid the bills.

Based on the Arbitrator's finding regarding causal connection above, Respondent is not entitled to a reduction in the award for bills that it paid but claims are not related.

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

Petitioner is entitled to TTD benefits from April 17, 2013 through August 9, 2013, a period of 16 – 3/7 weeks. Petitioner surrendered his Chauffer's License on April 17, 2013 and August 9, 2013 is the date that Dr. Mysliwiec placed Petitioner at MMI.

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

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

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

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

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

16IWCC0360

(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

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

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a cab driver at the time of the accident and that he is not able to return to work in his prior capacity as a result of said injury. This factor is given great weight in determining PPD

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 58 years old at the time of the accident. This factor is given substantial weight in determining PPD because Petitioner will not likely have an improvement in his condition, given his age.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that there will not be much of a labor market for Petitioner given his age, experience, education and medical condition. The Arbitrator does note that Petitioner is receiving SSDI as of September of 2013, he did not seek employment after the accident and he maintains his CDL license (he will have to pass a DOT physical to drive a truck again). This factor is given substantial weight in determining PPD.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the records and medical opinions substantiate that petitioner is no longer capable of working as a cab driver due to the condition of his lumbar spine.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% loss of use of a person as a whole, pursuant to § 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Queen,
Petitioner,
vs.

NO: 13 WC 16894

16IWCC0350

County of Perry,
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 temporary total disability, causal connection, medical, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 16, 2015, is hereby affirmed and adopted.

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

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

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

DATED: MAY 23 2016
O050516
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

QUEEN, DANIEL
Employee/Petitioner

Case# 13WC016894

16IWCC0350

COUNTY OF PERRY
Employer/Respondent

On 9/16/2015, 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 0.26% shall accrue from the date listed above to the day before the 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:

1413 BRAD L BADGLEY
26 PUBLIC SQUARE
BELLEVILLE, IL 62220

0000 INMAN & FITZGIBBONS LTD
DANE KURTH
201 W SPRINGFIELD
CHAMPAIGN, IL 61820

16IWCC0350

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
CORRECTED ARBITRATION DECISION

DANIEL QUEEN
Employee/Petitioner

v.

COUNTY OF PERRY
Employer/Respondent

Case # 13 WC 16894

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Herrin**, on **January 13, 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 **10/30/12**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**38,332.92**; the average weekly wage was $**737.17**.

On the date of accident, Petitioner was **58** years of age, ***single*** with **no** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $491.44 per week for 12 3/7 weeks, commencing May 24, 2013 through August 19, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule of Dr. James Michael Davis in the amount of $125.00; Herrin Hospital in the amounts of $1,615.00 and $54,443.15 and the lien of UMWA in the amount of $3,281.86.

Respondent shall pay Petitioner permanent partial disability benefits of $442.30 per week for 150.5 weeks, because the injuries sustained caused 70% loss of the left leg as provided in Section 8(e) of the Act.

Respondent is entitled to a credit of 45% of the left leg against the Arbitrator's permanent partial disability award.

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. Michael Nowak — 9/9/15 Date

SEP 16 2015

FINDINGS OF FACT

The parties stipulate that Petitioner has two prior settlements before the Illinois Workers' Compensation Commission in regard to injuries to his left leg. His May, 2002 injury was settled under case number 02 WC 026619 for 20% loss of use of the left leg. His February, 2011 injury was settled under case number 12 WC 019880 for 25% loss of use of the left leg.

In May of 2002 Petitioner suffered a medial meniscus tear which required a left knee partial synovectomy and chondroplasty. Petitioner returned to work full duty on November 14, 2002, but still had some pain symptoms. During the course of treatment he was noted to have minimal degenerative change in the left knee. Petitioner sustained another work-related injury to the left knee on February 18, 2011. Petitioner treated with Dr. J.T. Davis in regard to this injury and was diagnosed with a contusion and exacerbation of his underlying arthritis. Petitioner treated conservatively for several months before Dr. J.T. Davis recommended a left knee arthroscopic chondroplasty, debridement, and partial meniscectomy. Prior to surgery, Petitioner underwent an MRI that revealed a meniscus tear and significant degenerative changes. Petitioner proceeded with arthroscopic surgery to his left knee and returned to work without restrictions on November 1, 2011. As far back as 2011, Dr. J.T. Davis referenced a possible need for a left knee arthroplasty in the future.

Petitioner testified he had no treatment or significant symptoms between his release in November 2011 and his accident of October 30, 2012

Neither party disputes that Petitioner suffered from preexisting arthritis in his left knee. Rather, the disputes in this case are whether the partial knee replacement Petitioner underwent is causally related to this accident, Respondent's liability for medical expenses and TTD related to the surgery and nature and extent of disability.

At the time of trial, Petitioner was a 60 year-old man who had worked for Respondent as an animal control officer for approximately eight and a half years. Petitioner testified that while he was working at the kennel on October 30, 2012, a dog ran between his legs and caused him to fall to the concrete and strike his knees on the ground. His left knee struck the concrete first, followed by the right, and he experienced pain in both knees following the incident. Petitioner completed his shift at work on October 30, 2012.

On November 1, 2012, Petitioner presented to Dr. Patrick Riley and reported that on October 30, 2012, he fell at work and struck his left knee on the concrete after getting tangled up with a dog. Petitioner was referred to the Orthopedic Institute of Illinois where he was seen by Dr. J.T. Davis on December 13, 2012. Dr. J.T. Davis reviewed x-rays and found severe tricompartmental osteoarthritis of the left knee. He diagnosed Petitioner with an acute exacerbation of his underlying left knee osteoarthritis and he opined that the exacerbation of the symptoms was caused by the October 30, 2012 incident. Dr. J.T. Davis initially recommended conservative care, including steroid injections. A January 16, 2013 MRI revealed severe maceration with near complete loss of a large portion of the posterior horn of the medial meniscus, severe tricompartmental degenerative change in the medial compartment, full thickness cartilage defect, and muscle strain/probable partial tear of the popliteus muscle which appeared chronic. Following the MRI, Dr. J.T. Davis recommended a series of viscosupplementation injections which Petitioner underwent on January 30, 2013 and February 6, 2013. When conservative measures failed Dr. J.T. Davis recommended surgery to address

Petitioner's left knee Condition and referred Petitioner to Dr. James Michael Davis (Hereinafter Dr. M. Davis) for further evaluation on April 1, 2013. Dr. M. Davis diagnosed Petitioner with osteoarthritis of the left knee with failed conservative management and recommended proceeding with a left knee arthroplasty.

Petitioner attended a Section 12 examination with Dr. Lyndon B. Gross on April 11, 2013. Dr. Gross opined that Petitioner suffered from underlying osteoarthritis of the left knee which may have been acutely exacerbated by the October 30, 2012 incident. However, he opined that the October 30th accident did not change the natural history with regard to the knee or the need for further management. In his opinion Petitioner's continued symptoms and his need for surgery were related to his underlying osteoarthritic condition which was present before the October 30, 2012 accident. Dr. Gross opined that Petitioner had reached a state of maximum medical improvement by the time of his examination on 4/11/13 and required no further treatment. Dr. Gross felt Petitioner could return to work full duty in regard to the October 30, 2012 accident. Dr. Gross opined that the treatment he received prior to the § 12 exam on April 11, 2013 was reasonable to treat someone with osteoarthritis and an acute temporary exacerbation of the knee. Dr. Gross also acknowledged that the surgery performed by Dr. M. Davis was reasonable; however, he testified that the need for surgery was not caused by the October 30, 2012 accident.

Dr. M. Davis performed an Oxford medial partial knee replacement of the left knee on May 24, 2013. Petitioner began physical therapy on June 6, 2013 and returned to work full duty on August 12, 2013. Petitioner testified that he was off work from May 24, 2013 through August 19, 2013. On March 10, 2014, Petitioner was released from care by Dr. M. Davis and continued working full duty. Following his release from care, Petitioner continued working for Respondent as an animal control office. He testified that he was not having any problems with his left knee at the time of trial.

Dr. M. Davis testified that Petitioner undergone conservative management including medications, rehabilitative exercises, and intraarticular injections of Euflexxa before being referred to him because Dr. J.T. Davis did not perform arthroplasty-type procedures. He further testified that he diagnosed Petitioner with medical compartment osteoarthritis of the left knee which was exacerbated by the October 30, 2012 accident and led Petitioner to proceed with surgery.

CONCLUSIONS OF LAW

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

Petitioner's primary treating physician, Dr. James Michael Davis, testified that the accident of October 30, 2012 aggravated and accelerated the degenerative change in Petitioner's left knee and further, that aggravation and acceleration prompted the need for surgery, consisting of a partial knee replacement.

Dr. Gross, Respondent's examining physician, testified that Petitioner's work accident of October 30, 2012, did not cause his preexisting arthritic condition, and resulted only in a temporary aggravation of his condition. The Arbitrator notes, however that Dr. Gross' report refers to the October 30 incident as an "acute exacerbation."

The Arbitrator finds the opinions of Dr. Davis more persuasive. 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 his injury of October 30, 2012.

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

Petitioner offered into evidence the bills of Dr. James Michael Davis - $125.00; Herrin Hospital - $1,615.00 and $54,443.15. Additionally, a number of bills had been paid by Petitioner's UMWA Health and Retirement Fund which now asserts a lien in the amount of $3,281.86.

Respondent did not dispute the reasonableness and necessity of these charges, rather, based its dispute on medical causation. For the reasons stated in subpart (f) above, the Arbitrator finds that Respondent is obligated to pay the above bills in accordance with the medical fee schedule and reimburse the lien of UMWA Health and Retirement Fund.

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

Petitioner and Respondent stipulated that by reason of the accident of October 30, 2012, Petitioner was temporarily totally disabled from May 24, 2013 through August 19, 2013, a period of 12 3/7 weeks. Respondent disputes its obligation to pay temporary total disability benefits on the basis of medical causation. For the reasons stated in subpart (f) above, the Arbitrator concludes that Petitioner is entitled to temporary total disability benefits for the above period.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 are to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner was employed by Respondent as an Animal Control Officer. The job required heavy physical labor involving capturing, transporting, impounding, and handling stray animals. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 58 years old at the time of his injury. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. Although Petitioner has returned to work without restrictions he had suffered a new injury to an old injury site. He suffered a much more significant permanent injury necessitating the partial knee replacement than that which he experienced by reason of the prior meniscal tears. The surgical procedure was extensive, required insertion of an artificial joint with bone and tissue removal the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 70% loss of use of his left leg pursuant to §8(e) of the Act.

Petitioner had received a prior settlement of 20% of a left leg and 25% of a leg, respectively, for prior meniscal tears and Respondent is entitled to credit for the prior amounts.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jennifer Whiteford,
Petitioner,

vs. NO: 13 WC 17037

16IWCC0308

State of Illinois,
Fifth Dist. Appellate Court,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 5, 2015 is hereby affirmed and adopted.

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

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

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

DATED: MAY 6 - 2016

Joshua D. Luskin

o-03/23/16
jdl/wj
68

Ruth W. White

DISSENT

I respectfully dissent and find the opinion of Petitioner's treating physician, Dr. Morgan, more persuasive than that of Dr. Sudekum regarding Petitioner's carpal tunnel syndrome and its causal relationship with her job duties. I would find that Petitioner did sustain accidental injuries arising out of and in the course of her employment, which manifested on January 14, 2013, when the electrodiagnostic studies were performed by Dr. Alam. Petitioner provided proper notice by completing a Notice of Injury on February 4, 2013. Based on the above, I would award temporary total disability, medical expenses, and permanent partial disability.

Charles J. DeVriendt

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WHITEFORD, JENNIFER
Employee/Petitioner

Case# **13WC017037**

SOI/FIFTH DIST APPELLATE COURT
Employer/Respondent

16IWCC0308

On 5/5/2015, 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 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

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

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

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

MAY 5 - 2015

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

16IWCC0308

☐ 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

Jennifer Whiteford
Employee/Petitioner

v.

State of Illinois/Fifth Dist. Appellate Court
Employer/Respondent

Case # **13** WC **17037**

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 **March 10, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 4, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $**80,059.50**; the average weekly wage was $**1,539.61**.

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

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

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

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

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

ORDER

Petitioner failed to prove she sustained an accident on January 4, 2013 that arose out of and in the course of her employment with Respondent or that her condition of ill-being in her hands/wrists was causally connected to her injury or her employment with Respondent. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Nancy Ruddy
Signature of Arbitrator

May 3, 2015
Date

MAY 5 - 2015

JENNIFER WHITEFORD v. STATE OF ILLINOIS/FIFTH DIST. APPELLATE COURT
Case # 13 WC 17037

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner alleges repetitive trauma injuries to her bilateral hands and wrists with an accident date of January 4, 2013. At the time of arbitration the disputed issues were accident, notice, causal connection, medical bills, and the nature and extent of any permanent injury. Petitioner was the sole witness testifying at the hearing.

The Arbitrator finds:

Petitioner began working for Respondent in August of 2005.

According to medical records Petitioner was treated in 2005 and 2006 by Dr. Richard Morgan for bilateral knee symptoms and complaints. The records from this time period are silent as to any bilateral hand/wrist complaints. (RX 5)

According to other records Petitioner was a patient of Southern Illinois Family Medicine from November of 2006 through January of 2011. (RX 4) When initially examined at Southern Illinois (hereafter referred to as "SIFM") in November of 2006 Petitioner reported she had been seeing Dr. Kaarsberg in Marion and doing well but having problems with carpal tunnel syndrome. Petitioner had undergone nerve conduction studies but the doctor had not gone over options with her. She had been using wrist splints off and on for three weeks. Petitioner's complaints included nighttime awakening, numbness in her fingers, and left wrist pain. Petitioner's symptoms were worse on the left side than the right side. Petitioner was advised to continue wearing her wrist braces regularly and to use Motrin for 21 days. She was to return in one month. (RX 4, pp. 99 - 101)

Petitioner returned to SIFM on December 11, 2006 regarding her carpal tunnel condition. She reported some improvement with the splint. Her Ibuprofen was changed to 800 mg., as needed. Petitioner was instructed to wear her splint daily and return if her symptoms worsened, in which case she would be referred to an orthopedist. (RX 4, pp. 96-98)

Petitioner returned to SIFM on January 9, 2007 due to symptoms of depression. The doctor noted Petitioner was continuing to have carpal tunnel symptoms relieved by Motrin. (RX 4, pp. 94-95)

When Petitioner was seen in follow-up at SIFM on February 6, 2007 the focus of attention was on her ongoing symptoms of depression. Her carpal tunnel condition was not mentioned or addressed. (RX 4, pp. 91-93)

Petitioner was re-examined on May 8, 2007 at SIFM regarding her depression. During this visit Petitioner mentioned that she had stopped using her braces for her wrists and her pain had started up again. Petitioner also wanted to discuss some test results done per her OB/GYN doctor who

had found she had fibrocystic disease. Petitioner was advised to continue wearing her braces for her wrists. (RX 4, pp. 88-89)

On August 6, 2007 Petitioner returned to SIFM with complaints of numbness in her hands but improvement with the brace. Her depression was also improving. Petitioner was told to continue wearing her splints/braces. (RX 4, pp. 85-86)

Thereafter Petitioner continued being seen and treated at SIFM for a variety of medical issues but not carpal tunnel syndrome. (RX 4, pp. 1 - 84)

Petitioner established care with Dr. Pestka at Shawnee Health Care in Marion on December 3, 2012. She provided a history of high cholesterol and a five week history of cold symptoms. She also gave a history of Carpal Tunnel Syndrome. The doctor's notes state, "Pertinent negatives include fever. Additional information: Has had it for years, had EMG yrs. ago. Got worse while she was pregnant. Wakes her up at night. Hasn't." No examination findings regarding Petitioner's wrists was noted; however, the doctor mentioned "Records of EMG. In meantime try wrist splint [bilaterally]." (RX 2)

On January 2, 2013 Petitioner returned to Shawnee Health Care with complaints of bronchitis and high cholesterol. Carpal Tunnel Syndrome was listed as a chronic problem. No discussion, complaints, or treatment recommendations were made regarding the Carpal Tunnel Syndrome. (RX 2)

Petitioner returned to see Dr. Morgan on January 17, 2013 after having last seen him in 2006. The purpose of the visit was to address some symptoms of chondromalacia she was experiencing in her knee. He further noted that she was having some carpal tunnel symptoms and had already undergone nerve conduction studies. According to his notes, Dr. Morgan suspected Petitioner would probably have to have carpal tunnel surgery before her knee surgery. (RX 5)

On January 29, 2013 Petitioner completed a questionnaire for Dr. Morgan in anticipation of their visit that same date. Petitioner reported that her chief complaint was numbness, tingling, burning in both hands/wrists and her right elbow. Petitioner reported her symptoms began in her hands in 2006 and in her elbow the previous Monday. Her symptoms were worse with sleeping, writing, driving, and typing. When Dr. Morgan examined Petitioner he noticed she did a "fair amount" of clerical work both on the computer and writing. "She does some files." According to the history Petitioner had pretty severe bilateral carpal tunnel syndrome and while she had it in 2006 it had "dramatically accelerated" and she now needed surgery. Petitioner also reported the recent onset of a right elbow problem. She hadn't fallen and hurt it but was tender over the anterior aspect of her elbow and she was having trouble fully extending her elbow without obvious pain. Dr. Morgan suspected a capsular issue. He ordered physical therapy for her elbow and if it went pretty well they would progress to her carpal tunnel surgeries and then turn to her knees. (RX 5)

On February 4, 2013 Petitioner underwent an EMG/NCV study with Dr. Alam, per the referral of Dr. Pestak. According to the history, Petitioner was a 36 year old female with a complaint of numbness, tingling, and pain involving her hands. In another history portion of the records, Petitioner's symptoms were listed as "Numbness in both hands and fingers/Tingling in both hands and fingers/ Pain in both hands, fingers, wrists, lower arms and knees." Dr. Alam's impression post-testing was moderately severe bilateral Carpal Tunnel Syndrome, right worse than the left. (RX 3)

On February 4, 2013 Respondent completed an Illinois Form 45, First Report of Injury. According to it, Petitioner alleged an accident date of January 4, 2013 with injuries to her wrists as a result of repetitive motion. (RX 1) Petitioner's supervisor completed a Supervisor's Report of Injury or Illness on February 6, 2013 in which she stated Petitioner had notified her that her orthopedist had told her that her bilateral carpal tunnel syndrome had worsened to moderate on the left and moderate to severe on the right and that the duties of "her employment contributed to cause this aggravation." Petitioner had worked in her current position for eight years and claimed that her injury was due to "repetitive flipping through voluminous documents, handwriting notes, conducting on line research, and typing dispositions." (RX 1)

A "Demands of the Job" form was completed on February 6, 2013 for Petitioner's job as a "Law Clerk." According to it, Petitioner used her hands for gross manipulation and fine manipulation 4 - 6 hours per day. (RX 1) Petitioner also completed a "Repetitive Trauma Cases Daily Activities Questionnaire" on that same day. Petitioner acknowledged that she provided care to six month old twins, was a beginning yoga student, did not knit or crochet, did not participate in any sports, did not have a second job and did not sue any home repair or remodeling tools. She acknowledged engaging in internet banking and helping with personal family and business forms such as "insurance, etc." Petitioner believed she drove about 165 miles per week. (RX 1)

Petitioner began occupational therapy on February 5, 2013 and in the initial evaluation she mentioned starting a Power Yoga workout and noticing increasing soreness in her right elbow. Petitioner also carried twin infants which would increase her elbow pain. (RX 5)

Petitioner returned to see Dr. Morgan on February 21, 2013. According to her history, she was a "legal secretary" with patellofemoral arthralgia of both knees for which she had been scoped. She was now being treated for lateral tracking and chondromalacia. She was also having problems with her elbow which lacked significant range of motion. In light of the foregoing, along with her diagnosis of Carpal Tunnel Syndrome, Dr. Morgan wanted a rheumatologic work-up done along with an MRI of her elbow. (RX 5)

Petitioner underwent a right elbow MRI on February 25, 2013. It revealed an ulnar collateral ligament sprain with mild adjacent edema but not tear, brachialis tendinopathy, likely chronic, and a small elbow joint effusion. (RX 5)

On February 28, 2013 Dr. Morgan authored a letter of introduction to Dr. Sandra Hoffman. In Dr. Morgan described Petitioner as a secretary for a local judge who had presented with "a plethora of musculoskeletal problems," including chondromalacia of the patella, which he felt was

probably due to weight gain during pregnancy and the "onset" of right carpal tunnel syndrome and an effusion and limited motion of her right elbow with exquisite elbow pain. Her x-rays and MRI were described by the doctor as "fairly nonspecific" with a "trace effusion." She really had no other major abnormalities, no trauma to the elbow, and the carpal tunnel syndrome was of "recent onset." Her sed rate was 19 on testing with her "CRP three times normal at 1.9>" Her ANA rheumatoid factor was normal. Concerned there might be some linkage between these problems Dr. Morgan wanted Dr. Hoffman to examine Petitioner. (PX 5)

As of May 14, 2013 Dr. Morgan noted that Dr. Hoffman had Petitioner on Abilify and meloxicam and she was starting to feel better and her elbow had improved. Petitioner was scheduled for right carpal tunnel surgery in July. (RX 5)

On May 16, 2013 Petitioner signed her Application for Adjustment of Claim in this proceeding. (AX 2)

Petitioner underwent a right carpal tunnel release on July 24, 2013. (RX 5)

Petitioner underwent a left carpal tunnel release on August 14, 2013. (RX 5) As of August 22, 2013 Petitioner's wound looked good and her sutures were removed. Petitioner reported she had already returned to work. (RX 5)

Dr. Morgan re-examined Petitioner on September 12, 2013. Petitioner was doing well except for some pillar pain and was to continue cross fiber friction massage and visits with the occupational therapist. He felt the pillar pain should resolve in time. (RX 5)

Petitioner returned to see Dr. Morgan on December 26, 2013. She reported being much better and her wounds were well healed. He saw no evidence of a palmar cutaneous branch neuroma and noted "Everything seems to be moving along well." Her pillar pain had largely resolved. Petitioner was discharged to return as needed. (RX 5)

On March 26, 2014 Petitioner's attorney sent an e-mail to Dr. Morgan's office regarding his upcoming deposition and enclosing a job description prepared by Petitioner. Petitioner wrote:

> I routinely flip through voluminous records on appeal, consisting of hundreds to thousands of pages,....I also conduct expensive legal research on the computer using westlaw and lexis and type the dispositions of the appeals. I also often fill in for the job duties of our administrative clerk, and type letters of concurrence and other correspondence with other judges, manipulate the filing cabinets and library books in our library and moving the records around. Over the nine years that I have worked for Justice Spomer, I have typed over 120 dispositions, ranging anywhere from 5 to 30 pages each." (PX 8 – Pet. Ex. 2)

Dr. Morgan was deposed on March 27, 2014. (PX 8) He has been a practicing orthopedic surgeon in Williamson and Jackson Counties since 1980. (PX8, p.5) He testified that he examined Petitioner's wrists, and that Petitioner's findings on examination were consistent with

her symptoms and the findings in the electrodiagnostic studies. (PX8, p.9, 10) Dr. Morgan testified that he was aware of Petitioner's occupation as an assistant for Judge Spomer and that he had a job description from Petitioner in his file in addition to her oral job description. *Id.* at 11, 12, 13. He also testified that Petitioner did not have any hobbies or non-occupational systemic factors such as diabetes, renal failure, or rheumatoid arthritis, as the latter had been ruled out by Dr. Hoffman. *Id.* at 13, 14. He also testified that he did not consider Petitioner obese. *Id* at 13. Based on his clinical examination, the written and oral job description from Petitioner and his review of the diagnostic studies, Dr. Morgan testified that all of the factors of employment mentioned in Petitioner's job description were the proximate cause of her carpal tunnel syndrome. *Id.* at 14, 26. He noted that Petitioner's pregnancy had come to term before she was evaluated for her carpal tunnel syndrome, and that her symptoms had persisted afterward. *Id.* at 15.

Dr. Morgan testified that Petitioner remains under his care but only for her knees. (PX 8, p. 11)

On cross-examination, Dr. Morgan testified that pregnancy induced carpal tunnel syndrome resolves a couple months after pregnancy. *Id* at 18, 19. He testified that if Petitioner delivered in August, pregnancy induced carpal tunnel syndrome would have resolved. *Id.* at 20. He also testified that repetition was the issue in carpal tunnel syndrome rather than force. *Id.* at 24.

On cross-examination Dr. Morgan acknowledged that he has no certificate in hand surgery. He also testified that an aggravation of carpal tunnel syndrome can be caused by pregnancy but it usually isn't long lasting and normalizes within a couple of months of delivery. Dr. Morgan acknowledged that he didn't know when Petitioner delivered and that would be helpful to know in reaching a causation opinion. (PX 8, pp. 19-20) Dr. Morgan testified that if Petitioner delivered in August of 2012 any pregnancy-related complaints should have resolved by January. (PX 8, p. 20) Dr. Morgan did not believe that smoking was a risk factor for carpal tunnel syndrome.

When asked about Petitioner's job duties Dr. Morgan testified that Petitioner worked for a judge and did a lot of research, "computer based research, apparently." She told the doctor she spent "hours behind a computer. She types reports, briefs for the judge. Most of what she does is what our court reporter is doing, sitting at a desk with a computer typing. (PX 8, p. 21)

Dr. Morgan testified that Petitioner's job description was sent to him on March 26, 2014. He further testified that Petitioner's routinely flipping through voluminous records could "potentially" have something to do with carpal tunnel syndrome. (PX 8, p. 23) He did not feel that there was any force involved in that activity but he further felt the amount, if any, of force was irrelevant as the key was repetition. (PX 8, p. 24) Petitioner had no ergonomic complaints about her job, according to the doctor. (PX 8, p. 24)

Dr. Morgan also explained that pillar pain is pain in the palm from opening up the skin and it

usually resolves with time. (PX 8, p. 25)

On redirect examination Dr. Morgan testified that all of the job items found in "PX 2" of the deposition "in combination with the other work that she does" are contributing factors to carpal tunnel syndrome. (PX 8, p. 26)

At the request of Respondent Petitioner underwent a records review pursuant to Section 12 with Dr. Sudekum. He issued his report on August 26, 2014. (RX 6) Dr. Sudekum's report reviewed Petitioner's medical records going back to October of 2006 with the doctor noting the absence of any causation opinions by early treating doctors. He acknowledged little mention of carpal tunnel syndrome symptoms in the records from 2006 to 2013. Dr. Sudekum noted Petitioner's onset of symptoms with a pregnancy in 2012 – 2013. He also reviewed a "Demands of the Job" form and a description prepared by Petitioner. In response to the request for a specific diagnosis/cause of Petitioner's current condition, he never provided a direct response. (RX 6, pp. 37-38) He could not address the question of whether Petitioner's surgeries were necessary and causally related to Petitioner's work duties because he never saw the operative reports. (RX 6, p. 38) It was Dr. Sudekum's opinion that Petitioner's bilateral upper extremity complaints and/or carpal tunnel syndromes were not caused or aggravated by her activities as a law clerk. He further stated that she "might" have developed it due to non-work-related factors (her sex, "significant" symptoms during pregnancy, a history of arthritis, a possible rheumatalogic condition, high cholesterol, weight gain, and a long history of smoking). (RX 6, pp. 38-39) He further opined that Petitioner's need for surgery was not the result of a work-related injury and he felt Petitioner was at maximum medical improvement and could work unrestricted duty. (RX 6, pp. 39-40)

Dr. Sudekum also stated that there was no indication in any of the records of Petitioner's treating physicians that her condition was caused or aggravated by her activities as a law clerk. (RX6, p.1-5) He also did noted that he did not believe that Dr. Morgan examined Petitioner's wrists when he initially saw her and diagnosed her problem. (RX6, p.3, 36, 37)

Dr. Sudekum noted that Respondent's Demands of the Job form indicated that Petitioner used her hands for gross manipulation for 4-6 hours per day and fine manipulation up to 2 hours per day. (RX6, p.6) Dr. Sudekum also noted that Petitioner's job description included routinely flipping through voluminous records on appeal, consistent of hundreds to thousands of pages, and also conducting extensive legal research and typing dispositions of the appeals. (RX6, p.7) The description also indicates that Petitioner assisted with administrative duties such as typing letters of concurrence and other correspondence with judges, manipulating the filing cabinets and law library books, and moving around records. *Id.* Petitioner estimated in the description that she had typed over 120 dispositions, ranging anywhere from 5 to 30 pages each. *Id.*

Dr. Sudekum was deposed on January 8, 2015. (RX 7) He testified generally consistent with his

report. However, he acknowledged an error in his report in that Petitioner's Demands of the Job form indicated Petitioner used her hands for fine manipulations for between 4 and 6 hours per day. He further testified that even assuming Petitioner performed fine manipulations for between 4 and 6 hours per day that would not change his opinion.

Dr. Sudekum testified that in making the causation determination the most important issue is probably the amount of forces involved in the activity. In his words, it has nothing to do with repetition. (RX7, p.27, 28) Dr. Sudekum explained that you can find it with vibratory tools and instruments. However, flipping through hundreds of thousands of pages of documents is not a forceful activity. Dr. Sudekum acknowledged various occupations that involve some vibration and frequent impact which can aggravate carpal tunnel syndrome. However, there is very scant support, if any, for a significant association between typing and keyboard work and the development of carpal tunnel syndrome, even less when that activity is performed intermittently and interspersed with various other types of clerical activities including filing, paperwork, copying, handling books, and handling papers. Those are normal activities that the hand is designed to perform. He stated, "The hand is not going to develop a pathologic condition from doing normal things typically." *Id.* at 28, 29. He believed that Petitioner was predisposed for the development of carpal tunnel syndrome regardless of her employment as a result of her sex, her increased symptomatology during her pregnancy, her body mass index, and indications of a rheumatologic condition. *Id.* at 29, 30. He also testified that the medical literature did not support the conclusion that keyboarding had any significant association with carpal tunnel syndrome. *Id* .at 32, 33. He also believed that a number of women who give birth develop carpal tunnel symptoms that do not go away. *Id.* at 38, 39.

Dr. Sudekum explained his causation opinion noting that he did not feel Petitioner's work rose to the level of causation because it wasn't strenuous, did not involve significant persistent stressors of pinching, gripping, grasping, vibratory exposure or abnormal postures and she perfoermed clerical activities. (RX 7, pp. 31-32) Dr. Sudekum also testified regarding the lack of peer-reviewed medical literature showing a "significant association" betwee n moderate and even repetitive high levels of keyboarding and carpal tunnel syndrome. Furthermore, he considered the forces used in flipping through pages to be minimal. (RX 7, pp. 32-33) Dr. Sudekum testified that he didn't think Petitioner's typing of "depositions" would rise to a very high frequency type activity as it would equate to only one deposition per month. (RX 7, p. 34)

Dr. Sudekum also testified that Petitioner's symptoms increased dramatically with her pregnancy and eventually led to her need for surgery. (RX 7, p. 36) He further testified that he incorrectly stated Petitioner delivered in August of 2013 as it was 2012. (RX 7, p. 36)

Dr. Sudekum testified on cross-examination that he has performed 169 IMEs out of the 207 requested by the State of Illinois, has given 91 depositions on their behalf over the course of 4 years, and has earned $1,206,000.00. *Id.* at 43, 44. He charged $5,000.00 for his records review in Petitioner's case and $2,000.00 per hour for his deposition. *Id.* at 44. He acknowledged "cutting and pasting" parts of his reports from other reports when he is discussing general

matters. (RX 7, p. 48) Dr. Sudekum acknowledged that in Petitioner's medical records from 2006, there was no indication that any of her physicians advised her that her condition was related to work. (RX7, p.49). He also acknowledged that Petitioner's condition began well before her pregnancy, and that her 2006 and 2013 nerve conduction studies showed evidence of median neuropathy. *Id.* at 51.

Dr. Sudekum did not believe that Petitioner's gross manipulation/hand duties as a law clerk would lead to carpal tunnel syndrome. While he acknowledged never seeing a law clerk perform his/her job, he testified that his sister was a law clerk. (RX 7, p. 54) He also testified that Dr. Morgan compared Petitioner's job to that of a court reporter which was not his impression. (RX 7, pp. 54-55) He also testified that repetition is not the most important factor; force was and Dr. Morgan had it backwards. (RX 7, p. 56)

Dr. Sudekum denied having any knowledge that the Mayo Clinic study which he referenced had been discredited in the medical community for lack of a control group, selection bias and inaccurate exposure. *Id.* at 58. He also disputed the critique of the other studies which he cited. *Id.* at 60-62. He also acknowledged that each individual is different as to if or when he or she would develop carpal tunnel syndrome while performing his or her job duties. *Id.* at 62, 63. He admitted there is medical literature which correlated keyboarding with carpal tunnel syndrome; however, he testified that he was not aware of any peer-reviewed journals making a significant correlation between the two. *Id.* at 63, 64. He also testified that he never became aware that Petitioner's physicians ruled out the existence of a rheumatologic condition, despite the fact that he testified that he reviewed the deposition of Dr. Morgan. *Id.* at 52, 64. He acknowledged that Dr. Morgan had been practicing for 35 years, 16 years longer than he has been in practice. *Id.* at 65.

Dr. Sudekum further testified that one could reasonably conclude that Petitioner had bilateral carpal tunnel syndrome. (RX 7, p. 68) He had no idea why he wasn't asked to examine Petitioner. (RX 7, p. 70)

At her arbitration hearing Petitioner testified that she is a right-hand-dominant, 36-year-old law clerk for the Fifth District Appellate Court. Petitioner testified that she began working for the Fifth District in August of 2005 and served as the law clerk for the Honorable Stephen Spomer for nearly 10 years until his retirement in November of 2014. Petitioner currently clerks for Justice Randy Moore.

Petitioner testified that when records were first brought to the office, she followed a precise process to make sure that all of the records were present. She had to lift the volumes out of the box, check them in, count them and store them until it was time retrieve the cases and work on them. Petitioner testified that organizing the volumes by hand was tedious as most of the time the volumes are out of order and so the first thing she has to do is flip through each volume and try to put them in some sort of coherent order so that when she goes to start looking through them they are in chronological order.

Petitioner also testified that she read through hundreds of volumes containing thousands of

pages, took extensive notes and performed extensive typing. This required significant finger manipulation. Petitioner testified that she rapidly flipps through pages of the records until she reached the desired portion of the transcript. Petitioner took notes with her right hand and firmly grasped and held the record open with her left. The further she was into a record, the more grip force was required to hold the transcript open. She testified that she spends 5.5 to 6 hours of her 7.5 hour day using her hands to reference records, take notes by hand or keyboard and/or write dispositions. Petitioner testified that the most difficult part of her job is holding the records open while she is taking notes. She testified that her hands get "really tired" during this process.

Respondent's typed "Demands of the Job" form clearly indicates that Petitioner uses her hands for gross manipulation (grasping, twisting and handling) for 4 to 6 hours per day, and also for fine manipulation (typing and good finger dexterity) for 4 to 6 hours per day. (RX1).

Petitioner testified that during the course of her employment, she began experiencing paresthesias in her hands. She testified that these symptoms began in 2006, after she began working with Justice Spomer. She was diagnosed with bilateral carpal tunnel syndrome; but since her condition was not severe, it was managed conservatively with splints and medication. Petitioner testified that these symptoms grew more bothersome as she continued to work. Petitioner testified that she does not suffer from gout, rheumatoid arthritis, diabetes or hypothyroidism. Petitioner testified that she became pregnant during the development of her condition, causing her symptoms to increase. Petitioner testified that after she delivered, her symptoms returned to the pre-pregnancy intensity level.

Petitioner testified that when her symptoms persisted following her delivery, she finally saw a specialist for her condition in January of 2013.

Petitioner testified that she alleged an accident date of January 4, 2013, as that was the day she had nerve conduction studies with Dr. Alam and discovered that her condition progressed and had become disabling. Petitioner testified that her primary doctor referred her to Dr. Morgan for consultation and that after that appointment it was her understanding that she needed surgery due to the severity of the symptoms and the way in which they were affecting her life.

After the consultation with her orthopedic doctor, Dr. Morgan, Petitioner completed a Notice of Injury on February 4, 2013, and submitted it to Respondent. Petitioner was asked why she waited so long to have surgery for her condition and explained that it was her understanding that pregnancy could temporarily aggravate pre-existing carpal tunnel syndrome; however, if the pregnancy was the source of the aggravation the symptoms should subside after delivery. Therefore, she waited about six months after delivery to see anyone. Petitioner's testified that her post-pregnancy symptoms were still unbearable and surgery improved her condition.

Petitioner testified that despite the improvement from surgery, her hands feel weaker and she has less endurance for writing and typing activities. She testified that she has to take breaks more frequently and feels that she cannot work as fast as she used to. She also has sensitivity in her palms over her incision sites. Petitioner testified to palm pain with any load bearing or if she brushes up her palm against any surface. Her hobby of yoga, which she recently began, has been adversely affected.

The Arbitrator concludes:

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
Issue (D): What was the date of the accident?
Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner failed to prove that she sustained an accident on January 4, 2013 that arose out of and in the course of her employment with Respondent or that her current condition of ill-being is causally related to that injury. In support thereof the Arbitrator relies and adopts the testimony and opinions of Dr. Sudekum, whose opinions and testimony are found more persuasive than those of Dr. Morgan.

In cases involving a repetitive trauma theory, the claimant generally relies on medical testimony to establish a causal connection between the claimant's work and the claimed disability. See, e.g., *Peoria County Bellwood,* 115 Ill.2d 524 (1987); *Quaker Oats Co.* v. *Industrial Commission,* 414 Ill.2d 326 (1953). When the question is one specifically within the purview of experts, expert medical testimony is mandatory to show claimant's work activities caused the condition of which the employee complains. See, e.g., *Nunn v. Industrial Commission*, 157 Ill. App. 3d 470, 478 (4th Dist. 1987). The causation of compression neuropathy via repetitive has been deemed to fall in the area requiring such expert testimony. *Johnson v. Industrial Commission*, 89 Ill. 2d 438 (1982).

Liability in this case hinges on whose expert opinion is found to be more persuasive – Dr. Morgan (Petitioner's treating physician) or Dr. Sudekum (Respondent's Section 12 physician). Between the two physicians, Dr. Sudekum is more qualified in that he holds the added certificate of hand surgery. The Arbitrator is fully aware that Dr. Sudekum did not examine Petitioner and that he did not review the operative report for Petitioner's surgeries. In this particular instance, those factors do not diminish his opinions or testimony. The operative report would shed no light on the causation issue. While the examination of a claimant is most beneficial in many cases, Dr. Sudekum had a copy of her written job description and one may reasonably infer that what is contained in that description is what she would have told him. More importantly, Dr. Sudekum, unlike Dr. Morgan, reviewed all of Petitioner's medical records pre-dating her alleged injury and he had a more accurate understanding of Petitioner's job. Dr. Sudekum referred to Petitioner as a law clerk and while he never saw Petitioner perform her job, he testified that his sister is a law clerk. In contrast, Dr. Morgan's office notes reflect his descriptions of Petitioner as a "legal secretary", and a law clerk and he testified that her job was similar to that of a court reporter. Dr. Morgan could not cite to any articles supporting a causal link between computer use and carpal tunnel syndrome. Dr. Sudekum cited several articles which do not support a relation between computer use and carpal tunnel syndrome. The record shows that Petitioner had an increase in her carpal tunnel symptoms during pregnancy and that following her delivery, she continued to have symptoms. Dr. Morgan opined that following pregnancy, the carpal tunnel symptoms from pregnancy "usually" resolve. Dr. Sudekum stated that about 30% of women who have carpal tunnel symptoms during pregnancy do not get better.

Dr. Sudekum persuasively explained why the issue of force was more relevant to the causation determination than the amount of repetition and that in Petitioner's case her job duties did not require/involve force. Dr. Sudekum persuasively explained that Petitioner's job involved the use of her hands in a manner for which one's hands are naturally designed. Many, if not most, people use their hands all day long – both at home and at work. Petitioner's duties were varied and she had intermittent breaks and changes in her movements. In this instance, Petitioner's use of her hands all day long does not rise to the level of "repetitive activity" as intended under the Act. Petitioner failed to meet her burden of proof. Her claim for compensation is denied and no benefits are awarded.

Based upon the foregoing, all other issues are moot.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin Clayton,

Petitioner,

vs. NO: 13 WC 17336

Pontiac Correctional Center,

Respondent.

16IWCC0320

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident under the Workers' Occupational Diseases Act, causal connection, medical expenses, and permanent disability benefits, hereby reverses the Arbitrator's Decision and finds that Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on April 15, 2013, that his current condition of ill-being is causally related to the April 15, 2013 work accident.

Section 1(d) of the Workers' Occupational Diseases Act (hereinafter "OD Act"), states that:

> "In this Act the term "Occupational Disease" means a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public.
>
> A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease. The disease need not to have been foreseen or expected but after its contraction it must appear to have had its origin or aggravation in a

> risk connected with the employment and to have flowed from that source as a rational consequence.
>
> An employee shall be conclusively deemed to have been exposed to the hazards of an occupational disease when, for any length of time however short, he or she is employed in an occupation or process in which the hazard of the disease exists." 820 ILCS 310/1(d) (2006)

In *Luttrell v. Industrial Commission*, 154 Ill.App.3d 943, 954 (1987), the court, citing *Bunney v. Industrial Commission*, 75 Ill.2d 413, 422 (1979), the court explained that:

> "a claimant under the Workers' Occupational Diseases Act must prove both: (1) the existence of a 'disease'; and (2) either (a) that there is a causal connection between the contraction of that disease and claimant's working environment (Ill. Rev. Stat. 1983, ch. 48, par. 172.36(d)), or (b) that claimant's working environment aggravated and rendered disabling a previously existing disease."

And as explained by the court in *Dodson v. Industrial Commission*, 308 Ill.App.3d 572, 575-576 (1999):

> [w]hether an employee's injuries "arose out of" the employment may be determined under two different approaches. First, an injury arises out of the employment where its origin stems from a risk connected with, or incidental to, the employment. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. "A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties." *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. Second, an injury arises out of the employment where it is caused by some risk to which the employee is exposed to a greater degree than the general public by virtue of his employment. *Orsini*, 117 Ill. 2d at 45.

Furthermore, as explained in *Organic Waste Systems v. Industrial Commission*, 241 Ill.App.3d 257, 260 (1993):

> [I]t is well established that a finding of a causal relationship may be based on a medical expert's opinion that an accident "could have" or "might have" caused an injury. (*Mason & Dixon Lines, Inc. v. Industrial Comm'n* (1983), 99 Ill. 2d 174, 457 N.E.2d 1222, 75 Ill. Dec. 663.) Further, a chain of events which demonstrates a previous condition of good health, accident and subsequent injury resulting in disability may be circumstantial evidence to prove a causal nexus between the accident and claimant's injury. *International Harvester v. Industrial Comm'n* (1982), 93 Ill. 2d 59, 442 N.E.2d 908, 66 Ill. Dec. 347.

16IWCC0320

There is no question that Petitioner has latent tuberculosis (hereinafter "TB"). There is also no question that Petitioner's job exposes to him to the risk of contracting TB to a greater degree than the general public. As explained by Teresa Arroyo, Respondent's health care unit administrator and an RN, the hazard of TB exists at the prison and that someone who works at the prison is exposed to a greater risk of TB exposure than the general public. (T.29-30-34)

Petitioner testified that it is "fairly common to have what they call guest inmates from other facilities that will travel through for court writs, medical furloughs, that kind of thing. Also if there is an issue at another facility inmates will be bused to Pontiac." (T.14) Ms. Arroyo testified that while they test inmates and employees at Respondent facility, she explained that when guest inmates "come to the institution they come with what we call a health status, any current medical conditions...all of that information is on the health status." (T.27) The Commission notes that there was no evidence presented regarding if guest inmates traveling through for court writs, medical furloughs, etc., were tested or came with health status reports. The Commission further notes that, regarding the 90 guest inmates that stayed at Respondent facility between 2012 and 2013, Ms. Arroyo testified that she and a co-worker reviewed the health statuses of those inmates. (T.30-32) Ms. Arroyo admitted to not having reviewed all of the health statuses herself. (T.30-32) As such, the Commission finds that while Ms. Arroyo can account for the health status of the inmates permanently housed at Respondent facility, she cannot account for the health status of guest inmates and transient inmates traveling through the facility with which Petitioner had contact. Therefore, the Commission finds that Petitioner established a rebuttable presumption of exposure to TB, shifting the burden of proof to Respondent.

The Commission notes that Respondent failed to provide any alternative way Petitioner could have been exposed to TB. As explained above, Ms. Arroyo agreed that the hazard of TB exists at the prison and that a person who works at the prison is exposed to the risk of TB exposure more so than the general public. Based on the nature of Petitioner's employ, the risk of exposure associated with his employment and the testimony of Ms. Arroyo, Respondent has failed to prove the existence of an alternate way Petitioner could have been exposed to TB. Therefore, the Commission reverses the Arbitrator's Decision and finds that Petitioner has proved that his latent TB arose out of and in the course of his employment with Respondent.

In following the criteria laid out in Section 8.1b of the Act, the Commission notes that:

(i) *the reported level of impairment pursuant to subsection (a);*
An AMA report was not provided.

(ii) *the occupation of the injured employee;*
Petitioner works as a correctional officer, and continues to be exposed to the risk of exposure to TB and the risk of his latent TB becoming active TB.

(iii) *the age of the employee at the time of the injury;*
Petitioner was 30 years of age at the time of the accident.

16IWCC0320

(iv) *the employee's future earning capacity; and*
No evidence was provided regarding the effect Petitioner's condition would have on his future earning capacity.

(v) *evidence of disability corroborated by the treating medical records.*
The Commission notes that Petitioner must continue to undergo tests evert 2 years to gauge the status of his TB and that it can become active at any time. Petitioner testified that he is unable to undergo treatment for his condition because he and his wife are trying to have a baby and the medication could affect his fertility. (T.19-20)

After considering the facts and following the criteria listed in Section 8.1b of the Act, the Commission finds that Petitioner has suffered a 3% loss of use of the person as a whole under Section 8(d)2 of the Act.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. Furthermore, we have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. Finally, one should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

IT IS THEREFORE ORDERED BY THE COMMISSION that that the Decision of the Arbitrator, filed on May 27, 2015, is reversed as stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $638.31 per week for a period of 15weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused the 3% loss of use of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay all medical expenses pursuant to Sections 8(a) & 8.2 of the Act. Respondent shall have credit for amounts paid under Section 8(j) of the Act.

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

16IWCC0320

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

DATED: MAY 12 2016
MJB/ell
o-03/21/16
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Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CLAYTON, KEVIN
Employee/Petitioner

Case# **13WC017336**

PONTIAC CORRECTIONAL CENTER
Employer/Respondent

16IWCC0320

On 5/27/2015, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0190 LAW OFFICE OF PETER FERRACUTI
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OTTAWA, IL 61350

0502 STATE EMPLOYEES RETIREMENT
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CODY KAY
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0498 STATE OF ILLINOIS
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CHICAGO, IL 60601-3227

1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAY 27 2015

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Kevin Clayton
Employee/Petitioner

v.

Pontiac Correctional Center
Employer/Respondent

Case # 13 WC 17336

Consolidated cases: _____

16IWCC0320

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

DISPUTED ISSUES

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

16IWCC0320

FINDINGS

On **April 15, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**37,475.00**; the average weekly wage was $**957.46**.

On the date of accident, Petitioner was **30** 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 $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

Because Petitioner did not sustain an accident that arose out of and in the course of employment, all benefits are denied.

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

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

D. Dylan MacCarthy
Signature of Arbitrator

May 18, 2015
Date

MAY 27 2015

Kevin Clayton v. Pontiac Correctional Center
13 WC 17336

16IWCC0320

Arbitrator Findings of Fact:

Petitioner Kevin Clayton Jr. filed an Application for Adjustment of Claim under the Occupational Disease Act which alleged a date of accident of April 15, 2013 from his employment at Pontiac Correctional Center (Pontiac CC) as a correctional officer. At hearing, it was revealed that Petitioner had a positive skin test for tuberculosis that resulted in Petitioner undergoing x-rays which confirmed he did not have active tuberculosis.

Petitioner testified he began to work for Pontiac CC in June 2012 as a correctional officer. At the start of his employment he received medical safety training where he was taught to treat every inmate as if they were infected with every disease. He testified he had a negative skin test for tuberculosis prior to beginning work and that it is Pontiac CC policy for everyone to be tested for tuberculosis annually. Medical records from Ottawa Regional Medical Center Petitioner confirm a negative July 2012 test. (PX 3).

Petitioner testified he has always been on detail duty but his duties have varied. He is occasionally in the maximum security unit, but spends most of his time in the medium security unit. He explained he does a lot of gallery walks and security checks. Further, he would also escort inmates which required him to pat inmates down, strip search them, and then take them to and from medical and dental appointments.

Petitioner explained that Pontiac CC occasionally has guest inmates, specifically citing when Dixon Correctional Center (Dixon CC) had it roof blown off and inmates had to be relocated, as an example. Further explaining the Dixon CC example, Petitioner testified that he helped process the inmates by going on the bus with them, putting handcuffs on them, removing the restraints that were attached to the bus, bringing them into a holding cell, and strip searching all of them one by one. He then explained that this same process was done in reverse weeks later when returning them to Dixon CC.

Petitioner then testified with specifics on the process of a strip search. An inmate stands within arm's reach of Petitioner and then the inmate strips off all of their clothes to bare skin. Each article of clothing is handed to Petitioner to check for contraband. Petitioner then has inmates open their mouth (which he checks), along with checking behind an inmate's ears and in all their bodily orifices. Following the checks, Petitioner would hand back the inmate's clothes one item at a time and observe them dress. If an inmate became combative, Petitioner testified he could come in contact with an inmate's orifices.

Petitioner then testified he had a positive skin test for latent tuberculosis. Medical records from Ottawa Regional Medical Center confirm Petitioner had a skin test taken on April 13, 2013 that was read as positive on April 15, 2013. (PX 3). An x-ray taken at OSF Saint Elizabeth Medical Center on April 15, 2013 found no evidence of active TB in Petitioner's lungs. (PX 2). Petitioner returned to work and is currently on no medication.

Petitioner testified about possible future treatment including the possibility of medication and needing to get an x-ray every two years. Petitioner testified a doctor told him not to take medication since he is trying to have a child. On cross-examination, Petitioner confirmed he had no direct knowledge of any inmates, including guests, having active tuberculosis.

Teresa Arroyo testified as a witness for the Respondent. Ms. Arroyo testified she holds a registered nursing license and was currently employed as a health care unit administrator at Pontiac CC, a position she had held for nine-and-a-half years. She testified her work duties were to oversee all the activities in the health care unit. These duties include scheduling clinics for offenders, sick calls, interviewing inmates when they come in, and doing monthly reports for the state including reports on communicable diseases.

Ms. Arroyo testified she had learned about tuberculosis in her educational and work background. She explained latent tuberculosis occurs when a person comes in contact with someone who has active tuberculosis. She explained it is transmitted through droplets and that it is a respiratory disease. Further, latent tuberculosis is usually found by a skin test since a person would not have to have active symptoms and then a chest x-ray would be done with a negative result ruling out active tuberculosis. Ms. Arroyo explained a person with active tuberculosis would be showing signs and symptoms such as excessive coughing, coughing up blood, and especially night sweats.

Ms. Arroyo explained that someone with active tuberculosis would be put in isolation at a correctional facility. A chest x-ray would then be done that would come back positive and then sputum would be tested as well. She then confirmed that only active tuberculosis is transmittal to other people. She then also confirmed that there were no active cases of tuberculosis at Pontiac CC from June 2012 to April 2013. Ms. Arroyo knew there was no active tuberculosis because of her history of monthly communicable disease reports for Pontiac CC. She would have been required to report it to the Illinois Department of Public Health since tuberculosis is a reportable disease.

Ms. Arroyo explained that the monthly communicable disease reports she made included guest inmates. She testified when a guest inmate comes to Pontiac CC, they do a health status which includes any current medical conditions, whether they have a psychiatric history, and if the guest inmate is taking any medications.

On cross-examination, Ms. Arroyo was asked if a "hazard of tuberculosis exists at a correctional center like Pontiac," and she testified "hazard exists because you are in close contact." She later confirmed that since there is a hazard, staff and inmates are tested yearly.

Ms. Arroyo was asked about the Dixon CC inmates coming to Pontiac CC and she testified approximately 90 inmates came over. She testified that health reports came with all of the inmates and that she was one of two people who went through all of the reports. When asked about the health status reports reviewed by the other person, Ms. Arroyo testified "Based on her education and her background, yes, I feel confident in saying that the health statuses that she reviewed, none had active tuberculosis." (T. 32).

Ms. Arroyo was then asked about any history of active tuberculosis at Pontiac CC and she testified there had been no cases in the nine-and-a-half years she had been there and she was not aware of any active cases prior to her working there. When asked about the process of treatment after a positive skin test, Ms. Arroyo explained that a person with a positive skin test would be treated with INH and B-6, a medication specifically used in people that test positive with a PPD of 10 millimeters or more in duration. She continued that INH and B-6 is a medication that will basically encapsulate the germ that the person has so it doesn't become active.

Ms. Arroyo explained that besides the yearly skin test for tuberculosis, Pontiac CC helps to safeguard against active tuberculosis by putting anyone who starts to show possible symptoms of the disease in isolation and have a x-ray done to confirm they do not have active tuberculosis. When asked to consider how often positive skin tests occurs, Ms. Arroyo testified that maybe there were four positive skin tests in the last year. Those people would be kept in what Pontiac CC calls their tuberculosis clinic because they are receiving INH and B-6. She then confirmed Pontiac CC specifically has a tuberculosis clinic because they have to monitor people while they are taking INH and B-6 because there are certain labs that need to be drawn.

Arbitrator Findings on the Issues:

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator concludes that Petitioner failed to prove by a preponderance of the credible evidence that he suffered from a disease that arose out of and in the course of his employment with Respondent.

According to the Occupational Disease Act, an occupational disease is "a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public." 820 ILCS 310/1(d). In an Occupational Disease Act claim, Petitioner "must prove both: (1) the existence of a 'disease'; and (2) either (a) that there is a causal connection between the contraction of that disease and claimant's working environment or (b) that claimant's working environment aggravated and rendered disabling a previously existing disease." Luttrell v. Indus. Comm'n, 154 Ill. App. 3d 943, 954, 507 N.E.2d 533, 541 (1987).

Here, Petitioner did not provide any records of treatment or current condition beyond the April 15, 2013 records. Those records only show that, based upon one positive skin test, petitioner had latent tuberculosis. There was no evidence submitted that the Petitioner had active tuberculosis.

Regarding possible exposure and contact, Ms. Arroyo testified that there had been no active cases of tuberculosis in her nine-and-a-half years working at Pontiac CC. To support her knowledge that there was no active tuberculosis, Ms. Arroyo explained how she is responsible

for making monthly reports for Pontiac CC on all communicable diseases including tuberculosis. All staff and inmates are tested for tuberculosis yearly. Additionally, Pontiac CC will put anyone who displays possible symptoms of tuberculosis in isolation to be tested for active tuberculosis. She confirmed this scenario has happened several times a year, but upon further medical follow up, none of the possibly symptomatic individuals was revealed to have an actual active case of tuberculosis.

Ms. Arroyo also testified she was confident all guest inmates of Pontiac CC were checked and that no guest ever had active tuberculosis. She specifically testified to the process of 90 inmates coming over from Dixon Correctional Center and how she and another worker went through all health status reports to confirm none of the guests had tuberculosis.

Additionally, Petitioner testified he had no direct knowledge of any inmates, including guests, having active tuberculosis.

Given the unquestioned testimony of Ms. Arroyo, Petitioner's positive skin test for latent tuberculosis could only be related to his work at Pontiac CC if he was exposed and came into contact with someone who had active tuberculosis at the correctional facility. Ms. Arroyo's monthly reports, along with her in depth testimony about all of the precautions Pontiac CC takes to prevent any exposure to active tuberculosis, prevent the Arbitrator from drawing a reasonable inference that Petitioner was exposed and came into contact with someone who had active tuberculosis while working for the Respondent.

The Arbitrator is mindful of Section 1 (d) of the Act which establishes a conclusive presumption of exposure to an occupational disease if there is proof of any exposure to a hazard of said disease. Here, Nurse Arroyo testified that there would be a hazard to TB if the Petitioner had been in contact with anyone at the prison who had active disease. However, she testified convincingly without rebuttal that no such contact had been made. The Petitioner presented no evidence, either direct or circumstantial, to rebut her testimony. Accordingly, there is no proof that Petitioner was exposed to the hazard of tuberculosis, and, as such, the presumption does not apply.

Based on the above, the Arbitrator concludes Petitioner did not suffer from a disease that arose out of or in the course of his employment. Further, Petitioner presented no medical records of having any current condition at all. Petitioner's claim for benefits is denied.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
Issue (L): What is the nature and extent of the injury?

Having found Petitioner did not suffer from a disease that arose out of or in the course of his employment, the Arbitrator finds the remaining issues moot.

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

Briggitte Womack,

Petitioner,

vs. NO. 13 WC 21347

State of Illinois, Department of Corrections,

Respondent.

16IWCC0361

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, causal connection, permanent disability, 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 28, 2015 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.

16IWCC0361

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: MAY 2 6 2016
SJM/sj
o-5/5/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WOMACK, BRIGGITTE Case# **13WC021347**

Employee/Petitioner

STATE OF ILLINOIS/DEPT OF CORRECTIONS

Employer/Respondent

16IWCC0361

On 7/28/2015, 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 0.14% 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:

2934 BOSHARDY LAW OFFICE PC
JOHN V BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

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

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

1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUL 28 2015

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

16IWCC0361

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

Briggitte Womack
Employee/Petitioner

v.

State of Illinois/Department of Corrections
Employer/Respondent

Case # 13 WC 21347

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on May 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. ☒ 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 Statute of Limitations

FINDINGS

On October 17, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $68,375.32; the average weekly wage was $1,314.91.

On the date of accident, Petitioner was 49 years of age, single with 3 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

Respondent shall pay Petitioner temporary total disability benefits of $876.61 per week for 23 1/7 weeks commencing March 24, 2014, through September 2, 2014, as provided in Section 8(b) of the Act.

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 15% loss of use of the right hand; 20% loss of use of the left hand; and 20% loss of use of the right ring finger.

Respondent shall pay Petitioner permanent partial disability benefits of $712.55 per week for 71.9 weeks because the injuries sustained caused the 15% loss of use of the right hand; 20% loss of use of the left hand; and 20% loss of use of the right ring finger, as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

July 24, 2015
Date

JUL 28 2015

Findings of Fact

On July 1, 2013, Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent. The Application alleged a date of accident (manifestation) of October 17, 2012, and that Petitioner sustained repetitive trauma to the "left and right hands, arms, ring and middle finger" (Petitioner's Exhibit 1). Respondent disputed liability on the basis of accident and causal relationship. Further, Respondent claimed that the Application was not filed within the filing period required by Section 6(d) of the Act (Arbitrator's Exhibit 1).

Petitioner became employed by Respondent in January, 1988, and has worked for different departments of Respondent. Petitioner has worked for the State Police, Department of Revenue and Department of Corrections. For all of the time Petitioner has worked for Respondent, she has typed and performed data entry.

Petitioner testified that when she was doing data entry, her keyboard was on a flat desk and it was necessary for her to type with her hand and an upward angle. Petitioner had a quota of keystrokes which was monitored and she never fell below what was required of her.

Sometime in 2007, Petitioner's position changed and she began doing data entry for the State Police; however, she still had to type with her hands at an upward angle. Petitioner also had to sit on a chair that was not adjustable.

In 2010, Petitioner began to have symptoms of stiffness in her fingers as well as right arm pain. She initially sought medical treatment from Dr. Dennis Yap, her family physician, on April 20, 2010. Dr. Yap examined Petitioner, but his findings on clinical examination were benign. He did order that Petitioner undergo EMG/nerve conduction studies (Petitioner's Exhibit 2).

Dr. Cecile Becker saw Petitioner on May 7, 2010, and performed EMG/nerve conduction studies at that time. The diagnostic studies were positive for mild median mononeuropathy in both the right and left wrist. Dr. Becker recommended Petitioner use wrist splints to see if that would improve her symptoms (Petitioner's Exhibit 2).

On May 11, 2010, Petitioner was provided with bilateral wrist splints that were prescribed by Dr. Yap. She was given instructions on how to use them and the record indicated that "No further follow-up needed at this time." (Petitioner's Exhibit 2).

On June 1, 2010, Petitioner signed a form from Health Alliance which stated that her "Corpal tunnel" was work-related. On June 7, 2010, Petitioner signed a medical authorization for the use of the Attorney General's office which stated that it was for "...adjudicating a Workers' Compensation claim..." (Respondent's Exhibits 5 and 6).

On June 7, 2010, Petitioner signed a "Workers' Compensation Employee's Notice of Injury" form in which Petitioner stated that she had sustained an injury to the wrist and elbows. The injury is described as having occurred after 22 years of typing (Respondent's Exhibit 8).

Petitioner did not file an Application for Adjustment of Claim in regard to the accident (manifestation) date of May 7, 2010. Further, she did not seek any additional medical care after she received the wrist splints.

In September, 2010, Petitioner was transferred to the Department of Corrections but continued to perform data entry; however, it was approximately 50% of what she previously was required to do. Even so, Petitioner stated that the workstation she was assigned was very difficult for her to use because it was a flat desk and the chair that was provided for her use was very low and could not be adjusted. The fact that Petitioner is 4'11" tall made it extremely difficult for her to type.

Petitioner testified that over the next two years, she experienced gradually worsening symptoms in her hands. Petitioner stated that her hands would go to "sleep" both at work and at home and that she experienced a "pin" type feeling in her fingers.

Petitioner sought medical treatment from Dr. Kotswara Narla, on October 17, 2012 (the date of manifestation alleged in the Application). At that time, Petitioner advised that she had tingling/numbness in both of her hands for the preceding two and one-half months. Dr. Narla ordered nerve conduction studies which were performed that same day. The nerve conduction studies were positive for severe carpal tunnel compression on the right and moderate to severe carpal tunnel compression on the left (Petitioner's Exhibit 2).

Petitioner was subsequently seen by Dr. Joel Wietfeldt, a plastic surgeon, on November 13, 2012. At that time, Petitioner informed Dr. Wietfeldt of both the symptoms she had in 2010 and her more recent symptoms. She also informed Dr. Wietfeldt that she had been doing computer work for 25 years and worked at a computer five hours a day five days a week. In addition to her hand symptoms, Petitioner also complained of triggering of her right ring finger. Dr. Wietfeldt recommended Petitioner have right carpal tunnel surgery and a steroid injection in the right ring finger. Once the right hand was functional, Dr. Wietfeldt indicated that he would then proceed with left carpal tunnel surgery.

Dr. Wietfeldt deferred proceeding with any surgical procedures, pending approval from workers' compensation. Petitioner continued to be treated by him and, in addition to bilateral carpal tunnel syndrome, Dr. Wietfeldt also diagnosed Petitioner with bilateral de Quervain's. In regard to causality, Dr. Wietfeldt prepared a letter dated June 27, 2013, wherein he opined that 25 years of typing could aggravate carpal tunnel syndrome (Petitioner's Exhibit 2).

At the direction of Respondent, Petitioner was examined by Dr. Patrick Stewart, a hand surgeon, on August 20, 2013. In connection with his examination of Petitioner, Dr. Stewart reviewed medical records and data regarding Petitioner's job duties provided to him by Respondent. Dr. Stewart agreed that Petitioner had bilateral carpal tunnel syndrome and bilateral trigger ring fingers, for which surgery was appropriate. He also opined that Petitioner's de Quervain's had resolved. In regard to causality, Dr. Stewart stated that Petitioner's repetitive activities did not have a sufficient amount of force to be an aggravating factor for the development of those conditions (Respondent's Exhibit 1; Deposition Exhibit 2).

Petitioner continued to be treated by Dr. Wietfeldt. On March 28, 2014, Dr. Wietfeldt performed surgery which consisted of right carpal tunnel release, pronator release, right ring finger trigger release and steroid injections in the right dorsal second compartment. On July 11, 2014, Dr. Wietfeldt performed surgery which consisted of left carpal tunnel release and a bilateral second dorsal compartment release (Petitioner's Exhibit 2).

Subsequent to both surgeries, Dr. Wietfeldt authorized Petitioner to be off work and ordered physical therapy. At trial, Petitioner and Respondent stipulated that Petitioner was temporarily totally disabled from March 24, through September 2, 2014.

Dr. Wietfeldt saw Petitioner for the last time on February 20, 2015. At that time, Petitioner advised that, in regard to the right hand, she had no residual symptoms and good function of the hand. In regard to the left hand, Petitioner stated that she still has some decreased sensation and function. Dr. Wietfeldt stated that Petitioner's left hand symptoms were due to pronator syndrome and recommended possible surgery (Petitioner's Exhibit 2).

Dr. Stewart was deposed on July 22, 2014, and his deposition testimony was received into evidence at trial. Dr. Stewart reaffirmed the opinions given in his narrative medical report and stated that Petitioner's repetitive activities at work did not require enough force to develop compression neuropathies. Dr. Stewart also observed that Petitioner had other risk factors, including morbid obesity, her age and being postmenopausal. On cross-examination, Dr. Stewart agreed that there was no specific amount of force needed to cause carpal tunnel syndrome and that the amount of force necessary to do so would vary from one person to another. He also agreed that he had no specific knowledge of the ergonomics of Petitioner's work station (Respondent's Exhibit 1; pp 14-18, 22-27).

Dr. Wietfeldt was deposed on March 9, 2015, and his deposition testimony was received into evidence at trial. Dr. Wietfeldt's testimony regarding his treatment of Petitioner was consistent with his medical records. In regard to causality, Dr. Wietfeldt stated that the carpal tunnel syndrome, de Quervain's and trigger fingers can be aggravated by repetitive use. In regard to pronator syndrome, he opined that it was possible that it was related to repetitive use but he could not state so with certainty. In regard to the other predisposing risk factors, Dr. Wietfeldt stated that neither age nor Petitioner being a female placed her at an increased risk for carpal tunnel syndrome. He also disputed that Petitioner was morbidly obese, but he did not believe that obesity was a contributing factor either (Petitioner's Exhibit 7; pp 18-27).

At trial, Petitioner testified that she returned to work to her regular job in September, 2014, and was still working in that capacity. Petitioner still has complaints of tingling/numbness in both hands as well as some diminished strength.

Conclusions of Law

In regard to disputed issues (C), (D) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner sustained a repetitive trauma injury arising out of and in the course of her employment for Respondent that manifested itself on October 17, 2012, and that Petitioner's current condition of ill-being is causally related to same.

In support of this conclusion the Arbitrator notes the following:

Petitioner had bilateral hand symptoms and was diagnosed with bilateral carpal tunnel syndrome on May 7, 2010, after EMG/nerve conduction studies were performed. The diagnostic studies described the severity of the conditions in both hands as "mild."

On May 11, 2010, Petitioner received wrist splints and sought no further medical treatment until October 17, 2012, when EMG/nerve conduction studies were performed which revealed that Petitioner had "severe" carpal tunnel compression on the right and "moderate to severe" carpal tunnel compression on the left.

Obviously, Petitioner's bilateral carpal tunnel syndrome condition was much worse in 2012 than it was in 2010.

In addition to carpal tunnel syndrome, Petitioner was also diagnosed with de Quervain's and trigger fingers.

Based on the preceding, the Arbitrator concludes that Petitioner's upper extremity conditions in 2012 were significantly different than what they were in 2010 and that said conditions manifested themselves on October 17, 2012.

Petitioner credibly testified in regard to the keyboarding requirements of her job and her testimony was unrebutted.

Dr. Wietfeldt opined that Petitioner's work activities aggravated the carpal tunnel syndrome, de Quervain's and trigger finger conditions and further stated that Petitioner's other risk factors did not contribute to the development of those conditions.

While Dr. Stewart testified that the amount of force used by Petitioner in her repetitive job duties was insufficient to cause carpal tunnel syndrome, on cross-examination he could not specify what amount of force would be necessary.

The Arbitrator finds the opinion of Dr. Wietfeldt to be more persuasive than that of Dr. Stewart.

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. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and

Respondent shall hold Petitioner harmless from any claims by the providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

Based on the stipulations of the parties, the Arbitrator concludes that Petitioner is entitled to temporary total disability benefits of 23 1/7 weeks commencing March 24, 2014, through September 2, 2014.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 15% loss of use of the right hand; 20% loss of use of the left hand; and 20% loss of use of the right ring finger.

In support of this conclusion the Arbitrator notes the following:

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

Petitioner returned to work to the same job she had at the time she sustained the injury. The Arbitrator gives this factor moderate weight.

Petitioner was 49 years old at the time of the injury. Because Petitioner has returned to work to the same job that she had at the time she sustained the injury, she will have to perform the same job duties that caused the injury. The Arbitrator gives this factor moderate weight.

There was no evidence that the injury will have any impact on Petitioner's future earning capacity. The Arbitrator gives this factor minimal weight.

Petitioner sustained repetitive trauma injuries to both upper extremities that caused/aggravated carpal tunnel syndrome, de Quervain's and trigger fingers which ultimately required either corrective surgery or injections.

Carpal tunnel release surgeries were required for both the left and right hands and the left hand also had a de Quervain's release procedure. A surgical release of the right ring trigger finger was also required.

Petitioner still has complaints consistent with the injuries she sustained and the surgical procedures there were performed.

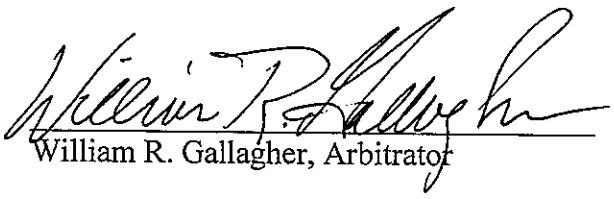
The Arbitrator also notes that, because Petitioner was diagnosed with not only bilateral carpal tunnel syndrome, but also de Quervain's of the hands, that the 15% statutory limit may be exceeded.

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

The Arbitrator concludes that Petitioner's Application for Adjustment of Claim was filed within the filing period as prescribed by the Act.

In support of this conclusion the Arbitrator notes the following:

As noted in the Arbitrator's conclusion of law in disputed issues (C), (D) and (F), Petitioner sustained a repetitive trauma injury that manifested itself on October 17, 2012. Petitioner's Application for Adjustment of Claim was filed on July 1, 2013, which is within the filing period as prescribed by the Act.



William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Claude Donzelli,

Petitioner,

vs.

NO: 13 WC 22359

Best Courier & Delivery Service,

16IWCC0336

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 22, 2015, 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.

16IWCC0336

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

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

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

DATED: MAY 17 2016
TJT:yl
o 5/10/16
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

DONZELLI, CLAUDE
Employee/Petitioner

Case# **13WC022359**

BEST COURIER & DELIVERY SERVICE
Employer/Respondent

16IWCC0336

On 7/22/2015, 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 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

3150 JAMES M KELLY LAW FIRM
4801 N PROSPECT RD
SUITE 832
PEORIA HEIGHTS, IL 61616

16IWCC0336

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

- [ ] 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)

Claude Donzelli
Employee/Petitioner

v.

Best Courier & Delivery Service
Employer/Respondent

Case # 13 WC 22359

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Waukegan**, on **June 29, 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

16IWCC0336

FINDINGS

On the date of accident, **May 20, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**22,435.40**; the average weekly wage was $**431.45**.

On the date of accident, Petitioner was **65** 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 $**4,227.92** for TTD, $**68.23** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**4,296.15**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $695.00 as provided in Sections 8(a) and 8.2 of the Act.

The Respondent shall authorize and pay for the additional reasonable, necessary and related medical treatment as prescribed by Dr. Citow including the two level anterior cervical discectomy and fusion at C5-C7 and any other reasonable, necessary and causally connected treatment.

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

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

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

Signature of Arbitrator

July 22, 2015
Date

ICArbDec19(b)

JUL 22 2015

Statement of Facts

Petitioner Claude Donzelli testified that on May 20, 2013, he was employed by Respondent Best Courier & Delivery Service as a driver/courier. He had been employed by Respondent since February, 2011. He testified that he would be given a package or pallet of material and told to deliver it to a client. He would drive his personal cargo van. He was paid as an owner/operator. He would make deliveries locally and out of state.

Petitioner testified that on May 20, 2013, he was going to Kenosha for a pick up. As he was going north on Milwaukee Avenue, he was stopped at a red light and was rear ended by a car. He was wearing his seat belt. His air bag did not deploy. Petitioner testified his van sustained a dented bumper. His vehicle was drivable. He filled out a police report and finished his route to Kenosha. Petitioner testified that he felt pain in his neck and had a headache. Petitioner testified that he had no prior complaints in his neck.

Petitioner testified that he contacted his dispatcher to advise him of the accident. He was told to come to the office and was sent to Advocate Condell Immediate Care. This occurred the next day. He testified that he was treated with an MRI and physical therapy for one month.

The records of Advocate Condell Immediate Care were admitted as Petitioner's Exhibit 1. They confirm that Petitioner was initially seen on May 21, 2013. He provided a history of the accident and complained of neck pain of 6/10 radiating to the left side of his head and shoulder (Px 1, p 201). The examination did not find any neurological deficits and he was released to limited duty with 10 pound lifting and no driving. Petitioner was seen on May 23, 2013 with complaints of pain radiating into the left arm and numbness into his thumb (Px 1, p 165). On May 30, 2013, Petitioner noted 75% improvement of his symptoms. No radiation of pain into the back or arms was reported (Px 1, p 129).

Dr. Samuels' note on June 7, 2013 states Petitioner's complaints are not improving and prescribes an MRI, Medrol Dosepak and physical therapy (Px 1, p 88). The examination records limited range of motion in the neck, numbness and tingling into the left hand (Px 1, p 72). The MRI was performed on June 14, 2013 and was read as showing a left disc herniation at C5-6 causing impingement upon the left foramen and spinal stenosis and a milder disc herniation causing some impingement at C6-7. The age of the herniation at C5-6 and C6-7 cannot be determined by the study (Px 1, p 34).

Petitioner was seen for physical therapy from June 11, 2013 through June 28, 2013. On June 20, 2013, Petitioner was referred to Dr. Citow for a neurosurgical consult with a diagnosis of cervical disc herniation (Px 1, p 28).

Petitioner testified that he saw Dr. Citow on July 5, 2013. Dr. Citow's records were admitted as Petitioner's Exhibits 2a and 2b. The July 5, 2013 report shows complaints of pain in the neck and radiating down the left arm into the thumb and fingers. Dr. Citow's examination notes decreased sensation. His review of the MRI study confirms a disc herniation at C5-6 and a spur at C6-7. He recommended an epidural steroid injection.

This was performed on August 9, 2013. Dr. Caner's records were admitted as Petitioner's Exhibit 3. His August 5, 2013 note contains the history of the accident and pain beginning about 1.5 to 2 hours after the accident. Complaints were of pain in the neck radiating into the left extremity towards the 1-2 digits and into the back of the head and the left eye. Dr. Caner notes that Petitioner is to follow up with Dr. Citow. Injections can be repeated up to two additional times.

Petitioner testified that he noticed slight improvement following the injection. Dr. Citow's August 30, 2013 report notes benefit from the injection with pain reduced to 1/10. Petitioner reported intermittent paresthesia. Petitioner was released to work with a 20 pound restriction. He was to return to unrestricted work in two weeks. He was to complete three weeks physical therapy (Px 2a). Petitioner requested by telephone that the 20 pound lifting restriction not be lifted on September 12, 2013. Dr. Citow issued a Work Status Report on September 12, 2013 maintaining the restriction (Px 2a). Petitioner testified that his restriction was accommodated.

Petitioner's physical therapy records from Advocate Condell from September 23, 2013 through October 18, 2013 were admitted as Respondent's Exhibit 3. The September 23, 2013 note includes a history that the injection has helped, but with the driving, Petitioner's neck gets very stiff. Petitioner continues with limited neck motion. The notes reflect Petitioner reporting he is getting better, but continues to complain of soreness with a lot of driving. The October 18, 2013 discharge report states Petitioner reports the neck is feeling great. He is driving full time but still avoids lifting heavy objects. He has met the short term and long term goals.

Dr. Citow saw Petitioner on October 18, 2013. His report notes mild neck pain which is worse with lifting over 45 pounds. His examination notes full range of motion with 5/5 strength and normal sensation. Dr. Citow released Petitioner to be seen as needed with a permanent 40 pound lifting restriction. He stated Petitioner was at maximum medical improvement. He prescribed refills of Voltaren gel and Cyclobenzaprine and Mobic tablets (Px 2b, Rx 5).

Petitioner testified that Respondent accommodated his restrictions and he returned to work full time. His pain was not going away. The pain gradually increased. He testified that he had no new accident or injury. He testified that he has not been symptom free at any time since the accident. (Px 2a). He returned to Dr. Citow on January 17, 2014 (Px 2b). Dr. Citow's report contains a history of worsening neck pain extending to the left side of the head and into the left shoulder. There was no numbness or paresthesia of the hand. The physical examination records tenderness of the cervical paraspinal musculature with limited range of motion secondary to pain. Strength, reflexes and sensation were normal. Dr. Citow's assessment was spondylosis of the cervical spine. He refilled the medications and recommended an updated cervical MRI, a MRI of the brain and another epidural injection (Px 2b). Petitioner testified that this was not authorized.

Petitioner returned to Dr. Citow on October 3, 2014 (Px 2c). His complaints were of neck pain and left-sided headaches extending through the left upper extremity toward the thumb, index and middle fingers with numbness and paresthesia. Petitioner notes significant pain if he works beyond his 40 pound lifting restriction. Dr. Citow's examination is essentially the same as in January, 2014. He refilled Petitioner's prescription for Mobic. He recommended a C5-7 anterior decompression and stabilization (Px 2c). Petitioner testified that the surgery was not authorized. It is his desire to have the surgery.

Petitioner testified that he continues to work for Respondent within his restrictions. He is limited to doing smaller jobs less than 40 pounds. He testified that he used to carry several boxes of 45-50 pounds each up stairs to stack at the facility. He would work with skids that could weight 1300 to 2000 pounds. Other drivers now do those jobs. He still works full time, but got paid more before.

The transcript of Dr. Citow's April 17, 2015 deposition was admitted as Petitioner's Exhibit 4. Dr. Citow testified that he is a board certified in neurological surgery (Px 4, p 5). On his initial visit he diagnosed cervical

radiculopathy based upon the MRI finding of a C5-6 and C6-7 disc herniation and bone spur and radicular symptoms of neck pain extending to the left upper extremity towards the thumb and index fingers with numbness, weakness and pins and needles. The sensation was decreased appropriately in the left index finger corresponding to the nerve root that was pinched (Px 4, p 6). He opined that the condition diagnosed was causally connected to the work accident. Dr. Citow testified to his office visits on August 30, 2013, October 18, 2013 and January 17, 2014. He testified that the problems advanced on January 17, 2014 were related to what he had before. He testified that the epidural injection does not cure the problem, when the effect wears off, the symptoms return (Px 4, p 10). He recommended another epidural and a new MRI which were not authorized. Dr. Citow testified that at the October 3, 2014 visit Petitioner's symptoms were similar, even worsening, with numbness and pins and needles in the thumb, index and middle fingers. He is now recommending a two level anterior cervical discectomy and fusion at C5-7. It is still his opinion that the condition is causally related to the accident (Px 4, p 11).

Dr. Citow testified that he did not review the original x-ray studies from Condell Immediate Care. He does not feel that this placed him at a disadvantage regarding his diagnosis and opinion on causation. The MRI findings predated the accident. This can be asymptomatic and become symptomatic with trauma such as the accident described by Petitioner. Dr. Citow opined that is what happened in this case (Px 4, p 14). Dr. Citow testified that he agreed with the radiologist that the age of the herniation cannot be determined on the MRI (Px 4, p 19). A bone spur tells you that there is previous degenerative disease at the level. Petitioner had disc osteophyte complexes at C5-6 and C6-7. These are not traumatic changes (Px 4, p 23). Dr. Citow testified that a cervical disc and herniate without trauma (Px 4, p 23). His opinion on causation is based upon the temporal relationship of the accident and the onset of symptoms (Px 4 p 26). Dr. Citow testified that if Petitioner had gone a year after the injection before his symptoms worsened that he would consider this related to the underlying degenerative condition. In the present case, with return three months after the MMI release and within 6 months of the injection, he opined that the pain was related to the accident (Px 4, p 29-32). Petitioner still had mild neck pain on October 18, 2013 which was worse with lifting over 45 pounds. When Petitioner returns in three months he has the same pain, but worse (Px 4, p 40-41). There is no objective test for pain (Px 4, p 42).

Petitioner was examined by Dr. Morris Marc Soriano at Respondent's request on May 1, 2014. The report of that examination was admitted as Respondent's Exhibit 1. The transcript of Dr. Soriano's July 10, 2014 deposition was admitted as Respondent's Exhibit 2. (Px 2a). Dr. Soriano testified that he is board certified in neurological surgery. Dr. Soriano testified he reviewed the medical records and took a history from Petitioner as contained in his report. His physical examination was normal except for some tenderness at the base of his neck. He found full range of motion. Neurological testing was normal except for a finding of carpal tunnel (Rx 2, p 12-13). Petitioner had extensive pre existing degenerative conditions of the cervical spine at C5-6 and C6-7. This was a disc osteophyte complex (Rx 2, p 24). Dr. Soriano opined that the accident did not aggravate this condition. It would be virtually impossible for the bones at C5-6 and C6-7, which were basically fused, to have been aggravated or caused to progress from their pre accident status (Rx 2, p 16).

He opined that Petitioner suffered a cervical strain in the accident. Petitioner does not require any time off from work. He does not require any work restrictions. He does not require any further medical treatment, including not requiring any further injections or surgical intervention. Dr. Soriano opined that Petitioner was at maximum medical improvement and had suffered no permanent disability as a result of the accident (Rx 2, p 15-18). Dr. Soriano testified that Petitioner did not have disc herniations. He testified that he reviewed the MRI and the plain x-rays. The plain x-rays show that there is no disc left and the discs are collapsed and have large

osteophytes surrounding them. Neither the radiologist nor Dr. Citow did this comparison (Rx 2, p 46-47). Dr. Soriano testified that the radiologist characterizing the pathology at C5-5 and C6-7 as herniations is wrong.

Dr. Soriano testified that a rear end collision at 20 miles per hour with the head snapping back and then forward could result in a herniated disc. The symptoms reported by Petitioner at Condell were causally connected to the accident. The MRI and initial physical therapy were reasonable, necessary and causally connected to the accident (Rx 2 p 20-2). Epidural steroid injections are for patients with radicular complaints. Dr. Soriano testified that at no time did Petitioner suffer from radiculopathy (Rx 2, p 27, 29). Radicular pain would go down the arm, with numbness, tingling or weakness down the arm or into the hand.

Conclusions of Law

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

It is undisputed that Petitioner sustained an injury to his neck in the accident on May 20, 2013 when his van was rear ended. The dispute is whether the complaints and treatment after the October 18, 2013 office visit with Dr. Citow, at which time Dr. Citow stated Petitioner was at maximum medical improvement, remain causally connected to the accident. In support of his position, Petitioner has presented the opinions of Dr. Citow that his condition remains causally connected to the accident and that he is in need of additional medical treatment. Respondent has presented the opinions of Dr. Soriano to dispute causation. After review of the evidence in this matter, the Arbitrator finds the opinions of Dr. Citow more persuasive than those of Dr. Soriano.

Petitioner testified that he had no neck complaints prior to the accident on May 20, 2013 and no evidence of any prior complaints, treatment or injury was presented. Prior good health followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is the result of the accident. Petitioner testified that following the accident on May 20, 2013, his symptoms, while they did improve with treatment including the injection and physical therapy, never were completely resolved. The Arbitrator observed the Petitioner and found his testimony credible.

The medical records also support Petitioner's testimony. Although Petitioner reported resolution of his radicular symptoms and on many visits advised Dr. Citow and the therapists that his symptoms were improved, the Arbitrator notes that he was not doing his full duty on those occasions and he always noted that he was not doing heavy lifting. The therapy records note that when Petitioner increased his physical efforts that symptoms increased or recurred. When Dr. Caner noted improvement after the August 9, 2013 injection, his notes reflect that the injections could be repeated. Even when Dr. Citow released Petitioner on October 18, 2013, he prescribed ongoing medication and continued a permanent 40 pound lifting restriction. The medical records support that Petitioner's symptoms waxed and waned, as testified to by Dr. Citow. He improved with treatment modalities and noted additional complaints as his physical activity increased.

Dr. Citow, the treating neurosurgeon, diagnosed cervical disc herniations. This is in agreement with the radiologist reading of the MRI and the diagnosis carried by Advocate Condell Immediate Care. It is the ongoing complaints and MRI findings that were a component in the referral to Dr. Citow for a neurosurgical consult from Advocate Condell. Dr. Citow's concurs that Petitioner had a pre existing degenerative condition in

his cervical spine. It is his opinion is that the previously asymptomatic pre existing degenerative condition in Petitioner's cervical spine became symptomatic as a result of the accident. Dr. Soriano agreed that the original symptoms following the accident were causally related and the initial treatment as well. Dr. Soriano's statement that Petitioner did not suffer from radicular complaints, which he defined as pain going down the arm, with numbness, tingling or weakness down the arm or into the hand, is disputed by the complaints recorded by Advocate Condell, Dr. Caner and Dr. Citow. Dr. Citow testified that the fact that Petitioner had a favorable response to the injection also supported the diagnosis of radiculopathy.

Based upon the totality of the medical evidence and Petitioner's credible testimony, the Arbitrator finds the diagnosis and opinions of Dr. Citow more credible that that those of Dr. Soriano that the Petitioner's condition is a bony disk osteophyte complex that could not be aggravated by the rear end accident. Dr. Soriano's opinion does not find support in the other medical records and is inconsistent with the onset of symptoms and continuing complaints advanced by Petitioner.

The Arbitrator does not find the gap in treatment between October 18, 2013 and January 17, 2014 sufficient to break causation in this matter and finds Dr. Citow's explanation persuasive, despite the cross examination as to the exact timeframe required to break causation. The Arbitrator adopts the opinion of Dr. Citow that the ongoing treatment is a continuation of the work related condition. The Arbitrator notes the history provided on January 17, 2014, supported by Petitioner's credible testimony, was that he had developed worsening of his symptoms.

Based upon the record as a whole, including the credible testimony of the Petitioner, the medical records and the deposition testimony of Dr. Citow and Dr. Soriano, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that as a result of the accidental injuries on May 20, 2013, he sustained an aggravation of his pre existing degenerative condition in the cervical spine including the disc herniations at C5-6 and C6-7. The Arbitrator further finds that the Petitioner's current condition of ill being in the cervical spine as diagnosed by Dr. Citow is causally connected to the accidental injuries sustained on May 20, 2013.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Petitioner has submitted medical bills from Dr. Citow showing out of pocket payments by Petitioner for visits on January 17, 2014 and October 3, 2014 totaling $300.00 and receipts for prescriptions paid by Petitioner for Voltaren Gel as prescribed by Dr. Citow from October 3, 2014 through June 15, 2015 totaling $395.00 (Px 5). Based upon the Arbitrator's decision with respect to Causal Connection, the Arbitrator finds that the treatment and medication are reasonable, necessary and causally connected to the accidental injuries sustained on May 20, 2013.

Based upon the record as a whole including the Petitioner's credible testimony, the medical records and depositions submitted, the Arbitrator finds that Respondent is responsible to reimburse Petitioner for reasonable, necessary and causally connected medical expenses of $695.00 pursuant to Section 8(a) and Section 8.2 of the Act.

In support of the Arbitrator's decision with respect to (K) Prospective Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's opinion with respect to Causal Connection including the Arbitrator's finding that the opinions of Dr. Citow are more persuasive that those of Dr. Soriano, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he is in need of further prospective medical care which is reasonable, necessary and causally connected to the accidental injuries sustained on May 20, 2013.

On January 17, 2014, Dr. Citow recommended an updated cervical MRI, a MRI of the brain and another epidural injection. Those were never performed. At the October 3, 2014 visit, Dr. Citow recommended a C5-7 anterior decompression and stabilization. At his deposition, Dr. Citow testified that Petitioner's condition had worsened by October 3, 2014 and confirmed that his current recommendation is the two level anterior cervical discectomy and fusion at C5-C7.

Based upon the record as a whole, and in light of the Arbitrator's findings with respect to Causal Connection including the finding that the opinions of Dr. Citow are more persuasive that those of Dr. Soriano, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he is entitled to additional prospective medical treatment as recommended by Dr. Citow including the recommendation for a two level anterior cervical discectomy and fusion at C5-C7 and any other reasonable, necessary and causally connected treatment.

STATE OF ILLINOIS)
) SS.
COUNTY OF LA SALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gregory Yeargin,

Petitioner,

vs. NO: 13 WC 23046

ATL Siding and Windows,

16IWCC0281

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission affirms and adopts the Arbitrator's decision in all respects, except with regard to TTD. For the reasons set forth below, the Commission modifies the Arbitrator's decision and finds that Petitioner is due ten (10) additional days of TTD.

The parties stipulated that Petitioner's accident date was July 2, 2012. We find that the Petitioner's entitlement to TTD began on July 3, 2012. Accordingly, the Petitioner is awarded 10 additional days of TTD (July 3, 2012 through July 13, 2012). The Commission concurs with the subsequent TTD period awarded by the Arbitrator (July 13, 2012 through August 7, 2013).

16IWCC0281

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 5, 2015 is hereby modified.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $266.67 per week for a period of 57 and 2/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $15,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 3 - 2016

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

TJT/gaf
O: 3/8/16
51

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

YEARGIN, GREGORY
Employee/Petitioner

Case# **13WC023046**

ATL SIDING WINDOWS
Employer/Respondent

16IWCC0281

On 1/5/2015, 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 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0491 SOSTRIN AND SOSTRIN PC
NEAL K WISHNICK
33 W MONROE ST SUITE 1510
CHICAGO, IL 60603

0358 QUINN JOHNSTON HENDERSON ETAL
CHRIS CRAWFORD
227 N E JEFFERSON ST
PEORIA, IL 61602

16IWCC0281

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Gregory Yeargin
Employee/Petitioner

v.

ATL Siding and Windows
Employer/Respondent

Case # 13 WC 23046

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Ottawa**, on **11/21/14**. 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 _____

16IWCC0281

FINDINGS OF FACT

This claim arises out of an undisputed accident that occurred while Petitioner was working for Respondent on August 30, 2011. There is no dispute regarding the accident. At issue is the sole question of whether the Petitioner is entitled to TTD benefits and penalties/attorney fees.

Petitioner testified that he began working for Respondent in June of 2012. On July 2, 2012 he was working with siding. He fell off a ladder. He injured his left upper extremity. He suffered a distal radius fracture. He underwent emergency surgery on July 3, 2012. This was performed by Dr. Dennis Williams. He also underwent a skin grafting surgery on July 16, 2012.

He was prescribed physical therapy in August of 2012. He participated in physical therapy. During that time, Petitioner continued to smoke. Petitioner was advised that smoking could prevent non-union of the distal radius fracture. Petitioner was referred to the Indiana Hand Center on December 17, 2012, and visited with Dr. Knox. He was given a five pound lifting restriction. He was advised to quit smoking.

Petitioner returned to see Dr. Knox on February 12, 2013. He reported improvement after receiving an injection. An EMG showed positive carpal tunnel on the unaffected right side. Indications showed that his left distal radius fracture appeared to have healed. However, there was non-union suggested. He eventually underwent a second surgery with Dr. Knox on April 2, 2013. A left carpal tunnel release was performed. A left ulnar shortening osteotomy was also performed. Petitioner was continued on restrictions following surgery. He was in a cast as of April 16, 2013.

Petitioner followed up on August 7, 2013. He was released to full duty work. He was released from care as of October 1, 2013. Dr. Knox had commented that the Petitioner achieved MMI.

Thereafter, Petitioner went to work for Marfell Enterprises. Marfell Enterprises is located in St. Louis. Petitioner did not return to work for Respondent. Petitioner worked as a heavy machine mechanic for this employer.

Petitioner was referred to Dr. Daniel Nagel as of February 25, 2014. The history indicates Petitioner had not seen any other physician since October of 2013. Dr. Nagel stated that the patient presented with what appeared to be a hypertrophic non-union of the left ulnar shortening osteotomy. He continued to have tingling in the median nerve and ulnar nerve distributions. A bone stimulator might be helpful. The Petitioner reported that he continued to work. Dr. Nagel thought he could continue to work as a heavy machine mechanic as of April 10, 2014. Dr. Nagel had commented there was evidence of healing. He felt the bones were coming together. The patient was still living in St. Louis. On April 17, 2014, the Petitioner was complaining of discomfort along the ulnar side of the left forearm. A bone stimulator was applied. He was to wear it at night. Dr. Nagel indicated there would be no residual nerve compression. He was still released to work full duty.

Dr. Nagel then saw the Petitioner on June 16, 2014. Petitioner acknowledged suffering a heart attack on May 11. Petitioner testified that he could not continue to work for Marfell Enterprises because of his heart attack. He had not worked for any employer since that time. He described discomfort over the ulnar side of the forearm. The Petitioner was given a 15 pound lifting restriction with the left arm. Dr. Nagel still recommended conservative care.

16IWCC0281

Petitioner testified that after given these restrictions by Dr. Nagel, he tried unsuccessfully to find other work within the 15 pound restrictions. Petitioner testified that he tried to go back to work for the Respondent, but the Respondent had relocated in 2014. Petitioner also recalled that from his conversation with the Respondent's owner in August, 2013, there was no work for Petitioner.

Andres Tirso testified on behalf of the Respondent. Mr. Tirso indicates that he is the owner of ATL Siding. He hired the Petitioner. He acknowledges that the Petitioner was injured on July 2, 2012. Mr. Tirso accompanied the Petitioner to the hospital. Mr. Tirso indicates that he and the Petitioner had several conversations following the Petitioner's accident on August 30, 2011. Mr. Tirso invited the Petitioner to return to work at any time. He indicated that once the Petitioner felt up to it, he could have his old job back.

Mr. Tirso testified to several specific conversations. The first occurred in October of 2012. He recalls telling the Petitioner to come back to work. Petitioner indicated that he felt his left arm was healing. A second conversation occurred in January of 2013. Petitioner again asked about the status of his old job. Mr. Tirso invited the Petitioner to return back to work. A third conversation occurred in March of 2013. Petitioner gave Mr. Tirso some advice on this radiator. Mr. Tirso indicates Petitioner helped him fix it. There was a fourth conversation that occurred in the summer of 2013. Petitioner indicated that he was going to go to work as a mechanic. He had asked to borrow $50.00 from Mr. Tirso. Mr. Tirso accepted Petitioner's ladder as collateral. Petitioner told Mr. Tirso that he was going to work for somebody else and would not return to work for the Respondent.

Mr. Tirso testified that he had not moved his company. His address remained the same. He would have been at the same address in February of 2014 when the Petitioner allegedly called upon him.

CONCLUSIONS OF LAW

1. With regard to the issue of TTD, the Arbitrator finds that the Petitioner entitled to TTD from August 30, 2011 through August 7, 2013 – the date he was placed at MMI. Petitioner failed to prove that he is entitled to TTD beyond his original MMI date of August 7, 2013. In support of this finding, the Arbitrator notes that the evidence raised many questions of credibility regarding the Petitioner's claims. The records clearly show that the Petitioner was able to return to full duty work in August, 2013, and then he chose to work for another employer in St. Louis as a heavy machine mechanic. Petitioner continued to work as a mechanic without any physical restrictions. Petitioner himself testified that he stopped working for this other employer because of his heart attack. Although the Petitioner began seeing Dr. Nagle in February, 2014 for complaints regarding his hand/arm, Dr. Nagle's records indicate that the Petitioner could continue to work full duty as a heavy machine mechanic despite his complaints. The records indicate that the Petitioner's 15 pound work restriction was not put in place until after he had his heart attack while working for this other employer.

Even more questionable is the Petitioner's claim that he was not offered any work by Respondent after his full duty release in August, 2013, and after the 15 pound restrictions in June, 2014. The Arbitrator finds credible the testimony of Mr. Tirso, the owner of Respondent, who indicated that there was always work available to the Petitioner, who never availed himself of the opportunity – either after his full duty release or after he stopped working for another employer. Mr. Tirso went so far as to describe the available light duty work of bending and cutting aluminum, which was within Petitioner's 15 pound lifting restriction. Mr. Tirso's testimony clearly rebuts Petitioner's claim that there was no light duty work offered to him. Based on the testimony of both the Petitioner and Mr. Tirso, it appears that the

16IWCC0281

Petitioner never really sought out the Respondent for any work following the receipt of his light duty work restrictions from Dr. Nagle.

Given these facts, the Arbitrator concludes that the Petitioner is not entitled to TTD beyond his MMI date of August 7, 2013.

2. Based on the Arbitrator's findings with regard to the issue of TTD, the petition for penalties and attorney fees is denied.

16IWCC0281

FINDINGS

On the date of accident, **07/02/2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**20,800**; the average weekly wage was $**400**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**17,218.83** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**17,218.83**.

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

ORDER

TTD IS AWARDED FROM 7/13/12 TO 8/07/13 FOR A TOTAL OF 56-5/7 WEEKS AT THE RATE OF $266.67. PETITIONER'S CLAIM FOR TTD FROM 05/09/14 TO 11/21/14 IS DENIED. RESPONDENT IS DUE A CREDIT TOTALING $17,218.83 AGAINST THIS AWARD OF BENEFITS.

PETITIONER'S REQUEST FOR PENALTIES AND FEES PURSUANT TO §§19(K), (L) AND 16 OF THE ACT ARE DENIED.

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

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

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

Signature of Arbitrator

12/24/14
Date

JAN 5 - 2015

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Howard,
Petitioner,

v. Case No. 13 WC 23529

Precision Brand Products,
Respondent.

ORDER

This matter comes before the Commission on Petitioner's Petition for Additional Compensation Pursuant to §19(k) and Attorneys' Fees Pursuant to §16 of the Act. Due notice having been given, this cause came before Commissioner Thomas J. Tyrrell for hearing on February 18, 2016 in Chicago, Illinois. The Commission having jurisdiction over the persons and subject matter and after being advised in the premises, denies said petition, for the reasons set forth below.

1. The record shows that a Motion to Consolidate claim numbers 12 WC 29209 and 13 WC 23529 was granted by Arbitrator Carlson on 9/3/13. Thereafter, the matter proceeded to hearing on both claims before Arbitrator Cronin on 6/5/14. Arbitrator Cronin subsequently issued a separate decision for each claim on 1/5/15 wherein he specifically "... render[ed] one PPD award for the sum of the injuries caused by the accidents claimed in 12 WC 29209 and 13 WC 23529", said PPD award representing 15% person-as-a-whole pursuant to §8(d)2 of the Act.

2. On 2/29/15 Respondent filed a Petition for Review showing the proper parties in the caption and a case number of 12 WC 29209 but not showing case number 13 WC 23529, the subject of the present petition. The Commission notes that this Petition for Review set forth exceptions to the Arbitrator's decision on multiple issues, including the nature and extent of the injuries.

3. On 5/8/15 Petitioner filed the present petition for penalties and fees alleging that Respondent's failure to reference case 13 WC 23529 in its Petition for Review

form resulted in the Commission having no jurisdiction to review said claim. As a result, Petitioner argues that the Arbitrator's award is final and payable and Respondent's refusal to pay the award with respect to case 13 WC 23529, following Petitioner counsel's request for same in a letter dated 3/30/15, was unreasonable and vexatious and deserving of the imposition of additional compensation pursuant to §19(k) and attorneys' fees pursuant to §16 of the Act.

4. On 2/18/16, the parties appeared before Commissioner Tyrrell and a hearing was held on Petitioner's Petition for Penalties for the alleged nonpayment of the award in case 13 WC 23529. The matter was taken under advisement at that time.

Based on the above, and the record taken as a whole, the Commission denies Petitioner's Petition for Additional Compensation Pursuant to §19(k) and Attorneys' Fees Pursuant to §16 of the Act. The Commission finds that based on the case of *Shafer v. Illinois Workers' Compensation Commission*, 976 N.E.2d 1, 364 Ill.Dec. 1 (4th Dist. 2011) Respondent substantially complied with the applicable statute and rules governing practice before the Commission in perfecting its review and that Respondent's failure to include claim number 13 WC 23529 in addition to 12 WC 29209 amounted to essentially a clerical error in an otherwise timely and properly drafted Petition for Review. As the court in *Shafer* noted, while a party seeking review before the Commission must strictly comply with the statute conferring jurisdiction upon the Commission, §19(b), which governs petitions for review, "... does not prescribe any specific requirements regarding the form of petitions for review... [but] merely requires that petitions for review be filed within 30 days and that they 'contain a statement of the petitioning party's specific exceptions to the decision of the arbitrator.'" *Shafer*, 976 N.E.2d at 10.

Along these lines, the Commission notes that the Petition for Review in question clearly shows that the Arbitrator's award as to the nature and extent of the injury was part of Respondent's Review, and that the Arbitrator's nature and extent award represented "... one PPD award for the sum of the injuries caused by the accidents claimed in 12 WC 29209 and 13 WC 23529." Thus, for all intents and purposes, the permanency award for one claim was inextricably linked with the permanency award for the other. Indeed, the Commission questions how Respondent could have paid on the 13 WC 23529 award without also paying on the 12 WC 29209 award, unless one were to do what the Arbitrator chose not to – namely, divide the award between the two claim numbers.

Accordingly, the Commission finds that both claim numbers were and remain the subject of Respondent's Petition for Review and that as such the Commission retains subject matter jurisdiction with respect to claim number 13 WC 23529 as well as 12 WC 29209. To rule to the contrary would improperly elevate form over substance and deny a reviewing party the opportunity to fully contest the findings in one case that was inextricably connected with another by virtue of an Arbitrator's award incorporating both.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Additional Compensation Pursuant to §19(k) and Attorneys' Fees Pursuant to §16 of the Act is hereby denied.

DATED: MAY 26 2016

r-02/18/16
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kenneth Bender,
Petitioner,

vs.
Southwire Company LLC,
Respondent,

NO: 13 WC 32398

16IWCC0315

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 8, 2015 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1.00. 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: MAY 12 2016

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:5/5/16
43

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

BENDER, KENNETH
Employee/Petitioner

Case# **13WC032398**

16IWCC0315

SOUTHWIRE COMPANY LLC
Employer/Respondent

On 10/8/2015, 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 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0139 CORNFIELD & FELDMAN LLP
JIM M VAINIKOS
25 E WASHINGTON ST SUITE 1400
CHICAGO, IL 60602

0180 EVANS & DIXON LLC
KARIE E CASEY
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

16IWCC0315

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Kenneth Bender
Employee/Petitioner

v.

Southwire Company, L.L.C.
Employer/Respondent

Case # 13 WC 032398

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Mount Vernon** , on **5 March 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 _____

16IWCC0315

FINDINGS

On the date of accident, **5 August 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**36,097.20**; the average weekly wage was $**694.18**.

On the date of accident, Petitioner was **54** years of age, ***single*** with **0** dependent children.

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

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

Respondent is entitled to a credit of $**4,751.95** under Section 8(j) of the Act.

ORDER

Because Petitioner failed to meet his burden of establishing that an accident occurred which arose out of and in the course of his employment with Respondent, and further failed to prove that his current condition of ill-being is causally related to his employment, benefits are denied.

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

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

Signature of Arbitrator

10/5/15
Date

ICArbDec19(b)

OCT · 8 2015

FINDINGS OF FACT

Petitioner worked for Respondent as a Cable Rewind Operator for thirteen years. He worked the day/swing shift for all but his first six months as an employee of Respondent, during which time he worked the third shift. Petitioner testified that his hours would vary, but, on average, he would work approximately 48 hours a week with overtime considered mandatory. As a Cable Rewind Operator he was primarily responsible for the set-up and operation of a cable rewind unit. The machine produces reels of cable for shipment and distribution. He also makes necessary repairs to non-conforming cables before they are approved for shipment. Non-conforming cable may be damaged or poorly laid, and the cable rewind unit corrects these mistakes before the cable is shipped to customers. During the process cable is mechanically transferred from a Payoff reel to the shipment reels. Petitioner testified he was required to make all necessary payoff and shipment reel changes. Petitioner introduced photographs depicting the reel. The reel shown in the photographs is an S300 reel, which stands about eight feet tall. Petitioner testified that while the reels used by Respondent can vary in size, the unit he operated for the last five years of his employment was only compatible with the S300 reel. Petitioner testified that while an empty S300 reel weighs approximately 1,200 pounds, a fully loaded S300 reel can weigh more than 21,000 pounds.

Operation of the cable rewind unit required placing the reel to be rewound in the payoff using an electric magnetic crane. The payoff would go into the center of the reel, pick it up and allow it to spin to unload wire. Petitioner would then take the end of the cable to be rewound and feed it into the unit. The unit would then rewind the cable and place it on a shipment reel. Once the cable was completely rewound onto the shipment reel, the machine operator would lower the loaded reel onto a set of ramps by using a hydraulic lift. Petitioner testified that the platform at the top of the ramps develops a depression over time and you have to push the reels to get them started down the ramps. Once out of the depression gravity takes over and the reels roll ten (10) to fifteen (15) feet to the area where they would be picked up for shipment. The reels would stop when they hit chalks placed on the concrete. The operator would then place chalks behind the reels as well. Petitioner testified he would push the reels out of the depression to start them down the ramps by using his right leg as a lever to rock the reel until it began to roll. Petitioner testified he would rewind approximately four reels in an eight hour shift and five to six reels in a twelve hour shift.

Petitioner testified that while the unit he was operating rewound the cable, he would continuously walk forty or fifty feet back and forth between the payoff reel and the shipment reel and spray oil onto the wire as required. In addition to working with and changing the reels as necessary to keep the rewind unit running, he was also responsible for making all necessary repairs to broken cables including "kold welding" any splintered wires as necessary. Petitioner testified the Cable Rewind Operator position allowed for little to no downtime other than scheduled breaks. He would be up on his feet walking around his entire shift. Petitioner also testified that the position required lifting as much as forty to sixty pounds of cable.

Apex Network Physical Therapy completed a task analysis of the Cable Rewind Operator position which was admitted into evidence as Respondent's Exhibit 3. (RX C).The analysis rated the position at the light work demand level. The analysis found the essential functions of the job required occasional lifting of ten pounds above the waist level, occasional carrying of ten pounds, occasional pushing of up to 28 pounds and occasional

pulling of up to eight pounds. (RX C, p.1). The task analysis found that every twelve hour shift involved two (2) hours of walking, three and a half (3.5)hours of dynamic standing, two and a half (2.5) hours of static standing,, and four (4) hours of sitting. (RX C, p.5). Petitioner did not agree with this assertion, suggesting that while it was possible a shift would require three and a half hours of dynamic standing or two and a half hours of static standing, a shift required more than two hours of walking and did not allow four hours of sitting.

Richard Barnett, Petitioner's direct supervisor at Southwire testified on behalf of Respondent. Mr. Barnett testified that operation of the cable rewind unit did not require the operator to forcibly push fully loaded reels as the incline of the ramps allowed the reel to roll forward without any additional force. Mr. Barnett testified that once the shipment reel is completely loaded with the rewound cable, a hydraulic lift drops the finished shipment reel onto the inclined ramps, which allow the reels to naturally, with the force of gravity alone, roll down the ramp and to the stop point. The operator will merely walk behind the reel as it rolls down to the endpoint and throw wooden chalks behind the reel as it reaches the endpoint to keep it from rolling back. Mr. Barnett testified that not much effort is required to roll the reels down for shipment. Mr. Barnett testified the ramps do the job almost all of the time. He did acknowledge, however that they become bowed with time. Mr. Barnett agreed with the details of the job task analysis marked Respondent's Exhibit C.

On August 5, 2013 about 11:00 am, Petitioner reported a work injury to Respondent when he felt his right hip give out, forcing him to grab onto a nearby guard rail to keep from falling. Petitioner testified the incident occurred when he was returning to his machine from lunch around 11:00 am. Specifically, Petitioner testified that, after starting his machine he began walking back to talk to his supervisor when he felt his right hip give out. Petitioner testified that he began to fall, but was able to grab onto the cable guard rail for support and hold himself up. He did not fall to the ground or hit any machinery. Petitioner testified that his supervisor saw this happen and immediately told him to take a seat for the time-being. Petitioner wanted to finish the reel he was working on, however he said that his Safety Coordinator, Jeremy Gaddy, came over and told him to shut down his machine and go home for the day. Petitioner testified that prior to August 5, 2013 he has never injured nor received treatment for his right hip.

Petitioner first sought medical treatment on August 7, 2013 at Clay County Hospital. (PX 1). Petitioner visited Nurse Practitioner Susan Mack reporting severe hip pain. A CT scan of Petitioner's right hip revealed evidence of avascular necrosis of the right femoral head. (PX 1, p.9). X-rays of the right hip revealed no fracture or dislocation with mild degenerative changes, but increased density sclerosis of the femoral head in line with a diagnosis of avascular necrosis. (PX 1, p.8).

On August 29, 2013 an MRI of Petitioner's right hip was taken at Advanced Open MRI which showed avascular necrosis of the head of the right femur with the lesion involving more than 75% of the articular surface with areas of marrow edema in the neck and intertrochanteric region of the right femur and right acetabulum. (PX 2 p.4). On follow up at Clay County Hospital, Susan Mack recommended Petitioner see an orthopedic surgeon for further treatment of his right hip symptoms. (PX 1, p.13).

On October 7, 2013, Petitioner visited Dr. Timothy Gray at the Bonutti Clinic with continued complaints of right hip pain. (PX 3, p. 7). The initial intake sheet filled out by Petitioner on 12-7-2013 indicated he had pain in the right hip at a level of 9. The intake sheet further indicated that Petitioner was having severe pain in

the right hip that was stabbing and constant while at "rest/sitting/with activity/at night and when sleeping." (PX 3, p. 7; RX B, p. 1) Dr. Gray diagnosed Petitioner with hip pain as the result of avascular necrosis of the femoral head of the right hip. (PX 3, p. 14). Records from this visit indicate Dr. Gray's opinion that Petitioner's "symptoms are at least aggravated if not caused by his work activities". (PX 3, p 14). Dr. Gray could not pinpoint any significant risk factor for the development of avascular necrosis. Dr. Grays' records indicate: "I think this is work related". (PX 3, p.14). Dr. Gray did not testify live or by deposition to elaborate on this opinion. Dr. Gray referred Petitioner for an evaluation with Dr. Frank Lee. (PX 3, p.8).

Petitioner was evaluated by Dr. Lee on October 23, 2013, who noted extensive avascular necrosis of the right femoral head as well as avascular necrosis of the right hip with slight collapse. Dr. Lee recommended a total hip replacement.

Petitioner sought treatment from Dr. James Stiehl on November 11, 2013 reporting continued right hip complaints. Dr. Stiehl diagnosed Petitioner with chronic synovitis of the right hip and a possible early case of avascular necrosis that would progress with time. Dr. Stiehl recommended a right hip cortisone injection, which the Petitioner received November 25, 2013. (PX 4).

On follow up with Dr. Stiehl on December 17, 2013, Petitioner reported great results for a few days following the injection, however his right hip pain quickly returned. Dr. Stiehl found that Petitioner appeared to be suffering from an impingement problem in his hip, possibly a labral entrapment. Dr. Stiehl indicated Petitioner was a candidate for right hip arthroscopy and issued a referral to Dr. Ryan Nunley for further treatment. (PX 4, p. 2).

On January 20, 2014 Dr. James Burke, Jr. performed a §12 evaluation of Petitioner. Dr. Burke also diagnosed Petitioner with stage three avascular necrosis of the right hip. (RX A, p.7; attachment 1, p 4). Dr. Burke testified that "avascular necrosis is a disruption of the blood supply… where blood supply in the bone is disrupted. When the bone loses its blood supply that area of the bone dies, as does the cartilage on top of it." (RX A, p. 8) He indicated dead bone causes swelling and pain and can, over time, as the bone continues to progress in its "deadness" eventually collapse. (RX A, p. 8) Dr. Burke noted that most of the time the cause of avascular necrosis is unknown. (RX A, p.8). "It's an idiopathic condition 80% of the time." (RX 1, p. 8). It can be caused by a closed dislocation of the hip, excessive alcohol use, steroid use, or blood dyscrasia such as sickle cell anemia, but most of the time the cause is unknown. (RX A, p. 8). Dr. Burke noted that Petitioner was under the impression his condition was caused by being on his feet and walking on concrete for twelve hours a day. (RX A, p.10). Dr. Burke testified that he had no knowledge and could not find any literature showing any association between standing and walking on concrete floors and the development of avascular necrosis. (RX A, p. 10-11). He testified that standing and walking do not cause an acceleration of avascular necrosis even if done 10-12 hours a day. He did indicate that weight bearing would cause some increasing pain when you are weight bearing on an area of dead bone in your hip, but it would not accelerate the disease process. The damage was done at the moment of the disruption of the blood supply. He further indicated the size of the lesion and severity of it is defined at the time of the blood flow disruption. (RX A, p11-12). Dr. Burke testified that any weight bearing activity would cause increased symptoms, but would not aggravate or contribute to the condition

of avascular necrosis itself. (RX A, p. 11-13). Dr. Burke analogized the condition to that of having a tumor in the proximal head of the femur. He testified:

> Of course, weight bearing on a tumor, a pathology in the proximal femur, of course it's going to hurt more, but again, that weight bearing has nothing to do to make that tumor worse or better or make it progress any faster. The same can be said about avascular necrosis; not that it's a tumor, but it's a pathologic condition on the main weightbearing surface of the hip. (RX A, p. 25)

Dr. Burke also indicated Petitioner will continue to have worsening symptoms with weight bearing, or any activity, with the natural progression of the condition over time, regardless of whether he is at work or at home. (RX A, p.13).

Petitioner continued to receive treatment for his right hip complaints at the Orthopaedic Center of Southern Illinois with Nurse Practitioner Devin Haertling through March of 2014. (PX 5).

On July 30, 2014, Petitioner returned to Clay County Hospital to visit Nurse Practitioner Susan Mack and was released to return to work full duty without restrictions. (RX D). Petitioner testified the reason he wanted to return to work and secured the release to do so was in order to receive a severance package as part of Respondent's upcoming workforce reduction. Petitioner testified that if he did not return to work when his medical leave ran out on August 5, 2014, he would be terminated and therefore not entitled to a severance. Therefore, in order to receive a severance, Petitioner secured a work release from Susan Mack with no restrictions and returned to work on August 5, 2014 after his medical leave ran out. Upon his return, Petitioner was placed in a special operations unit as his previous position as Cable Rewind Operator had been filed during his absence. Petitioner worked from August 5, 2014 to September 2, 2014 in a desk job as part of the special operations unit filing and performing other sedentary tasks. On September 2, 2014 Petitioner was laid off as part of Respondent's workforce reduction and Petitioner received a monetary severance package.

Petitioner testified that since being laid off in September of 2014, he has applied for employment elsewhere, and was hired on at North American Lighting Company. Petitioner testified that following two days of orientation at North American Lighting he was only able to work for two days because of right hip pain caused by walking around and being up on his feet all day. Petitioner testified that he has received one additional right hip injection since he was released to return to work full duty and is scheduled to receive another injection.

Petitioner expressed complaints of continued right hip pain, testifying that he experiences symptoms with any activity, including standing, walking, and even sleeping. Petitioner testified that he experiences right hip symptoms with any activity, regardless of whether at work or not, noting it is very hard for him to get comfortable.

16IWCC0315

CONCLUSIONS OF LAW

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

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

These issues are somewhat overlapping, therefore the Arbitrator will address them jointly. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture,* 99 I.I.C. 0961 (1999) A claimant must prove by the preponderance of credible evidence all elements of the claim in order to receive compensation under the Act. *Orisini v. Industrial Commission*, 509 N.E.2d 1005 (1987)

The Petitioner in this case is relying upon a repetitive trauma theory rather than one of traumatic injury. The Petitioner must still show the injury arose out of and in the course of his employment. *Peoria County Bellwood Nursing Home v. Industrial Commission*, 505 N.E.2d 1026 (1987) In such cases the claimant generally relies on medical testimony to establish causal connection between the claimant's work duties and the condition of ill-being. *Id.* When the question at issue is one specifically within the purview of experts, expert medical evidence is required to show that the work activities caused the condition of which the employee complains. See, e.g., *Nunn v. Industrial Commission*, 157 Ill. App. 3d 470, 478 (4th Dist. 1987). A claimant need not establish that work activities are the sole or even the primary cause of his or her condition. It must be proven, however that work activities are at least a cause of his or her condition. The right to recover benefits cannot rest upon speculation or conjecture. *County of Cook v. Industrial Commission*, 68 Ill. 2d 24 (1977)

Petitioner relies on two brief mentions of causation contained within the treatment records of Dr. Gray to establish a causal connection between avascular necrosis and his job activities. The records however do not provide any explanation of the medical condition of avascular necrosis or how any job duties caused or contributed to the condition. Records from Petitioner's October 7, 2013 visit state that Petitioner's avascular necrosis is work related as it was at least aggravated, if not caused by his work activities, without any additional explanation as to how Dr. Gray came to this conclusion. It does not detail any job activities or duties with an explanation regarding the mechanism of injury or how the duties caused or contributed to Petitioner's avascular necrosis. The statement from Petitioner's November 25, 2013 visit is even more equivocal. Dr. Gray indicates that he is unable to rule out Petitioner's employment as at least an aggravating factor of his condition. Again without any further explanation of this "causation opinion". The records are unclear as to whether Dr. Gray thinks underlying condition itself, avascular necrosis, was caused or aggravated by job duties or if Petitioner simply experienced an increase in his symptoms.

Dr. Burke found the work activities, even as described to him by the Petitioner himself, could not cause, aggravate or contribute to Petitioner's condition as avascular necrosis is a pre-existing idiopathic condition. Dr. Burke was not only provided a job description from Petitioner, but was also able to review the job task analysis completed by Apex Networks Physical Therapy.

Dr. Burke credibly explained that most of the time the cause of avascular necrosis is unknown. (RX A, p.8). Risk factors for the development of this condition include excessive alcohol abuse, steroid use and blood dyscrasia, but "most of the time the cause is unknown. It's an idiopathic condition 80% of the time." (RX A, p.

8). Dr. Burke also reasonably explained that while weight bearing activity will undoubtedly cause increased symptomatology, "the pathology was defined at the moment the blood disruption happened." (RX A, p 11). Dr. Burke indicated that over time the dead bone will become soft like butter and collapse. (RX A, p.12). Dr. Burke explained the diagnosis of avascular necrosis and his opinion as to causation and the rationale behind it in great detail. The Arbitrator finds the opinions Dr. Burke more persuasive than those in the office notes of Dr. Gray.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner failed to prove his right hip condition arose out of and in the course of employment. Petitioner further failed to meet his burden of proving that his avascular necrosis was causally related to his employment with Respondent. Therefore benefits are denied.

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?

There is no evidence in the record to refute the reasonableness and necessity of the treatment Petitioner has received to date as a result of his avascular necrosis. Likewise, the proposed future treatment is reasonable and necessary. However, because Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment or that his condition of ill-being is causally related to his employment, benefits are denied.

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

The parties stipulated that Petitioner was temporarily and totally disabled from 8/6/13 through 8/5//14, and 9/3/14 through 3/5/15, the date of hearing. However, because Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment or that his condition of ill-being is causally related to his employment, benefits are denied.

Issue (N): Is Respondent due any credit?

The parties stipulated that Respondent is entitled to $4,751.95 credit for medical bills which were paid through the group carrier.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jordan Turner,
Petitioner,
vs.
Wal-Mart Inc.,
Respondent,

NO: 13WC 33058

16IWCC0323

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 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 12, 2015, is hereby affirmed and adopted.

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

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

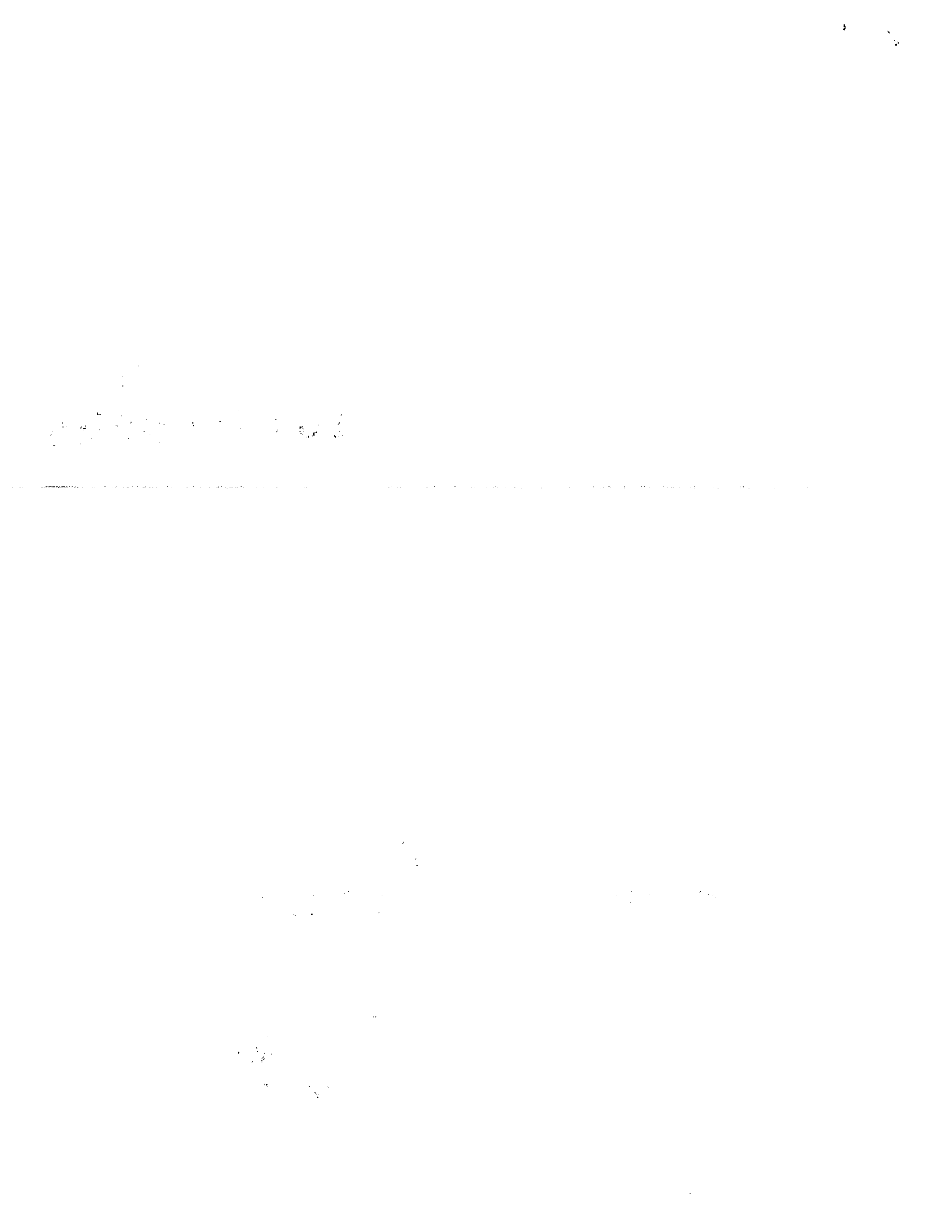
Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 12 2016
MJB/bm
o-5/9/16
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell



ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TURNER, JORDAN
Employee/Petitioner

Case# **13WC033058**

WAL-MART ASSOCIATES INC
Employer/Respondent

16IWCC0323

On 8/12/2015, 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 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 BLACK & JONES
TRACY L JONES .
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

0560 WIEDNER & McAULIFFE LTD
JAMES W STEVENSON JR
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jordan Turner
Employee/Petitioner

v.

Wal-Mart Associates, Inc.
Employer/Respondent

Case # **13 WC 33058**

Consolidated cases: **N/A**

16IWCC0323

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Rockford**, on **June 15, 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

16IWCC0323

On **9/16/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$10,314.72**; the average weekly wage was **$198.36**.

On the date of accident, Petitioner was 20 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 $ **N/A** for TTD, $ **N/A** for TPD, $ **N/A** for maintenance, and $ **N/A** for other benefits, for a total credit of $ **N/A**.

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

ORDER

As petitioner failed to prove an accident which arose out of and in the course of her employment, all benefits are denied.

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

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

#01 George J Andros

Signature of Arbitrator

Date 8-10-15

AUG 12 2015

STATEMENT OF FACTS
Jordan Turner v. Wal-Mart Associates 13 WC 33058

The petitioner, Jordan Turner, was a 20-year old part-time cashier for Wal-Mart. On September 16, 2013, after she finished her shift, she was assaulted in the store's parking lot by a stranger. The facts are not in dispute. Petitioner had finished work for the day. Her timecard for September 16, 2013 reflects clocking in at 3:00 p.m. and clocking out at 10:03 p.m. (RX 1) Petitioner testified that after her shift had ended, she clocked out, and decided to grocery shop in the store. Her grocery receipt was received into evidence as respondent's exhibit #2 and demonstrates petitioner was procuring items for her own health and benefit, which she corroborated through her testimony. (RX 2) Petitioner also testified on cross examination that it was her choice to shop at the store after work, that she was not required to shop at the store after work, that shopping was not part of her job nor an extension of her employment, that she was not getting paid while shopping, was not told by anyone to stay and work late, was not working overtime and was not subject to any orders or requests from management while shopping. She testified that nothing associated with her employment kept her at the store after her shift ended at 10:00 p.m.

Her grocery receipt is time-stamped 10:23pm. (RX 2) Petitioner testified that the store was open 24 hours, and other customers were in the store at the time she was shopping. After she purchased her groceries, at approximately 10:27 p.m., she left the store and proceeded to the parking lot where she had parked her car. She testified she parked in an employee designated area at the front of the lot by the garden center, where customers parked as well. Time-stamped pictures of the lot from petitioner's alleged date and time of accident corroborate that the lot was well-lit, and that other cars were parked around her car. (RX 3) Petitioner testified she was pushing a shopping cart and on the phone with her fiancé as she walked to her car. She put the groceries in the passenger side of the car, and then walked to the driver's side, at which time, she felt a hit to the back of her head and top of her neck. Petitioner was thrown into the driver's seat by the attacker, who then grabbed her purse from the floor of the passenger's side of the vehicle. The attacker then fled.

Petitioner testified she was afraid of the attacker having access to her address, so she pursued him, jumping on his back, trying to stop him. At that point, he turned around and hit her. The next thing petitioner recalled, a red pickup truck sped past her, pursuing the attacker, who ran off but dropped her purse. Petitioner testified that she did not know the attacker, that he was not a co employee, and that the assault had nothing to do with work.

Medical Treatment:

Petitioner was seen in the emergency room following the incident on September 17, 2013. She complained of a headache and feeling lightheaded. A CT scan of the brain was unremarkable. Petitioner was diagnosed with a contusion over the right mid-forehead and some swelling around the right eye. (RX 5)

When petitioner followed up with Dr. Ulmer of Rockford Health on September 20, 2013, she still reported some nausea when getting up in the morning but no changes in vision or any reports of dizziness.

She reported being anxious, unable to sleep, worried to leave the house, and dreading work since the accident, although she did not miss anytime from work. Throughout October and November of 2013, petitioner was seen a handful of times by Dr. Ulmer complaining of anxiety and sleep disturbance. She was also given a diagnosis of PTSD and a concussion. (RX 6)

On October 8, 2013, petitioner met with Dr. Raja on referral by Dr. Ulmer. She reported having headaches since the accident. Dr. Raja assessed post-concussion syndrome, occipital neuralgia, and migraine variant. He opined petitioner could return to work. An MRI of the brain on October 17, 2013 was negative. (PX 2)

Petitioner met with Dr. Garcia at the referral of an attorney, Kim McClosky, on March 7, 2014. She reported having flashbacks about the incident, and her symptoms were noted to be more anxiety than depression. Dr. Garcia assessed PTSD, which he did causally connect to the September 16, 2013 incident. He also noted that there may be a biological predisposition for mental illness and substance abuse due to family history. Petitioner was prescribed medications and referred for counseling. Petitioner met with Dr. Garcia a total of six times, the final visit on May 29, 2015, wherein she reported being anxious due to the impending workers' compensation claim hearing. She also reported a recent passing of her grandfather, which increased her depression. Dr. Garcia noted her affect was sad and tearful, and her mood was anxious and dysphoric. Petitioner was prescribed medication for a diagnosis of depression and PTSD. This is petitioner's final medical record.

CONCLUSIONS OF LAW

As to C, whether an accident occurred that arose out of and in the course of petitioner's employment, the Arbitrator finds:

It is undisputed the primary issue in this case is that of accident, namely whether petitioner being attacked outside of the store, after her shift had ended and following a personal shopping expedition, arose out of and in the course of her employment. The Arbitrator finds, based upon the current case law and the facts at hand, petitioner's accident did not arise out of and in the course of her employment and therefore compensation is denied. The Arbitrator finds that petitioner is unable to prove either element of her claim, and for the sake of thoroughness, will discuss each factor independently.

"In the course of"

It is undisputed petitioner had clocked out for the day, and therefore arguably petitioner cannot prove that she was still in the course of her employment when the attack occurred. That being said, the Arbitrator acknowledges that there are cases which allow for an extension of time before and after the employment in order for a claimant to meet the "in the course of" prong. Typically, however, for those injuries to be compensable, they must occur within a "reasonable amount of time" before or after work. Hiram Walker & Sons v. Industrial Commission, 41 Ill.2d 429, 244 (1968). Also, case law on point highlights that when leaving work, a personal deviation can sever the nexus to employment, and subsequent injuries will have not occurred in the course of employment. Aaron v. Industrial Commission, 59 Ill.2d 267, 268-70 (1974).

16IWCC0323

In the current case, it is undisputed petitioner clocked out and then engaged in personal shopping. (RX 2) While she was on the employer's premises, she was no longer an employee and must be categorized therefore as a paying customer. Simply put, petitioner engaging in personal shopping at Wal-Mart which severed the nexus to her employment, as she was no longer doing or scheduled to do any activities for the employer's benefit. And, in the present case, petitioner did not contemplate a return to work following shopping at the store. In its strictest sense, a deviation contemplates a return to work after the deviation is complete, as opposed to the instant matter, where there was no work to return to. Her shopping, therefore, represented a complete and permanent severing from her employment.

In Bill Morrison v. BB&K Development Corporation, 04IIC 0759, the Commission held that when an employee remains on the employer's premises after work but solely as a paying customer, he is no longer in the course of his employment and subsequent injuries when leaving cannot be found to occur in the course of employment. There, the employee stayed on the employer's premises after his shift ended to have drinks at the bar where he worked. He regularly spent time in the bar as a customer when he finished his work shift. While in the bar, after his shift ended, the claimant saw a little girl running across the parking lot toward the highway and went after her to save her, injuring his back in the process. Compensation was denied because at the time of the injury, the employee was simply a paying customer and was no longer in the course of his employment because his work duties did not require him there.

The case at bar shows similar patterns as Morrison. It is undisputed petitioner's shift ended at 10:00 p.m., and that on her own accord, with no connection to work, she decided to remain on her employer's premises to do personal grocery shopping. The grocery shopping lasted approximately 20-25 minutes, and during that time, petitioner engaged in no job duties, as her shift was over. Petitioner's decision to stay on the employer's premises was solely personal and not motivated by any consideration of work. The Arbitrator therefore finds that petitioner's personal shopping spree severed the tie to her employment. When petitioner clocked out, she became an ordinary paying customer of Wal-Mart, and injuries sustained while acting as a member of the general public are not compensable under the Act. The argument that somehow her employment was extended to cover the time spent shopping also fails. Petitioner testified that normally, after her regular duty, she would go home following a similar route out of the store. Here however, she went shopping throughout the grocery department (see RX2) prior to leaving, which would not fit with her customary exit pattern. As such, petitioner failed to prove she was in the course of her employment, and the Arbitrator denies accident on this fact alone.

"Arising out of"

The Arbitrator however notes that even in the event petitioner could prove that she was in the course of her employment, she is still unable to meet the "arising out of" prong. The reason being, the Illinois Courts have clearly asserted that "increased risk" is a necessary element for compensability when the injury is sustained in the parking lot that the employer owns, controls, maintains, or provides.

16IWCC0323

When an employee is injured at a point off the employer's premises while traveling to or from work, the general rule is that the resulting injuries do not arise out of and in the course of the employment and are not compensable. Illinois Bell Telephone Company v. Industrial Commission, 131 Ill.2d 478 (1989). This is referred to as the "general premises rule." The Arbitrator acknowledges there are two exceptions to this rule. First, compensation is permitted when the employer owns, controls, maintains, or provides the parking lot where the employee is injured and the employee is subjected to either a hazardous condition or an increased risk. Second, compensation is permitted when the employee's presence at the place where the accident occurs is required in the performance of his duties, and the employee is exposed to a risk common to the general public to a greater degree than others. Petitioner must prove that she was exposed to a hazardous condition or an increased risk. Athough the facts of this older case may not yield the same result today, its law is still black letter in Illinois.

Here, petitioner admitted that she parked in the parking lot provided by Wal-Mart, but that employees and customers alike were permitted to park in the area where she did. Additionally, petitioner was parked at the front of the store, the lot was well-lit, and she testified that at the time of the attack, she noticed other cars around her as well. Pictures of the lot taken at the time of the attack support that testimony. (RX 3)

Also noteworthy is that the store was still open, and therefore members of the general public were able to shop there and in fact were still shopping there, according to petitioner's own testimony. The Arbitrator notes that in the case of Heath v. The Industrial Comm'n, the Appellate Court discussed the concept of increased risk as it related to a claimant that had been shot while working. There, claimant worked at a grocery store and testified he was shot by an intruder while he and two co-workers were finishing their job duties for the day. Claimant argued he was exposed to a risk to a greater degree than the general public in large part because the store was closed, he was with two other employees, and a man with a gun was in the store after it was closed. 256 Ill. App. 3d 1008 (1993) He argued therefore that he was at a higher degree of risk because the public was not allowed in the store. The Appellate Court stated, "Claimant however, does not cite any authority for the proposition that being in one's place of employment at the time when the general public is excluded is in itself sufficient to mandate recovery as a matter of law." Id. At 1015.

Despite extreme concern for such attacks and sequela by this Arbitrator, the case at bar presents an equally compelling case for denial, as the Wal-Mart and the parking lot surrounding the same was still open to the general public, and members of the general public were still in there shopping.

The Arbitrator notes that another factor that can support the concept of increased risk is where evidence is presented suggesting that the location of the employment increased the risk of an attack. Holthaus v Industrial Comm'n, 127 Ill. App. 3d 732 (1984). In Holthaus, a swimming pool manager sustained injuries from an escaped convict who approached her while she was working at the pool; he had attempted to take her car from a deserted parking lot. While the Commission denied accident, the Appellate Court reversed, holding that the evidence established an increased risk to petitioner as the site at which she was required to work created an enhanced risk of criminal assault.

16IWCC0323

The factors the Court found compelling in finding increased risk were that the pool was "isolated to a significant extent" compared to the rest of the community at the time of year when the assault took place, that the pool was closed and therefore the general public had no occasion to visit the pool area, that claimant's car was the only one in the parking lot, that claimant's job included protecting the property and preventing illegal entry of the premises, that her employer had instructed her to call the police in the event of trouble, and that claimant had actually called the police on two occasions for suspicious activity in the months preceding her injury. Id.

Here, the Arbitrator notes no evidence was presented suggesting an enhanced risk of criminal assault, and therefore petitioner cannot prove increased risk via that theory. Even so, the Holthaus case is particularly compelling in the present matter, as the Arbitrator notes that the facts at hand are in direct contrast to those the Court found in Houlthaus as being indicative of increased risk. In other words, in the present case, claimant was not on the clock, the store was open to the general public, other cars were in the lot at the time of the attack, and there was no evidence that petitioner's job required her to monitor the premises for illegal activity, nor were police called in the past for prior assaults in the parking lot.

To that end, the "arising out of" prong cannot be met as petitioner was similarly situated as any other customer shopping at Wal-Mart and exposed to no increased risk as compared with that of the general public. Accordingly, the Arbitrator finds that even in the event the "in the course" of prong could be extended in this matter, petitioner would still be unable and is still unable to meet the "arising out of prong."

Based upon the totality of the evidence, the Arbitrator finds a a matter of fact and as a conclusion of law that the Petitioner did not sustain an accident in the course and scope of her employment in the case at bar. This is so despite the compelling nature for some kind of remedy as a consequence of such attacks and very unfortunate results for this employee.

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

Michael Franklin,
Petitioner,

vs. NO: 13 WC 33396

City of Chicago,
Respondent.

16IWCC0297

DECISION AND OPINION ON REVIEW

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

This claim proceeded to hearing pursuant to Sections 8(a) and 19(b) of the Act and the nature and extent of the injury was not placed in dispute. The Arbitrator acknowledged such at the hearing, but did not overtly specify that an additional hearing for further benefits would be proper in the Order, so the Commission adds the following language to the Order section of the Arbitrator's Decision:

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

All else is otherwise affirmed and adopted.

16IWCC0297

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 16, 2015, is hereby affirmed and adopted.

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

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

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

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: MAY 4 - 2016

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-04/27/16
jdl/wj
68

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

FRANKLIN, MICHAEL
Employee/Petitioner

Case# **13WC033396**

CITY OF CHICAGO
Employer/Respondent

16IWCC0297

On 3/16/2015, 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 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0154 KROL BONGIORNO & GIVEN LTD
JACK GILHOOLY
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
WILLIAM F O'BRIEN
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Michael Franklin
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

16IWCC0297

Case # 13 WC 33396

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 , Arbitrator of the Commission, in the city of , on . 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, **9/6/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**73,219.64**; the average weekly wage was $**1,408.07**.

On the date of accident, Petitioner was **54** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**40,364.53** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**40,364.53**.

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

ORDER

Respondent is liable for and has paid Petitioner temporary total disability benefits of $938.71/week for 43 weeks, commencing 9/10/2013 through 7/7/14, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**40,364.53** for TTD, $**0** for TPD, and $**0** for maintenance benefits, for a total credit of $**40,364.53**.

The Arbitrator finds that Petitioner's current condition of ill-being is not causally related to the work injury. Prospective medical is denied.

The Arbitrator finds that Petitioner suffered bilateral sprain/strain in his shoulders and back.

Prospective medial in the form of arthoscopic surgery of the right shoulder is denied.

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

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

Signature of Arbitrator

3/15/15
Date

ICArbDec19(b) MAR 16 2015

FACTUAL HISTORY

Petitioner Michael Franklin (hereinafter "Petitioner") worked for Respondent City of Chicago (hereinafter "Respondent") as a laborer in the Water Department. The parties stipulated to an employer/employee relationship; that on September 6, 2013 Petitioner was 54 years old, single, with zero dependent children; and that he earned an average weekly wage of $1,408.07.

Petitioner testified in court that he was working for the Respondent on September 5, 2013 when he injured both his shoulders and his low back. He testified that he did so when lifting a gang box from a truck. Per reports provided to medical provider and testimony the box weighed from 150-300 pounds and Petitioner claimed he tried to lift the box without assistance. The accident was reported to Supervisor, on September 10, 2013 (PX1) and an accident report was prepared to document the same. The accident report signed by the Petitioner states that he was 'Disconnecting" the gang box". (PX1) Petitioner testified under oath that he was lifting the box by himself. (PX1)

On September 10, 2013 Petitioner first sought treatment at Mercy Works and indicated that while lifting a "game box, he injured his shoulders and lower back." X-rays were normal. Petitioner was diagnosed as suffering from bilateral shoulder strains and a sprain of the lower back. Petitioner was given an off-work note and given pain medication and home exercise program. (Note that Petitioner was also simultaneously treating for a hernia injury at this time) Petitioner remained under the case of Dr. Diadula.

An MRI of the right shoulder was performed on November 8, 2013 compared to the right shoulder MRI from May 16, 2012. (Petitioner has prior injury to his shoulders) The findings from the November, 2013 MRI are as follows:

> "supraspinatus tendinopathy, hypertrophic changes of acrmioclavicular joint with type III acromion process impinging on supraspinatus muscle predisposing to impingement syndrome. Inflammatory changes of the a.c. joint are seen. Subacromial and subdeltoid bursitis. (PX)

On February 3, 2014. Petitioner had an MRI of the left shoulder. All findings remained unchanged compared to his left shoulder MRI study of May 16, 2012.

Dr. Diadula's work status notes of 2/6/14 indicate a diagnosis of bilateral impingement syndrome of the shoulders and a L4-5 disc herniation as well as a hernia.

The notes also indicates that Petitioner is discharged to further care with disability status to be determined by Specialist. (PX2) Petitioner was to remain off work.

On February 21, 2014 Petitioner treated with Dr. William Heller at Midland Orthopedics for bilateral shoulder pain. Petitioner related that his injuries are from "lifting activities he was performing as a city laborer in 10/13 [October 2013]." Dr. Heller noted Petitioner "would not cooperate with [the] exam. Dr. Heller reviewed the recent left and right shoulder MRIs compared to the previous MRIs. He concluded "they are basically unchanged." No tears in either shoulder. There was "no significant progression or changes in the tendinopathy." He diagnosed "recurrent bilateral shoulder pain". No surgery. He recommended injections and therapy.

He began low back treatment with Dr. Theodore Fischer on March 6, 2014. Per the medical history questionnaire, signed and completed by Petitioner, the low back onset was September 10, 2013. Petitioner skipped the section to indicate how the injury occurred by failing to circle "car accident / work injury / sports injury / fall / other."

In the March 6th report from Dr. Fischer, he notes Petitioner was injured from working on "September 10, 2013" while "unloading a truck, including pipes, wheelbarrow, and a gang box, along with a 2 x 8 piece of wood". Dr. Fischer noted that Petitioner "is a very poor historian"...something Dr. Fischer mentions in every single one of his reports. Dr. Fisher reviewed the lumbar MRI reports and recommended epidural injections and physical therapy and well as light duty work.

Petitioner did not participate in the therapy due to his hernia and Respondent was unable to accommodate the light duty restrictions. He obtained the injection and TTD was continued.

Petitioner followed up with Dr. Heller on April 4, 2014 and Mary 19, 2014. Dr. Heller noted that Petitioner complained of numbness and burning pain following the injection and was guarded with right shoulder. Dr. Heller notes that Petitioner did not provide him with a clear history. (RX3 Dr. Heller recommended only medication and ice. Dr. Heller felt Petitioner was not fully cooperating. He noted it was difficult to communicate with Petitioner and that Petitioner was a poor historian.

On June 12, 2014, Petitioner returned to Dr. Fisher for his low back. The doctor noted Petitioner lack of clarity in providing answers and recommended PT, steroid injection and light duty.

On June 30, 2014, Petitioner underwent an IME with Dr. John Cherf. Dr. Cherf notes that Petitioner denied using hearing aid. He examined the MRI findings and noted that there is no documents acute pathology. Specifically the left shoulder MRI showed degenerative changes but that the findings are essentially unchanged from the prior MRI of February 3, 2014, approximately five months post injury. Dr. Cherf noted Petitioner's inability or unwillingness to communicate during the examination. Petitioner was unable to provide any specific details about his back or shoulder pain but indicated

that the pain in the right shoulder and back was 10/10 and the left shoulder was a 7/10. Petitioner denied any prior problems with his back of shoulders but confirmed that he had a pending Worker's Compensation case related to his hernia.

Dr. Cherf diagnosed bilateral shoulder sprains/strains and lower back sprain/strain and indicated that the Petitioner could not have suffered an aggravation of a pre-existing condition as he (Petitioner) denies any prior problems with his shoulders and lower back. He found Petitioner at MMI and able to return to work full duty without restrictions. He also found the treatment up to that point, reasonable and necessary. Lastly, Dr. Chert made a note that the Petitioner, during his evaluation suggested significant abnormal illness behavior and what appeared to be purposeful misrepresentations. He noted the lack of any objective findings that would be associated with Petitioner's work related injury.

On September 16, 2014 Petitioner presented to Dr. James Cohen for the bilateral shoulder pain. Petitioner indicated that the box weighed 300 pounds. Dr. Cohen recommended new MRI's and noted the tenderness/swelling in the right AC joint. Dr. Cohen recommended injections and right shoulder arthroscopy if the Petitioner did not significantly improve. Dr. Cohen also noted that impingement test was positive bilaterally.

Petitioner underwent the injection but stated it provided no relief.

On October 24, 2014, Dr. Cohen noted conservative treatment failed. Dr. Cohen notes that Petitioner "believes that his injury is work related." Dr. Cohen recommended arthroscopic evaluation of the right shoulder.

Petitioner was cross examined and conceded that he had prior problems with his shoulder which occurred at in March 2012. He confirmed that he had undergone treatment and MRI's for the same but was released from care in October, 2012 and prior to his September, 2013 accident. He testified that he had not returned to work and continues with medical care.

ANALYSIS/FINDINGS

(C) IN SUPPORT OF THE ARBITRATOR DECISION IN REGARD TO WHETHER PETITIONER'S INJURY AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT, THE ARBITRATOR FINDS THE FOLLOWING:

Initially, as to the accident, there is ample, if not clear testimony and evidence that Petitioner suffered an accident while at work. Although the records and testimony conflict as to a precise date, the City of Chicago Accident Report (PX1) document in writing that Petitioner claims an accident/injury on September 5th or 6th of 2013 while he was disconnecting a gang box. (Petitioner testified that he was lifting the box on 9/6/13)

There is fairly immediate treatment at Mercy works and at the least there is a diagnosis and/or complains of bilateral shoulder and low back pain. The Arbitrator finds that the Petitioner has met his burden that he was involved in an accident on or around 9/6/13.

Petitioner also bears the burden to show by a preponderance of the evidence that his injury arose out of and in the course of his employment. In order for accidental injuries to be compensable under the Illinois Workers' Compensation Act, a claimant must show such injuries arose out of and in the course of his or her employment. For an injury to arise out of one's employment, it must have an origin in some risk connected with or incidental to the employment so that there is a causal connection between the employment and the injury. Nabisco Brands, Inc. v. Industrial Commission, 266 Ill.App.3d 1103

Based on the evidence, the Arbitrator finds that Petitioner has meet his burden to show by a preponderance of the evidence that his bilateral shoulder injuries and low back injury arose out of and in the course of his employment with Respondent on September 6, 2013, or any other date.

In so finding, the Arbitrator notes that the Petitioner's testimony and evidence are not clear.

1. There are inconsistencies of dates (City of Chicago accident report filled out less than 3 days after the alleged accident does not have a clear date and list the injury as occurring when disconnecting and not lifting).

2. There is an inconsistency regarding cause of accident (Petitioner told Dr. Heller that he was injured from "lifting activities" but failed to mark the medical questionnaire that his injury is "work injury).

3. The testimony of the actual accident is unclear including there is a steady and marked acceleration in the Petitioner's description of how the accident occurred. Initially the injury was caused when 'disconnection' the box, then it occurred when lifting the 150 pound box single handedly and ultimately the weight of the box is reported by Petitioner as 300 pounds.

Although mindful of these disparities in Petitioner's delivery, the Arbitrator notes that the accident report supports that there was an accident and that Petitioner was consistent in his claim that he was hurting in both shoulders and his low back. This aspect is constant and supported by the medical records of every provider.

Therefore, the Arbitrator concludes that Petitioner suffered an injury to his bilateral shoulders and back that arose out of and in the course of his employment.

(F) IN SUPPORT OF THE ARBITRATOR DECISION IN REGARD TO WHETHER PETITIONER'S INJURY IS CAUSALLY RELATED, THE ARBITRATOR FINDS:

Although the Petitioner has successfully proven that he suffered an injury that arose out of and in the course of his employment, he has failed to prove by a preponderance of the evidence that his current condition is causally related to his work accident of September 6, 2013.

The burden of proof is upon the Petitioner and his testimony and credibility are woefully inadequate in this regards. The Arbitrator is mindful and sympathetic of the fact that the Petitioner is hard or hearing. He wore prominent hearing aids in court. The Arbitrator has given the Petitioner, the benefit of the doubt that perhaps some of the problems as evidenced by the discrepancies in his medical records may have been the result of his hearing issues. However, this does not explain or excuse his conduct in clearly withholding pertinent information regarding his prior shoulder issues from his providers and the IME. His simple denial to the IME that he needs hearing aid can be explained away but his failure to be truthful and honest about issues that are absolutely crucial to an accurate diagnosis cannot be ignored.

Petitioner claims that he is suffering from great pain and discomfort form his bilateral shoulder impingement and that the same arose out of his work accident. The Arbitrator finds that the Petitioner suffered only a strain to his shoulders and back. The Arbitrator finds that the strain to his left shoulder and lower back were minor and that all had reached MMI on or before June 30, 2014. The Arbitrator finds the opinion of Dr. Cherf to be persuasive on the issue. The Arbitrator agrees with the finding of Dr. Chert that Petitioner suffered a bilateral sprain/strain and a lower back sprain/strain.

In support of her finding the Arbitrator notes as follows:

1. It is clear and uncontroverted by Petitioner's own admission in court that he had suffered an injury to his shoulders in 2012 and that there were MRI/films from May, 2012 that documents his physical condition at the time.

2. Dr. Heller, Petitioner's treating physician examined and compared May, 2012 MRI's with the right shoulder MRI of November 8, 2013 and the left shoulder MRI of February 3, 2014. Dr. Heller expressly notes that he compared these MRIs to bilateral shoulder MRIs taken on May 16, 2012. Dr. Heller noted the diagnostics were essentially "unchanged". There is no evidence that any other physicians – Fischer, Cohen or Cherf – made this comparison.

3. Petitioner denied the prior treatment to IME, Dr. Cherf, and arguably obtained a favorable report from him that his sprains were causally connected.

4. Petitioner's lack of co-operation and honesty with the physicians in relating his history as well as during examination sheds doubt on the findings and opinion that Petitioner presents to prove his cause. The Arbitrator is not persuaded that this is simply explained away as Petitioner's inability to provide a clear history.

5. In spite of Petitioner's testimony and belief that his current symptoms are causally connected there is a compelling lack of medical causation opinion from his treating doctors. Dr. Heller does not provide a causation opinion. Dr. Fischer neglects to do so. Dr. Cohen merely stated that Petitioner is of the belief that his injury is causally related but noticeably reserves his own formal causation opinion. Dr. Cherf notes Petitioner's bilateral shoulder and lumbar strains/sprains are related but this is based on Petitioner's misleading information – no prior bilateral shoulder treatment and no prior MRI comparisons.

Based on the foregoing, the Arbitrator concludes that Petitioner has failed to meet his burden to show by a preponderance of the evidence that his current issues regarding his shoulders and low back are causally related to the disputed work injury of September 6, 2013. Rather, the Arbitrator finds that he suffered minor sprains/strains and that his conditions had healed and reached MMI in the 43 week period following his accident and the IME examination of June 30, 2014.

(J) (K) & (L) IN SUPPORT OF THE ARBITRATOR DECISION IN REGARD TO WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER WERE REASONABLE AND NECESSARY, WHETHER RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL TREATMENT, WHETHER TEMPORARY TOTAL DISABILITY BENEFITS ARE OWED, AND WHETHER PETITIONER IS ENTITLED TO PROSPECTIVE MEDICAL, THE ARBITRATOR FINDS THE FOLLOWING:

Based on the foregoing, Arbitrator finds that the treatment provided to the Petitioner up to and including June, 30, 2013 was reasonable and necessary. TTD is awarded and has already been paid by the respondent until the IME date of June 30, 2014. By stipulation between the parties, the Petitioner acknowledges that the medical bulls and TTD to this date have been paid. Respondent is to receive credit for the same. Based on the findings and reasoning relating to causation, Petitioner's is denied the requested prospective treatment.

Signature of Arbitrator Ketki Shroff Steffen

Date 3/25/15

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

George Marron,

Petitioner,

vs.

NO. 13WC 33775

16IWCC0294

M&M Service Company,

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 medical expenses, causal connection, prospective medical care, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 21, 2015 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 $14,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 4 - 2016
SJM/sj
o-4/7/16
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARRON, GEORGE
Employee/Petitioner

Case# **13WC033775**

16IWCC0294

M&M SERVICE COMPANY
Employer/Respondent

On 8/21/2015, 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 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICES
DAVID M GALANTI
PO BOX 99
EAST ALTON, IL 62024

0000 RUSIN & MACIOROWSKI LTD
MARK COSIMINI
2506 GALEN DR SUITE 106
CHAMPAIGN, IL 61821

16IWCC0294

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

GEORGE MARRON
Employee/Petitioner

v.

Case # 13 WC 33775

Consolidated cases: _____

M&M SERVICE COMPANY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the **Honorable Molly Dearing,** Arbitrator of the Commission, in the city of **Springfield,** on **June 22, 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 **March 14, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$33,983.04**; the average weekly wage was **$653.52.**

On the date of accident, Petitioner was **28** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$4,668.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$4,668.00.**

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

ORDER

Respondent shall pay Petitioner the sum of $392.11/week for a further period of 37.5 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused 7.5% loss of use of the person as a whole.

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

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

Arbitrator Molly Dearing

August 21, 2015
Date

AUG 21 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GEORGE MARRON
Employee/Petitioner

v. Case #13 WC 33775

M&M SERVICE COMPANY
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On his date of accident, Petitioner was twenty-eight years of age (Arb. X 1) and he was employed by Respondent as the shop manager. He had been employed by Respondent for six years.

On March 14, 2012, Petitioner sustained chemical burns from his navel to his knees when a valve on a tank of anhydrous ammonia exploded.

Petitioner sought emergent medical care at the Emergency Department at St. Joseph's Hospital. The affected areas were noted to be reddened and painful, and the burns on his legs were causing Petitioner difficulty walking. Petitioner sat in a water bath and cool compresses were applied to the burn areas on his thighs, penis, and scrotum. Petitioner was diagnosed with chemical burns to the bilateral inner thighs, and he was transferred for evaluation to the Burn Unit at Mercy Hospital. PX 1.

Petitioner was admitted to Mercy Hospital on March 14, 2012. Petitioner was treated by Dr. Jonathan Pollack and Dr. Cyrus Orandi, who both noted burns to Petitioner's bilateral thighs, scrotum, penis, and perineum. Petitioner reported difficulty urinating, and pain and a burning sensation with urination. Petitioner was noted to have first and second degree burns covering approximately ten percent of the surface area of his body with blistering on the ventral surface of the penile shaft and right scrotum. Dr. Pollack discussed the pathophysiology of chemical burns and stated that "they can progress to deeper burns over time and it is difficult for me to say at this time if these are simply first-degree burns or if they will progress to a superficial second or even deeper burn." Petitioner was discharged on March 16, 2012, and he was removed from work until he was reevaluated. PX 2.

Following his discharge from Mercy Hospital, Petitioner returned to Dr. Pollack for treatment through May 17, 2012. Petitioner was released to return to work with restrictions of no lifting more than ten pounds on April 11, 2012, and he was allowed to return to managing and directing work only as of May 1, 2012. On May 17, 2012, Dr. Pollack noted that Petitioner had sustained third degree burns to less than ten percent of his body, and he counseled Petitioner on sun avoidance and scar massage. Petitioner was released to return to work without restrictions on June 1, 2012. PX 3.

Petitioner also presented for treatment with his family physician, Dr. Roger Fulton. On April 16, 2012, Petitioner complained of muscle cramps in his legs and tightening of his scarring. Dr. Fulton noted chemical burns to Petitioner's inner thighs, groin area, and external genitalia, and he ordered Petitioner to undergo laboratory testing. On April 27, 2012, Dr. Fulton assessed Petitioner with cellulitis of his burns on his right thigh, for which Petitioner was prescribed Bactrim. Thereafter, Petitioner returned to Dr. Fulton for follow-up care and he continued to complain of pain in his burn areas for which Dr. Fulton prescribed him Lidoderm patches and Lyrica. On October 23, 2012, Petitioner presented to Dr. Fulton. Petitioner had discontinued the use of Lyrica and Cymbalta for one month and reported increased pain in his burn areas. Dr. Fulton prescribed Petitioner Lidoderm patches, Lyrica, Cymbalta, and a starter pack of Viibryd. On November 21, 2012, Petitioner presented to Dr. Fulton and complained in part of low libido. Dr. Fulton ordered Petitioner to undergo testosterone testing, as well as a CMP, CBC, lips, and B12 examination. Petitioner's testosterone testing of November 21, 2012 revealed a below normal range of testosterone of one hundred ninety seven with a reference range of two hundred forty one to eight hundred twenty seven ng/dL. Following his testosterone testing, Dr. Fulton prescribed Petitioner testosterone replacement medication. Petitioner continued to follow-up with Dr. Fulton through February 20, 2015, and undergo periodic testosterone testing during that time. On February 20, 2015, Petitioner underwent additional laboratory testing, and Dr. Fulton noted his testosterone level to be four hundred fifty two. PX 5, 8.

Dr. Fulton authored a letter dated February 13, 2013. He stated that "I have been treating Mr. Marron for the past several months since he receives severe third degree burns to his pelvic region, external genitalia and upper legs form an accident with anhydrous ammonia. He has had persistent symptoms of pain and parasthesias in that region since the severe burns." Dr. Fulton noted that Petitioner is treated with Viibryd to alleviate the pain from damaged nerve endings in his burn regions, as well as by sublingual testosterone replacement medication twice daily, both medications of which Dr. Fulton stated were necessary in the treatment of the damage caused by the severe burns Petitioner sustained in March 2012. Dr. Fulton opined that Petitioner "suffers now from low Testosterone level which I believe was also caused by the damage from the severe burns to the external genitalia." PX 5, 8. Dr. Fulton also authored a letter dated July 24, 2014, wherein Dr. Fulton states that "[s]ubsequent to the severe burn injury this man developed symptoms of low testosterone. Blood testing was done and he was found to have a markedly low testosterone level. He was treated with testosterone replacement therapy and has had significant improvement with this treatment. He continues to require daily testosterone supplementation, which is ordered by prescription as ten milligrams sublingual twice a day. It is my medical opinion that the testosterone deficiency was caused by his severe burns to the external genitalia." PX 5, 8.

Following his work accident, Petitioner testified that he had persistent pain and discomfort in his burn areas, and he had difficulty with his injuries healing properly. He returned to work for Respondent in May 2012. Petitioner continued to work for Respondent until April 2013 when he obtained new employment with USF Holland in Edwardsville, Illinois as a delivery driver driving an air-conditioned truck. In that capacity, he drives locally, and he loads and unloads his freight with a forklift. He testified that he is able to perform all of his job duties of his current employment, and that he currently earns more income than he was working for Respondent at the time of his accident. Petitioner presently complains of daily pain, aching, cramping and burning in his legs and upper thighs. He occasionally experiences a burning sensation in those areas. Petitioner's symptoms are worsened with changes in temperature and weather, such as with moving from a warm environment to an air-conditioned one. Petitioner's pain awakens him approximately four

nights per week. He rated his pain as a four on a ten-point scale with the utilization of Viibryd medication and he rated his pain as an eight or nine without same. Petitioner is unable to remain in warm temperatures for prolonged periods of time, as he does not sweat normally around the burns on his thighs due to the formation of scar tissue. Petitioner continues to undergo water therapy for his legs twenty minutes per day, six to seven times per week that he testified decreases the knots and fatty tissue that accumulate in his burn areas. He described the remaining scars on his thighs as measuring ten inches by four to six inches on each leg.

The parties stipulated that Petitioner was off of work from March 15, 2012 through May 28, 2012, a period of 10 5/7 weeks, and that all temporary total disability benefits commensurate with that time period have been paid.

Dr. Fulton testified by way of evidence deposition on March 3, 2015. Dr. Fulton testified that he initially treated Petitioner for chemical burns to his inner thighs, groin area, and external genitalia in June 2012. Dr. Fulton explained that when he began treating Petitioner following his work accident, his burns were beginning to heal, and his treatment of Petitioner primarily focused on his other symptoms, including pain, fatigue, and loss of libido, for which Dr. Fulton prescribed Petitioner Viibryd, a serotonin uptake inhibitor to deal with the chronic pain, paresthesias and dysesthesias, and testosterone replacement therapy. Dr. Fulton testified that Petitioner's first report of low libido was in November 2012, and at that time, his burns were healed. Dr. Fulton testified that Petitioner may not have sought treatment for complaints of loss of libido for eight months following his work accident because "I speculate he was preoccupied with the healing process, and maybe, you know, maybe it wasn't an issue at that time because of the burns." Dr. Fulton testified that symptomatology of loss of libido, sexual issues, and fatigue are unusual for a man of Petitioner's age. Petitioner underwent testosterone testing, and Dr. Fulton testified that he had documented low testosterone levels and some of the testing revealed levels below two hundred, which Dr. Fulton stated "would be quite low for someone his age." Dr. Fulton explained that the typical testosterone range for a man his age at the time of his accident was three hundred fifty to four hundred, while the acceptable range varies between two hundred forty and eight hundred twenty. Dr. Fulton testified that he correlated Petitioner's low testosterone levels with his work injuries, as "those symptoms started after the burn...and as far as I was aware, he did not have those symptoms prior to that." Dr. Fulton opined that Petitioner's low testosterone resulted not from the actual physical burns to his genitalia, but from a systemic effect of major emotional trauma secondary to the chemical burns, and he explained that such trauma can affect the hypothalamus, pituitary, testicular axes from where the hormones originate. Dr. Fulton testified that Petitioner had a Vitamin D deficiency prior to the work accident, and he acknowledged that there was not a way to rule out the Vitamin D deficiency as being responsible for his complaints of lower extremity cramping, low testosterone, fatigue, and sexual dysfunction. Dr. Fulton noted that Petitioner was treated for Vitamin D deficiency in December 2009, but did not report complaints of low libido or erectile dysfunction. He acknowledged that he could not rule out the possibility that Petitioner had low testosterone prior to his work accident. Dr. Fulton testified that Petitioner is sensitive to temperatures changes following his work accident due in part to scarring from the chemical burns and the burning of his sweat glands, which may cause him to feel overheated quickly. PX 8.

On April 8, 2014, Petitioner underwent an examination with Dr. Thomas Kibby pursuant to Section 12 of the Act. Petitioner reported to Dr. Kibby a history of his work accident of March 14, 2012. Petitioner also reported that following the work accident, he had difficulty ambulating and required the use of a cane. As a consequence of the chemical burns, Petitioner noted an intolerance

to temperature changes and that his legs have reduced sweating capacity. He was given an air-conditioned office at work to continue working his normal duties. Petitioner complained of achiness or his thigh areas with changes in the temperature and occasional cramping in his upper legs, which he treats with hot water soaks. Petitioner described the pain in his burn areas as "achy, pokey" with an altered sensation and painful effect. He had been treated unsuccessfully with Lyrica, but was presently taking Viibryd for symptomatic relief. Petitioner also described experiencing low energy several months after the accident, for which his testosterone levels were assessed, and he was prescribed testosterone supplements by his family physician. Petitioner noted that his sexual activity with his wife had decreased over the past year from one time per day to monthly, and he denied particular issues with arousal, erection or orgasm, but stated his desire for intercourse has reduced with only minor improvement since taking testosterone. After conducting a physical examination of Petitioner and reviewing his pre and post-accident medical records, Dr. Kibby assessed Petitioner with anhydrous ammonia dermal burns, second degree to scrotum and third degree to bilateral thighs, with no evidence of testicular injury, history of muscle cramps and fatigue without a medical diagnosis from age nineteen through twenty seven, hypotestoeronism with uncertain etiology, and mild to moderate thrombocytopenia. Dr. Kibby opined that Petitioner's use of Viibryd was reasonable treatment for the ongoing dysesthesias in the areas of his burn. Dr. Kibby further opined that Petitioner's low testosterone condition and need for testosterone replacement therapy as treatment for same was not causally related to his work accident. Dr. Kibby did not find a clear etiology for Petitioner's low testosterone levels in his medical records, and he noted that Petitioner sustained no testicular injury in the work accident "which would be required for the burn to be the proximate cause for his low testosterone level." He acknowledged that Petitioner reported a history of erectile dysfunction and decreased sex drive as occurring subsequent to the accident, but noted that Petitioner's complaints of fatigue pre-dated his work accident. Dr. Kibby noted that Petitioner's reports of fatigue from 2009 to 2011 could have been an indication of low testosterone levels at that time, though he noted that this cannot be objectively verified due to the absence of testosterone testing prior to the work accident. RX 3.

Dr. Kibby testified by way of evidence deposition on January 13, 2015. Dr. Kibby is board certified in occupational medicine, and his practice includes clinical care and other aspects of occupational medicine. Dr. Kirby noted that Petitioner reported that his symptoms of muscle cramps, fatigue, joint pain, and muscle aches had resolved by the time he was twenty years of age, though Dr. Kibby's review of Petitioner's medical records revealed that his had such symptoms until he was at least twenty six years of age. Dr. Kibby testified that it was "kind of hard to say" that the symptoms Petitioner complained of before the accident were consistent with a decreased testosterone level, given that "[a]ll those symptoms were looked at very closely by a rheumatologist, hematologist, by a neurologist, and no one could offer good objective evidence of why he was having these symptoms, but nowhere in the record did I find anyone did a test for testosterone." Dr. Kibby opined that Petitioner's second and third degree burns to his thighs were causally related to his work accident, as was the subsequent neuralgia pain he suffered. Dr. Kibby opined that Petitioner's low testosterone level was not causally related to his work accident, and stated that there was no plausible injury to the testicles themselves to account for the decreased testosterone production. Dr. Kibby testified that Petitioner did not require any further treatment relative to his work accident, with the exception of use of Viibryd for pain for his burns, and that he could continue to work without restrictions. Dr. Kibby acknowledged that Petitioner's reports of heat intolerance and an inability to sweat from the affected burn areas is consistent with third degree burns. Dr. Kibby testified that for there to be a causal connection, in his opinion, between Petitioner's work accident and his low testosterone level, Petitioner would have had to sustain

"worse than burns to the scrotum. It would have to be actually injuring the testicle itself", and Dr. Kibby stated that there was no evidence in the record that his testicles were injured in the work accident and he had a normal testicular examination with Dr. Kibby. RX 3.

Petitioner's treating medical records from dates of service prior to the work accident were admitted into evidence. On February 11, 2009, Petitioner presented to Dr. David Nyquist at St. Joseph's Hospital and complained of episodes of leg cramping since his mid-teens. Dr. Nyquist's assessment was severe lower leg pain, acute right tonsillitis with lymphadenopathy, cold feet, slightly elevated hemoglobin, possibly consistent with dehydration, borderline low potassium and magnesium, and mild left shift on CBC. Dr. Nyquiest recommended fluids at a rapid rate, magnesium sulfate by way of IV for four hours, normal saline thereafter, a urinalysis, and a B12, folate, MMA, TSH and PTH testing. Petitioner was prescribed Toradol and Tylenol for pain. .

On April 29, 2010, Petitioner presented to Dr. Katherine Temprano at the Division of Rheumatology at Saint Louis University with complaints of fatigue, joint pain, and muscle cramps that inhibited his usual activities. He had previously undergone electrodiagnostic studies, which were normal. Dr. Temprano's differential diagnosis was a metabolic versus neurologic or vascular cause. Dr. Temprano ordered laboratory studies, including a repeat CBC, CMP, ANA and profile, rheumatoid factor, anti-CCP, CK, aldolase, lactic acid, desedimentation rate, CRP, hepatitis panel, and urine electrolysis, including sodium, potassium, chloride, creatinine and HIV. RX 2.

On May 24, 2010, Petitioner presented to Dr. Ganesh Kudva in the Division of Hematology at Saint Louis University Hospital with complaints of painful cramping in his calves for several years with present generalized cramping in multiple muscle groups. Dr. Kudva noted that Petitioner had mild to moderate asymptomatic thrombocytopenia from at least February 2009 to the present date, but an otherwise normal CBC. Dr. Kudva opined that most individuals with thrombocytopenia maintain a stable count over many years and require no treatment. Dr. Kudva offered to see Petitioner again in two months. RX 2.

On May 11, 2010, Petitioner presented to Dr. Francisco Gondim at the Department of Neurology & Psychiatry at Saint Louis University Hospital with complaints of a history of cramping in his legs for eight years worsening over the last year. He also reported fatigue that prevented him from working adequately. Dr. Gondim's assessment was cramps and generalized pain of uncertain significance. Dr. Gondim ordered a lactate ammonia test, as well as the copper level, homocysteine and methylmalonic acid level. Dr. Gondim prescribed Petitioner Cymbalta and ordered him to return in one month. RX 2.

On June 18, 2010, Petitioner returned to Dr. Gonim with complaints of episodic leg cramps and questionable idiopathic thrombocytopenia versus normal variant. Petitioner reported some improvement in his leg cramps, but no correlation of the improvement with the utilization of Cymbalta. Petitioner further reported improvement in his energy level within three weeks of taking Cymbalta, but that "felt to the point that he was doing things that he did not used to do according to his wife." Petitioner was diagnosed with myalgia and fatigue of uncertain etiology, and ordered to undergo a combined psychiatric evaluation due to his present increased levels of energy indicated the possibility of hypomania. Petitioner was instructed to return. RX 2.

On August 30, 2011, Trisha Hustedde, PA-C, wrote to Dr. Shinawi for consultation regarding a possible referral of Petitioner for treatment. Ms. Hustedde noted that Petitioner had suffered from fatigue and extremely painful muscle craps in his extremities since he was nineteen

years old. She stated that his pain has been severe enough for hospitalization. Petitioner was taking Hydrocodone, Cymbalta, and Baclofen at that time. Petitioner had complained of atrophy of his calves bilaterally and involuntary jerking of his lower extremities. Ms. Hustedde stated that Petitioner's "workup has been extensive and has not yet revealed a cause to his muscle cramping...I am concerned about a more rare form of organic muscle disease. Please let me know if you feel a geneticist referral is appropriate or if you have any other suggestions for work up." RX 2.

CONCLUSIONS OF LAW

In regard to disputed issue (F), Respondent disputes the causal relatedness of Petitioner's low testosterone condition and necessity of testosterone therapy to his work accident. Arb. X 1.

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to his work accident of March 14, 2012. In so concluding, the Arbitrator notes that "[a] chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *International Harvester v. Industrial Comm'n*, 93 Ill.2d 59, 63-64 (1982). The preponderance of the evidence in this case indicates that Petitioner's low testosterone condition began subsequent to the work accident and the healing of his physical burns sustained therein. Petitioner's low testosterone levels were confirmed with testing, and he continued to undergo testosterone testing thereafter. PX 8. Although Petitioner complained of and sought treatment for symptoms of fatigue prior to the work accident, which Dr. Kibby found may have been some indication of low testosterone levels at that time, the Arbitrator notes that the last notations in the record of any such complaints occurred more than eight months prior to the work accident. RX 2. The Arbitrator finds the absence of complaints of fatigue during this time period, as well as the lack of any complaints or treatment for low libido or sexual dysfunction at any time prior to the work accident, probative in determining causal connection. The Arbitrator notes that despite the numerous physicians of various specialties and litany of tests Petitioner underwent prior to the work accident for complaints of fatigue and lower extremity cramping, he was never diagnosed with low testosterone (RX 2), which the Arbitrator finds significant.

Furthermore, the Arbitrator finds the opinions of Dr. Fulton more persuasive than those of Dr. Kibby. Dr. Kibby fails to appreciate the significance of any lack of erectile dysfunction and loss of libido symptoms by Petitioner prior to the accident when formulating his opinions, and his opinions seem guided by the presence of complaints of fatigue prior to his work accident, which the Arbitrator does not find dispositive, in light of the temporal remoteness, discussed further above, of his complaints of fatigue prior to March 17, 2012 with the work accident and given that it is well-established than an employee will not be denied recovery simply because of the presence of a pre-existing condition so long as it can be shown that the employment was a causative factor. *Sisbro v. Industrial Comm'n*, 207 Ill. 2d 193, 205 (2003). Dr. Kibby's opinions also appear guided by a causation standard different from that required under the Illinois Worker's Compensation Act. Dr. Kibby testified that an actual testicular injury "would be required for the burn to be the proximate cause for his low testosterone level." RX 3. However, in Illinois, a claimant need not prove that a work injury was the proximate cause of his current condition, but only that the injury was a factor in the development of his condition of ill-being. *Sisbro*, 207 Ill. 2d at 205. Moreover, Dr. Kibby failed to proffer any medical basis for his opinion that Petitioner would have had to actually injury the testicles in order for him to develop low testosterone as a result of the work accident, and as such, the Arbitrator is disinclined to give his opinions evidentiary weight. RX 3.

Dr. Fulton, on the other hand, found the absence of any complaints by Petitioner of low libido and sexual dysfunction prior to the work accident significant in formulating his causation opinion, which the Arbitrator finds probative as well. Dr. Fulton was aware of the temporal onset of Petitioner's low libido and sexual dysfunction complaints eight months following his work accident, and Dr. Fulton testified that Petitioner may have delayed seeking treatment for his loss of libido because his was preoccupied with the healing process of his burns or because "maybe it wasn't an issue at that time because of the burns." PX 8. The Arbitrator agrees with Dr. Fulton, and notes in support of same, Petitioner testified that following his work injury, he suffered persistent pain and discomfort in his burn areas, and he had difficulty with the healing of his burns. Petitioner's testimony is corroborated by his treating records of Dr. Fulton, which reflect that from April 2012 through October 23, 2012, Petitioner continued to complain of significant pain in his burn areas. PX 8. The Arbitrator finds Petitioner continued pain and difficult healing process may have distracted him from seeking treatment for his low libido complaints or delayed the discovery of such symptomatology. Dr. Fulton opined that Petitioner's low testosterone condition was causally related to his work accident due to the systemic effect of the major emotional trauma Petitioner likely suffered as a result of the severe burns he endured, and he explained that significant emotional trauma can affect the hypothalamus, pituitary, and testicular axes from where the hormones originate. PX 8. The Arbitrator finds Dr. Fulton's opinions persuasive, in that they are well-reasoned and well-founded in the record, and in light of the aforementioned, the Arbitrator accordingly places greater weight on the opinions of Dr. Fulton than those of Dr. Kibby.

Based upon the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner's current condition of ill-being is causally related to his work accident of March 14, 2012.

In regard to disputed issue (J) and in accordance with the Arbitrator's foregoing conclusions, the Arbitrator finds that Petitioner's testosterone replacement therapy treatment is reasonable, necessary and causally related to his work accident. Respondent shall pay all reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act, and subject to the fee schedule. Respondent shall be given a credit for 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.

In regard to disputed issue (L), consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With regard to subsection (i) of 8.1b(b), neither party proffered an impairment rating pursuant to the American Medical Association Guides to Physical Impairment, Sixth Edition, and therefore, the Arbitrator places no weight on this factor in ascertaining permanency.

With regard to subsection (ii) of 8.1b(b), Petitioner was employed by Respondent as the shop manager at the time of his accident and he continued in that capacity until April 2013, when he became employed by USF as a local driver. Petitioner testified that his complaints in his lower extremities are worsened with temperature changes, such as moving from a warm environment to an air-conditioned one, as with getting in and out of his truck. However, Petitioner failed to proffer

evidence concerning the frequency with which his job duties expose him temperature changes, or evidence regarding his other work activities that may otherwise increase or worsen the symptoms associated with his work injuries. In the absence of such evidence, the Arbitrator is disinclined to conclude that Petitioner's permanent partial disability is greater due to his occupation as a delivery driver. Therefore, the Arbitrator places lesser weight on this factor when determining permanency.

With regard to subsection (iii) of 8.1b(b), Petitioner was twenty-eight years of age at the time of his accident. Arb. X 1. The Arbitrator finds Petitioner to be a very young individual, and concludes that Petitioner's permanent partial disability will be greater than that of an older individual, as he will have to live and work with the ill effects of his injury for a longer period of time. The Arbitrator places greater weight on this factor in making the permanency determination.

With regard to subsection (iv) of 8.1b(b), Petitioner returned to work without restrictions following his work injury, and gained employment with USF as a local delivery driver in April 2013. He testified that he presently earns more in his capacity as a driver for USF than he did for Respondent at the time of the accident. Therefore, the Arbitrator finds that Petitioner's work injury has not impaired his future earning capacity and the Arbitrator places lesser weight on this factor.

With regard to subsection (v) of §8.1b(b), as a result of his work accident, Petitioner suffered severe burns to his upper thighs, penis and scrotum, and he subsequently developed complaints of loss of libido. Petitioner presently complains of daily pain, aching, cramping and burning in his legs and upper thighs, and an occasional burning sensation in those areas. Petitioner's symptoms are worsened with changes in temperature and weather. Petitioner's pain awakens him approximately four nights per week. He rated his pain as a four on a ten-point scale with the utilization of Viibryd medication and he rated his pain as an eight or nine without same. Petitioner is unable to remain in warm temperatures for prolonged periods of time, as he does not sweat normally around the burns on his thighs due to the formation of scar tissue. Petitioner continues to undergo water therapy for his legs twenty minutes per day, six to seven times per week that he testified decreases the knots and fatty tissue that he states accumulates in his burn areas. He described the remaining scars on his thighs as measuring ten inches by four to six inches on each leg.

The records of Dr. Pollack note that Petitioner sustained third degree burns to less than ten percent of his body. PX 3. Dr. Fulton's records reveal that Petitioner complained of persistent pain and parasthesias in his burn areas, and he continues to require Viibryd for symptom relief. The records of Dr. Fulton note that following the healing of his burns, Petitioner developed complaints of loss of libido and testing confirmed the presence of low testosterone levels. Petitioner was prescribed testosterone replacement medication, and he continues to require that medication daily. PX 5. Dr. Fulton also testified that Petitioner is sensitive to temperature changes due in part to scarring resultant from the chemical burns and the burning of his sweat glands, which may cause him to feel overheated quickly. PX 8. The Arbitrator concludes that Petitioner's treating records corroborate his continued complaints and limitations following his work injury, and the Arbitrator accordingly gives greater weight to this factor when making the permanency determination.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 7.5% loss of use of his person as a whole, pursuant to Section 8(d)2 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

RICHARD TUCKER,

Petitioner,

vs. NO: 13 WC 36029

CATERPILLAR,

16IWCC0345

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 28, 2015 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 $16,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

PARTIAL

16IWCC0345

DATED: MAY 2 3 2016

MJB/tdm
O: 5/16/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TUCKER, RICHARD
Employee/Petitioner

Case# 13WC036029

CATERPILLAR INC
Employer/Respondent

16IWCC0345

On 7/28/2015, 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 0.14% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
JON WALKER
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2994 CATERPILLAR INC
MARK FLANNERY
100 N E ADAMS ST
PEORIA, IL 61629-4340

16IWCC0345

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

Richard Tucker
Employee/Petitioner

v.

Caterpillar, Inc.
Employer/Respondent

Case # 13 WC 36029

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on May 26, 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 October 21, 2013, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $38,668.76; the average weekly wage was $743.63.

On the date of accident, Petitioner was 36 years of age, single with 1 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $70.82 for TTD, $0.00 for TPD, $0.00 for maintenance, and $5,113.50 for other benefits, for a total credit of $5,184.32.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 1, 4, 5 and 6 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $495.75 per week for nine weeks commencing February 25, 2014, through April 27, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $446.18 per week for 37.5 weeks because the injuries sustained caused the seven and one-half (7 ½%) loss of use of the body as a whole, as provided in Section 8(d)2 of the Act.

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

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

William R. Gallagher, Arbitrator

July 24, 2015
Date

JUL 28 2015

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on October 21, 2013. According to the Application, a cart jerked Petitioner's left arm which caused an injury to the left arm and man as a whole (Arbitrator's Exhibit 2). The parties stipulated that Petitioner sustained a work-related accident; however, Respondent disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a Material Handler and his job duties consisted primarily of moving/transporting parts and other materials in carts that he had to push on what Petitioner described as a docking station. The docking station was pulled by another vehicle and Petitioner described the arrangement as being a "train."

Petitioner testified that there were three types of carts that he had to push into this docking station, a flatbed, a tube and a shelf cart, which he also described as a mother/daughter cart. All three carts were on wheels and, when they were pushed into the docking station, they would lock into place. It was important that the carts be pushed in correctly because, if a cart was not aligned properly, one side would get stuck.

Petitioner testified that on October 21, 2013, he was in the process of pushing one of the mother/daughter carts into the docking station. The cart got stuck on the right side but, the left side continued to move forward which caused Petitioner to sustain a jerking type injury to his left arm/shoulder. At the time of this accident, Petitioner felt a sharp pain in his left shoulder and he immediately reported the accident to Chelsea Sargent, his supervisor.

On October 21, 2013, Petitioner completed and signed a "Caterpillar Employee Incident Report" this report stated that when Petitioner was pushing a cart onto a train, the cart got "hung up" which caused Petitioner to have "sharp pain" in the left shoulder (Petitioner's Exhibit 2).

On October 21, 2013, an "Initial Licensed Health Care Professional Incident/Injury Form" was completed. This report noted that Petitioner was brought to the medical department by his supervisor and that Petitioner was pushing an empty cart onto a train when it got hung up on the track which pulled Petitioner's left shoulder. Petitioner complained of "Deep pain" in the shoulder and the range of motion was restricted. Ice was applied to the left shoulder (Petitioner's Exhibit 2).

On October 22, 2013, Petitioner was seen at Respondent's medical department. At that time, Petitioner rated his pain as a 7/10 when he raised his shoulder above 90°. The following day, Dr. Fabrique of the Respondent's plant medical department conducted a "Shop Walk" in which he went to the site of the accident and reenacted its occurrence by pushing a partially loaded cart. Dr. Fabrique noted that the left upper extremity remained below shoulder level and the left elbow did not fully extend when the right side of the cart was intentionally hung up on the train. Dr. Fabrique recorded that 37 pounds of force was necessary to move the cart. He noted that a left shoulder injury would not be expected to be caused by this activity (Petitioner's Exhibit 2).

Petitioner subsequently sought medical treatment from Dr. Dennis Heim, his family physician, who referred him to Dr. Blair Rhode, an orthopedic surgeon. Dr. Rhode initially evaluated Petitioner on December 4, 2013. At that time, Petitioner informed Dr. Rhode that he had sustained a left shoulder injury when he was pushing a cart onto a train and the cart got hung up on the right side which pulled his left arm causing a sudden onset of lateral and deep anterior pain. Petitioner denied having sustained any prior shoulder injuries and stated that he had been working light duty since the time of the accident. Dr. Rhode's initial diagnosis was a rotator cuff sprain and SLAP lesion. Dr. Rhode ordered an MRI of the left shoulder with gadolinium (Petitioner's Exhibit 1).

The MRI was performed on December 11, 2013, which revealed a tear of the posterior labrum that extended to the posterior inferior glenoid labrum. The radiologist also stated that a small SLAP tear could not be completely excluded (Petitioner's Exhibit 1).

Petitioner was again seen by Dr. Rhode on December 18, 2013. At that time, Dr. Rhode examined Petitioner and reviewed the MRI. Dr. Rhode opined that Petitioner had sustained a work-related injury on October 21, 2013, when a cart that he was moving caused a traction type injury to his left arm. Dr. Rhode opined that the MRI and findings on examination were positive for a SLAP tear. He recommended surgery (Petitioner's Exhibit 1).

On February 25, 2014, Dr. Rhode performed left shoulder surgery which consisted of an arthroscopic SLAP repair and subacromial decompression. Following surgery, Dr. Rhode continued to see Petitioner and ordered physical therapy. When Dr. Rhode saw Petitioner on April 23, 2014, he authorized Petitioner to return to work without restrictions effective April 28, 2014. On June 4, 2014, he opined Petitioner was at MMI (Petitioner's Exhibit 1).

At the direction of Respondent, Petitioner was examined by Dr. Stephen Weiss, an orthopedic surgeon, on April 30, 2014. In connection with his examination of Petitioner, Dr. Weiss reviewed medical records and reports regarding the accident of October 21, 2013, as well as a video which showed a cart being pushed into a docking station. Dr. Weiss agreed that Petitioner had a SLAP tear of the left shoulder; however, he opined that the work incident of October 21, 2013, did not cause the SLAP tear and the subsequent need for surgery. He opined that SLAP tears are usually degenerative or the result of a severe traction injury which he described as hanging by one hand. He did opine that Petitioner sustained a shoulder strain as a result of the accident, but that this would have resolved in two to seven days post injury (Respondent's Exhibit 2; Deposition Exhibit 2).

On July 9, 2014, Dr. Rhode examined Petitioner and he prepared an AMA impairment rating report. In this report, Dr. Rhode opined that Petitioner had zero percent (0%) impairment of both the extremity and whole person (Petitioner's Exhibit 1).

Dr. Weiss was deposed on December 1, 2014, and his deposition testimony was received into evidence at trial. Dr. Weiss' testimony was consistent with his medical report and he reaffirmed his opinion that the SLAP tear was neither caused nor aggravated by the accident of October 21, 2013. On cross-examination, Dr. Weiss agreed that the video he watched showed the cart being moved into place without any great difficulty and that nothing occurred which would have

caused an injury. He opined that if the right side of the cart was hung up, there would not have been sufficient force to cause a labral tear (Respondent's Exhibit 2; pp 11, 31-32).

Dr. Rhode was deposed on May 11, 2015, and his deposition testimony was received into evidence at trial. Dr. Rhode's testimony regarding his treatment of Petitioner was consistent with his medical records. He reaffirmed his opinion that the accident of October 21, 2013, caused the SLAP tear in Petitioner's left shoulder. In explaining this opinion, Dr. Rhode testified that if the cart pulled on his shoulder suddenly that the biceps, while trying to stabilize the arm, placed traction onto the shoulder. He also noted that if someone is not prepared or expecting something like that to happen, then the biomechanics of the injury will change (Petitioner's Exhibit 7; pp 47-50, 60).

Dr. Rhode also testified in regard to his AMA impairment rating. He stated that there was a distinction between impairment and disability and that Petitioner had a zero percent (0%) impairment (Petitioner's Exhibit 7; pp 70, 77).

Chelsea Sargent testified at the trial and she confirmed that Petitioner reported the accident to her on the day it occurred. Sargent testified that she had both observed and participated in the movement of the various carts. In regard to moving the cart into the docking station, she stated that if one side got hung up, there would be very little movement on the other side that was not hung up.

At trial, Respondent tendered into evidence the video of the cart being moved that was reviewed by Dr. Weiss. The video is less than one minute long and it shows an individual moving a cart into the docking station of the train and intentionally moving it so that it will not properly engage. At trial, Petitioner testified that the video was not an accurate depiction of how the accident occurred. He noted that the cart in the video was a flatbed cart and not a mother/daughter cart like the one he moved on the day of the accident. He noted that because the mother/daughter carts are higher than a flatbed cart they are more difficult to maneuver because of the fact that the mother/daughter cart will obstruct the vision of the individual moving it. Further, Petitioner stated that the area where the accident occurred was also dark.

At trial, Petitioner testified that he was able to return to work without restrictions and he continued to work for Respondent as a Material Handler until he was laid off on February 28, 2015. Petitioner still has some complaints of occasional irritation in the left shoulder for which he takes ibuprofen. Petitioner was unemployed at the time the case was tried.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the accident of October 21, 2013.

In support of this conclusion the Arbitrator notes the following:

The fact that Petitioner sustained a work-related accident on October 21, 2013, which was immediately reported to Respondent was not disputed.

Petitioner's description of how the accident occurred and the symptoms he experienced it immediately thereafter was consistent in Respondent's accident reports, Petitioner's medical records, the histories of the accident provided to Dr. Rhode and Dr. Weiss as well as Petitioner's testimony at trial.

The video depiction of a cart being moved into the docking station was not an accurate depiction of how the accident occurred. Obviously, the operator in the video intentionally moved the cart in such a way to where it would not engage properly so there was very little, if any, resistance to be noted. Further, the cart in the video was a flatbed cart and not a mother/daughter cart. Finally, in the video the area in question was well lit and Petitioner's unrebutted testimony was that the accident occurred in a dark area.

The Arbitrator finds that Petitioner was moving a mother/daughter cart in a dark area and the right side of the cart became hung up which caused a jerking type injury to Petitioner's left arm/shoulder.

When Dr. Rhode was deposed, he explained the physiology of how the accident could have caused the SLAP tear.

While Dr. Weiss testified that there was not a causal relationship between the accident of October 21, 2013, and the SLAP tear. He opined that Petitioner sustained a strain, but had no explanation as to how Petitioner sustained the SLAP tear that ultimately required surgery.

Petitioner's statement that he had no prior left shoulder injury or symptoms was unrebutted.

The Arbitrator finds the opinion of Dr. Rhode to be more persuasive than that of Dr. Weiss.

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 Exhibits 1, 4, 5 and 6 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of nine weeks commencing February 25, 2014, through April 27, 2014.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of seven and one-half percent (7 ½ %) loss of use of the body as a whole.

In support of this conclusion the Arbitrator notes the following:

Dr. Rhode opined that Petitioner had an AMA impairment rating of 0% to the extremity and 0% to the whole person. The Arbitrator gives this factor moderate weight.

Petitioner was a Material Handler at the time of the accident and was able to return to work to that job. The Arbitrator gives this factor moderate weight.

Petitioner was 36 years old at the time of the accident. Petitioner will have to live with the effects of this injury for the remainder of his working and natural life. The Arbitrator gives this factor moderate weight.

There was no evidence that this injury will have any effect on Petitioner's future earning capacity. The Arbitrator gives us factor minimal weight.

As a result of the accident, Petitioner required left shoulder surgery which consisted of repair of a SLAP tear and a subacromial decompression. Petitioner's complaints are consistent with the injuries he sustained. The Arbitrator gives this factor moderate weight.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anthony Moushon,
Petitioner,
vs.

NO: 13WC 37478

Illinois American Water Works,
Respondent,

16IWCC0342

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 14, 2015, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 20 2016
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CJD/jrc
049

Joshua D. Luskin

Ruth W. White

JOINT EXHIBIT 3

Luke W White

DISSENT

I must respectfully dissent from the majority's decision that the Petitioner failed to prove that his current condition of ill-being was not causally connected or caused by an alleged accident on October 29, 2013. I would instead reverse the findings of Arbitrator Erbacci and find that the Petitioner did prove he sustained injuries to his right shoulder as a result of his work activities at that time.

The Petitioner credibly testified that he worked for the Respondent for 31 years. (Transcript 6-13) Part of that job was using a 90 pound jackhammer. He used the 90 pound jackhammer until four years prior to his alleged accident. Petitioner used a 20 pound jackhammer since they stopped using the 90 pound jack hammer. (Transcript Pgs. 47-50)

Dr. Merkley testified that the Petitioner's use of vibratory tools like a jackhammer is going to place sheer force on the shoulder joint and therefore could be specifically considered aggravating to that joint. (Petitioner Exhibit Pgs. 6-8, Pgs. 15-16)

The Petitioner testimony along with that of Dr. Merkley sustained the burden of proof that the work performed for the Respondent clearly aggravated the arthritic condition in his shoulder and was the cause for his need of a shoulder arthroplasty.

DATED:

Charles J. DeVriendt

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

MOUSHON, ANTHONY
Employee/Petitioner

Case# **13WC037478**

ILLINOIS AMERICAN WATER WORKS
Employer/Respondent

16IWCC0342

On 4/14/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0192 CUSACK GILFILLAN & O'DAY LLC
DANIEL CUSACK
415 HAMILTON BLVD
PEORIA, IL 61602

5196 CLAYBORNE SABO & WAGNER
JENNIFER L BARBIERI
525 W MAIN ST SUITE 105
BELLEVILLE, IL 62220

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Anthony Moushon
Employee/Petitioner

Case # 13 WC 37478

v.

16IWCC0342

Illinois American Water Works
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Peoria**, on **February 19, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0342

FINDINGS

On the date of accident alleged, **October 29, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the alleged injury, Petitioner earned $**62,400.00**; the average weekly wage was $**1,200.00**.

On the date of accident alleged, Petitioner was **57** years of age, ***married*** with **0** dependent children.

ORDER

The Petitioner failed to meet his burden of proof with regard to the issues of accident and causation. The Petitioner's claim for benefit is, therefore, denied and no benefits are awarded herein.

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.

Arbitrator Anthony C. Erbacci

April 2, 2015
Date

13 WC 37478
ICArbDec19(b)

APR 14 2015

FACTS:

The Petitioner testified that on October 29, 2013 he was a 31 year employee of the Respondent. The Petitioner testified that he started his employment with the Respondent as a "meter reader" and was later employed in "service" and then "distribution and repairs" where, for the last 25 years, he has been a "working foreman". The Petitioner described his work as heavy labor which requires the use of various tools including hammers, chisels, pry bars, and jack hammers. The Petitioner testified that at some point prior to October of 2013, the Respondent eliminated the need for the use of hand held jack hammers and that he had not "recently" done any jack hammering. The Petitioner testified that the job description admitted into the record as Respondent's Exhibit 3 was generally accurate.

The Petitioner testified that in early 2013 he began to experience pain in his right shoulder. He testified that when he went to see his primary care physician for a routine physical examination, he mentioned his shoulder pain and was referred to Dr. Michael Merkley who gave him an injection and recommended surgery.

The medical records reflect that the Petitioner saw Dr. Merkley on July 16, 2013. The Petitioner reported that he began having gradually worsening right shoulder pain for the last six months. Dr. Merkley diagnosed the Petitioner with advanced glenohumeral arthritis in his right shoulder. He gave the Petitioner an injection and recommended that he return if he did not get better. No work restrictions were noted.

The Petitioner continued to perform his regular full duty work for the Respondent through October 29, 2013 when he returned to see Dr. Merkley. At that time, the Petitioner reported that he had received temporary relief from the injection, but that the pain had returned as well as decreased range of motion. Dr. Merkley recommended the Petitioner have a total shoulder arthroplasty. In his office note of that date, Dr. Merkley's indicated that his impression was that the Petitioner had a pre-existing glenohumeral arthritis that is aggravated by his work activities as a laborer.

The Petitioner testified that the prescribed surgery was scheduled for December 13, 2013 but that it was cancelled due to lack of insurance authorization. The Petitioner has continued to work his regular job through the present time. The Petitioner testified that he continues to have a limitation of his range of motion in his shoulder as well as severe crepitus. He testified that he now has to use his left arm much more than he did previously but he acknowledged that he is not currently under any medical restrictions.

Dr. Michael Merkley, a board certified orthopedic surgeon, testified by way of evidence deposition which was taken on October 10, 2014. Dr. Merkley testified as to the two occasions that he examined the Petitioner and his recommendation that the Petitioner have a total right shoulder replacement. Dr. Markley testified that x-rays of the Petitioner's right shoulder demonstrated advanced arthritic changes at the glenohumeral joint and that his diagnosis was that the Petitioner had glenohumeral arthritis. Dr. Merkley testified that cause of glenohumeral arthritis was "multifactorial" and that he could not testify that the Petitioner's

glenohumeral arthritis was caused by his work activities. Dr. Merkley opined the Petitioner's job activities "certainly could be considered an aggravation of his pre-existing condition". Dr. Merkley acknowledged that he had not reviewed any job description regarding the Petitioner's job and that he had no idea how much the Petitioner may have used a jack hammer. Dr. Merkley further opined that once shoulder arthritis is bad enough or has progressed to a severe enough level, "most any use of that shoulder is going to cause increased pain". Dr. Merkley testified that his expectation was that the Petitioner would remain painful and that he continues to recommend surgery for the Petitioner's right shoulder.

At the request of the Respondent, the Petitioner was examined by Dr. Leo Ludwig on July 24, 2014. Dr. Ludwig testified as to his examination of the Petitioner and the medical records he reviewed, and his December 4, 2014 deposition testimony was admitted into the record as Respondent's Exhibit 5. Dr. Ludwig testified that he diagnosed the Petitioner as having degenerative joint disease of the right shoulder which was "a process of aging". Dr. Ludwig testified that the Petitioner had no specific injury to his shoulder and he opined that any type of activity would temporarily aggravate an arthritic joint. Dr. Ludwig opined that the Petitioner's work activities would temporarily increase his symptoms but would not "be a catalyst to accelerate his degenerative joint disease". Dr. Ludwig agreed that the Petitioner's arthritis was not caused by his work activities and he opined that the Petitioner's work activities would only temporarily aggravate the Petitioner's symptoms. Dr. Merkley also agreed that a total right shoulder replacement was appropriate treatment for the Petitioner.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, (F.), Is Petitioner's current condition of ill-being causally related to the injury, and (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

It is axiomatic that the Petitioner bears the burden of proving all of the elements of his claim by a preponderance of the credible evidence. The Arbitrator finds that the Petitioner failed to meet that burden here.

The Arbitrator notes that both Dr. Merkley and Dr. Ludwig testified that the Petitioner had a pre-existing degenerative arthritic condition in his right shoulder which was not caused by his work activities. Dr. Merkley opined that some of the Petitioner's job activities "could be considered an aggravation of his pre-existing condition" but he also acknowledged that once shoulder arthritis is bad enough or has progressed to a severe enough degree, "most any use of that shoulder is going to cause increased pain." Dr. Merkley did not specifically opine that the Petitioner's pre-existing condition was permanently aggravated or accelerated as a result of his job activities nor did Dr. Merkley opine that the need for the surgery he prescribed was accelerated by the Petitioner's job activities. Similarly, Dr. Ludwig opined that the degenerative joint disease in the Petitioner's right shoulder was a process of aging and that any kind of activity would temporarily aggravate an arthritic shoulder. Specifically, Dr. Ludwig

opined that the Petitioner's work activities would increase his symptoms but "would not be a catalyst to accelerate his degenerative joint disease".

The Arbitrator also notes that Dr. Merkley acknowledged that he had not seen any written description of the job duties the Petitioner performed and he had no idea how much the Petitioner may have used a jack hammer in the performance of his job. In fact, there is nothing in the record which indicates or demonstrates that Dr. Merkley had any real understanding of the Petitioner's actual job activities. While the Petitioner testified that he talked to Dr. Merkley about what he did at work, he gave no details as to what he may have told Dr. Merkley and neither Dr. Merkley's records nor his testimony demonstrate what his understanding, if any, of the Petitioner's actual job activities was. While the Arbitrator notes Dr. Merkley's opinions, the Arbitrator finds those opinions to be insufficiently reliable and persuasive so as to satisfy the Petitioner's burden of proof. In addition, the Arbitrator notes that the opinions of Dr. Ludwig are as reliable and persuasive as the opinions of Dr. Merkley.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that an accident occurred which arose out of and in the course of the Petitioner's employment with the Respondent. The Arbitrator further finds that the Petitioner failed to prove that his current condition of ill-being or the need for prospective medical treatment is causally related to the Petitioner work activities for the Respondent.

Having found that the Petitioner failed to meet his burden of proof with regard to the issues of accident and causation, determination of the remaining disputed issues is moot.

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

13 WC 39955

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

Robin Manning,
Petitioner,

vs.

NO: 13 WC 39955

St. Clair County Circuit Clerk,
Respondent.

16IWCC0346

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 11, 2015 is hereby affirmed and adopted.

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

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

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: MAY 23 2016
MJB:ell
O-05/16/16
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Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MANNING, ROBIN
Employee/Petitioner

Case# **13WC039955**

ST CLAIR COUNTY CIRCUIT CLERK
Employer/Respondent

16IWCC0346

On 8/11/2015, 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 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5236 CULLEY FEIST KUPPART & TAYLOR
KREIG B TAYLOR
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

0810 BECKER HOENER THOMPSON ET AL
RODNEY W THOMPSON
5111 W MAIN ST
BELLEVILLE, IL 62226

16IWCC0346

STATE OF ILLINOIS)
)SS.
COUNTY OF ST. CLAIR)

☐ 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

Robin Manning
Employee/Petitioner

v.

St. Clair County Circuit Clerk
Employer/Respondent

Case # 13 WC 039955

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **June 25, 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 3/8/13, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this *alleged* 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 $27,180.61; the average weekly wage was $522.70.

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

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

Respondent *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

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that she sustained an accident arising out of and in the course of her employment on March 8, 2013. In addition, Petitioner failed to prove by a preponderance of the evidence that the alleged accident of 3/8/13 was causally related in any degree to her condition of ill-being, namely right-sided carpal tunnel syndrome and left-sided carpal tunnel syndrome. As a result, all other benefits under the Act are denied and all other issues between the parties are rendered moot.

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

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

Signature of Arbitrator

7/31/15
Date

AUG 11 2015

STATE OF ILLINOIS)
)
COUNTY OF ST. CLAIR)

16IWCC0346

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION, continuation
Robin Manning v. St. Clair County Circuit Clerk
Case Number: 13 WC 039955

Findings of Fact and Conclusions of Law:

Petitioner asserted in her Application for Adjustment of Claim that as a result of repetitive activities performed during her employment with the County Circuit Clerk's office, she developed bilateral carpal tunnel syndrome. At the time of the hearing Petitioner was 57 years of age and had been employed by Respondent for 14 years. Her current title was switchboard operator. Prior to that, she worked in the civil division for the Clerk's office that included functions such as working the counters for attorneys and customers, computer work, organization and filing away of file materials and answering telephones. She said that her recent job duties have been primarily that of answering the phone and then separating documents so that they can be placed into the proper files. Petitioner stated that she would answer the phone all day long and that it was a hand set. She works 7½ hours a day, 5 days a week. With regard to the separation of documents, she testified that various documents would need to be filed into the proper files for storage. These documents would come back from the scanning department in various stacks. She said there could be as many as 500 pages in one stack. She would sort the documents by making proper division of the paperwork based upon date, type of document filed etc. She would use both hands in performing this task. On occasion, she would actually put the papers into the files themselves. She would also continue to answer the phone during the day. She testified that sometimes she would stop sorting to answer the phone, and sometimes that she could sort and answer the phone at the same time. She stated that she is right handed. She testified that although she would sort with both hands, she would sort more with her right hand. Her job did not involve a lot of typing. During her 7½ hours of work each day, she has two 15 minute breaks and an hour for lunch.

She testified that she started having some pain in her right shoulder in January 2012. She said that she also noticed some pain and tingling in her hand after work. She would notice it when she was driving home. She initially sought treatment with her family doctor in Collinsville and then started seeing Dr. Harvey Mirly.

She first saw Dr. Mirly on 2/14/13. He ordered nerve conduction studies for her and confirmed that she had carpal tunnel syndrome in her right hand. The study was negative with regard to her left hand. Dr. Mirly gave her a splint to wear on her right

hand and also provided her with an injection. She continued to have the symptoms and she eventually underwent surgery on her right hand on 11/11/13. She was released to return to work by Dr. Mirly on 11/20/13.

Petitioner testified that her hand was better after the surgery, but that recently it was bothering her a little bit more. She complained of numbness and tingling in the tips of the fingers of her right hand. She also complained of some weakness in the right hand. She did not really have any complaints of pain. She stated that her carpal tunnel syndrome had not prevented her from performing the activities that she needs to perform.

On cross-examination petitioner testified that Dr. Malcharek was her personal physician and that he had been treating her for high blood pressure, high cholesterol and hypothyroidism and had been for at least three years. She noted that she was a smoker and was smoking about a pack a day for the last several years. She noted that whenever she saw her doctor, he would record her height and weight. She stated that the dates of her visits with her personal physician might not be as she recalled them and that his records would be more accurate.

She was then questioned regarding how long she had been a telephone operator with the Clerk's office, as the medical records seem to indicate that she had only been performing that job for about a year before her symptoms started. However, petitioner testified that she actually became a telephone operator for Respondent in 2004.

Petitioner testified that she had not seen any other physician for her hand since Dr. Mirly on 11/19/13.

She stated that she recalled seeing Dr. R. Evan Crandall at the request of Respondent and that she explained to him the problems she was having with her hands to the best of her ability. She also outlined to him all of the medical conditions for which she was being treated prior to the visit and advised him that she was a smoker. She acknowledged that she also discussed with Dr. Crandall what her job functions were as a telephone operator for Respondent. She discussed with him the papers that she would separate as well. She stated that she also talked to Dr. Crandall about the number of phone calls that she would answer in the course of a day, agreeing that she told him that she would answer about 200 calls per day, or about 25 per hour. She also agreed that she told him that each phone call would take about two minutes, and that she would therefore have ten minutes left of each hour when she worked to perform her other job duties, including sorting papers.

Petitioner did not know how long it might take to separate up to 500 pages of documents.

She did not have any complaints with her right or left hand before January 2013 and denied any further injuries to her right hand since January 2013. She returned to full duty work on 11/20/13 and has been working full duty since that time. She said that she was capable of performing all of the functions of her job, was making more money than she did in January 2013, had not been disciplined in any manner for the performance of her job since she returned to work following her surgery and had not requested any reassignment to another position because of any problems she had with her hand after surgery by Dr. Mirly.

The medical records offered into evidence indicate that Petitioner saw Dr. Malcharek, her personal physician, on 4/3/12 and he noted that she was suffering from high blood pressure, high cholesterol, hypothyroidism, smoked a pack a day of cigarettes and was 5'5" tall and weighed 171 pounds. He began treating her for all of these conditions. He provided her with medication for her high blood pressure, high cholesterol and hypothyroidism.

Her first complaint of upper extremity difficulty was to Dr. Malcharek on 1/23/13. She complained of an achiness in her right shoulder and numbness and tingling in the right hand. She said that it started a couple of months before and she would have pain from her shoulder that radiated down to her wrist and hands at night. She had bilateral hand pain, right greater than the left. She told Dr. Malcharek that she did a lot of repetitive work and that she was going to see Dr. Mirly in a month. He thought that she was suffering from carpal tunnel syndrome and a strain to the subscapularis muscle. He gave her a trigger point injection in the right shoulder and a splint to wear on her right hand.

Petitioner saw Dr. Mirly on 2/14/13 and complained of numbness and tingling in her hands, right greater than the left. He examined her and ordered an EMG that was performed on 3/8/13 and revealed carpal tunnel syndrome on the right side. Dr. Mirly testified that she returned to see him on 3/25/13 and she advised him that she thought that her carpal tunnel syndrome was work related. She informed Dr. Mirly that she had symptoms for about a year, which he said corresponded to her job change from a more diverse position in the Respondent's office to that of a telephone operator. He said that she did a lot of separation and correlation of papers, but did not perform much typing in her new position.

Dr. Mirly injected her right carpal tunnel and gave her a splint, but she continued to have symptoms. She underwent surgery on her right hand by Dr. Mirly on 11/11/13. She saw Dr. Mirly for the last time on 11/19/13 and he noted that she was doing well and he released her to return to work on 11/20/13 without restrictions.

Dr. Mirly testified that he thought that her work activities were related to her carpal tunnel condition based on petitioner's association of the change in her job duties to that

as a telephone operator with the onset of her symptoms. He described her job duties as stapling and un-stapling papers; separating papers; copying paper; collating papers and answering the telephone. He further reiterated on cross-examination that his opinion on causation was based on the timing of the onset of her complaints with the beginning of her new primary position as a telephone operator for Respondent.

Dr. R. Evan Crandall testified on behalf of Respondent. When Petitioner met with Dr. Crandall on 5/4/13 she was 5'4" tall and weighed 170 pounds. She said she was a Deputy Clerk and would separate papers, put papers in order and take 200 phone call per day. She said she had done some typing in the past. She advised him that she was taking medications for hypothyroidism, high blood pressure and high cholesterol. She advised Dr. Crandall that she thought the cause of her problem was separating papers and putting them in order. Dr. Crandall confirmed with her that she thought that she took 200 phone calls a day, or 25 per hour and that each phone call lasted two minutes, so that she spent 50 minutes of every hour on the phone answering questions and inquiries of attorneys and the general public. She told him that she did not know how many pages she would type during a day. Dr. Crandall diagnosed her condition as right carpal tunnel syndrome and he did agree that surgery was warranted. However, he testified that there was no relationship between her condition of ill-being and her work activities. He stated that she had many comorbidities that caused her condition of ill-being, namely her weight, age, gender, high blood pressure, high cholesterol, hypothyroidism and smoking history.

In order for Petitioner to successfully prosecute her claim for benefits under the Act, she must prove that she sustained an accident arising out of and in the course of her employment. *See Tower Automotive v. Illinois Workers' Compensation Commission*, 943 N.E. 2d 153 (1st Dist. 2011). The Petitioner must also prove that a causal connection exists between her condition of ill-being and her employment. *See Tower Automotive v. Illinois Workers' Compensation Commission*. An accident cannot be based on evidence that leads to conjecture. *See Baldwin v. Illinois Workers' Compensation Commission*, 409 Ill. App. 3rd 472, 478 (4th Dist. 2011). Further, an accident cannot be based upon circumstantial evidence unless it supports an inference which is reasonable and probable, not merely possible. *See First Cash Financial Services v. Industrial Commission*, 367 Ill. App. 3rd 102, 106 (1st Dist. 2006).

The Petitioner in this case alleges that as a result of her work activities as described above, she suffered from bilateral carpal tunnel syndrome, right greater than the left. Initially, the Arbitrator notes that Petitioner did not testify as to any continuing problem with her left hand and therefore that alleged condition will not be considered. Based upon the evidence outlined above and the case law cited, Arbitrator finds that Petitioner has failed to prove that she sustained an accident arising out of her employment and that said accident caused or contributed to cause the condition of ill-being in her right hand and right upper extremity, namely carpal tunnel syndrome.

Petitioner admitted that she would spend 50 minutes per hour answering the phone, which would include fielding questions from the general public and from attorneys, providing them with the required information or referring them to other departments within the County. Although she testified that she would sometimes sort papers as she answered the phone, she did not testify as to how many times that would occur during the course of the day, nor how long that would last during the course of the day. She seemed to imply to the physicians that it was her belief that it was the sorting and correlating of papers that contributed to her carpal tunnel condition. However, the Arbitrator finds that the performance of that duty was not a risk of injury to which the Petitioner was exposed to at a greater basis than a member of the general public. Members of the general public make the same kind of hand motion on a daily basis and the rapidity of her performance of that activity was not made clear. The amount of weight or the actual motion of the hands in performing this activity was certainly nothing greater than that to which a member of the general public would be exposed on a daily basis.

In addition, Dr. Mirly clearly testified that he was not familiar with the specifics of her job activities, but generally knew of them. Further, his opinion was based solely on the "timing" of the onset of her complaints of ill-being with what he understood to be her change of position to that of a telephone operator with Respondent. Therefore, the complaints began when she was performing a task that was not subjecting her hand to repetitive trauma or to a risk of injury greater than a member of the general public. Dr. Crandall, on the other hand, testified that there were a number of co-morbidities present in Petitioner that could certainly cause her condition of ill-being.

As a result of the Arbitrator's finding that Petitioner did not sustain her burden of proof with regard to the issue of accident and the issue of causation, any and all benefits under the Act are hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

☐ 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

Todd Dosemagen,

Petitioner,

vs.

NO: 14 WC 1659

16IWCC0307

City of Peoria,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's Decision finding that Petitioner failed to prove a causal relationship exists between the accidental injuries he sustained to his right knee on January 2, 2014 and his current condition of ill-being for his left knee. The Commission affirms the Arbitrator's finding that a causal relationship exists for Petitioner's current condition of ill-being for his right knee. The Commission vacates the Arbitrator's finding that Petitioner is entitled to prospective medical care for his left knee and Respondent's liability for left knee treatment.

At arbitration, the parties did not dispute that an accident occurred on January 2, 2014 which resulted in a right knee injury. The parties also did not dispute that a causal relationship exists for Petitioner's condition of ill-being for his right knee. The parties did dispute whether a causal relationship exists for a claimed left knee injury.

Petitioner, a 45 year old firefighter, testified that on January 2, 2014, he was responding to an EMS call. It was storming, there was snow and it was icy. Petitioner testified, "I just stepped off of the fire apparatus and just slipped. I did not fall, I just slipped, caught myself." When Petitioner slipped, "Actually I just kind of did the splits, and as I was falling my right hand grabbed onto – There is a handrail that helps us in and out of the machines. I grabbed onto that and kept myself from falling." Petitioner noticed, "I felt a little twitch on my right knee upon the actual splits and felt pain. As we proceeded to go up to the house the pain started to get worse. Kneeling in front of the patient that we were attending to then something happened. After we were done treating the patient I climbed in the apparatus to drive to the hospital. We were taking the patient to the hospital with a firefighter/paramedic on board the ambulance, and we were going to meet them at St. Francis. And as soon as I put my foot down on the accelerator it felt like someone took a baseball bat to my knee, I couldn't breathe. I had severe pain, told my captain, asked if I could drive safely to the hospital, I said yes." Petitioner went to the hospital in the fire truck. At the hospital, he was taken from the fire truck in a wheelchair. Petitioner's right knee was examined and x-rayed. At that point, Respondent directed Petitioner to Dr. Moody, the company physician. Dr. Moody saw Petitioner and ordered a right knee MRI.

OSF Occupational Health records, Rx2, indicate Petitioner was seen at Saint Francis Medical Center Emergency Department on January 2, 2014. The following history was noted: "Pt presents with c/o right knee pain. Pt is Peoria fire/rescue and was on site to bring another patient to ED. Pt states that when he stepped off the truck, his foot slid causing pain over 10/10 to medial aspect of right knee. Pt knee appears swollen in comparison to left knee. Pt relates that knee is 8/10 with flexion but is 10/10 with extension or weight bearing." Petitioner was diagnosed with right knee pain. He was not to weight bear for 3-5 days, apply ice and elevate his right leg at rest. He was prescribed medication and was to follow-up with occupational health. Petitioner also saw Dr. Moody at OSF Occupational Health on January 2, 2014 and it was noted that he was a firefighter for Respondent. Petitioner reported, "He states that approximately 4 this morning he was on a call, and stepped off of the fire truck onto an icy patch, causing his right leg to slip out. He did not sustain any impact to his right knee, but based on his history, it was probably forced into valgus. He did not note any dislocation of his kneecap or sensation of subluxation. He was able to keep working for a while, the pain increased and he went to the emergency department." Petitioner complained of substantial pain and difficulty with weight-bearing. On examination, Dr. Moody found right knee range of motion 0-30 degrees, 2+ effusion, no patellar edge tenderness or apprehension, collateral ligaments were non-tender, his right knee was stable and there was no significant pain with varus-valgus stress, McMurray's test could not be adequately performed and there may have been some laxity of the ACL. X-rays were taken and reviewed and appeared unremarkable other than for effusion. Dr. Moody's assessment was rapid onset of effusion after injury which may indicate hemearthrosis. He noted

the examination was difficult due to pain. Dr. Moody ordered a right knee MRI. He authorized Petitioner off work the rest of this day and sedentary work, office environment only, the next day with no use of ladders or unprotected heights, no slippery or uneven surfaces and no firefighting or training exercises. Petitioner was issued a hinged brace and crutches and prescribed medications. He was to follow-up two days post-MRI.

A right knee MRI was performed on January 10, 2014 and compared to the January 2, 2014 x-rays. The history was noted as a December 7, 2013 twisting injury with medial pain. The radiologist found mild increased signal in the medial collateral ligament raising the possibility of Grade II sprain; a complex tear of the posterior horn and body of the medial meniscus; a possible tear of the medial meniscofemoral ligament; moderate to large joint effusion; a cystic structure at the musculotendinous junction of the popliteus muscle, probably a ganglion cyst; fibrillation of the patellar articular cartilage without underlying bone marrow edema; mild thinning medial compartment articular cartilage. The radiologist's impression was: 1) complex tear of the posterior horn and body of the medial meniscus and possible medial meniscofemoral ligament tear; 2) possible Grade 1 sprain medial collateral ligament; 3) Ganglion cyst associated with the popliteus tendon; 4) Grade II to Grade III chondromalacia medial and patellofemoral compartments.

Petitioner saw Dr. Moody on January 14, 2014 and reported continuing right knee pain, mainly in the medial compartment. He reported getting a rare catching of the right knee, but no locking. He did not have any true giving way, but he did find himself frequently seeking support when ambulating. On examination, Dr. Moody found Petitioner was able to bend his right knee to 115 degrees, there was slight effusion, a positive McMurray's test in the medial compartment, no significant ligamentous tenderness of the collateral ligaments and no significant pain or instability with varus-valgus stress. He reviewed the MRI findings. Dr. Moody noted that Petitioner had already made an appointment with an orthopedic of his own choosing and suspected he would be offered arthroscopy for the meniscal tear. Petitioner was to follow-up after seeing the orthopedic. Petitioner was to continue sedentary office type work only and no firefighting or training activities, no ladder use and no slippery surfaces. (Rx2).

Midwest Orthopedic Center records, Px1, DepEx2, indicate Petitioner saw Dr. Brent Johnson on January 15, 2014 on referral from primary care physician Dr. Leslie Johnson. The Medical History Form noted that the reason for this visit was right knee pain which started two weeks ago with an injury at work on January 2, 2014 from a slip on ice while exiting a fire truck. Petitioner rated his pain at 9/10 and sharp and aching. He had swelling, locking/catching and giving way. The problem was unchanged and symptoms were worse with lying in bed, walking, sitting, kneeling and use of stairs. Rest helped. Petitioner indicated he had physical therapy and bracing. He had been seen at OSF emergency room on January 2, 2014. In his Office Notes, Dr. Johnson noted Petitioner's chief complaint of right knee pain and the following history: "He injured his knee 2 weeks ago at work. He slipped off the fire truck. He was legs went into an abducted position. He felt significant pain on the medial aspect of his knee. He reports he

helped the patient but when he got back into the truck to drive and pressed the accelerator, he had severe pain on the medial aspect of his knee." Dr. Johnson noted what Petitioner reported on the Medical History Form. On examination, Dr. Johnson noted alignment was normal, gait antalgic, no atrophy, range of motion right 0/3/125, left 3/0/140, positive effusion to the right knee, medial joint line tenderness of the right knee, positive McMurray test and no crepitus. X-rays were taken and standing AP, PA and Merchant views showed good maintenance of the medial and lateral joint space, patella was aligned on the Merchant view and no fracture was noted. Dr. Johnson reviewed the right knee MRI scan and noted it revealed a complex tear in the posterior horn of the medial meniscus with a displaced meniscal flap in the medial gutter and some mild Grade 2 chondromalacia of the medial and patellofemoral compartments. Dr. Johnson's assessment was right knee displacement and meniscal tear. Dr. Johnson opined, "I feel this injury goes along with the mechanism he describes." Dr. Johnson recommended surgery consisting of a right knee arthroscopy and partial medial meniscectomy. Surgery was scheduled and post-operative physical therapy was ordered.

Dr. Johnson performed surgery on January 21, 2014. In his Operative Report, Dr. Johnson noted a pre-operative diagnosis of a right knee medial meniscus tear. The following procedures were performed: 1) right knee arthroscopy, partial medial meniscectomy; 2) chondroplasty patella. In a follow-up Medical Questionnaire dated January 24, 2014, Petitioner noted he was 80% better and rated his pain at 6/10. The quality of pain was aching. Pain awakened him from sleep. He also had weakness, swelling, locking/catching. Anti-inflammatories helped. On January 24, 2014, Petitioner saw Benjamin Holman PA-C at Dr. Johnson's office for a post-operative follow-up visit. Mr. Holman reviewed the above and noted Petitioner's pain was reasonably controlled. He was ambulating with crutches and had mild effusion. Mr. Holman ordered physical therapy for range of motion and strengthening. Mr. Holman authorized Petitioner off work for 2 weeks and may return to work February 10, 2014 to sit down sedentary work only. Petitioner was to follow-up in 6 weeks. On January 24, 2014, the physical therapist noted the following: "Was doing fine till yesterday afternoon. Admits to walking around the house without the crutches and going up/down the stairs 6 x with alternating step without AD. The pain was in severe in the knee. Doing okay today till he got in here today. Has been elevating the leg and icing it. Difficulty with sleeping. No driving yet." Petitioner rated his pain from 0-7/10. The physical therapist's assessment was moderate limitation with right knee range of motion especially flexion. There was improved mobility by end of the session. There was moderate knee swelling and Petitioner was to continue physical therapy. (Px1, DepEx2).

On February 4, 2014, the physical therapist noted the following: "Todd fell down an entire flight of stairs two days ago and felt pain in the right knee like he has never felt before. He laid on the floor for 30 minutes and then gradually moved the leg. Since then he has steadily improved and has limited pain today." Petitioner was walking with a bit of a limp, and the physical therapist was unclear if the limp was from surgery or the fall. On examination, Petitioner had active range of motion of 0/125, there was mild edema remaining and crepitus

with active knee extension, which felt worse in the lateral facet of the patella at about 80 degrees of flexion, good quad set and no extensor lag. The physical therapist assessed that Petitioner was doing well and could continue home exercises program only. Petitioner was to start using a stationary bike for range of motion and endurance and start using an elliptical machine in two weeks, as well as kneeling desensitization. (Px1, DepEx2).

Petitioner saw Dr. Moody on February 12, 2014. In the Treatment Record, the surgery was noted and Petitioner reported his right knee pain was better, but the knee was stiff and sore. He was still in physical therapy and doing knee exercises at home. Physician Assessment was noted as negative infection, decreased range of motion, unable to kneel and doing physical therapy. In his Office Notes, Dr. Moody noted the January 21, 2014 arthroscopy and there were no post-operative infections or wound problems. Petitioner reported that he had continued limitation and range of motion and was unable to kneel on his right knee. He denied any clicking, catching or giving way. He was attending physical therapy. On examination, Dr. Moody found 2+ effusion, range of motion 0-110 degrees and McMurray test was negative. Dr. Moody's assessment was the limitations of range of motion were likely due to residual fluid in the knee which should resolve over the next few weeks. Dr. Moody reviewed the operative report and also saw the note authorizing his return to work at light duty effective February 10, 2014. Dr. Moody gave a work status of 10 minutes per hour maximum standing/walking through February 23, 2014 and 20 minutes from February 24, 2014 to March 6, 2014 and no crawling, no kneeling, rare squatting, no firefighting or training exercises. Petitioner was to follow-up on March 6, 2014. (Rx2).

Petitioner saw Benjamin Holman PA-C at Midwest Orthopedic Center on March 3, 2014 and reported 85% improvement. He had intermittent 1/10 pain with more aggressive physical activities. Petitioner reported he had been working extensively at the gym to get back his strength. He reported right knee pain with direct pressure on the front of the knee and at end range of flexion. On examination, Mr. Holman found right knee range of motion at 3/0/140, trace effusion, mild medial and lateral retinacular tenderness and mild quadriceps atrophy. Mr. Holman's assessment was Petitioner was doing very well. Petitioner was to continue strengthening and endurance training. Mr. Holman determined, "He may return to work on 03/10/2014 without restrictions." He was to follow-up in 5 weeks. (Px1, DepEx2).

On March 5, 2014, the physical therapist noted that Petitioner was supposed to take his work evaluation the following week. Petitioner reported pain anteriorly under the right kneecap, especially with kneeling and end range flexion. The physical therapist noted Petitioner had really been hitting the gym hard and had no pain with any of those activities. On examination, the physical therapist found full range of motion, normal quad tone and girth, very mild swelling remaining, good patellar mobility and no pain with palpation. The physical therapist's assessment was Petitioner was doing well. The physical therapist noted Petitioner could take the work restriction test and should not do any damage structurally to his knee and that kneeling would improve with desensitization over time. Petitioner had near full strength and full range of

motion. The plan was for Petitioner to follow-up as needed if issues arise once he returned to work at full duty. (Px1, DepEx2).

Also on March 5, 2014, Petitioner saw Dr. Moody at OSF Occupational Health. In his Office Notes, Dr. Moody noted Petitioner reported he was doing pretty well and was not requiring any pain medications. Petitioner reported he did get some pain with exercise and significant pain with kneeling. He had not yet resumed running. On examination, Dr. Moody found 1+ effusion, tenderness in both medial and lateral patellar borders, diffuse lateral joint line tenderness, negative McMurray's test and quadriceps atrophy. Dr. Moody assessed that Petitioner may have some limitations in functional status due to residual effusion and also likely had patellofemoral syndrome related to quadriceps atrophy. Dr. Moody ordered a work capacity evaluation. (Rx2).

Petitioner underwent a Work Capacity Evaluation on March 6, 2014. The physical therapist noted Petitioner's firefighter job was rated at heavy physical demand level. It was noted that Petitioner demonstrated good range of motion and strength across all joints in all planes of motion. He demonstrated normal grip and pinch strength and hand coordination bilaterally. Petitioner demonstrated good material handling in the heavy physical demand level. There were no limitations with sitting/standing/walking, low level work, elevated work, forward bending while reaching and stair climbing. Petitioner completed job simulation, which included stair climbing, ladder climbing, elevated work, dummy dragging, 2 man lift up and down a flight of stairs, floor sweep, hose roll and 200 pound spine board lift with his firefighting bunkers with jacket, helmet and air tank on. Petitioner gave good effort and consistent performance with testing. Good body mechanics were used. The physical therapist opined Petitioner met all the physical demands required to return to work at his previous position and recommended he return to work without restrictions. (Rx2).

Petitioner saw Dr. Moody on March 10, 2014. In his Office Notes, Dr. Moody noted Petitioner was 7 weeks post-op. Petitioner reported some pain when kneeling on his right knee, but otherwise was doing well. He did not have any significant flare-up of symptoms following his work capacity evaluation. Dr. Moody noted that the note from the orthopedic physician assistant Mr. Holman cleared Petitioner to return to work. On examination, Dr. Moody found 1+ effusion, full range of motion, no joint line tenderness and negative McMurray's test. Dr. Moody reviewed the work capacity evaluation, which Petitioner passed without any difficulty. Dr. Moody assessed that Petitioner was ready to return to unrestricted duty. Petitioner was to follow-up as needed.

Petitioner testified he was performing his firefighter duties from March 10, 2014. Petitioner testified, "The first part of April to the mid part of April I started getting a locking and catching and slight pain in my left knee." (Tr 28). Petitioner was asked if he was performing his activities from March 2014 to April 2014 in a different fashion post-surgery (Tr 28-29). Petitioner stated, "I was probably favoring one leg over the other, I mean just a little nervous and didn't want to ruin it again. I mean just kind of being a little extra careful with it." (Tr 29). He

was being extra careful with his right knee (Tr 29). Petitioner stated, "I would use it (his left knee) more than my right when it comes to kneeling in front of patients and getting on and off the apparatus (fire truck) was just a little bit different. Getting in to turn on the system a little different as far as, you know, how you on and off your equipment." (Tr 29-30). Petitioner attended a regularly-scheduled appointment in mid May 2014 with Dr. Johnson (Tr 30). At that time, he told Dr. Johnson how he was feeling (Tr 30). Petitioner testified he noticed after the right knee surgery when he returned to work in March 2014 that his left knee would have pain off and on, discomfort, locking and catching (Tr 31). Petitioner stated he did not have that in his left knee before he returned to work in March 2014 (Tr 31-32).

Midwest Orthopedic Center records, Rx3, indicate Petitioner saw Dr. Johnson on April 9. 2014 for right knee follow-up. Dr. Johnson noted Petitioner was 10 weeks post-op right knee arthroscopy. Petitioner reported a 95% improvement in his right knee. Petitioner reported he had dull, intermittent type pain which he rated at 1/10 with occasional catching. It did not bother him with sleep. He was not taking any medications. On examination, Dr. Johnson found right knee range of motion 3-0-140, trace effusion, some tenderness over the medial and lateral retinacula and no patellafemoral crepitus. Dr. Johnson's assessment was post-op right knee arthroscopy with partial meniscectomy. Petitioner was to continue work without restrictions and to continue his home exercise program. He was to follow-up in 4 to 6 weeks for a final check.

Midwest Orthopedic Center records, Px1, DepEx2, indicate Petitioner saw Benjamin Holman PA-C on May 5, 2014. At that time he was 4 months post-op. Petitioner reported continued pain and difficulties in the right knee. Petitioner reported his right knee pain was not as severe as pre-op, but is still up to 5/10. Mr. Holman noted, "He reports the left knee over the past several weeks has started to give him significant pain and difficulties as well. He reports pain at work, particularly when ambulating up and down an incline. He does note some swelling towards the end of the day at work. He notes pain over the anteromedial aspect of the knee." The Commission notes that this is the first mention of left knee complaints in the medical records. On examination, Mr. Holman found range of motion of bilateral knees was 3/0/140, no appreciable effusion, mild medial retinacular tenderness, trace joint line tenderness, negative McMurray's testing, the knees were stable to varus and valgus stressing and mild quadriceps atrophy with 4+/5 strength. Mr. Holman's assessment was: 1) Four months status post-op right knee arthroscopy with partial medial meniscectomy; 2) Left knee pain. Mr. Holman opined: "I think his current pain and difficulty is from deconditioning." Mr. Holman recommended Petitioner return to an aggressive exercise program for quadriceps strengthening. Petitioner was given bilateral knee injections since he was having significant pain which was slowing his ability to be able to exercise as well as limit his ability to perform work successfully. Petitioner was to continue with activities as tolerated and follow-up in 4 weeks.

Petitioner saw Dr. Johnson on June 2, 2014 for follow-up for his bilateral knees. Petitioner reported that his right knee was doing much better. He had been able to return to working out and there was no significant improvement with regards to the pain. Dr. Johnson noted, "He reports his left knee is bothering him more so now at this point. Is nowhere near as

bad as the right was initially. Still having some intermittent catching and pain in the medial aspect of his knee." On examination, Dr. Johnson found neither knee had any evidence of a significant effusion, no joint line tenderness in the right knee, medial joint line tenderness left knee, mildly positive McMurray's test left knee and negative right knee. Dr. Johnson's assessment was: 1) status post-op right knee arthroscopy with partial medial meniscectomy; 2) left knee internal derangement. Dr. Johnson discussed options for the left knee and noted that Petitioner did not wish to do anything at this time regarding his left knee. Dr. Johnson opined Petitioner was at maximum medical improvement for his right knee and released him from care for his right knee. Petitioner was to continue to work without restrictions. He was to return as needed with regards to either knee. (Px1, DepEx2).

Petitioner saw Dr. Johnson on January 16, 2015 regarding his left knee pain. Dr. Johnson noted that Petitioner was previously seen for his right knee and there was a brief evaluation of his left knee done. Petitioner presented for a formal left knee evaluation. Petitioner reported left knee pain at 8/10, fairly constant, but he can have an exacerbation of pain. Sometimes at night he would get a locking type sensation when he was lying in bed. Petitioner reported this was similar, but not as severe as, the previous right knee meniscus tear that he had. He took Ibuprofen. On examination of the left knee, Dr. Johnson found range of motion of the right knee at 3-0-140, left knee at 3-0-140, no effusion, no crepitus, medial joint line tenderness, negative McMurray's test, strength 5-/5, no instability and an intact sensory examination. Left knee x-rays were taken and revealed trace degenerative changes in the medial compartment with a small osteophyte off the medial femoral condyle, joint space was fairly well maintained, patella was well-aligned on Merchant view and no fractures. Dr. Johnson's assessment was left knee pain. Dr. Johnson noted that Petitioner was having some subtle findings of a meniscus tear, but he also had some degenerative changes. Petitioner elected to proceed with a cortisone injection as the previous injection gave him about 4 to 5 months of relief and this injection was given. Petitioner was to continue activities as tolerated. Dr. Johnson discussed long term management with repeat cortisone injections, a trial of visco supplementation or an MRI scan with consideration of arthroscopy if a meniscus tear was confirmed. (Rx3). This was the last treatment Petitioner had for either knee.

On cross-examination, Petitioner testified he had not been given any restrictions since he returned to work on March 10, 2014. He had continued to work his regular firefighter duties since that time. Petitioner did not recall a specific mechanism of injury regarding his left knee (Tr 54). He could not recall a specific day in which he began experiencing left knee pain (Tr 54). Petitioner did not recall reporting any left knee pain to any of his supervisors at the department prior to May 5, 2014 (Tr 55). Petitioner did not report any difficulty or pain with his left knee to any of his supervisors at Respondent prior to the day of the arbitration hearing (Tr 55). Petitioner was asked the following: "Q. So you are not really sure how you injured your left knee, correct? A. I am not sure, no." (Tr 56). Not one specific task caused his left knee problem (Tr 57). A follow-up examination was scheduled with Dr. Johnson approximately three months after his January 16, 2015 visit, but Petitioner did not remember if he attended that scheduled appointment (Tr 61). Petitioner would probably not have any reason to dispute the

records if they show that he did not attend the follow-up exam (Tr 61). Petitioner has not received any medical treatment for his left knee since he saw Dr. Johnson on January 16, 2015.

In his June 3, 2015 deposition, Px1, Dr. Johnson opined causal connection for Petitioner's right knee injury of January 2, 2014 (Dp 18). May 5, 2014 was the first time Petitioner had complained of his left knee (Dp 29). On that date, Petitioner reported that he had left knee pain at work, particularly when ambulating up and down an incline, and swelling towards the end of the day (Dp 29). Dr. Johnson opined that it is possible that the activities Petitioner was performing as a fireman full duty leading up to May 2014 could have aggravated his left knee condition to the point that it brought on subjective complaints (Dp 30). Dr. Johnson opined that it is possible that the activities Petitioner was doing as a fireman could have brought on the need for treatment after that date to the left knee (Dp 30). On cross-examination, Dr. Johnson testified that at the April 9, 2014 visit, Petitioner did not complain of any pain or difficulty with regard to his left knee (Dp 37). Dr. Johnson continued him on full unrestricted duty (Dp 37). May 5, 2014 was the first time Petitioner reported any pain or difficulty with regard to his left knee and physician assistant Benjamin Holman gave him bilateral knee injections and Petitioner was continued on full unrestricted duty (Dp 38). Dr. Johnson examined Petitioner on June 2, 2014 and found him at maximum medical improvement for his right knee and released him from care for his right knee (Dp 38). At that visit, Petitioner also reported he had intermittent catching and pain in his left knee (Dp 39). Dr. Johnson continued Petitioner on regular unrestricted duty (Dp 39-40). Dr. Johnson did not recommend a specific course of treatment for Petitioner's left knee (Dp 40). There was no diagnosis for Petitioner's left knee condition and no testing has been done (Dp 40). Based on his examination, Dr. Johnson suspected Petitioner most likely had a meniscus tear or he has some chondromalacia, wear and tear in his left knee, a less likely diagnosis (Dp 41). Dr. Johnson opined that those conditions could possibly be aggravated by his work duties (Dp 41). Over 7 months later, Petitioner returned to Midwest Orthopedic on January 16, 2015 (Dp 42). Dr. Johnson had no record of treatment in that 7-month period (Dp 42). No specific course of treatment was set in place at that time (Dp 44). Petitioner never followed-up after the January 16, 2015 visit (Dp 45).

At Respondent's request, Petitioner saw Dr. Nord on September 11, 2014 for a permanent impairment rating of his right knee. In his September 11, 2014 Permanent Medical Impairment Report, Rx1, DepEx3, Dr. Nord noted the January 2, 2014 right knee accident and treatment. On examination of the right knee, Dr. Nord found portal incisions measuring 15mm in length well healed, no specific areas of discomfort and no muscle spasm on palpation, normal stability, range of motion within normal limits of 0-135 degrees; motor strength testing within normal limits of Grade 5/5 and normal sensory findings. Dr. Nord noted his left knee examination was within normal limits. Dr. Nord diagnosed right knee medial meniscus tear and patella chondromalacia. Dr. Nord opined Petitioner's current right knee symptoms resulted from the January 2, 2014 work injury. Dr. Nord rated the percentage of impairment at 1% (LEI) and 1% (WPI). In summary, Dr. Nord opined Petitioner had 1% Whole Person Impairment. Dr. Nord opined Petitioner had reached maximum medical improvement for his right knee.

In his November 10, 2014 deposition, Rx1, Dr. Nord testified that at the time of his September 11, 2014 examination, Petitioner did not relate any specific symptoms that he was having and opined he was asymptomatic regarding his right and left knee (Dp 18). Dr. Nord stated he did not examine Petitioner's left knee and he did not have any complaints of it (Dp 18). Dr. Nord was shown the June 2, 2014 record from Midwest Orthopedic Center and read same (Dp 25). Dr. Nord opined that record would not change his AMA rating of Petitioner (Dp 26).

On cross-examination, Dr. Nord explained that despite putting "within normal limits" for the left knee in his report, he did not examine Petitioner's left knee and put that down because Petitioner was not really complaining of anything and he was evaluating the right knee (Dp 33). Dr. Nord had no knowledge of any type of injury to Petitioner's left knee and had no opinions related to any left knee injury (Dp 34). Dr. Nord had heard of the term/phrase/theory of "overcompensation." (Dp 34-35). Dr. Nord had cases in the past where due to a surgery like Petitioner had, getting better and going through different rehabilitation, they put more stress on the opposite knee (Dp 35). Dr. Nord had seen situations in his practice where individuals could sustain an injury to their opposite knee due to overcompensation (Dp 35). Based on his knowledge, injuries to the meniscal tear include complaints such as giving away of the knee, swelling, locking and pain and having pain and soreness after a day's work after the surgery (Dp 36). In the past Dr. Nord has testified that taking out or shaving a meniscus could create the beginning of an arthritic situation (Dp 40-41). Dr. Nord testified that on September 11, 2014, his trainer noted that Petitioner reported left knee pain which had been present since April 2014 and seemed to be getting worse at times (Dp 56-57). Petitioner reported to Dr. Nord's trainer, who noted, "He does not recall any mechanism of injury of his left knee but notes history of torn meniscus in right knee and that he's been rehabilitating his right knee when the left knee pain started." (Dp 57). The trainer noted Petitioner reported that his left knee pain was 6/10 and varied day-to-day, that his pain was along the medial aspect of the left knee and stated that it was intermittent at times. Petitioner reported stairs and walking for extended periods of time exacerbated his symptoms and he had been using over-the-counter medications to help his pain (Dp 57). Dr. Nord noted that it appeared, according to the trainer, that Petitioner had ongoing left knee pain at the time of the impairment rating (Dp 57). Dr. Nord opined that the left knee complaints could be related to overcompensating for the right knee (Dp 58).

On re-direct examination, Dr. Nord indicated he was only requested to do an impairment rating on Petitioner's right knee and that was why everything in the history that his trainer took regarding the left knee was not relevant (Dp 58). Dr. Nord did not note the left knee in his report because it was irrelevant to what Petitioner was seeing him for (Dp 59). Petitioner may have complained of his left knee and Dr. Nord did not remember (Dp 59). Dr. Nord noted that Petitioner returned to work on March 10, 2014, two months after the right knee surgery. Dr. Nord opined, "So for him to have a compensatory injury to his other knee when he's not even back working and somewhere within literally ten weeks, it's hard to understand how he could have injured the other knee in that short of period of time from just compensation." (Dp 64). Dr. Nord opined that Petitioner may have had some ongoing problem in his left knee, but he did not

think Petitioner was going to develop a significant compensatory problem with his left knee if he was off work for just 10 weeks (Dp 64).

At Respondent's request, Petitioner saw Dr. Cole for a §12 evaluation of his right knee. In his March 2, 2015 report, Rx4, Dr. Cole noted Petitioner was currently working at full duty. Dr. Cole noted Petitioner's right knee injury of January 2, 2014, his treatment, surgery and that Petitioner was released to return to work full duty in March 2014 and did so. Dr. Cole noted, "After a few weeks back on the job he began to incur anteromedial left knee pain that felt similar in nature. He reported this and has been managed with physical therapy plus 2 additional cortisone injections in the left knee over the last several months." Petitioner reported he had not undergone a left knee MRI. Petitioner reported his left knee bothered him at a moderate level, but he continued to work full duty with no restrictions. Dr. Cole noted, "There was no injury to the left knee per se, with no discrete slip, twist, pivoting event, etc. He would like something done for the left knee at some point given the nature and chronicity of the symptoms." Dr. Cole reviewed the medical records. On examination of the left knee, Dr. Cole found mild tenderness anteromedially in the anteromedial patellofemoral joint, no effusion, he was neurovascularly intact, manual muscle testing was full and he was ligamentously stable bilaterally. On right knee examination, Dr. Cole found well healed arthroscopic incisions. Left knee x-rays were taken and were found to be essentially normal in flexion, PA bilateral, AP bilateral, lateral and sunrise views.

It was Dr. Cole's impression that there was a left knee possible medial meniscus tear, pre-existing, unrelated to Petitioner's job nor right knee surgery given the fact pattern provided. Dr. Cole opined, "Todd may have a medial meniscus tear in the left knee but whether he treats it or not is his decision. I would submit that the evidence does not support a causal relationship between his left knee and his right knee; nor his left knee and the injury in question on January 2, 2014, for that matter." Dr. Cole noted that if Petitioner wanted to go forward with a left knee arthroscopy, then he should undergo a MRI as a pre-surgical tool. Dr. Cole opined: "At this point I cannot state categorically whether his symptoms warrant it or not, but in either regard it would not be related to the right knee claim." Dr. Cole felt Petitioner could work full duty with no restrictions. Maximum medical improvement for the left knee remained to be determined. Dr. Cole diagnosed left knee pain, possible medial meniscal tear, non-work related. Dr. Cole noted he had been asked his opinion whether Petitioner's reported left knee complaints and subjective symptoms were the result of overcompensating for his prior right knee injury. Dr. Cole opined, "There is no evidence to suggest that this is the case. There is no research to suggest that overcompensation of one knee due to another can or would cause a meniscus tear." Dr. Cole further opined that Petitioner had manifested symptoms in his left knee unrelated to work. Dr. Cole opined that without further treatment, Petitioner would be at maximum medical improvement for his left knee. With further treatment, maximum medical improvement was in the range of 8 weeks post arthroscopy.

The Commission modifies the Arbitrator's Decision finding that Petitioner failed to prove a causal relationship exists between the accidental injuries he sustained to his right knee on January 2, 2014 and his current condition of ill-being for his left knee. Petitioner underwent right knee surgery on January 21, 2014. He was released to return to work at full duty with no restrictions for his right knee on March 10, 2014. Treating Dr. Johnson opined Petitioner was at maximum medical improvement for his right knee on June 2, 2014. Petitioner testified on cross-examination, "Q. So you are not really sure how you injured your left knee, correct? A. I am not sure, no." Dr. Johnson opined that it is possible that the activities Petitioner was performing as a fireman full duty leading up to May 2014 could have aggravated his left knee condition to the point that it brought on subjective complaints. Respondent's impairment rater Dr. Nord opined on direct examination that Petitioner's left knee complaints could be related to overcompensating for his right knee. However, on cross-examination, Dr. Nord opined it was hard to understand how Petitioner could have injured his left knee in a short of period of time of 10 weeks from just compensation. §12 Dr. Cole was asked his opinion whether Petitioner's reported left knee complaints and subjective symptoms are the result of overcompensating for his prior right knee injury. Dr. Cole opined, "There is no evidence to suggest that this is the case. There is no research to suggest that overcompensation of one knee due to another can or would cause a meniscus tear." The Commission finds the opinions of §12 Dr. Cole most persuasive. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove a causal relationship exists between the accident of January 2, 2014 and Petitioner's condition of ill-being for his left knee, the Arbitrator's finding of entitlement to prospective medical care and Respondent's liability for left knee treatment is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $1,133.50 for reasonable, necessary and related medical expenses for the treatment of Petitioner's right knee under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act.

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

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

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

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

DATED: MAY 6 - 2016
MB/maw
o04/07/16
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DOSEMAGEN, TODD
Employee/Petitioner

Case# **14WC001659**

16IWCC0307

CITY OF PEORIA
Employer/Respondent

On 9/16/2015, 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 0.26% shall accrue from the date listed above to the day before the 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:

5354 STEPHEN P KELLY LLC
2710 N KNOXVILLE AVE
PEORIA, IL 61604

0980 HASSELBERG GREBE SNODGRASS
KEVIN DAY
401 MAIN ST SUITE 1400
PEORIA, IL 61604

16IWCC0307

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Todd Dosemagen
Employee/Petitioner

v.

City of Peoria
Employer/Respondent

Case # **14** WC **1659**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **July 24, 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 **Prospective Medical**

FINDINGS

On **01/02/14**, Petitioner *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**57,200.00**; the average weekly wage was $**1,100.00**.

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

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

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

ORDER

- **Petitioner sustained a work-related accident on January 2, 2014.**
- **Petitioner's condition of ill-being is related to the accident of January 2, 2014.**
- **That the Respondent is responsible for paying the outstanding medical bills outlined in Petitioner's Exhibit #2 equaling $1,133.50 to Midwest Orthopedic Center, pursuant to the Fee Schedule..**
- **Respondent is hereby ordered to authorize, and be held responsible, for costs incurred for treatment to Petitioner's left leg recommended by Dr. Johnson.**

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

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

D. Daleo McCarthy
Signature of Arbitrator

September 9, 2015
Date

SEP 16 2015

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

1. The Petitioner has been employed for the Respondent as a firefighter for the past 12 years. The Petitioner's duties as a firefighter required him to perform normal firefighter duties. These duties include, but are not limited to, maintaining the fire trucks, fighting fires, working with ladders, and lifting weights up to 200-300 lbs throughout the day.

2. On January 2, 2014, the Petitioner was working for the Respondent in his firefighting capacity. On this date, Petitioner was responding to an emergency call. The Petitioner proceeded to get out of the fire truck and stepped on to a patch of ice. The Petitioner fell from the truck and did the splits at this time.

3. The Petitioner testified he immediately noticed pain in his right knee.

4. Petitioner testified he went to the hospital on January 2, 2014 and received medical care.

5. Petitioner testified that he was given an examination and x-rays were taken of his right knee. The Petitioner was then released by the hospital on January 2, 2014.

6. On January 2, 2014, the Petitioner was seen by Dr. Moody. Petitioner provided a history to Dr. Moody of responding to a call, slipping on ice when coming out of the truck, and had an injury to his right knee. The diagnosis at this time was an injury to the right knee. Dr. Moody ordered an MRI for the Petitioner on January 2, 2014. (Respondent's Exhibit #2).

7. On January 10, 2014, Petitioner underwent an MRI. The MRI of the right leg showed an acute meniscal tear in addition to chondromalacia in the patella. (Respondent's Exhibit #2).

8. Petitioner testified he came under the care of Dr. Brent Johnson. Petitioner first saw Dr. Johnson on January 15, 2014. Dr. Johnson saw the petitioner and diagnosed him suffering from an acute meniscal tear to the right leg in addition to chondromalacia of the patella. (Petitioner's Exhibit #1, pg. 18).

9. Dr. Johnson was of the opinion the Petitioner was in need of an arthroscopic procedure for his work-related injury to the right knee. On January 21, 2014, the Petitioner underwent a right knee arthroscopy with a partial medial meniscectomy which meant trimming away portions of the meniscus and a chondroplasty of the patella. (Petitioner's Exhibit #1, pg. 19).

10. Dr. Johnson testified in this matter that he took the Petitioner off work as of the day of surgery and had him off work completely until March 10, 2014.

11. Petitioner testified he followed up with his care to his right knee with Dr. Johnson.

Petitioner testified that, he followed up with Dr. Johnson and was doing well. His right knee was doing well. The Petitioner went to physical therapy and was having success with the physical therapy program.

12. The Petitioner testified that as of March 10, 2014, Dr. Johnson released him to full duty. The Petitioner's full duty release was to go back as a firefighter for the City of Peoria.

13. During cross-examination, the Petitioner confirmed he went through a functional capacity evaluation for the Respondent prior to returning back to work. Petitioner testified he was able to do this activity without any pain to his right knee. The test, a work capacity evaluation, was performed on March 6, 2014. It was determined that the Petitioner could return to his previous position at full duty. (RX 2)

14. On May 5, 2014, Petitioner returned to Dr. Johnson for a follow-up visit. At that time, Petitioner provided a history to Dr. Johnson of his left knee, over the past several weeks, started giving him a significant amount of pain. Petitioner also provided a history to Dr. Johnson of the Petitioner's left knee difficulty. Petitioner advised Dr. Johnson he is having problems with ambulating up and down and performing work activities for the Respondent. He also said that he was still having right knee pain at level 5 on the normal 10 point scale. The doctor noted quadriceps atrophy and physical therapy was ordered. (Petitioner's Exhibit #2).

15. Petitioner testified that when he returned to work, from March 10, 2014 to May 5, 2014, he performed regular activities as a firefighter. Petitioner testified he would favor, and overcompensate for, his right leg while performing these activities. Petitioner confirmed these activities were heavy in nature and would require him to be on his knee. Petitioner performed bending, stooping, and climbing activities. He performed additional activities such as climbing ladders and cutting holes into roofs.

16. Petitioner testified that from March 10, 2014 to May 5, 2014, while overcompensating with left leg, he noticed left knee pain developing. Petitioner testified that favoring his knee while working for the Respondent seemed to manifest the pain in his left leg. The pain in his left leg was such that he reported this to Dr. Johnson on May 5, 2014.

17. On May 5, 2014, physical examination of the left knee did show a mild positive finding on McMurray's test. The diagnosis was left knee pain and four months post right knee arthroscopy with partial medial meniscectomy.

18. On May 5, 2014, Dr Johnson's office provided injections to both the right and left knees.

19. On June 2, 2014, petitioner was seen by Dr Johnson for follow-up. At that time, petitioner was at MMI as far as the right knee. Dr Johnson testified the petitioner did have left knee internal derangement. Petitioner was to return for further care of the left knee.

20. Dr Johnson testified that although petitioner was at MMI of the right knee, there is a decrease of tendons and support as a result of the surgery performed. Dr Johnson testified that the type of surgery performed on the right knee could lead into a degenerative

condition needing further care.

21. Dr Johnson testified that as of June 2, 2014, the complaints the petitioner had in May of 2014 of the left knee could have been aggravated by the petitioner overcompensating for his right leg working as a fireman. Dr. Johnson testified this aggravation in the petitioner's left knee could necessitate medical care the petitioner was receiving at the time.

22. The petitioner was last seen on January 16, 2015. At that time, an injection was once again provided to the petitioner's left knee. Dr Johnson testified the petitioner may need an MRI for further knee care.

23. Respondent had the Petitioner examined by Dr. Nord for an AMA assessment on September 11, 2014. Dr. Nord did testify in this case. He said that the petitioner presented to his trainer with complaints of pain in the left knee at level 6. The pain was over the medial aspect, was intermittent and aggravated by stairs and walking for extended periods. (RX 1 at 57)

24. Dr. Nord testified that the treatment the Petitioner received, up to November 10, 2014, was directly related to the work injury. (Respondent's Exhibit # 1, pg. 29).

25. Dr. Nord's testimony confirmed the Petitioner could have injured his left knee by overcompensating during the recovery of his right knee. (Respondent's Exhibit #1, pg. 29, 58). He further explained that he probably would not have signs of overcompensation in early March because he had not yet returned to his regular job. (Id at 64)

26. On March 2, 2015, Petitioner was examined by Dr. Cole at the request of the Respondent. Dr. Cole testified that he did not believe that Petitioner's left knee condition was related to any type of overcompensation issue because there was no research supporting such a theory. (RX 4)

27. The Arbitrator notes the Petitioner's work activities are noted in the work capacity evaluation in Respondent's Exhibit #2. The Arbitrator notes the Petitioner's job tasks required him to lift and carry up to 100 lbs. The Petitioner's job activities required him to push and pull on an occasional basis. Petitioner was also required to stand, walk, bend, reach, and work on an elevated activity on a constant basis. The Petitioner's jobs required him to climb stairs, climb ladders, perform lifting objects over 200 lbs, elevated work with bunkers, jackets and air tank on, floor sweep with bunker, jacket, and air tank, 200 lb spine board lift with bunkers on.

28. The Arbitrator notes the Petitioner testified that from March of 2014 until May of 2014, he performed these normal activities while favoring his left leg.

29. The Arbitrator further notes the evidence shows the Petitioner's left leg symptoms began while performing this activity for the Respondent during this time frame.

30. The Arbitrator further notes that Dr. Johnson, the treating physician, opined that the left

knee complaints are related to the Petitioner's work activity for the Respondent. The Arbitrator also notes that Dr. Nord, who examined the petitioner at the respondent's request, also said the left knee complaints could be due to overcompensation. (RX 1 at 58)

31. Wherefore, the Arbitrator finds that the Petitioner's condition of ill-being of his right leg is causally related to the January 2, 2014 work accident. The Arbitrator further finds the Petitioner's subjective complaints and treatment and diagnosis of the left knee are also causally related to said accident due to overcompensation.

32. That Arbitrator relies upon Mark Cook v URS Corporation, 14 IWCC 0852, in finding that there is a causal relationship between the Petitioner's condition of ill-being and the described work accident.

33. Wherefore, the Arbitrator finds the Respondent is responsible for medical treatment the Petitioner is seeking for the left knee at the time of trial.

J. ISSUE AS IT RELATES TO MEDICAL EXPENSES

The Arbitrator finds the Respondent is responsible for the outstanding medical bills Petitioner incurred for treatment of the left knee in the amount of $1,133.50 to Midwest Orthopaedic Center, pursuant to the Fee Schedule.

O. IS THE RESPONDENT RESPONSIBLE FOR PROSPECTIVE MEDICAL EXPENSES

The Arbitrator incorporates his finding in Section F of this Decision.

Wherefore, the Respondent is responsible for prospective medical care to the Petitioner's left leg recommended by Dr. Johnson.

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

Leszek Janiszewski,
Petitioner,
vs.

Idea Furniture,
Respondent,

16IWCC0318

NO: 14WC 003013

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed Septemeber 8, 2015, 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 $20,945.00. 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: MAY 12 2016
MJB/bm
o-5/9/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JANISZEWSKI, LESZEK
Employee/Petitioner

Case# 14WC003013

IDEA FURNITURE
Employer/Respondent

16IWCC0318

On 9/8/2015, 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 0.27% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2333 WOODRUFF JOHNSON & PALERMO
DEXTER J EVANS
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

2837 LAW OFFICE JOSEPH A MARCINIAK
BRENT HALBLEIB
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Leszek Janiszewski
Employee/Petitioner

v.

Idea Furniture
Employer/Respondent

Case # 14 WC 3013

16IWCC0318

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **August 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 _____

16IWCC0318

FINDINGS

On **January 10, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**13,776.63**; the average weekly wage was $**353.25**.

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

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

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

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

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

ORDER

- Respondent shall pay reasonable and necessary medical services pursuant to the medical fee schedule in the amount of $122,544.87 directly to Petitioner as provided in Sections 8(a) and 8.2 of the Act.
- Respondent shall pay Petitioner temporary total disability benefits of $253.00/week for 7 & 5/7 weeks, commencing January 11, 2014 through March 5, 2014, as provided in Section 8(b) of the Act.
- Respondent shall pay Petitioner permanent partial disability benefits of $253.00/week for 75.25 weeks because the injuries sustained caused 35% loss of use of the right leg, as provided in Section 8(e) of the Act.

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

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

David A. Kane
Signature of Arbitrator

September 8, 2015
Date

SEP 8 - 2015

16IWCC0318

FINDINGS OF FACT

Petitioner testified that his primary language is Polish and he testified through a Polish to English translator. Petitioner was an employee for Respondent on January 10, 2014. His job primarily entailed him making furniture deliveries to residential properties. Additionally, he would sometimes assemble furniture in Respondent's showroom. His typical workday would include packaging furniture into one of Respondent's trucks and delivering the furniture to residential customers. He would then return back to Respondent's building with the truck. During his deliveries, Petitioner would take a break to get food. Petitioner testified that Respondent was aware of the lunch breaks taken during the delivery schedule and even deducted time from his paycheck to account for said breaks.

On January 10, 2014, Petitioner and another employee, Paul, left Respondent's building to make deliveries. At some point in the late afternoon/early evening, Petitioner and Paul parked the company truck in a shopping center because Paul needed to go to the Jewel store present there. Petitioner walked across Irving Park Road to get food at a restaurant. Petitioner testified that it was dark, raining, and there was snow everywhere.

After eating his food at the restaurant, Petitioner testified that he crossed Irving Park Road to get back to the work truck. While walking through the parking lot of the shopping center, he slipped and fell on a thin patch of ice on the parking lot surface. Petitioner testified that he immediately notice that his right foot was turned the opposite way and he could see blood coming from his leg. At some point, Petitioner realized

that the bone was sticking out of his leg. Petitioner testified that he was unable to walk after falling to the ground.

The Chicago Fire Department responded to the scene of Petitioner's accident. Page 58 of 1,006 of Petitioner's Exhibit No. 1 reflects that the Chicago Fire Department ambulance responded to the shopping plaza at West Irving Park Road and North Narragansett Avenue in Chicago. (PX1, Page 58 of 1,006). The history from the Chicago Fire Department indicated that it took longer than usual for the ambulance to arrive "due to ice on the roads." (PX1, Page 58 of 1,006). The report also notes that the parking lot had "all ice on pavement." (PX1, Page 58 of 1,006). The history also indicates that Petitioner reported he had fallen while walking in the parking lot landing on his right leg. (PX1, Page 58 of 1006). The report notes an obvious open fracture of Petitioner's right lower leg. (PX1, Page 58 of 1006). Petitioner was transported to Illinois Masonic Medical Center. (PX1, Page 59 of 1006).

In 3 separate notes while Petitioner was treated on January 10, 2014 at Illinois Masonic Medical Center, Petitioner reported that he slipped and fell on ice while walking in the parking lot. (PX1, Pages 73, 131, and 784 of 1,006). Additionally, medical notes from physical medicine and rehab on January 14/15, 2014 reflect that Petitioner sustained his injury after falling on ice. (PX1 – Page 112/122 of 1,006). Furthermore, another note from Dr. Julie Whittington on January 15, 2014 also indicates that Petitioner sustained the injury to his right leg as a result of a fall on ice. (PX1, Page 134 of 1,006).

On January 11, 2014 Petitioner underwent surgery on his right leg by Dr. Jan Szatkowski. Dr. Szatkowski diagnosed Petitioner with an

open right comminuted tibial shaft fracture and comminuted fibula fracture. (PX1, Page 141 of 1,006). An external fixator was initially applied. (PX1, Page 141 of 1,006). On January 13, 2014, Dr. Szatkowski performed a second operation which entailed removal of the external fixator and intramedullary nailing of the open tibia. (PX1, Page 145 of 1,006). Petitioner was transferred from Illinois Masonic Medical Center to Weiss Memorial Hospital on January 16, 2014 for in-patient rehabilitation which lasted until January 25, 2014 at which point Petitioner was discharged home. (PX1 & PX3). The patient information form from Weiss indicates that Petitioner was injured when he slipped and fell on ice. (PX3). On cross-examination, Petitioner testified that a single note from the orthopedic resident, Ivan Eck, which indicated he fell on a sidewalk and denied slipping on ice was not accurate. He testified that the doctor knew very little polish and that following his injury, his bone was sticking out and he was unable to move from where he fell in the parking lot.

Petitioner testified that he continued to follow up with Dr. Szatkowski following his discharge from the hospital. A medical history form from Illinois Bone & Joint dated February 5, 2014 indicated once again that Petitioner reported his injury as work-related. (PX4). On February 21, 2014, Petitioner was examined for follow-up by Dr. Szatkowski. At that time, it was noted that Petitioner has an infection at the surgical site. (PX4). Dr. Szatkowski sent Petitioner back to Illinois Masonic Medical Center for irrigation and debridement of the wound and treatment for the infection. Petitioner was admitted to Illinois Masonic Medical Center that same day. (PX1, Page 36 of 231). While there, it

was determined that antibiotics had significantly improved Petitioner's condition and it was determined that he did not require excisional debridement and irrigation at that time. (PX1, Page 37 of 231). He was discharged on February 23, 2014. (PX1, Page 37 of 231).

On March 8, 2014, Petitioner underwent a right lower extremity venous duplex study at Advocate Lutheran General Hospital to rule out deep vein thrombosis. (PX5). Petitioner also underwent outpatient wound care at Lutheran General Hospital from April 1, 2014 through May 13, 2014 which included compression wrapping and debridement. (PX5). It is noted that each and every progress note from the Lutheran General Wound Care Center reflects that Petitioner slipped and fell on black ice in a parking lot. (PX5). On May 13, 2014, Petitioner was discharged from the Wound Care Center and advised to use topical steroids and compression stockings to control edema as needed. (PX5).

Dr. Szatkowski had Petitioner off work from the date of his injury on January 10, 2014 through the date he last saw Petitioner on March 5, 2014. (PX7). Petitioner did not follow-up with Dr. Szatkowski after that time due to financial and insurance constraints. (PX7). Petitioner testified that he was never officially terminated by Respondent. Petitioner just began working as a driver for Elizabeth Cleaning Service one week prior to hearing in this matter.

Petitioner testified that he currently still has problems with his right leg. He has pain when he walks up and down stairs. Weather changes cause his right leg to hurt as he still has hardware in his leg up to his knee. Prior to the work accident, Petitioner testified that he would often run and ride his bicycle. Currently, he can only walk and ride a bike for a

16IWCC0318

short period of time because of pain and fatigue. He also testified that his leg swells up after a long day at work while doing his current job.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to "C", whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator makes the following conclusions:

The Arbitrator finds that Petitioner suffered a work-related injury to his right leg on January 10, 2014 that arose out of and in the course of Petitioner's employment with Respondent. A traveling employee is one who is required to work away from the employer's premises. To establish that a traveling employee's injury arose out of and in the course of his employment, he must establish that his conduct "might normally be anticipated or foreseen by the employer." *Wright v. Industrial Comm'n*, 62 Ill.2d 65, 70 (1975). "Stated another way, a traveling employee may be compensated for an injury as long as the injury was sustained while he was engaged in an activity which was both 'reasonable and foreseeable.'" *Id.* at 70-71.

The Arbitrator finds that Petitioner was a traveling employee as it is unrebutted that Petitioner was a delivery driver who was required to work away from Respondent's premises and that Respondent knew Petitioner would take food breaks along his delivery route. This is further supported by the fact that Petitioner testified that time for meal breaks was taken out of his paycheck by Respondent to account for such food

breaks. Accordingly, the Arbitrator finds that Petitioner's conduct at the time of his injury, walking across a parking lot back from his meal break during his delivery route, was both reasonable and foreseeable.

Petitioner testified and the medical records reflect that Petitioner slipped and fell on black ice in the parking lot of a shopping plaza across the street from where he got food on the date of the incident. The overwhelming medical record evidence indicates Petitioner suffered his open right tibia/fibula fracture when he slipped and fell on black ice in the parking lot of the plaza. The Arbitrator notes that when the Chicago Fire Department ambulance came to the accident scene, they found Petitioner on the ground of the parking lot and with an obvious open fracture of his right leg. Additionally, the ambulance record indicates that the entire parking lot was full of ice and that the ambulance itself was delayed due to ice on the roadways.

The Arbitrator notes that there is a single note authored by an orthopedic resident, Ivan Eck, on January 10, 2014, which indicates that Petitioner "was walking down sidewalk when his leg gave way and broke. Denies tripping, slipping on ice, or stepping off curb." (PX1, Page 147 of 1006). The Arbitrator finds this note unpersuasive as to the cause of Petitioner's injury. Every other medical history from every single provider that treated Petitioner consistently stated that Petitioner sustained his injury when he slipped and fell on black ice in the parking lot. Additionally, the ambulance found Petitioner on the ground in the parking lot and ambulance personnel noted that the entire parking lot was full of ice. Petitioner testified that he could not walk after his injury and the Arbitrator notes that, due to the nature of Petitioner's injury (i.e.

open tibia fracture), it would be unlikely he could have walked from another area to the parking lot after the injury. Due to the fact that Petitioner's primary language is Polish and this note was authored at 11:16 p.m., several hours after Petitioner had been admitted and administered pain medications, it is more likely than not that the history was as a result of a language barrier. The overwhelming evidence present in all of the other medical records/histories suggests that Petitioner suffered his injury as a result of a slip and fall on ice in the subject parking lot.

The Arbitrator finds from the testimony of Petitioner and all of Petitioner's medical records that Petitioner suffered an injury to his right leg on January 10, 2014 as a result of an accident that arose out of and in the course of his employment with Respondent.

In support of the Arbitrator's decision relating to "F", whether Petitioner's current condition of ill-being was causally related to the injury, the Arbitrator makes the following conclusions:

Petitioner was found by ambulance personnel in the shopping plaza parking lot with an obvious open right tibia/fibula fracture. (PX1). Petitioner provided unrebutted testimony that he slipped and fell on ice in the parking lot and sustained the open fracture of his right leg at that time. Petitioner also testified that, because of his injury, he was unable to walk or move from the area where he slipped and fell. He was taken directly from the parking lot via ambulance to Illinois Masonic Medical Center. (PX1). At the hospital, Dr. Szatkowski diagnosed Petitioner with an open right comminuted tibial shaft fracture and comminuted fibula

fracture. (PX1). The Arbitrator also notes that, at hearing, Respondent stipulated to the fact that Petitioner suffered a right tibia/fibula fracture.

Having already found in Petitioner's favor on accident and noting that Respondent's only dispute is to accident in this matter, the Arbitrator finds that Petitioner's current condition of ill-being in his right leg was causally related to his slip and fall on ice in the parking lot on January 10, 2014.

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

Petitioner's Exhibit No. 6 reflects medical charges in the amount of $238,953.72 which were necessitated as a result of the January 10, 2014 work accident. Having already found for Petitioner on the issue of accident and causation and noting Respondent's only argument was to accident, the Arbitrator finds that all medical services provided to Petitioner were reasonable and necessary and further orders Respondent to pay directly to Petitioner the fee schedule amount of those bills which is $122,544.87. (PX6i). It is further noted that Respondent stipulated to the fee schedule amount of $122,544.87 and that it had not paid any of the bills.

In support of the Arbitrator's decision relating to "K", what amount of compensation is due to Petitioner for Temporary Total Disability, the Arbitrator makes the following conclusions:

Petitioner is claiming temporary total disability benefits from the date of accident on January 10, 2014 through his final appointment with Dr. Szatkowski on March 5, 2015 which equates to 7 & 5/7 weeks. Dr. Szatkowski opined that Petitioner would have been off work for at least that period of time. (PX7). The Arbitrator also notes that Respondent's only argument was to accident and that it did not dispute the time period for TTD.

Having already found for Petitioner on the issue of accident and causation and noting Respondent's only argument was to accident, the Arbitrator orders Respondent to pay Temporary Total Disability benefits to Petitioner in the amount of $253.00 (the minimum TTD rate for a petitioner with 1 dependent) for 7 & 5/7 weeks for a total of $1,951.71.

In support of the Arbitrator's decision relating to "L", the nature and extent of the injury, the Arbitrator makes the following conclusions:

Petitioner's accident date falls after September 1, 2011 and therefore, Section 8.1b of the Act shall be discussed concerning the permanent partial disability (PPD) award being issued. It is noted when discussing the permanency award being issued that no impairment report pursuant to Section 8.1b(a) and 8.1b(b)(i) of the Act was offered into evidence by either party. This factor is thereby waived and the Arbitrator gives no weight to this factor.

Concerning Section 8.1b(b)(ii) of the Act (Petitioner's occupation), Petitioner was a delivery driver and assembled furniture for Respondent. Petitioner returned to work 1 week prior to hearing for a different

company as a driver for a cleaning service. The Arbitrator notes that Petitioner's permanent partial disability, given his job duties, will be larger than an individual who performs sedentary work. The Arbitrator gives significant weight to this factor in determining the PPD award.

Concerning Section 8.1b(b)(iii) of the Act (Petitioner's age at the time of the injury), it is noted that Petitioner was 59 years old on January 10, 2014. The Arbitrator notes that Petitioner is a middle-aged individual with several working years ahead of him. Additionally, based on Petitioner's advanced age and continuing complaints, the Arbitrator notes that it will be more difficult for Petitioner to completely recover from his injury. The Arbitrator gives some weight to this factor in determining the PPD award.

Concerning Section 8.1b(b)(iv) of the Act (Petitioner's future earning capacity), Petitioner testified that he is making similar income to what he was making at the time of the work accident. The Arbitrator gives some weight to this factor in determining the PPD award.

Concerning Section 8.1b(b)(v) of the Act (evidence of disability corroborated by Petitioner's treating medical records), the Arbitrator finds that Petitioner's current symptoms and problems are corroborated by the medical records. Petitioner suffered an open right comminuted tibial shaft fracture and comminuted fibula fracture. He underwent 2 surgical procedures which included the placement of hardware in Petitioner's right leg which he continues to live with. Petitioner spent approximately 1 week in the hospital following surgery and was transferred to an in-patient rehabilitation center for therapy. He also suffered a post-operative infection and underwent several weeks of wound care

following surgery. Petitioner testified that he continues to have pain and problems with his right leg. He has trouble walking up and down stairs. His right leg fatigues easily and swells up after working a full day. His right leg causes him problems when walking and riding his bicycle. The Arbitrator gives great weight to this factor in determining the PPD award.

Applying Section 8.1b of the Act, the Arbitrator finds Petitioner sustained a 35% loss of use of his right leg. Respondent, therefore, shall pay Petitioner permanent partial disability benefits of $253.00/week for 75.25 weeks because the injury sustained caused a 35% loss of use of the right leg, as provided in Section 8(e) of the Act.

CONCLUSION

1. Petitioner sustained an accidental injury that arose out of and in the course of his employment on January 10, 2014.
2. A causal connection exists between Petitioner's present condition of ill-being and the January 10, 2014 work accident.
3. Respondent shall pay directly to Petitioner the fee schedule amount of his medical bills which is equivalent to $122,544.87.
4. Respondent shall pay Petitioner TTD benefits from January 11, 2014 through March 5, 2014 which equates to 7 & 5/7 weeks and a total amount of TTD equal to $1,951.71.
5. Respondent shall pay Petitioner a PPD award of 35% loss of use of his right leg which equates to payment of $253.00/week for 75.25 weeks.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BELINDA STEEVENSZ,

Petitioner,

16IWCC0351

vs. NO: 14 WC 6987

ILLINOIS DEPARTMENT OF
HUMAN SERVICES,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the petitioner herein and notice given to all parties, the Commission, after considering the issues of prospective medical treatment, and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all of the testimony, exhibits, pleadings and arguments submitted by the parties. Based upon its review of the evidence, the Commission finds that Belinda Steevensz has not exceeded her choice of two physicians as provided in Section 8(a) of the Act. Thus, petitioner is entitled to continued care with Dr. Bruce Montella. All else is affirmed and adopted.

Ms. Steevensz sustained an undisputed work-related accident on February 12, 2014. On that date, petitioner was transferring a patient to her wheelchair when the patient's knee gave out causing her to start to fall. Petitioner caught the patient and had to twist to get the patient into her wheelchair. Petitioner felt pain in her back immediately. T.12.

Petitioner presented to Alexian Brothers emergency room on February 12, 2014 complaining of pain in her left back radiating into both legs. Examination revealed left paravertebral sacral tenderness on movement and palpation. She had limited range of motion due to pain. There was no vertebral tenderness. She was prescribed Norco and advised to follow-up with Dr. Demetrios Petrovas. The assessment was a low back strain. PX.1.

Petitioner testified that TriStar did not approve follow-up treatment with Dr. Petrovas.

Ms. Steevensz continued to work despite her pain. Then, on February 28, 2014, Steevensz presented to Northwest Community Hospital due to continued low back pain. She reported a sharp pain radiating into both legs. She denied numbness or tingling. Norco provided minimal relief only. The doctor was unable to assess petitioner's range of motion secondary to pain. The sitting straight leg raise revealed pain in the left low back. She was prescribed Flexeril and Norco and advised to follow-up with Barrington Orthopedics. She was given restrictions of no lifting greater than 10 pounds, no bending, no twisting or stooping, and to walk and stand as tolerated. The impression was a lumbar strain. PX.2.

Petitioner testified that she was not aware that both ER visits were paid for by the Respondent. T.59.

Petitioner did not follow-up with Barrington Orthopedics and instead presented to Dr. Bruce Montella of Midwest Sports Medicine & Orthopaedic Surgical Specialists on March 12, 2014. It was noted that petitioner heard about Dr. Montella through a friend. Examination revealed mild tenderness and mild lumbar spasms in the lower lumbar spine. She had diminished range of motion in flexion and extension with pain. She had painful lateral flexion. She had a positive straight leg raise, positive contralateral straight leg raise, and a downgoing Babinski. She had no Waddell signs. The impression was a work-related lumbar disc herniation. Dr. Montella noted petitioner's condition was work-related and that she may require surgery. An MRI was recommended. Dr. Montella prescribed a course of physical therapy 2 -3 times a week for 4 to 6 weeks. He prescribed anti-inflammatory medication. PX.3.

Steevensz presented to Dr. Montella on May 22, 2015 with constant, worsening low back pain that radiated into her legs. She had increased pain with standing, walking, sitting, bending and twisting. She had been attending physical therapy 2-3 times a week; however, the last few sessions had been very difficult and her symptoms had gotten worse. Examination revealed intermittent paraspinal spasms, and limited range of motion of lumbar flexion and extension. She had decreased motor function. The impression was lumbar disc herniation. Dr. Montella prescribed physical therapy two to three times per week for four to six weeks. PX.3.

Ms. Steevensz testified that she has not seen Dr. Montella since May 22, 2015 as continued treatment has been denied. She would like to resume treatment with Dr. Montella and obtain a second opinion from Dr. Spencer of Lutheran General. T.50.

Petitioner testified that she has to pay for her Norco and Tramadol prescriptions. T.35. Because of her injury, she can only perform basic dusting and has trouble vacuuming and washing the floors. T.44. She takes 3 to 4 10 mg Norco pills per day due to her extreme back pain. *id.* She is depressed all the time and just sits in her house. T.47. She cannot drive far and does not stand for long periods of time. Petitioner testified that she pulled a back muscle 5 years ago. She was prescribed Flexeril and did not miss any work due to that incident.

Pursuant to Section 8(a) of the Act, the employer's liability to pay for such medical services selected by the employee shall be limited to:

> (1) all first aid and emergency treatment; plus
>
> (2) all medical, surgical and hospital services provided by the physician, surgeon or hospital initially chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said initial service provider or any subsequent provider of medical services in the chain of referrals from said initial service provider; plus
>
> (3) all medical, surgical and hospital services provided by any second physician, surgeon or hospital subsequently chosen by the employee or by any other physician, consultant, expert, institution or other provider of services recommended by said second service provider or any subsequent provider of medical services in the chain of referrals from said second service provider. Thereafter the employer shall select and pay for all necessary medical, surgical and hospital treatment and the employee may not select a provider of medical services at the employer's expense unless the employer agrees to such selection. At any time the employee may obtain any medical treatment he desires at his own expense.

The Respondent argued that the treatment at Alexian Brothers constituted emergency care under Section 8(a). Petitioner's treatment at Northwest Community constituted her first choice of physicians and her treatment with Dr. Montella constituted her second choice of physicians.

The Commission finds that petitioner's treatment at Alexian Brothers and Northwest Community constituted emergency care only. Petitioner presented to Northwest Community due to continued pain as her treatment had been denied by the respondent. Thus, the treatment at Alexian Brothers and Northwest Community constituted emergency care only and are not counted as a choice of physicians under Section 8(a).

Accordingly, petitioner's first choice of physicians is Dr. Montella. Dr. Montella has recommended continued physical therapy and treatment. The Commission therefore orders the respondent to authorize and pay for continued care as recommended by Dr. Montella.

The petitioner has asked the Commission to allow her to obtain a second opinion from Dr. Spencer. The Commission notes that the record is void of any referral to Dr. Spencer. However, petitioner is entitled to medical treatment from a second physician of her choice as she has not exhausted her choice of two physicians under Section 8(a).

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed August 20, 2015, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $447.35 per week for a period of 40 weeks, May 8, 2014 through August 15, 2014 and December 10, 2014 through June 7, 2015, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $55,261.40 for medical expenses under §8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for prospective medical treatment as recommended by Dr. Bruce Montella.

IT IS FURTHER ORDERED BY THE COMMISSION that respondent shall be given credit for any amount paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

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.

DATED: MAY 2 5 2016

MJB/tdm
O: 4-11-16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

16IWCC0351

STEEVENSZ, BELINDA
Employee/Petitioner

Case# 14WC006987

IL DEPT OF HUMAN SERVICES
Employer/Respondent

On 8/20/2015, 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 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

4036 MILLON & PESKIN LTD
MITCHELL PESKIN
2100 MANCHESTER RD SUITE 1060
WHEATON, IL 60187

5273 ASSISTANT ATTORNEY GENERAL
MEGAN MURPHY
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUUREAU OF RISK MGMT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

AUG 20 2015

DONALD D. BARBIA, Acting Secretary
Illinois Workers' Compensation Commission

☐	Injured Workers' Benefit Fund (§4(d))
☐	Rate Adjustment Fund (§8(g)
☐	Second Injury Fund (§8(e)18)
☒	None of the above

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19B ARBITRATION DECISION

16IWCC0351

BELINDA STEEVENSZ
Employee/Petitioner

Case #14 WC 6987

v.

ILLINOIS DEPARTMENT OF HUMAN SERVICES
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on July 22, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☒ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☒ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☐ What is the nature and extent of injury?

M. ☒ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☒ Prospective medical care?

FINDINGS

- On February 12, 2014, the respondent was operating under and subject to the provisions of the Act.

- On this date, an employee-employer relationship existed between the petitioner and respondent.

- Timely notice of this accident was given to the respondent.

- In the year preceding the injury, the petitioner earned $34,893.32; the average weekly wage was $671.03.

- At the time of injury, the petitioner was 54 years of age, single with no children under 18.

- The parties agreed that the respondent paid $16,680.87 in temporary total disability benefits and $10,701.91 in medical costs.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $447.35/week for 40 weeks, from May 8, 2014, through August 15, 2014, and from December 10, 2014, through June 7, 2015, which are the periods of temporary total disability for which compensation is payable. The respondent paid $16,680.87 in temporary total disability benefits and is given an offset for that amount.

- The medical care rendered the petitioner for her lumbar spine was reasonable and necessary and is awarded. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- The petitioner's request for penalties and fees is denied.

- The petitioner's request for prospective medical care is denied.
- The petitioner's request for more than two choices of medical providers, including Dr. Spencer, is denied.
- 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.

Robert E. Williams

Signature of Arbitrator

August 18, 2015
Date

AUG 20 2015

FINDINGS OF FACTS:

The petitioner, a personal assistant, sought medical care at Alexian Brothers on February 12, 2014, and reported back pain radiating to her legs after trying to lift and prevent a patient from falling to the floor. The diagnosis was lumbosacral strain for which she was given medication and light-duty restrictions. On February 28th, the petitioner sought care for back pain at Northwest Community Occupational Health Services and reported working. She complained of 7-8/10 pain radiating into both legs without numbness or tingling. X-ray showed degenerative disc disease, facet degenerative changes and minimal anterolisthesis at L5-S1, and facet degenerative changes at L4-L5. Their diagnosis was lumbar strain for which compresses, medication and work restrictions were prescribed.

On March 12, 2014, the petitioner saw Dr. Montella at Midwest Sports Medicine and Orthopaedic Surgical Specialists for complaints of pain in her left buttocks, thigh, and low back with symptoms greatest on her left. The doctor noted positive straight and contralateral leg raise tests. His diagnosis was a lumbar disc herniation. He prescribed physical therapy and medication. An MRI on May 2nd revealed a 3-4 mm broad based posterior disc herniation indenting the thecal sac with spinal stenosis and bilateral neuroforaminal narrowing exacerbated by ligamentum flavum hypertrophy at L4-L5 and a 4-6 mm posterior disc herniation with generalized spinal stenosis and bilateral neuroforaminal narrowing exacerbated by facet arthrosis and ligamentum flavum hypertrophy at L5-S1 with possible pars interarticularis defects. On May 5th, Dr. Montella's diagnosis was L4-5 and L5-S1 lumbar disc herniations. He noted an antalgic gait pattern. He continued the petitioner's medications and physical therapy and advised

her not to work. On May 16th, Dr. Montella noted negative straight and cross leg raise tests. He recommended three lumbar epidural steroid injections. He reiterated his recommendations on June 16th. The petitioner had left and right S1 transforaminal epidural steroid injections on June 23rd, which provided only three days of pain relief. On August 12th, the petitioner reported worsening left-sided back pain after left and right L5-S1 transforaminal epidural steroid injections on July 21st. The petitioner had a left L5-S1 transforaminal epidural steroid injection on August 18th The petitioner had twelve physical therapy visits at Athletico between July 12th and August 15th. On December 10th, Dr. Montella started physical therapy again and continued her medications and off-work status.

On February 9, 2015, and March 11th, the petitioner reported significant improvement in her back pain with physical therapy. Pursuant to Dr. Montella's recommendation on January 7, 2015, Dr. Friedman at Midwest Sports Medicine and Orthopaedic Surgical Specialists evaluated the petitioner on March 5th, assessed flexible cavus feet and prescribed orthotics. The petitioner reported worsening symptoms on April 8th. At her last visit with Dr. Montella on May 22nd, the petitioner reported continued low back pain with radiation to her legs, aggravated with standing, walking, sitting, bending and twisting. The straight leg raise test was negative. The doctor continued the physical therapy and medication and recommended no work for a month. The petitioner attended therapy sessions at Athletico through June 2, 2015.

The petitioner sustained prior injuries to her lumbar spine. On April 6, 2004, she received medical care at Alexian Brothers for a pulled back muscle after lifting a patient. On May 2, 2005, she sought care at Alexian Brothers for left lower back pain radiating to

her left leg caused while moving a patient. She returned on May 28, 2005, for sudden back pain. On September 8, 2005, she received care at Alexian Brothers for severe back pain after tripping and twisting her back. She was diagnosed with sciatica at Alexian Brothers on September 14, 2006, after a ceiling fell on her causing her to twist her back.

FINDING REGARDING WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF THE EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner proved that she sustained an accident on February 12, 2014, arising out of and in the course of her employment with the respondent.

The petitioner sought medical care for back pain at Alexian Brothers the same day and reported trying to lift and prevent a patient from falling to the floor. The patient's husband testified that he heard the petitioner scream, ran to the bathroom and helped her into a chair.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for her lumbar spine was reasonable and necessary and is awarded.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that her current condition of ill-being with her lumbar spine is causally related to the work injury.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The petitioner was off work pursuant to her doctor's recommendation from May 8, 2014, through August 15, 2014, and from December 10, 2014, through June 7, 2015. The respondent shall pay the petitioner temporary total disability benefits of $447.35/week for 40 weeks, from May 8, 2014, through August 15, 2014, and from December 10, 2014, through June 7, 2015, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner. The respondent paid $16,680.87 in temporary total disability benefits and is given an offset for that amount.

FINDING REGARDING PENALTIES AND FEES:

The petitioner failed to prove that she is entitled to §19(l) and §19(k) penalties and fees. The evidence was insufficient to establish that the respondent's conduct was vexatious or unreasonable. The respondent paid temporary total disability benefits and medical bills were not sent to the respondent is accordance with the medical fee schedule and the Act. The petitioner's request for penalties and fees is denied.

FINDING REGARDING PROSPECTIVE MEDICAL CARE:

The petitioner failed to establish that there is a recommendation for medical care by a provider; therefore, her request for prospective medical care is denied. Moreover, it is noted that the petitioner first sought care at Alexian Brothers. Her next choice was at North Community Health Services and then she chose to treat at Midwest Sports. The petitioner's request for more than two choices of medical providers, including Dr. Spencer, is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Peter Grant,
Petitioner,
vs. NO: 14WC007043

IL Dept. of Transportation,
Respondent,

16IWCC0319

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 30, 2015, 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.

MAY 12 2016

DATED:
MJB/bm
o-5/10/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRANT, PETER
Employee/Petitioner

Case# **14WC007043**

IL DEPT OF TRANSPORTATION
Employer/Respondent

16IWCC0319

On 10/30/2015, 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 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0013 DUDLEY & LAKE LLC
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LIBERTYVILLE, IL 60048

0000 ASSISTANT ATTORNEY GENERAL
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1430 CENTAL MANGEMENT SERVICES
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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

OCT 30 2015

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Peter Grant
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # 14 WC 07043

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Waukegan**, on **September 24, 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 **February 20, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did not* sustain an accident that arose out of and in the course of employment.

Petitioner's current condition of ill-being *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned $**26,977.55**; the average weekly wage was $**1,348.87**.

On the date of accident, Petitioner was **61** years of age, *single* with **0** dependent children.

Petitioner *has* received all reasonable and necessary medical services.

Respondent *has* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**0.00**.

Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act.

ORDER

BECAUSE PETITIONER HAS FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH RESPONDENT AND FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HIS CONDITION OF ILL BEING IS CAUSALLY CONNECTED TO HIS EMPLOYMENT WITH RESPONDENT, THE CLAIM FOR COMPENSATION IS DENIED.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

October 29, 2015
Date

OCT 30 2015

16IWCC0319

Statement of Facts

Petitioner Peter Grant testified that he was employed by Respondent Illinois Department of Transportation as a seasonal snowplow operator. In February, 2012, he had been so employed for six years. He testified that he would work from late fall though March or April of the following spring. He testified that his job duties included maintenance on vehicles, garbage pickup, highway maintenance including pot hole patching when it was not snowing. When there was snow, he would have a route to drive his 10 wheel dump truck with a salt body and a plow.

Petitioner testified that to enter the truck he needed to climb a 20 to 22 inch step, a 15 inch step and then step into the cab, about another 12 inches. Petitioner testified he is 5 foot 7 inches tall. He would start with his left foot on the first step, hold the railing with his right hand and climb with his right foot onto the second step, he would then enter the cab with his right foot first. He testified that this required he flex his knees. It was different from normal steps which he would climb in his daily activities. During snow plowing he would get in and out of the cab four to six times per shift. When he was doing rolling road work to fill pot holes he could get in and out up to 40 to 50 or even 100 times per shift depending on the road.

Petitioner also testified that during snow season he would need to climb into the back of the truck because the salt would freeze with ice. To do this task, he needed to jump up to the first step about three feet off the ground and then climb the ladder. He would then climb down into the hopper which was angled to funnel the salt to the conveyer. He would need to do this about once per shift. He testified he also would climb onto the back of the truck to check if the salt was empty three to four times per night.

Petitioner testified that the winter of 2013/2014 was a busy year. In December, 2013, he developed pain in his left knee. Petitioner testified he had no persistent knee symptoms before December, 2013. Petitioner testified that the pain became progressively worse and he sought medical treatment from Dr. Chams on February 20, 2014. He chose Dr. Chams from a commercial for Illinois Bone & Joint.

Petitioner testified that he called Colin McIntyre, a lead worker, on February 20, 2014 to tell him he was seeing the doctor. He testified that he later prepared a written report to Joe Wolfe that afternoon.

In 2014, Dr. Elizabeth Sofer was Petitioner's family doctor. Her records of Orchard Medical Center were admitted as Respondent's Exhibit 2. The records reflect Petitioner was treated for lumbar disc disease on May 18, 2011. The 2012 and 2013 records state that Petitioner did not have insurance. Petitioner saw Dr. Sofer on February 12, 2014 for a current problem of joint pain in the left knee. He advised he now has insurance and is ready to see orthopedics for evaluation. Petitioner complained of pain, stiffness, decreased range of motion, locking and difficulty bearing weight. He reported onset 8 months ago. The symptoms are intermittent and worsening. Petitioner was started on Norco and referred to Dr. Bruce Summerville. The impression was that Petitioner may need replacement. On February 19, 2014, the note indicates referral to Dr. Summerville and Dr. Chams.

The records of Illinois Bone & Joint Institute were admitted as Petitioner's Exhibit 1. Petitioner was first seen on February 20, 2014 by Dr. Chams for an initial evaluation for his left knee pain which he states began after a work injury. Petitioner stated the left knee pain had several months of onset since December and has been progressively worsening. He notes he is currently taking Norco. X-rays were read as showing minimal arthritic changes. The impression was patellofemoral chondromalacia. Petitioner received an injection and was

scheduled for physical therapy (PX 1, p 15-17). Petitioner received a Work Status Report taking him off work with a diagnosis of left knee patellofemoral degenerative joint disease (PX 1, p 37). Petitioner testified that the prescribed physical therapy afforded no lasting relief. Petitioner underwent an MRI on March 14, 2014. The MRI impression was a complex, unstable tear of the medial meniscus, tricompartmental osteoarthritis and small joint effusion. On March 17, 2014, Dr. Chams notes that the cortisone shot provided minimal relief. The MRI demonstrated a significant meniscal tear. Dr. Chams recommended surgery and stated that he would petition Workman's Compensation for approval of the arthroscopy and post operative care.

Petitioner was examined at Respondent's request by Dr. Michael Bryan Neal on June 11, 2014. His June 25, 2014 report was admitted as Respondent's Exhibit 1. Dr. Neal reviewed and Employer's First Report which lists the date and time of accident at 9:45 a.m. on February 20, 2014. The accident is described as the repetitive motion of climbing in and out of the work truck. There was no fall or specific incident of trauma. Dr. Neal diagnosed left knee osteoarthritis with a degenerative medial meniscus tear. He opined that the condition is not related to any accident on February 20, 2014, or to any repetitive event. He opined that the Petitioner's underlying arthritis and meniscus condition is symptomatic with activities such as sitting, ambulating and weight bearing regardless of whether these are done at work, or elsewhere. He opined that the condition is not caused, aggravated or accelerated by his work activities.

Dr. Chams performed arthroscopic surgery on August 6, 2014. The post operative diagnosis was left knee medial and lateral meniscus tear, as well as grade 3 chondromalacia of the medial compartment (PX 1, p 22-23). Petitioner had post operative rehabilitation. He was released to restricted work on September 2, 2014. Petitioner testified that no light duty was offered by Respondent. Post operatively, Petitioner had additional physical therapy at Colletti Physical Therapy. He was released for light duty on September 2, 2014 and to regular work duties as of October 7, 2014 (PX 1, p 32-33). At that time, Petitioner reported feeling 95% of normal.

Dr. Chams testified by evidence deposition taken on March 25, 2015 (PX 5). He testified that he received a history that Petitioner was a truck driver and that he started having pain in his left knee which he thought was work related. The initial diagnosis of chondromalacia is a degenerative type of condition. The MRI noted a complex unstable tear of the meniscus and some arthritic changes, mostly by his kneecap. The findings of arthritic changes were chronic. The meniscus tears looked acute. Dr. Chams opined that the work activities of being a truck driver, climbing in and out of a truck could have contributed in part to the problems. The need for surgery was due to the injury sustained at work. Climbing up and jumping down from a high step over the course of a couple of months is a competent cause of aggravating a previously arthritic knee.

Dr. Chams testified that Petitioner did not state there was a specific event that caused his injury. He did not issue a written opinion linking the knee problem to the injury. He did not see the official work duties list from IDOT or the actual truck that Petitioner works on.

Petitioner testified he left the light duty paperwork from Dr. Chams in the office at Respondent's Grayslake location. He was released to full duty on October 7, 2014. He was not taken back to work for Respondent.

Petitioner testified that his symptoms improved with surgery. He testified his knee is not 100%. In the morning he will notice pain going down stairs. If he stands for long periods he will have pain that evening. He is able to do his normal daily activities including playing golf. He has not had any further treatment for his knee since October 7, 2014. He currently takes Aleve two to three times per week if he as symptoms. He lives in a two

story home. Petitioner testified that when he was not working for Respondent, he would do part time jobs or collect unemployment. He does not recall if he had any part time work during the summer of 2013. He testified that he is currently hiking cars and receiving a small pension from a previous employer.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident and (F) Causal Connection, the Arbitrator finds as follows:

Petitioner is seeking compensation for the condition of ill being of his left knee based upon a theory of repetitive trauma as a result of his employment by Respondent as a truck driver. An employee who suffers a gradual injury due to repetitive trauma is eligible for benefits under Workers Compensation Act, but he must meet the same standard of proof as a petitioner alleging a single, definable accident. Even under a repetitive trauma concept, the claimant must establish that the injury was related to his employment. An employee who alleges injury based on repetitive trauma must show that the injury is work related and not the result of a normal degenerative aging process. A claimant bears the burden of showing that a preexisting condition was aggravated by his employment and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment.

Repetitive trauma claims generally rely upon medical testimony to establish the causal connection between the work performed and the claimant's disability. In cases where the repetitive trauma is alleged to aggravate a preexisting condition, medical opinion testimony is particularly crucial to the question of causation since the ultimate question is whether the claimant's work activities have adversely affected an already deteriorated physical condition. Thus, repetitive trauma claims involving the alleged aggravation of a preexisting condition, like the claim asserted here, cannot succeed unless the claimant presents medical evidence suggesting that (1) the claimant had a preexisting condition that was or could have been aggravated by his repetitive work activities, and (2) his current condition of ill-being was or could have been caused by this work-related trauma and is not simply the result of a normal, degenerative aging process.

The Arbitrator must weigh the medical opinions in this matter. Petitioner presented the testimony of Dr. Chams that the work activities of being a truck driver, climbing in and out of a truck could have contributed in part to the problems. The need for surgery was due to the injury sustained at work. Respondent presented the opinion of Dr. Neal that the condition is not related to any accident on February 20, 2014, or to any repetitive event. He opined that the Petitioner's underlying arthritis and meniscus condition is symptomatic with activities such as sitting, ambulating and weight bearing regardless of whether these are done at work, or elsewhere. The condition is not caused, aggravated or accelerated by his work activities.

The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts.

In evaluating Dr. Chams' opinion, the Arbitrator notes that Petitioner sought treatment the same date that he signed the Application for Adjustment of Claim. The initial February 20, 2014 medical note does not give any explanation of the work activities other than Petitioner has left knee pain "which he states began after a work

injury." Dr. Chams opinion at deposition is that the surgery was "due to the injury sustained at work." But Petitioner is very clear that he did not sustain a specific injury, but rather that the pain got gradually worse. Dr, Chams did not have any job description or details as to the nature of the work that was purportedly the cause of the condition. The testimony provided did not provide detail as to the nature of the activity, the frequency or the duration of the activities performed.

Dr. Chams' opinion was based upon the statements that the condition began in December, 2013. Petitioner's testimony that the pain began in December, 2013 is also contradicted by the history he gave to Dr. Sofer on February 12, 2014 where he reported onset 8 months ago, which would have been months before he returned to work for Respondent. He also advised he now has insurance and is ready to see orthopedics for evaluation, supporting that the condition has been long standing.

An expert's opinion is only as valid as the bases and reasons for the opinion. Where the factual support is lacking the conclusions alone do not create a question of fact. Dr. Neal provided an opinion that Petitioner's condition was not related to the work activities but rather to the progression of the underlying degenerative condition. After reviewing the evidence, the Arbitrator finds the opinions of Dr. Neal more persuasive.

Based upon the record as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment with Respondent, and further, that Petitioner failed to prove by a preponderance of the evidence that his condition of ill being in the left knee was causally connected to his employment with Respondent.

In support of the Arbitrator's decision with respect to (E) Notice, (J) Medical, (K) Temporary Compensation, and (L) Nature and Extent, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the issues of Notice, Medical, Temporary Compensation, and Nature and Extent are moot.

The Petitioner's claim for compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Accident/Causation	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Catherine Palese,

Petitioner,

vs.

No. 14 WC 08452

16IWCC0311

Touhy Animal Hospital,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under §19(b) having been filed by the parties herein and proper notice given, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care, penalties, attorney fees and "[f]rivolous [a]ppeal," and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons stated below.

On March 12, 2014, Petitioner filed an application for adjustment of claim alleging that on January 27, 2014, she sustained unspecified injuries to the person as a whole that arose out of and in the course of her employment. Petitioner, who was 54 years old at the time of the incident, testified on direct examination that she worked for Respondent as a veterinary technician for almost 10 years. Petitioner described the incident as follows: "I was walking the dog that was there. *** [A]nd as I was putting the dog back into the cage something bizarre happened, it was like I had a lightning bolt. I was squatting, I picked the dog up, went to put it in the cage, had to twist to get it into the cage. The dog did not want to go into the cage and was difficult, and as I was stretching and twisting, I had like an electrical shock go down my neck to my arms and my leg." Petitioner estimated the dog weighed 13 to 15 pounds. The dog's cage was approximately a foot above the floor. Petitioner elaborated that she was squatting, "leaning probably towards [her] left side," with her hands extended and her torso "a little bit twisted

because the dog started like squirming to get out." Petitioner indicated she felt the pain when she was "halfway in the cage with the dog." Petitioner denied prior pain in her neck or arms, or numbness in the arms. She also denied previously treating for a stroke, heart condition or diabetes.

Petitioner further testified the accident was witnessed by Anna, Respondent's receptionist, and Iwonna, Respondent's manager, who were making coffee or tea in an area approximately 20 feet from the cage. Petitioner continued that she made "some kind of noise and *** realized they were standing right there." Anna and Iwonna seemed a little startled and asked Petitioner if she was okay. When Petitioner stood up, Iwonna stated that Petitioner did not look good and again asked if she was okay. Iwonna then told Anna to call an ambulance.

Petitioner further testified that she complained to the paramedics of feeling like she had been struck by lighting and of heaviness in her arms. The ambulance took her to Lutheran General Hospital. Petitioner was hospitalized for almost a week. Petitioner denied that she suffered a stroke and/or a heart attack on January 27, 2014.

The medical records from Lutheran General Hospital contain an ambulance report, which notes an onset of left arm numbness and weakness at 10:45 a.m. The paramedics noted the following history and complaints: "Called for fainting pt. Arrived to find pt CAOX3 sitting in chair. Pt states while lifting a medium sized dog into cage at shoulder height, she felt a strange twinge at base of neck on the left side at shoulder. Took her breath away and she felt lightheaded. After sitting left arm below deltoid became numb with some tingling. Pt denies any other symptoms. No facial droop, no slurring, pupils PERL, grasp equal but pt unable to lift left arm fully." Petitioner was transported to Lutheran General Hospital.

The emergency room staff noted the following history and complaints: "This right handed 54-year-old female does not have a relationship with a physician nor seeks regular medical care. She was in her usual state of health this morning lifting a dog at her work in a Veterinary Clinic when she had a severe electrical like pain from her neck down her left arm leaving her with left upper extremity weakness and hypoesthesia. She states slightly later she had difficulty with ambulation and she felt unsteady. She denies any headache. She denies history of cervical disc disease. She denies any chest pain. She is not aware of being diabetic. She has no hx of ACS." The attending physician suspected cervical disc disease or carotid/vertebral dissection.

Lab results were notable for high glucose level. Imaging studies of the head and neck showed focal moderate stenosis of the distal cervical portion of the left internal carotid artery. An MRI of the brain showed "[a]cute right cerebral hemisphere watershed vascular territory infarction." An MRI of the cervical spine showed "[h]ypertrophic degenerative changes at C4-C5 and C5-C6 with severe spinal stenosis. There is cord edema at C4-C5."

Petitioner was admitted to the intensive care unit. At some point, a note was added to Petitioner's chart of an "injury to the left lateral neck and now with arm heaviness. I suspect nerve insult causing her heaviness and this does not seem c/w cva." Upon further diagnostic workup in consultation with the cardiology and the neurology staff, Petitioner was diagnosed with acute stroke in the right hemisphere with associated severe neck pain and left forearm hemiplegia, and a recent myocardial infarction. In addition, Petitioner was examined by Dr. Martin Herman, a neurosurgeon, who stated in his report: "MRI scan of the cervical spine *** demonstrated C4-5 and C5-6 stenosis with cord signal changes, and spinal cord compression. This stenosis was fundamentally due to disk herniations anteriorly at C4-5, C5-6, but there was also a component of facet hypertrophy posteriorly." Dr. Herman recommended surgery after Petitioner recovered from the stroke. Lastly, the internal medicine staff diagnosed a new onset of diabetes mellitus type I. On February 1, 2014, Petitioner was discharged home. After discharge, Petitioner underwent a course of occupational therapy for her motor functions. Her mental, cognitive and communication functions were determined to be essentially intact.

Petitioner testified that after being discharged from the hospital, she returned to work for Respondent. On March 24, 2014, Petitioner consulted Dr. Avi Bernstein, a spine surgeon, about worsening numbness and paresthesias in her arms and hands. The medical records from Dr. Bernstein show that Petitioner complained of neck pain and radiating numbness in the arms. Dr. Bernstein noted the following history: "The patient reports that on January 27, 2014 she was involved in a work related incident. She went to work and took a small white dog for a walk. While putting the dog into his cage, she developed an acute sensation of neck pain and L'hermittes phenomena with shock-like sensation into the upper extremities. She described the incident as awkward requiring extreme positioning of her neck. The left sided shock which was very severe improved immediately, but she had lingering tingling in her upper extremities. She had bilateral pins and needles into her arms. Her left arm was worse than her right arm." Dr. Bernstein noted a history of hospitalization at Lutheran General Hospital, where Petitioner underwent a full cardiac workup. Dr. Bernstein was under the impression Petitioner "underwent an angioplasty with placement of a stent." Dr. Bernstein's records do not mention a recent history of stroke and heart attack. Dr. Bernstein examined Petitioner and reviewed the cervical MRI from January 27, 2014. His assessment was: "This patient is suffering from cervical myelopathy on the basis of central disc herniations and spinal cord compression, particularly at the C4-5 level. This likely is a chronic pre-existing slowly progressing degenerative condition which was suddenly aggravated as the result of her work incident. She requires surgical intervention. She requires a two level decompression and fusion."

On August 11, 2014, Petitioner was examined at Respondent's request by Dr. Kern Singh, an orthopedic surgeon. Dr. Singh noted the following history: "On January 27, 2014, [the patient] states that she went to work and took a small white dog weighing approximately 15 pounds for a walk. While putting the dog into his cage she felt an acute sensation of neck pain and shock-like sensation to her upper extremity." Dr. Singh noted that Petitioner was hospitalized at Lutheran General Hospital and diagnosed with acute stroke and cervical spondylosis. Dr. Singh reviewed the cervical MRI from January 27, 2014, and the report from

Dr. Bernstein. After examining Petitioner, Dr. Singh diagnosed: a right cerebral hemisphere transient ischemic attack; severe spinal stenosis at C4-C5 and C5-C6; and cervical myeloradiculopathy. Dr. Singh agreed with Dr. Bernstein's surgical recommendation.

Regarding causation, Dr. Singh stated: "It appears the patient's symptoms are global in nature and not consistent with her cervical myelopathy. This would be more correlative with her transient ischemic attack which it appears she has suffered at the time of her original work-related event. With regard to the patient's cervical spine condition, she has severe spinal stenosis that is not acute in nature causing cord edema. In essence, this means that it is a chronic longstanding problem which resulted in spinal cord myelomalacia. I do not believe that the mechanism is plausible as a result of her aggravation of her underlying degenerative condition, as I believe that her condition was critical to begin with prior to intervention." Dr. Singh clarified: "I believe her condition is not work-related and preexisting in nature." "I do not believe [the proposed surgery] is related to her work-related injury. The patient has a unique situation in that she has severe spinal stenosis associated with myelomalacia and cord edema. This is very unusual and not commonly found in work-related injuries, as this is a chronic degenerative process, longstanding in nature, that results in spinal cord changes. I do not believe her dog lifting event is a plausible mechanism for the resultant stenosis becoming symptomatic, as I believe that is the natural history and progression of her underlying cervical spinal stenosis and myelopathy."

Respondent also introduced into evidence Petitioner's handwritten and signed statement of the incident, dated January 27, 2014. The document states: "I *** came in at 7:45, took small dog outside, put dog back in cage and felt lightning bolt type pain from neck to left hand. Left hand felt heavy and week [*sic*]. Pain in neck went away. Did a laser treatment on patient – felt fine, but arm still heavy – Iwona, manager said I did not seem right, that my color was off and my arm still feeling heavy – An ambulance was called and took me to Lutheran General Hospital."

On cross-examination, Petitioner was questioned about her handwritten statement of the incident. Petitioner recalled the incident as follows: "When I was putting the dog back in the cage dog started to get kind of crazy and decided it didn't want to get in the cage, and I felt like a lightning bolt go down my neck." Petitioner acknowledged her handwritten statement did not mention anything about the dog going crazy. Petitioner admitted subsequently being diagnosed with a blockage in her artery. However, Petitioner denied suffering a stroke. Petitioner admitted she was prescribed a blood thinner, but did not remember why. When questioned about the chronology of the events subsequent to her release from the hospital, Petitioner repeatedly responded that she did not recall. On redirect examination, Petitioner did not recall when she wrote her statement. On re-cross examination, Petitioner testified she wrote her statement after she returned to work following her hospital stay. On further redirect examination, Petitioner stated that she only vaguely remembered writing the statement. She further stated that she did not put much thought into it.

Anna Lazarz, Respondent's receptionist, testified that she started work at the same time as Petitioner, 7:45 a.m. The morning of January 27, 2014, Petitioner looked "happy." Ms. Lazarz recalled talking to Petitioner and Iwonna while Petitioner was putting a dog into a cage. Ms. Lazarz stood fairly close to Petitioner and did not notice anything unusual. It did not look like Petitioner was struggling to control the dog, which weighed approximately 15 pounds. However, after putting the dog into the cage, Petitioner looked tired and pale and said that she "felt something." About an hour to an hour and a half later, when Petitioner was walking, "[s]he was kind of falling over." Ms. Lazarz also noticed that Petitioner's left arm "was just hanging there." Ms. Lazarz called an ambulance at approximately 10 a.m.

The Arbitrator found that Petitioner proved accident and causal connection. The Commission disagrees. The Commission is concerned that after suffering a stroke and a heart attack, Petitioner did not accurately recall the events of January 27, 2014. Although Petitioner testified that she felt a sharp pain in her neck and arms when she was putting into a cage a small dog, which was "squirming to get out" and went "crazy," none of the medical records in evidence mention a struggle with a dog, and neither does Petitioner's handwritten statement. Ms. Lazarz, who was standing close to Petitioner, did not notice anything unusual when Petitioner put the dog into a cage. The Commission notes that after direct examination, Petitioner appeared to have poor recollection of the events, including the events she had just testified to when she was asked leading questions. The Commission also notes that Petitioner denied suffering a stroke and/or a heart attack on January 27, 2014.

The evidence shows Petitioner suffered a stroke and a heart attack at work the morning of January 27, 2014. At the hospital, she underwent a thorough diagnostic work-up, which also revealed previously undiagnosed stenosis with spinal cord signal changes and cord compression at C4-C5 and C5-C6, as well as diabetes. Dr. Herman and Dr. Singh did not think the cervical spine condition was acute, and Dr. Singh did not believe the event with the dog was a plausible mechanism to cause the underlying degenerative cervical spine condition to become symptomatic. Although Dr. Bernstein opined that putting a dog into its cage "suddenly aggravated" Petitioner's cervical spine condition, he based his opinion on Petitioner's description of the event as "awkward requiring extreme positioning of her neck." However, the weight of the evidence does not support this description of the event. Furthermore, Dr. Bernstein was evidently unaware that Petitioner suffered a stroke and a heart attack the morning of January 27, 2014. Accordingly, the Commission gives little weight to his causal connection opinion.

For the foregoing reasons, the Commission finds that Petitioner failed to prove a work accident/causal connection, and denies the claim.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 31, 2015, is hereby reversed and Petitioner's claim is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid 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.

MAY 11 2016

DATED:
o-04/21/2016
JDL/sk
44

Joshua D. Luskin

Mario Basurto

David L. Gore

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

Robert Hayes,
Petitioner,
vs. NO: 14WC 10648

SIU/ State of Illinois,
Respondent,

16IWCC0321

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent, herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 5, 2015, 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.

DATED: MAY 12 2016
MJB/bm
o-5/10/16
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAYES, ROBERT
Employee/Petitioner

Case# **14WC010648**

SIU/STATE OF ILLINOIS
Employer/Respondent

16IWCC0321

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.

A copy of this decision is mailed to the following parties:

1167 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
PO BOX 1355
CARBONDALE, IL 62903

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0558 ASSISTANT ATTORNEY GENERAL
NICOLE M WERNER
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

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

OCT 5 - 2015

RONALD A. RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF **WILLIAMSON**)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERT HAYES
Employee/Petitioner

v.

SIU/STATE OF ILLINOIS
Employer/Respondent

Case # **14** WC **010648**

Consolidated cases: _____

16IWCC0321

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **EDWARD LEE**, Arbitrator of the Commission, in the city of **HERRIN**, on **08/11/2015**. 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 **09/23/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**52,788.90**; the average weekly wage was $**1015.17**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**22,914.85** for TTD, $**0** for TPD, $**0** for maintenance, and $**8,833.51** for other benefits, for a total credit of $**31,748.36**.

Respondent is entitled to a credit for any bills paid under Section 8j of the Act

ORDER

THE MEDICAL SERVICES PETITIONER RECEIVED WERE REASONABLE AND NECESSARY AND RESPONDENT IS LIABLE FOR THE MEDICAL BILLS IN THE AMOUNT OF $ 26,108.50 SUBJECT TO 8A AND 8.2 OF THE ACT. SEE PE X 6. RESPONDENT IS ENTITLED TO A CREDIT FOR THE AMOUNT THEY HAVE PAID.

RESPONDENT IS ALSO RESPONSIBLE FOR PAYMENT TO PETITIONER FOR 45 WEEKS OF TEMPORARY TOTAL DISABILITY. THE RESPONDENT IS ALSO DUE A CREDIT OF $31,748.36.

ARBITRATOR FINDS THAT PETITIONER'S SUSTAINED INJURY RESULTED IN A 17.5% LOSS OF MAN AS A WHOLE. RESPONDENT SHALL PAY PETITIONER PERMANENT PARTIAL DISABILITY BENEFITS OF $609.10 PER WEEK FOR 87.5 WEEKS.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Edward Lee — Signature of Arbitrator

10/1/15 — Date

OCT 5 - 2015

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERT HAYES,
Employee/Petitioner

v. Case No. 14 WC 10648

STATE OF ILLINOIS-SOUTHERN ILLINOIS UNIVERSITY, CARBONDALE,
Employer/Respondent.

16IWCC0321

FINDING OF FACTS

Petitioner suffered a work injury while at work on September 23, 2013. Petitioner works at Southern Illinois University-Carbondale as a heavy equipment operator.

On September 23, 2013, Petitioner was lifting one end of a heavy desk when he experienced pain in his neck.

On October 8, 2013, Petitioner filled out paperwork, at work, reporting his lifting accident and complaining of pain in his neck through his shoulders and arm.

On October 8, 2013, Petitioner went to his family doctor complaining of neck and shoulder blade pain. Over the next two days, x-rays of Petitioner's cervical and thoracic spine were taken.

On October 11, 2013, Petitioner went back to his family doctor, Dr. Yohannan, with more neck complaints. Dr. Yohannan ordered an MRI and took Petitioner off work.

On October 23, 2013, Petitioner had an MRI of his cervical and thoracic spine.

On October 31, 2013, Petitioner returned to Dr. Yohannan and they reviewed the MRI findings and Petitioner was referred out to Dr. Jeffrey Jones, a spine specialist at

Orthopedic Institute of Southern Illinois.

On December 5, 2013, Petitioner was seen by Dr. Jeffrey Jones at the Orthopedic Institute. Petitioner gave a history of neck pain after his work accident of September 23, 2013. Dr. Jones had the ability to look at Petitioner's films and noted that it was difficult to tell whether Petitioner's C5-6 and C6-7 had fully fused from a prior procedure Petitioner had done in 2003. Dr. Jones ordered a CT scan and ordered Petitioner to remain off work. Physical therapy was also ordered.

On December 13, 2013, Petitioner followed up with Dr. Jones to go over the CT scan. Dr. Jones felt that Petitioner had a pseudoarthrosis at level C5-6 and C6-7. Dr. Jones then recommended another fusion procedure at C5-6 and C6-7 to fix Petitioner's complaints.

On February 24, 2014, Petitioner was evaluated by the Respondent at Dr. Frank Petkovich's office. Dr. Petkovich had the opportunity to meet with Petitioner and discuss his complaints as well as Petitioner's medical history. After meeting with Petitioner and reviewing Petitioner's medical records and films, Dr. Petkovich opined that Petitioner suffered a cervical and thoracic sprain at the time of his accident in September of 2013. Dr. Petkovich ordered an EMG to try and determine the source of Petitioner's pain.

On April 11, 2014, Petitioner completed an EMG study.

On April 22, 2014, Petitioner followed up with Dr. Jones. Dr. Jones felt that Petitioner's C5-6 and C6-7 were not fused and he recommended that Petitioner have a C5-6 and C6-7 posterior cervical fusion.

On May 22, 2014, the IME doctor, Dr. Petkovich, added an addendum to his

previous report after he review the EMG results and obtained some physical therapy records. His addendum opined that, although Petitioner may have a pseudoarthrosis, that he felt this would be unrelated to the work injury and because of his previous fusion in 2003. Dr. Petkovich opined that Petitioner had reached maximum medical improvement from his work related cervical and thoracic sprain and that he could work full duty as far as his September 23, 2013, work injury was concerned.

On May 27, 2014, Petitioner met with Dr. Jones and they decided that even though workers' compensation was fighting over the surgery, that they would proceed under Petitioner's group health plan.

On July 7, 2014, Petitioner underwent a posterior cervical fusion with lateral mass screws at C5-6 and C6-7 with Dr. Jones.

On October 9, 2014, Petitioner followed up with Dr. Jones after having gone through physical therapy and recovery from the surgery with several follow up appointments. At that time, Petitioner felt he was doing very well. He was not taking any pain medication and his pain had diminished significantly since surgery. Petitioner wanted to return to work and Dr. Jones released him back to work with no restrictions on November 3, 2014.

On November 20, 2014, Petitioner underwent a cervical CT scan.

On December 9, 2014, Petitioner had a follow up appointment with Dr. Jones where Petitioner noted he was improving.

On June 16, 2015, Petitioner underwent a cervical CT scan.

On June 19, 2015 Petitioner followed up with Dr. Jones who noted that all

the instrumentation was intact and that he appeared to be fusing. Dr. Jones released Petitioner from care.

ARGUMENTS

Issue F: Is Petitioner's current condition of ill-being causally related to the injury?

During Arbitration, Petitioner testified that he had not had many problems with his neck since the time of his 2003 fusion surgery. He had been working as a heavy equipment operator for the Respondent prior to the agreed accident date of September 23, 2013, without incident or problems. On the agreed to accident date, Petitioner picked up one end of a heavy desk and felt a pop in his neck, which brought an onset of pain in his neck and shoulder blade area as well as into his left arm that he had not experienced previously.

Dr. Jones, the treating physician, found and opined that Petitioner had a pseudoarthrosis and that the pain and symptoms that Petitioner was dealing with were coming from the non-fused C5-6 and C6-7. Dr. Jones opined that Petitioner became symptomatic and felt a pop in his neck at the time of the accident and that after looking at films, he felt Petitioner's condition was related to the work accident. He also opined that the need for treatment in the form of a posterior cervical fusion at C5-6 and C6-7 was related to Petitioner's work accident.

Dr. Petkovich opined that Petitioner suffered a cervical and thoracic sprain as a result of his work accident of September 23, 2013. Dr. Petkovich felt that Petitioner had returned to baseline after June of 2014. Dr. Petkovich failed to explain how

Petitioner had reached maximum medical improvement from his cervical and thoracic sprain in June of 2014 even though Petitioner was still suffering pain that began on the date of the accident.

CONCLUSION

After reviewing the testimony of Petitioner and the expert testimony of both Dr. Jones and Dr. Petkovich, the Arbitrator finds that the current condition of ill-being of the Petitioner is causally connected to the work injury of September 23, 2013.

Issue J: Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical care?

CONCLUSION

As Arbitrator has found that Dr. Jones' opinion was more persuasive than that of Dr. Petkovich, the medical services that were provided to Petitioner as a result of the September 23, 2013 work injury, including the surgery performed by Dr. Jones on July 7, 2013 and all subsequent care are found to be reasonable and necessary.

Respondent has not paid all appropriate charges for all reasonable and necessary medical services and are hereby found to be liable for such bills from September 23, 2013 through the final release of Petitioner by Dr. Jones in November of 2014.

Issue K: What temporary benefits are in dispute?

Petitioner was injured and under the care of a doctor with work restrictions from October 9, 2013 through June 2, 2014 and then again from July 3, 2014 through November 2, 2014 for a total of 45 weeks.

CONCLUSION

Respondent is responsible to pay Petitioner 45 weeks of temporary total disability Benefits.

Issue N: Is the Respondent due any credit?

Respondent paid Petitioner temporary total disability benefits from October 9, 2013 through June 2, 2014 for a total of $22,914.85. Petitioner was paid SURS non-occupational disability from July 3, 2014 through November 2, 2014 for a total of $8,833.51.

CONCLUSION

Respondent is due a credit of $31,748.36.

Issue L: What is the nature and extent of the injury?

CONCLUSION

Since the accidents occurred after September 1, 2011, Section 8.1(b) of the Act applies. As neither party presented an AMA rating, the Arbitrator relies on the remaining four factors: (i) the occupation of the injured employee; (ii) the age of the employee at the time of the injury; (iii) the employee's future earning capacity; and (iv) evidence of disability corroborated by the treating medical records.

(i) Occupation: Petitioner is employed as a heavy equipment operator at Southern Illinois University Carbondale. Petitioner is working full duty with no restrictions.

(ii) Age: Petitioner was 54 years old at the time of his injury. No evidence was submitted to show how Petitioner's age would impact his employment. Therefore, the Arbitrator will not weigh this factor to determine permanent disability.

(iii) Earning Capacity: There is no direct evidence of diminished future earning capacity in the record. Petitioner is still employed in the same position as a heavy equipment operator for Respondent.

(iv) Disability: Petitioner testified that he has difficulty turning around to look back by and sitting in wooden chairs for a long period of time. Petitioner's current complaints are due to the aggravation of his pre-existing cervical condition

resulting in a cervical fusion as opined by treating surgeon, Dr. Jones. The Arbitrator finds Dr. Jones to be more credible than Dr. Petkovich, Respondent's IME doctor. The Arbitrator gives great weight to this factor.

Based upon the foregoing, the Arbitrator finds that Petitioner has sustained injuries on September 23, 2013, that resulted in the 17.5% loss of man as a whole. Respondent shall pay Petitioner permanent partial disability benefits of $609.10/week for 87.5 weeks.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

- ☐ Injured Workers' Benefit Fund (§4(d))
- ☐ Rate Adjustment Fund (§8(g))
- ☐ Second Injury Fund (§8(e)18)
- ☐ PTD/Fatal denied
- ☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TANGULA BROWN,
Petitioner,

vs. No. 14 WC 17000

BI-STATE DEVELOPMENT AGENCY, d/b/a METRO TRANSIT,
Respondent.

ORDER

This matter comes before the Commission on Petitioner's Petitioner for Penalties and Fees for alleged unpaid medical bills following a settlement contract. A hearing was held before Commissioner White in Collinsville on March 14, 2016. The parties were represented by counsel and a record was taken.

The settlement contract was approved by the Commission on March 20, 2015. Respondent agreed to pay Petitioner benefits representing 17.5% loss of the left leg for a shin and knee "contusion" after a fall on concrete. It was also noted that Respondent paid Petitioner temporary total disability benefits for "31.7" weeks between April 13, 2014 and November 7, 2015 (*sic*)(likely should be 2014). The contract also provides that "employer agrees to hold harmless the employer (*sic*) for any medical bills which have been paid to the date of this contract by her group health plan." The Commission concludes that in actuality Respondent held Petitioner, and not itself, harmless for those payments. In addition, the Commission notes that the settlement contract has the incorrect claim number of 14 WC 1700 rather than 14 WC 17000. However, the settlement was correctly entered under the correct claim number in the official records of the Commission.

The record also includes a transcript from a previous proceeding. A hearing was held before Arbitrator Zanotti in Mt. Vernon on July 10, 2014. Petitioner sought authorization for meniscus surgery recommended by Dr. Mall. Respondent denied that the need for surgery was related to the alleged accident based on the opinion of its Section 12 medical examiner. Petitioner would not stipulate to the examiner's report in *lieu* of a deposition. Despite its refusal to accept liability for the meniscal injury, Respondent agreed to pay temporary total disability benefits after Petitioner submitted the bills related to the prospective surgery to Petitioner's group health insurance carrier. Petitioner agreed to that arrangement.

At the instant hearing, it became clear that Petitioner had the meniscus surgery and associated physical therapy. She argued that expenses associated with that treatment should be paid based on the settlement contract which provided that Respondent paid all related medical expenses. Once again, Petitioner argued that the meniscus tear was causally related to the work accident. She also indicated that Respondent had drafted the settlement contract and that if there were any ambiguity it should be interpreted against Respondent and in favor of Petitioner. Respondent argued that the settlement contract was for the contusion only and it had paid all expenses related to treatment for that condition. It then recited the agreement between the parties at the previous hearing.

Petitioner then represented that she had submitted the disputed bills to her group health insurer but they were denied. Respondent responded that the meniscus surgery was performed nine months prior to the contract but it did not have notice that the bills were denied by group insurance until six months after the contract was approved. The record also includes a series of e-mail correspondences. One from Petitioner's lawyer to Respondent's lawyer dated September 15, 2015 indicated that group insurance had denied payment for the surgery and demanded payment from Respondent under the settlement contract.

The Commission agrees with Respondent's argument in this instance. The contract is not ambiguous. Respondent settled the claim only relating to the knee/shin contusion and not for any meniscus injury. It paid all expenses associated with the condition for which it settled pursuant to the contract. The contract does not provide that if group health insurance denied the claim for surgery, Respondent would be liable for those expenses under workers' compensation. Simply because group insurance denied the claim does not mean that Respondent accepted liability for a condition in addition to the one for which it settled. Respondent had disputed liability for the meniscal condition throughout the litigation. Group insurance likely denied the claim because Respondent was paying temporary total disability benefits associated with that condition. However, once it becomes clear that these expenses are not covered under workers' compensation, Petitioner can resubmit the claims to the group insurer.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Penalties and Fees is hereby denied.

DATED: MAY 18 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
R-3/14/16
46

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

Lordine Davis,
Petitioner,
vs.

NO: 14 WC 14286

16IWCC0284

Addus Healthcare,
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, temporary total disability, causal connection, medical, permanent partial disability, penalties, fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 21, 2015, 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.

16IWCC0284

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: MAY 4 - 2016
o042116
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

DAVIS, LORDINE
Employee/Petitioner

Case# 14WC014286

16IWCC0284

ADDUS HEALTHCARE
Employer/Respondent

On 10/21/2015, 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 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0598 LUSAK & COBB
JOHN LUSAK
221 N LASALLE ST SUITE 1700
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
RYAN J McCARTHY
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

16IWCC0284

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

LORDINE DAVIS
Employee/Petitioner

v.

ADDUS HEALTHCARE
Employer/Respondent

Case # 14 WC 14286

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **July 21, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other _____

16IWCC0284

FINDINGS

On **April 2, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* not sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned $**18,655.00**; the average weekly wage was $**358.75**.

On the date of accident, Petitioner was **53** years of age, *single* with **0** dependent children.

Petitioner *has* received all reasonable and necessary medical services.

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

ORDER

The Petitioner has not proven, by a preponderance of the evidence, that an accident occurred which arose out of and in the course of her employment by Respondent therefore, no benefits are awarded, pursuant to the Act.

Credits
It was agreed upon by the parties that the Respondent would receive a credit equal to the amount, if any, paid by a group insurance carrier, which group insurance was obtained through the employer. To the extent that any such payments were made by a group insurance carrier to medical providers, the Respondent is entitled to a credit in that amount.

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.

The disputed issues in this matter are: 1) accident; 2) causal connection; 3) medical bills; 4) temporary total disability; 5) penalties; 6) attorney's fees; and 7) the nature and extent of Petitioner's injuries. *See*, AX1.

Lordine Davis, ("Petitioner"), testified that she worked for Addus HealthCare (the "Respondent"), for approximately 12 years and during this time; she worked as a home healthcare assistant and provider. All of her job duties were carried out at the homes of Respondent's healthcare recipients. She testified that Addus reimbursed her for all travel expenses for going to and from the homes of the healthcare recipients.

Her job duties consisted of cleaning homes, preparing meals, assisting individuals with bathing; taking individuals to doctors' appointments and shopping for groceries. The Petitioner performed absolutely no job duties at the site of Addus HealthCare and all of her job duties were performed at offsite locations.

The petitioner was assigned to Mrs. Trice, as a healthcare recipient. Petitioner testified that she worked approximately 15 hours a week at Mrs. Trice's home and that she had performed services for Mrs. Trice for approximately three years, prior to the date of accident. On April 2, 2014, the Petitioner drove to Mrs. Trice's home to provide healthcare services for her. She testified that Mrs. Trice's house had two entrances, a front and back door entrance. Mrs. Trice insisted that the petitioner only use the back door when entering and exiting her house, to protect her living room carpet.

Petitioner testified that at the end of her work day on April 2, 2014, Mrs. Trice asked Lordine Davis to arrange yard furniture when she left her premises. While exiting the back door, the Petitioner testified that she stepped on the door threshold and that the threshold sank under her foot. Pictures introduced by the petitioner showed that there was a wooden support board under the threshold. The board appeared to be in a rotted condition.

The Petitioner testified that when she stepped on the threshold, it gave under her foot, causing her to lose her balance. The Petitioner grasped a side rail. The rail was wobbly and as a result, she lost her balance and fell to the ground injuring her right foot.

Upon cross-examination of Petitioner was shown respondent's Exhibit 3, she testified that that she completed as accident report which she sign, that indicated that the "condition was clear". Petitioner testified that she thought the question was referring to the weather. She was also shown Respondent's Exhibit 4, which she identified as the "incident report", which she testified she signed after someone else filled it out. Petitioner had a previous lumbar condition where she stated that a sharp pain radiated

to her right foot and that she was treating for this condition, up to one week before this accident.

Petitioner's Medical Treatment

The petitioner immediately called her supervisor at Addus HealthCare and she was directed to go to Advocate Illinois Masonic Hospital. These records dated June 26, 2014, state that the petitioner was treating for "pain radiating down her left back and that Bilateral L3-L5 facet joint injection done on 1/29/2014 helped this pain significantly. Pt says her back pain returned after she "feel and broke her right too" on April 2. In addition she is having shooting sharp pains down her posterior right thigh to her knee." The Arbitrator notes that the mechanism of injury for the fall is not documented. On April 2, 2014, emergency room records state that Petitioner arrived at 1:18 PM with a Jones fracture, which have a limited ability to heal. The records state further under 'History of Present Illinois' "Patient states that about 11 AM she stepped off a curb and landed awkwardly on her right foot causing pain. She denies motor, sensory deficits to the right lower showing. She denies all other injuries."

The petitioner then sought treatment at Fullerton Drake Medical Center ("Fullerton"). The doctor at Fullerton referred the Petitioner to Advanced Foot and Ankle Center of Illinois. Lastly, the Petitioner treated at Union Health Services, Inc. Records from all of the aforementioned treating facilities were introduced into evidence by the petitioner.

The medical records state that Petitioner sustained a transverse fracture to the base of the fifth metatarsal. This fracture was identified in the medical records of Illinois Masonic Medical Center and Union Health Center.

The records of Advanced Foot and Ankle Center of Illinois and specifically of Dr. Joel Anderson confirm that Dr. Anderson recommended surgery for the Petitioner's foot. When questioned regarding surgery, the Petitioner testified that she never had surgery because the Respondent refused to approve same. The records of Union Health Center verify that the Petitioner continued to treat with them through March 13, 2015. On March 13, 2015 the records indicate that there was continued soft tissue swelling at the site of the little toe. This corroborates the testimony of the Petitioner that when she walks on her right foot, for an extended period of time, it swells.

Petitioner's Current Condition

Petitioner testified that she returned to work on May 19, 2014. She testified that the reason that she returned to work at that time, notwithstanding the fact that she was limping and had considerable pain in her right foot was because she was without monetary funds to support herself. The Arbitrator notes that the Respondent refused to

pay any temporary total disability benefits to the Petitioner and said refusal continued through the date of trial. In any event, the Petitioner returned to work for Addus however, at the present time she is employed by a company who performs similar services as Addus.

Testimony of Petitioner's Witness

Mr. Anthony Ortelano, a licensed personal injury investigator, testified that he examined and took photos of the steps and railing at Mrs. Trice's home. He testified that the railing was simply struck in the ground with no cement support and that the wooden board under the threshold was, indeed, in a rotten condition. He testified that the board was actually crumbling.

Respondent's Witness

Ms. Heather Dunn testified, on behalf of Respondent that she was the claims adjuster for Gallagher Bassett and had spoken to the petitioner on two occasions. She testified that she asked the petitioner about the incident and the petitioner told her that she fell on the back porch but did not know the cause of her fall. When asked if her leg gave out, the petitioner answered in the affirmative. She further testified that the petitioner never mentioned the rotted steps or railing or any condition of the porch. In addition, she denied that claim because she had no evidence that it arose out of the petitioner's employment.

CONCLUSIONS OF LAW

C. Did an accident occur that arose out of and in the course of Petitioner's employment by the Respondent? .

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission, must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a causal connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs.*

Industrial Commission, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

The Petitioner told an entirely different story regarding the mechanism of injury, to her first treating doctors at Advocate Illinois Masonic then she testified to at trial. The Arbitrator does not find the Petitioner's testimony to be credible and Petitioner has not proven, by a preponderance of the evidence, that she sustained an accident which arose out of and in the course of her employment by the Respondent. As the petitioner has not proven a compensable accident, all other issues and moot and will not be addressed.

16IWCC0284

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
14WC14286
SIGNATURE PAGE

Signature of Arbitrator

October 13, 2015
Date of Decision

OCT 2 1 2015

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Miroslaw Adamczyck,

Petitioner,

vs.

NO: 14 WC 20758

16IWCC0302

Diamond Blast,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, notice, medical, temporary total disability, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below. The Commission further remands this case to the Arbitrator for findings and a determination on medical, temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. One should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the Arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

The Petitioner testified that he worked as a machine operator for Respondent beginning in 2012. Petitioner was working at a machine referred to as the 'cabinet machine' that was used for a particular purpose (namely, grinding metal). The Petitioner was working on this machine because the Respondent had a special order that needed to be completed. (T 10-14).

The Petitioner testified that he would insert his arms into the cabinet machine in order to do the work. He was not able to rest his arms in the holes because of the nature of the work. After he would complete about two sessions of working on six pieces, he would have to lift up a table inside the machine in order to jar some material loose that would become stuck. The part that he would have to lift was approximately 25 to 30 pounds. (T 19-22).

According to Petitioner, before he started work on March 20, 2014 his arms did not hurt him, but his hands felt tired because of the work he did daily. The Petitioner had complained to his manager, Bob, before March 20, 2014 about Petitioner's hands being tired. He asked Bob if he could do a different type of work instead of working at the same machine, but his request was denied. On March 20th while Petitioner was lifting the table in the cabinet machine to clean it out, he felt a sharp pain in his right shoulder. The pain was so intense that he almost urinated on himself. He dropped the table and tried to figure out where the pain was coming from, and then reported to his boss that he was in pain and had to stop working. The Petitioner did not receive any help, returned to his machine, and finished the rest of the work day. But he did not actually work on any more parts in the machine before he left work. When he arrived home he took some pain pills. (T 22-25).

Petitioner further testified that he returned to work the day after he was hurt at work. He did his regular job at the same machine, albeit with great pain and very slowly. He worked a full day that day (a Friday). He could not grind the pieces like he should have because of his intense pain. He spoke to his manager, Bob, about how Petitioner was feeling. The Petitioner also worked on Saturday because there was a special order that needed to be done. He was also in great pain on Saturday: He was supposed to work 8 hours but he only worked 6. He also worked Monday, even though he was in great pain. Petitioner took vacation days on Tuesday and Wednesday because his boss did not take him off of the cabinet machine. (T 26-28).

The Petitioner testified that he went to see his family physician, Dr. Kowalczyk, on March 25, 2014. Dr. Kowalczyk gave Petitioner pain medication and told him not to work for one month. However, Petitioner returned to work to be loyal, and told his boss about the situation. Petitioner worked light duty by only using one hand, but he did use his second hand sometimes even though it was in a sling. He ultimately had an MRI on May 2, 2014, and then was referred to Dr. Dzwinyk. Dr. Dzwinyk suggested an arthroscopic rotator cuff repair surgery which was ultimately performed on July 9, 2014. The Petitioner was not working at that time. After the surgery, Petitioner followed up with Dr. Dzwinyk and had physical therapy. In September of 2014 while in physical therapy, the Petitioner only felt slightly better. He could not perform everything during rehab that he was asked to do. Dr. Dzwinyk recommended another MRI, which was done on October 14, 2014. Dr. Dzwinyk recommended a second

surgery, and then Petitioner had an intraarticular injection while under anesthesia performed on December 1, 2014. Petitioner underwent physical therapy post-surgery and still was at the time of hearing. He last saw Dr. Dzwinyk on February 10, 2015, and he was scheduled to see him in March. Dr. Dzwinyk has not released the Petitioner back to work. (T 28-31).

According to the Petitioner, he cannot dress himself due to his right shoulder issues, and he cannot sleep on his right shoulder. He is taking Hydrocodone for his pain. He has to be very careful when he is driving because it's painful for him to turn the steering wheel. It is difficult for him to shower because he cannot move his hand to reach all of his body parts, and he cannot wash his hair. He has had improvement since his second surgery, but he has not fully recovered. (T 33-35).

David Collignon, the owner of Respondent's company, also testified. Mr. Collignon handles payroll, insurance, and customer interaction. Its facility is 10,000 square feet, and Mr. Collignon's office is located on a second floor which is not the production floor. Mr. Collignon would walk around the production floor between 3-4 times per day, but he spends the majority of his time in his office. (T 44-48).

Mr. Collignon testified that the blasting cabinet that Petitioner worked on is called blast cabinet #3, which Mr. Collignon agreed was depicted in Px1a. Mr. Collignon has only "toy[ed] around" with it, but not operated it. In March 2014, they had an order of stainless steel handles that were 18 inches long and weighed 3-5 pounds each that Petitioner was working on. In order to use cabinet #3, the operator would be standing with their arms in the openings in the front of the machine. There is an air nozzle inside that's tethered a little bit to the top of the machine. There are 2 hoses: an air pressure hose and then a hose that gathers the steel balls. (T 54-58).

Mr. Collignon testified that the operator's arms are not outstretched when using cabinet #3, and they are at a 45-90 degree angle. Mr. Collignon provided Respondent's attorney with a video (containing 3 files) of cabinet #3, which was played during the hearing. The video is a fair and accurate description of the use of cabinet #3. (T 58-62).

According to Mr. Collignon, as of the end of the day on March 27th, neither Mr. Collignon nor Respondent had notice of Petitioner's injury at work. He also denied knowing of a request from Petitioner to seek medical care. P also worked on the 28th, although David didn't work that day. On March 28th, Petitioner came to work with a note, which he presented to the manager, Bob, indicating that he was on light duty restrictions. The note from Dr. Kowalczyk dated March 27, 2014 detailed Petitioner's work restrictions. Respondent accommodated the work restrictions. (T 63-68).

Mr. Collignon testified that he spoke with Petitioner the following week about his light duty status, and Petitioner responded that "my arms, my hands are just fatigued." The Petitioner did not report a shoulder injury to David. (T 68-71).

16IWCC0302

Mr. Collignon testified that he did not receive notice that Petitioner was claiming a work related injury until mid-May 2014 when Petitioner approached Mr. Collignon requesting workers' compensation information for Petitioner's physician. Mr. Collignon replied to Petitioner: "I don't—didn't believe—you did not report this injury. That this was not a workers' comp injury. It didn't happen on the premises." (T 72-75).

Mr. Collignon was shown Px2 which is a handwritten office note of Dr. Kowalczyk dated March 25, 2014. Mr. Collignon disagreed with the note because it describes the machine as a 'power washer for metal,' and Petitioner's arms were not extended because they were actually supported. Respondent has a power washer for washing their delivery truck, but it was not being used in March 2014. (T 75-78).

The Petitioner testified on rebuttal that he and Bob (the manager) had an unwitnessed conversation in Bob's office on March 20, 2014 regarding what took place while Petitioner worked at the cabinet machine. The Petitioner told Bob that something happened to his arm because it hurt him. Bob "opened his arms and said 'I don't believe you.'" The Petitioner and Bob also had subsequent conversations about Petitioner's injury. When Petitioner approached Bob about getting information regarding the insurance, Bob told him: "I know what I'm doing, my son is an attorney so...go talk to whoever, to David." (T 81-83).

According to Petitioner, Mr. Collignon's testimony is not correct that he did not know that Petitioner was claiming a work injury until he received papers from a lawyer. The Petitioner told Mr. Collignon about the incident and Mr. Collignon also did not believe Petitioner. In April or May 2014, Mr. Collignon told Petitioner that nothing like Petitioner's injury could happen from working at the cabinet machine, and that it would happen if the Petitioner was playing golf. Before that conversation Petitioner had only been communicating with Bob because Bob was Petitioner's "immediate boss." (T 83-84).

The Petitioner testified that despite Mr. Collignon's testimony that there was no reason to lift the table inside the cabinet machine because the gun inside the cabinet could blow the material away or be recycled back into the system, the Petitioner would still have to lift the table: "That round table is sitting on another flat piece. And...netting is where the grains fall through on the outer rim do they continue failing all the way down where they are brought up through the system. But the center part is not, and you have to take it apart to clean it out." The balls go into a shelf underneath the round cabinet, and to get at the grains that are in the center, it needs to be lifted up off the axle because the axle turns it. So it has to be lifted off to clean it out. The Petitioner also testified that he has never played golf before. (T 84-87).

The Petitioner watched some film clips that were provided by the Respondent regarding the operation of the cabinet machine. The parts that were used in the machine in the video clips were not the kinds of parts that are used in the machine. The grinding in the video lasted for about 1 minute, whereas Petitioner spent 45-50 minutes per 6 pieces. Also, the video did not depict how the table would be taken out of the machine in order to clean it. (T 25-26).

The Commission viewed the aforementioned film clips. Clip #1 depicts a worker using the cabinet machine/ cabinet #3 with his hands and arms inside of the machine. The Commission observed that the worker's arms do not appear to be supported while using the machine. They appear to be suspended in air while inside of gloves which are inside the machine. This observation is contrary to Mr. Collignon's testimony that the arms could be supported. Furthermore, the worker's arms in the film clip are only slightly bent while they are inside of the machine compared to the 45 - 90 degree angle that Mr. Collignon noted

The Commission finds Petitioner's claim to be credible and further finds that Petitioner proved by a preponderance of the evidence that he was injured while working for Respondent on March 20, 2014.

The Commission finds that Mr. Collignon was less credible than Petitioner, particularly due to Mr. Collignon's refusal to cooperate with Petitioner's workers' compensation claim and requested paperwork based on his presumption that the Petitioner could not have been injured while working on the cabinet machine. Mr. Collignon testified to only having toyed around with the cabinet machine; thus, he was in no position to presume that he knew that it was impossible for Petitioner to be hurt from working on the machine.

The Commission finds that Petitioner sustained a rotator cuff tear on March 20, 2014 while working at the cabinet machine. Petitioner's treating physician, Dr. Kowalczyk, attributed Petitioner's condition to his work: "3/20/14 injury right shoulder, after using power washer for metal for many hours every day." Mr. Collignon testified that he disagreed with the note because it describes the machine as a 'power washer for metal.' The Commission finds this to be disingenuous because a reasonable person could interpret the cabinet machine's function as a 'power washer for metal.' In furtherance of the Commission's causal connection determination, the Commission relies on Dr. Dzwinyk's May 19, 2014 progress note that stated: "6-8 week history of right shoulder pain acutely exacerbated by work activities. At work he began using a high pressure power washer for metal with the right arm outstretched, unsupported, for up to 8 hours a day, on a daily basis."

The Commission further finds that timely notice of Petitioner's work injury was provided to Respondent. The Petitioner testified that he told his manager, Bob, on March 20, 2014 and on subsequent times that he was injured and/ or hurting from working on the cabinet machine. Bob did not testify. Mr. Collignon testified to not having received notice until mid-May 2014. The Commission has misgivings regarding Mr. Collignon's credibility because he went to great lengths to not file a workers' compensation claim for Petitioner's injury. We find Petitioner to be more credible on the issue of notice as well.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision, filed on June 11, 2015, is hereby reversed, as the Commission finds that Petitioner sustained an accident that arose out of and in the course of Petitioner's employment with Respondent.

16IWCC0302

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 6 - 2016

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

TJT/gaf
O: 3/7/16
51

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF JEFFERSON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeremy Snow,

Petitioner,

16IWCC0287

vs. NO: 14 WC 20834

White County Coal,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary disability, causal connection of current condition and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 8, 2015, 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.

16IWCC0287

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 4 - 2016
o4/13/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

16IWCC0287

SNOW, JEREMY
Employee/Petitioner

Case# 14WC020834

WHITE COUNTY COAL
Employer/Respondent

On 7/8/2015, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0696 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0693 FMGR
D BRIAN SMITH
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

16IWCC0287

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [ ] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JEREMY SNOW
Employee/Petitioner

v.

WHITE COUNTY COAL
Employer/Respondent

Case # 14 WC 020834

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **May 8, 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **2-17-14**, 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 **$65,000.00**; the average weekly wage was **$1,111.10**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **2** dependent children.

Respondent *has* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$all paid** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of $.

Respondent is entitled to a general credit for any medical bills paid by its group medical plan for whichcredit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's Exhibit #1, as provided in Section 8(a) of the Act. Respondent shall be given credit for any medicalbills 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 theAct.

Respondent shall authorize and pay for an additional injection at L5-S1 should Dr. Gornet still recommend such treatment is necessary.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the*Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

July 5, 2015
Date

JUL 8 - 2015

ICArbDec19(b)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Respondent stipulated that Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent as a coal miner on February 17, 2014, and agreed to Petitioner's claimed period of temporary total disability. In this 19(b) proceeding, Petitioner seeks prospective medical care. The disputed issues include causal connection, medical expenses, and future medical care. Petitioner was the sole witness testifying at the hearing.

The Arbitrator finds:

Petitioner testified to having prior back surgery in 2008, but he returned to work without restriction following same and saw his surgeon, Dr. Gornet, in July of 2013 only for an annual follow-up. He testified that he had not seen any medical provider for back problems from 2012 onward and had not missed any time from work because of his low back.

On the date of the accident, February 17, 2014, Petitioner was preparing an underground mining platform when a piece of the roof came down and struck him in the lower back and hip and knocked him to the ground. Petitioner testified that the roof is made of solid slate rock and that the piece that struck him was approximately 2 feet wide, 8 feet long, and 6 inches thick. Petitioner was unable to get up and was lifted out of the mine on a back board. Petitioner was thereafter admitted to Deaconess Hospital where he was administered a morphine injection for blunt trauma from the mining accident. (PX3). He was discharged the following day with unresolved back pain and numbness and tingling in his left leg and a prescription for Norco and a home therapy program.

Petitioner saw his spine surgeon, Dr. Gornet, on February 24, 2014, who noted that prior to the accident, Petitioner had been "very pleased and he was doing very well" with a normal physical examination during his annual post-operative checkup on August 5, 2013. (PX5, 2/24/14). Petitioner reported general low back pain radiating into his buttocks, hips and legs with tingling in his feet, particularly in his left leg. *Id.* Dr. Gornet took a consistent history of Petitioner being struck in the back by an 8x2x6 piece of rock, and noted that Petitioner had significant complaints that were constant, limiting, and worsened by prolonged sitting, standing, bending or lifting. *Id.* Dr. Gornet compared an old MRI with a new MRI obtained that day that revealed a new, obvious, acute disc herniation at L1-2. *Id.* Dr. Gornet stated that this is a new injury which Petitioner sustained as a direct result of the February 24th accident and opined that Petitioner's current complaints were related to same. He placed Petitioner on light duty with restrictions of no lifting over 10 pounds, no repetitive bending or lifting, and no prolonged sitting or standing, alternating between the two as needed; and he prescribed muscle relaxants, anti-inflammatory medication and oral steroids. (PX 5, PX 6)

Petitioner was seen in follow up by Dr. Cherukupalli on February 26, 2014. Petitioner reported feeling much better than when he was in the hospital. He was able to walk but mentioned pain in the left gluteal region after walking a block and a half and would need to rest. Petitioner also reported that most of his pain was associated with ambulating or standing for long times. Dr. Cherukupalli recommended that Petitioner follow up with Dr. Gornet for any further back issues. (PX 4)

Petitioner participated in the physical therapy program recommended by Dr. Gornet, but Petitioner continued to have back pain. (PX5, 3/25/14; 5/29/14; PX 7). Dr. Gornet recommended epidural and transforaminal injections. (PX5, 5/29/14; PX 8). On follow-up, Dr. Gornet noted that Petitioner was "improving somewhat" from his injections. (PX5, 7/21/14). He felt that Petitioner had also suffered an aggravation of his pre-existing lumbar condition. *Id.* He recommended an injection at L5-S1 and a trial of return to work. *Id.*

Petitioner returned to see Dr. Gornet on September 22, 2014. Petitioner reported "dramatic" improvement for 7 to 10 days with the L5-S1 injection and some improvement in his upper symptoms with the L1-2 injection, but Dr. Gornet stated that Petitioner was "definitely not at maximum medical improvement." Petitioner reported he was working full duty. (PX5, 9/22/14). Dr. Gornet recommended an additional L5-S1 injection with consideration of L5-S1 fusion in the event Petitioner's symptoms remained refractory. *Id.*

Respondent sent Petitioner for an examination with Dr. Bernardi on October 14, 2014. Petitioner acknowledged undergoing four epidural steroid injections (two at L1-2 and two at L5-S1). He reported improving well enough to return to work on August 4, 2014 but noting residual pain. Petitioner described improved symptoms of 40 to 50 percent. Petitioner described diffuse lumbar pain, primarily concentrated at his waist but extending right and left equally and into the lateral pelvic/gluteal areas. He also described occasional aching in his left groin and pain going down the medial aspect of his left thigh and lower leg when his symptoms are aggravated. Petitioner also noted an occasional sense of weakness in his left lower extremity which tends to worsen as the day progressions. Unsupported lumbar flexion and prolonged siting were reportedly the most uncomfortable. Petitioner reported that he felt like the injections were most helpful for his mid-upper lumbar symptoms but less effective for those at the lumbosacral juncture. Petitioner's symptoms diagram showed aching and burning across the low back at the lumbosacral level. He also noted numbness and paresthesia involving the posterior aspect of the left thigh and lower leg. Petitioner displayed no evidence of Waddell's signs. Petitioner's physical examination findings were noted with evidence of bilateral buttocks pain and leg pain with rotation of Petitioner's hips. He also had some slight tenderness on exam. (RX 2)

In his report Dr. Bernardi acknowledged that Petitioner might require surgery at L1-2. (RX2). He stated:

> I do not believe Mr. Snow's current complaints are related to any of the pre-existing abnormalities in his low back. In my opinion, they are most likely due to the disc herniation seen at L1-2 on his 02/24/2014 MRI. I suspect this is acute. I suspect it was caused by his work accident. It was not present on his 08/27/2008 scan. He describes a mechanism of injury that could plausibly produce a herniated disc. His records document a very close temporal relationship between that accident and the onset of his symptoms. . . In my opinion, Mr. Snow's symptoms are most consistent with an acute and post-traumatic L1-2 ruptured disc. *Id.*

Dr. Bernardi did not, however, believe that Petitioner suffered an aggravation of his L5-S1 level and did not believe the injections given at this level were related to Petitioner's work accident. *Id.* He agreed that Petitioner had not reached maximum medical improvement with regard to his work injury. *Id.*

Petitioner returned to Dr. Gornet on November 6, 2014, with a copy of Dr. Bernardi's IME report. (PX5, 11/6/14). Dr. Gornet reviewed the report and noted that while Dr. Bernardi acknowledged Petitioner's improvement with injections, "He seemed to skirt over the issue that Mr. Snow had injections at both L1-2 as well as L5-S1." *Id.* Dr. Gornet pointed out that Petitioner's L5-S1 injection dramatically improved his condition and stated that the fact that there is not a dramatic difference in disc pathology "does not mean that the patient is not symptomatic from this level." *Id.* He stated:

> While Dr. Bernardi spends a large portion of his time emphasizing whether or not there is nerve compression, he completely avoids the issue of whether or not a disc at L5-S1 in its already pre-weakened state could be injured in such an accident as described by Mr. Snow. We have learned from new information and data that more than the anatomical structural findings of the disc, more than whether it is herniated or not herniated, it is the chemical aspect of the disc that ultimately causes pain. This is why a discogram is felt to be provocative. It is not because there is a "pinched nerve." It is because the structure is irritated/injured and therefore, symptomatic. . . *Id.*

Dr. Gornet further explained that his treatment approach is the same approach that was successful in managing Petitioner's prior injury at L2-3 without the use of discectomy. *Id.* He observed that Petitioner had clear signs of L5-S1 symptomatology and clinical response to the treatment of same. *Id.* He again noted that Petitioner was "definitely not at maximum medical improvement" from the aggravation that he sustained at his L5-S1 or L1-2 levels, and recommended a repeat discogram at L5-S1 and continuance with MRI spectroscopy. *Id.*

Dr. Gornet testified by way of deposition taken on January 29, 2015. (PX9). Dr. Gornet is a board certified orthopedic surgeon whose practice is devoted to spine surgery and the treatment of neck and low back pain. (PX9, p.5, 6). He testified that he focuses on newer types of treatment for neck and low back pain, that he is heavily involved in research and clinical trials in furthering the science for care and treatment in the neck and low back, and that he has participated in authoring many publications regarding same. *Id.* at 6. He testified that he also lectures around the country and around the world on these topics. *Id.* at 6. He sees approximately 130 patients and performs 5 to 10 surgeries per week. *Id.* at 7.

Dr. Gornet testified that Petitioner first became a patient of his on June 5, 2008. *Id.* at 8. Dr. Gornet testified that Petitioner did remarkably well following the laminectomy with distractor placement at L2-3 that was performed on September 2, 2008 (see PX5, 11/6/14), and that Petitioner continued to do well up through the time of the work accident on February 17, 2014. (PX9, p.9). He testified that the L2-3 level of Petitioner's spine was the only level that required treatment in 2008. *Id.* at 9, 10. Dr. Gornet stated that Petitioner's mechanism of injury and complaints was entirely consistent with lumbar spine injury. *Id.* at 11-13. While Petitioner's L1-2 injury was clear, when only partial relief was obtained from treatment of that level, Dr. Gornet believed that Petitioner may have aggravated his L5-S1 level. *Id.* at 15. Dr. Gornet noted that Petitioner's initial presentation of symptoms were entirely consistent with L5-S1 injury rather than L1-2 injury:

> Q: What symptoms did he present with that would have been consistent with an injury or an aggravation at L5-S1? *Id.* at 15.

A: Well, his symptoms of what he described, low back pain to both buttocks, hips, and into his legs, tingling, and feet, particularly his left leg, all that is consistent. His initial presentation of symptoms is not diagnostic of L1-2. What we can say is that the MRI clearly showed a change at L1-2, but at this point where are treating his symptoms, and his symptoms easily could be emanating from one or other segments. That's why, as I stated in the note prior, my feeling was that he may have aggravated his underlying condition. So from our standpoint, the whole idea is to cure and relieve the effects of his work-related injury. If he's having symptoms consistent in his low back that emanate from another segment, obviously we should treat that as part of his work-related injury. *Id.* at 15, 16.

While Respondent maintained that Petitioner's complaints were only consistent with L1-2 pathology; Dr. Gornet explained on cross-examination that Petitioner's non-descript subjective complaints upon which Dr. Bernardi so heavily relied could not be traced or localized to any specific level, not even L1-2. *Id.* at 37, 38. Petitioner's objective MRI findings were what prompted the initial evaluation of L1-2 as a source of his complaints. *Id.* at 37, 38.

Dr. Gornet testified that although Petitioner's pre-existing foraminal stenosis could certainly have been aggravated; he believed it was Petitioner's actual L5-S1 disc itself that was aggravated by the accident. *Id.* at 47, 48. Dr. Gornet described how Petitioner's mechanism of injury resulted in structural disc injury at L5-S1 without nerve compression or impingement:

> We know from the science that we are doing that it isn't necessarily about nerve compression or nerve impingement. It is a structural injury to the disc and disc mechanism. Applying a sudden mechanical load to the back such as was described we already know can easily cause a disc that previously had been fairly normal to fail mechanically. The L5-S1 disc that was in a weakened state could easily have been aggravated as a result of that increased mechanical load. *Id.* at 19.

Dr. Gornet testified that injection is an effective conservative treatment for this type of injury (structural versus neurological) because it works locally to calm inflammation. *Id.* at 41. Contrary to the claims of Dr. Treister, Dr. Gornet testified that the Depo/Medrol and Lidocaine mixture is a local anesthetic, rather than a systemic treatment such as oral medication. *Id.* at 41. He explained:

Q: So an injection of Depo-Medrol and Lidocaine into the lumbar spine at any level, there's going to be some effect up and down the lumbar spine. Is that a fair statement?

A: Not necessarily. I'm sure you have been involved in cases, quite honestly, that steroid injections did nothing to help a patient. It depends on the patient's pathology, the amount of inflammation, and whether or not that injection is enough to turn the chemical process around. Remember, injections don't relieve nerve pressure. The fact he had a clinical response at L1-2, it's not because we relieved nerve pressure, but we relieved a chemical irritation that is causing some of the back pain in a nondescript situation. Similarly, L5-S1 works the same way. . .

> . . . If you think about it, in this particular situation, both injections helped his structural back pain because they're changing the chemical environment and the inflammatory environment in that local vicinity. The whole idea about injections is they act locally. The injection at L1-2 wouldn't affect L5-S1 or vice versa. *Id.* at 41-43.

Given that Petitioner's spine as a whole was doing well prior to the work injury of February 17, 2014, and Petitioner's response to injection at L5-S1 was significantly positive; Dr. Gornet opined that Petitioner sustained injury to L1-2 and L5-S1 as a result of his work accident, that both of those discs play a role in Petitioner's current pain and symptoms, and that his [Dr. Gornet's] current recommendations for treatment at L1-2 and L5-S1 are causally related to the work accident. *Id.* at 16, 17, 21. Although Petitioner responded well to treatment at L1-2 and L5-S1, Petitioner continued to have complaints and was therefore not at maximum medical improvement. *Id.* at 17-20.

On February 5, 2015, Dr. Gornet again saw Petitioner and noted that Petitioner had been working in a shuttle car and experiencing significant pain. (PX5, 2/5/15). Dr. Gornet recommended observation, but believed that he would eventually have to take Petitioner off work. *Id.* "I am trying to be as conservative as possible," he stated. *Id.* He recommended repeat injections and/or further conservative care to "try and manage him [Petitioner] in the best possible light." He again reiterated that Petitioner now has an "irrefutable" L1-2 problem and an aggravated underlying condition at L5-S1, including foraminal stenosis and disc pathology. *Id.*

On February 27, 2015 Dr. Michael Treister issued a retrospective utilization review on the L5-S1 injections Petitioner had previously undergone. This request was made by Respondent's counsel. (RX 4) Dr. Treister reviewed medical records from Deaconess Hospital, Dr. Gornet and Dr. Boutwell. He also reviewed diagnostic films. He did not feel the injections Petitioner had undergone at L5-S1 were reasonable or necessary treatment. In support of his opinion he noted that Petitioner has degenerative disc disease which has been present for many years and no evidence of recent symptom production or physical findings at that level. (PX 4)

Dr. Bernardi was deposed on March 6, 2015. Dr. Bernardi, a board certified neurosurgeon, testified by way of deposition that he did not believe that Petitioner's L5-S1 level was impacted by the work accident because there was no change in the interpretation of that level between Petitioner's 2008 and 2014 MRI scans. (RX1, p.11, 12). He also testified that he did not believe that Petitioner's complaints were consistent with L5-S1 pathology. *Id.* at 14. Shortly before he made that statement, however, he was asked to describe the sort of symptoms he would expect to see with an L5-S1 aggravation, and he testified:

> Yeah, that's a question that's impossible to answer. The – in terms of an aggravation of degenerative disc disease, there are no well-defined set of symptoms associated with that. Likewise, there are no well-defined set of physical findings associated with that which is why making that diagnosis is so difficult and often so problematic. . . *Id.* at 12, 13.

Dr. Bernardi testified that Petitioner related to him that the 12 weeks of physical therapy and the four epidural injections had helped him considerably. (RX1 at 21). Petitioner never related to Dr. Bernardi that the L5-S1 injections alone had dramatically helped his pain, or that the L5-S1 injections helped his pain more than the L1-2 injections. (RX1 at 21-22, 35). Dr. Bernardi testified he would have documented such statements had Petitioner made them. (RX1 at 21-22). Dr. Bernardi testified

that Petitioner's description of his relief following the injections suggested the injections helped more with the pathology at L1-2. (RX1 at 35).

Dr. Bernardi further testified that epidural steroid injections are of no proven benefit for treating or diagnosing back pain that is not associated with nerve root symptoms. (RX1 at 22). In terms of treatment, Petitioner did not have any neurological symptoms related to L5-S1, and had no radicular pain consistent with L5 or S1. *Id.* On that basis, Dr. Bernardi would not have recommended the two L5-S1 injections. (RX1 at 22-23).

In terms of diagnosing Petitioner's back pain, Dr. Bernardi testified that no weight can be placed on Petitioner's response to the L5-S1 epidural steroid injections. (RX1 at 23, 35-36). When an epidural steroid injection is performed, the medicine is absorbed throughout the lumbar spine. *Id.* In the absence of any acute findings on Petitioner's MRI at L5-S1, and in the absence of complaints referable to L5-S1, drawing a conclusion that L5-S1 is responsible for Petitioner's symptoms based solely on his subjective response to epidural injections is dangerous. *Id.*

Even assuming Petitioner's L5-S1 pathology was symptomatic, Dr. Bernardi testified there was no causal relation between those symptoms and Petitioner's work accident. (RX1 at 19). Such a finding would require multiple assumptions in the face of the obvious L1-2 disc herniation and associated symptoms. (RX1 at 31-32). Dr. Bernardi testified the simplest answer is almost always the best answer, and in this case, it is far more reasonable to conclude the pathology at L1-2 was responsible for Petitioner's symptoms. (RX1 at 33). It was likewise unreasonable to assume that L5-S1, which showed no new pathology on the MRI and did not correlate with Petitioner's complaints, was the source of his symptoms. *Id.*

Dr. Bernardi also testified that none of Petitioner's current complaints are related to L5-S1, and testified that Petitioner's L5-S1 injections were not reasonable and necessary treatment. (RX1 at 25-26). Petitioner does not have symptomatic structural back pain emanating from L5-S1. (RX1 at 48).

Since Dr. Bernardi did not believe that Petitioner was symptomatic at L5-S1; when asked if Petitioner was symptomatic at that level whether he would causally relate those symptoms to Petitioner's work accident, he stated, "I'm not sure I can answer that. I haven't really thought about that." *Id.* at 25, 26. He agreed that the epidural injections administered to Petitioner at L1-2 were reasonable and necessary treatments. *Id.* at 25.

On cross-examination, Dr. Bernardi testified that he performs 150 independent medical examinations a year "almost always for the defense." *Id.* at 27, 28. Dr. Bernardi acknowledged that Petitioner had no treatment or low back complaints prior to the February 2014 injury. *Id.* at 30. He admitted that being struck in the lower back by a large piece of rock can cause new disc injury and/or aggravate pre-existing injury. *Id.* at 30, 31. He admitted that if Petitioner was experiencing problems at the L5-S1 level, that it would be a "workable hypothesis" to conclude that Petitioner's accident aggravated his L5-S1 level. *Id.* at 31, 32. He admitted that there was no other explanation for Petitioner's low back pain and symptoms besides the February 2014 work accident. *Id.* at 33, 34. He admitted that he was aware that Dr. Gornet documented dramatic improvement in L5-S1 pain with injection. *Id.* at 35.

Dr. Bernardi admitted that he believed that even trivial trauma can aggravate underlying pre-existing stenosis. *Id.* at 38. He acknowledged that a patient can sustain an injury that causes structural back pain without neurological symptoms. *Id.* at 38, 46. He admitted that a patient can have pathology

and be asymptomatic, and have an increase in symptoms without having an objective change in pathology on an MRI. *Id.* at 38, 39. He also acknowledged that the driving force behind treatment recommendations for patients is symptoms rather than MRI findings. *Id.* at 39. He admitted that he could not rule out L5-S1 as a contributing source of Petitioner's pain. *Id.* at 42, 43. Although he initially testified in his own words on that his opinion as to treatment approach for structural back pain was a "philosophical" difference, he denied stating same when a confirming question was asked about his previous statement. *Id.* at 37, 47. He testified that he did not have the opportunity to review the deposition testimony of Dr. Gornet. *Id.* at 38.

Respondent next requested an additional utilization review by Dr. Treister in which he was asked to consider the reasonableness and necessity of additional treatment at L1-2 and L5-S1. (RX5). Dr. Treister did not believe that any further injections were needed now or in the future at either of these levels. *Id.*

Dr. Treister was deposed on May 4, 2015. He testified that Dr. Gornet's first note of February 24, 2014 documented only one objective physical finding, that being decreased sensation in the L2 dermatome. (RX3 at 13). He testified Petitioner's lumbar MRI showed a small disc herniation at L1-2 on the left, and some degenerative disc disease, which was unchanged from Petitioner's previous studies. (RX3 at 14-16).

Dr. Treister also testified it was possible that the pathology at L1-2 he observed on the MRI would irritate the L2 nerve root and therefore correlate with Dr. Gornet's finding of decreased sensation in the L2 dermatome. (RX3 at 16). However, Dr. Treister stated none of Petitioner's subjective complaints correlated to Petitioner's L5-S1 degenerative disc disease. (RX3 at 16-17). Nothing in Dr. Gornet's records documented anything by way of subjective complaints or objective physical findings that correlated to Petitioner's degenerative pathology at L5-S1. (RX3 at 18-22, 24-25, 30-33).

Dr. Treister testified the two L5-S1 injections were not reasonable and necessary treatment. (RX3 at 29). He testified that epidural injections are used for active radiculopathy, where a patient has pain radiating in a classic nerve root pattern from a certain level, or for patients who have symptomatic spinal canal stenosis. (RX3 at 23-24). Dr. Treister testified Petitioner had no active radiculopathy or symptomatic spinal stenosis at L5-S1. (RX3 at 24).

Dr. Treister testified that when an epidural steroid injection is administered, the injected material dissects up and down the lumbar spine without regard to the level at which it is administered. (RX3 at 68). An epidural steroid injection is only useful from a diagnostic perspective if the patient has no response at all, indicating a possible psychological origin of symptoms. (RX3 at 68-69). A patient can have an injection at one level of the lumbar spine and experience relief at another level. (RX3 at 69).

With regard to Petitioner's injections, Dr. Treister testified there was nothing objective in the records that substantiated Petitioner's subjective statements of relief following the L5-S1 injections, as documented by Dr. Gornet. (RX3 at 78). A patient with a disc herniation at L1-2 will experience relief if injected at L5-S1. *Id.* Effectiveness of a lumbar epidural injection is not dependent upon which level is injected. (RX3 at 79).

Dr. Treister testified that no additional treatment directed at L5-S1, including injections, would be reasonable and necessary treatment regardless of causation. (RX3 at 33).

Regarding L1-2, Dr. Treister testified that, regardless of causation, no additional treatment would be reasonable and necessary, including additional injections. (RX3 at 34). Dr. Treister testified that Dr. Gornet's most recent treatment notes do not document any subjective complaints or objective physical findings sufficient to justify additional treatment at L1-2. (RX3 at 32).

Dr. Treister also testified during his deposition that he no longer has an active medical practice and does not see patients. (RX3, p.37). He has not performed spine surgery in 6 to 7 years. *Id.* at 39. He testified that he did not believe that injections had any significant diagnostic value, and he did not believe that reduction in pain at the level of injection was any indicator that symptoms were emanating from that level. *Id.* at 67-69. He believed that the medicine had a global rather than a local effect and spread "willy-nilly" from the point of injection. *Id.* When asked whether he could rule out the L5-S1 level as a source of back pain, he stated, "Well, I can't say that there's absolutely no way that it's not coming from L5-S1 . . ." *Id.* at 76, 77. He testified that he could not identify which if any level the pain was coming from. *Id.* at 76, 77. When asked if he could state within a reasonable degree of medical certainty that Petitioner's symptoms were not coming from L5 to S1 if Petitioner received injections at L5-S1 and experienced significant relief, he stated, "I can't state anything one way or the other." *Id.* at 82.

Petitioner's case proceeded to arbitration on May 8, 2015. At the time of his accident Petitioner was a miner operator/continuous miner for Respondent. Petitioner acknowledged undergoing back surgery with Dr. Gornet in 2008 and that he returned to work on a full duty basis thereafter. Petitioner testified that prior to his February 17, 2014 accident he had undergone annual exams with Dr. Gornet to monitor the device Dr. Gornet had surgically placed in his back. His last visit prior to his accident was in July of 2013. He was doing well at that time and having no difficulties. Petitioner testified to no lost time from work in 2012, 2012, or prior to February 17, 2014 on account of his back.

Petitioner testified that he continues to suffer pain in his lower back, hips, groin and upper legs for which he takes Tramadol twice a day and muscle relaxers at night. Petitioner wishes to receive the discogram and injections recommended by Dr. Gornet and cease taking Tramadol. Petitioner further testified that he has undergone two injections at L5-S1 already and they lasted for about one week.

Petitioner was off work from February 18, 2014 through August 3, 2014 and since then has been working full duty as a "scoop operator." In this position he sits in a cab.

Petitioner also testified that Respondent ceased providing compensation for mileage after June of 2014. There are no spine surgeons in the county where Petitioner resides.[1]

The Arbitrator concludes:

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner's current condition of ill-being in his low back at L5-S1 and L1-2 is causally related to his undisputed accident of February 17, 2014. This conclusion is based upon Petitioner's credible testimony, a chain of events, and the opinions and testimony of Petitioner's treating physician, Dr. Gornet. With regard to a chain of events analysis, the Arbitrator notes that Petitioner, while having undergone low back surgery in 2008, was essentially asymptomatic prior to his undisputed accident on February 17, 2014 and had lost no time from work or undergone any active treatment in the recent

[1] Petitioner, however, is not seeking any mileage reimbursement in this proceeding.

years pre-dating his accident. While Dr. Gornet's medical records are not a model of completeness, the doctor's testimony, together with the mechanism of injury, and Petitioner's lack of treatment prior to the accident, indicate Petitioner remains symptomatic in his low back and has since the accident.

An accidental injury need not be the sole causative factor, or even the primary causative factor, as long as it is *a* causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 797 N.E.2d 665, 673 (Ill. 2003) (emphasis original). "Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Industrial Commission*, 309 Ill.App.3d 1037, 723 N.E.2d 846 (3rd Dist. 2000). In addition to or aside from expert medical testimony, circumstantial evidence may also be used to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill.App.3d 92, 631 N.E.2d 724 (4th Dist. 1994); *International Harvester v. Industrial Comm'n*, 442 N.E.2d 908 (1982).

The uncontroverted evidence in the record establishes that Petitioner was not suffering from any back complaints prior to the accident. (PX5). While Dr. Bernardi and Dr. Gornet disagree in their opinions regarding Petitioner's back condition and the type of treatment he might need, there disagreements are, as Dr. Bernardi testified, largely philosophical. Dr. Bernardi acknowledged Petitioner was not suffering from any back complaints prior to his accident. (RX1, p.30) Both Dr. Gornet and Dr. Bernardi agree that Petitioner's undisputed accident resulted in new injury at L1-2. (RX2) Dr. Bernardi also agreed that Petitioner's mechanism of injury (being struck by a huge piece of slate in the back) could result in an L5-S1 injury. (RX1, p.38) With regard to any L5-S1 injury, Dr. Gornet thoroughly explained in his treatment note of November 6, 2014, and testified extensively as to the basis of his belief in his deposition, that Petitioner's accident also resulted in a L5-S1 disc injury and/or aggravation. (PX5, 11/6/14; PX9) Yet, Dr. Bernardi did not believe that Petitioner's L5-S1 level was impacted by the accident. While Dr. Bernardi did not believe Petitioner had any neurological symptoms even remotely related to the L5-S1 level, Dr. Gornet is focusing on structural back pain, not neurological back pain. With regard to any structural injury, Dr. Bernardi simply indicated he thought such a belief was highly unlikely but not impossible. (RX 1, p. 24)

Dr. Bernardi relied upon Dr. Gornet's medical records in rendering his opinions. Those records, as Dr. Gornet openly acknowledged, weren't the best reflection of what was going on with Petitioner. Dr. Bernardi did not review the doctor's deposition and, thus, was unable to read/hear from Dr. Gornet himself why he felt Petitioner's L5-S1 disc condition was related to the accident. As Dr. Gornet explained, Petitioner has a pre-existing structural problem in his back and was presenting with nondescript complaints of back pain. When Dr. Gornet examined Petitioner on July 21, 2014, Petitioner's back pain had improved to some degree but not altogether. The doctor noted that since Petitioner's symptoms were improving in one area but still present in another, perhaps there was an aggravation to one of his other discs. (PX 9, pp. 33-37)

Dr. Bernardi acknowledged that Petitioner had degenerative disc disease at L5-S1. In his written report he stated that Petitioner's leg and back symptoms were "most likely" due to the disc herniation at L1-2. Thus, even at that time, Dr. Bernardi could not be certain that Petitioner's symptoms were solely due to the herniation at L1-2. During his deposition Dr. Bernardi testified that he "hadn't really thought about" causal connection at L5-S1, and was "not sure he could answer" a hypothetical question about causation if there was L5-S1 pathology (RX1, p.25, 26). On cross-examination he admitted that if Petitioner was experiencing problems at the L5-S1 level, that it would be a "workable hypothesis" to conclude that Petitioner's accident aggravated his L5-S1 level. *Id.* at 31, 32. He admitted that there was no other explanation for Petitioner's low back pain and symptoms besides the February 2014 work

accident. *Id.* at 33, 34. He also admitted that he was aware that Dr. Gornet documented dramatic improvement in L5-S1 pain with the injection. *Id.* at 35. His opinion with regard to L5-S1 is simply not persuasive given his admissions and concessions during his cross-examination.

The Arbitrator notes that Dr. Gornet is also in a unique position to render an opinion on causal connection, as he was monitoring Petitioner's condition before and after the accidental injury. Dr. Gornet testified that Petitioner's injury is not neurological, but mechanical and partially chemical in nature. (PX9, p.47, 48). Consequently, Petitioner's condition would not manifest itself on MRI studies. Dr. Bernardi admitted that this was possible during his deposition, and ultimately admitted that he could not rule out L5-S1 as a contributing source of Petitioner's pain. (RX1, p.38, 39, 42, 43, 46).

While Respondent has understandably challenged liability for Petitioner's L5-S1 condition, the gap in time before Dr. Gornet began addressing the L5-S1 level is not alarming to the Arbitrator in this instance as Dr. Gornet credibly explained how Petitioner's condition at L1-2 was improving during that gap but Petitioner was not altogether asymptomatic. His explanation, combined with the mechanism of injury, and lack of treatment to Petitioner's low back for some time prior to the accident, make the gap less significant in this case. Respondent also challenges liability based upon the lack of objective physical findings found in Dr. Gornet's records. While this is true, there is objective evidence of Petitioner's condition found in the therapy records and even Dr. Bernardi noted objective findings on his physical examination in October of 2014. Furthermore, it does not appear that Dr. Bernardi reviewed Petitioner's physical therapy records. While Dr. Treister commented that he reviewed them, he felt they revealed no "meaningful positive physical examination findings" or "detailed subjective complaints." The Arbitrator disagrees with the doctor's assessment of the physical therapy records as they do reflect subjective complaints. Additionally, the notes show that Petitioner was not to engage in any leg exercises during this time and was consistently reporting difficulty walking, sitting, standing, stair climbing, bending, and lying down. He could not sleep throughout the night. Petitioner continues to complain of lower back, hip and groin pain. When examined by Dr. Bernardi, Petitioner told the doctor he noted such complaints with prolonged sitting. Respondent has Petitioner sitting in a cab all day long working.

Based upon the opinions and testimony of Dr. Gornet, the overwhelming circumstantial evidence, and the admissions and concessions of Dr. Bernardi, Petitioner met his burden of proof on causation and has established that his current condition of ill-being with respect to his lumbar spine at both L1-2 and L5-S1 is causally related to the undisputed accident that occurred on February 17, 2014.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Respondent shall pay the medical expenses contained in Petitioner's group exhibit #1 and shall have credit for any amounts already paid. Employers are responsible for providing the medical care reasonably required in order to diagnose, relieve, or cure the effects of the claimant's injury. *Plantation Mfg. Co. v. Indus. Comm'n,* 294 Ill.App.3d 705, 691 N.E.2d 13 (2000); *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill.App.3d 527, 758 N.E.2d 18 (1st Dist. 2001); 820 ILCS 305/8(a). In so concluding, the Arbitrator relies upon her causation determination above and incorporates it herein by reference.

While Respondent disputes liability for the costs of the injections Petitioner has undergone at L5-S1 relying upon the opinions and testimony of Dr. Bernardi, the Arbitrator did not find Dr. Bernardi's testimony on this issue persuasive. Essentially, Dr. Bernardi and Dr. Gornet share a

philosophical difference of opinion on the topic of epidural injections. Dr. Gornet persuasively explained his basis for recommending them and Petitioner derived some benefit from them. Dr. Treister's utilization review of the two injections at L5-S1 was not persuasive. While Dr. Treister commented that he reviewed Petitioner's physical therapy records, he felt they revealed no "meaningful positive physical examination findings" or "detailed subjective complaints." The Arbitrator disagrees with the doctor's assessment of the physical therapy records as they do reflect subjective complaints. Additionally, the notes show that Petitioner was not to engage in any leg exercises during this time and was consistently reporting difficulty walking, sitting, standing, stair climbing, bending, and lying down. He could not sleep throughout the night. Petitioner continues to complain of lower back, hip and groin pain.

Respondent shall indemnify and hold Petitioner harmless from any claims from the medical providers contained in PX 1 arising out of the expenses for which it claims credit, pursuant to § 8(j) of the Act.

Issue (K): Is Petitioner entitled to any prospective medical care?

Respondent shall authorize and pay for the further necessary care in the form of a repeat injection at L5-S1 as discussed by Dr. Gornet but only if Dr. Gornet still feels it is warranted. Any further award of prospective medical care would be speculative at this juncture.

At the time of his January 2015 deposition, Dr. Gornet testified that he would first recommend a repeat injection at L5-S1 if he still felt it was warranted. He then added that if the injection at L5-S1 failed consideration would be given to either an injection at L1-2 or further work-up to see whether surgery at one of those levels might be appropriate. Thus, at this juncture, any further treatment recommendations are somewhat speculative. When Dr. Gornet last examined Petitioner on February 5, 2015 he recommended observing Petitioner and seeing how he did. He then added that Petitioner might need to be taken off work and that if treatment could be approved, he would recommend conservative treatment and care, including repeat injections.

Respondent disputes the reasonableness and necessity of further injections at either level based on the opinions of Dr. Treister. While Dr. Treister did not believe any further repeat injection would be reasonable or necessary because he found no subjective complaints or objective physical findings documented in Petitioner's medical records, he had no opportunity to discuss the matter with Dr. Gornet as Respondent's counsel specifically told him not to contact the doctor. Dr. Gornet testified that the injections at L5-S1 improved Petitioner's pain complaints. Dr. Treister did not discuss the matter with Dr. Gornet in an attempt to understand the basis on which the doctor was recommending a repeat injection at L5-S1. Dr. Gornet credibly explained the basis for his recommendation of injections at L5-S1.

With regard to whether or not Petitioner requires any type of further treatment, the Arbitrator notes that neither Dr. Bernardi nor Dr. Gornet has placed Petitioner at maximum medical improvement. Dr. Bernardi testified during his deposition in March of 2015 that Petitioner may require repeat injections at L1-2 (RX1, p.25); however, in his report he acknowledged that Petitioner may very well require surgery. (RX2). Dr. Gornet stated on more than one occasion that Petitioner was "definitely not at maximum medical improvement" and held to that belief at the time of his deposition taken in February of 2015. (PX5, 9/22/14, 11/6/14; PX9, p.17-20). Petitioner testified he continues to suffer pain in his lower back, hips, groin and upper legs for which he takes Tramadol and muscle relaxers, and

stated he wishes to receive the discogram and injections recommended by Dr. Gornet and cease taking Tramadol. Dr. Gornet did not testify that he is currently recommending a discogram. Rather, he testified that any additional work up or surgery would be wholly dependent on Petitioner's response to further injections.

****

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

Vickie Gow,

Petitioner,

vs. NO: 14WC 26143

Ricklee Vans,

Respondent,

16IWCC0322

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent, herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 13, 2015, 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.

16IWCC0322

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 $16,217.00. 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: MAY 12 2016
MJB/bm
o-5/10/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

GOW, VICKIE
Employee/Petitioner

Case# 14WC026143

RICHLEE VANS
Employer/Respondent

16IWCC0322

On 10/13/2015, 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 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0222 GOLDBERG WEISMAN & CAIRO
SANDY ECHEVESTE
ONE E WACKER DR 39TH FL
CHICAGO, IL 60601

0208 GALLIANI DOELL & COZZI LTD
ROBERT J COZZI
20 N CLARK ST SUITE 825
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

- ☐ Injured Workers' Benefit Fund (§4(d))
- ☐ Rate Adjustment Fund (§8(g))
- ☐ Second Injury Fund (§8(e)18)
- ☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

VICKIE GOW
Employee/Petitioner

v.

RICHLEE VANS
Employer/Respondent

Case # **14** WC **26143**

Consolidated cases: **D/N/A**

16IWCC0322

An *Application for Adjustment 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 **09/24/15**. 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. ☒ 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

16IWCC0922

On the date of accident, **05/16/14**, 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.

For the reasons set forth in the attached decision, the Arbitrator finds that the accident of May 16, 2014 aggravated an underlying cervical spine condition of ill-being and brought about the need for additional testing and treatment, including the "add on" cervical spine surgery Dr. Bernstein has recommended. The Arbitrator further finds that Petitioner failed to prove a causal connection between the accident and the flank pain/urinary tract infection for which she underwent care at Palos Community Hospital between May 24 and May 25, 2014 and on June 5, 2014. PX 23.

In the year preceding the injury, Petitioner earned **$13,432.64**; the average weekly wage was **$258.32**.

On the date of accident, Petitioner was **45** years of age, *single* with **2** dependent children.

Respondent *has not* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$1,976.26** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,976.26**.

Respondent is entitled to a credit of **$0**, under Section 8(j) of the Act.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $6,117.00 to Little Company of Mary Hospital and $291.05 to The Spine Center (Dr. Bernstein) as provided in Sections 8(a) and 8.2 of the Act. PX 23.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $258.32 per week, commencing 05/20/14 through 09/24/15, a period of 70 3/7 weeks, as provided in Section 8(b) of the Act, with Respondent receiving credit for the $1,976.26 in benefits it paid prior to the hearing.

Prospective Care

The Arbitrator awards prospective care in the form of a return visit to Dr. Bernstein along with the "add on" cervical spine surgery Dr. Bernstein has recommended.

Penalties/Fees

For the reasons set forth in the attached decision, the Arbitrator declines to find Respondent liable for penalties or fees.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

16IWCC0322

Molly C Mason
Signature of Arbitrator

10/12/15
Date

ICArbDec19(b)

OCT 13 2015

16IWCC0322

Vickie Gow v. Richlee Vans
14 WC 26143

16IWCC0322

Statement of Disputed Issues

Petitioner, a school bus driver with a complicated medical history, including a cervical spine fusion in December 2013, alleges a neck injury at work on May 16, 2014. She claims temporary total disability benefits from May 19, 2014 through the hearing of September 24, 2015 along with medical expenses, a prospective "add on" cervical spine fusion, as recommended by Dr. Bernstein, and penalties/fees. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified she began working as a school bus driver for Respondent on August 26, 2013. Prior to being hired by Respondent, she was a stay-at-home mom for 23 years. She testified she underwent and passed a pre-employment physical examination at Little Company of Mary Care Station prior to starting work for Respondent. She indicated her hiring was contingent on passing this examination. She denied being the subject of any disciplinary action between her hire date and her claimed work accident of May 16, 2014. She testified she passed a drug test before being hired and passed two additional drug tests in early 2014. PX 11.

Petitioner testified she transported about 14 students per day. The students she transported were disabled. She drove routes in the morning and afternoon. Her duties involved conducting pre-trip inspections, keeping the bus aisles clear, picking up/dropping off students and operating the bus lift. A bus attendant always rode with her. When she dropped off or picked up students from Aero School, a nurse also rode on the bus.

Petitioner acknowledged undergoing extensive treatment for various non-work-related medical problems before the work accident. Her records reveal a history of major lumbar spine surgery in 1996, 1997 and 2000, with the last of these performed by Dr. Bernstein. In 2003, she underwent a work-up for neck and bilateral arm pain, including a cervical spine MRI and EMGs. PX 15, p. 11. In approximately 2006, she was diagnosed with fibromyalgia. She was treated via medication. In early 2007, she was diagnosed with right arm sympathetic dystrophy, which Dr. Amine treated via medication and stellate ganglion blocks. PX 15, pp. 6, 15-16. In August 2008, Dr. Amine prescribed various medications, including Norco, for migraines. PX 15, p. 5. On April 14, 2011, Petitioner's primary care physician, Dr. Alawad, found her "not medically fit" for jury duty, noting a 10-year history of chronic pain, a history of three major operations and a fibromyalgia diagnosis. PX 14, p. 115. Petitioner testified she went through a stressful period in late 2012 and 2013 due to marital problems, divorce proceedings and her mother's death. On June 13, 2012, she saw Dr. Alawad and requested a Norco refill. The doctor noted that Petitioner was "potentially addicted" to Norco. He recommended a psychology consultation. PX 14, p. 27. On February 6, 2013, Petitioner underwent right shoulder surgery. PX 17. Later in

2013, Petitioner's former husband beat her, causing a neck injury. In October 2013, Dr. Curtin admitted her to the hospital for treatment of headaches.

Records in PX 15 include a cervical spine MRI report dated October 21, 2013, documenting a left paracentral disc extrusion at C6-C7 and a shallow left paracentral disc protrusion at C5-C6. PX 15, pp. 12-13. On November 26, 2013, Dr. Amine reviewed the MRI, prescribed Norco for neck and left arm pain and recommended cervical spine surgery. PX 15, p. 3.

Petitioner testified she saw Dr. Bernstein for a second opinion on December 9, 2013. On that date, Dr. Bernstein wrote to Dr. Alawad, noting Petitioner's remote lumbar spine revision fusion in 2000, her long history of migraines and her more recent complaints of neck pain radiating down her left arm. He indicated that Petitioner attributed these complaints to being abused by her husband. He noted that Petitioner was working as a school bus driver.

On examination, Dr. Bernstein noted a decreased range of cervical spine motion, a positive Spurling's maneuver and decreased sensation primarily in the mid digits of the left hand. He reviewed the October 21, 2013 cervical spine MRI. He interpreted this scan as showing a moderate to large left-sided herniation causing nerve root compression at C6-C7 and a "small shallow paracentral disc protrusion or herniation at C5-C6." He targeted the C6-C7 herniation as the cause of Petitioner's left-sided symptoms. He characterized the C5-C6 abnormality as "asymptomatic." He indicated he discussed various treatment options with Petitioner, with Petitioner electing to proceed with surgery as soon as possible. PX 4, pp. 66-67.

On December 18, 2013, Dr. Bernstein performed a left-sided anterior cervical discectomy with fusion at C6-C7. PX 9. Dr. Bernstein prescribed Norco postoperatively. PX 4, pp. 41-42. PX 9.

On December 26, 2013, Dr. Spencer (Dr. Bernstein's partner) wrote to Dr. Alawad, informing that Petitioner was "doing fine" and that her X-rays looked good. Dr. Spencer indicated he had released Petitioner to resume driving a bus as of January 6, 2014. PX 4, p. 65.

On January 3, 2014, Petitioner saw Dr. Lopez at the Little Company of Mary Care Station for purposes of a "fit to work" examination. In his note of that date, the doctor documented the December 18, 2013 cervical fusion and Dr. Spencer's full duty release. He also noted that Petitioner's current medications included Norco, Neurontin, Flexeril and Amytriptyline. He noted a full range of neck motion on examination. He found Petitioner fit to resume full duty as of January 6, 2014. PX 11, pp. 27-30.

Petitioner testified she resumed her normal bus driving duties for Respondent on January 6, 2014. She indicated she resumed working shortly after the surgery because she had a mortgage and other bills to pay. Before resuming work, she obtained clearance at Little Company of Mary Care Station. She needed to be cleared before she could resume driving.

On January 13, 2014, Dr. Bernstein wrote to Dr. Alawad, informing him that Petitioner was "dramatically improved from her pre-operative status." Dr. Bernstein also indicated that Petitioner's X-rays looked good but that he was recommending a bone stimulator due to Petitioner's smoking history. PX 14, p. 97.

On February 6, 2014, Dr. Bernstein wrote to Dr. Alawad and noted that Petitioner was experiencing neck pain but denied any radicular symptoms. Dr. Bernstein also noted that Petitioner felt she "went back to work too quickly." He indicated he prescribed Motrin, Flexeril and physical therapy. PX 4, p. 63.

On February 25, 2014, Dr. Spencer wrote to Dr. Alawad, indicating that Petitioner was "having some severe neck pain" following the fusion. He expressed hope that the pain was "just some muscle spasm," noting that Petitioner's X-rays looked good. He prescribed steroids, muscle relaxants and pain medication, indicating that a repeat MRI might become necessary. PX 4, p. 62.

On March 5, 2014, Petitioner saw Dr. Alawad, with the doctor noting complaints of right-sided rib cage pain, dizziness, depression, anxiety and neck pain. On cervical spine examination, the doctor noted limited flexion and extension. He prescribed Buspar and directed Petitioner to stop taking Norco. PX 14, p. 13.

Under cross-examination, Petitioner acknowledged she continued taking Norco after March 5, 2014 despite Dr. Alawad's instructions to discontinue the medication. On direct examination, Petitioner testified she passed drug tests at Little Company of Mary Care Station in March and April 2014. Petitioner further testified that Respondent would have terminated her had she failed these tests. Petitioner indicated that Respondent knew she was on medication and allowed her to continue working. She took her prescribed medication at the end of her work shifts and at bedtime.

Records in PX 11 reflect that Petitioner underwent random drug testing at Little Company of Mary Care Station on March 13, 2014. PX 11, pp. 21-26.

On March 20, 2014, Petitioner returned to Dr. Bernstein. The doctor noted that Petitioner's "acute flare-up appears to be improved." The doctor interpreted the recent repeat MRI as showing a "persistent left-sided disc protrusion at C5-6 which appears to be no worse and in fact be slightly improved." He found it "possible this is responsible for some of [Petitioner's] current pain" but went on to state: "nevertheless, she is functional – her radiculopathy is gone and her X-rays look good." After noting that Petitioner "may not have any insurance available due to her divorce," he recommended she "try to obtain some insurance for her benefits and her future." He recommended she follow up in three months. PX 4, p. 61.

On April 23, 2014, Petitioner saw Dr. Alawad and complained of a bladder infection as well as back pain and anxiety. The doctor started Petitioner on Cipro and recommended exercise and smoking cessation. PX 14, p. 10.

Petitioner denied reinjuring her neck at any point between January 2014 and May 2014. She testified she did not live with her former husband during this period.

Petitioner testified she was injured at work at about 8:40 AM on Friday, May 16, 2014. The accident occurred while her assigned bus was parked outside of Aero School in Burbank. Children on her bus were being dropped off at the school. Immediately before the accident, she was standing at the front of the bus. There were three other adults on the bus: Tamika Brown, a bus attendant who was filling in for the regular attendant that day, Karen, a nurse, and a teaching assistant from the school, who was on the front bus steps. The teaching assistant told a boy on the bus to get up. The boy stood up and Tamika guided him to the bus aisle. Then the boy came running toward Petitioner. The boy was about 9 years old. Petitioner testified that the boy made contact with her, causing her to fall backward into the dashboard. She managed to catch herself but felt as if the wind had been knocked out of her. She was shaken up.

Petitioner testified the bus was equipped with a surveillance camera. When she inspected the bus, at the start of her shift, she made sure this camera was on.

Petitioner testified she was able to finish her shift after the accident. She began experiencing headaches as the day went on. By early evening, she was experiencing "horrible pain" in her head and neck. The pain was different than the pain she had experienced before the work accident.

Petitioner testified she reported the accident to her supervisor, Candise Bradley, on Sunday, May 18, 2014. Petitioner testified that Bradley came to her house that day.

Under cross-examination, Petitioner acknowledged completing an accident report. [She testified she completed this report on May 19, 2014 but her supervisor, Candise Bradley, testified Petitioner actually started preparing the report on May 16, 2014. Bradley denied going to Petitioner's house on Sunday the 18th. Bradley testified that Petitioner did not complete the form to her satisfaction until May 20, 2014.] In this report, Petitioner indicated she was standing in the front of the bus at 8:40 AM on May 16, 2014 when a boy started walking down the aisle and then began running toward her, head first, striking her in the upper body and chest and "knocking [her] backwards into the dash and windshield." Petitioner complained of severe migraine headaches, nausea, fatigue and neck pain. She indicated she had previously seen Dr. Bernstein. She listed three witnesses to the accident. A note that appears to be in different handwriting indicates Petitioner "originally didn't want to go to clinic." RX 1.

Petitioner testified she reported to work on Monday, May 19, 2014, but managed to work only half a day. At about 11:24 AM that day, Petitioner saw a nurse and Dr. Brown at

Little Company of Mary Care Station. The nurse noted a history of the work accident and previous cervical spine surgery, a complaint of 9/10 pain and no observable signs of abuse. PX 11, p. 18. The doctor noted a past history of lumbar spine surgeries, neck surgery in December 2013 and migraines. She also noted a history of the work accident. She indicated that, at 8 AM on May 16, 2014, a "student ran into" Petitioner's neck area, with Petitioner describing her head as moving backward. The doctor indicated that Petitioner was "unsure whether [she] hit back of head on windshield" but experienced a "moment of dizziness." The doctor also indicated that it was later in the day on May 16, 2014, at about 4:30 PM, that Petitioner began experiencing headaches, nausea and more neck pain. On examination, Dr. Brown noted a reduced range of cervical spine motion, indicating that Petitioner reported being "unable to do chin to chest." She prescribed CT scans of the brain and cervical spine on a STAT basis, along with Zotran and Toradol. She took Petitioner off work and directed her to return the next day. She instructed Petitioner to seek Emergency Room care if she experienced vomiting, blurred vision or worsening headaches. PX 11, pp. 16-18. A note in PX 11 reflects that Petitioner's supervisor, Candise Bradley, approved the CT scans. PX 11, pp. 19-20.

Petitioner underwent the CT scans at Little Company of Mary Hospital on May 19, 2014. The brain CT scan was negative. PX 4, p. 37. The cervical spine CT scan showed the fusion hardware and no fracture or dislocation. The radiologist saw no large disc herniation. PX 4, pp. 35-36.

On May 20, 2014, Petitioner returned to the Little Company of Mary Care Station, as directed, and saw Dr. Skomurski. The doctor noted complaints of headaches, nausea and neck stiffness. He kept Petitioner off work and indicated she should apply heat/ice to her neck and seek Emergency Room care if she worsened. PX 11, pp. 13-14.

On May 21, 2014, Petitioner went to the Emergency Room at Palos Community Hospital. A triage note reflects that Petitioner complained of 9/10 head pain, nausea and "just not feeling right" since a work accident of May 16, 2014. The note sets forth the following account of that accident: "was struck to the chest by a student at work – fell backwards and struck head." Petitioner indicated she had seen a company doctor the previous day who had advised her to seek Emergency Room care if her symptoms worsened.

The Emergency Room physician, Dr. Chester, noted that Petitioner complained of head and neck pain since being struck in the chest by a 7-year-old student on a bus. Dr. Chester indicated that Petitioner reported falling backward into the dashboard after getting struck, striking her head on the windshield. He noted a past history of cervical and lumbar spine surgery, anxiety and migraines. He further noted that Petitioner reported being on Norco and Flexeril and "using narcotics while driving the school bus." It appears that Dr. Chester relayed this information to a Little Company of Mary company physician.

On examination, Dr. Chester noted no abnormalities other than elevated blood pressure. He ordered a head CT scan. The radiologist described this scan as unremarkable. PX 12, p. 24. Dr. Chester diagnosed blunt injury, cephalgia and cervical strain. He prescribed

Prednisone and Acetaminophen and recommended that Petitioner follow up with an orthopedist.

Petitioner returned to Little Company of Mary Care Station on May 22, 2014 and again saw Dr. Skomurski. The doctor noted that Petitioner complained of neck stiffness, worsening headaches and dizziness. He also noted the results of the CT scan performed at the Emergency Room. He kept Petitioner off work, recommended Fioricet with Codeine and indicated Petitioner might need physical therapy if she failed to improve. PX 11.

On May 24, 2014, Petitioner saw Dr. Brown at Little Company of Mary Care Station. The doctor noted complaints of headaches, blurred vision, nausea, dizziness and neck stiffness. A discharge note dated May 24, 2014 reflects that the doctor took Petitioner off work and sent her to the Emergency Room due to "no improvement of headache and now blood in urine." Dr. Brown's diagnoses included "blunt head trauma." PX 11. PX 12, p. 147.

Petitioner returned to the Emergency Room at Palos Community Hospital on May 24, 2014. A triage note reflects that Petitioner reported suffering blunt trauma on May 16, 2014, after being "attacked at work." The note also reflects that Petitioner complained of blood in her urine and 5/10 right upper abdominal pain.

The Emergency Room physician, Dr. Cairo, noted that Petitioner complained of nausea of eight days' duration, right-sided flank pain of five days' duration and hematuria of two days' duration. Dr. Cairo also noted that Petitioner reported having a mechanical fall on May 16th "where her right flank did hit the dashboard," with Petitioner expressing concern that this fall could have caused her current symptoms. On examination, Dr. Cairo noted very mild right upper quadrant abdominal tenderness. She started Petitioner on IV fluids and ordered lab work and CT scans of the abdomen and pelvis. The scans showed no stones or masses. Urinary studies showed red blood cells that were too numerous to count. Dr. Cairo started Petitioner on IV antibiotics and admitted her to the hospital.

A handwritten note dated May 25, 2014 reflects that Petitioner reported a history of multiple urinary tract infections. This note also reflects that Petitioner reported taking aspirin daily. PX 12, p. 101.

Petitioner saw a urologist, Dr. Steinberg, at the hospital on May 25, 2014. Dr. Steinberg noted that Petitioner reported "recent trauma to the back while on the job after she was tackled by a student and thrown backwards onto the steering wheel."

Dr. Steinberg's impression was "probable urinary tract infection with gross hematuria from aspirin daily plus possible effect of trauma while on anti-coagulants. The patient did suffer a blow to the back while on the job one week ago." He recommended that Petitioner stop taking aspirin, continue the antibiotics and follow up with him. Petitioner was discharged from the hospital on May 25, 2014. PX 12.

On May 29, 2014, Petitioner saw Dr. Bernstein, with the doctor noting a history of a "new injury on May 16th." The doctor indicated that Petitioner had resumed working before this injury and was "doing reasonably well without much in terms of pain complaints" when a "large, 8-year-old autistic child charged her." The doctor described the impact as causing a "whiplashing motion of [Petitioner's] neck" and complaints of neck and diffuse shoulder pain since that time. He interpreted the May 19, 2014 CT scan as showing a stable cervical spine fusion with no evidence of hardware or screw loosening. On examination, he noted a guarded range of cervical spine motion and tenderness to palpation.

Dr. Bernstein expressed hope that the new injury only involved soft tissue. He kept Petitioner off work, prescribed Norco and recommended physical therapy and follow-up. PX 4, p. 60.

Petitioner saw Dr. Alawad on June 5, 2014, with the doctor noting that Petitioner reported being injured while working on May 16th due to a student "charging into her" on a bus. The doctor also noted that Petitioner reported feeling a "pop" in her lower right abdominal area the previous night. He diagnosed an abdominal contusion. PX 14, p. 9.

Petitioner returned to the Emergency Room at Palos Community Hospital on June 5, 2014. The triage note of that date reflects that Petitioner reported feeling something "pop" in her right abdomen the previous night and was now experiencing constant back pain as well as elevated blood pressure. The note also reflects that Petitioner reported seeing her primary care physician earlier in the day and being started on Amlodipine.

The Emergency Room physician, Dr. Elmosa, noted that Petitioner complained of right lower abdominal pain that had progressively worsened since the previous day. On examination, Dr. Elmosa noted soft mild tenderness to the right lower abdomen. He ordered lab work and an abdominal CT scan, which was unremarkable. PX 12, pp. 184-185. He started Petitioner on Macrobid after a urinalysis showed evidence of a urinary tract infection. He recommended that Petitioner follow up with Dr. Alawad. PX 12, pp. 158-161.

On June 16, 2014, Dr. Bernstein noted that Petitioner had not had a chance to begin therapy. He directed Petitioner to start therapy and remain off work. PX 4, p. 58. Petitioner began a course of physical therapy at ATI three days later. PX 13.

On June 30, 2014, Dr. Bernstein noted that Petitioner described therapy as "so-so" and was still complaining of neck pain, especially when turning her head to the right. He recommended a cervical spine MRI. PX 4, p. 57.

Petitioner underwent the recommended cervical spine MRI on July 9, 2014. The MRI showed evidence of the prior C6-C7 fusion, disc desiccation at C2-C3 to C5-C6 levels and a focal left paracentral disc protrusion indenting the thecal sac at C5-C6. The radiologist described the spinal canal as "compromised in its left half." PX 16.

On July 18, 2014, an adjuster at Gallagher Bassett Services, Inc. sent Petitioner a letter indicating that Respondent was temporarily suspending all medical and TTD benefits pending Petitioner's attendance at a Section 12 examination that was to be scheduled "within the next two to four weeks." PX 10.

Petitioner was discharged from therapy on July 30, 2014, after undergoing seventeen sessions. At discharge, the therapist noted that Petitioner's symptoms were slowly getting better but that she was still symptomatic. PX 13.

Petitioner testified her bus driver certificate expired in August 2014. She submitted to a physical examination and drug testing at Work Right, in an effort to renew this certificate, but was told she could not be certified until after Dr. Bernstein had released her.

At Respondent's request, Petitioner saw Dr. Wehner for purposes of a Section 12 examination on August 15, 2014. Petitioner testified that Dr. Wehner spent about ten minutes with her.

Dr. Wehner's report sets forth the following account of the claimed work accident:

> "There was an autistic boy [who] did not want to get off the bus. The teacher came on the bus and spoke with him. [Petitioner] states the boy came charging at her and head-butted her on her chest and she went flying back into the dashboard and window. It buckled her knees but she did not fall to the ground. The teacher was nine months pregnant but she was able to get the boy under control. She then went back to drop her bus off. This was at 8:40 in the morning. She began having neck and head pain by early noon. By 5:00 PM she states she was in bed for the entire weekend. She states her boss came over Sunday afternoon on another matter and she told him [sic] then. She then went to Little Company of Mary Care Station. She ended up following with Dr. Bernstein [with] whom she had treated prior to this. She remains off work. She has been on Flexeril, Norco, Neurontin and Ibuprofen."

Dr. Wehner noted that Petitioner complained of 8/10 pain in the back of her neck radiating out to both shoulders and down both arms to her thumb, index and middle finger. She also noted complaints of pain radiating up from the back of the head to the forehead.

Dr. Wehner indicated she reviewed a cervical spine MRI report dated February 27, 2014 as well as a report and films concerning a cervical spine MRI performed on July 11, 2014. She indicated the February 27, 2014 report documented a left C5-C6 paramedian disc protrusion as well as surgical fusion of C6-C7. She interpreted the July 11, 2014 films as showing both the fused levels and focal left paracentral disc protrusion at C5-C6 indenting the thecal sac.

Dr. Wehner also indicated she reviewed a video of the accident and other treatment records, with the latter showing that Petitioner had been receiving Hydrocodone from both Dr. Amin and Dr. Bernstein simultaneously and was also obtaining Norco from a prior prescription from Dr. Amine. According to Dr. Wehner, Petitioner indicated she was proceeding in this fashion "because her insurance was ending after her divorce and she would no longer have the ability to get the Norco under her insurance."

Dr. Wehner indicated that Petitioner reported both chronic cervicalgia and an acute episode of cervicalgia occurring on May 15, 2014. Dr. Wehner opined, based on her comparison of the MRIs, that the alleged acute episode caused only a soft tissue injury "as there are no new MRI findings and [Petitioner] has had the same type of subjective complaints."

Dr. Wehner indicated she would find it helpful to review the records of Drs. Amine, Bernstein and Alawad. She found it reasonable for Petitioner to undergo twelve physical therapy sessions as a result of the soft tissue injury. She saw no need for any treatment beyond this therapy. She found Petitioner to be capable of full duty, noting that, according to records from ATI, Petitioner's job was sedentary in nature.

On September 12, 2014, Respondent's counsel sent Dr. Wehner's report to Petitioner's counsel and indicated that, based on the doctor's opinions, no temporary total disability benefits would be paid after August 15, 2014. PX 4, p. 77.

On October 2, 2014, Dr. Bernstein sent a report to Petitioner's counsel, outlining the pre- and post-accident care and indicating he had not seen Petitioner since June 30, 2014. He addressed causation as follows: "This patient is status post a new injury on May 16, 2014, superimposed on a prior fusion as well as a known cervical disc abnormality at the C5-C6 level." He opined that the work accident aggravated the C5-C6 condition, "resulting in chronic and continuous neck pain." He recommended follow-up care and described Petitioner as disabled from work "as a result of the new incident." PX 4, pp. 54-55.

Petitioner returned to Dr. Bernstein on October 16, 2014, with the doctor noting "progressively worsening neck pain" radiating into both arms. He interpreted the July 2014 cervical spine MRI as showing a "worsening disc herniation at the C5-C6 level." He linked this to the "recent work incident" and, after discussing various options, recommended an "add on anterior cervical decompression and fusion" at C5-C6. PX 4, p. 53.

In an addendum dated January 21, 2015, Dr. Wehner noted that Petitioner used narcotic pain medication after the 2013 cervical fusion and obtained a Norco refill through Dr. Bernstein the day before the work accident. She opined that the need for the C5-C6 surgery "was present based on [Petitioner's] subjective complaints, her need for narcotic pain medication and the MRI findings that were all present prior to the May 16, 2014 alleged injury." Wehner Dep Exh 3.

Dr. Wehner issued another report on April 22, 2015, after reviewing a number of pre-accident records dating back to 1998 and re-reviewing the MRIs. She opined that the MRI taken on July 11, 2014 showed findings at C5-6 "that are in the same location and the same size" as the findings on the pre-accident February 27, 2014 MRI. She indicated she had "no reason to believe [Petitioner] sustained any significant injury on the date of May 16, 2014." Wehner Dep Exh 4.

On June 24, 2015, Dr. Bernstein released Petitioner to work subject to multiple restrictions, including no lifting over 10 pounds, no repetitive bending, twisting, reaching or lifting and no bus driving. PX 4a. Petitioner testified she requested this release. She has not found work because of the nature of the restrictions and because her 8-year-old son had to undergo major hand surgery.

Dr. Wehner testified by way of evidence deposition on August 14, 2015. RX 8. Dr. Wehner testified she is a fellowship-trained, board certified orthopedic surgeon who devotes 90% of her practice to spinal issues. RX 8, p. 5. Wehner Dep Exh 1. She examined Petitioner once, on August 15, 2014. She summarized her history and examination findings. RX 8, p. 7.

Dr. Wehner testified she later compared the October 21, 2013 pre-fusion cervical spine MRI with the post-operative February 27, 2014 MRI. In her opinion, the two MRIs "showed similar findings." RX 8, pp. 11, 16. Later still, she reviewed another cervical spine MRI taken on July 11, 2014. This MRI showed no substantial change since February 27, 2014. RX 8, p. 18. It is commonplace for her to review and compare MRI images. The February and July 2014 MRIs were taken at different facilities. The shading can vary from facility to facility but, in her opinion, the two images that Dr. Bernstein referenced in his deposition are "clinically the same." RX 8, p. 20. Both show a left paracentral herniation at C5-C6 impinging on the thecal sac, which is the whitish area on the images, and without causing significant compression of the cord. "There's no difference between these two." RX 8, p. 22.

Dr. Wehner testified Petitioner was taking Norco, Flexeril, Ibuprofen and migraine medication before the work accident. In fact, Petitioner obtained 60 tablets of Norco the day before the accident. In her opinion, this meant that Petitioner was "having serious pain" before the accident. RX 8, p. 12. It is normal to have post-operative pain following a cervical fusion but not to the extent Petitioner complained of. If a patient is doing well following a fusion, there is no need to order a post-operative MRI. RX 8, p. 16.

Dr. Wehner testified she watched a video of the bus accident. The video showed Petitioner getting hit in the chest area by a student. Petitioner's "neck was not impacted" in the accident. RX 8, pp. 22-23. Based on what she saw on the video, the accident could not have aggravated the already damaged C5-C6 disc. RX 8, p. 23. Petitioner was hit in the chest, not the neck. "Getting hit in the chest is not really a mechanism for a whiplash injury or a neck injury." Petitioner did not fall down. She was standing in a "free space area." She was not restrained by anything. A kid hit her in the chest. RX 8, p. 23. Moreover, Petitioner "had pain

the day before," as evidenced by her obtaining Norco that day. Finally, the MRI findings did not change after the accident. RX 8, p. 23.

Dr. Wehner testified she has not changed any of her opinions since she issued her addendum on April 22, 2015. RX 8, p. 24.

Under cross-examination, Dr. Wehner testified she issued three reports. She charged $1200 for examining Petitioner and $250 to $300 for each report. RX 8, p. 25. She performs between five and ten IMEs per week. She does not know how many she routinely performs for Gallagher Bassett or Respondent's firm. She devotes 25 to 30% of her practice to IMEs. RX 8, p. 25. Almost all of the examinations she performs are for respondents. RX 8, p. 26. Petitioner told her she "went flying into the dashboard and window" but did not fall on the ground. RX 8, p. 26. Petitioner also told her that her knees buckled after getting hit and that she had the wind knocked out of her. RX 8, p. 28. Dr. Wehner testified she would not say that Petitioner returned to work "without any issues" after the fusion because she was still taking pain medication and muscle relaxants up to the time of the work accident. RX 8, p. 27. Petitioner should not have been taking Norco or Flexeril and driving a bus. RX 8, p. 27. She did not see any drug tests. RX 8, p. 27. Nor should Petitioner have been driving a bus 20 days after a cervical spine surgery. That is not a safe situation for children on the bus or other people around the bus. RX 8, p. 27. A whiplash injury occurs when someone is struck from the rear while seated and restrained, causing the neck to move back and forth on a stationary body. Petitioner's body was not restrained so she did not sustain a whiplash kind of injury. RX 8, p. 28-29. A true whiplash motion could cause a neck injury or aggravate an underlying neck condition. RX 8, pp. 29, 33. The video showed a child getting up and hitting Petitioner in the chest. The video "didn't show much after that." RX 8, p. 30. She never saw any footage showing Petitioner striking her head against a window. RX 8, p. 33. Petitioner reported to Dr. Bernstein that her condition dramatically improved after the cervical spine fusion. RX 8, pp. 30-31. As of August 15 report, she had reviewed the February 27, 2014 MRI report but not the film. As of her April 22, 2015 report, she had access to both MRI films. RX 8, p. 32. When a football player is tackled and hit in the chest, with his head snapping back, that is a hyperextension rather than whiplash injury. With a whiplash injury, you do not have to get hit in the neck in order for the neck to be injured. RX 8, p. 34. The color/clarity differences in the MRIs is due to the fact they were done at different facilities, using different machines. RX 8, p. 36. Both show disc herniations. RX 8, p. 36.

On redirect, Dr. Wehner testified she reviews many MRIs every day. She always tries to have MRIs done at the same facility because otherwise you can get caught up in little differences. RX 8, pp. 37-38. If a person is standing still but with freedom to move, and gets head butted, the natural instinct is for the whole body to go backward, not for the head to snap back and forth. RX 8, p. 40.

Under re-cross, Dr. Wehner testified she did not find that Petitioner was lying or embellishing. RX 8, p. 41. She finds causal connection in cases "every day" and not just in situations involving her own patients. RX 8, pp. 41-42.

Dr. Bernstein testified by way of evidence deposition on July 16, 2015. Dr. Bernstein testified he is a fellowship-trained, board certified orthopedic surgeon who has practiced at Lutheran General since 1991. PX 5 at 5. He teaches residents at the University of Illinois. PX 5 at 5. He has published a number of articles concerning spine surgery. PX 5 at 6. Bernstein Dep Exh 1.

Dr. Bernstein testified he has some recollection of Petitioner but needed his notes to testify. PX 5 at 7. He authored several reports at the request of Petitioner's attorney. In two of these reports, he responded to opinions expressed by Dr. Wehner, Respondent's examiner. PX 5 at 8.

Dr. Bernstein testified he operated on Petitioner's lumbar spine in 2000. After he released Petitioner in 2000, following that surgery, he did not see Petitioner again until December 13, 2013, at which time she consulted him concerning a cervical spine issue. PX 5 at 9. He performed a single level anterior cervical fusion on Petitioner on December 18, 2013. This surgery relieved Petitioner's arm pain but she had some residual neck pain. He evaluated this pain via an MRI "which was unimpressive." He "basically discharged" Petitioner at that point. PX 5 at 9. Petitioner returned to him on May 29, 2014 and indicated she had done well until a work accident in which a large eight-year-old boy "charged her," causing a whiplashing motion of her neck. PX 5 at 10. She complained of neck and diffuse shoulder pain. She denied arm pain. PX 5 at 11. When he examined her on May 29, 2014 he hoped she had suffered merely a soft tissue injury. He initially recommended therapy. On June 16, 2014, Petitioner reported slight improvement and told him she had not had the opportunity to undergo therapy. PX 5 at 12. On June 30, 2014, Petitioner complained of severe pain when turning her head to the right. He then recommended an MRI scan, which was performed on July 9, 2014. PX 5 at 13. That MRI "revealed a distinct disc herniation on the left side at C5-C6." PX 5 at 13.

Dr. Bernstein testified he compared the July 9, 2014 MRI to the MRIs Petitioner underwent in October 2013 and February 27, 2014. Both of the pre-accident MRIs showed a "small bulge of the disc at C5-C6 toward the left side but no distinct disc herniation." The July 9, 2014 MRI showed a "clear, distinct disc herniation that's distinctly different than the prior MRI scans." PX 5 at 13. He discussed the new MRI with Petitioner and presented surgery as an option. Petitioner wanted to proceed with surgery. PX 5 at 13-14.

Dr. Bernstein testified he disagrees with Dr. Wehner's opinions that the MRIs are similar and that Petitioner was symptomatic due to a C5-C6 disc herniation before the work accident. Petitioner definitely had some post-operative neck pain after the fusion healed, along with some degeneration at C5-C6, but she "clearly did not have a disc herniation at that level prior to the work accident." In his opinion, the May 16, 2014 work accident led to new or worsening symptoms. He is recommending a procedure known as an "add-on decompression and fusion at C5-C6." This would involve removing the existing C6-C7 plate, performing a discectomy at C5-C6 and then doing a fusion with instrumentation. PX 5 at 15.

In addition to the exhibits previously discussed, Respondent offered into evidence a two-page document showing the results of a "prescription monitoring program patient search" concerning Petitioner. This document shows the prescriptions Petitioner filled at various pharmacies between August 29, 2013 and July 31, 2014. The prescribed medications include Hydrocodone, Lorazepam, Oxycodone, Diazepam, Tramadol and Butalbital. The prescribing physicians include Drs. Bernstein, Amine, Al-Awad, Curtin, Pai and Najera. The list also reflects Hydrocodone prescriptions filled by a dentist on August 29, 2013 and July 30, 2014. The list reflects that Petitioner obtained a thirty-day supply of 5-325 mg Hydrocodone via Dr. Amine on April 23, 2014, a one-day supply of 10 mg-325 mg Hydrocodone via Dr. Bernstein on May 15, 2014 and a five-day supply of 10 mg-325 mg Hydrocodone on May 16, 2014, the date of the accident. RX 9.

Petitioner testified her neck is stiff and she experiences headaches "24/7." She self-treats via rest and ice packs. She finds it difficult to take care of her children and home.

Under cross-examination, Petitioner indicated she did not recall undergoing treatment for neck pain and arm symptoms in 2003 and 2004 but would not dispute her records if they reflect this. When she saw Dr. Amine in November 2013, she complained of neck and severe left arm pain. Dr. Amine recommended cervical spine surgery. She then consulted Dr. Bernstein. She was having neck problems before she began working for Respondent. In March 2013, she underwent treatment for these problems with Drs. Alawad and Najera. She last saw Dr. Najera on October 1, 2013. She also saw Dr. Curtin in October 2013 for migraines and neck pain. Dr. Bernstein operated on her neck in December 2013. Postoperatively, Dr. Bernstein directed her to use a bone stimulator due to her cigarette smoking. Dr. Bernstein told her that smoking could cause a sub-optimal surgical result. After she returned to work, in January 2014, she had good and bad days. She underwent therapy at Dr. Bernstein's direction. Dr. Bernstein ordered a cervical spine MRI after the surgery due to her persistent intermittent symptoms. Dr. Bernstein discussed the MRI results with her on March 20, 2014. Dr. Bernstein told her the MRI showed a "slight" protrusion at C5-C6. She does not recall him telling her this protrusion was causing some of her pain. She had health insurance as of that date but lost it later due to her divorce. She saw Dr. Alawad on March 5, 2014. She does not recall telling Dr. Alawad she had a C5 herniation. It is possible he noted very limited neck motion on that date. She was "still healing" at that point. He told her to stop taking Norco but she continued taking it on an "as needed" basis for headaches and neck pain. She filled a Norco prescription on May 15, 2014, the day before the accident. Three weeks earlier she had obtained Norco from a different prescription. She used Dr. Amine's prescription to obtain Norco between February and April 2014 even though she had not seen Dr. Amine since November 2013. She used a different pharmacy to obtain the refills via Dr. Amine's prescription. Her upper body made a "swaying motion" after the boy hit her in the chest, causing her to fall backward. She hit the dashboard but caught herself with one arm. She "could have" hit her head but is not sure because everything happened so fast. She was "shaken up" but did not feel neck pain at that time. The teacher who was outside the bus, waiting for the boy, came up a step and asked her if she was okay. After she got home that night, at about 5 or 6 PM, her headaches "got really bad." She could not get out of bed that evening. There was no one available to drive her to the

Emergency Room on Saturday. She owned a car but did not feel capable of driving. She does not know why she did not seek care on Sunday. RX 1, the accident report she completed, is accurate. Having reviewed it, she guesses she did hit the windshield. She was able to continue driving after the accident. It was not until later that day, in the afternoon, that her headache started. She did not tell a urologist at Palos Community Hospital that a student "tackled" her. She does not know whether she told him she hit her head in the process. On her last visit to Dr. Bernstein before the accident, he told her she needed insurance. He told her to "get a good job with benefits."

On redirect, Petitioner testified that her acute flare-ups had improved by March 20, 2014. On that date, Dr. Bernstein told her that her X-rays looked good. When she returned to work following the December 2013 surgery, she had good and bad days but was able to drive the school bus. After the work accident, she continued having migraines and neck pain but her headaches were different. The boy who struck her in the chest is autistic. He was supposed to be restrained. She is 5 feet, 4 inches tall. The boy came up to about her nose level.

Under re-cross, Petitioner testified was she was on public aid when she discussed insurance coverage with Dr. Bernstein. She does not recall him telling her to return to him in three months.

On further redirect, Petitioner acknowledged telling Dr. Bernstein in February 2014 that she felt she had returned to work "too quickly."

Under re-cross, Petitioner acknowledged continuing to take Norco through the day before the work accident but denied taking it every day.

Candise Bradley testified on behalf of Respondent. Bradley testified she has worked for Respondent for seven years. She started out as a bus driver and was promoted to safety compliance officer in November 2013. One of her duties in that position was to investigate accidents. She is now a manager who oversees training. She still has to drive a bus on occasion, as needed.

Bradley testified she learned of Petitioner's accident on May 16, 2014. Respondent's dispatcher called her and informed her of the accident. Petitioner began completing an incident report on that date but she told Petitioner to complete a different document called an "employee injury form." She (Bradley) subsequently realized the form was incomplete and unsigned. Petitioner did not complete and sign the form until May 20, 2014.

Bradley acknowledged going to Petitioner's house on two occasions after the work accident, in order to get some fish from Petitioner's pond, but denied visiting Petitioner on Sunday, May 18, 2014.

Bradley testified that each Respondent bus is equipped with a camera that is mounted above the dashboard and faces the rear of the bus. The camera is on while the bus is in operation.

Bradley testified that Petitioner drove bus #479 on the date of the accident. Bradley testified she obtained video footage taken on that date from this bus after the accident. She viewed the video in her office on May 19, 2014 and again on the morning of the hearing. The video she watched on the morning of the hearing is the same video she watched on May 19, 2014. The video is about 38 minutes long. RX 5.

The Arbitrator and counsel viewed the relevant portion of the video (i.e., footage starting at the 28-minute point) during the hearing. The video shows the center aisle and rear section of a small school bus. It does not show the driver's seat or the front of the bus. A boy can be seen getting out of his seat and coming down the center aisle of the bus to the front. The parties agreed that Petitioner was at the front of the bus and facing the rear of the bus at that point. Petitioner's arm can be seen, as she holds a backpack. There is no footage of the portion of the bus that is behind Petitioner. Nor is there any footage of the immediate aftermath of the contact between the boy and Petitioner. The audio portion reflects that Petitioner verbally reacted to the contact. Not long after the contact, Petitioner resumes driving the bus.

Bradley testified she has driven buses similar to the bus shown in the video. The video does not show the front of the bus. There is a distance of four feet between the first set of seats and the dashboard. There is a distance of six feet between those seats and the windshield. Based on these measurements, it would not have been possible for Petitioner to be thrown into the steering wheel or dashboard.

Under cross-examination, Bradley testified she has no ownership interest in Respondent. The video does not show the driver's seat or the accident.

On redirect, Bradley reiterated she is familiar with the configuration of the bus shown on the video. The video does not show the front of the bus but it does show Petitioner's arm. Based on Petitioner's position, it would not have been possible for her to have been thrown into the dashboard or windshield.

Under re-cross, Bradley acknowledged that anything is possible and that the video does not enable you to see what was going on in the front of the bus.

Arbitrator's Credibility Assessment

Petitioner's testimony as to the extent of her pre-accident cervical spine complaints was credible and supported by Dr. Bernstein's records. Petitioner readily acknowledged she continued to experience neck pain after the December 2013 cervical spine fusion but contended she was able to perform her bus driving duties between January 2014 and the work

accident. When Dr. Bernstein saw Petitioner on March 20, 2014, about two months before the accident, he described her as "functional" and devoid of radicular symptoms. He recommended general follow-up in three months but did not recommend any specific care, let alone more cervical spine surgery. The Arbitrator does not view his suggestion that Petitioner obtain health coverage as anything more than a reasonable recommendation any prudent physician would make to an uninsured patient with multiple health conditions.

Petitioner's account of the accident was detailed and in no way inconsistent with Respondent's video, which actually showed very little other than a boy moving down the center aisle of a small bus toward Petitioner. Petitioner credibly testified she was positioned between the boy and a teaching assistant affiliated with the school, who had started ascending the bus steps in order to take charge of the boy. Petitioner had reason to place herself there, given that the boy was unpredictable and the teaching assistant was nine months pregnant. Petitioner's supervisor, Candise Bradley, did not contradict Petitioner's testimony that the boy is autistic. Viewers of the video could disagree as to whether the boy is "good-sized," as Petitioner described him, but Petitioner is a petite individual. They could also disagree as to whether the boy "charged" Petitioner, as Drs. Bernstein and Wehner noted, but he is not moving slowly.

This is not to suggest that Petitioner was 100% believable on all points. Petitioner exhibited some tendency to exaggerate the effects of the work accident. For example, she attributed her flank pain and hematuria to the accident when she went to the Emergency Room on May 24, 2014, even though she did not testify to any flank injury. Overall, however, the Arbitrator found her credible.

Petitioner testified she informed Ms. Bradley of the accident when Ms. Bradley came to her house on Sunday, May 18, 2014. Ms. Bradley denied visiting Petitioner on that date but acknowledged having twice come to Petitioner's house to pick up fish from Petitioner's pond. The Arbitrator views the discrepancy as of little consequence, given the stipulation to notice (Arb Exh 1) and the fact that Petitioner partially completed an accident report on May 16, 2014. There was no delay in reporting but there was some delay in treatment, with that delay taking place over a weekend. It was on Monday, May 19, 2014, following an unsuccessful attempt to resume bus driving, that Petitioner sought care. The Arbitrator discounts the possibility that Petitioner suffered additional spousal abuse over the weekend, noting Petitioner's testimony that she was no longer living with her husband at that time and the Little Company of Mary Care Station nurse's notation that she observed "no signs of abuse" on the morning of May 19, 2014. PX 11, p. 18.

Respondent's examiner, Dr. Wehner, characterized Petitioner as a drug hoarder, citing the pharmacy records. The records do in fact document multiple prescriptions for narcotic pain medication (in varying amounts) but Petitioner explained she needed to obtain a supply of such medication prior to the divorce-related termination of her prescription insurance coverage. Dr. Wehner concluded that Petitioner must have been experiencing significant neck pain the day before the accident since she filled a Norco prescription on that day. The Arbitrator notes that Petitioner acknowledged having a number of pain-causing conditions having nothing to do with

the neck, including migraines and fibromyalgia, before the accident. Dr. Amine's records also suggest that Petitioner became dependent on Norco well before the work accident. This dependence is unfortunate but the fact Petitioner obtained Norco on May 15, 2014 does not automatically lead to the conclusion she was experiencing significant neck pain that day.

Dr. Wehner's credibility was undermined by her admission that she performs five to ten IMEs (at a price of $1,200 per IME) per week, almost all of which are for respondents.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident arising out of and in the course of her employment on May 16, 2014?

The Arbitrator finds in Petitioner's favor on the issue of accident. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible accident-related testimony; 2) the fact Petitioner was on her assigned bus, performing a work-related task, when the autistic student made contact with her; 3) the fact Petitioner completed an accident report on May 16, 2014, complaining of neck pain and other symptoms; and 4) the initial treatment records, which reflect a student ran into Petitioner on the morning of May 16, 2014, with Petitioner beginning to experience severe headaches and neck pain by the afternoon/early evening on that date.

Did Petitioner establish causation as to her claimed current cervical spine condition of ill-being and the need for the "add on" cervical spine surgery Dr. Bernstein has recommended?

Having reviewed all of the evidence, the Arbitrator elects to rely on Dr. Bernstein rather than Dr. Wehner and finds that the May 16, 2014 accident was a factor leading to the need for additional cervical spine surgery. In so finding, the Arbitrator relies on the following: 1) the fact that, on January 3, 2014, providers at Little Company of Mary Care Station found Petitioner "fit to work" as of January 6, 2014; 2) the fact that Petitioner was able to perform her bus driving duties between January 6, 2014 and the work accident; 3) the fact that Dr. Bernstein documented improvement and described Petitioner as "functional" on March 20, 2014; 4) the fact that Petitioner did not return to Dr. Bernstein between March 20, 2014 and the work accident; 5) the fact that Dr. Bernstein did not recommend the "add on" cervical spine surgery until after the accident; 6) the fact that Dr. Bernstein treated Petitioner over an extended period, both before and after the accident, while Dr. Wehner saw Petitioner only once; 7) the doctors' respective MRI interpretations, with Dr. Wehner attempting to ascribe the differences between the pre- and post-accident scans to variations in facility techniques; 8) Dr. Wehner's reliance on the video in opining that Petitioner was standing in a "free space" as of the accident and that Petitioner's neck was "not impacted by" the accident; 9) Dr. Wehner's admission that she earns between $6,000 and $12,000 per week from IMEs, with the vast majority of those performed for respondents.

In addressing causation, the Arbitrator readily acknowledges that Petitioner had a cervical spine condition of ill-being prior to the work accident, with that condition bringing

about the need for the insertion of surgical hardware in December 2013. Despite this surgery, Petitioner was able to resume her regular duties on January 6, 2014, with a Little Company of Mary Care Station physician noting her current medications, including Norco, and finding her fit to work. PX 11. Under Illinois law, "it is axiomatic that employers take their employees as they find them," Baggett v. Industrial Commission, 201 Ill.2d 187, 199 (2002). Petitioner continued full duty after January 6, 2014 and passed a random drug screening on March 13, 2014.

The Arbitrator further finds that Petitioner failed to prove a causal connection between the work accident and the care she underwent at Palos Community Hospital from May 24-25, 2014 and on June 5, 2014. The records concerning this care document treatment for a urinary tract infection and a longstanding history of such infections. It appears that Petitioner targeted the work accident as a possible cause of her abdominal/flank discomfort but Petitioner never testified to striking this area of her body.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims she was temporarily totally disabled from Monday, May 19, 2014 through the hearing of September 24, 2015. Based on the foregoing accident- and causation-related findings, and noting that Petitioner acknowledged working part of the day on May 19, 2014, the Arbitrator finds that Petitioner was temporarily totally disabled from May 20, 2014 through September 24, 2015, a period of 70 3/7 weeks, with Respondent receiving credit for the $1,976.26 in benefits it paid prior to the hearing. The Arbitrator declines to award temporary total disability benefits at the weekly rate suggested by Petitioner, i.e., $286.00, because that figure exceeds the stipulated average weekly wage of $258.32. Arb Exh 1. The Arbitrator awards benefits at the rate of $258.32 per week.

In awarding these benefits, the Arbitrator relies in part on the Little Company of Care Station records, which reflect that Dr. Brown made various treatment recommendations and took Petitioner off work on May 19, 2014. PX 11. The Arbitrator also relies on Dr. Bernstein's records and reports, which reflect he kept Petitioner off work beginning on May 29, 2014. Px 4.

The Arbitrator has elected to rely on Dr. Bernstein rather than Respondent's examiner, Dr. Wehner, on the issues of causation, treatment needs and work capacity. After the work accident, Dr. Bernstein initially took a conservative approach, recommending therapy and a repeat MRI. He subsequently recommended an "add on" cervical spine surgery. The Arbitrator views Petitioner's causally related cervical spine condition as unstable prior to and as of the hearing, based on that surgical recommendation. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010). Dr. Bernstein did release Petitioner to work, subject to multiple restrictions (including no bus driving), on June 24, 2015 (PX 4a), but there is no evidence indicating that Respondent offered Petitioner work within those restrictions.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner offered various medical bills into evidence (PX 23). The Arbitrator having reviewed these bills, notes that some show $0 balances while others relate to treatment of general health conditions having nothing to do with the work accident. The Arbitrator has previously found that Respondent is not liable for the care Petitioner underwent at Palos Community Hospital from May 24-25, 2014. To the extent that Respondent adjusted this bill or made payments toward it, as the bill reflects, Respondent is entitled to credit. Respondent is also not responsible for any billing for the subsequent Emergency Room visit of June 5, 2014.

The Arbitrator awards the following bills, subject to the fee schedule: 1) Little Company of Mary Hospital, 5/19/14, 5/20/14, 5/22/14 and 5/24/14, $6,117.00; and 2) The Spine Center (Dr. Bernstein), 5/29/14 and 6/16/14, $291.05.

Is Petitioner entitled to prospective care?

Having already found in Petitioner's favor on the issues of accident and causation, the Arbitrator awards prospective care in the form of a return visit to Dr. Bernstein along with the "add on" cervical spine surgery the doctor discussed during his deposition.

Is Respondent liable for penalties and fees?

At the hearing, Petitioner's counsel indicated he would be requesting an award of penalties and fees. He did not offer any penalties/fees petition into evidence but he did offer a letter sent to Petitioner by an adjuster on July 18, 2014, temporarily suspending the payment of all benefits pending Petitioner's attendance at a Section 12 examination that had yet to be scheduled. PX 10. The examination took place about a month later. Following the examination, Respondent's counsel sent Petitioner's counsel another letter on September 12, 2014, indicating Respondent would not pay any benefits after August 15, 2014 based on Dr. Wehner's opinions. PX 4, p. 77.

Petitioner maintains that Respondent failed to comply with Commission rules in sending a suspension letter in advance of, rather than in reliance on, a Section 12 examination. The Arbitrator does not disagree with this argument, as far as it goes, but declines to award penalties and fees. It appears to the Arbitrator that Respondent authorized some initial care and ultimately paid benefits through the date of Dr. Wehner's examination. PX 4, p. 77. Moreover, with Petitioner having undergone a cervical fusion in December 2013 and having followed up with her surgeon, Dr. Bernstein, as recently as two months before the May 16, 2014 work accident, the Arbitrator is unable to find that Respondent acted in an objectively unreasonable manner in relying on Dr. Wehner.

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

Susan Qualls,

Petitioner,

vs. NO: 14 WC 27732

Glister-Mary Lee Corp.,

16IWCC0317

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, and evidentiary rulings, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission notes that in its Statement of Exceptions and Supporting Brief, Respondent correctly pointed out that the bills from Dr. Howard for services rendered on May 22, 2014 and June 19, 2014, the March 21, 2014 bill from Midwest Occupational and the Sparta physical therapy bill for physical therapy from May 29, 2014 through June 5, 2014 all deal with Petitioner's unrelated right elbow condition. At Oral Argument, Petitioner acknowledged this and stipulated that Respondent is not liable for those bills. As such, the Commission finds that the above listed bills, totaling $1,069.50, are not Respondent's responsibility and shall not be paid by Respondent.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. Furthermore, we have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. Finally, one should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

16IWCC0317

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 16, 2015 is modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable and necessary medical expenses as outlined in Petitioner's group exhibit, as provided in Sections 8(a) & 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given credit for medical benefits paid by Respondent and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the treatment recommended by Dr. Mall, including but not limited to surgery.

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 Section 19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $29,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 12 2016
MJB/ell
o-03/21/16
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

QUALLS, SUSAN
Employee/Petitioner

Case# 14WC027732

GLISTER-MARY LEE CORP
Employer/Respondent

16IWCC0317

On 7/16/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0698 F/M/G/R
BRANDY JOHNSON
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903-1570

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)

Susan Qualls
Employee/Petitioner

v.

Gilster-Mary Lee Corp.
Employer/Respondent

Case # 14 WC 27732

Consolidated cases: _____

16IWCC0317

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **May 12, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On the date of accident, **August 23, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $**28,239.20**; the average weekly wage was $**556.99**.

On the date of accident, Petitioner was **55** 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 $**107.69** for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of $**107.69**.

Respondent is entitled to a credit of $**any benefits paid** under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical services outlined in Petitioner's group exhibit, as provided in § 8(a) of the Act.

Respondent shall be given credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in § 8(j) of the Act.

Respondent shall authorize and pay for the treatment recommended by Dr. Mall, including but not limited to 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.

Signature of Arbitrator

7/10/15
Date

ICArbDec19(b)

JUL 16 2015

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SUSAN QUALLS
Employee/Petitioner

v. Case # 14 WC 27732

GILSTER-MARY LEE CORP.
Employer/Respondent

16IWCC0317

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The Parties stipulated that Petitioner sustained compensable injuries arising out of her employment as a janitor on August 23, 2013. (AX1). On that date, Petitioner was pulling a pallet of cartons out of a rack with a hand jack when she felt a pop in her left shoulder and experienced an immediate onset of severe pain. (T.10). Petitioner testified that she had not suffered any prior left shoulder injuries; she required no treatment for her left shoulder; and she had no functional pain limitations or restrictions in range of motion in her left shoulder prior to this accident. (T.10, 11, 37, 38).

Respondent sent Petitioner to Midwest Occupational Medicine, where Andy Colon PA-C took a consistent history of the injury and noted that Petitioner attempted to resolve her pain conservatively without success using Tylenol, ice and rest. (PX3, 9/9/13). He noted Petitioner had difficulty bringing her arm above her head and that she experienced pain that awoke her at night. *Id.* His physical examination provoked pain with internal rotation and pain over the mid deltoid. *Id.* He recommended an MRI, placed Petitioner on restrictions and advised Petitioner to continue taking anti-inflammatory medication. *Id.*

Petitioner's MRI revealed superior and posterior labral tears; multiple partial thickness rotator cuff tears in the subscapularis, supraspinatus and infraspinatus; a possible full-thickness rotator cuff tear in the interval; a probable partial tear of the long head of the biceps tendon; acromioclavicular hypertrophy and synovitis; and glenohumeral effusion. (PX4). Given the results of Petitioner's MRI, Respondent sent Petitioner to Dr. Howard for evaluation, and on October 1, 2013, he saw Petitioner and observed the complex tearing depicted on MRI. (T.11; PX5, 10/1/13). He assessed left shoulder superior labral tearing with biceps tendinopathy and recommended left shoulder arthroscopic superior labrum debridement with biceps tenotomy. *Id.* Dr. Howard performed surgery on October 11, 2013. (PX7).

Petitioner testified that while surgery improved her condition somewhat, she continued to have difficulty with her left shoulder. (T.13). "I was never without pain," she stated. (T.13). The records of Dr. Howard support Petitioner's testimony. (PX5, 11/5/13). On November 5, 2013, Petitioner reported pain. *Id.* On November 26, 2013, Dr. Howard noted that Petitioner was experiencing "significant pain." (PX5, 11/26/13). Dr. Howard's

records indicate that he advised Petitioner that, ". . . [T]here is certain aspects of her pain that I am not going to be able to resolve . . ." *Id.* While he felt that this was due to arthritis rather than the work injury, the record shows that Petitioner was asymptomatic prior to her accident. (PX5, 11/26/13, 5/22/14). Dr. Howard performed an in injection on December 19, 2013, and Petitioner continued to take medication and participate in therapy following surgery. (PX5, 12/19/13; T.13, 14). Dr. Howard released Petitioner to work with permanent restrictions of limited to no overhead activity with her left upper extremity and placed Petitioner at maximum medical improvement on May 22, 2014. (PX5, 5/22/14, 6/3/14).

Petitioner testified that as a result of these permanent restrictions, she could not wash walls, clean curtains or perform all of the necessary dusting. (T.15). She testified, ". . . [T]here is a lot of overhead work that we do that I was limited on and not able to do." (T.15, 16). Petitioner is unable to work overtime during the weekdays due to her restrictions. (T.16, 35). Petitioner testified that she worked overtime often before the accident. (T.38). Petitioner also testified that her condition and restrictions hinder her ability to function around her home. (T.18, 19). Petitioner testified that she cannot even reach for the seatbelt in her vehicle with her left arm and is unable to reach behind her back. (T.19, 20). Petitioner demonstrated her limited range of motion before the Court. (T.19, 20). Petitioner testified that she was in pain during the hearing, and rated her pain as a 5 on a scale of 10. (T.34).

Petitioner sought a different opinion with Dr. Nathan Mall. (T.17). Dr. Mall noted that Petitioner suffered persistent pain and stiffness since Dr. Howard's surgery, and that the post-surgery cortisone injections brought limited improvement for only a couple of months. (PX11, 8/27/14). He observed Petitioner's limited range of motion and noted that it did not appear that a capsular release was performed during Dr. Howard's surgery based on the operative report. *Id.* In addition to significantly limited range of motion, Dr. Mall's physical examination revealed pain with palpation over the AC joint, pain with cross-body adduction, and pain with end range of motion and external rotation of the shoulder. *Id.* Dr. Mall also reviewed x-rays and observed that Petitioner's arthritis was not as severe as the oral indication given by Dr. Howard to Petitioner. *Id.* Dr. Mall rendered the following assessment:

> Mrs. Qualls is still having significant symptoms that never were relieved by her prior surgery after her injury on August 23, 2013. She was not having pain prior to her work-related injury on August 23, 2013, and therefore, I do believe that her current symptoms that she is experiencing are causally connected to her work injury. Her prior surgery was covered under a Workman's Compensation claim. While it is likely that she aggravated a superior labral injury, it would not be uncommon to see a superior labral injury in conjunction with some glenohumeral arthritis. Again, she was not having any symptoms relating to a superior labral injury prior to the work accident, and therefore, it would be impossible to date that superior labral injury. However, regardless, her symptoms were initiated at the time of her work injury. Also, the symptoms that she is currently experiencing in relation to her AC joint and glenohumeral joint arthrosis also were aggravated by her work injury on 8/23/13 as the symptoms that she has experienced since that time have not been resolved or relieved following the surgery by Dr. Howard. Therefore, I do believe that the treatment we are rendering today and any future treatment that is required to completely resolve, cure, or alleviate her recurrent symptoms should be related to this work accident on 8/23/13. . . *Id.*

Dr. Mall performed diagnostic/therapeutic cortisone injection into Petitioner's AC joint during the visit and noted that this resolved a large portion of Petitioner's pain with respect to reaching behind her back. *Id.* The injection performed into the shoulder joint relieved Petitioner's pain with end range of motion and abduction/external rotation. *Id.* Petitioner's range of motion and subscapularis stiffness, however, was not restored. *Id.* Dr. Mall recommended additional physical therapy, and if Petitioner's symptoms returned, additional surgery. *Id.* He believed that Petitioner's subscapularis stiffness would benefit from a capsular release. *Id.*

When Petitioner returned to Dr. Mall with recurrent persistent complaints, Dr. Mall recommended additional surgery on the left shoulder superior labrum by way of left shoulder arthroscopy, biceps tenodesis, and AC joint resection. (PX5, 10/1/14). He again noted that there was "no point at which she [Petitioner] had complete resolution of her symptoms, and therefore these continued symptoms are part of the initial symptoms complex." *Id.* Petitioner testified that she wants to have the surgery recommended by Dr. Mall because, "I don't want to be in the pain that I'm in, and I want to be able to use my arm normally, you know, to do everyday duties and my job." (T.18).

Respondent had Petitioner examined by Dr. Michael Nogalski on November 4, 2014. (RX1). Dr. Nogalski authored a report indicating that he did not believe that Petitioner sustained any substantial or permanent aggravation of her osteoarthritis. *Id.* He acknowledged that Petitioner "might have or could have sustained a glenoid labral tear" as a result of the August 23rd 2013 work accident, and acknowledged, "it appears that the claimed 8/23/13 event might have or could have been the cause of the need for treatment by Mr. Colon at Midwest Occupational Medicine as well as Dr. Howard." *Id.* He believed, however, that Petitioner reached maximum medical improvement and concluded reasonable care with her discharge from Dr. Howard's care with permanent restrictions on January 9, 2014; even though Petitioner, who was symptom-free prior to the accident, continued to suffer significant pain and symptoms. *Id.*

Dr. Nogalski gave restrictions and an impairment rating of Petitioner's *right* upper extremity; he believed that Petitioner should be limited to no lifting more than 10 pounds and no use of the arm over chest level, and that Petitioner suffered 5% impairment of the upper extremity due to her labral tear. *Id.* He stated that Petitioner did not have a ratable impairment with respect to her "secondary" arthritic condition because it was "not related to trauma or posttraumatic injury condition." *Id.* Dr. Nogalski testified by way of deposition that 90% of his medical/legal work is done on behalf of employers, Respondents and third-party administrators. (RX2, p.52, 53).

Dr. Nogalski testified in his deposition on direct examination that Petitioner's current complaints had nothing to do with her accidental work injury, and were solely attributable to the pre-existing condition of her shoulder. (RX2, p.26, 27). He even suggested that Petitioner was likely not asymptomatic prior to her accident, because he believed that "very few, if any" patients would be asymptomatic with Petitioner's pre-existing shoulder condition. *Id.* at 26. He further stated that he did not see anything with respect to Petitioner's arthritis that would be related to her surgery or work related activities. *Id.* at 27. Yet, he stated that activities like reaching out away from the body, holding things out in a static position, rotation, and/or lifting heavier objections – some of which forces were involved in Petitioner's work accident – would aggravate osteoarthritis or cause symptoms. *Id.* at 27, 28. He again, at the time of his deposition, referred to impairment of Petitioner's *right* upper extremity rather than her left. *Id.* at 34.

On cross-examination, Dr. Nogalski admitted that there was no indication in the records that Petitioner had any left shoulder treatment, left shoulder diagnostic imaging, or office visits for left shoulder symptoms prior to her accidental work injury. *Id.* at 38-40. He admitted that Petitioner advised him that she has at no point been symptom free in her left shoulder since the accident. *Id.* at 45. Despite these acknowledgements, he testified that Petitioner's accident had nothing to do with her restrictions, and that she would have required these restrictions regardless of the accident. *Id.* at 46, 47. Dr. Nogalski was unaware that it was Respondent that directed Petitioner to Dr. Howard for treatment and he made no mention that Petitioner was sent to Midwest Occupational Medicine by Respondent; yet, he took note that Petitioner was referred to Dr. Mall by her attorney. *Id.* at 40-43. Leaving causation aside, Dr. Nogalski admitted that if Petitioner continued to experience symptoms at this point, he would recommend conservative care until she had enough pain to consider a shoulder replacement. *Id.* at 49, 50.

Respondent also obtained a utilization review from Dr. Aimee Hachigian-Gould to inquire as to whether the surgery recommended by Dr. Mall was reasonable, necessary, and causally related to the August 23, 2013 accident. (RX3). Dr. Hachigian-Gould determined that the proposed surgery would "partially" be reasonably necessary based on the fact that Petitioner had a positive response to diagnostic and therapeutic injection of the AC joint and glenohumeral aspect of the shoulder, Petitioner had failed to improve with conservative treatment. *Id.* Dr. Hachigian-Gould certified the left distal clavicle resection, but did not agree with or recommend the capsular release or biceps tenodesis based on outlines set forth in the Occupational Disability Guidelines (hereinafter ODG). *Id.* Dr. Hachigian-Gould did not believe, however, that the surgery was necessitated by the August accidental injury. *Id.*

Respondent to the deposition of Dr. Hachigian-Gould, and she testified on cross-examination that she no longer has an active practice and that she last performed surgery in January of 2009. (RX4, p.38). Upon further questioning, she admitted that she is **not a shoulder surgeon** and had not performed any type of shoulder surgery since her residency in 1985. *Id.* at 38, 39. She testified that she currently works as an independent contractor with 11 different companies and performs 20 to 30 utilization reviews per week. *Id.* at 39. She testified that her report was dictated to and transcribed by Physician's Review Network, and she could not testify that her report was a true and accuracy of her dictation without comparing it to her original dictation. *Id.* at 60, 61

Dr. Hachigian-Gould testified that her recommendations in this case were made solely based on the ODG without the use of her opinion or knowledge of practice. *Id.* at 43, 44. She testified that she was advised on several occasions by the owner of the Physician's Review Network, Linda Chef, and various case managers for the Physician's Review Network that "for the purposes of Illinois Work Comp that the ODG Guidelines are the first line with regard to the criteria to be relied upon for the review." *Id.* at 45. She testified, however, that it would not surprise her to learn that Illinois has not adopted the ODG standards. *Id.* While she was aware that the ODG was prepared by the Work Loss Data Institute; she testified that she was unaware that this was a private corporation funded by the insurance industry, and she denied having knowledge that the ODG was promulgated as a means to limit costs and liability for insurance carriers. *Id.* at 49, 50.

Although she denied having any independent knowledge of whether a procedure is approved once her review is conducted, she later admitted, "[T]here are still companies that will allow that treatment or procedure to be done on occasion." *Id.* at 52-54. She testified that she did not believe that there was sufficient evidence-based, peer reviewed literature to establish the non-certified procedures recommended by Dr. Mall. *Id.* at 56.

Dr. Mall also testified by way of deposition. (PX12). Dr. Mall is board certified orthopedic surgeon who specializes in sports medicine, including shoulder surgery. (PX12, p.3-5). He has published numerous papers on various surgical approaches to shoulder pathology. *Id.*; (Pet. Dep. Exh. 1). Dr. Mall testified that Petitioner's accident clearly caused superior labral injury and aggravated her existing arthritis. (PX12, p.9). He noted:

> . . . I think that clearly she was not having any pain beforehand. There's no notes or no one's seen any documentation that she's had prior imaging to the left shoulder, no prior doctor's visits for the left shoulder, and as I mentioned before, many people with shoulder arthritis can be going along just fine without any problems for years and years and years without any issues, and then something usually will aggravate it, whether it's some sort of injury, or something like that will irritate it. . . *Id.* at 20.

He also noted that there was no documentation of whether or not Petitioner's AC joint was a problem, and believed that Petitioner's AC joint has been an unaddressed problem since the accident. *Id.* at 20, 21.

Dr. Mall also testified that a physician cannot, as Dr. Nogalski suggested, look at an MRI and determine whether or not a patient is experiencing pain. *Id.* at 24. He also testified that Dr. Nogalski's statement that "very few" people have arthritic changes that are asymptomatic was "completely false." *Id.* at 25. He testified:

> I would say that's completely false. I mean, I have people at least once a week that come in and have way worse arthritis than Ms. Qualls does and have been having no pain for a period of time until some sort of injury aggravates their pain or aggravates their arthritis. So clearly three years ago when they were probably at the same stage as Ms. Qualls was, they were having absolutely no pain in their shoulder related to their arthritis. So the fact that – I would say that's completely false. I see it every day. I mean, it's just something that's not true. *Id.* at 25, 26.

Dr. Mall testified that Petitioner has progressively worsened in both symptomatology and range of motion after her surgery. *Id.* at 13. Dr. Mall testified that he recommended physical therapy to preserve or improve what range of motion Petitioner had and hopefully avoid further surgery. *Id.* at 15, 16. Dr. Mall testified that Respondent initially would not approve physical therapy; but when it did, Petitioner did not benefit due to a capsular block and he ceased same. *Id.* at 17, 18.

Dr. Mall explained that preserving range of motion in patients with arthritis is vital, and that Petitioner's loss of range of motion due to arthritis is the exact reason that a capsular release is indicated. *Id.* at 13, 18, 19. He stated, "Once we've got that capsular block, there's really no way of improving that without releasing the actual tissue." *Id.* at 18. Dr. Mall testified that Petitioner did not recover from her first surgery because there was no capsular release performed. *Id.* at 19. He explained:

> So in someone that has stiffness in their shoulder and has decreased range of motion, that's something that we'll do, especially when there's arthritis there, because that increased range of motion can reduce the amount of forces on the joint and can alleviate some of the symptoms of arthritis. *Id.* at 19, 20.

Dr. Mall produced 6 peer-reviewed articles containing positive evidence-based outcome analyses as proof of the efficacy of his proposed arthroscopy with capsular release. *Id.* at 27-29. These were tendered as Petitioner's

Deposition Exhibits 2 through 7. Dr. Mall testified that Petitioner's positive response to the injections confirmed his diagnosis and the necessity of his proposed surgery. *Id.* at 31, 32.

CONCLUSION

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is *a* causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003). [Emphasis original]. "Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Indus. Comm'n*, 723 N.E.2d 846 (3d Dist. 2000). Employers are to take their employees as they find them. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *A.C. & S. v. Indus. Comm'n*, 710 N.E.2d 837 (1st Dist. 1999) citing *General Electric Co. v. Indus. Comm'n*, 433 N.E.2d 671, 672 (Ill. 1982). If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (Ill. 2003); *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65, 67-68 (Ill. 1967); *see also Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 362 N.E.2d 339 (Ill. 1977). The Supreme Court's decision in *Sisbro, Inc.* highlighted that even though a workers' compensation claimant has a preexisting condition which may make him or her more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003).

In addition to or aside from expert medical testimony, circumstantial evidence may also be used to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Industrial Comm'n*, 631 N.E.2d 724 (4th Dist. 1994); *International Harvester v. Industrial Comm'n*, 442 N.E.2d 908 (Ill. 1982).

The Arbitrator finds it significant that Petitioner was working full duty and had no prior complaints or treatment prior to the accident. Following her accident, however, Petitioner continued to experience unrelenting complaints. Therefore, the only logical conclusion supported by the evidence is that Petitioner sustained new injury with complex tearing and aggravation of her pre-existing left shoulder condition. Dr. Mall acknowledged the evidence and logically explained the etiology of Petitioner's injury and her current condition. (PX11; PX12). The Arbitrator therefore finds the causation opinion of Dr. Mall to be credible. While Dr. Nogalski felt that Petitioner would have needed restrictions regardless of her work injury (RX2, p.46, 47); the evidence and chain of events does not support his theory, and the evidence undeniably demonstrates that *at the least* Petitioner's need for treatment for her arthritis was undeniably accelerated by her accidental injury.

Both Dr. Nogalski and Dr. Hachigian-Gould ignore the fact that the law only requires that accidental injury be *a* factor and not the sole or prevailing factor. The Arbitrator notes that Dr. Hachigian-Gould is not even a shoulder specialist and has not been involved in shoulder surgery since 1985. (RX4, p.38, 39). Therefore, the Arbitrator gives no weight to her opinion on the matter of causation. During his deposition, Dr. Nogalski admitted that some of the same forces at work in Petitioner's accidental injury would aggravate osteoarthritis or cause symptoms. (RX2, p.27, 28). He acknowledged that the accident was sufficient to cause complex tearing of the labrum that warranted surgery. (RX1). He admitted that there was no indication that Petitioner needed or sought care for her left shoulder prior to the accident. *Id.* at 38-40. Despite the evidence and despite being advised by Petitioner that she had no complaints prior to her work accident, he assumed that Petitioner must have been symptomatic prior to the accident rather than accepting the evidence and acknowledging that Petitioner may have been one of the "very few," in his opinion, that had asymptomatic arthritis. *Id.* at 26, 45. The Arbitrator thus finds that the opinion of Dr. Nogalski is not credible and is unsupported by the evidence, and relies on the opinion of Dr. Mall.

Based on the law and the evidence, the Arbitrator finds that Petitioner met her burden of proof on the issue of causal connection.

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?

Employers are responsible for providing the medical care reasonably required in order to diagnose, relieve, or cure the effects of the claimant's injury. *Plantation Mfg. Co. v. Indus. Comm'n,* 691 N.E.2d 13 (2d Dist. 2000); *F & B Mfg. Co. v. Indus. Comm'n*, 758 N.E.2d 18 (1st Dist. 2001).

The Arbitrator finds that Petitioner has not reached maximum medical improvement. While Dr. Howard concluded that Petitioner had reached maximum medical improvement; Dr. Nogalski admitted that he would recommend further conservative care for Petitioner until she required a shoulder replacement (RX2, p.49, 50), and even Dr. Hachigian-Gould acknowledged that Petitioner required surgery. (RX3). The Arbitrator again notes, however, that Dr. Hachigian-Gould is not a shoulder surgeon, and that she failed to cite the ODG authority upon which she relied. *Id.* The Arbitrator notes, however, that the ODG has not been expressly adopted by the Commission and are not binding as to the reasonableness and necessity of treatment. With regard to the type of surgery required, the Arbitrator defers to Dr. Mall. Dr. Mall was able to identify the source of Petitioner's pain, logically explain why Petitioner's first surgery failed to improve her complaints, and provide evidence-based medical literature to support the necessity of his current recommendations. (PX11, PX12).

Respondent shall therefore pay the medical expenses contained in Petitioner's group exhibit and shall have credit for any amounts already paid. Respondent shall authorize and pay for the further necessary care recommended by Dr. Mall Respondent shall indemnify and hold Petitioner harmless from any claims from these medical providers arising out of the expenses for which it claims credit, pursuant to § 8(j) of the Act.

This award shall in no instance be a bar to a subsequent hearing and determination of an additional amount if 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Paul House,

Petitioner,

vs. No. 14 WC 29263

City of Springfield – Fire Department,

16IWCC0330

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of occupational disease, causal connection, medical expenses and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission agrees with the Arbitrator in all respects, except the finding that the occupational disease, latent tuberculosis, caused permanent disability of 5 percent of the person as a whole. Although the Commission agrees with the Arbitrator's determination of how much relative weight to give each of the factors enumerated in section 8.1b(b) of the Workers' Compensation Act (the Act), the Commission is of the opinion that a more appropriate permanency award is 2 percent of the person as a whole.

In this case, the permanency award is mainly based on subsection (v) of section 8.1b(b)—evidence of disability corroborated by the treating medical records. The Commission notes there is scant evidence of disability corroborated by the treating medical records. The medical records show Petitioner was released to return to work full duty. Petitioner testified that he now feels he has less endurance than before he tested positive for tuberculosis. However, Petitioner conceded this could be because he is getting older. On the other hand, Petitioner mentioned that during the

16IWCC0330

time he was treating for latent tuberculosis, he worked with a dietician and lost 50 pounds. There are no medical records in evidence from Petitioner's last visit to Dr. Kulkarni. Petitioner testified that when he last saw Dr. Kulkarni approximately a month before the arbitration hearing, his white blood cell count was normal. Inasmuch as Petitioner underwent a nine-month course of INH (Isoniazid) and Pyridoxine treatment for latent tuberculosis, the Commission believes an award of some permanent partial disability benefits is warranted, even though Petitioner's chest X-ray was normal. The Commission finds the appropriate award is 2 percent of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 8, 2015, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for all reasonable and necessary medical services related to Petitioner's latent tuberculosis, pursuant to §§8(a) and 8.2 of the Act. Respondent is not liable for any medical expenses related to Petitioner's low white blood cell count, mild thrombocytopenia or splenomegaly. 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 §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $721.66 per week for a period of 10 weeks, as provided in §8(d)2 of the Act, for the reason that the occupational disease caused the 2 percent disability to the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 13 2016
o-04/07/2016
SM/sk
44

Stephen Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOUSE, PAUL
Employee/Petitioner

Case# 14WC029263

16IWCC0330

CITY OF SPRINGFIELD-FIRE DEPT
Employer/Respondent

On 9/8/2015, 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 0.27% shall accrue from the date listed above to the day before the 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:

4494 SGRO HANRAHAN DURR & RABIN LLP
ALEX RABIN
1118 S 6TH ST
SPRINGFIELD, IL 62703

0332 LIVINGSTONE MUELLER ET AL
DENNIS O'BRIEN
PO BOX 335
SPRINGFIELD, IL 62705

16IWCC0330

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

PAUL HOUSE,
Employee/Petitioner

v.

CITY OF SPRINGFIELD-FIRE DEPARTMENT,
Employer/Respondent

Case # 14 WC 29263

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **7/27/15**. 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 _____

FINDINGS

On **2/24/14**, 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 latent tuberculosis ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $**77,991.16**; the average weekly wage was $**1,499.83**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **0** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**00.00**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay all reasonable and necessary medical services related to petitioner's latent tuberculosis as provided in Sections 8(a) and 8.2 of the Act. Respondent shall not pay any medical expenses related to petitioner's low white blood count, mild thromocytopenia or splenomegaly.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $721.66/week for 25 weeks, because the injuries sustained caused the 5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

8/20/15
Date

SEP 8 – 2015

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 50 year old firefighter, alleges he sustained an occupational disease that arose out of and in the course of his employment by respondent on 2/24/14.

Petitioner has been a firefighter for respondent for the past 15 years. His duties include responding to fire calls, handling hazardous conditions, and providing first aid, medical care and treatment. Most of petitioner's calls are medical calls. During any given shift petitioner responds to 3 to 10 calls. As a firefighter for the City of Springfield petitioner's unit responds to many calls at the Bel Air Hotel. The Bel Air Hotel is a low-cost, transient place for people to stay long and short term. Petitioner also had concurrent employment that respondent had knowledge of. Prior to 2010 petitioner worked as a registered nurse at St. John's Hospital. Beginning in 2011 petitioner began working at Prairie Surgical Center.

While petitioner worked for St. John's Hospital he was tested annually for tuberculosis and never tested positive. Prairie Surgical Center does not test for tuberculosis. However, petitioner testified that they do not deal with patients who have infectious disease, and all patients at Prairie Surgical Center are screened at first with a history and physical.

On 1/27/14 petitioner underwent a blood test as part of a pre-employment screening for his second job. Petitioner tested positive for Quantiferon-TB. This sample demonstrated an immune response to M. Tuberculosis. Petitioner denied that he had any health problems at the time of this test.

On 2/24/14 petitioner presented to Dr. Pradeep Kulkarni at Central Illinois Allergy and Respiratory Service, Ltd. Dr. Kulkarni noted that before this positive test petitioner had PPD skin testing, as recently as 2010, and it was negative. Dr. Kulkarni was of the opinion that the petitioner had a recent conversion. He noted that petitioner was asymptomatic. He was of the opinion that petitioner could have been exposed either in his line of duty as a fireman where he visits various households, or as a nurse where he was exposed to different patients. Petitioner's hepatic function studies were normal, and his ESR was low. Petitioner's chest x-rays were normal. Dr. Kulkarni was of the opinion that petitioner had latent tuberculosis. He was of the opinion that there is no evidence that petitioner had an active disease, and that petitioner was not contagious. Dr. Kulkarni started petitioner on INH, and Pyridoxine. Petitioner was warned of side effects that include liver dysfunction and peripheral neuropathy.

Petitioner reported this TB finding to respondent and on 2/24/14 petitioner completed a City of Springfield Lost Control – Medical Slip informing respondent that he tested positive for Quantiferon. Petitioner was allowed to return to work without restrictions, and did alternate work within the firehouse.

On 3/26/14 petitioner followed up with Dr. Kulkarni. Petitioner reported that he had a little bit of nausea after taking the medicine, but that seemed to be settling down. Dr. Kulkarni checked his lab work. These labs showed hyperglycemia. Therefore, Dr. Kulkarni obtained a hemoglobin A-1C, but that was normal. Dr. Kulkarni was of the opinion that at some point he may want petitioner to see a hematologist to determine whether there is anything that needs to be done regarding his low white count. On 4/30/14 Dr. Kulkarni noted that petitioner's lab work was unremarkable, except for a low white count. Petitioner stated that he has had low white counts for the last three or four years. Dr. Kulkarni noted that the reason for this was unclear. He noted that petitioner's white count was low long before he started on INH therapy, which he seemed to be tolerating well. Petitioner's liver functions were normal.

On 7/9/14 petitioner followed up with Dr. Kulkarni. Dr. Kulkarni noted that petitioner was currently on INH therapy and vitamin B6 therapy. He was of the opinion that petitioner had completed four months and was tolerating it well without any adverse effects. Petitioner's white blood count remained low.

On 7/14/14 petitioner presented to Dr. Hui Zhang at Central Illinois Hematology Oncology Center, on the referral of Dr. Kulkarni, for an evaluation of leukopenia. Petitioner noted that he was found to have a low white count in December 2010, 2013, and 2014. He gave a history of his treatment for his latent tuberculosis to date. Dr. Zhang noted that petitioner had recurrent bronchitis in the past years, 1 to 2 episodes a year, and was treated with Z-Pac and prednisone in the past. Dr. Zhang ran some blood tests and was of the opinion that petitioner still had a risk of neutropenia since he has been on the medication INH. He instructed petitioner to follow-up with a CBC every two weeks. He noted that petitioner had mild thrombocytopenia that could be from the side effects of INH, but could also be a lab error from platelet clumping. Dr. Zhang noted that since petitioner's neutropenia had resolved, there was no need to give him the filgrastim or adjust the dose of INH. He noted that petitioner's white blood count differential was normal. He continued petitioner on his INH course. An ultrasound performed on 7/20/14 revealed in a large spleen without any focal masses.

On 8/11/14 petitioner returned to Dr. Zhang. Petitioner's blood smear did not show any abnormal morphology of the white blood cells. His white blood count was improved, his normal differentiation. His mild leukopenia was likely related to the side effects of INH. It was also likely related to the splenomegaly. Dr. Zhang also noted that petitioner's thrombocytopenia was resolved. He was of the opinion that petitioner's splenomegaly could be related to a virus infection.

A bone marrow biopsy was performed on 9/10/14 revealing normal cellular marrow with trilineage hematopoiesis maturation. A repeat ultrasound on 11/12/14 again identified splenomegaly.

On 1/22/15 petitioner presented to Dr. Elaine Majerus at Washington University School Of Medicine – Siteman Cancer Ctr., Department of Internal Medicine – Division Of Hematology. Petitioner presented as a self referral for a second opinion regarding his splenomegaly and leukocytosis. Petitioner told Dr. Majerus that as a result of the splenomegaly he could not engage in any strenuous physical activities or heavy lifting which would put him at risk for splenic rupture. He stated that the problem with this was that he was a fireman, and as a result of this restriction, he was placed in a desk job through the respondent. He stated that he would like to return to his activities as a fireman, but was told by Dr. Kulkarni that splenectomy would put him in a very high risk for recurrent infections in the future and would not be pursued unless his spleen enlarged dramatically, or if he would become symptomatic from splenomegaly. Petitioner reported mild discomfort in the left upper quadrant intermittently, mostly at night. Following an examination and record review, with regards to leukopenia, Dr. Majerus was of the opinion that if his white blood count had improved to normal following isoniazid and no further follow-up would be necessary for this problem. With respect to his splenomegaly, the etiology was unclear. Dr. Majerus referred petitioner to Dr. Blunt.

Petitioner presented to Dr. Brunt on 2/3/15. Dr. Brunt performed a CT scan of petitioner's spleen. He was of the opinion that it did not look particularly bulky. He noted that petitioner's neutropenic issue had pretty much resolved. Dr. Brunt spoke with Dr. Majerus and she did not feel that petitioner needed his spleen taken out. Dr. Brunt recommended no restrictions in petitioner's activity and released him back to his regular duty job as a firefighter.

Petitioner last saw Dr. Kulkarni in June 2015. His white blood count results were normal. Petitioner noted that he no longer works his concurrent employment. He testified that when he was on light duty he worked from Monday through Friday, and those were the same hours as his concurrent employment. No other firefighters in petitioner's firehouse tested positive for TB. However, respondent did not check firefighters for TB on a regular basis, although respondent's standard operating guidelines indicate that firefighters should be tested for TB regularly.

Petitioner offered into evidence receipts from Walgreens that showed various prescription numbers for various dates. What those prescription numbers were for was not identified on any of the receipts, and the drug datasheets that accompanied these prescriptions were not offered into evidence.

Petitioner testified that the INH and vitamin B6 therapy caused him fatigue. Once his INH therapy was completed and his blood tests returned to normal, petitioner was no longer fatigued. Petitioner testified that the only thing that is not back up to normal is his endurance level. He stated that at this time he is not able to jog and do cardio as he did before the accident. He testified that he cannot complete a 5K run. Petitioner noted that

he developed high blood pressure as a result of the therapy. He went and saw dietician, and lost 50 pounds. Petitioner testified that he did not know if his spleen was enlarged before the date of accident.

While petitioner was unable to work full duty as a firefighter he did not miss any work. He was assigned to other jobs within the fire department. These jobs included setting up three firehouses to become ALS. He also ordered materials, and tracked medical conditions at all firehouses.

C. DID PETITIONER SUSTAIN AN OCCUPATIONAL DISEASE THAT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT BY RESPONDENT?

Petitioner alleges he sustained an Occupational Disease in the form of latent tuberculosis, that arose out of and in the course of his employment respondent on 2/24/14. "Occupational Disease" means a disease arising out of and in the course of the employment or which has become aggravated and rendered disabling as a result of the exposure of the employment. Such aggravation shall arise out of a risk peculiar to or increased by the employment and not common to the general public. 820 ILCS 310/1(d).

Section 820 ILCS 310/1 (d) of the Illinois Workers Occupational Disease Act provides that "Any condition or impairment of health of an employee employed as a firefighter, emergency medical technician (EMT), or paramedic which results directly or indirectly from any blood borne pathogen, lung or respiratory disease or condition, heart or vascular disease or condition, hypertension, tuberculosis, or cancer resulting in any disability (temporary, permanent, total, or partial) to the employee shall be rebuttably presumed to arise out of and in the course of the employee's firefighting, EMT, or paramedic employment and, further, shall be rebuttably presumed to be causally connected to the hazards or exposures of the employment. This presumption shall also apply to any hernia or hearing loss suffered by an employee employed as a firefighter, EMT, or paramedic. However, this presumption shall not apply to any employee who has been employed as a firefighter, EMT, or paramedic for less than 5 years at the time he or she files an Application for Adjustment of Claim concerning this condition or impairment with the Illinois Workers' Compensation Commission. The rebuttable presumption established under this subsection, however, does not apply to an emergency medical technician (EMT) or paramedic employed by a private employer if the employee spends the preponderance of his or her work time for that employer engaged in medical transfers between medical care facilities or non-emergency medical transfers to or from medical care facilities. The changes made to this subsection by this amendatory Act of the 98th General Assembly [P.A. 98-291] shall be narrowly construed. The Finding and Decision of the Illinois Workers' Compensation Commission under only the rebuttable presumption provision of this paragraph shall not be admissible or be deemed res judicata in any disability claim under the Illinois Pension Code arising

out of the same medical condition; however, this sentence makes no change to the law set forth in Krohe v. City of Bloomington, 204 Ill.2d 392."

On 2/24/14 petitioner was employed as a firefighter for respondent for 15 years, and is alleging that his latent tuberculosis arose out of an in the course of his employment by respondent. As such, pursuant to Section 820 ILCS 310/1 (d) of the Illinois Worker's Occupational Disease Act petitioner's latent tuberculosis shall be rebuttably presumed to arise out of and in the course of his firefighting, and shall be rebuttably presumed to be causally connected to the hazards or exposures of the employment.

Petitioner has worked as a firefighter for 15 years for respondent and most of petitioner's calls are medical calls. During any given shift petitioner responds to 3 to 10 calls. As a firefighter for the City of Springfield petitioner's unit responds to many calls at the Bel Air Hotel. The Bel Air Hotel is a low-cost, transient place for people to stay long and short term. Petitioner also had concurrent employment that respondent had knowledge of. Prior to 2010 petitioner worked as a registered nurse at St. John's Hospital. Beginning in 2011 petitioner began working at Prairie Surgical Center.

While petitioner worked for St. John's Hospital he was tested annually for tuberculosis and never tested positive. Prairie Surgical Center does not test for tuberculosis. However, petitioner testified that they do not deal with patients who have infectious disease, and all patients to Prairie Surgical Center are screened at first with a history and physical. Although respondent's standard operating guidelines indicate that firefighters should be tested regularly for tuberculosis, petitioner presented unrebutted testimony that this procedure was not followed. Petitioner knew of no other firefighters who tested positive for tuberculosis.

Respondent failed to offer any evidence in defense of this claim. Respondent claims that since no other firefighter tested positive for tuberculosis, and petitioner had current employment as a registered nurse for St. John's Hospital and Prairie Surgical Center since 2011, that petitioner has failed to prove by a preponderance of the credible evidence that petitioner's tuberculosis arose out of and in the course of his employment by respondent on 2/24/14. The arbitrator finds respondent's argument speculative at best and does meet the threshold for rebutting the presumption that petitioner's tuberculosis arose out of and in the course of his employment. The arbitrator finds it significant that while petitioner worked for St. John's Hospital he was tested every year for tuberculosis and never tested positive. Additionally, the arbitrator finds it significant that all patients at Prairie Surgical Center are screened with a history and physical, and firefighters in petitioner's firehouse are not regularly screened for tuberculosis.

Based on the above as well as the credible evidence, the arbitrator finds the respondent has failed to overcome the rebuttable presumption that petitioner's latent tuberculosis arose out of and in the course of his employment by respondent on 2/24/14.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner claims his latent tuberculosis is causally connected to the hazards or exposures of his employment for respondent on 2/24/14. On 2/24/14 petitioner was diagnosed with latent tuberculosis. As recently as 2010 petitioner had tested negative, and therefore Dr. Kulkarni was of the opinion that petitioner had a recent conversion. Dr. Kulkarni was of the opinion that petitioner could have been exposed either in his line of duty as a fireman where he visits households, or as a nurse where he is exposed to different patients. However, since petitioner has worked as a fireman for respondent in excess of 5 years, pursuant to Section 820 ILCS 310/1 of the Worker's Compensation Occupational Disease Act petitioner's latent tuberculosis shall be rebuttably presumed to be causally connected to the hazards or exposures of the employment with respondent. The arbitrator finds the respondent offered no evidence to overcome this rebuttable presumption by offering anything other than speculation, with no credible evidence to support a finding that petitioner's latent tuberculosis came from a source other than his employment by respondent .

In addition to his latent tuberculosis, petitioner was diagnosed with a low white blood count (leukopenia, and neutropenia), as well as mild thromocytopenia and splenomegaly. With respect to his low white blood count, petitioner was diagnosed with this in 2010 and on several other occasions, when he did not test positive for tuberculosis. As such, the arbitrator finds petitioner's low white blood count is not causally related to the occupational disease he sustained. Dr. Zhang was of the opinion that petitioner's mild thromocytopenia could be from the side effects of INH or a lab error from platelet clumping. Since there was no definitive cause identified the arbitrator finds petitioner's mild thromocytopenia is not causally related to petitioner's occupational disease. With respect to petitioner's splenomegaly, Dr. Majerus opined that the etiology was unclear. Therefore, the arbitrator finds the petitioner has failed to prove a causal connection between these conditions and his current condition of ill-being.

Based on the above as well as the credible evidence, the arbitrator finds the petitioner's latent tuberculosis is causally related to his current condition of ill-being. The arbitrator further finds petitioner's low white blood count, mild thromocytopenia and splenemegaly are not causally related to his occupational disease.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found petitioner's latent tuberculosis is causally related to his current condition of ill-being, the arbitrator finds all treatment related to this condition was reasonable and necessary to cure or relieve petitioner from the effects of his occupational disease. Additionally, since the arbitrator has found the petitioner has failed to prove by a preponderance of the credible evidence that his low white blood cell count, mild thromocytopenia, and his splenomegaly are causally related to his occupational disease, the arbitrator finds treatment related to these conditions was not reasonable or necessary to cure or relieve petitioner from the effects of his occupational disease.

Based on the above, as well as the credible evidence, the arbitrator finds the respondent shall pay all reasonable and necessary medical services related to petitioner's latent tuberculosis as provided in Sections 8(a) and 8.2 of the Act. Respondent shall not pay any medical expenses related to petitioner's low white blood count, mild thromocytopenia or splenomegaly.

Petitioner also offered into evidence receipts from Walgreens that showed various prescription numbers for various dates. What those prescription numbers were for was not identified on any of the receipts, and the drug datasheets that accompany these prescriptions were not offered into evidence. As such, the arbitrator has no idea what drugs these are and the conditions they treat, and finds the petitioner has failed to prove by a preponderance of the credible evidence that these prescriptions were reasonable and necessary to cure or relieve petitioner from the effects of his latent tuberculosis. Petitioner's reimbursement of these out of pocket expenses is denied.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

As a result of the injury on 2/24/14 petitioner developed latent tuberculosis, and as a result of the treatment for the latent tuberculosis.

With regard to subsection (i) of §8.1b(b), neither part offered into evidence an impairment rating. As such, the Arbitrator gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that petitioner was employed as a firefighter for respondent at the time of the accident. Petitioner

was never taken off work, and worked light duty before ultimately being released to full duty work without restrictions. Petitioner testified that he is able to perform all duties of his job, and do the job he is required to do. Because petitioner was released to his regular duty job and continues in that capacity today, the Arbitrator gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of the accident. Because of the fact that petitioner has many more working years ahead of him where he can work full duty without restrictions, the Arbitrator gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was offered into evidence regarding any impact petitioner's occupational disease has on his future earnings. The Arbitrator gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that petitioner last saw Dr. Kulkarni in June of 2015 and had completed his treatment for his latent tuberculosis. At that time his white blood cells were normal and he had returned to full duty work for respondent without restrictions. Petitioner reported that once he completed his INH therapy his fatigued resolved. Petitioner claims he developed high blood pressure as a result of the therapy, but there is nothing in the medical records to corroborate this claim. Additionally, there is nothing in the medical records to corroborate petitioner's claims that his endurance level is not equal to what it was pre-accident and this is due to his latent tuberculosis versus his other unrelated conditions.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained a permanent partial disability to the extent of 5% loss of use of his person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KEVIN WILSON,

Petitioner,

16IWCC0289

vs.

NO: 14 WC 34195

ERMI, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, and prospective medical care, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission affirms and adopts the Arbitrator's finding of a causal connection between Petitioner's March 16, 2014 work-related injury and his current cervical spine condition of ill-being at the level of C6-7. However, with regard to prospective medical treatment as it relates to the foraminal stenosis at level of C5-6, the Commission reverses the Arbitrator's award in the form of a two level fusion surgery at C5-6 and C6-7, finding the opinion of Dr. Soriano more persuasive than that of Dr. Salehi for the reasons stated herein.

On April 21, 2014 Petitioner was seen for an initial neurosurgical consultation with Dr. Salehi, at which time the doctor examined Petitioner, and reviewed Petitioner's April 3, 2014 cervical MRI report. Dr. Salehi noted the MRI report documented degenerative disc disease at C6-7, with right paracentral foraminal disk protrusion impinging on the exiting C7 nerve root. Dr. Salehi diagnosed a herniated disc at C6-7, and recommended one to two right C6-7 epidural steroid injections, continue physical therapy and full duty work. On June 9, 2014 Petitioner was seen in follow up, at which time he reported the one injection he received provided 50% relief of his pain symptoms, but that he continued to have persistent residual numbness in the first three digits of his right hand, as well as complaints of right upper extremity weakness. Dr. Saleh noted right upper extremity weakness and atrophy of the right pectoral and triceps muscles, requested that Petitioner follow-up with his MRI imaging for personal review, and opined that Petitioner may require surgical intervention in the form of a fusion or possibly decompression. (PX1).

Although the June 13, 2014 office visit note is not contained within the record, Dr. Salehi testified he next examined Petitioner on that date, and reviewed the MRI imaging. Dr. Salehi testified that his review of the MRI study indicated that Petitioner had a moderate to large herniated disc at C6-7, as well as moderate right C5-6 foraminal stenosis, which was a degenerative condition. Dr. Salehi testified that on that date he discussed a two-level discectomy and fusion from C5 to 7. Dr. Salehi admitted that he could perform a one-level fusion at C6-7 to address the herniation, but was recommending a two-level fusion because Petitioner has foraminal stenosis at the level above, at C5-6, on the same side he has atrophy, "which in a way can contribute somewhat to the compression as well. But more importantly, leaving that adjacent level untreated increases the chances that he may require an additional surgery down the road." (PX2, T11-13). Dr. Salehi also testified that the herniated disc at C6-7 was related to his work injury, but that the foraminal stenosis he diagnosed at the C5-6 disc level was not caused by it, and "at most, it could have been aggravated. It's a degenerative process." (PX2, T15-16).

On cross-examination, Dr. Salehi admitted that based upon the moderate to large herniation at C6-7, he knows that for the most part Petitioner's nerve problems are coming from that level. Dr. Salehi further admitted: 1)If C6-7 is either the exclusive cause or primary cause of the problem, then addressing that level separately could resolve all the problems; and, 2) If only C6-7 level is addressed, it is possible, probable, more likely than not, that that could resolve all of Petitioner's problems. Dr. Salehi testified that he did not know for sure that C5-6 is completely asymptomatic because of the dermatomal overlap and compression seen, but he further admitted that his concern was that at a later point in time there might be some problems with C5-6. (PX2, T19-23).

On August 11, 2014, Petitioner underwent a Section 12 examination with Dr. Soriano, pursuant to Respondent's request. At that time, Dr. Soriano examined Petitioner, and reviewed treating medical records and the April 3, 2014 cervical MRI scan. Dr. Soriano opined Petitioner's diagnosis for his work injury was an acutely herniated disc at C6-7, with C7 radiculopathy, which was improving. He further opined that Petitioner's current subjective complaints were related to his work injury, and that Petitioner had no history of a prior

preexisting condition, but that his disc osteophyte at C5-6 was present and not aggravated by his work injury. Dr. Soriano opined that Petitioner's outside activities like the weightlifting and exercising Petitioner reported had impacted his discs and probably predisposed him to progressive degenerative changes at the C5-6 level, and weakness at the C6-7 level. Dr. Soriano noted that Petitioner himself admitted that the college football he played likely caused trauma to his neck. With regard to the cervical MRI study, Dr. Soriano opined the film revealed an acute disc herniation at C6-7, and that the findings at C5-6 were all chronic and degenerative in nature. Dr. Soriano opined the results at the C6-7 level relate to his work injury, but not at the C5-6 level. Finally, Dr. Soriano opined that a two-level fusion is not necessary, that Petitioner is a candidate for C6-7 discectomy, that a C5-6 discectomy has no relation to his work injury and would be for broad based mild degenerative disc with some narrowing of the right C6 foramen, and that the disc at C5-6 is not injury related. (RX1).

Based upon review of the record as a whole, the Commission reverses the Arbitrator's finding that Petitioner's work accident aggravated and caused the C5-6 level to become symptomatic, and vacates the Arbitrator's aware of a two-level discectomy and fusion from C5-7. The Commission finds the testimony of Dr. Salehi to be equivocal as to the C5-6 disc level. Dr. Salehi testified that Petitioner's foraminal stenosis at the C5-6 disc level was not caused by his work injury, but "at most, could have been aggravated," and is a degenerative condition. The record fails to reflect that Dr. Salehi was of the opinion that the C5-6 disc level became symptomatic from the work injury. Instead Dr. Salehi testified he would prefer to include the C5-6 level with the C6-7 level surgery to prevent possible need for any future surgery at the C5-6 level. However, Dr. Salehi admitted that a one level discectomy at C6-7 could possibly resolve all of Petitioner's symptoms, and that he could not say with certainty which level Petitioner's symptoms were coming from, C6-7 or C5-6. The Commission finds the opinions of Dr. Soriano more persuasive and unequivocal on the issue. Dr. Soriano opined that Petitioner's current subjective complaints were related to his work injury, that Petitioner had no history of a prior preexisting condition, but that his disc osteophyte at C5-6 was present and not aggravated by his work injury and that a two-level fusion is not necessary, that Petitioner is a candidate for C6-7 discectomy, that a C5-6 discectomy has no relation to his work injury and would be for broad based mild degenerative disc with some narrowing of the right C6 foramen, and that the disc at C5-6 is not injury related.

Based upon the Commission's finding herein with regard to causal connection, the Arbitrator's award of prospective medical in the form of a two-level cervical fusion, from C5 though C7, is hereby vacated. The Commission awards prospective medical in the form of a one-level discectomy at C6-7, as recommended by Dr. Soriano.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 11, 2015, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's prospective medical award, in the form of a two-level fusion surgery from C5 though C7 as recommended by Dr. Salehi, is vacated.

IT IS FURHTER ORDERED BY THE COMMISSION that Respondent authorize and pay for the single level discectomy at C6-7 as recommended by Dr. Soriano pursuant to §8(a) of the Act and subject to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

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: MAY 4 - 2016
KWL/kmt
O-03/08/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

16IWCC0289

WILSON, KEVIN
Employee/Petitioner

Case# **14WC034195**

ERMI INC
Employer/Respondent

On 6/11/2015, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1357 RATHBUN CSERVENYAK & KOZOL
LUIS J MAGANA
3260 EXECUTIVE DR
JOLIET, IL 60431

0832 HOLECEK & ASSOCIATES
STUART PELLISH
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

STATE OF ILLINOIS)

)SS.

COUNTY OF **COOK**)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

16IWCC0289

KEVIN WILSON
Employee/Petitioner

v.

ERMI, Inc.
Employer/Respondent

Case # **14** WC **34195**

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 **Steffen**, Arbitrator of the Commission, in the city of **Chicago**, on **4-8-15**. 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. ☒ Is Petitioner entitled to any prospective medical care?

L. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On the date of accident, **3-16-14**, 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 **$119,964.00**; the average weekly wage was **$2,307.69**.

On the date of accident, Petitioner was **38** years of age, ***single*** with **1** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent is liable for Petitioner's prospective medical care in the form of two level fusion surgery as recommended by Dr. Salehi.

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.

KBS

Signature of Arbitrator

6/10/15

Date

ICArbDec19(b)

JUN 11 2015

FACTUAL HISTORY

Petitioner, Kevin Wilson, worked for respondent, ERMI, as a sales representative. ERMI sells post-surgical medical equipment to medical providers. As a sales representative, Petitioner travels in his personal vehicle from downtown Chicago north to Milwaukee selling and delivering medical equipment. On March 26, 2014 Petitioner was working within this capacity when he suffered an injury. On that date, Petitioner testified that he was attempting to remove a piece of equipment from his truck when the equipment became stuck and as he was yanking on it with both of his hands, he felt immediate pain in his chest, shoulder and neck. Mr. Wilson immediately called his boss and was told to call the human resources department. Upon calling the HR representative, Petitioner was told to seek medical assistance as needed.

Petitioner indicated that this incident happened while he was in downtown Chicago and he was familiar with the area and local medical providers so he went to Occupational Health Centers of Illinois. Upon arriving at the clinic on the day of accident, Petitioner met with Dr. George Bridgeforth. Petitioner indicated that he hurt his right shoulder when he was arranging medical equipment for delivery. (P2) The doctor noted, "he was trying to pull equipment out of his care when he felt a pop in his rt shoulder followed by severe pain and soreness along the rt side of his neck which spread across his rt shoulder." (P2) The doctor also noted that Petitioner had severe soreness along the right side of his neck and pain and numbness into his right arm. At hearing, Petitioner testified that immediately after the accident, he noticed much more severe shoulder than neck problems. Dr. Bridgeforth also noted that Petitioner had never had prior cervical or shoulder surgery but had a history of prior right shoulder

dislocations. Upon examination, the doctor noted that Petitioner did not dislocate his shoulder but that he suspected a partial tear his shoulder and cervical radiculopathy. Dr. Bridgeforth prescribed Petitioner medication and indicated that he was restricted to light duty work. (P2)

Following his initial examination, Petitioner testified that he continued to work but that he had two employees who lifted any heavy equipment. He continued to notice symptoms including the numbness and tingling into his right arm and hand. By his next examination, Dr. Bridgeforth noted that Petitioner's right shoulder strength was improving but that he continued to have severe soreness along the right side of his neck radiating to his right thumb and middle finger. (P2) The doctor ordered a cervical MRI and physical therapy for Petitioner. Petitioner underwent the MRI and returned to Dr. Bridgeforth on April 8, 2014. Upon review of the MRI, Dr. Bridgeforth indicated that Petitioner had a herniated disc on the right at C6-C7 and a posterior disc osteophyte complex at C5-C6. (P2) Given the diagnosis, the doctor referred Petitioner to a neurosurgeon for possible epidural injections. (P2)

Despite undergoing the physical therapy and taking medication, Petitioner testified that he continued to have symptoms in his neck and numbness and tingling down his arm. Petitioner first saw neurosurgeon Dr. Sean Salehi on April 21, 2014 and described his accident and symptoms. (P1) After examining Petitioner, Dr. Salehi diagnosed Mr. Wilson with a herniated disk at C6-7 and prescribed additional therapy and epidural steroid injections. (P1) Petitioner indicated that he underwent the injection but that it did not alleviate his symptoms. By his next appointment with Dr. Salehi on June 9, 2014, Mr. Wilson had undergone the cervical MRI (P1) Dr. Salehi reviewed the MRI film and indicated that he saw a moderate to large herniated disc at C6-7 with

moderate right C5-6 foraminal stenosis. (P3 at 11). Given the findings, Dr. Salehi discussed with Petitioner a two level discectomy and fusion from C5 to 7 to address his injury and complaints. (P3 at 12)

Following Dr. Salehi's diagnosis and recommendation that Petitioner undergo a two level fusion, Respondent sent Petitioner for a Section 12 examination. Petitioner saw Dr. Morris Soriano on August 11, 2014 and described his accident and current symptoms. After Dr. Soriano examined Petitioner and reviewed his medical records and MRI he gave his opinion that Petitioner suffered an acutely herniated disc at C6-7 with C7 radiculopathy. (R1) Despite finding causation between the accident and Petitioner's condition and agreeing that he needs further treatment for his herniation at C6-7, Dr. Soriano opined that Petitioner is a candidate for a C6-7 discectomy only. (R1) Dr. Soriano explained that Petitioner had a herniated disk as C6-7 but that the findings at C5-6 are all chronic and degenerative in nature and, as such, a C5-6 discectomy would have no relationship to Petitioner's work injury and that a two level fusion is not necessary. (R1)

Petitioner testified that after the examination with Dr. Soriano, his symptoms continued and he saw Dr. Salehi weekly. In his December 8, 2014 note, Dr. Salehi indicated that he reviewed Dr. Soriano's IME report and stated, "we continue to recommend surgical intervention in the form of a two level ACDF C5 though 7 despite the IME's recommendation that he needs only a single-level fusion. To not include the C5-6 level would only lead to ongoing symptoms following the surgery and the need for further surgeries in the future." (P2) At hearing, Petitioner testified that he last saw Dr. Salahi approximately 1 ½ weeks prior and that he continued to recommend the two level fusion. Mr. Wilson testified that he continues to notice severe neck pain that

radiates from the middle of his neck down his right arm with weakness and numbness down into his fingers. He indicated that he notices that he is a lot weaker in his right arm and has to use his left arm while working. If an object at work is too heavy, he indicated that two employees who work for him will lift for him. Petitioner further said that he has noticed left wrist pain because he compensates his right arm weakness by using his left arm. When asked about if he has limitations with daily activities, Petitioner testified that he cannot do a lot and that he cannot workout like he used to. Given his symptoms, Mr. Wilson indicated that he has had a lot of emotional side effects because of the constant pain and symptoms he has as a result of the accident.

Mr. Wilson testified that he has not had any surgery for his neck injury. He indicated that he intends to return to Dr. Salehi to undergo the two level fusion recommended by Dr. Salehi. Even though Petitioner indicated that he is aware the Respondent has approved the surgery indicated by Dr. Soriano, he intends to undergo the two level fusion because that is what Dr. Salehi recommended to him.

FINDINGS/ANALYSIS

Causal Connection and Prospective Medical:

Petitioner, Kevin Wilson, suffered an uncontested work accident on March 26, 2014. He was attempting to remove a piece of equipment from his truck and trying to yank it out when he felt pain in his chest, shoulder and neck. Petitioner immediately sought treatment and gave notice to his employer. Accident is uncontested.

A cervical MRI was ordered and Dr. Bridgeforth indicated that the Petitioner has herniated disc on the right at C6-C7 and a posterior disc osteophyte complex at C5-C6 (PX2). Following conservative case including epidural injections, medications and physical therapy; Petitioner consulted with neurosurgeon Dr. Sean Salehi on April 21,

2014. Dr. Salehi reviewed the MRI film and indicated that he saw a moderate to large herniated disc at C6-7 with moderate right C5-6 foraminial stenosis. (PX3 and PX11) Dr. Salehi recommended a two level discectomy and fusion from C5-7 to address his injury and complaints.

Respondent's IME Dr. Morris Sariano examined Petitioner on August 11, 2014 and agreed as to causation and the need for surgery. He opined that Petitioner is a candidate for a C6-7 discectomy only. He explained that Petitioner had a herniated disk at C6-7 from the work accident but that the findings of C5-6 are all chronic and degenerative in nature. He opined that a C5-6 discectomy is not causally connected to the work injury and that a two level fusion is not necessary. (RX1)

Initially, it is noted that Respondent only contests the causal connection as to the pathology at the C5-6 level and contends that the same is not related to the work accident but is caused by pre-existing degenerative condition. Both Petitioner's and Respondent's doctors are in agreement that Mr. Wilson is not yet at MMI and that he is a surgical candidate. The remaining issues are causation regarding the C5-6 level and prospective medical.

Medical rights and obligations are governed by Section 8 of the Illinois Workers Compensation Act. The employer is obligated to furnish causally related medical care that is "necessary" and "reasonably required" to cure or relieve the injured worker from the effects of the accidental injury. Upon review of the testimony and medical evidence the Arbitrator finds that Petitioner's current condition at the C6-7 level as well as the C5-6 level are causally connected to his work accident. The Arbitrator finds that all the medical opinions support that the moderate to large herniated disc at C6-7 was caused

by the work accident. As to the moderate right C5-6 foraminial stenosis the Arbitrator finds, based on Dr. Salehi's opinion, that the work accident aggravated and caused this level to also become symptomatic. (PX3 and PX11) The Arbitrator awards a two level discectomy and fusion from C5-7 to address his injury and complaints per the recommendation of Dr. Salehi..

In support of her findings, the Arbitrator gives greater weight to the opinions of Dr. Salehi as opposed to the opinions of Dr. Soriano. Dr. Salehi gives a clear diagnosis of a herniated disk at C6-7 was related to the work accident. (P3 at 16) There is a consistent mechanism of injury of lifting a box and feeling a pop in the neck that supports his opinion. Dr. Salehi has documented Petitioner's symptoms of pain and numbness going to the first three digits that indicate a C6-7 herniation." (P3 at 16) Dr. Soriano concurs with this causation opinion so the issue really concerns the foraminal stenosis at the C5-6 level.

In regards C5-6 level, Dr. Salehi opined that this "it wasn't caused...it could have been aggravated. It's a degenerative process." (P3 at 17) Dr. Soriano believes this to be a purely degenerative condition. Dr. Salehi explained that Petitioner had never had any prior symptoms in his neck or arm. (P3 at 17) This was confirmed by Petitioner at trial who indicated that prior to the accident, he had never had neck symptoms or numbness and tingling down his right arm into his fingers. Dr. Salehi's opinion is well-reasoned and supported by medical records that Petitioner had no previous complaints relating to his neck.

Respondent's examining physician, Dr. Soriano, also opined that he believed Petitioner's herniation at C6-7 was caused by the work accident. (R1) His opinion

differed from that of Dr. Salehi in that he did not believe that Petitioner's findings at C5-6 were related to the work accident. Instead, Dr. Salehi said those findings were chronic and degenerative in nature.

Dr. Salehi's opinions are more credible because Dr. Soriano offered no explanation why this dormant condition became painful following the accident. There is some evidence that Petitioner played college football and may have suffered shoulder issues, there is no evidence suggesting that he had cervical problems of any kind and there is a large time span between the football years and the work accident..

Given the above, the Arbitrator finds that Petitioner's neck condition including the herniation at C6-7 and stenosis at C5-6 are causally related to his March 26, 2014 work accident.

In regards to the request for prospective medical, Petitioner testified that it is his intention to proceed with the two level fusion recommended by Dr. Salehi. Respondent contends that Dr. Salehi's recommendation is not reasonable based on the opinions offered by Dr. Soriano. The Arbitrator awards the two level fusion based on the following reasoning as explained by Dr. Salehi during his deposition testimony.

Dr. Salehi explained that that even if Mr. Wilson did not have degeneration at C5-6, he would continue to recommend a two level fusion including C5-6 and C6-7. (P3 at 17) He explained that, "because the foraminal stenosis is to a moderate degree at C5-6, which is on the same side as where his symptoms of the pain and atrophy and the numbness is. So I feel uncomfortable just treating one level, knowing that there is an adjacent level which is also causing some compression on the nerve, and that compression is to a moderate degree. Also, when you do a discectomy and fusion at one level, you accelerate the rate of degeneration of the adjacent level. So he's already

starting with a degenerative disc at the C5-6 level. If I fuse the C6-7 level, we know that that rate is going to go up, the rate of degenerative is going to go up at C5-6 requiring an additional surgery down the road." (P3 at 17) In contrast, Dr. Soriano only indicated that a C5-6 discectomy would have no relationship to the injury and did not rebut Dr. Salehi's opinion to a satisfactory level.

The evidence demonstrates that Dr. Salehi's opinion on surgery is more reasonable than that offered by Dr. Soriano. As Dr. Salehi indicated, given the nature of Petitioner's symptoms at C5-6 and C6-7, only fusing one level would leave Petitioner at risk to have to undergo another surgery in the future to address the adjacent level. Further, even if C6-7 is degenerative in nature, Petitioner had never had any symptoms of any kind before his acute work accident. Although even Dr. Salehi indicated the one level procedure is reasonable, it is more reasonable for Petitioner to undergo the two level fusion so as not to risk further cervical surgery in the future.

Although Respondent does not dispute Petitioner's acute cervical injury, they dispute that the two level fusion is a reasonable course of care. Respondent's argument is that a cervical discectomy per Dr. Soriano's recommendation is not harmful to the Petitioner and that Dr. Salehi cannot guaranty that the cervical fusion would provide relief with any certainty. The Respondent urges a more conservative and less evasive procedure, perhaps to be followed by more as needed.

Although Respondent's position is not unreasonable, Petitioner cannot and should not be deprived of have some control over his own medical treatment and procedures. He may opt for a more conservative option, followed to a second procedure. However the Arbitrator finds that in light of her finding of causal connection as to both levels, an injured worker may reasonably make the self-determination to

undergo the procedure that is recommended by his own treating physician. The medical opinion to support this procedure and reasonable and the lack of guarantee of success of any medically reasonable procedure is not required.

KSS

Signature of Arbitrator Ketki Shroff Steffen

6/10/15

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jadwiga Bobek,
Petitioner,

vs.

NO: 14 WC 34833

ABM Industries, Inc.,
Respondent,

16IWCC0354

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, notice, temporary total disability, causal connection, medical, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 21, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to

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: MAY 26 2016

MB/mam
o:5/12/16
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Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

BOBEK, JADWIGA
Employee/Petitioner

Case# **14WC034833**

ABM JANITORIAL SERVICES
Employer/Respondent

16IWCC0354

On 5/21/2015, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1938 BELCHER LAW OFFICE
BRIAN WIEHE
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

0560 WIEDNER & McAULIFFE LTD
ROMA P DALAL
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

16IWCC0354

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)

Jadwiga Bobek
Employee/Petitioner

v.

ABM Janitorial Services
Employer/Respondent

Case # **14** WC **34833**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen Friedman**, Arbitrator of the Commission, in the city of **Chicago**, on **March 12, 2015 and April 2, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [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. [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 _____

16IWCC0354

FINDINGS

On the date of accident, August 8, 2013 or **June 5, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

On these dates, Petitioner ***did 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 **$31,980.00**; the average weekly wage was **$615.00**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **0** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$812.68** for other benefits, for a total credit of **$812.68**.

Respondent has paid medical bills of **$3,609.11** under Section 8(j) of the Act.

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT SHE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT ON EITHER AUGUST 8, 2013 OR JUNE 5, 2014 AND FAILED TO PROVE THAT HER CONDITION OF ILL BEING WAS CAUSALLY CONNECTED TO ANY ALLEGED ACCIDENT ON AUGUST 8, 2013, PETITIONER'S CLAIM FOR COMPENSATION IS HEREBY DENIED

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

May 21, 2015
Date

ICArbDec19(b)

MAY 21 2015

Statement of Facts

Petitioner Jadwiga Bobek testified that she has been a "cleaning lady" for Respondent ABM Janitorial Services for 21 years. She has held the same position and worked at the same building at One South Wacker in Chicago for those 21 years. Petitioner worked full time from 4:50 p.m. until 12:50 a.m., 5 days a week, with occasional overtime. She was allowed a 30 minute break for lunch and additional 10 minute break. Petitioner testified that she was responsible for cleaning the 26th floor and bathroom, half of the 27th floor, and the 33rd floor corridor hallway and bathroom. She testified that this area is 37,000 square feet, which did not account for the bathrooms. Her general cleaning duties included taking out garbage, dusting, vacuuming, mopping, and cleaning bathrooms.

Petitioner testified to her typical work day. She testified that she starts each day by preparing her cart and then collecting garbage on the 26th floor. The cart weighs 20 lbs. She testified that it was hard to push on the thick carpet. She testified this duty takes about 2 hours. She would then take her 10 minute break around 7:00 p.m. Following her break, she would collect garbage on the 27th floor for around 2 more hours, at which point she would take her lunch break. Petitioner testified that after lunch, she would clean the bathroom on the 26th floor. She testified that there were 8 stalls with wall dividers. She had to wipe each wall and use a device to clean inside the toilet bowl, and urinal. Petitioner testified that she would use both hands to wipe. She would also need to mop the bathroom floors. She testified that cleaning the bathroom on the 26th floor would take her about 30 to 35 minutes. Her next duty involved similar cleaning of the bathrooms on the 33rd floor, however, she testified that it was more difficult to wipe these dividing walls because they were made of stainless steel and thus took longer to clean. This bathroom would take her approximately 30 to 35 minutes. Petitioner further testified that there were large mirrors in the bathroom that also needed to be wiped clean.

Petitioner next testified that she would vacuum the 26th floor. She testified that she was responsible for vacuuming 20,000 square feet, which is the area around the desks and does not include the corridor and hallway on the 26th floor. Petitioner described the vacuum she used as heavy and stiff and testified that it was difficult to maneuver around and under the desks. She testified that the vacuum weighed 20 lbs. She testified that she was right handed but would vacuum with both arms when one would get tired. She testified that she was only using her left arm the last few months she worked because her right arm hurt too much. She testified that she would spend approximately 2 hours vacuuming the 26th floor. Petitioner demonstrated to the Arbitrator how she would vacuum "straight," which the Arbitrator noted involved her right arm with the elbow flexed, moving the hand down near the hip, her wrist down near her hip, moving her arm forward and backward with the hand coming up slightly. She also demonstrated how she would vacuum when she needed to bend down and get around corners, which the Arbitrator noted involved her bending forward with her right hand with the elbow flexed, her wrist was moving inverted and then everted to move the vacuum head.

Petitioner testified that she would clean the two kitchens on the 26th floor, which involved mopping the floor. She testified that she used both arms to mop and this required her to use a strong force in her back and arms. She demonstrated mopping, which the Arbitrator noted involved her holding her elbows flexed, hands slightly at the chest level, moving in a circular motion back and forth and out and back. Petitioner testified that she would then vacuum the 27th floor, but only the offices and not the hallway and corridor, which would take about 1.5 to 2 hours. Next, petitioner would clean the kitchens on the 27th floor. Finally, Petitioner would vacuum the hallway and corridor on the 33rd floor, which would only take about 5 to 10 minutes because the carpeting was easier than on the 26th and 27th floors. Petitioner also testified that she was responsible for cleaning and dusting the windowsills, shelves, and radiators if she had time after finishing her other duties.

On cross examination, Petitioner stated that her time estimates for the various job assignments were too many hours. Petitioner testified that her description of the duties was when the offices were empty. She sometimes does spot vacuum cleaning. If someone was working she would work around them and vary her tasks. Petitioner identified Rx 5A-5E as the mop bucket, mop, vacuums and barrel that she used. She testified that if the garbage was very heavy she would notify another man to come and get it. Sometimes he is busy and cannot come.

Respondent introduced the ABM job description for General Cleaner into evidence (RX 4). The job description provides petitioner's job duties including removing waste paper and rubbish, empty ashtrays, remove finger marks from vertical surfaces, vacuum rugs, dust and wipe furniture, police stairwells, damp dust items, keep slop sink rooms clean, wipe and polish fixtures, and sweep with a broom.

Ms. Zofia Latocha, petitioner's supervisor, testified pursuant to subpoena. Ms. Latocha testified she had worked for ABM for 30 years. Of those 30 years, she testified she had performed the job duties of a cleaner for 20 years, and was very familiar with the job duties of a cleaner. Ms. Latocha testified petitioner's job duties consisted of collecting garbage and removing any visible handprints or finger prints on the desks. She would then sweep the floors, mop if necessary and spot vacuum. Ms. Latocha explained spot vacuuming meant that you did not have to vacuum the whole space, rather just the spot; you would only vacuum the areas that may have visible crumbs or dirt. Ms. Latocha advised petitioner was able to spot clean floor 26 and part of floor 27. She testified that Petitioner would only vacuum for a maximum of one to two hours. She testified that petitioner did not vacuum continuously; rather this was broken up as petitioner was cleaning each office space.

Ms. Latocha testified that petitioner did not lift any heavy objects. She testified there was a male co-worker during the lunch hour that was responsible for collecting all the heavy garbage. Although Petitioner mopped and cleaned the bathrooms daily, Ms. Latocha explained the mop only weighed one pound and petitioner did not have to mop all the areas every day, only the areas that were dirty. She testified mopping in total took approximately 40 minutes per day. Ms. Latocha further testified that the vacuum and the barrel were easy to push. She clarified that the barrel had wheels and required only a light push. She further testified petitioner did not have to forcefully push the mop and that no job duties were considered forceful. She testified that the vacuum was a "typical vacuum" and not considered heavy. Ms. Latocha testified petitioner did not have to lift the vacuum.

Ms. Latocha reviewed the job description (RX 4) and advised it was accurate, except numbers 2, 11, 12, 13, and 20. She testified the job did not require any type of buffing. She testified that petitioner was able to work as fast or how slow she wanted.

Respondent also produced the testimony of Ms. Sylvia Diemer, the HR manager. Ms Diemer testified that she did not know petitioner personally. She testified she created the job analysis form (PX 8) with petitioner's immediate supervisor Ms. Zofia Latocha. She noted that she had no firsthand knowledge Petitioner's job duties. The job analysis indicates that Petitioner's job duties would include reaching and lifting up to 25 pounds 8 hours per day.

Petitioner testified that she started experiencing numbness, tingling and pain in her hands and wrists in 2012. The symptoms gradually increased. They were worse with vacuuming and mopping. She sought treatment with Dr. Jurkiewicz at Union Health Care.

The records of Union Health Care were admitted as Petitioner's Exhibit 1. The records include treatment notes beginning May 15, 2009. Petitioner was noted to have essential hypertension, high lipids, and high cholesterol. On September 1, 2010 she was noted to be post menopausal. She did not have diabetes. On February 12, 2012, the records state she had diffuse pain in both hands. On June 5, 2012, the complaints were of bilateral arm and leg pain. Petitioner underwent an EMG by Dr. Slavik on June 4, 2013 (PX 1, PX 2). The report includes a two year history of pain in both hands, worse the last two months, with complaints of loss of sensation and strength, worse on the right and neck pain. Petitioner is noted to be non-diabetic. The EMG testing was normal.

Petitioner was seen for a periodic physical on August 8, 2013 with complaints of severe hand pain and numbness. The problem was listed as carpal tunnel syndrome. Petitioner is noted not to be diabetic. The normal EMG was noted. Petitioner was also seen for complaints of low back pain and was diagnosed with degenerative disc disease (PX 1).

Petitioner returned to Dr. Jurkiewicz on January 28, 2014 with bilateral hand numbness. The record notes history of carpal tunnel with the normal EMG. Patient improved after a steroid injection in the past. Petitioner was to follow up with orthopedics. She was seeing a chiropractor, who is identified as her son-in-law for her back on a weekly basis. Petitioner saw Dr. Mess on February 3, 2014 with complaints of numbness and tingling especially in the right middle finger. Dr. Mess recommended a carpal tunnel release. Petitioner obtained a second opinion from Dr. Glickman on June 5, 2014. He notes the prior injection with relief of symptoms for four months. Petitioner states she is fearful of another injection or surgery. She states her son-in-law, the chiropractor advised against it. Dr. Glickman advised that her osteoarthritis is not likely the cause of her symptoms. On August 15, 2014, Petitioner advised Dr. Mess that she would like the carpal tunnel release. The surgery was performed on the right hand on September 11, 2014.

Petitioner was noted to be much better at the September 26, 2014 visit. The left hand was scheduled of surgery on November 6, 2014. Dr. Mess released Petitioner to return to work as of October 13, 2014, with a restriction to avoid vacuuming. Petitioner was seen by Dr. Adamji on October 10, 2014 for an unscheduled visit with complaints in the right hand and advised the doctor she did not feel ready to return to work. Dr. Adamji provided an off work note through November 3, 2014 (PX 1). Petitioner testified that she did not undergo the surgery at the direction of her attorney.

Petitioner testified that she sought a second orthopedic opinion from Dr. Jaroslaw Dzwinyk She testified that she was referred to Dr. Dzwinyk by her attorney, but that she liked treating with him and continued to treat with him because they could communicate in Polish. Petitioner testified that she discussed her medical history and work duties with Dr. Dzwinyk. She testified that Dr. Dzwinyk ordered injections and physical therapy, which provided her some relief. She testified that Dr. Dzwinyk has recommended a left carpal tunnel release and that she has not been released to any work by Dzwinyk. She testified that she wants this surgery to feel better so she can sleep at night and return to work.

Dr. Dzwinyk's records were admitted into evidence as Petitioner's Exhibit 3. Petitioner first presented to Dr. Dzwinyk on November 4, 2014 with complaints of pain and loss of sensation in both hands. Dr. Dzwinyk recorded a history of working in housekeeping and the development of pain, numbness, and paresthesia in both hands approximately 1.5 years ago. He recorded that Petitioner reported her worsening symptoms to her employer in August, 2013 and a claim for bilateral carpal tunnel syndrome was accepted. He recorded

Petitioner's statement that her use of a heavy mop and maneuvering a heavy vacuum cleaner aggravated her symptoms the most. Dr. Dzwinyk opines that, based on patient's history, description of work activities, the bilateral carpal tunnel syndrome is a work related condition to a reasonable degree of medical history. Dr. Dzwinyk ordered an injection, physical therapy, and removed Petitioner entirely from work. At her next visit on November 25, 2014, Dr. Dzwinyk recommended a left carpal tunnel release and continued to remove Petitioner from work.

Petitioner's therapy records at Wlodarski Therapy Group were admitted into evidence as Petitioner's Exhibit 4. These records include progress summaries directed to Dr. Dzwinyk indicating improvement and requesting additional recommendations. Dr. Dzwinyk's records up to the date of hearing indicate that Petitioner was slowing improving with physical therapy, which he continued to recommend. Dr. Dzwinyk's notes show that Petitioner was removed from work entirely through April 14, 2015 (PX 3).

Petitioner testified that she thought her carpal tunnel was related to her work duties in 2012. Petitioner testified that beginning in 2013, she asked for her work load to be reduced. Ms. Latocha testified that Petitioner did not report a work accident, but she advised her of pain. She said her hands were hurting a few times in 2014. Petitioner testified that she asked her boss to take away one of the bathrooms in February, 2013. Respondent did not reduce her workload. Ms. Latocha testified that Petitioner told her it was difficult to mop and vacuum and asked for the bathroom to be taken away. Ms. Latocha testified she advised Petitioner to get a doctor's note so she could take it to the company. On September 8, 2014, Petitioner gave Human Resources a letter advising she has recently been diagnosed with carpal tunnel, a work-related condition, and requested her workload by lessened (PX 9). Ms. Diemer testified her first notice of a work injury was in September, 2014. On October 4, 2014, Petitioner submitted a Workplace Modification Request Form seeking light duty (PX 10). Petitioner testified that she asked that the bathrooms be taken away from her, but the form discussed avoiding vacuuming. Ms. Diemer began the process of accommodation, but Petitioner then brought a further off work slip.

Petitioner was examined by Dr. Charles Carroll on January 19, 2015 at Respondent's Section 12 request. The parties proceeded with Dr. Carroll's deposition on February 25, 2015 (RX 1). Dr. Carroll testified that Petitioner presented with a diagnosis of bilateral carpal tunnel syndrome. With respect to the issue of causation, he opined that the job activities described by petitioner and those contained in the job description he was provided for review, did not cause petitioner's condition, need for carpal tunnel release surgery and associated care, any future medical care and current work restrictions. Instead, he found that petitioner had risk factors there were the cause of her carpal tunnel syndrome mainly that she was overweight, had a history of diabetes, history of hypertension and she was middle aged female (RX 1, p. 13).

On cross-examination, Dr. Carroll testified that petitioner's work activities, although they may be repetitive did not cause, aggravate or accelerate petitioner's carpal tunnel syndrome (RX 1, p. 22). He opined that a degree of force must accompany repetition for him to re-consider his opinions on the issue of causation. The same was not present in this case (RX 1, p. 25). He testified that although petitioner used her hands for a variety of things, this did not mean that her carpal tunnel was related to her work duties (RX 1, p. 25). With respect to the job analysis form (PX 8), Dr. Carroll testified that this document did not provide any information that would change his opinions with respect to causation, which included, but was not limited to repetition, force, awkward hand positions, heavy mopping or cleaning.

Dr. Carroll testified that Petitioner maintained an active job, but this was not synonymous with a physically demanding job. Dr. Carroll testified he did not feel that the amount of vacuuming described in the job description and associated with this case influenced his opinion regarding causation (RX 1, p. 27). The type of job activities involving "vibrations" he had in mind when considering causation were activities such as jack hammering, power tools, grinders, and floor scrubbers (RX 1, p. 42). He testified that petitioner did not have any significant stress on the palm of her hands to qualify her job duties to be a cause in repetitive trauma case (RX 1, p. 29).

On February 19, 2015, Dr. Obermiller conducted a UR for the physical therapy treatment. The UR reviewed 32 physical therapy visits from November 10, 2014 through January 23, 2015. Of the 32 visits, only eight were certified. The parties proceeded with the deposition of Dr. Obermiller on March 17, 2015 (RX 7). Dr. Obermiller stated he was personally certified to perform URs in the State of Illinois (RX 7, p. 30). The doctor testified that he reviewed physical therapy records from Wlodarski Physical therapy, the Section 12 report from Dr. Charles Carroll, medical records from Dzwinyk, operative report for the carpal tunnel surgery and a MRI of the lumbar spine. Dr. Obermiller based his UR opinions on the ODG guidelines, Occupational Disability Guidelines. He found that of the 32 physical therapy visits, only eight were reasonable and necessary. He testified that the ODG guidelines supported the same. He testified that Petitioner's range of motion and strength were beyond normal by the eighth physical therapy visit. Based on the same, there were no extenuating circumstances to require more than eight visits of physical therapy (RX 7, p. 16). Dr. Obermiller further testified that he attempted to conduct a peer to peer review, but Dr. Dzwinyk never called him back (RX 7, p. 18).

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, (D) Date of Accident and (F) Causal Connection, the Arbitrator finds as follows:

Petitioner bears the burden of proving by a preponderance of the credible evidence that she sustained accidental injuries arising out of her employment and that her condition of ill being is causally connected to the work related accident. An employee who alleges injury based on repetitive trauma must still meet the same standard of proof as other claimants alleging an accidental injury. A claimant must establish a precise identifiable date when the accidental injury manifested itself, i.e., the date on which both the fact of injury and the causal relationship of the injury to the employment would become plainly apparent to a reasonable person.

Petitioner in the present matter is seeking compensation, claiming that her work activities as a cleaner for Respondent included sufficient repetitive activities to be the cause of her carpal tunnel syndrome. She testified to multiple activities including vacuuming, mopping, and cleaning kitchens and bathrooms. The Application for Adjustment of Claim and the 19(b-1) Petitioner originally filed in this matter allege a date of accident on August 12, 2013, shortly after Petitioner was seen at Union Health Care on August 8, 2013 with complaints of severe hand pain and numbness. The Request for Hearing submitted by the parties alleges an accident date of June 5, 2014 (Arb. Ex. 1), the date Petitioner was seen by Dr. Glickman and advised that osteoarthritis was unlikely to be the cause of her symptoms. The Arbitrator does not need to address which is an appropriate date of manifestation since, based upon the evidence submitted, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that she sustained an accident arising out of her employment or that her condition of ill being is causally connected to her work activities regardless of the date of manifestation chosen.

Petitioner's job duties were testified to by both Petitioner and Zofia Latocha. The job description and job analysis were also submitted as exhibits. Petitioner's testimony of the physical requirements of her job were significantly more rigorous that the description of Ms. Latocha, particularly the extent of vacuuming, which by Petitioner's testimony was a primary function in the development of her complaints. By her own admission, Petitioner's description of the time spent on the activities, if accurate, far exceeded the total hours she worked each day. Her estimates of the weight of her tools such as the mop and vacuum were excessive given Ms. Latocha's estimates and the photos demonstrating these items.

The Arbitrator also notes that despite Petitioner's extensive testimony on the difficulty and stress from vacuuming, that when she did finally seek modification of her work activities in September, 2014, her primary demand was removal of the bathrooms from her assignment, activities which do not include any vacuuming and require only some mopping as part of other multiple tasks taking only a total of about an hour per day.

After viewing the testimony and witnesses, the Arbitrator finds the testimony of Ms. Latocha more credible that that of the Petitioner.

In cases relying on the repetitive-trauma concept, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability. The Petitioner first raised complaints in her hands in February, 2012. Later that year, complaints in the arms and legs were advanced. Petitioner testified that she believed her problems were related to her work in 2012, but did not indicate any complaint to her employer at that time. The records of Union Health Care do not note any history claiming Petitioner's symptoms were caused by work activities. Although the office visit of April 22, 2013 does not record any hand complaints, there is an assessment of carpal tunnel with EMG and splints prescribed. The EMG in June, 2013 notes employment as a housekeeper but no claim of work activity as inciting symptoms. The EMG was negative. There is no work history provided throughout 2014 including Dr. Glickman's second opinion and the operative report. Postoperatively, Dr. Mess released Petitioner to return to her housekeeping duties on October 13, 2014 pending the other surgery on the left hand. Petitioner presented no causal connection opinion from any provider at Union Health Care, not Dr. Jurkiewicz, the family doctor, Dr. Glickman, the rheumatologist, or Dr. Mess, her surgeon.

At her attorney's request, Petitioner cancelled the scheduled left hand carpal tunnel release scheduled with Dr. Mess and transferred her care to Dr. Dzwinyk. Dr. Dzwinyk recorded that Petitioner reported her worsening symptoms to her employer in August, 2013 and a claim for bilateral carpal tunnel syndrome was accepted. He recorded Petitioner's statement that her use of a heavy mop and maneuvering a heavy vacuum cleaner aggravated her symptoms the most. Dr. Dzwinyk opines that, based on patient's history, description of work activities, the bilateral carpal tunnel syndrome is a work related condition.

Dr. Carroll agreed that Petitioner presented with a diagnosis of bilateral carpal tunnel syndrome, but as to the issue of causation, he opined that the job activities described by petitioner and those contained in the job description he was provided for review, did not cause petitioner's condition, need for carpal tunnel release surgery and associated care, any future medical care and current work restrictions. Instead, he found that petitioner had risk factors there were the cause of her carpal tunnel syndrome mainly that she was overweight, had a history of diabetes, history of hypertension and she was middle aged female.

The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. An expert's opinion is only as valid as the bases and reasons for the opinion. Expert opinions must be supported by facts and are only as valid as the facts underlying them. A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts.

Dr. Dzwinyk does not detail the work activities outlined by Petitioner that form the basis of his opinion. The onset reported 1½ years before his first office visit on November 4, 2014 does not correspond to the 2012 treatment, the reporting of two years of symptoms records on the June, 2014 EMG, or Petitioner's testimony. The statement that the claim was reported to the employer and accepted in August, 2013 is contradicted by the testimony of Ms. Latocha and Ms. Diemer. The reference to heavy mopping and vacuuming are also contradicted by the testimony of Ms. Latocha, which the Arbitrator finds more credible that that of the Petitioner.

Dr. Carroll includes an incorrect notation that Petitioner suffered from diabetes in his opinion. This appears to arise from a misreading of the June 5, 2012 Union Health Care note listing pre printed Cardiac Risk Factors, but not confirming their existence in this patient. However, this inaccuracy does not go to the primary basis of Dr. Carroll's opinion. After reviewing complete medical records, review of the job description and job analysis and obtaining a description from Petitioner of her work duties, he opined that he did not find a causal relationship between her work duties and the development of her bilateral carpal tunnel syndrome. The basis of the opinion was the nature of the forces and activities involved in her work activities. During his deposition he testified to the nature of the activities necessary to provide a nexus to the development of carpal tunnel syndrome and the degree of force must accompany repetition for him to re-consider his opinions on the issue of causation. Diabetes was mentioned in conjunction with the non occupational risk factors that Petitioner had to develop carpal tunnel in conjunction with being overweight, middle aged, and female.

After reviewing the medical opinions and considered the bases of each, the Arbitrator finds the opinion of Dr. Carroll more persuasive that that of Dr. Dzwinyk with respect to whether Petitioner's job duties were sufficient to be a causative factor in the development of her carpal tunnel syndrome.

Based upon the record as a whole, including the testimony of Petitioner and Respondent's witnesses and considering the medical records, testimony and opinions, and the exhibits submitted, the Arbitrator finds that the Petitioner failed to prove by a preponderance of the evidence that she sustained accidental injuries arising out of her employment. The Arbitrator further finds that the Petitioner failed to prove by a preponderance of the evidence that her condition of ill being is causally connected to her work activities with Respondent.

In support of the Arbitrator's decision with respect to (E) Notice, (J) Medical and (K) Prospective Medical, and (L) Temporary Compensation, the Arbitrator finds as follows:

In light of the Arbitrator's findings with respect to Accident and Causal Connection, the remaining issues of Notice, Medical and Prospective Medical, and Temporary Compensation are moot.

Petitioner's claim for compensation is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gregory Mayer,

Petitioner,

vs.

NO: 14 WC 38552

Sleepy's Llc,

16IWCC0348

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical, prospective medical, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator file September 23, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 23 2016
o051216
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

MAYER, GREGORY
Employee/Petitioner

Case# 14WC038552

16IWCC0348

SLEEPY'S LLC
Employer/Respondent

On 9/23/2015, 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 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0247 HANNIGAN & BOTHA LTD
RICHARD D HANNIGAN
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

0532 HOLECEK & ASSOCIATES
MARYA SAVICH
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

16IWCC0348

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

- [ ] 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)

Gregory Mayer
Employee/Petitioner

v.

Sleepy's LLC.
Employer/Respondent

Case # **14** WC **38552**

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 **George Andros**, Arbitrator of the Commission, in the city of **Waukegan**, on **August 31, 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

16IWCC0348

FINDINGS

On the date of accident, **1/22/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$30,058.60**; the average weekly wage was **$578.05**.

On the date of accident, Petitioner was **62** years of age, ***single*** with **0** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$-0-** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$-0-**.

Respondent is entitled to a credit of **$-0-** under Section 8(j) of the Act.

ORDER

THE RESPONDENT SHALL AUTHORIZE AND PAY FOR THE TREATMENT AND SURGERY TO THE PETITIONER'S LEFT SHOULDER AS PRESCRIBED BY DR. ROBERT HALL ON AUGUST 14, 2014 INCLUDING BUT NOT LIMITED TO THE LEFT SHOULD TOTAL ARTHROPLASTY. THIS INCLUDES ALL PRE OP TESTING AND POST OP THERAPY AND CARE.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS UNLESS a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE IF the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

#01 Stephen J. Baker

Signature of Arbitrator

September 21,15

Date

ICArbDec19(b)

SEP 23 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Gregary Mayer
Employee/Petitioner

Case # **14** WC **38552**

v.

Sleepy's LLC.
Employer/Respondent

Findings of Fact and Law

The petitioner has filed an 8(a) petition praying that the Illinois Worker's Compensation Commission order the respondent to authorize left shoulder surgery. The respondent has denied authorization placing causal connection in dispute. It is very clear that the section 12 examiner did not understand the mechanics of the injury based upon the Petitioner's testimony. No company witness testified in rebuttal which might have included the co-worker present flipping the mattress, namely Vince Verstraete, below. This loquacious yet extremely articulate individual explained in great detail in credible fashion how the injury occurred.

On January 22, 2014, the petitioner was 62 years of age and moving a queen-size mattress. He and another individual, Vince Verstraete, picked up the mattress and the petitioner brought it up over his head to place it on top of a box spring. The petitioner felt a pop and pain in his left shoulder. He testified that he never receive treatment or had similar symptoms in the left shoulder before this lifting episode of January 22, 2014. Neither the petitioner nor respondent produced any evidence of treatment for the left shoulder prior to January 22, 2014. On February 6, 2014, an accident report was prepared (Px.3) and the petitioner schedule an appointment to see Dr. Robert Hall.

On February 12, 2014, the petitioner saw Dr. Hall. The history contained in Dr. Hall's records includes, "This is a 62-year-old male who has had the onset of left shoulder pain after lifting the mattress above his head." (Px.1 pg.20). The diagnosis was left rotator cuff impingement syndrome with bursitis and possible rotator cuff tear. At that time the petitioner received a cortisone injection into the subacromial space of the left shoulder. (Px.1 pg.19) On February 26, 2014, Dr. Hall prescribed an MRI of the left shoulder. (Px.1 pg.18) The MRI was performed on March 4, 2014. The radiologist conclusion was severe osteoarthritis of the left shoulder joint, small shoulder effusion, tendinosis of the supraspinatus tendon, with high grade small partial thickness tear, diffusely frayed glenoid labrum, presumably due to degenerative type with changes/tearing, hypertrophic changes in the AC joint, tendinosis of the intra–articular portion of the long head of the biceps tendon and moderate amount of fluid in the subacromial/subdeltoid bursa, probably due to bursitis. (Px.1 pg.31)

On April 3, 2014, Dr. Hall's records indicate that the patient has a history of osteoarthritis which has been aggravated by a recent work-related injury. He again administered a cortisone injection within the glenohumeral joint. (Px.1 pg.17) On April 23, 2014, Dr. Hall's diagnosis was end stage osteoarthritis of the left shoulder. He went on to state, "We may consider left total shoulder arthroplasty, as his pain is not resolving. It seems as though this work-related injury has caused his left shoulder arthritis to become symptomatic." (Px.1 pg.16) On August 14, 2014, Dr. Hall noted that the patient agreed to go forward with the left total shoulder arthroplasty and surgery was set for October 7, 2014. (Px.1 pg.13) Surgery was not authorized and again rescheduled for November 4, 2014 as an IME was pending. (PX.1 pg.12) The respondent has denied authorization for said surgery.

The petitioner underwent a section 12 evaluation with Dr. David Schafer on October 21, 2014. The doctor testified on May 15, 2015 that the petitioner was lifting the mattress only 2 feet off of the ground to the box spring. This was refuted by the petitioner who demonstrated that he had lifted the queen-size mattress over his head and pushed it forward onto a box spring as was also documented in Dr. Hall's February 12, 2014 record. Dr. Schafer understood that the petitioner only lifted the mattress 2 feet off the ground. He did not believe that there was overhead lifting and therefore, based upon the mechanism of what he understood the injury to be, he found no causal connection between the stipulated accident of January 22, 2014 and the surgery prescribed by Dr. Hall. He did agree that the total shoulder arthroplasty was the appropriate procedure for treatment of the petitioner's condition of ill-being. (Rx.1 pg.22-23) Emphasis added by Arbitrator.

Relying on Dr. Schafer's opinion that the petitioner did not do any overhead lifting, the respondent refuses to authorize the left shoulder surgery. Petitioner's exhibit number three is the February 6, 2014 accident investigation report. The written statement from the coworker Mr. Verstraete, who was moving the mattress with the petitioner, was made known to the respondent 18 months before this hearing of August 31, 2015. Certainly that individual would know whether there was or was not any overhead lifting. The respondent did not produce this individual as a witness nor was Mr. Vince Verstraete subpoenaed to rebut the testimony of the petitioner and Dr. Hall's medical records. The respondent did not ask for a continuance to subpoena this witness. Given the medical records of Dr. Hall that states the petitioner did overhead lifting of the mattress and the petitioner's testimony, the arbitrator is compelled to believe and find that the petitioner lifted that queen size mattress overhead, felt a pop and develop pain in his left shoulder all of which constitutes and accident which arises out of the petitioner's employment and establishes a causal connection between the lifting of January 22, 2014 and the subsequent left shoulder symptoms, treatment and diagnosis.

Dr. Hall testified that he treated the petitioner for left hip and right shoulder issues going back to August 2004. He indicated that during that treatment there is no documentation of any complaints regarding symptoms in the petitioner's left shoulder. (Px.2 pg. 9-10) Dr. Hall testified that there is a causal connection between the lifting overhead of the queen-size mattress on January 22, 2014 and his treatment of the left shoulder. He indicated that that lifting aggravated the underlying condition and essentially the patient went from being asymptomatic to symptomatic. (Px.2 pg.13) (page two)

In order to prove that the Petitioner's condition of ill-being is causally related to the accident of January 22, 2014, the Petitioner need not produce medical testimony to establish said causal connection. Causal connection can be established based upon the chain of events *Clinton Price v Industrial Commission* 278 Ill. App. 3d 848, 663 N.E.2d 1057,215 Ill.Dec. 543.

The Supreme Court of Illinois has stated on numerous occasions that one needs not present medical evidence in order to prove causal connection. In *International Harvester v Industrial Commission* 93 Ill. 2d 59, 442 N.E.2d 908, 66 Ill.Dec. 347 the Supreme Court held:

> "This court has held that medical evidence is not an essential ingredient to support the conclusion of the Industrial Commission that an industrial accident caused the disability. A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. (Martin Young Enterprises, Inc. v. Industrial Com. (1972), 51 Ill.2d 149, 155, 281 N.E.2d 305.) In Union Starch & Refining Co. v. Industrial Com. (1967), 37 Ill.2d 139, 144, 224 N.E.2d 856, this court said, "We know of no case requiring a doctor's testimony to establish causation and the extent of disability, especially where, as here, the record contains the company doctor's report and hospital records showing findings of the employee's personal physician which are consistent with the employee's testimony." When the claimant's version of the accident is uncontradicted and his testimony unimpeached, his recital of the facts surrounding the accident may be sufficient to sustain an award. Thrall Car Manufacturing Co. v. Industrial Com. (1976), 64 Ill.2d 459, 463, 1 Ill.Dec. 328, 356 N.E.2d 516."

Illinois courts have held that, in workers' compensation proceedings, proof of prior good health and change immediately following and continuing after an injury may establish that an impaired condition was due to the injury. Waldorf v. Industrial Commission, 303 Ill. App. 3d 477, 708 NE 2d 476 (1999. As should be noted in the instant case, the chain of events herein indicates that the petitioner was able to perform his job without lost time or complaints prior to his work injury of January 22, 2014, that after the work injury he became symptomatic and required treatment. Prior to his injury no one had prescribed treatment, an MRI or surgery for the left shoulder. After his January 22, 2014 accident, for the first time a physician prescribed treatment for the left shoulder, an MRI for the left shoulder, and surgery for the left shoulder. Since January 22, 2014 the petitioner's symptoms have not abated. In fact they've gotten worse.

Don Young v Illinois Worker's Compensation Commission 2014 IL App (4th) 130392WC, 13 N.E.3d 1252, 383 Ill.Dec. 131 (2014) involved a petitioner whose job required him to retrieve items from a box. The box was not big enough to fit both of his hands and shoulders into it at the same time. Therefore he had to reach into the box with one arm and retrieve the parts one at a time.

He denied any problems with the left shoulder prior to this accident date to February 19, 2010. He noted that later on after this event his left shoulder developed a little pain. e also noted that he felt a pop in his shoulder when reaching into the box but did not immediately feel pain. A subsequent MRI noted a tear of the supraspinatus. The treating records all contained a history to the effect that when he was reaching deep into the box he overstretched his left arm and suffered a burning in the left shoulder. The medical providers noted that he had significant degenerative changes in the left shoulder that may well have been asymptomatic prior to the onset of symptoms. The respondent's doctor opined that the injury aggravated the pre-existing condition. The arbitrator ruled that the act of reaching for an item, without more, does not constitute an increased risk of injury peculiar to claimant's employment. It is a movement consistent with normal daily activities. The arbitrator denied that the injury arose out of the petitioner's employment and therefore not related to the accident because the petitioner was not subjected to an increased risk. The commission on review affirmed the decision of the arbitrator. The Circuit Court affirmed the decision of the commission. The appellate court reversed.

The appellate court reversed this case based upon a question of law and their *de novo* jurisdiction. In defining "arising out of" the court noted that:

> "... an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed performed by his employer, which he had a common law or statutory duty to perform, or which the employee might reasonably be expected to perform incident to his assigned duties. A risk is incidental to the employment where it belongs to or is connected with one an employee has to do in fulfilling his duties" Sisbro v. Industrial Commission 207 Ill.2d 193 at 204 (quoting Caterpillar Co. v Industrial Commission 129 I ll.2d 52, 58)"

In finding that the petitioner's injury in the Young's case arose out of the employment, the court noted the unequivocal evidence that the claimant was performing acts that the employer might reasonably expect him to perform in fulfilling his assigned duties. In noting that the commission found that the activities of the claimant were similar to the activities of the general public, the court noted that the claimant was injured due to an employment related risk distinctly associated with his employment and therefore it was unnecessary to perform a neutral–risk analysis to determine whether the claimant was exposed to a risk of injury greater to that to which the general public is exposed.

In the case at bar, it is the finding of the arbitrator that the petitioner sustained an accidental injury on January 22, 2014 which aggravated his pre-existing osteoarthritis in his left shoulder. This finding is based upon the testimony the petitioner, the medical records contained in petitioner's exhibit number one and the testimony of Dr. Hall in petitioner's exhibit two. Both Dr. Hall and Dr. Schafer agree that the petitioner's prescription for the left total shoulder arthroplasty is reasonable and necessary.

Based upon the totality of the evidence, The arbitrator orders as a matter of law the respondent in the case at bar under section 8(a) to authorize the left total shoulder arthroplasty and the related treatment thereto post pre surgery and post surgery and maintenance.

As per the above holding, Respondent shall be liable for all associated costs with the treatment of the left shoulder since January 22, 2014. As noted in Dr. Hall's deposition Exhibit 2, the petitioner has incurred medical expenses for this treatment.

It is hereby ordered as matter of law that in the case at bar this respondent shall pay for said treatment pursuant to the fee schedule or the negotiated rate, whichever is less.

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.

Arbitrator George Andros #01

Date 9/21/2015

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Vanessa Aguilar,

Petitioner,

vs. NO. 15 WC 24214

Pitt Ohio,

16IWCC0359

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 accident, medical expenses, prospective medical care, permanent disability, causal connection, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 4, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 26 2016
SJM/sj
o-5/12/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

AGUILAR, VANESSA
Employee/Petitioner

Case# **15WC024214**

PITT OHIO
Employer/Respondent

16IWCC0359

On 12/4/2015, 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 0.41% 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:

0154 KROL BONGIORNO & GIVEN LTD
RANDALL W SLADEK
129 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

2337 INMAN & FITZGIBBONS LTD
MARK CARTER
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

16IWCC0359

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)

Vanessa Aguilar
Employee/Petitioner

v.

Pitt Ohio
Employer/Respondent

Case # **15** WC **24214**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **9/24/15; 11/17/15**. 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] 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, **7/29/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**23,120.37**; the average weekly wage was $**456.33**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **1** dependent children.

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

Respondent is entitled to a credit of $**858.41** under Section 8(j) of the Act.

ORDER

Petitioner has proved an accident arising out of and in the course of her employment.

Petitioner has proved that her current condition of ill-being in regards to the right shoulder, right wrist and left knee is causally related to the July 29, 2015 work accident.

Petitioner shall receive a consultation with an orthopedic surgeon, including required diagnostic testing.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

David A. Kane
Signature of Arbitrator

December 3, 2015
Date

ICArbDec19(b)

DEC 4 - 2015

Findings of Fact

16IWCC0359

Petitioner testified that she was working for respondent on July 29, 2015 as a customer service representative. (T. 8-9) At approximately 7:20 am she was exiting the restroom and slipped on water on the floor. (T. 10-11) Her right foot slid causing her left leg and ankle to move backward. (T. 11) She landed on her left leg, left knee and right hand. (T. 11) There were no witnesses present. (T. 12)

After the slip and fall, she went to the dispatcher room to alert her supervisor, Dan Harry. (T. 12) She advised him that she would like to file a report and also took him to the accident spot. (T. 13) According to petitioner's testimony, Mr. Harry viewed the accident spot and observed where the floor was wet. (T. 37) In filling out the accident report, petitioner stated that the floor was just mopped with no indication of "wet floor" and that she slipped. (T. 40)

Mr. Harry provided petitioner with documents to seek treatment at Concentra. (T. 13) While waiting for the paperwork, petitioner took a picture of the accident spot with her telephone. (Px. 3) During her testimony, petitioner circled the location of her fall in the pictures. (T. 15, Px. 3)

At Concentra, petitioner presented with left knee and right wrist pain. (Px. 1) She stated that she slipped on a wet floor and landed on her left knee and right hand with the arm extended. (Px. 1) She also reported shoulder pain as result of falling on her outstretched right

arm. (Px. 1) On examination, it was noted that petitioner had limited flexion and extension of the right wrist. (Px. 1) Petitioner was diagnosed with contusion of the knee and right wrist sprain. (Px. 1) She was kept off of work for the rest of the day and was to return to full activity the following day. (Px. 1)

On the morning of July 31, 2015 petitioner felt sore and called into work. (T. 45) She returned to Concentra that afternoon with right shoulder, right wrist and left knee and ankle complaints. (Px. 1) The shoulder pain was described as throbbing in nature and located in the right posterior shoulder. (Px. 1) She described pain in the right wrist which was throbbing in nature. (Px. 1) Symptoms were noted as stiffness, swelling, and tenderness. (Px. 1) As far as the left knee, petitioner described similar symptoms. (Px. 1) She had not reported to work due to soreness. (Px. 1) She was referred to physical therapy and diagnosed with contusion of the left knee, right wrist sprain and right shoulder pain (Px. 1)

Following her appointment, petitioner accompanied her son to the mall where he works. (T. 51) Her son had driven petitioner to her Concentra appointment. (T. 52)

On August 4, 2015, petitioner returned to Concentra for follow-up. She continued to have right shoulder, right wrist and left knee pain. (Px. 1) Her symptoms were generally unchanged. (Px. 1) She participated in her first physical therapy session that day. (Px. 1) She had her second session on August 7, 2015. (Px. 1)

Petitioner described ongoing right shoulder complaints on August 11, 2015. (Px. 1) She stated that her arm felt "dead and weak" and was producing a popping noise. (Px. 1) Her pain had become sharp and throbbing. (Px. 1) She was unable to tolerate shoulder therapy. (Px. 1) The right wrist pain was not as severe but was ongoing. (Px. 1) The left knee complaints had generally resolved. (Px. 1) The record indicates a request for outside radiology and physician referral. (Px. 1) It was noted that petitioner's pain may be emanating from the neck/trapezius or shoulder. (Px. 1)

No further treatment was authorized by the respondent. Petitioner testified that she attempted to see a specialist but this was denied. (T. 24) She testified that she continues to have constant pain in the right shoulder and wrist. (T. 25) She continues to work her regular job. (T. 25) Respondent's cross-examination of petitioner focused on her lack of paid time off available and her pre-injury requests for time off.

Daniel Harry testified for respondent. He indicated that he was on duty on the day of the accident and that petitioner did report that she slipped and fell. (T. 59-60) Mr. Harry testified that he did not observe wetness in the spot of the fall but did see a black scuff mark. (T. 66) He stated that he had never known petitioner to fabricate a story. (T. 63)

Respondent next called the maintenance tech, Jesus Alvarez, to testify. He testified that he mops "pretty much every day." (T. 75)

According to his testimony, on July 29, 2015, he only mopped the men's and women's bathrooms as well as the area in front of Roman Sakic's office as there was some spilled coffee. (T. 76) He did not bring a bucket to mop the restrooms which are just beyond where petitioner fell. (T. 78) Instead, he just carried a damp mop. (T. 78) He carried the mop from the storage room to mop both bathrooms. (T. 83)

He stated that he would normally mop the area where petitioner fell but on the date in question he had to work on the air conditioner instead. (T. 77) He has mopped all of the floors every day since the date in question. (T. 87)

Respondent's third witness was Minyon Favela. She testified that on the date in question Mr. Alvarez mopped the men's and women's rest rooms and then a small area in front of Roman's office because there was a scuff mark. (T. 95) She was not present for the accident. (T. 97-98) She stated that Mr. Alvarez did not mop the floors each day. (T. 100)

Respondent's final witness was an investigator who conducted surveillance. Respondent submitted a significant amount of surveillance. The totality of the footage shows petitioner not engaging in any physical activity. At times, she is wearing her wrist brace.

Conclusions of Law

The evidence and testimony at trial support petitioner's contention that she was injured at work on July 29, 2015 when she slipped and fell in the area outside of the bathroom. When reporting the injury as well as during medical treatment, petitioner was consistent in regards to what occurred—she slipped on wetness on the floor and fell. Petitioner supplemented her account with photographs taken immediately after the accident which show what appears to be water on the floor with a streak representing petitioner's foot slipping.

Respondent presented extensive inconsistent testimony which ultimately was not enlightening on the issue of accident. It is clear that no other person was present when petitioner fell and that she immediately provided notice to the supervisor on duty.

The Arbitrator finds sufficient evidence that the floor was wet given the testimony of the respondent's maintenance individual who stated he had mopped the bathrooms just beyond the accident site. The individual carried a wet mop over the area to reach the bathrooms. He was clear that he had not used a mop bucket to transport the wet mop which he used to mop two bathroom areas.

It is evident that petitioner's ongoing right shoulder and right wrist pain emanate from her fall on July 29, 2015. The Arbitrator awards petitioner prospective treatment for the right shoulder and right wrist including diagnostic testing recommended by an orthopedic

specialist. Since Petitioner is pending a consultation with an orthopedic surgeon, no further treatment can be ordered at this time, beyond that consultation and the associated diagnostic testing.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Wolnik,
Petitioner,

vs. NO: 98 WC 68392

Die-Tech Industries, Inc.,
Respondent.

ORDER

Petition for Attorneys' Fees and Costs having been filed by Petitioner's Law firm herein and due notice given this matter came on for hearing before the Illinois Workers' Compensation Commission on March 31, 2016 in Chicago, Illinois.

Upon consideration of said Petition and the Commission's independent review of the record and file, the Commission is of the belief that the Petition for Attorneys' Fees and Costs should be granted.

The Commission finds on August 21, 2014 an Arbitration hearing was held before Arbitrator Williams. On September 29, 2014, Arbitrator Williams entered a decision and awarded 20% man as a whole under Section 8(d)2 of the Act which totaled $120,000.00, $19,473.91 net in temporary total disability benefits ($40,952.59-a credit of $21,478.68) under Section 8(b) of the Act and $2,984.62 in medical expenses under Section 8(a) of the Act. Petitioner appealed the Arbitrator's decision. On June 4, 2015, the Commission affirmed and expanded on the Arbitrator's decision. Petitioner appealed the Commission decision to Cook County Circuit Court. On November 6, 2015, Petitioner's attorneys' filed a Petition for Attorneys' Fees in the amount of $28, 491.04 and costs in the amount of $8,423.11. On November 15, 2015 the Circuit Court granted Petitioner's attorneys' motion to withdraw as Petitioner's attorney. On January 16, 2016, the Cook County Circuit Court dismissed Petitioner's appeal for want of prosecution and at this time the Commission decision became final. As a result, Petitioner's attorneys' are seeking payment of attorneys' fees and costs and are requesting that Respondent not issue the payment of the Commission decision until such time that the Commission rules on Petitioner's Attorneys Petition for attorneys' fees and costs.

Having reviewed the entire record, the Commission finds Petitioner's former attorneys are entitled to $28, 491.04 in attorneys' fees and $8,423.11 in costs related to the prosecution of the above captioned claim. The Commission further finds that Respondent is ordered to pay Petitioner's former attorneys said attorneys' fees and costs and to pay the remaining of the award to the Petitioner in the above captioned claim.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent is to pay Petitioner's former attorneys $28, 491.04 in attorneys' fees and $8,423.11 in costs related to the prosecution of the above captioned claim and to additionally pay the remaining of the award to the Petitioner in the above captioned claim.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission notice of Intent to file for Review in Circuit Court.

DATED: MAY 20 2016

MB/jm

R: 3/31/16

43

Mario Basurto

David L. Gore

Stephen Mathis