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

Israel Bucio,
Petitioner,

vs.
Shark Transport Services,
Respondent,

NO: 09 WC 11161

14IWCC0064

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, 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 10, 2012 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 $22,600.00. 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: FEB 03 2014

Mario Basurto

MB/mam
O: 1/16/14
43

David L. Gore

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUCIO, ISREAL
Employee/Petitioner

Case# **09WC011161**

14IWCC0064

SHARK TRANSPORT SERVICES
Employer/Respondent

On 9/10/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% 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:

2830 THE MARGOLIS FIRM PC
CHARLES J CANDIANO
55 W MONROE ST SUITE 2455
CHICAGO, IL 60603

1973 ATSAVES, LOUIS G LTD
200 W JACKSON BLVD
SUITE 1050
CHICAGO, IL 60606

14IWCC0064

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

Israel Bucio
Employee/Petitioner

v.

Shark Transport Services
Employer/Respondent

Case # 09 WC 11161

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Chicago**, on **8/7/12**. After reviewing all 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 **2/27/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,480.00**; the average weekly wage was **$600.00**.

On the date of accident, Petitioner was **33** years of age, ***married*** with **4** dependent children.

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary 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

Respondent shall pay Petitioner permanent partial disability benefits of $360.00/week for 62.5 weeks, because the injuries sustained caused the 12.5% 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.

Carolyn Doherty
Signature of Arbitrator

9/10/12
Date

SEP 10 2012

FINDINGS OF FACT

This matter was previously tried under Section 19(b) on 10/6/10. Respondent sought review of the Arbitrator's 19 (b) Decision. The Commission modified the Decision on the issue of medical expenses and affirmed and adopted all other findings of the Arbitrator. The case was remanded to this Arbitrator for further hearing.

The remand hearing was held on August 7, 2012. Petitioner again testified that on 2/27/09, he sustained work related injuries to his low back as a result of lifting at work. Petitioner underwent an MRI on 3/27/09 which indicated a 4 to 5mm herniation at L5-S1. Petitioner received conservative care in the form of physical therapy and a series of epidural injections. Petitioner returned to work for Respondent performing lighter duty welding work prior to eventually leaving Respondent's employ in 2010.

Place at issue at the remand hearing of 8/7/12 was the nature and extent of Petitioner's injury. In addition, Petitioner also requested medical expenses. Specifically, Petitioner requested a medical bill from Marque Medicos reflecting charges of $22,875.00 and a medical fee schedule allowance of $13,351.49. PX 5. The bill covers services rendered Petitioner from March 2009 through May 2009. The bill at PX 5 was submitted at the time of the 19(b) hearing and awarded by the Arbitrator. However, on Review, the Commission vacated the award of that bill from the Marque Medicos facility stating that no medical records were submitted at Arbitration to support that bill. At the hearing on remand, Petitioner again submitted the same Marque Medicos bill along with medical records to support the charges. PX 6. These medical records were not submitted at the 19(b) hearing on 10/6/10.

At the hearing on remand, Petitioner placed two additional medical bills at issue that were not presented at the prior 19(b) hearing. Petitioner submitted a bill from Prescription Partners in the amount of $526.30 reflecting prescription medication prescribed on 4/16/09. PX 10. Lastly, Petitioner submitted a bill from Delaware Place MRI totaling $1,839.18 reduced to $1,625.63 pursuant to the fee schedule. PX 8. The supporting MRI report dated 3/27/09 was also submitted. PX 9.

Petitioner testified that he currently experiences pain on a daily basis. He testified that the pain starts out light but gets bad after work. Petitioner testified that he bends at work and when he stands up he feels pain in his low back. Petitioner testified that he takes pain medication. Petitioner currently performs that same type of mechanic work that he did for Respondent and has worked full time for the last 2 years. Finally, Petitioner testified that he has not received any medical treatment for his back since the 19(b) hearing in 2010.

CONCLUSIONS OF LAW

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

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

To the extent Respondent raised the issue of causal connection at the hearing on remand, the Arbitrator finds that Petitioner's current condition of ill-being remains a disc herniation at L5-S1, as identified at the prior 19(b) hearing and affirmed by the Commission on Review.

J. Were 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 Petitioner is not entitled to the medical bill from Marque Medicos submitted at the hearing on remand at PX 5. In so finding, the Arbitrator notes that all issues with regard to the Marque Medicos bill were presented before the Arbitrator and reviewed by the Commission. The Commission vacated the Arbitrator's award of the Marque Medicos charges at PX 5. For this Arbitrator to award the bill at PX 5 would be to allow the re-litigation of a closed issue.

The Arbitrator further finds that Petitioner is not entitled to the prescription and medical (MRI) bills submitted at PX 8 and PX 10. In so finding, the Arbitrator notes that although these bills reflect conditions, treatment and services which pre-date and were at issue at the first hearing in 2010, there is no indication that these two bills were presented at that 19(b) hearing.

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

The Arbitrator notes that Petitioner sustained a disc herniation at L5-S1 as a result of this accident. He received conservative treatment and returned to work performing the duties of a mechanic. Petitioner currently experiences pain on a daily basis which progressively worsens throughout the work day. Petitioner testified that he bends at work and when he stands up he feels pain in his low back. Petitioner takes pain medication but has not received treatment since 2010 for his injury. Based on the foregoing, the Arbitrator finds that Petitioner sustained 12.5% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Katherine A. Bergmann,

Petitioner,

vs.

NO: 12 WC 31282

14IWCC0065

St. Elizabeth's Hospital,

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 2, 2013 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 $28,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 03 2014

MB/mam
O:1/23/14
43

Mario Basurto

David L. Gore

Daniel R. Donohoo

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

BERGMANN, KATHERINE A
Employee/Petitioner

Case# 12WC031282

14IWCC0065

ST ELIZABETH'S HOSPITAL
Employer/Respondent

On 4/2/2013, 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 0.10% 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:

0071 BONIFIELD & ROSENSTENGEL PC
JON ROSENSTENGEL
16 E MAIN ST
BELLEVILLE, IL 62220

0164 DONOVAN ROSE NESTER PC
BRENDAN NESTER
201 S ILLINOIS ST
BELLEVILLE, IL 62220

14IWCC0065

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)

Katherine A. Bergmann
Employee/Petitioner

v.

St. Elizabeth's Hospital
Employer/Respondent

Case # 12 WC 31282

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on January 29, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, January 13, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $64,969.84; the average weekly wage was $1,249.42.

On the date of accident, Petitioner was 51 years of age, married with 1 dependent child(ren).

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

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

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 7 as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall be given a credit for 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 authorize and make payment for prospective medical treatment as recommended by Dr. Yazdi.

Respondent shall pay Petitioner temporary total disability benefits of $832.95 per week for 34 weeks commencing June 6, 2012, through January 29, 2013, as provided by Section 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

March 29, 2013
Date

APR 2 - 2013

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 January 13, 2012. According to the Application, Petitioner sustained an injury to her back when her chair rolled out from under her causing her to fall. Respondent stipulated that Petitioner sustained a work-related injury on January 13, 2012; however, Respondent disputed liability on the basis of causal relationship. This case was tried as a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits, medical, as well as prospective medical treatment.

Petitioner was a registered nurse and, in January, 2012, Petitioner worked for Respondent in the medical surgical wing of the hospital. Petitioner's job was to provide care for patients recovering from surgeries. On January 13, 2012, Petitioner was sitting at the nurses' station and was checking various patient charts. The charts are kept in a rack and as Petitioner was in the process of returning one of the charts to the rack, the chair that she was seated in (the chair is on rollers) slid out from behind her causing her to fall. When Petitioner fell, she landed on the concrete floor and experienced pain to her buttocks, left hip and low back. Petitioner also experienced some pain and discomfort in the right shoulder.

Prior to the accident of January 13, 2012, Petitioner had significant back problems. In the 1980's, Petitioner had back surgery which consisted of a fusion at the L5-S1 level. There were no medical records tendered into evidence at the trial of this case in regard to the prior surgery; however, Petitioner apparently made a good recovery and was able to return to work without restrictions.

On August 23, 2011, Petitioner was seen by Dr. Joseph Yazdi, a neurosurgeon, and, at that time, Petitioner complained of a nearly two-year history of low back pain with radiation into the bilateral buttocks. Prior to being seen by Dr. Yazdi, Petitioner had physical therapy, injections and facet blocks but did not experience any significant relief of her symptoms. Dr. Yazdi examined Petitioner and obtained x-rays of the low back which revealed a spondylolisthesis at L4-L5. Dr. Yazdi recommended a posterior fusion at that level with pedicle screw fixation. On September 8, 2011, Dr. Yazdi performed surgery consisting of a posterior fusion at L4-L5 with pedicle screw fixation. Interlocking rods and four screws were used in this procedure. Following the surgery, Dr. Yazdi prescribed physical therapy and some pain medication and Petitioner made a good recovery. X-rays obtained on October 25, 2011, noted the presence of the rods and screws at the fused L4-L5 level. The radiologist's report did not note that there was any loosening of the screws. Dr. Yazdi noted that the x-rays revealed proper placement of the instrumentation.

Dr. Yazdi saw Petitioner again on November 22, 2011, and she still had complaints of a dull, aching pain in her back worsened with increased activity; however, Petitioner's leg pain had resolved. Dr. Yazdi released Petitioner to return to work without restrictions and also prescribed a back brace. Petitioner testified that she returned to work following this release from Dr. Yazdi.

At trial, Petitioner testified that following the accident of January 13, 2012, she experienced pain in the low back and left leg as well as some right shoulder pain. She described the symptoms as

being a "new pain" because the pain she previously experienced stopped at the buttocks. Petitioner notified her supervisor and went to the ER. X-rays obtained on January 13, 2012, did not reveal any new pathology and noted the presence of "unremarkable posterior fusion hardware of L4–5." There was nothing noted about any loosening of the screws used in the prior fusion.

Subsequent to the accident, Petitioner was seen by Dr. Yazdi on January 24, 2012, and he noted that prior to the accident of January 13, 2012, Petitioner had minimal pain, about 2/10. Following the accident, Petitioner's pain increased significantly and Dr. Yazdi initially tried to treat her conservatively referring her to Dr. William Thom, for pain management. Petitioner underwent a series of injections and facet blocks but did not get any significant relief of her symptoms. On March 19, 2012, Dr. Yazdi obtained another x-ray which noted the prior fusion at L4–L5 was unremarkable. It also noted that "surgical hardware appears intact." Again, there was no indication of any loosening of the metal screws. Dr. Yazdi then obtained an MRI of the lumbar spine on March 24, 2012, which noted the L4–L5 fusion and that the hardware was in place. Petitioner continued to receive conservative treatment and remained at work on a light duty basis.

Dr. Yazdi saw Petitioner on May 22, 2012, and Petitioner continued to be symptomatic. At that time Dr. Yazdi opined that the "...fusion probably got disrupted when she fell at work." He recommended an interbody fusion at that same level. A CT scan of the lumbar spine was obtained on June 11, 2012, and it noted that the anterolisthesis at L4 was stable and that there was no evidence of disc herniations. Again, there was no reference to any loosening of the screws used to fuse L4–L5. Dr. Yazdi saw Petitioner again on June 13, 2012, and he reviewed the CT scan. Dr. Yazdi specifically noted that there were no signs of any loosening of the screws and he did not observe any halo area around them. Dr. Yazdi opined that Petitioner had a pseudoarthrosis and that the only way to fix it was a lateral fusion at L4–L5 with possible additional hardware.

Dr. Yazdi authorized Petitioner to be off work effective June 6, 2012, and he performed surgery on June 28, 2012. The surgical procedure consisted of an interbody fusion and lateral screw fixation at that level as well as a discectomy and disc implant. Following the surgery, Dr. Yazdi prescribed physical therapy and authorized Petitioner to be off work. Dr. Yazdi most recently saw Petitioner on January 22, 2013, and he continued to authorize her to be off work and stated that the next appointment would be in April, 2013.

Dr. Yazdi was deposed on November 16, 2012, and his deposition testimony was received into evidence at trial. Dr. Yazdi's testimony was consistent with the information contained in his medical records. Dr. Yazdi reaffirmed his opinion that the accident of January 13, 2012, caused the pseudoarthrosis at L4–L5 that he treated. At the time he was deposed, Dr. Yazdi stated that Petitioner was not at maximum medical improvement and he did not know what her permanent restrictions would be.

In regard to Petitioner's condition prior to this accident, Dr. Yazdi testified that he had the opportunity to both examine Petitioner and observe her at work following the prior fusion surgery. Dr. Yazdi testified that Petitioner she seemed to be doing well prior to the accident of January 13, 2012.

In regard to the stability of the hardware from the prior fusion, Dr. Yazdi testified that he did not observe any loosening of the screws at L4–L5 and that he personally reviewed all of the x-rays and scans that had been performed on the Petitioner and that he did just did not simply rely on the reports of the radiologist.

At the direction of Respondent, Petitioner was examined by Dr. Daniel Kitchens, a neurosurgeon, on May 23, 2012. Dr. Kitchens obtained a history from Petitioner, examined her and also reviewed various medical records provided to him. Dr. Kitchens also reviewed the x-ray of March 19, 2012, and the MRI of March 24, 2012, and opined that these revealed some loosening of the left L5 pedicle screw. He opined that Petitioner's non–union at L4–L5 was due to the complications following the September, 2011, surgery and were not causally related to the accident of January 13, 2012.

Dr. Kitchens was deposed on November 28, 2012, and his deposition testimony was received into evidence. Although Petitioner's surgery occurred subsequent to Dr. Kitchens' examination of her, he did review the surgical report and opined that even if Petitioner had not sustained the fall on January 13, 2012, she would have still required this additional surgical procedure. On cross-examination, Dr. Kitchens opined that even though Petitioner's symptoms were less after the prior surgery and greater following the accident that this did not have any particular significance in respect to his opinion of there being a non–union. Dr. Kitchens could not testify when the pedicle screw became loose other than the fact that it was sometime before the x-ray of March, 2012.

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 a pseudoarthrosis at L4–L5 is causally related to the accident of January 13, 2012.

In support of this conclusion the Arbitrator notes the following:

There is no dispute that Petitioner sustained a work–related injury on January 13, 2012. Further, Petitioner's testimony that her back symptoms had been improving prior to the accident and that they significantly increased afterward was unrebutted.

The Arbitrator finds the opinion of the treating physician, Dr. Yazdi, to be more credible than that of Respondent's examining physician, Dr. Kitchens. Dr. Kitchens opined that he observed loosening of the left L5 pedicle screw when he reviewed the x-ray of March 19, 2012, and the MRI of March 24, 2012; however, neither the radiologist nor Dr. Yazdi, both of whom reviewed the same studies, made such a finding. Further, other diagnostic studies were performed on Petitioner both before and after the accident of January 13, 2012, and no loosening of any of the pedicle screws were noted either by the radiologist or Dr. Yazdi. When Dr. Yazdi was deposed, he specifically noted that there was no loosening of any of the screws.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills associated therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 7 as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall be given a credit for 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 that Petitioner is entitled to prospective medical treatment as recommended by Dr. Yazdi.

In support of this conclusion the Arbitrator notes the following:

Petitioner remains under Dr. Yazdi's care at this time and is presently scheduled to see him sometime in April, 2013. Petitioner is not yet at maximum medical improvement.

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

The Arbitrator concludes that Petitioner is entitled to payment of temporary total disability benefits of 34 weeks commencing June 6, 2012, through January 29, 2013, as provided by Section 8(b) of the Act. Respondent shall receive credit for amounts paid as short-term and long-term disability benefits as provided by Section 8(j) of the Act.

In support of this conclusion the Arbitrator notes the following:

Dr. Yazdi authorized Petitioner to be off work from June 6, 2012, to the present and there is no evidence to the contrary.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gerald Elsner,

Petitioner,

vs.

NO: 12 WC 29596

14IWCC0066

Cook County Sheriff's Office,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, permanent partial 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 Februaryary 28, 2013 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: FEB 03 2014

Mario Basurto

David L. Gore

Michael J. Brennan

MB/mam
O: 1/16/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ELSNER, GERALD
Employee/Petitioner

Case# **12WC029596**

14IWCC0066

COOK COUNTY SHERIFF'S OFFICE
Employer/Respondent

On 2/28/2013, 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 0.13% 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:

2221 VRDOLYAK LAW GROUP LLC
MICHAEL P CASEY
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CHICAGO, IL 60654

0132 STATES ATTORNEY OF COOK COUNTY
JEREMY SCHWARTZ
500 DALEY CENTER ROOM 508
CHICAGO, IL 60602

14IWCC0066

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

Gerard Elsner
Employee/Petitioner

v.

Cook County Sheriff's Office
Employer/Respondent

Case # **12** WC **29596**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **2/4/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/15/12**, 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.

Petitioner provided Respondent with timely notice of his claimed left foot injury. Arb Exh 1.

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that Petitioner's participation in Respondent's "walking program" in April and May of 2012 was incidental to his job and that a claim for an injury stemming from that participation would not be barred by Section 11 of the Act. The Arbitrator further finds, however, that Petitioner failed to prove causation as to the MRSA infection diagnosed in August of 2012, the need for surgery and his current left foot condition of ill-being. Having found that Petitioner failed to establish causation, the Arbitrator finds it unnecessary to address the remaining disputed issues.

In the year preceding the injury, Petitioner earned **$70,000**; the average weekly wage was **$1,346.15**.

As of 5/15/12, Petitioner was **64** years of age, ***married*** with **0** dependent children.

ORDER :

FOR THE REASONS SET FORTH IN THE ATTACHED CONCLUSIONS OF LAW, THE ARBITRATOR FINDS THAT PETITIONER FAILED TO MEET HIS BURDEN OF PROOF ON THE ISSUE OF CAUSAL CONNECTION. 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.

Molly C Mason
Signature of Arbitrator

2/27/13
Date

FEB 28 2013

Gerard Elsner v. Cook County Sheriff's Office
12 WC 29596

Arbitrator's Findings of Fact

Petitioner testified he began working as a program coordinator for Respondent about four and a half years ago. T. 14. As of early 2012, he worked as a program coordinator for Respondent's Department of Corrections. His job involved enhancing employee morale and wellness so as to reduce absenteeism. T. 15. He was also in charge of the Sheriff's fitness gymnasium, where he physically trained Respondent employees. T. 43. His scheduled work hours were from 6:00 AM to about 2:30 PM. T. 44-45.

Petitioner testified he is about six feet, one inch tall. As of May 15, 2012, he weighed about 235 pounds. T. 12-13.

Petitioner denied having any left foot problems prior to February of 2012. He also denied being diagnosed with diabetes or having any problems with blisters before February or March of 2012. T. 13-14.

Petitioner testified he attended a work meeting in April 2012 at the direction of his immediate supervisor, Patricia Horne [hereafter referred to as "Horne"]. Prior to this meeting, Cook County Board President Toni Preckwinkle issued a statement indicating she wanted to put an employee wellness program into place. Petitioner testified the meeting was held in Director Jackson's office. In addition to Petitioner, Horne and Jackson, Petitioner's associate, Nora Fitzpatrick, and the jail's social worker, Elli Montgomery, attended the meeting. T. 16. At the meeting, Petitioner came up with the idea of a walking program. Petitioner testified this program fit the bill in the sense that it could be initiated right away, was "low risk" and did not require any facilities or funding. T. 19-20. Petitioner testified that, when he left the meeting, Horne "high-fived" him for "coming [up] with this great idea immediately." T. 20. At some later point, Horne attended a directors' meeting and then formally approved Petitioner's idea. After Petitioner received the go-ahead from Horne, he and Fitzpatrick developed a flyer so as to alert employees as to when and where to meet in order to participate in the walking program. Petitioner identified PX 1 as a copy of this flyer. The flyer has the following heading: "Sheriff's Summer Walking Club." The brochure directs "all walkers" to "meet Jerry at the white gate in front of post 5" at any of the following times: 6:00 AM, 9:00 AM and 11:00 AM. PX 1.

Petitioner testified he submitted the flyer to Horne for her approval. Horne, in turn, presented the flyer to Hickerson, the former executive director of Respondent's jail, for his approval. Petitioner testified it has always been Respondent's policy that nothing can be posted without the approval of the jail's executive director. After Hickerson gave his approval, the flyer "was read at roll calls" and posted throughout Respondent's eleven buildings. T. 26.

Petitioner testified it was Horne who decided that the walking program was to take place at 6:00 AM, 9:00 AM and 11:00 AM daily. According to Petitioner, Horne selected these

start times so as to maximize employee participation. Sworn personnel start their shifts at 6:00 AM, non-sworn personnel start at 9:00 AM and both types of personnel come and go at 11:00 AM. T. 28.

Per the flyer, the employees who wanted to participate in the walking program were required to meet "Jerry," i.e., Petitioner, at "the white gate in front of Post 5" at any one of the foregoing start times. Petitioner testified that Post 5 is "the main entrance" to Respondent's Department of Corrections. T. 29.

Petitioner testified he was required to present himself at the white gate in front of Post 5 at the designated start times because he was "in charge of the walk[s]." Participation on the part of other Respondent employees was voluntary. T. 29. Petitioner testified he acted as the "rear guard" while his associate, Nora Fitzpatrick, was out in front. Petitioner testified he was required to participate in the walk so as keep pace and ensure no participant strayed or was injured. Petitioner was also charged with the responsibility of getting everyone "back on time." T. 30-31. On the very first day of the program, he arrived at work at 5:30 AM, as was his custom, so as not to miss anyone who might show up for the 6:00 AM walk. T. 44.

Petitioner testified that Horne and Respondent's other directors were aware of the manner in which he guided the group. Petitioner identified PX 2 as a picture of him, Nora Fitzpatrick and other participants in an 11:00 AM walk. He and Nora Fitzpatrick can be seen wearing uniforms they purchased so that they would "stand out" from the other participants. The uniforms they purchased bore Respondent's logo, i.e., a sheriff's star. One of the participants shown in PX 2 is Dan Marici, the "assistant executive director" of the jail. Marici is the individual wearing a star on his tie. T. 32. The walk depicted in PX 2 took place in March or April of 2012, near the beginning of the walking program.

Petitioner identified PX 3 as a picture of him, Nora Fitzpatrick and another individual participating in a 6:00 AM walk on one of the first days of the walking program. T. 34.

Petitioner testified that the participants walked on a sidewalk that was just beyond the wall of Respondent's property. The north end of the property was actually owned by the City rather than Respondent. The meeting place, i.e., the "white gate," was on Respondent's premises. T. 36.

Petitioner testified that, when the program began, walks were offered at 6:00 AM, 9:00 AM and 11:00 AM each day, Monday through Friday. Each walk was a mile and a half long. When the program first got underway, Petitioner and Nora Fitzpatrick participated in each of the scheduled walks. Petitioner wore hiking boots during each walk. About a month into the program, Petitioner noticed a blister on the sole of his left foot. The blister was large when Petitioner first noticed it. T. 13, 37. This blister hurt a little but Petitioner did not think it was a big deal. He showed the blister to others, including Bill, a director. T. 39. He continued to lead the scheduled walks, thinking the blister would go away. T. 38.

Petitioner testified that, on the morning of Sunday, May 20, 2012, the blister broke. He went to his HMO physician. He testified he told the physician he was doing "fitness training for the Sheriff's Department." T. 40. The physician lanced the blister, cut off skin, applied a bandage and told Petitioner to keep an eye on the wound. T. 40.

Records from Adventist Health Partners reflect that Petitioner saw Sean Miran, D.O. on May 20, 2012 and indicated he "developed a blister due to training." The doctor noted that the blister broke the preceding Friday. The doctor also noted that the blister occurred in the context of "immune compromise" based on Petitioner's long-term usage of IV antibiotics for recurrent right leg cellulitis. [A previous treatment note dated May 14, 2012 reflects that Petitioner was using a PICC line for IV antibiotic therapy due to the cellulitis.]

When Dr. Miran examined Petitioner on May 20, 2012, he noted a 4-centimeter flesh-colored lesion on the sole of Petitioner's left foot. He described the lesion as "blister type." He "de-roofed" the blister, using sterile scissors and forceps, and instructed Petitioner to "continue wound care." PX 5.

Petitioner testified that, to his recollection, Dr. Miran did not prescribe any medication or schedule a follow-up visit.

Petitioner reported to work as usual the next day, Monday, May 21, 2012, but never again participated in the scheduled walks because his foot was bleeding. T. 41-42, 44. The blister "became big" and developed into an ulcer that "went deep into the skin, almost to the bone." T. 41.

On May 31, 2012, Petitioner returned to Adventist Health Partners and saw a different physician, Joel Brown, M.D. Dr. Brown's history reflects that Petitioner "was training in his combat boots" two weeks earlier and noticed a "giant blister on the plantar surface of his left foot." Dr. Brown indicated this blister popped and caused a pressure ulcer, which made it difficult for Petitioner to walk. Dr. Brown also noted that Petitioner was "still on antibiotics for his right leg." The "physical exam" portion of Dr. Brown's note is blank. Dr. Brown assessed Petitioner with an acute friction blister of the sole. Elsewhere in the note, he described the problem as mild in nature. The doctor's treatment is described only as "foot ulcer education." Petitioner testified the doctor did not give him any medication and said only "we have to keep watching this." On his own, Petitioner went to Walgreen's and bought a "little rubber doughnut," which he applied to the affected area. The blister was gone. In its place was a bleeding ulcer. T. 43.

Petitioner testified he continued performing his regular gym-related duties after May 21, 2012. He changed the bandages on his ulcer and made an effort to keep the wound clean. T. 43.

Based on the records in evidence, Petitioner next sought treatment for his left foot on July 31, 2012. Petitioner saw Dr. Brown on that date. The doctor noted that Petitioner had

had a "sore on the bottom of his left forefoot for at least 10 weeks" and had been wearing a pad so as to keep pressure off the wound. On examination, Dr. Brown noted a full-thickness ulcer over the head of the head of the left second metatarsal." On this occasion, he described the ulcer as 6 mm in diameter. He noted associated drainage. He obtained a culture and referred Petitioner to Dr. Salvino, a podiatrist. The culture showed heavy growth of pseudomonas. PX 5.

Petitioner testified he ended up seeing a different podiatrist, Dr. Rozanski, because the podiatrist to whom he was referred by Dr. Brown was not in his HMO. T. 46. He saw Dr. Rosanski at the referral of another doctor, who he saw only for a "couple of minutes." T. 46.

Records in PX 5 reflect that Petitioner saw Dr. Aftab, the infectious disease physician who was treating his right leg cellulitis, on August 3, 2012, at the referral of Dr. Salvino. [No records from Dr. Salvino are in evidence.] In her note of August 3, 2012, Dr. Aftab indicated that Petitioner was "well known" to her from prior hospitalizations for gram negative pneumonia and recurrent cellulitis. Dr. Aftab noted that Petitioner had most recently been hospitalized in March 2012 and had stayed on "IV Vancomycin for 4-6 weeks."

Dr. Aftab indicated that Petitioner "is with the police force/County jail" and "works out extensively." She noted that Petitioner was "not sure of his diabetic status" but had "some kind of neuropathy on the underside" of his left foot, where he had developed an ulcer about two months earlier. She described the treatment to date, noting that Dr. Brown had cultured the ulcer. She indicated that Petitioner denied stepping on any nail and denied "any previous history of MRSA infection."

On examination of Petitioner's right leg, Dr. Aftab noted "slight eczema" with "some residual erythema." On examination of the left leg, she noted "some erythema on the dorsal aspect of the left foot" and "an ulcer about 22 cm in diameter under the left second metatarsal bone" which appeared "quite deep on probing."

Dr. Aftab noted that Petitioner did not perceive the ulcer as painful. She indicated that the ulcer could "very well be a neuropathic ulceration." She prescribed a left foot MRI and blood work. She started Petitioner on oral Bactrim. She indicated that Petitioner's past history of recurrent cellulitis and bypass graft with vein harvesting done to the left leg "predisposed" Petitioner to "worsening infection of lower extremities."

No left foot MRI report is in evidence.

On August 6, 2012, Petitioner underwent left foot X-rays, which revealed a "surgical clip along the plantar surface of the foot at the level of the distal second and third metatarsals" and no radiographic evidence of acute osteomyelitis. The X-ray report describes Dr. Salvino as the ordering physician. PX 5.

On August 8, 2012, Petitioner saw Dr. Hasan at the referral of the La Grange Wound Center. The doctor's note sets forth the following history:

> "Mr. Gerard Elsner is a 64-year-old male who was sent to La Grange Wound Center for management of a left foot wound. He had been followed by a podiatrist outside the wound center and is now referred for ongoing treatment of this wound. He states that he developed the left foot wound approximately 2 to 3 months ago. He states that he was recently diagnosed with diabetes. He underwent a debridement by a podiatrist recently. He has been on antibiotic treatment. He has been followed by the infectious disease service (Dr. Aftab) for antibiotic treatment."

Dr. Hasan noted that Petitioner "works with the police force/county jail" and "is physically active."

On examination of Petitioner's left foot, Dr. Hasan noted a plantar ulcer with a surrounding callus. Given the "non-healing" nature of the ulcer, Dr. Hasan recommended follow-up with Dr. Rozanski. He started Petitioner on Aquacel AG dressing. PX 9.

Petitioner testified that, by the time of his initial visit to Dr. Rozanski, the pressure ulcer was much larger. T. 47.

The first treatment note in evidence authored by Dr. Rozanski is dated August 14, 2012, with the doctor indicating Petitioner was "returning" for treatment of a "Wagner Grade 3 ulceration on the bottom of the left foot." The doctor noted "minimal progress." He described the ulcer as 1 cm in diameter but with a depth of 0.3 cm, "tunneling" to the center, "to the capsule of the second MPJ," with no bone exposure. Dr. Rozanski debrided the wound, removing "fibrotic tissue in the base and border." He planned to discuss IV antibiotics with Petitioner's infectious disease physician. He applied Aquacel and gave Petitioner "a new surgical shoe." PX 6.

A culture of the tissue Dr. Rozanski removed on August 14, 2012 showed "moderate growth of Methicillin-Resistant Staphylococcus Aureus [MRSA]." PX 8.

Petitioner next saw Dr. Rozanski on August 21, 2012. The doctor noted no cellulitis but indicated the plantar ulcer was still warm. He described the ulcer as 0.8 centimeters in diameter and 0.3 centimeters deep. He indicated the ulcer "still tracts to bone." He debrided the ulcer with a #15 blade, re-dressed the wound and informed Petitioner he might need removal of the underlying bone. PX 6.

On August 27, 2012, Petitioner filed an Application for Adjustment of Claim alleging a left foot injury of May 15, 2012. Arb Exh 2.

On August 28, 2012, Dr. Rozanski operated on Petitioner's left foot at Adventist La Grange Memorial Hospital. The doctor's pre-operative diagnoses included "foreign body, left foot." In his operative report, the doctor indicated he dissected capsular tissue off the metatarsal head and then used a power saw to remove the second metatarsal head. He indicated it was necessary to remove the second metatarsal head because "the necrotic tissue within the ulcer did go deep to the capsular tissue." He went on to state:

> "Then we did remove the free margin of the second metatarsal and base of the proximal phalanx sent to pathology as well as micro for further microanalysis to rule out existing osteomyelitis. We irrigated with normal saline solution. Exploration for any more abnormal or necrotic tissue was performed and none was found, **so then we did do further exploration under fluoroscopy to find the part of the needle that was still in the foot** since it was in close proximity and this was removed under sterile technique with minimal dissection." [emphasis added]

The operative report lists the following procedures: "excision of osteomyelitis and surgical closure of ulcer, left foot, with removal of foreign body as well." PX 6.

A culture taken from bone in Petitioner's left foot on August 28, 2012 showed "light growth Methicillin-Resistant Staphylococcus Aureus [MRSA]."

Petitioner continued to see Dr. Rozanski postoperatively. He also continued to see Dr. Aftab, because he was receiving antibiotics intravenously via a PICC line. T. 50. He developed shingles after the surgery and had to undergo treatment for that disorder. T. 64. On September 4, 2012, Dr. Rozanski removed a surgical drain, left the sutures intact and prescribed "minimal ambulation with a Darco shoe." On September 5, 2012, Dr. Aftab issued a note releasing Petitioner to work in a "cleaner environment." PX 7. On September 18, 2012, Dr. Rozanski removed the surgical sutures and used a #15 blade to remove fibrotic tissue from the base and border of the ulcer. He instructed Petitioner to continue wearing an off-loading shoe. A week later, Dr. Rozanski debrided the ulcer again, removing nonviable tissue, and instructed Petitioner to follow up. On September 26, 2012, Dr. Aftab issued a note releasing Petitioner to work in a "clean office setting and away from jail." PX 7. On October 2, 2012, Dr. Rozanski noted that Petitioner was still wearing the off-loading shoe and denied any pain. The doctor sutured the wound closed and instructed Petitioner to "continue with off-loading shoe to minimize weight bearing." On October 9, 2012, Dr. Rozanski applied Steri-Strips and instructed Petitioner to continue wearing the off-loading shoe. PX 6. On October 16, 2012, Dr. Rozanski removed the sutures, debrided some tissue and instructed Petitioner to continue using the off-loading shoe and obtain a customized shoe insert to prevent recurrence of the ulcer. PX 5.

Petitioner testified that, when he learned of his MRSA diagnosis, he notified Horne per Respondent's protocol. According to Petitioner, Horne responded to this news by screaming and telling Petitioner to report to personnel and "list [him]self as injured on duty." T. 50-51. That same day, Petitioner reported to Steve Hensley, Respondent's "injured on duty person," and completed various forms other than the supervisor's report form. Petitioner testified that Horne refused to complete this particular form. T. 51. Petitioner testified he was "directed to leave the premises" once he completed the forms. T. 52. He left the premises and did not return to work until November 28, 2012. The walking program stopped the day he left the premises. T. 57-58. He testified he was off work from August 1, 2012 until November 28, 2012. T. 53-54.

Petitioner testified that his family physician, Dr. Brown, released him to return to work as of November 28, 2012, at which point his foot wound was "closed." It was his understanding that the MRSA infection could recur despite the wound closure. When he returned to work, Horne did not allow him to return to the warehouse. Rosemarie Nelson assigned him to work in the jail kitchen, alongside minimum wage workers. At some subsequent point, he was re-assigned to his original program coordinator position. He still held this position as of the hearing.

Petitioner testified that the sole of his left foot hurts. He restricts his walking due to left foot pain. He continues to work out on a regular basis, as he has done since high school, but avoids walking and running. He now swims and lifts weights. T. 59. He also uses a recumbent bicycle but avoids putting pressure on the bottom of his left foot. T. 61. He is able to walk but experiences throbbing pain when he walks more than a couple hundred yards. He wears a slightly oversized shoe on his left foot and places a customized pad in the shoe. T. 60, 62. When he takes a shower at some location other than home, he seals a plastic bag over his left foot so as to avoid spreading the MRSA infection. T. 61. He keeps a supply of broad-spectrum antibiotics in his car as a prophylactic measure in the event of a MRSA flare-up. Dr. Aftab prescribed these antibiotics. T. 64.

Petitioner identified PX 4 as a document that he, Horne and Nora Fitzpatrick generated for the purpose of making Respondent employees aware of the walking program and other wellness activities. PX 4 was given to Respondent's public relations department so that it could be published in the Cook County Sheriff's newsletter. T. 63.

Petitioner denied developing blisters on any other part of his body after he developed the blister on his left foot. T. 65-66.

Under cross-examination, Petitioner identified RX 1 as a waiver form that Respondent employees were required to sign in order to participate in a charity event known as the "Walk for Riley." This event was intended to generate interest in the walking program but it never took place. RX 1 was not intended to serve as a waiver for the walking program. T. 69.

Petitioner testified that the funds designated toward the walking program consisted of his and Nora Fitzpatrick's salaries. T. 69-70. His participation in the walking program was part of his job. It was not voluntary. T. 70. He and the program participants met at a gate that was on property owned by the Cook County Sheriff. They then ventured out onto a sidewalk that was owned by either the Sheriff or the City of Chicago. T. 71. The walking program grew out of a meeting at which various wellness programs were discussed. He "might have" come up with the idea of the program because the goal was to come up with a program that would not cost anything. T. 72-73. Respondent paid for the flyers. T. 73.

On redirect, Petitioner reiterated that the "Walk for Riley" was a charitable event that was intended to raise money for an officer whose daughter was undergoing treatment for cancer. It was separate from the walking program. It never took place. T. 74.

In addition to the exhibits previously discussed, Petitioner offered into evidence bills from Adventist Health, Dr. Rozanski, Dr. Aftab, LaGrange Hospital and Dr. Hasan. PX 5-9. Respondent did not object to any of these bills. T. 95-99.

Respondent called Patricia Horne. Horne testified she was promoted to her current position, director of support services for the Cook County Sheriff, in July of 2012. As of May 15, 2012, her job title was special assistant to the executive director of the Cook County Department of Corrections. T. 77-78.

Horne testified that the walking program was a strictly voluntary activity intended to improve the health and morale of Respondent employees. T. 80. The participants were required to sign a waiver. They were also supposed to participate in the walks during lunch or while otherwise off duty. The Department of Corrections has an "open campus," meaning that employees can leave the premises to take lunch. T. 79-80. The walks were to take place on public sidewalks that are adjacent to County property. T. 79.

The following exchange occurred:

> Q: "As [Petitioner's] supervisor, did you at any time have control or authority over [Petitioner], specifically with regard to the volunteer walking program?
>
> A: Well, that's a complicated question. It's complicated because [Petitioner] was asked to coordinate activities working with the community and working within the Sheriff's office. So he was asked to serve as a liaison to these various programs that we had going, the walking club being one."

T. 80.

Horne testified that she drafted RX 1, the waiver form, at Petitioner's request. She prepared RX 1 on her own time, using her home computer. T. 82. The form was intended to eliminate Respondent liability for walking-related injuries, such as injuries stemming from falls. To the extent that Petitioner participated in the walking program, the form applied to him. T. 82. Petitioner was a program coordinator and promoter, not an athletic trainer for the walking program. Petitioner was asked to "pull together interested persons who wanted to walk, which could have included him, and to involve them in the walking process" by advising them of the start times and meeting point. Petitioner's participation, like that of the other walkers, was strictly voluntary. T. 84. The Sheriff's office has no mandatory exercise program. T. 84. The walking program was just part of an overall wellness effort promoted by Respondent and other entities, such as Blue Cross/Blue Shield. T. 84-85.

Under cross-examination, Horne testified there were two agendas behind the "Walk for Riley": raising money for a specific officer's family and generating interest in the walking program. Respondent's overall wellness program was never intended to have a charitable purpose. T. 87. Horne acknowledged she has no signed copy of RX 1. She has seen a separate document, labeled "Waiver of Liability for the Walking Club Program," but she did not bring this document to the hearing. She has no signed copies of this document. T. 88. It was her understanding that the individuals who participated in the walking program were going to meet and walk wherever they wanted to walk. T. 89.

On redirect, Horne characterized the "Walk for Riley" as an "additional motivator" to get people to agree to participate in the walking program. T. 89. Petitioner was aware of RX 1 and saw RX 1 after she prepared it at his request. T. 90.

Arbitrator's Credibility Assessment

The Arbitrator finds credible Petitioner's testimony concerning the origins and purpose of the walking program. The Arbitrator also finds credible Petitioner's testimony that the role he played in the program, i.e., that of promoter and "rear guard," was mandated by his job.

The Arbitrator finds Petitioner less than forthright with respect to his pre-accident state of health. For example, Petitioner testified he first learned he was "borderline diabetic" after he returned to work in November of 2012. Dr. Hasan's note of August 8, 2012, reflects, however, that Petitioner told him he had recently been diagnosed with diabetes.

Based on the wording Dr. Rozanski used in his operative report, it appears that Petitioner stepped on a needle prior to the surgery and that the doctor knew a section of the needle remained lodged in the foot before the surgery. The Arbitrator finds it odd that Petitioner never addressed this.

Did Petitioner sustain an accident arising out of and in the course of his employment? Did Petitioner establish causal connection?

Petitioner claims he developed a blister on the bottom of his left foot on or about May 15, 2012, as a result of performing job-related duties in connection with Respondent's walking program. Petitioner viewed his participation in this program as wholly different from that of other Respondent employees in that it was his function, as a program coordinator, to generate enthusiasm and essentially "corral" those who elected to join him on the scheduled walks. It was clearly in Respondent's interest to have someone walk alongside the participants to ensure they maintained a certain pace, stayed on course, avoided injury and returned to the workplace. The photographs reflect that Petitioner and Nora Fitzpatrick wore uniforms bearing Respondent's logo while leading a walk in which one of Respondent's directors participated. Given the overall goal of fostering employee wellness, it was in Respondent's interest to have Petitioner appear at the meeting point at the beginning of each walk, especially since some of the walks started before it got light outside. Horne did not contradict Petitioner's testimony that she selected the start times and that all of the walks were scheduled during Petitioner's normal work hours. Petitioner, unlike the other participants, was clearly not expected to walk only when off duty.

Based on the foregoing, the Arbitrator finds that Petitioner's participation in the walking program was not voluntary. The Arbitrator further finds that Section 11 of the Act (commonly known as the "voluntary recreational program" exclusion) would not bar Petitioner from asserting a claim for an injury stemming from such participation. See, e.g., Elmhurst Park District v. IWCC, 395 Ill.App.3d 404, 408 (1st Dist. 2009), in which the Appellate Court upheld the Commission's award of benefits to a fitness supervisor who was injured while participating in a wallyball game during his work shift. The claimant testified he participated in the game at the request of a co-worker who told him the game could not otherwise proceed due to a lack of sufficient paying customers. No one told him he had to participate. Rather, he felt compelled to participate because one of his job duties was to promote his employer's programs. The Commission found that Section 11 did not apply because the claimant was injured while performing duties incidental to his employment. In affirming this result, the Court found that "recreation" was inherent in the claimant's job. The same logic applies in the instant case, particularly because Petitioner was a fitness trainer as well as a program coordinator.

It is Petitioner's failure to establish causation as to the MRSA infection, the need for surgery and his current left foot condition that prompts the Arbitrator to deny benefits. While causation can, in some cases, be established via the "chain of events," with no need for medical testimony, the "chain of events" in the instant case is not entirely clear. Petitioner did not testify that he developed a painful blister while engaging in one of the scheduled walks. While some of Petitioner's medical providers took note of his training duties, no physician specifically mentioned the walking program. Nor did any physician opine, even in a general way, that Petitioner's job duties caused or aggravated the blister. The first treating physician, Dr. Miran, indicated the blister developed in the context of "immune system compromise" due to Petitioner having been on intravenous antibiotics for his recurrent cellulitis. The second treater, Dr. Brown, described the lesion as "mild." After this initial course of care ended on May 31, 2012, with neither Dr. Miran nor Dr. Brown having diagnosed an infection, there was a two-month gap in treatment, during which time Petitioner, per his testimony, did not

participate in the walking program. On July 31, 2012, Dr. Brown referred Petitioner to Dr. Salvino, a podiatrist. On August 6, 2012, Petitioner underwent left foot X-rays per Dr. Salvino. These X-rays documented the presence of a surgical clip at the level of the distal second and third metatarsals. In early August 2012, Dr. Aftab, the infectious disease physician who treated the cellulitis, noted that Petitioner had recently undergone a debridement by a podiatrist. It appears to the Arbitrator that Dr. Salvino performed this debridement, based on the X-ray order and surgical clip, but Petitioner did not offer any records from Dr. Salvino into evidence. This omission is puzzling. Dr. Aftab opined that the blister could "very well be" neuropathic, based on the absence of painful response. Petitioner went on to see another podiatrist, Dr. Rozanski. Dr. Rozanski operated, at least in part, to remove a foreign object, specifically a part of a needle that was "still inside" Petitioner's foot. The operative report documents an insult to the foot that Petitioner did not acknowledge. Dr. Rozanski treated Petitioner over an extended period yet never mentioned Petitioner's occupation, let alone the walking program.

Based on the foregoing, the Arbitrator finds that Petitioner failed to establish causation as to his MRSA, the need for surgery and his current left foot condition of ill-being. Benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Taylor,

Petitioner,

vs.

NO: 11 WC 18537

14IWCC0067

Maschoff Transportation, LLC,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical 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 March 28, 2013 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.

14IWCC0067

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: FEB 03 2014

Mario Basurto

David L. Gore

Daniel R. Donohoo

MB/mam
O:1/23/14
43

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

TAYLOR, JAMES
Employee/Petitioner

Case# **11WC018537**

14IWCC0067

MASCHHOFF TRANSPORTATION LLC
Employer/Respondent

On 3/28/2013, 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 0.10% 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:

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

0180 EVANS & DIXON LLC
KIM M PARKS
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

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

14IWCC0067

TAYLOR, JAMES Case# **11WC018537**
Employee/Petitioner

MASCHHOFF TRANSPORTATION LLC
Employer/Respondent

On 3/28/2013, 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 0.10% 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:

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KIM M PARKS
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

James Taylor
Employee/Petitioner

v.

Maschhoff Transportation, LLC
Employer/Respondent

Case # 11 WC 18537

Consolidated cases: _____

14IWCC0067

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on January 28, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, April 14, 2011, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $43,466.21; the average weekly wage was $835.89.

On the date of accident, Petitioner was 50 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $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. The parties stipulated and agreed that all TTD benefits have been paid in full.

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

ORDER

Respondent shall pay for reasonable and necessary medical services as identified in Petitioner's Exhibit 15, as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit as provided in Section 8(j) of the Act.

Respondent shall authorize and make payment for prospective medical treatment as recommended by Dr. Gornet including, but not limited to, the low back 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.

William R. Gallagher, Arbitrator
ICArbDec19(b)

March 25, 2013
Date

MAR 28 2013

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on April 14, 2011. According to the Application, Petitioner sustained injuries to the cervical, thoracic, lumbar spines and left upper extremity as a result of a truck accident. Respondent stipulated that Petitioner sustained a work-related injury and paid both temporary total disability benefits and medical; however, Respondent disputed liability in regard to the low back on the basis of causal relationship. This case was tried as a 19(b) proceeding and Petitioner sought an order for payment of medical bills as well as prospective medical treatment in regard to the low back.

Petitioner worked for Respondent as a delivery driver and drove a semi truck/trailer. Petitioner with would also lift and move 50 pound bags of feed every week or two. When Petitioner was driving the truck, he would customarily drive it on back roads and he described the ride as being very rough as compared to what it would be on the interstate. Prior to April 14, 2011, Petitioner was able to perform all of his job duties without any particular difficulty.

On April 14, 2011, Petitioner was involved in a single vehicle accident. He was not certain as to exactly how it occurred because he lost consciousness and could only recall that the truck was laying on its left side. Emergency personnel that responded to the accident had to remove Petitioner from the truck cab.

Prior to the accident of April 14, 2011, Petitioner received chiropractic treatment for several years for low back symptoms from Dr. Josh Berger. Dr. Berger's records revealed that Petitioner was seen for a low back problem in April, 2008, and also had several visits in June and July, 2010. These records stated that Petitioner's back symptoms improved over time and Dr. Berger did not ever impose any work/activity restrictions upon Petitioner.

On January 26, 2011, Petitioner was seen by Dr. Thomas Forget for low back pain. Dr. Forget reviewed an MRI that had been obtained two weeks prior and opined that it revealed an L4–L5 spondylolisthesis. This MRI was performed on January 10, 2011, at the request of Dr. Richard Lehman and, in addition to the L4–L5 spondylolisthesis, it also noted the presence of an annular tear at L5–S1. No medical reports/records from Dr. Lehman were tendered into evidence at the time of the trial of this case. Dr. Forget examined Petitioner and noted that the neurologic exam was normal, that Petitioner was overweight, 6 feet tall and 260 pounds. Dr. Forget opined that Petitioner would benefit from a decompression and fusion, but that it was reasonable to wait and he prescribed some physical therapy and a weight loss program. Dr. Forget did not impose any work/activity restrictions.

Petitioner received physical therapy at St. Mary's Good Samaritan Hospital between January 31, 2011, and February 11. 2011. At the time of his initial assessment of January 31, 2011, Petitioner reported the pain as being 8/10. At the time of the last visit of February 11, 2011, he reported the pain as being 2/10. Petitioner also received chiropractic care at Thayer Medical Facility between February 21, 2011, and April 13, 2011. When Petitioner began treatment there on February 21, 2011, he reported that the pain was constant and rated as 6/10. Petitioner was seen at that facility several times and both the duration and seriousness of the pain gradually decreased. On April 13,

2011, (the day before Petitioner's accident) the duration of the pain was described as intermittent and the severity was rated as 5/10. In spite of Petitioner's low back symptoms, he continued to work in a full and unrestricted capacity and also engaged in various recreational activities such as golf and playing basketball with his grandkids.

Following the accident of April 14, 2011, Petitioner was taken to Fayette County Hospital where it was noted that Petitioner had multiple scalp and forehead lacerations and bruising to the left arm/shoulder. Petitioner reported that he had pain "all over." Multiple x-rays and CT scans were obtained which included a CT scan of the cervical spine which did not reveal any acute bony abnormality. At trial, Petitioner testified that he could not recall much about his time at Fayette County Hospital. Following his discharge, Petitioner was seen by Dr. Michael Darmadi, his family physician, who initially referred him to a cardiologist because he suspected Petitioner had an aneurysm.

Petitioner was seen by Dr. Berger on April 19, 2011, and Petitioner informed Dr. Berger that he had pains the back of the neck, left shoulder, low back as well as a headache. Dr. Berger opined that Petitioner had a fractured cervical vertebrae and referred him to Dr. James Coyle, an orthopedic surgeon.

Dr. Coyle initially saw Petitioner on April 28, 2011. In the medical history form completed by Petitioner, he stated he had various complaints secondary to the accident of April 14, 2011, including neck and back pain. Dr. Coyle's medical report of that date was focused on the cervical spine and that Petitioner had complaints of neck pain, left shoulder pain and numbness of the left thumb. Dr. Coyle had a CT scan of the cervical spine performed which confirmed the presence of a left sided facet fracture at C6–C7. Dr. Coyle prescribed a cervical collar and authorized Petitioner to be off work. In regard to the low back, Dr. Coyle's report did state that Petitioner had a history of low back pain for which he was treated but that it had been improving and that he presently had recurrent back pain since the time of the accident. Dr. Coyle ordered an MRI which was also performed on that date which revealed disc protrusions at C5–C6 and C6–C7. Dr. Coyle saw Petitioner on May 16, 2011, and recommended that more time was required to let the fracture heal. He continued to authorize Petitioner to remain off work.

Dr. Coyle saw Petitioner on June 14, 2011, and recommended surgery consisting of a discectomy and fusion at C5–C6 and C6–C7 with metal plating. At trial, Petitioner testified that it was his understanding that Dr. Coyle was going to initially fix the neck and wait on the low back.

At the direction of Respondent, Petitioner was examined by Dr. Marvin Mishkin, an orthopedic surgeon, on July 19, 2011. Dr. Mishkin reviewed various medical reports/records provided to him and examined the Petitioner. Dr. Mishkin opined that Petitioner's low back condition of spondylolisthesis at L4–L5 and degenerative disc disease were chronic and predated the accident of April 14, 2011, and were not causally related to it. In regard to the cervical spine, Dr. Mishkin opined that neck surgery was not indicated. At that time, Respondent had not approved the neck surgery recommended by Dr. Coyle.

Petitioner returned to Dr. Berger who referred him to Dr. Matthew Gornet, an orthopedic surgeon. Dr. Gornet initially saw Petitioner on August 25, 2011. In the information sheet

completed by the Petitioner in connection with that visit, Petitioner indicated that he had pain referable to the neck and left shoulder/trapezius area, numbness to the left thumb, and low back pain on both sides, more on the left than on the right. Petitioner indicated his current level of pain as being 9/10. Petitioner informed Dr. Gornet that he had low back symptoms, chiropractic care and an MRI performed before the work accident; however, he also advised Dr. Gornet that he had been able to work full duty with just some occasional symptoms. Dr. Gornet examined Petitioner and obtained x-rays of both the cervical and lumbar spine. The cervical spine x-rays confirmed the facet fracture at C6–C7 and the low back films revealed an isthmic type spondylolisthesis at L4–L5. Dr. Gornet also reviewed the MRI that had been obtained on April 28, 2011, and opined that it did show disc pathology at C5–C6 and C6–C7. Dr. Gornet opined that the cervical condition was related to the work injury and that surgery was indicated including a fusion at C6–C7 and possibly also at C4–C5 and C5–C6. In regard to the low back, Dr. Gornet noted that Petitioner had a problem that predated the accident but that it was clear from the history that Petitioner had aggravated this condition. Dr. Gornet requested the MRI that had been performed in January, 2011, and prior medical records and recommended that a new MRI be performed on the low back.

At Dr. Gornet's direction, a lumbar MRI was performed on September 15, 2011, which revealed an anterolisthesis of L4–L5 and disc bulges at L4–L5 and L5–S1. Dr. Gornet reviewed both this scan and the MRI that was performed on January 10, 2011, and opined that there was not an appreciable difference between the two. Dr. Gornet noted that while he could not measure the cellular inflammatory response, that the accident caused an aggravation of the pre-existing condition. At that time, Dr. Gornet recommended that Petitioner have some injections at L4–L5 and L5–S1.

On September 26, and October 10, 2011, Petitioner was seen by Dr. Kaylea Boutwell who administered epidural steroid injections at the L4–L5 and L5–S1 levels. Petitioner did not experience any significant relief of his symptoms as a result of those injections.

At Respondent's direction, Petitioner was examined by Dr. Robert Bernardi, on August 31, 2011. Dr. Bernardi obtained a history and examined Petitioner and reviewed various medical report/records that were provided to him. In regard to the cervical spine symptoms, Dr. Bernardi opined that they were causally related to the accident of April 14, 2011; however, he recommended that Petitioner undergo nerve conduction studies to determine whether or not there was any cervical radiculopathy and then, depending on those results, determine if surgery was indicated. In regard to the low back, Dr. Bernardi opined that Petitioner's low back condition was not related to the accident of April 14, 2011, basing this on the fact that the L4–L5 spondylolisthesis pre-existed the accident and that a single traumatic event could not cause it to become chronically symptomatic. Petitioner had nerve conduction studies performed by Dr. Dan Phillips on September 19, 2011, which revealed mild chronic left radiculopathy of C5, C6 and C7. Dr. Bernardi reviewed Dr. Phillips' report and opined that these were chronic and not related to the accident of April 14, 2011.

Dr. Gornet saw Petitioner on November 14, 2011 and, at that time, he reviewed the reports of both Dr. Mishkin and Dr. Bernardi. In regard to Dr. Mishkin, Dr. Gornet noted that Dr. Mishkin does not perform spinal surgeries and that his opinion in regard to causation is limited. In regard

to Dr. Bernardi's opinion regarding causality, Dr. Gornet acknowledged that Petitioner did have pre-existing low back symptoms and treatment; however, he noted that the medical records that pre-dated the accident did indicate that Petitioner's low back condition was improving. Dr. Gornet reaffirmed his opinion that the accident of April 14, 2011, was an aggravation of a pre-existing condition. While waiting for Respondent to authorize neck surgery, Petitioner was seen by Dr. Gornet on January 16, April 5, and July 9, 2012, and his symptoms and findings remained the same in respect to both the neck and low back.

Respondent approved the cervical disc surgery and, on November 6, 2012, Dr. Gornet performed surgery consisting of a microdiscectomy and fusion at C4–C5 and C6–C7 and a disc replacement at C5–C6. At trial, Petitioner testified that his neck condition was improved although he still had some pain and that his arm symptoms have resolved.

Dr. Gornet was deposed on June 28, 2012 (which was prior to the neck surgery). In regard to the low back, Dr. Gornet reaffirmed his opinion that the accident of April 14, 2011, aggravated the condition and again noted that while Petitioner had a pre-existing low back problem, that it was improving with conservative care. Although Dr. Gornet noted that while there were no significant differences between the MRIs of January 10, 2011, and September 15, 2011, the accident caused a cellular response and chemical changes within the disc that explain the increases in Petitioner's symptoms, especially given the force required to cause a neck fracture. Dr. Gornet also noted that the pre-accident medical records supported that Petitioner's symptoms had improved before the accident but that, after the accident, the symptoms were no longer waxing and waning but were unrelenting. Dr. Gornet recommended low back surgery consisting of a spinal fusion at L4–L5 and L5–S1. At trial, Petitioner testified that he wants to have the low back surgery performed as recommended by Dr. Gornet.

Dr. Bernardi was deposed on August 17, 2012, and his deposition testimony was received into evidence at trial. Dr. Bernardi's testimony was consistent with his medical records/reports and he reaffirmed his opinion that Petitioner's low back pain was not causally related to the accident of April 14, 2011, because Petitioner had a symptomatic L4–L5 spondylolisthesis prior to the accident. On cross-examination, Dr. Bernardi was asked whether the accident could have aggravated the condition and he responded that this was a completely subjective perception and something that he could not know with any certainty. Dr. Bernardi did agree that back surgery was indicated for Petitioner's low back condition.

Petitioner has been totally disabled since the time of the accident and Respondent has paid Petitioner temporary total disability benefits for this period of time.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to the lumbar spine is causally related to the accident of April 14, 2011, because the accident aggravated and made more symptomatic a pre-existing condition.

In support of this conclusion the Arbitrator notes the following:

Prior to the accident of April 14, 2011, Petitioner was diagnosed with an L4–L5 spondylolisthesis which was symptomatic and for which Petitioner received both medical and chiropractic care. While Dr. Forget opined that the condition could require surgery, both Petitioner and Dr. Forget agreed on a more conservative approach including physical therapy and weight loss. It is significant that Dr. Forget never imposed any work/activity restrictions on Petitioner and Petitioner was able to work full unrestricted duty driving a truck and lifting up to 50 pounds.

Petitioner's testimony and the medical records that pre-dated the accident of April 14, 2011, both indicate that Petitioner's low back symptoms were gradually improving prior to the accident of April 14, 2011.

The Arbitrator finds Dr. Gornet's opinion as to causality to be more credible than the opinions of Dr. Mishkin and Dr. Bernardi. Dr. Gornet's opinion is consistent with Petitioner's testimony in the pre-accident medical records regarding Petitioner's low back condition. Dr. Bernardi agreed that he could not state with any certainty whether or not Petitioner could have aggravated his low back condition as a result of the accident of April 14, 2011.

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 causally related to the accident of April 14, 2011. Respondent is thereby liable for payment of the medical bills associated therewith.

Respondent shall pay reasonable and necessary medical bills as identified in Petitioner's Exhibit 15, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner is entitled to prospective medical care including, but not limited to, the low back surgery recommended by Dr. Gornet.

In support of this conclusion the Arbitrator notes the following:

Dr. Gornet has recommended that Petitioner undergo low back surgery and Dr. Bernardi agrees that surgery is appropriate.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeffrey N. Garwood,
Petitioner,
vs.

NO: 12WC 4194

14IWCC0068

Lake Land College,
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 average weekly rate, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 3, 2013, 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: FEB 0 3 2014

Charles J. DeVriendt

Michael J. Brennan

Ruth W. White

o012914
CJD/jrc
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GARWOOD, JEFFREY N
Employee/Petitioner

Case# **12WC004194**

LAKE LAND COLLEGE
Employer/Respondent

14IWCC0068

On 1/3/2013, 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 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 & ASSOCIATES
CHARLES N EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

RUSIN MACIOROWDKI & FRIEDMAN LTD
TERRY SCHROEDER
2506 GALEN DR SUITE 104
CHAMPAIGN, IL 61821-7047

STATE OF ILLINOIS)SS.
COUNTY OF ADAMS)

14IWCC0068

☐ 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 N. Garwood
Employee/Petitioner

v.

Lake Land College
Employer/Respondent

Case # 12 WC 4194

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 **Quincy**, on **November 8, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 12, 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 **$40,520.00**; the average weekly wage was **$779.23**.

On the date of accident, Petitioner was **54** 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 **$1,595.33** for TTD, $ **0** for TPD, $ **0** for maintenance, and $ **0** for other benefits, for a total credit of $ **1,595.33**.

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 **$519.44/week** for **4 4/7** weeks, commencing **12/2/11** through **1/3/12**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$1,595.33** for temporary total disability benefits that have been paid.

As stipulated, Respondent shall pay reasonable and necessary medical services of **$113.00**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$467.54/week** for **43** weeks, because the injuries sustained caused the **20%** loss of the **left leg**, as provided in Section 8(e) of the Act.

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

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

Nancy Lindsay
Signature of Arbitrator

12/28/12
Date

JAN 3 - 2013

The Arbitrator finds:

Petitioner testified he began working for Respondent on January 30, 2006 as a vocational computer instructor. Petitioner testified that in June of 2010 all business and computer vocational classes were done away with; however, he was later brought back as an adjunct instructor (part-time instructor). Petitioner testified that as an adjunct instructor, he was paid per class. Petitioner testified he came back and taught computer-related classes, including introductions to computers and various other application, software, and keyboarding classes. Petitioner testified he was paid a different amount for each class based upon the number of credit hours for each class. Petitioner confirmed that for the wage periods shown on the wage statement beginning during November of 2010 and ending in June of 2011 he was working as an adjunct instructor (RX 3).

Petitioner further testified that beginning July 1, 2011 he became the vocational correctional occupational instructor at Western Illinois Correctional Center in Mt. Sterling, Illinois. This position was a full-time salaried position. When asked how he came to change his employment status he explained that when he was let go in June of 2010 he was on a "two-year recall," and when a previous instructor retired he was offered the job. Petitioner testified the difference in the job was that full-time employment included additional employment benefits such as healthcare and life insurance.

At arbitration, the parties stipulated that when Petitioner went to work as a full-time employee on July 1, 2011, he entered into an employment contract with Respondent and his annual salary payable under that contract is $40,519.48.

Petitioner testified that on 9/12/11 he was still working for Respondent as a full-time vocational instructor at the Western Illinois Correctional Center in Mt. Sterling, Illinois.

Accident and causation were undisputed. Petitioner testified that on September 12, 2011, he was walking to his vehicle after work when he tripped and fell in an area where concrete was in the process of being ground down to allow wheel chair access, landing first on his left knee and then onto his left hand, elbow and side. Petitioner testified that stood up on his own but noticed pain in his left knee, left elbow, ribs and left wrist. He continued home and that evening continued to experience increasing pain and swelling in his left knee. Petitioner testified that he reported the fall the next morning to his immediate supervisor, Tom Theiss, and to Tom Kerkhoff, Respondent's Executive Dean of Corrections.

Records show that Petitioner first sought medical care from his family doctor, Dr. Jennifer Schroeder, on September 13, 2011. Petitioner reported a consistent history of the accident and complained of pain in his left knee, as well as his left rib area and left elbow. (Pet. Ex. 3, p. 94) Petitioner was walking stiff legged and reported a sensation as if his leg would give way. He acknowledged having undergone a left knee arthroscopy previously but denied any further knee problems until his recent work accident. (Pet.

Ex. 3, p. 94)

On physical examination, Dr. Schroeder noted tenderness and abnormal range of motion of the left elbow and that Petitioner was walking stiff and not bearing weight on his left knee. She noted that x-rays of the left elbow and knee did not demonstrate any bony injury. (Pet. Ex. 3, p. 95, 99-100) Dr. Schroeder recommended the use of ice and heat, NSAIDS, range of motion exercise and a left knee immobilizer for comfort. (Pet. Ex. 3, p. 96) Petitioner returned to Dr. Schroeder on September 23, 2011, reporting continued concern regarding left knee pain and requesting a referral to Dr. Ronald Wheeler, an orthopedic surgeon. Petitioner also reported pain in his left chest wall while deep breathing or rubbing the chest wall and requested that it be x-rayed. (Pet. Ex. 3, p. 91) A rib and chest x-ray was taken but did not show any fracture. (Pet. Ex. 3, pp. 93, 98) Noting that Petitioner's left knee had not improved, Dr. Schroeder referred Petitioner to Dr. Ronald Wheeler. Petitioner's left elbow was not causing any problems.(Pet. Ex. 3, p. 93)

Petitioner initially saw Dr. Wheeler on October 3, 2011, reporting an onset of left knee pain after a fall at work about three weeks earlier with persistent discomfort thereafter. (Pet. Ex. 1, p. 16) On examination, Dr. Wheeler noted some swelling in the knee and vague tenderness and diagnosed pes anserine bursitis. He recommended adjustment of activities and consideration of therapy. (Pet. Ex. 1, p. 16)

Petitioner returned to see Dr. Wheeler a week later on October 10, 2011, reporting continued discomfort. (Pet. Ex. 1, p. 15)

Petitioner underwent an MRI of his left knee on October 10, 2011 at Blessing Hospital. The report of Dr. Stanton indicated mild chondromalacia of the patellofemoral compartment and mild thinning of the articular cartilage of the medial and lateral tibiofemoral compartments. Petitioner's medial meniscus appeared normal without tear. There was an oblique tear involving the posterior horn of the lateral meniscus with truncation of the inner third zone body of the lateral meniscus. It was Dr. Stanton's impression there was mild chondromalacia and arthritis involving the patellofemoral compartment and a complete tear of the posterior horn of the lateral meniscus. (RX 2,

Dr. Wheeler recommended therapy but noted that surgery might be required if Petitioner did not improve. (Pet. Ex. 1, p. 15) Records from Quincy Medical Group show that Petitioner began therapy on October 13, 2011, reporting a consistent history of accident and worsening pain in his left knee since that time. (Pet. Ex. 3, p. 86-87) Petitioner attended 8 sessions of therapy through October 27, 2011. (Pet. Ex. 3, pp. 76 – 85) At the final session, Petitioner continued to report pain of a level of 6-8/10 in all positions most of the time. Petitioner did not feel that he had experienced any improvement with therapy and showed no objective improvement in range of motion or strength. Petitioner reported difficulty with functional tasks as well as work tasks requiring prolonged standing and walking which would increase his left knee pain. The therapist opined that further functional improvement would be limited by worsening symptoms. (Pet. Ex. 3, p. 76)

Petitioner returned to Dr. Wheeler on October 31, 2011, reporting increasing pain in his left knee that was aggravated by activity. (Pet. Ex. 1, p. 14) On examination, Dr. Wheeler noted diffuse tenderness, positive McMurray testing and tenderness both medially and laterally. Dr. Wheeler therefore recommended surgery on the knee after clearance by Dr. Schroeder. (Pet. Ex. 1, p. 14)

Petitioner proceeded with arthroscopic surgery on December 2, 2011, at Blessing Hospital. (Pet. Ex. 1, pp. 11-13, Pet. Ex. 2, pp. 17-18) In the course of arthroscopic surgery, Dr. Wheeler confirmed his pre-operative diagnosis of medial and lateral meniscus tears and debrided those tears. He also found Class II chondromalacia of the medial femoral condyle and the medial tibial plateau and chondroplasty was performed. Some chondromalacia of the lateral tibial plateau was also noted and chondroplasty was performed. Synovectomy was also performed and a synovial plica was removed. (Pet. Ex. 2, pp. 17-18) Petitioner followed up with Dr. Wheeler on December 8, 2011, when sutures were removed and therapy was ordered. (Pet. Ex. 1, p. 10)

Records show that Petitioner began post-operative therapy on December 12, 2011, and attended 30 sessions through February 6, 2012. (Pet. Ex. 3, pp. 28-59) Petitioner continued to follow up with Dr. Wheeler on December 29, 2011, January 26, 2012 and February 6, 2012. (Pet. Ex. 1, pp. 7-9) At these visits, Dr. Wheeler noted some ongoing soreness, though improved, and some improvement in strength, though he noted a continued imbalance in the quads and hamstrings. (Pet. Ex. 1, pp. 8-9) In her last physical therapy note, Petitioner's therapist noted that the focus of treatment had been on normalizing Petitioner's left knee range of motion and progressive strengthening as tolerated. Petitioner's response had been good with only minimal complaints of pain with prolonged weightbearing activities. All goals were achieved and Petitioner was discharged to an established home exercise program per Dr. Wheeler's discretion. (Pet. Ex. 3, p. 28)

Petitioner returned for a final appointment on May 7, 2012, reporting that he was doing fairly well but was continuing to experience some soreness. (Pet. Ex. 1, p. 5) Dr. Wheeler noted "improved" range of motion and good strength in Petitioner's knee. There was no tenderness, effusion, or swelling noted. There was balance between Petitioner's quads and hamstrings. Dr. Wheeler released Petitioner from care finding him to be at maximum medical improvement. Dr. Wheeler did not anticipate any permanent disability. (Pet. Ex. 1, p. 5)

Petitioner was examined by Dr. Joseph T. Monaco at Respondent's request on August 3, 2012, in Bloomington, Illinois (Resp. Ex. 1) Dr. Monaco provided an impairment rating of Petitioner's injury under the 6th Addition of the AMA Guides. Dr. Monaco reviewed Petitioner's medical records, met with Petitioner and took a history and summary of his complaints. He also performed a physical examination. At the time of the exam, Petitioner reported he liked to walk for exercise and was doing so for about thirty minutes two to three times per week. Petitioner also reported taking two Aleve tablets about three times per week for arthritic knee pain. Petitioner provided the doctor with a typed report regarding his ongoing complaints. Petitioner reported pain from six inches above the knee to six inches below the knee. He described this pain as mild to moderate most of the time but getting as bad as 5/10 on occasion. Petitioner also reported that his knee would stiffen up if he sat for more than twenty minutes at a time with his knee bent, that he felt weak when arising from a sitting position or turning to his left, and occasionally he loses his balance while walking down a hallway. Petitioner also reported increasing pain

and stiffness when driving a car, walking in a store or on any concrete surface for a long period of time. Petitioner noted that his knee would also hurt when lying in bed at the end of the day. Petitioner explained that he could help lessen the pain and stiffness by elevating his leg during the day.

In his report Dr. Monaco noted that Petitioner walked with a slight left antalgic gait. Petitioner had seven degrees of valgus in both knees when supine and standing. Petitioner had full extension with 135 degrees of flexion, equal to the right knee. There was good straight leg raise and no extensor lag. There was trace patellofemoral crepitus bilaterally. There was no patellofemoral pain with ballottement of the left knee. Petitioner's left knee was stable to varus and valgus stress and anterior and posterior drawer sign. Lachman's test and Pivot-shift test were negative. McMurray testing revealed mild discomfort. He noted that Petitioner's left knee was slightly larger than the right (44 cm vs 43.2 or 43.5 cm) and that there was some discomfort with McMurray's testing, though there was no pop or click. Deep tendon reflexes were 2+ and equal bilaterally at both the knees and ankles. Motor function was graded 5/5 in all muscles tested in the lower extremities. Homan's sign was negative. Petitioner exhibited good dorsalis pedis pulses. Dr. Monaco also reviewed Petitioner's diagnostic studies. He concurred with Dr. Wheeler's earlier diagnoses and believed petitioner had reached maximum medical improvement as a result of his work accident. Dr. Monaco only believed the tears were due to the accident; Petitioner's chondromalacia pre-dated the accident and was not related. Based upon the AMA Guides (Sixth Edition), Petitioner's impairment was rated at 3% whole person impairment or 8% loss of the lower extremity. (RX 1 and RX 2, exhibit 2)

Dr. Monaco's deposition was taken on November 1, 2012. Dr. Monaco, a board certified orthopedic surgeon, testified consistent with his report.

Dr. Monaco testified that he diagnosed Petitioner with tears of the medial and lateral meniscus of the left knee and chondromalacia of the patellofemoral joint of the left knee. He further opined that the meniscus tears were causally related to Petitioner's fall but not the chondromalacia. (Resp. Ex. 2, pp. 20-21) In reaching an impairment rating, Dr. Monaco testified that he did not consider the chondromalacia to be related to the work injury but he did consider the medial and lateral meniscus tears to be related. (Resp. Ex. 2, p. 29). Accordingly, he looked to Table 16-3 of the AMA Guides, and used the Diagnostic Criteria (Key Factor) to be "Meniscal Injury" and assigned the injury to Class 1 as a "Partial (medial and lateral)". (Resp. Ex. 2, pp. 29-30) He noted that the Class assignment is based upon a tear of the meniscus and that the rating is not affected by whether it was treated surgically or not. (Resp. Ex. 2, p. 30) He testified that under the Guides he would initially assign the injury to Class C within that class, providing a default impairment of 10% of the lower extremity subject to grade modifiers and adjustment grids. (Resp. Ex. 2, p. 31) Dr. Monaco testified that generally there are three categories of modifiers – functional history, physical examination and diagnostic studies. (Resp. Ex. 2, p. 24) In considering Functional History Adjustment, Dr. Monaco looked to Table 16-6 of the Guides which shows five levels of Grade Modifier ranging from "no problem" to "very severe problem". Under the class definition of "Gait Derangement", Dr. Monaco assigned a Grade Modifier of 1 (Mild Problem) as Petitioner did have a limp. This Adjustment table also refers to the "AAOS Lower Limb Instrument", though Dr. Monaco stated that he used the "PDQ" (pain disability questionnaire) assessment tool instead as he felt it was a more reliable tool. He acknowledged that the Guides recommend use of the AAOS Lower Limb Instrument (outcome measure). (Resp. Ex. 2, p. 32, 27, 46-48)

On cross-examination, Dr. Monaco admitted that Petitioner's score on the PDQ would be classified as a "moderate" rather than "mild" (as indicated in his report) and a Grade Modifier "2" rather than the Grade Modifier "1" that he had assigned, but testified that he would reject that higher Modifier because it seemed inconsistent with the Gait Derangement modifier and because the Guides provide that if the Functional History modifier deviates two or more grades from any other modifier it should be considered unreliable and should not be used. (Resp. Ex. 2, pp. 49-52) Dr. Monaco next considered the Physical Examination Adjustment found in Table 16-7 of the Guides and concluded that all of Petitioner's physical findings were under Grade Modifier 0. Finally, he looked to the Clinical Studies Adjustment grade modifiers in Table 16-8 of the Guides, but did not use this table as he felt that the clinical studies were used to define the diagnosis and, as he interpreted the Guides, should not then be used to make a further adjustment. (Resp. Ex. 2, p. 35) However, he testified that if he did consider the fact that the clinical studies confirmed the diagnosis, the result would not change the impairment rating. (Resp. Ex. 2, p. 35-37) Dr. Monaco then testified that under the Guides, he would then subtract each grade modifier from the class of diagnosis resulting here in a net adjustment of minus 1. (Resp. Ex. 2, pp. 38-39) He testified that this would reduce the impairment rating to Class B within Class 1 in Table 16-3 of the Guides, resulting in a final impairment rating of 8% of the lower extremity. (Resp. Ex. 2, p. 39)

On further cross-examination, Dr. Monaco acknowledged that "impairment" is not synonymous with "disability" and that other factors than "impairment" must be considered to determine "disability". (Resp. Ex. 2, pp. 42-43) Dr. Monaco also acknowledged that the Guides note a difference between "legal" causation (judged at more than 50% probable) and "medical" causation (judged at 95% probable) and testified that in concluding that the chondromalacia was not related to the injury he was applying "medical" causation. (Resp. Ex. 2, p. 52) However, the testified that even if the chondromalacia were considered related, that fact would not affect the impairment rating because the Guides allow consideration of only one diagnosis in each part of the body. (Resp. Ex. 2, p. 53) Therefore, if an injury results in more than one diagnosis in one part of the body, the impairments related to each diagnosis are not added together and only the more serious diagnosis is taken into account. (Resp. Ex. 2, p. 53)

Dr. Monaco testified that he devotes 20 percent of his practice to performing IME examinations. (Resp. Ex. 2, p. 6) Dr. Monaco testified that he had performed 10 evaluations for impairment ratings since May or June 2012. (Resp. Ex. 2, p. 62-63) He testified that he performed his examination in Bloomington, Illinois (though his office is in Tinley Park, Illinois) through a vendor who "market[s] themselves to insurance companies for these kind[s] of services." (Resp. Ex. 2, p. 63) He testified that he travels to Bloomington about once a month for this vendor and sees four to six people over the course of a day. (Resp. Ex. 2, p. 63) Dr. Monaco further testified that all of the impairment ratings that he has done have been at the request of insurance companies or defense attorneys. (Resp. Ex. 2, p. 64-65) He testified that he also performs IMEs independent of impairment ratings and performs 10 to 12 per month and 95 percent of these are for insurance companies and defense firms. (Resp. Ex. 2, p. 65) Dr. Monaco testified that he does not do an impairment rating without doing a full medical examination, and that he charges $1,250.00 for the medical examination and an additional $250 for the impairment rating. He testified that he charges $650 per hour, with a minimum of two hours, for depositions and $325 for preparation time if there is a lot of preparation time. (Resp. Ex. 2)

At arbitration Petitioner testified that he is 54 years of age and remains employed as an instructor of Construction Occupations at the prison. Petitioner denied any problems with his left knee before his undisputed accident on September 12, 2011. Petitioner acknowledged that he is able to perform his present job duties but that he sits down whenever he can. He prefers to sit, rather than to stand, when teaching. Petitioner also testified that he occasionally puts his leg up on a desk and stretches it but doesn't do so when the students are around. Petitioner takes Aleve when the pain is "real bad." Petitioner also testified that he continues to experience the problems with his knee that he described in detail to Dr. Monaco. Petitioner further testified that he and his wife used to walk and that he is diabetic and they walk for exercise. He testified they walk less now because his knee will hurt and he just doesn't feel like it. Petitioner testified he and his wife used to walk four or five times per week. Petitioner is also diabetic.

Petitioner testified he is currently being paid under the collective bargaining agreement that was entered into evidence as Respondent's Exhibit 4 and that he has no reason to believe his employment with Respondent is in jeopardy or his salary might be reduced because of the injury. He further testified neither his work hours nor the number of classes he teaches have been reduced as a result of the injury.

Petitioner testified the payment of the $40,519.48 of his employment contract was paid out over 26 pay periods from July 1st forward.

Respondent called one witness, Mr. Ronald C. Frillmann, who is the associate dean at the Lake Land facility at Western Illinois Correctional Center.

Mr. Frillmann is Petitioner's direct supervisor. He testified he and Petitioner had been friends for some years. Mr. Frillmann identified the collective bargaining agreement that was entered into evidence as Respondent's Exhibit 4 and confirmed that it was signed 7/01/10 and involves a three-year contract expiring in June of 2014.

Mr. Frillmann testified that he has no knowledge of any complaints regarding Petitioner's performance of his job since he has been returned to work. He testified there are procedures included in the collective bargaining agreement for discipline and/or dismissal of employees. He further testified he has no reason as Petitioner's supervisor to think there is any reason that his position with Respondent might be terminated for any reason.

The Arbitrator concludes:

1. **Earnings.**

   Section 10 of the Illinois Worker's Compensation Act defines "average weekly wage" as the earnings of the employee "in the employment in which he was working at the time of the injury." The Arbitrator concludes that at the time of his undisputed accident Petitioner was working as a full-time instructor for Respondent at the stipulated salary of $40,520 per year, producing an average weekly wage of $779.23. Petitioner experienced a change in his employment status when

he was hired as a full-time instructor and, therefore, only the earnings during that employment should be considered. The Arbitrator finds significant that the manner of computing his earnings changed from being paid by the class to becoming salaried, and that he became eligible for employee benefits after becoming a full-time instructor. See, Walter vs. Jacksonville Developmental Center 99 IIC 1031 and Rios vs. United Parcel Service 01 IIC 860.

2. Nature and Extent of the Injury.

Petitioner suffered tears to the lateral meniscus and medial meniscus of his left knee. He was also diagnosed with synovitis and patellofemoral chondromalacia of the left knee. Petitioner's left elbow and chest complaints appear to have resolved.

The injuries to Petitioner's left knee were addressed in a timely manner and he appears to have had a good recovery as indicated in the medical treatment notes. Petitioner underwent one arthroscopic procedure from which he had a satisfactory recovery. Petitioner was last seen for his knee by Dr. Wheeler on May 7, 2012. At that time the doctor indicated that Petitioner had improvement in his range of motion, good strength and balance between the quads and hamstrings. There was no effusion, swelling, or tenderness. At that time the doctor's plans and recommendations indicate Petitioner should increase his activities. No permanent disability was anticipated." Petitioner was told to recheck as needed. The Arbitrator further notes Petitioner was seen again on May 31, 2012 and, according to his testimony at arbitration, had seen Dr. Wheeler several other times for treatment of a thumb injury. However, there was no additional medical documentation that would indicate Petitioner had seen Dr. Wheeler or any other medical professionals for complaints of his knee after the May 7, 2012 release date.

Pursuant to Section 8.1b of the Act, the following criteria and factors must be considered in assessing permanent partial disability:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion, loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) the reported level of impairment as assessed pursuant to the current edition of the AMA "Guides to the Evaluation of Permanent Impairment";
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

The Act provides that no single enumerated factor shall be the sole determinant of disability. With respect to these factors, the Arbitrator notes:

1. The reported level of impairment under the AMA Guides. With regard to the AMA impairment rating, the Arbitrator takes into account Dr. Monaco's rating of 8% impairment of a lower extremity. In determining that rating, Dr. Monaco acknowledged that he did not use the recommended "outcome measure" for lower extremity ratings and that he did not take into account any aggravation that Petitioner suffered to his pre-existing chondromalacia because he did not believe that condition was related to petitioner's accident. While Petitioner testified that Dr. Norregaard has told him he needs surgery that recommendation is not reflected in the doctor's office records. There is no August 31, 2012 office note setting forth any proposed treatment plan by Dr. Norregaard. (PX 6). The Arbitrator also notes that there were some other discrepancies between Petitioner's testimony and the medical records themselves with regard to Petitioner's care and treatment (for ex., physical therapy) While these discrepancies are not enough to undermine causation they create some "pause" regarding treatment recommendations and prospective care. Furthermore, looking at the "outcome measure" Dr. Monaco did utilize (albeit it was not the recommended one) Dr. Monaco agreed on cross-examination that Petitioner's score on the "PDQ" would place Petitioner in a "moderate" impairment category rather than a "mild" one as he indicated in his report.

As acknowledged by Dr. Monaco, "impairment" is not synonymous with "disability" and other factors must be considered to assess "disability." In assessing the weight to be assigned to the impairment rating as compared to the other enumerated factors, the Arbitrator notes these concessions by Dr. Monaco.

2. The occupation of the injured employee. Petitioner's current occupation is that of an instructor in Construction Occupations, a position he has held for a relatively short period of time. Previously, he was employed as a part-time instructor teaching computer-related courses. Prior to that Petitioner was employed as a dispatcher and he also had work experience in construction. This testimony was not rebutted by Respondent.

3. The age of the employee at the time of the injury. At the time of his accident, Petitioner was 53 years old. No evidence was presented as to how Petitioner's age might affect his disability.

4. The employee's future earning capacity. Petitioner testified that his current employer allows him to accommodate his ongoing problems in that he can sit and stand as desired and strenuous activity is not required. However, if he were to lose his current employment and be required to seek alternative employment, there could be issues with accommodation.

Petitioner's past skills are varied, however, which would theoretically present greater employment opportunities. No evidence was presented to show a diminishment in Petitioner's future earning capacity as a result of his injury.

5. Evidence of disability corroborated by the treating medical records. Petitioner testified credibly to ongoing problems with pain and stiffness in his injured left knee that limit his ability to stand and walk. These complaints are corroborated by medical records showing that he suffered medial and lateral meniscus tears as well as an aggravation of pre-existing chondromalacia, that these conditions were serious enough to require arthroscopic surgery as described above, and by references in Dr. Wheeler's treatment notes that Petitioner has suffered from persistent soreness through his last visit and had demonstrated muscle imbalance during his recovery. Though not a treating record, Petitioner's complaints are also objectively corroborated by Dr. Monaco's findings that Petitioner walked with a limp at the time of his evaluation and had swelling in his left knee, as well as the finding of "moderate" functional impairment on his "PDQ" evaluation.

Petitioner was off work for 4 4/7 weeks. He then resumed regular duty. Petitioner was released by Dr. Wheeler on May 7, 2012. At that time Dr. Wheeler anticipated no permanent disability.

After considering all of these factors, the Arbitrator concludes that Petitioner has sustained permanent partial disability of 20% loss of use of the left leg.

3. **TTD Underpayment.**

The period of temporary total disability was undisputed (December 2, 2011 through January 3, 2012); however, Petitioner claims an underpayment of TTD benefits based upon the average weekly wage/earnings dispute. The parties further stipulated that Petitioner was paid $1595.33 in TTD benefits. Based upon the Arbitrator's earnings determination there has been an underpayment of TTD benefits and Respondent shall pay same.

****

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

Gary D. Dorris,
Petitioner,
vs.

NO: 12WC 34462
14IWCC0069

Walgreen Co.,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, medical, "present condition of ill-being causally related" 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 22, 2013, 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: FEB 0 3 2014

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CJD/jrc
049

Charles J. DeVriendt

Michael J. Brennan

Ruth W. White

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

DORRIS, GARY
Employee/Petitioner

Case# **12WC034462**

WALGREENS CO
Employer/Respondent

14IWCC0069

On 4/22/2013, 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 0.09% 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:

0327 LAW OFFICES OF JEROME LEFTON
AARON D LEFTON
1015 LOCUST ST SUITE 808
ST LOUIS, MO 63101

1433 McANANY VAN CLEVE & PHILLIPS PC
SHELLEY A WILSON
515 OLIVE ST SUITE 1501
ST LOUIS, MO 63101

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)

Gary D. Dorris
Employee/Petitioner

v.

Walgreen Co.
Employer/Respondent

Case # 12 WC 34462

14IWCC0069

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 **Collinsville**, on **3/21/13**. After reviewing all 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 ___

14IWCC0069

FINDINGS

On the date of accident, **7/31/12**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$51,567.88**; the average weekly wage was **$991.69**.

On the date of accident, Petitioner was **52** 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 **$5,950.17** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$5,950.17**.

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

ORDER

Petitioner's claim for TTD and 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

4/16/13
Date

ICArbDec19(b)

APR 22 2013

Findings of Fact

Petitioner, has been employed with Walgreens for eleven years. On July 31, 2012, while unloading, lifting and stacking boxes, he complained of injury to his low back with pain down his legs. Despite this, Petitioner continued working that day and for the next two weeks performing his normal job duties. On August 14, 2012, while unloading another truck, Petitioner again complained of injury to his low back. He complained of low back pain and numbness in his legs.

On August 14, 2012, Petitioner treated at Missouri Baptist Hospital where he was diagnosed with low back pain, treated and released. He returned to Missouri Baptist Hospital on August 17, 2012, complaining of low back pain radiating into both hips and legs. He described a "pins and needles" sensation in both legs, left greater than right. Petitioner reported a prior low back injury 8 years earlier after a 15 foot fall, resulting in a diagnosed herniated disc. He described receiving injections in association with the prior injury with only temporary improvement. He described intermittent back pain since that time. He was diagnosed with low back pain with lumbar sacral radiculopathy. A lumbar MRI showed only minor degenerative changes. Petitioner received a right SI joint injection and an epidural steroid injection at L4-5.

Petitioner subsequently came under the care of Drs. Kennedy and Sturm. Dr. Kennedy diagnosed Petitioner with a lumbar strain and recommended treatment with Dr. Sturm. Dr. Kennedy did not believe Petitioner to be a surgical candidate. Dr. Sturm administered lumbar epidural steroid injections at L5 and L5-S1 on September 4 and 11, 2012. He administered bilateral facet joint injections at L4-5 and L5-S1 on November 29, 2012. He administered bilateral nerve blocks on January 2 and 17, 2013. He administered a right SI joint injection on January 8, 2013. Petitioner reported no relief from the numerous and repeated injections performed by Dr. Sturm. On December 17, 2012, Dr. Kennedy recommended a discogram, which was subsequently normal. Most recently, Dr. Kennedy has recommended an FCE.

On October 19, 2012, Petitioner attended an IME with Dr. DeGrange at the request of the Respondent . Dr. DeGrange diagnosed a lumbar strain and degenerative disc disease at L3-4, L4-5 and L5-S1. He found Petitioner's physical exam to be replete with nonorganic findings such as allodynia, give-way weakness in the bilateral lower extremities, and regional disturbances. He stated that Petitioner's subjective complaints were not substantiated by any objective findings either on physical exam or diagnostic studies. Dr. DeGrange found Petitioner's MRI to show age appropriate changes with no acute injury. He found no clinical indications for continued pain management treatments or for the prolonged and sustained levels of disability displayed by the Petitioner. He found the Petitioner capable of full duty work and placed him at MMI for his work injury. Dr. DeGrange found the Petitioner's injection treatment to be unreasonable and not necessary in light of his normal physical exam and diagnostic studies.

Dr. DeGrange testified via evidence deposition on February 8, 213, that an appropriate course of care for Petitioner's diagnosis of a lumbar strain would have been four weeks of physical therapy, activity modification, and the use of an anti-inflammatory medication. He testified that Petitioner's prolonged use of narcotic medications, receipt of pain management and receipt of multiple epidural injections was not reasonable or necessary treatment for his work injury. Dr. DeGrange repeatedly stressed that Petitioner's physical exam findings and normal diagnostic studies simply did not correlate with his extreme subjective complaints.

Dr. Kennedy testified by deposition taken on February 27, 2013, that Petitioner suffered a lumbar strain attributable to his work injury. Dr. Kennedy testified that he previously treated Petitioner's low back in 2008, 2009, and 2010 and that Petitioner's low back complaints never fully recovered prior to the current work injury. He testified that lumbar MRIs performed in 2008, 2009, and 2010 all showed Petitioner to have degenerative changes evidence by bulging at L3-4 and L4-5. With respect to Petitioner's current physical exam, Dr. Kennedy

testified that the only positive findings are subjective complaints of pain and range of motion loss. He testified that all objective testing, including spasm, muscle atrophy, leg length, straight leg raising and reflexes, were entirely normal. Dr. Kennedy testified that Petitioner's current MRI findings are normal with the exception of degenerative changes, which were also present on the MRIs from 2008, 2009, and 2010. Dr. Kennedy confirmed the normal discogram and testified that there is no evidence of nerve root impingement. He agreed that there is no objective evidence of any injury to Petitioner's low back. Finally, when questioned about Dr. DeGrange's findings of symptom magnification, Dr. Kennedy agreed that these types of findings are indicative of symptom magnification.

Petitioner has not worked since October 19, 2012, with the exception of November 5-19, 2012. Petitioner testified that his pain has improved only 30% throughout the duration of his treatment. He described current complaints of low back pain, bilateral hip pain, left leg and knee pain, tingling down his left leg, and occasional tingling down his right leg. He described his pain as 5/10 while on pain medication and 7/10 without pain medication. He takes two Vicodin per day and one Flexeril each night. On cross examination, Petitioner admitted to "at times" consuming up to 4 Hydrocodone per day and one Flexeril per night.

Petitioner also described prior injuries to his low back. In 2008, he fell 15 feet from a ladder and received treatment with Dr. Kennedy for low back pain. He missed 6 months from work for the 2008 injury, for which he experienced pain in his low back, hips, and left leg, and was treated with physical therapy and pain management. In 2009, Petitioner suffered a lifting injury to his low back. He treated with Dr. Kennedy and received physical therapy and a TENS unit. Following the 2009 incident, he was off work for 3-4 months and was treated with physical therapy and pain management. Petitioner described a third injury occurring in 2010, but testified that this injury primarily involved his cervical spine. He admitted that he also injured his low back from this 2010 accident and experienced complaints of low back and bilateral hip pain with radiation down his left leg. Petitioner testified that he received workers' compensation settlements for his 2008 and 2009 injuries totaling 15% MAW.

Based on the foregoing, the Arbitrator makes the following conclusions:

1. Petitioner has not met his burden of proof regarding the causal connection between his current condition of ill-being and his original work accident. Although the Arbitrator notes that the medical records support the Petitioner's claim that he sustained a back strain as a result of his non-disputed accident on July 31, 2012, it appears that the Petitioner's ongoing complaints are not supported by the various objective and diagnostic tests results – all of which have been normal. In this regard, the Arbitrator finds persuasive the opinions of Respondent's IME, in that the Petitioner has reached MMI and that further medical treatment is not warranted.

2. Petitioner has not met his burden of proof regarding the issue of temporary total disability and his entitlement to ongoing benefits. On this issue, the Arbitrator notes that all the objective findings and the diagnostic test results conducted by both the Petitioner's treating physicians and the Respondent's IME have been normal. While there is no doubt that the Petitioner sustained a back strain, there is some serious doubt that the Petitioner is medically unable to return to work because of this condition. It appears the main reason Petitioner has remained off work is because of his subjective complaints of pain. The Arbitrator notes that whenever the Petitioner has returned to his treating physician with such complaints, a physical exam or diagnostic test is ordered and all have shown normal results. There was no credible evidence presented that supports the Petitioner's claim that he cannot return to work. Accordingly, Petitioner's claim for TTD benefits is denied.

3. Based on the findings above, Petitioner's claims for medical expenses and prospective medical treatment are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

George Timmons,

Petitioner,

vs.

NO: 11WC 42903

14IWCC0070

Work Force,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, incurred 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 January 3, 2013, 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 $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: FEB 0 3 2014
o012814
CJD/jrc
049

Charles J. DeVriendt

Michael J. Brennan

Ruth W. White

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

TIMMONS, GEORGE
Employee/Petitioner

Case# **11WC042903**

14IWCC0070

WORK FORCE
Employer/Respondent

On 1/3/2013, 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 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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

0693 FEIRICH MAGER GREEN & RYAN
PIETER SCHMIDT
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

14IWCC0070

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)

George Timmons
Employee/Petitioner

v.

Work Force
Employer/Respondent

Case # 11 WC 42903

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on October 24, 2012. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

On this date, Petitioner did 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 $3,059.58; the average weekly wage was $339.95.

On the date of accident, Petitioner was 52 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $10,046.73 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $10,046.73.

Respondent is entitled to a credit of $27,875.38 under Section 8(j) of the Act.

ORDER

Pursuant to the agreement of the parties, case number 11 WC 42978 is dismissed.

Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibit 1 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of $27,875.38 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit as provided in section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the MRI and subsequent treatment that has been recommended by Dr. Houle.

Respondent shall pay Petitioner temporary total disability benefits of $253.00 per week for 75 weeks commencing May 17, 2011, through October 24, 2012, as provided in Section 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator

December 31, 2012
Date

ICArbDec19(b)

JAN 3 - 2013

Findings of Fact

There were two Applications for Adjustment of Claim filed on behalf of Petitioner in regard to this claim both of which alleged that Petitioner sustained a work-related accident on May 10, 2011, to his right knee/leg. The Applications were identical except that in 11 WC 42903 the Respondent was Workforce and in 11 WC 42978 the Respondent was Gilster-Mary Lee. Both Respondents were represented by the same law firm. At trial, both Petitioner's and Respondent's counsel stipulated that the appropriate Respondent was Workforce and that case 11 WC 42978 against Gilster-Mary Lee would be dismissed.

The Application alleged that Petitioner sustained an accidental injury arising out of and in the course of his employment for the Respondent, Workforce, on May 10, 2011. The Application stated Petitioner sustained an injury to his right knee/leg as a result of walking upstairs and jumping in and out of machines. This case was tried as a 19(b) proceeding and Petitioner sought an order for medical bills, prospective medical treatment and temporary total disability benefits. Respondent disputed liability on the basis of accident and causal relationship.

Petitioner testified that on May 10, 2011, he was employed by Respondent which is a temporary agency that supplies workers to local employers with the agreement that if the individual completes a 90 day probationary period, he/she will be hired as a full-time employee. On the date of accident, Petitioner was two weeks away from completion of this probationary period.

Petitioner testified that on May 10, 2011, he was operating a pasta machine. This machine is a very large piece of equipment and it is necessary to walk up and down stairs to access various components of the machine. Operation of this machine required the Petitioner to push buttons and periodically (40 to 50 times during a work day) jump off of the machine and go up and down stairs to make necessary adjustments. As Petitioner was in the process of operating this machine, an alarm went off which meant that something was stuck in the machine and that there was a malfunction. When Petitioner heard the alarm, he responded by running up the stairs to turn off the machine and fix whatever the problem was. Petitioner testified that when such an alarm goes off, an immediate response is required because if the situation is not addressed quickly, both the machine and pasta product contained in it may be damaged. As Petitioner was running up the steps to the machine, he felt something twist in his right knee.

Following the accident Petitioner went to the ER of Sparta Community Hospital. The history in the hospital records stated Petitioner was walking upstairs and thought he may have twisted his knee. An x-ray of the right knee was obtained which was negative. Petitioner was given some medication and authorized to work light duty only with the assistance of crutches. On that same day, Petitioner was given a drug screening test (the results of which were negative) and in that report it stated that Petitioner "...went up stairs to answer alarm and foot caught in the step." In response to the question how the accident could have been prevented, Petitioner's response was "Slow down when answering alarm."

On May 11, 2011, Petitioner went to WorkCare Occupational Health where he was seen by Dr. Mark Austin. The history contained in the WorkCare record was that Petitioner was "...walking upstairs, foot got caught in last step, and somehow the knee twisted." Dr. Austin examined

Petitioner and suspected that there was a torn meniscus. Dr. Austin treated Petitioner conservatively but when he failed to improve, he ordered an MRI. An MRI was obtained on May 23, 2011, which revealed findings suggestive of a peripheral tear of the medial meniscus.

Dr. Austin referred Petitioner to Dr. Angela Freehill, an orthopedic surgeon. Dr. Freehill initially saw Petitioner on June 7, 2011. The history in her records stated that Petitioner sustained an accident at work on May 10, 2011, when he was going up the stairs, was on the last step, and he came down "wrong," twisting his right knee. Dr. Freehill examined the Petitioner and reviewed the x-ray and MRI that had been previously obtained. Dr. Freehill's initial diagnosis was a bony contusion and meniscus tear. She recommended a cortisone injection which Petitioner declined, so she prescribed physical therapy. Petitioner saw Dr. Freehill on June 28, 2011, and there was no improvement in his symptoms. At that time, Dr. Freehill recommended arthroscopy.

The Petitioner was authorized to be off work during the preceding periods of time.

On August 24, 2011, arthroscopy was performed which revealed no evidence of a meniscal tear; however, there was a large cartilaginous flap, and a defect going down into the trochlea, which is the anterior aspect of the femur and the joint with the patella. Dr. Freehill described this as a very large grade 4 lesion. Dr. Freehill was deposed on September 25, 2012, and her deposition was received into evidence at trial. When Dr. Freehill was question about whether there was a causal relationship between the accident and the condition she observed in Petitioner's right knee, she stated that the "...trochlear cartilage lesion with a – – what I assume is a twist or a kind of a flexed knee injury, where he went to plant his knee on the step, his knee got caught, and he had I would assume, a flexion injury to the knee, where there is a shearing force of the patella directly on the trochlea. With an angle or a twist, I can see that the patella would forcefully impact the trochlea and could possibly shear away some of the cartilage there, leaving a defect that we saw in surgery." It was Dr. Freehill's opinion that this is what happened in this case.

Dr. Freehill saw Petitioner on September 2, 2011, and recommended that Petitioner consider ACI or Genzyme surgery, which is a cartilage transplant type of surgery. She referred Petitioner to Dr. Ben Houle, her partner because of his experience in performing this particular type of surgery. Dr. Houle saw Petitioner on September 21, 2011, and noted that at the time of the prior surgery, Petitioner was found to have a femoral trochlear divot secondary to a work injury. Dr. Houle performed surgery on October 13, 2011, which consisted of a femoral trochlear cartilage graft.

Petitioner was seen by Dr. Houle on October 28 and November 9, 2011, and his condition improved to where he was moved from a walker to a cane and finally to full weight beaing. Dr. Houle prescribed physical therapy which further improved his condition until November 29, 2011, at which time Petitioner was getting out of bed and, without any further incident, his knee simply buckled causing additional symptoms. Petitioner was seen by Dr. Houle that same day. Further physical therapy and medication improved Petitioner's symptoms to the point that on February 8, 2012, Petitioner informed Dr. Houle that he wanted to go back to work light duty while avoiding stair climbing. On February 24, 2012, Dr. Houle gave Petitioner a light duty slip with no squatting, climbing or lifting greater than 20 pounds. Petitioner continued to experience some swelling of the top portion of the right patella and when seen by Dr. Houle on June 20,

2012, Dr. Houle was attempting to obtain an MRI of Petitioner's right leg to determine if there was anything else of significance going on inside of the knee joint and proceed from there. This MRI has not been performed as Petitioner is waiting for authorization for additional medical treatment.

Petitioner testified at trial that since the time Dr. Houle released him to return to work with light duty restrictions, he has been attempting to find work but has been unsuccessful. He further testified that he would like to undergo the MRI scan that has been recommended and whatever follow-up treatment is indicated.

On February 18, 2012, Petitioner was examined by Dr. W. Christopher Kostman at the direction of the Respondent. Dr. Kostman was deposed on February 29 and March 6, 2012, and the deposition was received into evidence at trial. Dr. Kostman testified that Petitioner described an injury that occurred to his right knee on May 10, 2011, but opined that his current condition was not related to this injury stating that it was related to his genetics and weight. While he also opined that the arthroscopic procedure performed by Dr. Freehill was appropriate given the failure of conservative management, he was not certain that all conservative management had been pursued and would not have performed the second procedure. On cross-examination, Dr. Kostman acknowledged that Petitioner had no symptoms or problems with his knee prior to the accident and agreed that Petitioner had joint effusion immediately following the accident and acknowledged that Petitioner was on crutches because of the pain. He still, however, stated that he did not believe that the knee symptoms were a result of the work accident.

Conclusions of Law

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

The Arbitrator concludes that Petitioner sustained an accidental injury arising out of and in the course of his employment for Respondent on May 10, 2011.

In support of this conclusion the Arbitrator notes the following:

Petitioner was the only witness to testify at trial and he was a credible witness on his own behalf. Petitioner testified that he periodically had to jump on and off the machine and go up and down the stairs to access the components on the machine. Upon hearing the alarm, Petitioner responded by running up the steps because when the alarm went off, an immediate response was required to avoid damage to both the pasta machine and the pasta contained in it. This testimony was unrebutted.

The fact that the histories provided to the various medical providers described that Petitioner was "walking" or simply "going up" the stairs does not negate that Petitioner was responding to an alarm and moving at a faster than normal rate. It is noteworthy that in the report of the drug test, Petitioner stated that the accident may have been avoided by his slowing down when answering the alarm.

Petitioner sustained the injury to his right knee as he was in the process of responding to an alarm in haste because he did not want Respondent's machine or product to be damaged. While performing this job duty, Petitioner twisted his right knee and immediately felt pain and sought medical treatment shortly thereafter.

The Arbitrator thereby concludes that Petitioner was exposed to a risk of injury to a greater degree than the general public.

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 May 10, 2011.

In support of this conclusion the Arbitrator notes the following:

Immediately following the accident, Petitioner had significant symptoms to his right knee and sought medical treatment. Prior to the accident, Petitioner had no right knee injuries or symptoms.

Dr. Freehill testified that the twisting type injury to the right knee sustained by Petitioner could have caused the pathology she observed which required the treatment provided by her and Dr. Houle.

The Arbitrator finds the opinion of Dr. Freehill to be more credible than that of Respondent's Section 12 examiner, Dr. Kostman, who opined that the accident late no role whatsoever in the right knee injury.

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

The Arbitrator finds that all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for the medical bills associated there with.

Respondent is to pay reasonable and necessary medical bills as identified in Petitioner's Exhibit 1 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of $27,875.38 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:

Petitioner is entitled to prospective medical treatment including, but not limited to, the MRI recommended by Dr. Dr. Houle and subsequent treatment resulting therefrom.

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

Petitioner is entitled to temporary total disability benefits of $253.00 per week for 75 weeks commencing May 17, 2011, through October 24, 2012, as provided in Section 8(b) of the Act.

In support of this conclusion the Arbitrator notes the following:

Petitioner has not been released for full duty by any physician, including Respondent's examiner. Dr. Houle placed Petitioner under work restrictions and has recommended additional diagnostic testing and possible treatment. In spite of the preceding, Petitioner has been attempting to find work within his restrictions but has not been successful in doing so.

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

Nathan Daniels,
Petitioner,
vs.

NO: 10WC 47066

14IWCC0071

Caterpillar, Inc.,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, employer-employee relationship, notice, 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 4, 2012, 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: FEB 0 3 2014
o012814
CJD/jrc
049

Charles J. DeVriendt

Michael J. Brennan

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DANIELS, NATHAN
Employee/Petitioner

Case# **10WC047066**

CATERPILLAR INC
Employer/Respondent

14IWCC0071

On 12/4/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0225 GOLDFINE & BOWLES PC
ATTN. WORK COMP DEPT
124 S W ADAMS ST SUITE 200
PEORIA, IL 61602

5035 CATERPILLAR INC
DARCY K GIBSON
100 N E ADAMS ST
PEORIA IL 61629-4340

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

NATHAN DANIELS, Case # **10** WC **47066**

Employee/Petitioner
v.

CATERPILLAR INC.
Employer/Respondent

141WCC0071

An *Application for Adjustment 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 Mathis**, Arbitrator of the Commission, in the city of **Peoria**, on **September 21, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☐ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other 8(a) Prospective Medical

FINDINGS

On **November 11, 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.

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 $0; the average weekly wage was $0.

On the date of accident, Petitioner was **36** years of age, *single* with **3** children under 18.

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 **N/A** for TTD, **N/A** for TPD, $**N/A** for maintenance and $ **N/A** for other benefits, for a total credit of $ **N/A**.

ORDER

- Based on the above findings, no benefits are awarded.
- The respondent shall pay the petitioner the sum of $ **N/A**/week for a further period of **N/A** weeks, as provided in Section **N/A** of the Act, because the injuries sustained caused **N/A**
- The respondent shall pay the petitioner compensation that has accrued from **N/A** through **N/A**, and shall pay the remainder of the award, if any, in weekly payments.
- The respondent shall pay the further sum of $ **N/A** for necessary medical services, as provided in Section 8(a) of the Act.
- The respondent shall pay $ **N/A** in penalties, as provided in Section 19(k) of the Act.
- The respondent shall pay $ **N/A** in penalties, as provided in Section 19(l) of the Act.
- The respondent shall pay $ **N/A** in attorneys' fees, as provided in Section 16 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.

S/ Malm

Signature of Arbitrator

11-27-2012

Date

ICArbDec p. 2

DEC - 4 2012

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Nathan Daniels, Petitioner, is 38 years old. He was hired by Caterpillar in September 2003 as a Lathe Operator, CNC Specialist. In October 2007, he moved to being a Metalworking Specialist in the Forge Department. In the Forge Department, Petitioner finished tractor links for D9, D10, and D11 models. He also finished D11 tarsands. There were four main jobs in the forge area. Petitioner said he would rotate between at least 3 of the 4 jobs on a weekly basis.

Petitioner explained the process of making tractor links in the forge area. He testified they would start with raw billets that sometimes had to be cut. The billets would be loaded into an automated heat inductor system and sometimes the billets at 2300 degrees would have to be picked up with large tongs to put back on the line. The billets then had to be sprayed so they did not stick together. This was done with a spray gun similar to what is used at a car wash. In the forge press area, Petitioner indicated he would have to use an air impact gun and wrench for tightening and adjusting the machinery and fork truck to accommodate the different sized billets. Petitioner would also use from time to time a 3-foot hammer to knock pieces of the machinery back into place. Petitioner testified this was the most difficult of the four jobs in the forge area.

Petitioner testified he would use an impact wrench to change dyes. This involved taking out/putting in 12 large bolts. This task was not done every shift. In the punch press part of the forge area, Petitioner used a large rod to move the billets along and flip every third billet to inspect it. This step also stamped a serial number in the link. If the number was wrong it would have to be grinded off and corrected.

On March 31, 2009, Petitioner reported to the Caterpillar medical office in his building and filled out a Caterpillar Employee Incident Report. Petitioner described the incident occurring on March 30, 2009 as "Swinging a long hammer at transfer fingers for adjustment on Line 2 main press noticed pain and popping noise in shoulder and hand on right side...." On line seven of the incident report, Petitioner described his injury or pain as "pain sharp in shoulder, tingle and numbness in right hand." (Resp. Ex. 1)

On the initial nursing assessment from March 31, 2009, the examining nurse listed Petitioner's right shoulder, right hand, right elbow and right arm as being effected by the incident. The "Narrative" section of the nursing report indicates, "Currently has dull ache when lifting arm, has pain pinch and pop in right shoulder, has pain in fingers and warm feeling going from palm to right elbow." (Resp. Ex. 1)

Petitioner first saw Dr. Kent Miller at the Caterpillar medical office on April 16, 2009. In the exam notes, Dr. Miller states Petitioner has right shoulder soreness for approximately 1 year from an insidious onset over time and the pain was mild before 3/30/09 event. Petitioner mentioned transient tingling/paresthesia in the last 3 fingers of the right hand occurring over the last 6 months and worsening over time with heat sensation eventually going to the elbow. In addition to his shoulder assessment, Dr. Miller wrote Petitioner had right lateral epicondylitis and right ulnar neuritis. (Resp. Ex. 1)

On 4/23/09, Petitioner saw Dr. Miller again. Dr. Miller wrote in the exam notes "Elbow better..." and "resolving right lateral epicondylitis and resolving right ulnar neuritis." On 5/4/09, after examining Petitioner Dr. Miller wrote "Right lateral epicondylar area still exhibits mild point tenderness over the epicondyle" and "Mild residual right lateral epicondylitis." On 5/13/09 and 5/27/09, Petitioner saw Dr. Miller but only Petitioner's right shoulder was discussed in the exam notes. On 7/2/09, after examining Petitioner, Dr. Miller wrote "Also reporting constant tingling and hair dryer sensation of variable intensity on ulnar forearm to elbow and last 3 digits of right hand." On 8/11/09, after examining Petitioner, Dr. Miller wrote "Paresthesia resolved but still has slight [decreased] sensation in ulnar distribution below elbow on right. Tinel [negative] at elbow

and wrist." This is the last exam Petitioner had with Dr. Miller where his right elbow and hand condition were mentioned. In his last visit with Dr. Miller on 9/28/09 only the shoulder was discussed. (Resp. Ex. 1)

According to the Caterpillar medical notes, work restrictions were placed on Petitioner from 3/31/09 through his shoulder surgery date of 8/26/09. (Resp. Ex. 1) Caterpillar was able to accommodate these restrictions. After his shoulder surgery on 8/26/09, Petitioner received TTD benefits. Petitioner's employment ended with Caterpillar on October 15, 2009, but Petitioner's TTD benefits for his shoulder condition continued through his release from treatment in December 2009.

On 7/21/09, Petitioner was seen for a consultation by Dr. Garst at the referral of Dr. Miller. On the "Shoulder History" form in addition to the information on Petitioner's shoulder, it is mentioned, "Patient has numbness and pain in his right palm and numbness in his lateral right hand as well." On 8/26/09, Dr. Garst performed surgery on Petitioner's right shoulder. On 9/8/09, Dr. Garst examined Petitioner for his shoulder condition but noted "He had full range of motion of his right elbow." On 10/13/09, Dr. Garst examined Petitioner for his shoulder condition. On 11/13/09, Dr. Garst examined Petitioner for his shoulder condition and noted "he is significantly improved." On 12/15/09, Dr. Garst examined Petitioner and released him back to regular duty for his shoulder as of 12/21/09 and stated "See him back as needed, but if there are any further problems or concerns, he will return." (Resp. Ex. 4)

After being released from Dr. Garst, Petitioner contacted Shannon Ahten, a workers' compensation adjuster for Caterpillar, regarding a settlement for his right shoulder condition. In January 2010, Petitioner contacted Shannon Ahten to accept a settlement offer for his right shoulder condition. On 2/17/10, Petitioner met with Shannon Ahten and Mark Peters, an attorney for Caterpillar to sign settlement contracts for his right shoulder condition. Then Petitioner, Shannon and Mark went before Arbitrator Mathis to have the contracts approved. (Resp. Ex. 6)

After his TTD benefits stopped on December 21, 2009, Petitioner received unemployment benefits from 1/9/10 to 7/31/10. On 6/21/10, Petitioner began to work at CNH, a farm equipment manufacturer, through STS Staffing, a temp agency. (Resp. Ex. 5) Petitioner's job at CNH was a mig welder and he performed his welding duties approximately 6 hours a day. Petitioner testified in August 2010 while working for CNH, his hand and elbow symptoms returned. Petitioner testified the hand and elbow numbness and pain that returned when he was working at CNH was at the same intensity it had been during his time at Caterpillar. Petitioner quit working for CNH on 10/3/10. (Resp. Ex. 5) Petitioner testified he had to quit working for CNH because his hand and arm numbness and pain was so bad he couldn't perform his job duties. Petitioner testified he began working for Midas as a mechanic in October 2010. His job duties involved changing tires, oil and sparkplugs. Petitioner used a half-inch air impact wrench to perform his work duties at Midas. Petitioner testified he stopped working for Midas on or about 12/20/10 because of his hand and elbow symptoms. It was at that time Petitioner decided to get a job with less hand intensive job duties.

In August 2010, Petitioner contacted Shannon Ahten to report his hand and elbow symptoms from the 3/30/09 incident had returned. After calling to report the symptoms, Petitioner received a letter from Shannon Ahten stating any further treatment was being denied. Shannon testified she denied Petitioner's request for treatment in August 2010 because Petitioner had closed out the 3/30/09 incident with the shoulder settlement in February 2010 and Petitioner had not worked for Caterpillar since 10/15/09. Shannon Ahten also testified she was not aware of Petitioner's ongoing right hand and elbow symptoms until Petitioner called her in August 2010 and she had received no treatment requests for the right elbow and hand condition from 3/30/09 through August 2010.

Petitioner testified after his symptoms returned while working for CNH and after Caterpillar denied further treatment, Petitioner sought the help of an attorney. Petitioner further testified he returned to see Dr. Garst on

11/8/10, because of the hand and arm symptoms that returned when he was working for CNH. On 11/8/10, after performing an examination, Dr. Garst diagnosed Petitioner with probable carpal tunnel syndrome and/or cubital tunnel syndrome in the right arm and recommended an EMG/NCV. On November 22, 2010, Dr. Garst called Petitioner to relay the results of the EMG/NCV. The test showed mild right carpal tunnel and cubital tunnel syndrome. Surgery and conservative care were discussed and Petitioner was to call Dr. Garst back to discuss further. (Resp. Ex. 4) At the time of trial, Petitioner had not yet undergone any treatment by Dr. Garst for his right hand and elbow condition.

Petitioner testified he had paresthesia, numbness, tingling, and pain in his elbow and hands every day from 3/30/09 through the day of trial. He testified sometimes the pain wakes him up at night. Petitioner testified he has known since 3/30/09, his ongoing right hand and elbow symptoms were related to his work at Caterpillar. Petitioner testified his shoulder condition from 3/30/09 was accepted and all necessary workers' compensation benefits were paid. Petitioner testified from 3/30/09 through his last day at Caterpillar on 10/15/09 no one denied treatment for his ongoing right hand and elbow condition.

Petitioner testified he did not request treatment from anyone for his ongoing right hand and elbow symptoms until he contacted Shannon Ahten in August 2010. Petitioner testified he did not mention his ongoing elbow and hand symptoms to Shannon Ahten until he contacted her in August 2010 while working for CNH. Petitioner admitted he had talked with Shannon on September 9, 2009 to discuss a settlement for a prior work comp claim on his forearm. He also admitted he talked with Shannon in December 2009, January 2010 and February 2010 for his shoulder settlement.

Petitioner testified he did not mention his ongoing right hand and elbow symptoms to Dr. Garst at any of the visits from July to December 2009 because he was only treating for his right shoulder not his hand and elbow. Petitioner testified he knew Dr. Garst treated elbow conditions because Dr. Garst had been his surgeon for his left-sided carpal and cubital tunnel releases in 2006. Petitioner testified after his left-sided carpal and cubital tunnel treatment in 2006, he immediately began treating with Dr. Garst for his left shoulder condition. Petitioner testified he did not mention his ongoing right elbow and hand symptoms to Dr. Garst until 11/8/10.

In his deposition, Dr. Garst testified Petitioner returned to see him on 11/8/10 with complaints of right hand pain and numbness and a history of "he has numbness and tingling in his right hand and it's been getting worse." (Pet. Ex. 1, Pg. 14) Dr. Garst was given a lengthy hypothetical by Petitioner's attorney and he opined, based on the hypothetical, Petitioner's condition on 11/8/10 was related to his work at Caterpillar. (Pet. Ex. 1, Pg. 23) Dr. Garst testified he had treated Petitioner regularly from 2005-2009 for other conditions and during those years there were no indications he had right carpal or cubital tunnel syndrome. (Pet. Ex. 1, Pg. 25.) Dr. Garst opined Petitioner's job duties as a mechanic were hand intensive and could have been contributive to Petitioner's right elbow and hand condition but Dr. Garst acknowledged Petitioner had only been doing this job for one month. Dr. Garst did author a letter to Petitioner's attorney dated March 15, 2011. In that letter Dr. Garst opined Petitioner's carpal and cubital tunnel syndrome could be related to welding duties at Caterpillar. (Resp. Ex. 4) Dr. Garst admitted in his deposition he gave this opinion on a false impression. (Pet. Ex. 1, Pg. 29)

On 2/8/2012, Petitioner saw Dr. Leon Benson for an examination pursuant to Section 12. Dr. Benson opined the symptoms Petitioner presented with at the exam were not related to his work at Caterpillar because so much time had passed between his work at Caterpillar and the onset of the current symptoms. (Resp. Ex. 2) In his deposition, Dr. Benson testified the Petitioner's symptoms were "reasonably mild so it would stand to reason they're relatively recent in forming." (Resp. Ex. 3, Pg. 14) Dr. Benson did testify Petitioner's job duties with Caterpillar could have aggravated his right elbow and arm condition, but if Petitioner had symptoms in 2009 it was a temporary aggravation. (Resp. Ex. 3, Pg. 22)

THE ARBITRATOR MAKES THE FOLLOWING FINDINGS WITH REGARD TO:

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

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

Petitioner is alleging two dates of injury for his right hand and elbow condition. The first date of accident is 3/30/09 which corresponds with the Employee Incident Report filled out with Caterpillar medical on 3/31/09. Petitioner is trying to relate his current right arm and elbow condition back to the conditions reported on 3/30/09, but there is no credible evidence to support Petitioner's position. The second date of accident, 11/11/10 corresponds to the date of Petitioner's EMG/NCV with Dr. Russo. In this claim Petitioner is trying to allege the findings on the EMG and his current condition are related to his work at Caterpillar, but again, there is no credible evidence to support this.

With regard to the issue of accident, both doctors, Dr. Garst and Dr. Benson, opined that Petitioner's carpal tunnel and cubital tunnel could have arisen out of the job duties as described at Caterpillar before 3/30/09, but to the contrary, primarily all evidence presented at trial, even Petitioner's own testimony, dispute his current condition is causally related to the 3/30/09 incident or his work duties at Caterpillar. The Arbitrator finds the following facts most important in breaking the causal relationship between Petitioner's current condition and his work at Caterpillar:

1. Petitioner's right elbow and hand were examined by Dr. Miller and addressed in most of Dr. Miller's exam notes through 8/11/09 and no treatment was ever recommended by Dr. Miller for the right elbow and hand.

2. Dr. Miller's notes in August 2009, state Petitioner's paresthesia had resolved.

3. Petitioner did not mention ongoing elbow or hand complaints to anyone until August 2010 nor did he request any treatment for the condition until that same time.

4. Despite seeing him regularly from August to December 2009, Petitioner did not seek treatment from Dr. Garst for the right elbow and hand.

5. Petitioner let almost a year pass before he saw Dr. Garst again in November 2010.

6. Petitioner had regular direct contact with his work comp adjuster, Shannon Ahten, from September 2009 through February 2010 and didn't mention the ongoing symptoms or the need for treatment until August 2010.

7. Dr. Garst testified Petitioner had no signs of right carpal tunnel or cubital tunnel at least through December 2009.

8. Dr. Garst's causation opinion is based on inaccurate information. The hypothetical presented to him alleged Petitioner worked in a hand intensive job with Caterpillar from January 2009 through his last day of employment in October 2010, a span of 10 months. When in fact, from 3/31/09 to 8/25/09 Petitioner was working light duty with significant restrictions. After 8/25/09, Petitioner was off work for his shoulder surgery and never returned to work for Caterpillar. Also in the hypothetical, Dr.

Garst was asked to assume Petitioner was on unemployment through September 2010. This is not true. Petitioner began working as a welder in June 2010.

9. Petitioner had not performed his regular duty job with Caterpillar since 30/30/09. He began working at a hand intensive job in June 2010 and another hand intensive job October 2010. It wasn't until after performing work duties as a welder and a mechanic, he sought treatment with Dr. Garst for his right elbow and hand.

10. Dr. Garst opined both welding duties and mechanic duties could cause carpal tunnel and cubital tunnel syndrome.

11. Petitioner testified his right elbow and hand symptoms returned after he began working for CNH as a welder. Petitioner went on to testify the return of the symptoms caused Petitioner to call Shannon and request approval for treatment in August 2010, seek consultation with an attorney shortly thereafter and seek treatment with Dr. Garst in November 2010.

Petitioner's testimony about the continuation of his symptoms from 3/30/09 is not credible. He could have mentioned the ongoing symptoms on several occasions to Dr. Miller, Shannon Ahten or Dr. Garst, but he didn't. He could have requested treatment on several occasions from Dr. Miller, Shannon Ahten or Dr. Garst, but he didn't. Beyond Dr. Miller's August 2009 note, the only evidence of additional right hand and arm symptoms came after not performing his regular work duties at Caterpillar for 18 months and after working for two different employers. The fact Petitioner testified his symptoms returned after working at CNH in itself says he didn't have symptoms everyday since 3/30/09. With such a gap in time, no treatment, no mention of symptoms and alternate employment, there is nothing to support causal connection. Based on all evidence, the Arbitrator finds there is sufficient evidence of an accident occurring on 3/30/09, but not for the accident date of 11/11/10. The Arbitrator finds with regard to causation, Petitioner failed to prove his current right elbow and hand condition is causally related to the 3/30/09 incident or to his work duties at Caterpillar. Based on these findings, no other findings are necessary and all requested benefits are denied.

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

Nathan Daniels,
Petitioner,
vs.

NO: 11WC 17421

14IWCC0072

Caterpillar, Inc.,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, employer-employee relationship, notice, 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 4, 2012, 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: FEB 0 3 2014
o012814
CJD/jrc
049

Charles J. DeVriendt

Michael J. Brennan

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DANIELS, NATHAN
Employee/Petitioner

Case# **11WC017421**

CATERPILLAR INC
Employer/Respondent

14IWCC0072

On 12/4/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0225 GOLDFINE & BOWLES PC
ATTN WORK COMP DEPT
124 S W ADAMS ST SUITE 200
PEORIA, IL 61602

5035 CATERPILLAR INC
DARCY K GIBSON
100 N E ADAMS ST
PEORIA, IL 61629-4340

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

NATHAN DANIELS, Case # 11 WC 17421

Employee/Petitioner
v.

14IWCC0072

CATERPILLAR 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 **Stephen Mathis**, Arbitrator of the Commission, in the city of **Peoria**, on **September 21, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ **Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?**
D. ☐ What was the date of the accident?
E. ☒ **Was timely notice of the accident given to Respondent?**
F. ☒ **Is Petitioner's current condition of ill-being causally related to the injury?**
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☐ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ **Other 8(a) Prospective Medical**

FINDINGS

On **March 30, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$45,315.40**; the average weekly wage was **$871.45.**

On the date of accident, Petitioner was **35** years of age, *married* with **3** children under 18.

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 **N/A** for TTD, **N/A** for TPD, $**N/A** for maintenance and $ **N/A** for other benefits, for a total credit of $ **N/A** .

ORDER

- Based on the above findings, no benefits are awarded.
- The respondent shall pay the petitioner the sum of $ **N/A**/week for a further period of **N/A** weeks, as provided in Section **N/A** of the Act, because the injuries sustained caused **N/A**
- The respondent shall pay the petitioner compensation that has accrued from **N/A** through **N/A** , and shall pay the remainder of the award, if any, in weekly payments.
- The respondent shall pay the further sum of $ **N/A** for necessary medical services, as provided in Section 8(a) of the Act.
- The respondent shall pay $ **N/A** in penalties, as provided in Section 19(k) of the Act.
- The respondent shall pay $ **N/A** in penalties, as provided in Section 19(l) of the Act.
- The respondent shall pay $ **N/A** in attorneys' fees, as provided in Section 16 of the Act.

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

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

Signature of Arbitrator

11-27-2012
Date

ICArbDec., p. 2

DEC - 4 2012

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

This claim was consolidated with case 10 WC 47066 and all written findings by the Arbitrator are attached to that case number.

14IWCC0072

STATE OF ILLINOIS)
) SS.
COUNTY OF HENRY)

☒ 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

Marilyn Hancock,
Petitioner,

vs.

NO: 10WC 25331

14IWCC0073

Illinois Department of Corrections - Dixon,
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, 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 December 11, 2012, 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: FEB 0 3 2014
o012814
CJD/jrc
049

Charles J. DeVriendt

Michael J. Brennan

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HANCOCK, MARILYN
Employee/Petitioner

Case# **10WC025331**

IL DEPT OF CORRECTIONS-DIXON
Employer/Respondent

14IWCC0073

On 12/11/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% 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:

1097 SCHWEICKERT & GANASSIN
MARK M WILSON
2101 MARQUETTE RD
PERU, IL 61354

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0988 ASSISTANT ATTORNEY GENERAL
BRETT D KOLDITZ
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

DEC 11 2012

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0073

STATE OF ILLINOIS)
)SS.
COUNTY OF HENRY)

☐ 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

MARILYN HANCOCK,
Employee/Petitioner

v.

ILLINOIS DEPARTMENT OF CORRECTIONS-DIXON,
Employer/Respondent

Case # 10 WC 25331

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 H. Pulia**, Arbitrator of the Commission, in the city of **Kewanee**, on **11/14/12**. After reviewing all 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 **4/30/10**, 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 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 **$44,999.76**; the average weekly wage was **$865.38**.

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*** 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

The petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left arm, elbow, and hand due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 4/30/10, and she has failed to prove by a preponderance of the credible evidence that her current condition of ill-being as it relates to her left arm, elbow, and hand is causally related to any alleged injury on 4/30/10. The petitioner's 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

12/4/12
Date

DEC 11 2012

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 50 year old corrections officer, alleges she sustained an accidental injury to her left upper extremity due to repetitive trauma that arose out of and in the course of her employment, and manifested itself on 4/30/10. Petitioner had been employed by respondent for 30 years, and assigned to the Control Room in Housing Unit 27 for 2 years. Her shift was from 7 am to 3 pm. Petitioner is claiming that she sustained an accidental injury to her left upper extremity due to the repetitive way her left hand reached for the control panel buttons and chuck hole.

Respondent offered into evidence pictures of a control room that was similar to the control room where she worked on in Housing Unit 27 (RX7-9). Petitioner testified that she would sit in the same position as the officer in the photos. Petitioner testified that the chuck hole was beyond her reach if sitting in the chair. She stated that to reach it she would have to get up from her chair and lean forward. When she did this petitioner would push up off the desktop with the palm of her left hand and then extend with her right hand to the reach the chuck hole. When petitioner operated the control panel she would grab the edge of the desk with her left hand and scoot over to reach the control panel with her left hand. Petitioner testified that sometimes her chair had wheels and sometimes it did not. At times she sat in a plastic chair like the one shown in Respondent Exhibit 7. Petitioner stated that the floor tile in the Control Room was old, brittle and torn up, leaving the surface very rough. She also stated that there were some holes in the wood subsurface, and the wheels did not always turn.

Petitioner testified that she would go from the control panel to the chuck hole all day long. She stated that she was busy all day long except during early morning at about 8, during lockdown, and during breakfast and lunch. Petitioner testified that other than at these times she was continuously scooting her chair to reach the chuck hole and control panel. Petitioner would primarily use the front door and day room door buttons on the control panel. These buttons opened theses doors.

Petitioner used the front door and day room door buttons to open those doors to let the inmates move through the building for job assignments, go to the library or medical, in guard lines, gym lines and back and forth from meals. By pushing the button on the control panel the door would unlock. Petitioner testified that if there was a line of 40 inmates she might have to press the button 15 times because the inmates were not good about holding the door open for each other. Petitioner testified that she operated the control panel three out of the five days she worked a week. The other two days petitioner went to court with the inmates. When she went to court she carried a lot of bags filled with things such as lunches and extra shackles. She testified that the bag weighed 10-20 pounds. Even though she had another officer with her she would usually carry the bags and the

other officer would handle the inmates. She carried the bags anywhere from 100 feet to ½ of a block. She also opened doors.

Petitioner testified that she noticed problems with her left upper extremity in the spring of 2010. The pain in her left elbow started 5 months earlier. She stated that she noted numbness when she carried heavy items with her left hand. Petitioner gave a history of a right carpal tunnel release in 1992.

When petitioner first noticed her symptoms in her left upper extremity she called her primary care physician Dr. Inciong, who referred her to Dr. Shin and prescribed a Medrol dose pack. Petitioner presented to Dr. Shin on 4/30/10. She complained of left elbow pain and some popping sensations for the past 5-6 months. She stated that she had no known injury but did do a lot of reaching to the left over and over again at work. She stated that a prescription of Medrol dose pack gave her some relief. However, as soon as she finished it the pain returned in 2-3 days. She rated her pain from 4 to 10 on a scale of 10. She also stated that she had taken Naprosyn in the past with some relief. She described the pain as stabbing, dull and sharp in nature in her olecranon, over the olecranon bursa and over the distal end of the triceps. She also stated that sometimes it would radiate up her arm just along the most distal aspect of the triceps musculature. She stated it was fairly intermittent and was getting worse. She also reported numbness and tingling due to carpal tunnel on the left, and weakness in the left hand due to her carpal tunnel. She gave a history of smoking a pack of cigarettes a day for the past 30 years. She gave a history of numbness and tingling in both hands in the past, and a carpal tunnel release on the right in the past.

Following an examination and imaging, Dr. Shin assessed left elbow pain, left olecranon bursitis, left triceps tendonitis, and left carpal tunnel syndrome. Dr. Shin discussed her history of left carpal tunnel with petitioner. Petitioner stated that she did not undergo a left carpal tunnel release when she had the right done because she only had weakness, numbness and tingling, and not any pain. Dr. Shin recommended surgery because petitioner had bilateral thenar atrophy with the left side worse than the right. He recommended a left carpal tunnel release to prevent further thenar musculature loss. With respect to her left elbow he recommended Aleve and physical therapy to decrease the inflammation.

Petitioner gave notice to respondent on 5/5/10 when she reported an injury due to opening locks and the way she used her left hand to use the control panel. She alleged carpal tunnel syndrome of the left hand. Petitioner filled out an accident report that day and reported repetitive strain injury to her left hand while opening locks.

On 6/7/10 petitioner returned to Dr. Shin. He discussed the risks and benefits of the surgery with petitioner. Petitioner reported that her complaints were unchanged. Dr. Shin noted that her thenar atrophy on the left was the same as the right, maybe slightly worse. She had positive Tinel's sign and Durkan's test on the left. Dr. Shin assessed left carpal tunnel syndrome. Dr. Shin recommended an EMG of the left upper extremity, as it appeared to be a standard of care in this region and because her symptoms were milder on her left side than on her right side when she had surgery. Dr. Shin reviewed petitioner's job duties and anticipated that she would be off work 2-3 weeks after surgery, then return to light duty. Dr. Shin noted that her olecranon bursa and triceps region was improved. Petitioner also asked Dr. Shin to evaluate her bilateral knees which were painful and weak. Dr. Shin assessed bilateral knee pain, bilateral patellofemoral syndrome, bilateral knee degenerative joint disease, and left triceps tendonitis.

On 6/24/10 petitioner underwent a left carpal tunnel release. Her postoperative diagnosis was left carpal tunnel syndrome. Petitioner followed up postoperatively with Dr. Shin. This treatment included physical therapy. On 6/30/10 petitioner reported decreased numbness in her thumb, index and middle finger. She stated that the little bit of elbow pain she had postoperatively was gone.

On 7/2/10 petitioner filed her Application for Adjustment of Claim. She alleged injuries to her left arm, elbow and hand while performing job duties. She alleged an accident date of 4/29/10. Petitioner amended this alleged date of accident to 4/30/10 at trial. Respondent had no objection.

On 7/16/10 petitioner reported to Dr. Shin steady but slow improvement. She also reported to Dr. Shin that she had new left elbow pain and a right wrist mass. She reported that she could use her hands more, but did not have full strength grip. She reported tenderness in the left elbow in the olecranon and the triceps area. She reported new pain over her lateral epicondyle. She stated that when she twists and picks up objects it hurts. She denied any numbness or tingling. She reported some radiation down the dorsal aspect of her forearm toward her wrist. Dr. Shin continued petitioner off for another week.

Petitioner was off work from 6/24/10 through 7/24/10. She returned to full duty work on 7/25/10. Petitioner testified that after returning to work she performed her full duty job until she retired in June of 2012. Petitioner testified that during this period she still had pain in her left hand and wrist or elbow when carrying anything heavy. She reported weakness in her left hand due a lot of muscle atrophy. She testified that she had a weak grip and her elbow bothers her once in a while when she lifts or turns it a certain way.

On 8/6/10 petitioner followed-up with Dr. Shin. Her carpal tunnel was doing quite well. Her triceps tendonitis was improved. Her medial epicondylitis and forearm strain symptoms were more severe. He

recommended that she continue her use of Aleve and therapy to help the thumb, forearm, and elbow. Dr. Shin noted that since some areas were feeling better and some worse, he just wanted to try to globally decrease the inflammation. Dr. Shin was of the opinion that petitioner's cubital tunnel syndrome was fairly mild. Dr. Shin recommended that petitioner try to keep her elbow straighter. On 9/6/10 petitioner reported that her triceps and medial epicondyle had improved back to normal, and her left cubital tunnel had improved slightly. Petitioner stated that she had returned to full duty three weeks prior and reported less problems than she expected. She reported some residual weakness in her left hand and grip. Dr. Shin continued petitioner in therapy and told her to keep her elbow straight. On 10/18/10 petitioner reported that the pain about her elbow was almost completely resolved. She stated that it was 90% better. She denied any deep radiation or pain, numbness or tingling into her hand. She stated that her left hand was still somewhat weak, but getting stronger. Dr. Shin assessed that her left carpal tunnel syndrome was doing well, her left triceps tendonitits was improved, her left medial epicondylitis was resolved, and her left cubital tunnel was resolved. Dr. Shin believed her strength would continue to improve in her left hand. Dr. Shin instructed her to continue with her home exercise program. Dr. Shin released petitioner from his care on an as needed basis.

On 8/5/11 Petitioner underwent an independent medical examination performed by Dr. Robert Eilers. Petitioner gave a history of developing numbness and tingling in the left upper extremity, as well as pain in the epicondylar area. She stated that she reported it on 4/29/10. She gave a history of working in the control room and transporting prisoners. She stated that she carries heavy bags of chains for handcuffs, leg irons and leg cuffs, as well as her weapon. She noted that while working in the control room she would sit at the counter and pass information under her window, and then open and close doors by pushing a button. She stated that these were beyond the normal arm's reach. She noted that she would have to scoot and reach continuously throughout the day. She stated that she would have to reach about 4 feet to reach the hole to pass things through and 4 feet to the control panel. She also stated that she was constantly twisting, turning and reaching in order to see the mirror and door behind her and to her side to carry out her job. She stated that she developed left hand numbness and tingling, as well as left elbow pain and stiffness. She stated that she could not straighten her left elbow, then took a leave and it helped somewhat. She stated that in January of 2010 she had to go qualify for firearms, and she could not use her right hand to cock the gun or pull the slide. Petitioner gave a history of her treatment with Dr. Shin.

Petitioner gave Dr. Eiler a work history of constantly reaching farther than the normal 24 inch reach that is usually accompanied in the front extremeties, such as a kitchen counter. Petitioner told Dr. Eiler she was reaching up to 4 feet, scooting a stool and reaching. Dr. Eiler was of the opinion that these actions caused

petitioner to hyperextend and reach out with the arm on a continuous basis, scooting chairs, grabbing at the counter in order to pull, and using her hand to pull along the desk and counter in order to reach out to turn on the switches to open and close the various panels. She stated that she did this repeatedly throughout an 8 hour day, outstretching her left arm. She also reported that she had to reach to pass folders and materials through the pass-through base of the window continuously, in addition to the looking over her shoulder to the window. With respect to the control panel she stated that she would have to reach over with her body and then push and lift her hand from those controls rather than having them within a close reach. Again she stated that she did this throughout the day, and this contributed to her condition. Dr. Eilers believed her setup was not ergonomically designed. He noted that with her constant reaching, she would lean on the elbow and reach forward, and this caused the olecranon bursitis that she had, and the constant reaching in order to reach the controls on the far side caused her triceps tendonitis. He noted that both these conditions improved in therapy.

Following an examination and record review Dr. Eilers' impression was left carpal tunnel secondary to repetitive work activities of reaching, pushing and using weapons, which was a recurring problem that she had had within her work setting; left triceps tendonitis, resolved; left medial epicondylitis which is resolving and showing minimal findings on examination; and resolving left cubital tunnel syndrome. Dr. Eilers opined that petitioner's findings were consistent with an overuse syndrome due to poor ergonomic design. He was of the opinion that it was relatively classic with her left upper extremity developing the carpal tunnel, the olecranon bursitis, as well as the median epicondylitis which she described due to having to reach up to 3-4 feet. He was of the opinion that petitioner was exceeding the normal reach zone of 2 feet by upwards of 2 feet to reach the control panel. Dr. Eilers believed petitioner did this anywhere from 40-100 times an hour in an 8 hour day. He believed this would be considered repetitive. He also believed that with scooting and reaching, generally one would have to lean on the elbow and reach out. Dr. Eiler also believed that her table heights were higher and almost to her chest level. He was of the opinion that this would be more aggravating because she would be reaching and extending and impacting the olecranon with these activities, as well as slightly supinating in order to try and reach the buttons at a distance, hyperextending and extending her wrist. Dr. Eilers was of the opinion that these types of patterns she described were consistent with poor ergonomic design, and have resulted in her epicondylitis, the olecranon bursitis, as well as the cubital tunnel syndrome. He was of the opinion that all these things are related to hyperextension, and her reaching and resting on the olecranon. He also believed her carpal tunnel was caused by these repetitive tasks, as well as those of lifting, carrying, and the hauling of chains and other devices.

Dr. Eilers opined that petitioner's work activities are the direct and proximate cause of her injuries that were diagnosed on 4/29/10. He further opined that the treatment for the olecranon bursitis, carpal tunnel and the epicondylitis is directly related to the injury she sustained. He recommended a more ergonomical work setting.

On 12/1/11 the evidence deposition of Dr. Eilers was taken on behalf of petitioner. Dr. Eilers believed that petitioner would push up onto her left elbow and the put her left palm on the table to scoot up, and then reach to the window with her right hand. He opined that she pressed the buttons with her left hand. Dr. Eilers noted that petitioner had left hand numbness, tingling and numbness for 30 years, but only worked for respondent for 19 years. He also testified that he did not know how much the duffle bag she carried to court weighed, how often or long she carried it, and which hand she carried it in. He also did not know what time frame she carried this bag to court. Dr. Eilers also testified that he did not know where the buttons she pushed were located in relation to where she worked, or how much pressure was needed to press the button. Dr. Eilers also believed petitioner had to reach four feet to reach the chuck hole over a very high table. Dr. Eiler testified that he did not see a written job description detailing the scope of petitioner's job activities. Dr. Eilers could not state with any certainty the frequency with which petitioner reached and/or pushed the buttons. He did not think it mattered. He believed it was the activity itself that caused the problem.

Petitioner testified that she had a history of left hand pain, numbness and tingling for over 30 years. Then she stated that her right hand problems started that far back and her left hand symptoms started more recently. She attributed her right carpal tunnel to the opening of locks at another prison. She stated that she had no pain in her left hand when she had her right carpal tunnel release done. She also stated that in the time period leading up to the alleged injury she had different duties and did not got to the towers.

On cross examination petitioner testified that while working she covered two meals per day for the inmates and got a 30 minute break for herself. Petitioner testified that the chuck hole is used for passage of inmate work cards or passes. Petitioner testified that she would buzz in using the control panel button 100-120 times a day. She also testified that she reached to the chuckhole 100 times a day. She testified that throughout the day she did not always sit to perform her job. She testified that if she performed her job standing she would have to reach forward to get to the chuck hole. Petitioner testified that if a large line of inmates was passing through the doors she did not use the chuck hole. That was used only for passes. Petitioner testified that she would buzz the inmates in for food lines, gym lines, yard lines and school lines. For each worker or person with a pass she would access the control panel twice.

Petitioner testified that each time she pushed the control panel button 100-120 times a day it only took a second. She also testified that it only took a few seconds each time she had to reach for the chuckhole 100 times

a day. She agreed that the total time she spent pushing the button on the control panel was 2 minutes a day, and reaching to the chuckhole was a total of 6 minutes a day. When petitioner carried the duffle bags it was to and from the courthouse one time each time she took a prisoner to court. Petitioner did this two times a week. She testified that she carried the bag with her left hand.

On redirect examination petitioner testified that it was the reaching for the chuckhole and pushing off the counter to reach the chuck hole that caused her problems. She testified that the act of pushing the button did not cause her problems, but rather grabbing the counter and scooting over to the control panel to push the button that caused her problems. Petitioner testified that she did not use her feet to move the chair over to the control panel because the floor tile was broken. Petitioner denied her symptoms in her left hand in 2004 were due to carpal tunnel. She testified that that she believed they were due to the ruptured disc in her neck at that time.

Curt Eubanks, Public Service Administrator and Unit Superintendent at Dixon, was called to testify on behalf of the respondent. Eubank was the Duty Administrator for the Dixon facility, and performed inspections tours of the institution. He had knowledge of the control room and the job duties. He also had general knowledge of the control room officer job from working occasionally as a control room operator from 1985-1989. He testified that he was familiar with Control Room 27. He agreed that the tile in that control room was worn like in the other control rooms.

Eubanks testified that a control room officer is responsible for the security of the housing unit through the control and movement of the inmates and surveillance of the inmates and staff. He stated that the control room officer is also responsible for logging unit activities and reporting incidents. Eubanks testified that the job is mostly performed while sitting. Eubanks testified that petitioner would leave the control room each morning to verify the inmate count in the housing unit. To do this, petitioner would leave the control room and physically walk the unit and verify the count of the inmates.

Eubanks agreed that when large blocks of inmates are in line movement there may be gaps and petitioner may be have to hit the control button multiple times to open the doors. He testified that the morning meal line contains about 100-125 inmates and 2 officers escort them. He also testified that the chuck hole is used for work passes, education passes, and medical, dental or psych passes. He stated that passes are used for individual movement. No passes were needed for group movement. Eubanks testified that during the day shift, which petitioner worked, she may be presented with up to 40-80 passes a day through the chuck hole. Eubanks testified that in addition to her work at the control panel petitioner was also required to take inventory of three sets of keys, radio and other special equipment and enter it on a shift report.

Petitioner testified that she has been a ½ pack a day smoker for twenty years.

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?

Petitioner is alleging an accidental injury to her left arm, elbow and hand due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 4/30/10.

As a general rule, repetitive trauma cases are compensable as accidental injuries under the Illinois Worker's Compensation Act. In Peoria County Belwood Nursing Home v. Industrial Commission (1987) 115 111.2d 524, 106 Ill.Dec 235, 505 N.E.2d 1026, the Supreme Court held that "the purpose behind the Workers' Compensation Act is best serviced by allowing compensation in a case … where an injury has been shown to be caused by the performance of the claimant's job and has developed gradually over a period of time, without requiring complete dysfunction.." However, it is imperative that the claimant place into evidence specific and detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

The arbitrator finds the credible medical evidence shows that petitioner was diagnosed with bilateral carpal tunnel syndrome in 2004 when she underwent her right carpal tunnel release. Although petitioner had complaints of tingling and numbness in her left hand at that time she did not have any pain. As such, petitioner did not undergo any surgery for the left hand in 2004.

It is unrebutted that petitioner has worked for respondent for 30 years, and has been assigned to the control room for the past two years. Respondent offered into evidence three pictures of another control room that petitioner testified was the same as the one in Housing Unit 27, where she worked. She also testified that she would sit in the same position as the female in the picture was sitting. The petitioner gave a history to Dr. Eilers that she would have to reach 4 feet to reach the chuck hole. Neither party offered into evidence the exact length of the table petitioner worked at. However, after viewing respondent's exhibit 9 the arbitrator finds that if petitioner was sitting where the officer in the picture is, like she stated, the distance she would need to reach to get to the chuck hole looks more like a distance of a two feet at most.

The petitioner testified that to reach the chuck hole she would place the palm of her left hand on the edge of the table and push up and then reach to the chuck hole with her right arm. Petitioner offered no testimony that she would put any weight on her elbow on the desk when she performed this movement. In fact, she stated all the weight was on her left palm when she pushed up off the table.

Petitioner testified to reach the control panel, which appears in respondent's exhibit to be no further than two feet from where the officer is positioned in the picture, she would grab the edge of the table with her left hand and scoot her chair over so that she could reach the control buttons with her left hand. Petitioner testified that her left elbow would be extended when she would reach to press the buttons on the control panel. The arbitrator finds that if this is the case the petitioner would most likely not scoot more than a foot or so from where the officer is seated in respondent's exhibit 9 to be able to reach the control panel with an extended left arm. If petitioner scooted over further than that there would be no need for her to have her arm fully extended to reach the buttons on the control panel.

Petitioner would only work in the control room 3 out of the 5 days she worked per week. At the beginning of her shift she would leave the control room to verify the count of inmates in the Housing Unit. This would take maybe 5 minutes. She testified that she worked in the control room from 7 am to 3 pm. Petitioner testified that she got a 30 minute lunch during that period. Eubanks also testified that in addition to her work at the control panel petitioner would also be required to take inventory of three sets of keys, radio and other special equipment and enter it on a shift report each shift.

Petitioner would press the buttons on the control panel to let inmates move through the building for job assignments, going to the library or medical, in guard lines, gym lines and to and from meals. Petitioner testified that it was not the act of the pushing the button on the control panel that caused her problems, but rather the act of grabbing the edge of the table to slide over to press the button. Petitioner testified that she may press the control panel button 100-120 times a day. However, she also testified that many of these button pushes were associated with lines of inmates moving through at one time. For example, she stated that if a line of 40 inmates were passing through a door she may have to hit the button on the control panel 15 different times. The arbitrator notes that even though petitioner may have to hit the button 15 times to get the line through the door, she would only have to shift over to the panel once to push the button 15 times to let the line go through. Based on this testimony, the arbitrator reasonably infers that even though petitioner may have to hit the control panel button 100-120 times per day, the actual number of times she would have to scoot herself over to the control panel using her left arm could be considerably less than the total number of buttons pushed given that there could be up to 15 button pushes associated with only one scooting with the left hand.

With respect to the chuck hole the petitioner testified that she had to press down with the palm of her left hand on the edge of the table to push up so that she would reach the chuck hole with her right hand to process the passes. Petitioner testified that she would have to get up on the palm of her left hand about 100 times a day

to reach the chuck hole. However, Eubanks testified that petitioner may be presented with only 40-80 passes a day through the chuck hole.

Petitioner testified that the total time per day she spent reaching to the chuck hole and reaching to the control panel was less than ten minutes during her entire shift.

Petitioner testified that the two days she is not in the control room she is transporting prisoners to court. She testified that she is usually responsible for carrying the duffle bag with lunches and extra shackles. She testified that the bag would weigh between 10-20 pounds and she would carry it in her left hand from the Housing Unit to the car, from the car to court, from court back to the car, and then back into the housing unit. The distance she would carry the bag would vary from 100 feet to ½ block when she was at court. The arbitrator finds the most petitioner would carry this bag is 6 times a day, two days a week, with most distances being very short.

Based on the above, as well as the credible record, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left arm, elbow, and hand due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 4/30/10.

Petitioner provided a history to Dr. Shim of reaching to the left over and over again at work. The arbitrator finds this history inconsistent with the credible record. When petitioner had to reach to the chuck hole she pushed up on her left palm and in fact reached to the chuck hole with her right arm. And with respect to the control panel, petitioner testified that the reaching to push the button was not the problem. She stated that it was the grabbing of the table with her left hand to shift towards the control panel. Petitioner did this action far less than she did the pushing of the buttons on the control panel.

When petitioner presented to Dr. Eilers she reported that she had to scoot and reach continuously throughout the day. She also stated that she had to reach four feet to reach the chuck hole and another four feet to reach the control panel, and testified that she was constantly twisting, turning and reaching in order to see the mirror and door behind her and to her side. Dr. Eilers believed that petitioner would lean on her left elbow to reach the chuck hole. The arbitrator finds these activities are inconsistent with the testimony petitioner provided at trial and the credible evidence, including the respondent's exhibits 7-9. Additionally, in his deposition Dr. Eilers did not know the weight of the duffle bag petitioner carried, how long she carried it, or how much it weighed. He also did not know where the buttons petitioner pushed were in relation to where she worked. Dr. Eiler could also not state with any certainty the frequency with which petitioner reached and/or pushed button.

The arbitrator finds it discerning that Dr. Eilers did not feel that these things mattered as they relate to his opinions.

Based on the above, as well as the credible record, the arbitrator finds the opinions of Dr. Eilers and Dr. Shin were based on a job history that was not accurate with the actual duties petitioner performed. As such the arbitrator does not give much weight to the causal connection opinions of Dr. Shin and Dr. Eilers. 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 left arm, elbow, and hand is causally related to any alleged injury on 4/30/10.

J. WERE THE 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?
L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury to her left arm, elbow, and hand due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 4/30/10, and she has failed to prove by a preponderance of the credible evidence that her current condition of ill-being as it relates to her left arm, elbow, and hand is causally related to any alleged injury on 4/30/10, the arbitrator finds these 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

Paul Smith,
Petitioner,

14IWCC0074

vs.

NO: 12WC 32900

State of Illinois - Southwestern Illinois Correctional Center,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of 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 January 14, 2013, 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: FEB 0 3 2014

o012814
CJD/jrc
049

Charles J. DeVriendt

Michael J. Brennan

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SMITH, PAUL
Employee/Petitioner

Case# **12WC032900**

ST OF IL/SOUTHWESTERN ILLINOIS CORRECTIONAL CENTER
Employer/Respondent

14IWCC0074

On 1/14/2013, 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 0.10% 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:

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WORKERS' COMPENSATION CLAIMS
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CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

JAN 14 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0074

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 Smith
Employee/Petitioner

v.

State of Illinois / Southwestern Illinois Correctional Center
Employer/Respondent

Case # 12 WC 032900

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 **Springfield**, on **November 9, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **7/25/12**, 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 $**45,816.00**; the average weekly wage was $**881.08**.

On the date of accident, Petitioner was **30** years of age, ***single*** with **1** dependent child.

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

Respondent stipulated it will pay all appropriate charges for all reasonable and necessary medical services.

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of **$649.00**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$528.65**/week for 24.3 weeks, because the injuries sustained caused the 15% loss of **Petitioner's left eye**, 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

Jan. 4, 2013
Date

JAN 14 2013

Findings of Fact

Petitioner is a Correctional Officer at Southwestern Illinois Correctional Center. As a part of his employment, Petitioner is a member of the TACT team. The TACT team is a Special Operations Response Team (SORT) that takes care of riots, hostages, staff assaults, major shakedowns, and searches of facilities. SORT is called in to handle violent situations within prisons throughout the State of Illinois. To be a part of this Special Operations Response Team, Petitioner is required to attend 40 hour certification training course in Springfield, Illinois.

Petitioner explained that part of his training includes getting sprayed in the face with a chemical agent known as pepper spray. The purpose of this portion of the training is to give the officer of an understanding of what it feels like to have a chemical agent deployed so that the officer does not panic and is able to fight through the sensation during a riot situation. Furthermore, the training assists the officers to have empathy so that the officer doesn't use this chemical agent on an inmate in an unjustified manner.

During the week of 7/25/12, Petitioner was in Springfield for TACT training. Petitioner described that he was to be sprayed with pepper spray and then go through an obstacle course. When an officer is sprayed with pepper spray, he is to cover one eye with his palm and then look at the instructor who that is going to spray him with the chemical agent. He is instructed to state his name, rank, and institution. After he does so, he is to close his eye and then be sprayed in the mucous membrane. As the officer opens his eye, the chemical agent is to run into the eye and you are to look at the instructor until you are told to run through the obstacle course. The first portion of the obstacle course requires throwing ten elbow strikes at an instructor holding a pad. The second portion of the obstacle course requires running to the next station in which the officer throws ten knee strikes to an instructor holding a pad. The third station requires the officer to throw ten punches, take an inmate down, and hand cuff the inmate. The officer is then to be taken to decontamination.

On 7/25/12, Petitioner testified that this procedure was not followed completely. As he stood in front of his instructor, he covered one eye, looked at him, began to state is name, rank, and institution, but before he could get any further than his name, he was sprayed directly into his left eye. Petitioner closed his eye, finished what he was supposed to say, opened his eyes and looked at the instructor and was sprayed again for the second time in his open eye. Petitioner testified that he was able to complete the obstacle course and his training in Springfield, however, with much difficulty.

Petitioner described that the second day, his left eye was very irritated and very red. It was sensitive to light and the vision on his left was "pretty much gone," meaning everything was blurry. He could not make out anything more than 5 feet away from his left eye. Petitioner testified that his right eye, while irritated initially, resolved with no problems. Petitioner's left eye became so sensitive to light that he had to wear sunglasses, not only inside the gymnasium in Springfield, but also in his house when he returned home. He folded a wash cloth over his eye and taped it underneath sunglasses so he could bear sitting on the couch and looking at the TV. He testified he experienced a migraine because of the filtering of the light into his eye. Petitioner decided that he needed medical treatment and obtained this as soon as he returned from training.

Medical records indicate that Petitioner saw Dr. Trent McDaniel on 7/27/12 at 4:30 p.m. Dr. McDaniel took a consistent history of injury and noted that Petitioner continued to suffer with redness, drainage, and photophobia in his left eye. Physical examination revealed that Mr. Smith had moderate diffuse conjunctivitis of the left eye. Fluorscein examination revealed two moderately sized corneal abrasions, one on the interior aspect and one on the inferior aspect of his left cornea. Assessment was corneal abrasion, secondary to pepper spray in his eyes two days ago. Dr. McDaniel contacted poison control and they recommended a referral to an eye doctor. Dr. McDaniel personally spoke with Dr. Johnson at Illinois Eye Surgeons in Breese, who agreed to see Mr. Smith right away. Petitioner was instructed to go straight to Dr. Johnson's office in Breese that evening for "further and immediate evaluation."

The record reflects that on the same date, Petitioner was seen by Illinois Eye Surgeons. The history was pepper spray in left eye with corneal abrasion. Dr. Johnson noted a positive examination for photophobia and pressure in Petitioner's eye. The records note "feels like someone is pushing on eye." Examination was positive for water, matted shut, yellow junk, and blurry vision. Petitioner's eye exam revealed 20/20 vision in the right eye and 20/40-2 in the left eye. Dr. Johnson's impression was injury from close range, pepper spray. Medication and follow up were recommended.

Petitioner testified as to his examination at Illinois Eye Surgeons. A paper stick was used to put different dyes in his eyes. He was able to see UV light that infiltrated the inside of his eye because of the hole pierced through his cornea. It was his understanding that the UV light should have only been on the outer portion of his eye. Petitioner understood his diagnosis that there was a chemical burning inside of his cornea and there had been a hole pierced into his cornea by the stream of pepper spray. Petitioner was referred to a retinal specialist the next day. He was given a contact lens bandage to place over his eye to keep air and everything out of it until he saw the specialist the following morning at the Maryville office. He followed up with the retinal specialist, who took the bandage lens out of his eye for his examination and put a fresh one on and had him leave it there until his healing had progressed. He was prescribed lubricating eye drops and steroid eye drops. Petitioner was required to use these eye drops 2-4 times a day. During his treatment, Petitioner testified that he remained sensitive to light, was not able to go outside without sunglasses, and was not able to step in any situation where the lights changed because his pupil wasn't able to dilate. He testified that his eye was irritated and burned quite a bit. Crushed pepper continued to ooze out of Petitioner's eye from where it was sprayed and his vision was interrupted.

Petitioner was last seen for treatment on August 27, 2012 at the Illinois Eye Surgeon facility. His vision remained 20/25 on the left and 20/20 on the right. The impression was of a corneal abrasion resolved, with normal pressure. (PX 4)

Petitioner testified that, prior to this incident, he had only ever had 20/20 vision in both of his eyes. He had never had any prior medical treatment to his eyes. Notably, the medical records reveal that as of his second examination, Petitioner's vision in his left eye had decreased to 20/50+, it reached 20/30+2, and eventually 20/25 as of his last visit. The vision in his right eye remained constant at 20/20. Petitioner testified that when he was hired with the Department of

Corrections, he underwent an eye exam where both eyes were a perfect 20/20. Respondent produced no evidence in reubittal.

Petitioner testified that since the incident, he has continued to work full duty and he was told at Illinois Eye Surgeons that his left eye was as good as it was going to get. Petitioner continues to use lubricating eye drops. Due to the chemical burn, his eye dries out very quickly and he has to use the drops so he doesn't feel like he has something in his eye when it gets dried out. With regard to his vision, Petitioner testified that it has "definitely deteriorated." Petitioner testified to difficulty looking over long distances or looking at anything small. He has to close his eye and just look with his right eye and this helps him to see more clearly. Petitioner testified that when he tries to read a book for an extended amount of time, he begins to get headaches, which has never happened before. In his spare time, Petitioner enjoys working on computers. It is now difficult for him to work on small parts, make repairs to mother boards, and plug wires because he gets headaches easily. When he's driving, it is difficult to make out signs that are further away because he is used to being able to see at those distances and he is not able to do that anymore. Petitioner testified that his vision is 20/25 in the left eye, with a borderline of 20/30.

Petitioner also has difficulty shooting to qualify with different weapons annually with the Illinois Department of Corrections. Petitioner testified that this was the first year he was unable to qualify at the expert shooting level. His score dropped a total of 10 points. The two prior years of qualifying, he shot at the expert level. Additionally, he has had to change the way he shoots guns. Especially with rifles, where Petitioner is required to shoot to 150 yards, he can no longer get that far with both eyes open, so he has to close one eye to be able to see the target and shoot. Petitioner further testified that he loves to play billiards and longer shots are very difficult for him.

Conclusions of Law

With regard to whether Petitioner's current condition of ill-being is causally related to the injury (as it relates to nature and extent):

The Arbitrator finds that Petitioner's injury to his left eye is causally related to his work injury of 7/25/12. Both, Dr. McDaniel and Dr. Johnson at Illinois Eye Surgeons, related Petitioner's left eye condition to him being sprayed at a close range with pepper spray while in training for his employment. There is no other cause for the condition of his left eye in the record. Furthermore, Petitioner testified to perfect 20/20 vision prior to this incident and never having any other prior medical treatment with regard to either eye prior to this incident.

Respondent produced evidence in rebuttal, no witnesses to dispute Petitioner's testimony, and elected not to have Petitioner examined under Section 12 of the Act. As a result, based upon Petitioner's credible testimony, and the medical records of Dr. Trent McDaniel and Illinois Eye Surgeons, the Arbitrator finds that Petitioner's condition is causally related to his work injury of 7/25/12.

With regard to the reasonableness and necessity of Petitioner's medical services:

Petitioner's medical care and treatment was reasonable and necessary. He treated with his primary care physician who referred him to a specialist for approximately six weeks of care. Respondent stipulated it has or will pay the medical bills contained in Petitioner's group exhibit pursuant to Section 8.2, the medical fee schedule contained in the amendment to the Illinois Workers' Compensation Act. Respondent shall receive credit for any and all amounts previously paid. However, if Petitioner's group health carrier requests reimbursement, Respondent shall indemnify and hold Petitioner's harmless.

With regards to the nature and extent of the injury:

Pursuant to Section 8.1(b) of the Act, the following criteria must be weighed in determining the level of permanent partial disability, for accidental injuries occurring on or after 9/1/11:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion, loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:
   - (i) the reported level of impairment;
   - (ii) the occupation of the injured employee;
   - (iii) the age of the employee at the time of injury;
   - (iv) the employee's future earning capacity; and
   - (v) evidence of disability corroborated by medical records.

With regards to (i) of Section 8.1(b) of the Act:

Neither party submitted an AMA level of impairment in this matter. Consequently, the Arbitrator will consider the other four factors in rendering a decision with regard to permanent partial disability.

With regards to (ii) of Section 8.1(b) of the Act:

The Petitioner's occupation is Correctional Officer /TACT Team member whom the Arbitrator takes judicial notice of being heavy work and concludes that Petitioner's permanent partial disability will be larger than an individual who performs lighter work.

With regard to (iii) of Section 8.1(b) of the Act:

The age of Petitioner at the time of the injury was 30 years old. The Arbitrator considers Petitioner to be a younger individual and concludes that Petitioner's permanent partial disability will be more extensive than that of an older individual because he will have to live with his permanent partial disability longer.

With regard to (iv) of Section 8.1(b) of the Act:

At the present time, Petitioner's future earning capacity appears to be undiminished as a result of his injuries because he has been medically returned to his full time duties. However, upon his return to work, he has noted that his vision is worse and he is longer able to see long distances while driving and shooting, both of which are necessary for his job. The Arbitrator concludes that this may negatively affect Petitioner's future earning capacity.

With regard to (v) of Section 8.1(b) of the Act:

The Petitioner has demonstrated evidence of disability corroborated by his treating medical records. Petitioner's credibility testified that he currently experiences eye irritation, is required to use eye drops, experiences difficulty with vision loss, and experiences difficulty with tasks such as driving, reading, and shooting a gun. The medical records demonstrate that Petitioner has had reduced vision and continued symptoms up until the date of his last treatment.

The determination of permanent partial disability ("PPD") is not simply a calculation, but an evaluation of all 5 factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, applying Section 8.1b of the Act, 820 ILCS 305/8.1b, the Petitioner has sustained accidental injuries that caused 15% loss of use of the left eye. The Arbitrator further finds that Respondent shall pay the Petitioner the sum of $528.65/week for a further period of 24.3 weeks, as provided in Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(
☐ 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

Terri Eggers,
Petitioner,

vs. NO: 12 WC 26650

Steak N' Shake,
Respondent.

14IWCC0075

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 15, 2013 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.

14IWCC0075

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,100.00. 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: FEB 0 3 2014

Daniel R. Donohoo

Kevin W. Lamborn

Thomas J. Tyrrell

o-01/27/14
drd/wj
68

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

EGGERS, TERRI
Employee/Petitioner

Case# **12WC026650**

STEAK N' SHAKE
Employer/Respondent

14IWCC0075

On 4/15/2013, 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 0.09% 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:

0717 MOOS SCHMITT & O BRIEN PC
HENRY A SCHMITT
331 FULTON ST SUITE 314
PEORIA, IL 61602

0358 QUINN JOHNSTON HENDERSON ETAL
JOHN F KAMIN
227 N E JEFFERSON ST
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

TERRI EGGERS
Employee/Petitioner

v.

STEAK N' SHAKE
Employer/Respondent

Case # 12 WC 026650

Consolidated cases: N/A

14IWCC0075

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **February 25, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0075

FINDINGS

On the date of accident, **May 28, 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 **$5,077.04**; the average weekly wage was **$97.64**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$0** in TTD, **$0** in TPD, **$0** in maintenance, **$0** in non-occupational indemnity disability benefits, and **$0** in other benefits for which credit may be allowed under Section 8(j) of the Act.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $97.64/week for 39 1/7 weeks, commencing May 29, 2012 through February 25, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $10,157.00, as provided in Section 8(a) of the Act.

Petitioner's petition for penalties and attorney's fee 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.

Nancy Lindsey
Signature of Arbitrator

4.10.13
Date

ICArbDec19(b)

APR 15 2013

Terri Eggers v. Steak N' Shake, 12 WC 026650 (19(b))

ADDENDUM TO
ILLINOIS WORKERS' COMPENSATION COMMISSION
Arbitration Decision

The issues in dispute are accident, notice, causal connection, medical, temporary total disability, and penalties and fees. Petitioner and Sherry Hall testified at arbitration.

The Arbitrator finds:

Petitioner was employed by Respondent in Mattoon, Illinois in May of 2012. Her primary job involved working the fountain which involved preparation of desserts, sundaes, and milk shakes – primarily milk shakes. Petitioner testified that for several years prior to May 24, 2012 Petitioner would use a spade, similar to a spatula, to scoop either ice cream or shake mix into containers used to prepare drinks at the fountain. Petitioner is right-handed.

Petitioner testified that about a week before May 28, 2012 they received a bulletin informing them not to use the spade/spatula anymore. Petitioner's manager, Jessica, took the spade away and instructed Petitioner to use a scoop that she would pull across the top of the containers of ice cream and mixtures. Petitioner testified that she worked a couple of days using the scoop and noticed "it" started getting really sore. Petitioner thought she had perhaps twisted her wrist. Petitioner denied having any problems with her right wrist before she started using the scoop.

Petitioner testified that on May 25, 2012 (a Friday) she was using the scoop all the time. Petitioner came in on Saturday but didn't make shakes. Petitioner testified that on Sunday her wrist was worse so she wrapped it. Petitioner then came in to work on Monday, May 28th, at 9:00 a.m. to tear down the fountain. Petitioner testified that she had her hand wrapped and when she saw Ben, one of the managers, she told him she thought she had irritated it scooping. Petitioner returned to using the spade. Jessica, another manager, came in at 11:00 and told Petitioner she couldn't use the spade and had to use the scoop or else leave. Petitioner testified that she left.

Petitioner's testimony regarding the foregoing was unrebutted.

The following day, May 29, 2012, Petitioner went to Sarah Bush Lincoln Health Center emergency room. According to the medical records, Petitioner complained of right forearm pain, noting that she worked for Respondent scooping ice cream. Petitioner explained that she had recently begun using a new scoop at work and since then had developed a grinding sensation when moving her right forearm. She reported improvement when she was off work and not scooping but when she resumed working, things got worse. Petitioner complained of pain but no numbness, tingling, redness, swelling or bruising. On physical exam, Petitioner had a positive Finkelstein's test and the doctor was able to palpate a grinding sensation in her forearm with

range of motion. Petitioner was also tender along the tendon. The doctor's impression was right forearm pain with probable tendinitis and he recommended rest at home and a thumb spica splint. An off work slip was provided. Additional conservative treatment measures were discussed. An x-ray was negative for evidence of fracture or bony lesions. (PX 4)

Petitioner testified that she has not worked for Respondent since May 28, 2012.

Petitioner testified that she also met with the general manager of her store, Sherry Hall, on the Monday she was to start her shift. She described to her that she was having forearm pain and testified that she told Sherry Hall she did not know what was wrong with her arm.

Petitioner presented to Dr. Sandercock, a board certified doctor of osteopathy, on May 31, 2012. At that time, Petitioner described right wrist and upper extremity pain, noting she was having trouble since she had switched ice cream scoops at work a week or so earlier. Petitioner described a "squeaking sensation in her arm" which Dr. Sandercock confirmed on examination. (PX 1) Dr. Sandercock diagnosed tendinitis in the right forearm and prescribed therapy and medication. He continued her off work for two weeks. At his deposition Dr. Sandercock explained that then tendons Petitioner had injured were the ones used to extend one's wrist and fingers. (PX 1)

Petitioner presented for an occupational therapy evaluation on June 6, 2012. Petitioner reported right wrist tightness, pain with range of motion, and decreased grip which she associated with scooping ice cream at work. Petitioner's attendance at physical therapy was described as inconsistent. At the June 28th visit she reported tripping over her cat and falling on her hand. (PX 4) At arbitration Petitioner was asked about the history provided at this visit. Petitioner denied giving the therapist that history as she didn't even have a cat at that time.

Petitioner remained under the care of Dr. Sandercock who treated Petitioner with medication, a corticosteroid injection, and suggested a trial of prednisone which Petitioner was unable to try due to its side effects. As of July 16, 2012 his diagnosis remained tendinitis albeit chronic. He ordered an MRI and continued to keep Petitioner off work. (PX 1)

Petitioner underwent an MRI of her right radius, ulna, and forearm on July 17, 2012 which was read as normal. (PX 1; PX 2)

An Addendum to the July 17th MRI report was issued on July 24, 2012 and discussed with Dr. Sandercock. In the Addendum it was noted that subtle, peritendinous edema at the inter-section of the 1st and 2nd extensor tendons along the dorsal aspect of Petitioner's distal forearm was present. (PX 2)

Petitioner followed up with Dr. Sandercock on July 24, 2012. Her physical examination and diagnosis remained unchanged although Dr.Sandercock listed Petitioner's condition as that of right forearm intersection syndrome. Petitioner was still in therapy which he instructed her to continue going to. Otherwise, he told Petitioner she could return on an as-needed basis. (PX 1)

Petitioner returned to see Dr. Sandercock on August 9, 2012. Her complaints were unchanged and the doctor noted he wanted her to continue an aggressive occupational therapy program. Occupational Therapy was contacted by the doctor and it was reported that Petitioner had been inconsistent and noncompliant in her therapy program. Petitioner was advised of the importance of attending her therapy and given a prescription for meloxicam. Petitioner was to return in one month or as needed. Petitioner was given restrictions for work, a copy of which was mailed to Respondent. (PX 1)

Petitioner's attorney wrote Dr. Sandercock on September 25, 2012 requesting his opinion on causation between Petitioner's condition and her "work-related scooping of frozen shake base." (PX 1) In a letter to Petitioner's attorney dated October 8, 2012, Dr. Sandercock stated that it was his opinion that Petitioner's chronic tendinitis was caused by Petitioner's repetitive work-related scooping of frozen shake base. (PX 1; PX 3)

Petitioner next presented to Dr. Sandercock on October 9, 2012. Petitioner's symptoms had changed somewhat and she was now complaining of some numbness in her fingers. Petitioner was given a second injection. She questioned the possibility of carpal tunnel syndrome and, therefore, an EMG was ordered. (PX 1)

By letter dated October 19, 2012, Respondent's attorney forwarded information to Dr. Evan Crandall regarding an upcoming independent medical examination with Petitioner. Counsel wrote, "[Petitioner] was diagnosed with tendinits and intersection syndrome of her right forearm. We question whether or not this is related to the patient's work." (RX 1, dep. ex. 4)

The EMG was performed on October 25, 2012 and was normal. (PX 1)

Petitioner underwent an independent medical examination with Dr. Evan Crandall on October 24, 2012. Dr. Crandall issued a "24 Hour Quick Report" in which he indicated Petitioner needed a nerve conduction study and that he did not yet know if her condition was work-related and/or if she had reached maximum medical improvement. He did believe she could return to modified duty with no scooping using the right hand and no lifting over 15 lbs. (RX 1, dep. ex. 7) In his lengthier report of the same date, Dr. Crandall reviewed his physical examination noting a positive provocative test and positive arm raise test on physical examination. He found Petitioner's symptoms suggestive of, and consistent with, carpal tunnel syndrome and he agreed she needed a nerve conduction study. Once that was done, he would make further recommendations. In the interim, he recommended Petitioner refrain from scooping with her right hand. He did not believe that it was necessary to take her off work for five months. Based upon the medical records he reviewed, Dr. Crandall thought Petitioner's MRI was normal. He testified that if Petitioner did have carpal tunnel syndrome it would be work-related and that while she had minor medical risk factors for carpal tunnel syndrome (gender, menopause and smoking) these were not as important as the ice cream scooping. (RX 1, dep. ex. 2)

Dr. Crandall issued a supplemental report to Respondent's attorney on November 7, 2012[1]. In that report Dr. Crandall noted that the nerve conduction study was normal. He did not believe Petitioner had carpal tunnel syndrome but felt she should be treated conservatively with stretching exercises and anti-inflammatory medications as needed. He was also of the opinion Petitioner could return to work without any restrictions and that she had no objective evidence of any permanency. (RX 1, dep. ex. 3)

Petitioner returned to see Dr. Sandercock on November 26, 2012. Petitioner reported having seen Dr. Crandall and being advised by him that he felt she had a component of carpal tunnel syndrome even though the EMG did not correlate with that finding. Dr. Sandercock noted a positive Tinel's at the carpal tunnel and less tenderness at the intersection of the first and second compartments. Dr. Sandercock performed a carpal tunnel injection which he testified was done as a "partly diagnostic/partly therapeutic" measure. (PX 1) Dr. Sandercock testified that when he re-examined Petitioner six weeks later, she indicated some relief from the carpal tunnel injection. (PX 1)

By letter dated November 27, 2012, Respondent's attorney forwarded to Petitioner's attorney a copy of Dr. Crandall's initial and supplemental reports. Based upon Dr. Crandall's opinion that Petitioner could return to work without restrictions and the lack of any suggestion of permanent disability, Petitioner was asked to report to work. (PX 10)

Petitioner testified that after "we" got the November 27, 2012 report she called Sherry Hall about returning to work. Ms. Hall told her she would have to call her attorney. According to Petitioner, Ms. Hall later called her back and told her she could not come back to work with any restrictions – she had to be at one hundred percent and not need the brace. (See also PX 9, 12/11/12 correspondence) Petitioner did not return to work and she applied for unemployment which she has been receiving.

By letter dated November 30, 2012 Petitioner's attorney advised Respondent's attorney that Petitioner had contacted Ms. Hall and requested work but that, to date, Respondent had not offered her work. The letter also states that the opinions contained in the letters from Dr. Crandall appeared to be different from what Dr. Crandall told Petitioner at the time of the examination. (PX 9)

Petitioner testified that her right wrist still hurts and she has sharp pain in the front, back, and shooting up to her elbow. Petitioner testified that she performs her home exercises but they hurt. She also testified that she continues to wear her brace and does so all of the time except when showering or doing dishes. Petitioner sleeps with it on. Petitioner also testified that she tried scooping sherbet but it hurt really bad and almost had her in tears. Petitioner misses her work because she enjoyed it.

Petitioner was asked about any criminal background. Petitioner volunteered that prior to going to work for Respondent she had entered a plea in a forgery case stemming from a domestic

[1] The report is dated November 7, 2013

matter and a shared checking account. Petitioner received probation and ended up serving some prison time when she tested positive for drugs during her probation. Petitioner testified that Sherry Hall knew about Petitioner's past and there had never been any problems as a result of it. Petitioner testified she was grateful for the opportunity to work for Respondent.

Petitioner also testified that she was treated at Sara Bush Hospital on December 4, 2012 for an abcess on her right finger that is totally unrelated to this claim.

In follow-up with Dr. Sandercock on January 10, 2013 Petitioner reported some improvement with the carpal injection and she requested a second one; however, Dr. Sandercock felt it was too early for a re-injection and suggested waiting two weeks. Petitioner was diagnosed with carpal tunnel syndrome. (PX 1) As of January 29, 2013, Petitioner's complaints remained unchanged and she reported the injections provided only temporary relief. Petitioner had tried scooping some sherbet at home but was unsuccessful. Her right upper extremity was neurovascularly intact, her strength was 5/5, and Petitioner displayed good pronation and supination strength. He described the tenderness at the intersection of the first and second extensor compartments as "mild." Range of motion was excellent and a positive Tinel's was noted at the carpal tunnel. Dr. Sandercock expressed uncertainty as to how to proceed and why she was not improving. He suggested a second opinion. He injected her carpal tunnel. (PX 1)

Throughout the foregoing time period Dr. Sandercock continued to write work restrictions for Petitioner. As of January 29, 2013 Petitioner was to wear a brace on her right wrist and not lift, push, pull, or engage in high force gripping or grasping, or climbing or overhead work with her right hand. (PX 1)

Petitioner testified that she has provided Dr. Sandercock's work restrictions to Respondent who has advised her it cannot accommodate her restrictions.

Dr. Sandercock, a board certified doctor of osteopathy, was deposed on February 5, 2013. He testified consistent with his office notes and records. Additionally, he testified that he has continued to describe Petitioner's tendinits/intersection syndrome as chronic because it has lasted longer than he expected. While he has provided her with conservative treatment over time, Petitioner has felt she was getting worse. Dr. Sandercock explained that he ordered Mobic as an anti-inflammatory in light of the swelling shown on the MRI. Based upon Petitioner's reports, the Mobic helped reduce the inflammation but caused Petitioner to have an upset stomach. As of the date of his deposition, he felt Petitioner still needed work restrictions limiting the use of her right hand. She also needed to wear a brace. He was of the opinion that Petitioner's use of the new scoop caused or contributed to both conditions. Dr. Sandercock further testified that the fact Petitioner experienced some improvement in her wrist after the carpal tunnel injection supported a diagnosis of carpal tunnel syndrome.

Dr. Sandercock candidly testified that he has no idea why Petitioner's case has been so protracted. (P.X. 1, p. 26)

On cross-examination, Dr. Sandercock confirmed that the diagnostic and therapeutic injections initially given did not relieve any of the Petitioner's symptoms. He confirmed that his diagnosis of carpal tunnel was based upon the conclusions of Dr. Crandall, Respondent's examining physician. He noted that that was not something he initially felt she was suffering from but noted that the fact that Petitioner had some relief of symptoms from a carpal tunnel injection would support that diagnosis. He confirmed that the EMG/NCV study indicated Petitioner's nerves were working properly. (P.X. 1, p. 31)

Dr. Sandercock testified that he could not recall seeing any swelling and did not have any evidence of swelling recorded in his notes. He noted there is no evidence of swelling proximal to the wrist nor was there any evidence of a ganglion cyst or swelling over the dorsal extensor compartment. Dr. Sandercock also noted that the radiologist who originally read the MRI did not find any evidence of swelling and an addendum was prepared after Dr. Sandercock spoke to a second radiologist who authored an addendum. He further pointed out that extensor swelling isn't always seen with tendinits. (P.X. 1, p. 34)

Dr. Sandercock testified that occupational therapy was intended to assist Petitioner in developing the strength to be able to operate the ice cream scoop. He noted Petitioner had been inconsistent with therapy attendance which could prevent her from getting to a point where she could go back to work in an effective pain free manner. (P.X. 1, p. 36) He also noted Petitioner's strength has been normal throughout his treatment and confirmed that his work restrictions for the Petitioner at this point were limited to the fact that the Petitioner herself said she could not perform her work and he was relying upon her credibility in expressing pain complaints. (P.X. 1, pp. 37-38) Dr. Sandercock also confirmed that there was a disparity as Petitioner's physical exam findings have improved but her complaints have not. (P.X. 1, p. 39)

Dr. Crandall was deposed on January 22, 2013. (R.X. 1, p. 1) Dr. Crandall is board certified in plastic surgery and plastic surgery of the hand. Petitioner told Dr. Crandall that she was having right wrist and hand pain and had been having problems since May 24, 2012. He conducted an examination which showed negative ulnar Tinel's sign, a positive median Tinel's sign, a positive provocative test to the wrist, negative Phalen's test, positive arm raise, negative Finkelstein test. He noted no evidence of ganglions, triggering, or thenar muscle atrophy. He noted that the Petitioner's left upper extremity examination was normal. (R.X. 1, p. 9) He noted that on the objective testing, the only abnormal finding was that Petitioner had some decreased grip strength in the right hand compared to her left. When he saw her on that day, he suggested the Petitioner undergo a nerve conduction study, which Petitioner had scheduled the following day. He felt that Petitioner needed the study to determine if she had carpal tunnel syndrome and noted that that condition could not be diagnosed without such a study. (R.X. 1, pp. 10-11) He noted that she returned to her treating physician in Mattoon and had the EMG/NCV study the following day. He noted that that study was normal. In addition, he reviewed records including the MRI of the right wrist which was normal. Based upon his evaluation and the negative diagnostic test, he could not diagnose a particular condition of ill-being in the right upper extremity. (R.X. 1, p. 12) He acknowledged that Petitioner's job could cause carpal tunnel syndrome. (R.X.1, p. 12) He also felt Petitioner needed no work restrictions and had incurred no

evidence of any permanency. (R.X. 1, p. 13) Dr. Crandall recommended that Petitioner do stretching exercises and take anti-inflammatory medications as needed. However, Petitioner was not a surgical candidate and did not need to be off work. He confirmed that he did not find any evidence of forearm compartment syndrome or right forearm tendinitis. (R.X. 1, p. 13) He noted that if Petitioner was suffering from tendinitis in the first dorsal extensor compartment, she would have a positive Finkelstein test and swelling over the compartment, which Petitioner did not have. He noted that if Petitioner had second dorsal extensor compartment tendinitis, known as intersection syndrome, she would have had swelling just proximal to the wrist where the thumb extensor tendons cross over one another, which she did not have. He also noted that Petitioner had no evidence of ganglion, no point tenderness, and no swelling in her wrist or fingers and objectively there were no physical findings. (R.X. 1, p. 14) The Petitioner's report of some relief due to an injection in her carpal tunnel would not warrant surgery in the carpal tunnel as the nerve conduction study was normal. He noted that the latency reading of 2.7mm was a completely normal reading and this is not a case where Petitioner had borderline carpal tunnel. (R.X. 1, pp. 15-16) He further confirmed that he did not believe Petitioner was in need of work restrictions based upon his review of the records and diagnostic tests from May 2012 up until the time he had seen the patient. (R.X. 1, p. 16) On cross-examination, Dr. Crandall confirmed that the Petitioner attributed the onset of her symptoms to using a new ice cream scoop. He also noted that he performs several hundred IMEs a year and sees 1,000 new patients in a particular year. Almost all of his IMEs are for insurance companies. He noted that his initial intake from Petitioner indicated that she had worked at Respondent for four years and her last day of work was May 28, 2012. However, he would not characterize Petitioner's symptoms on May 24, 2012 as an injury. Dr. Crandall further confirmed that the Petitioner had symptoms consistent with carpal tunnel syndrome at his exam and agreed that she needed a nerve conduction study. (R.X. 1, p. 25) He also noted that at the time of his first exam he recommended Petitioner not scoop ice cream with the right hand pending completion of the nerve conduction study. He further noted his belief that if the Petitioner had scooped ice cream all day long with her right hand and if indeed she had carpal tunnel syndrome, it would be work related. Dr. Crandall did note that the Petitioner may benefit from an anti-inflammatory medication such as Celebrex. However, he disagreed with the diagnosis of chronic tendinitis as Petitioner had a normal MRI and no positive findings of tendinitis. (R.X. 1, pp. 30-31) Dr. Crandall confirmed that he had provided Petitioner a work restriction on the day of his visit because Petitioner had a nerve conduction study the next day. He confirmed he did not intend for it to be a permanent restriction and that when he saw the nerve conduction study was negative he opined that Petitioner could work without restrictions. (R.X. 1, p. 37) On re-direct, Dr. Crandall noted that his quick report, which had been identified as Exhibit 7 to his deposition, did contain a line indicating that it was "not yet determined" if Petitioner's condition was related to her work. He noted that any work restriction was pending completion of the nerve conduction study which he had offered to complete at his office, but she wanted to go back to her treating physician for same. He further noted that if the study performed at his office was identical to the one performed in Mattoon, he would not have given Petitioner a work restriction at that visit.

Petitioner testified that PX 12 accurately reflected her weeks and days worked and gross earnings. The hand-written noted contained on it are those of her attorney. As of May 28, 2012,

Petitioner's hourly rate was $8.65. Petitioner did not receive tips because she worked in the back. Petitioner also testified that she missed more than five calendar days in the year before May 28, 2012 partly because of health problems and partly because she has a disabled son. Petitioner testified that Respondent worked with her on her schedule.

Sherry Hall testified on behalf of Respondent. Ms. Hall was the general manager of the restaurant where Petitioner worked. Petitioner and Ms. Hall are friends. Ms. Hall testified that Petitioner typically worked two to three days per week and from eleven to three or eleven to four. Petitioner frequently missed a lot of work and would ask not to be scheduled on occasion as she had a lot of things going on and had been very sick at one point in time. All in all, Ms. Hall believed Petitioner probably worked 12 to 15 hours per week. She worked with Petitioner as best she could to accommodate her schedule.

Ms. Hall testified that the Petitioner had come to her in late May 2012 complaining of pain in her hand and wrist. Ms. Hall testified that Petitioner stopped working on May 28, 2012. Ms. Hall further testified that in July of 2012 she received paperwork on Petitioner's workers' compensation claim and that between May of July of 2012 she and Petitioner had conversations from time to time. Ms. Hall stated that within the week following Petitioner's cessation of work they spoke. According to Ms. Hall, Petitioner didn't know what was going on with her arm and whether it was work-related or not. She mentioned some popping in her wrist and Ms. Hall agreed that she had some.

Ms. Hall further testified that she had nothing before October 8, 2012 telling her it was work-related issue.

On cross-examination Ms. Hall acknowledged that both Ben and Jennifer were managers. She also testified that once Petitioner is fully released and "corporate" allows it, Petitioner can return to work if she can work the hours given to her.

On re-direct examination Ms. Hall identified the First Report of Injury (RX 3) which she completed on July 27, 2012. Ms. Hall testified that she put down that Petitioner was uncertain if her condition was work-related. Ms. Hall completed this Form after she had received the Application for Adjustment of Claim from Petitioner's counsel in July 2012. She testified that she had called in the claim to the insurance company upon receipt of the application. Up to that point, it was not clear that Petitioner was claiming she had a work-related condition. Ms. Hall also testified that she had no medical documentation indicating that Petitioner's condition was related to work at the time and was not aware of any such documentation until Dr. Sandercock's letter of October 8, 2012. Ms. Hall also testified that Respondent does accommodate light duty restrictions for employees who are off work due to an accidental work-related injury. However, in this instance Petitioner was not offered light duty because her claim was not accepted.

The Arbitrator concludes:

1. Petitioner's testimony was credible.

2. Petitioner sustained an accident on May 28, 2012 that arose out of and in the course of her employment with Respondent. Petitioner credibly testified that her repetitive trauma claim was based upon switching to a new ice cream scoop. She started using the scoop at the direction of her employer on May 24, 2012. She had only used it for one or two days before reporting her difficulties on May 28, 2012. Petitioner's testimony was corroborated by the histories found in the records of the treating physicians.

3. Petitioner provided timely notice of her accident to Respondent. Petitioner's testimony regarding her conversations with Ben and Jessica, her supervisors, was unrebutted. Additionally, the Arbitrator notes that, while it is not a part of the record, Respondent acknowledged in its proposed decision that notice, albeit perhaps defective, was provided. No prejudice from any defective notice has been shown.

4. Petitioner's condition of ill-being in her right upper extremity, namely tendinits and intersection syndrome, is causally connected to her accident of May 28, 2012. This is based upon a chain of events and the opinions of Dr. Sandercock. The Arbitrator notes that Respondent's examining physician, Dr. Crandall, never rendered an opinion on the question of whether or not Petitioner's tendinits/intersection syndrome was work-related. Furthermore, Dr. Crandall only examined Petitioner the one time and her examination findings at that time (in particular the negative findings of tendinitis) could be attributable to the injection Dr. Sandercock had given her just a few weeks before and which Petitioner subsequently reported had a positive effect. While Dr. Crandall testified the MRI of Petitioner's forearm was normal it is not clear if he had the benefit of the Addendum report which showed swelling consistent with intersection syndrome/tendinitis and Dr. Crandall testified swelling is indicative of tendinitis. Furthermore, Dr. Crandall seemed more focused on the presence or absence of carpal tunnel syndrome than the state and prognosis of Petitioner's tendinitis. The Arbitrator is not concluding that Petitioner has right carpal tunnel syndrome; however, whatever carpal-tunnel like symptoms Petitioner experienced in the fall of 2012 are causally related to her work accident. They were also transient in nature as Petitioner responded to an injection and has no objective evidence of same at this time.

5. Regarding earnings, Petitioner testified that she worked part-time and often had to modify her work schedule to care for a disabled child. Sherry Hall confirmed this. Petitioner's wage records show that Petitioner worked part-time between 2.47 hours and 27.08 hours a week during the 52-week period preceding the injury, earning $8.65 per hour at the time of the occurrence. The Arbitrator adopts Respondent's wage statement and finds that Petitioner had an average weekly wage of $97.64.

6. Medical Bills. The itemization of Petitioner's medical treatment bills totals $10,157.00. (PX11) Petitioner identified that list of bills as being for her treatment of her right wrist injuries. Dr. Sandercock identified the bills as being related to his care of Petitioner for her right wrist injury and said that they "could be" related to the repetitive trauma injury alleged. He stated that Petitioner's treatment thus far was "reasonable and necessary to treat her for her right wrist tendinitis and carpal tunnel." (PX1, p.28)

The Arbitrator finds that Petitioner's itemized treatment bills in the amount of $10,157.00 were for reasonable and necessary treatment of Petitioner's right wrist injury.

7. Temporary Total Disability Benefits. Petitioner testified that she has continued to treat with Dr. Sandercock for her right wrist pain since May 31, 2012. She has not had any intervening injuries or trauma and continues to have right wrist pain with gripping or grasping with her right hand. She has tried to scoop sherbet, but has experienced pain. Petitioner testified that Respondent has never offered her work with her restrictions.

Dr. Sandercock testified that he has never released Petitioner to return to her regular work. He has not declared that Petitioner is at maximum medical improvement. His continuing restrictions as of January 29, 2013 include the following: "lifting, pushing, pulling restricted to 0 pounds; no high force gripping or grasping; must wear brace on right wrist." (PX 1, deposition Ex. #2)

Dr. Sandercock admitted that his current work restrictions for Petitioner were based "principally on her credibility" and complaints. On re-direct, Dr. Sandercock testified that while Petitioner's chronic tendinitis has been particularly stubborn, her complaints have been consistent and he has "continued to treat her and give her the injections and the treatment . . . and the restrictions" based on his "feeling that she is credible." (Pet. Ex. 1, pp. 38-39)

While the Arbitrator shares Dr. Sandercock's concern as to why Petitioner is not getting better when she has been off work for so long and is troubled by Petitioner's lack of full attendance and effort with aggressive occupational therapy, Respondent did not have Petitioner go back and see Dr. Crandall again or, alternatively, set up a second opinion as requested by Dr. Sandercock. While Petitioner appears at or very near maximum medical improvement, Petitioner is entitled to receive temporary total disability benefits from the Respondent in the amount of $97.64 per week for 39 1/7 weeks, being the period from May 29, 2012 through February 25, 2013.

8. Regarding penalties and attorney's fees, the facts are in dispute on all issues and Respondent's failure and refusal to pay TTD and medical was not unreasonable. Petitioner's Petition for Penalties and Attorney's Fees is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sylvia Travis,
Petitioner,

vs. NO: 08 WC 45487

Gateway Center,
Respondent.

14IWCC0076

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 1, 2013 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.

14IWCC0076

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,800.00. 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: FEB 0 3 2014

Daniel R. Donohoo

Kevin W. Lamborn

Thomas J. Tyrrell

o-01/28/14
drd/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

TRAVIS, SYLVIA
Employee/Petitioner

Case# **08WC045487**

GATEWAY CENTER
Employer/Respondent

14IWCC0076

On 5/1/2013, 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 0.08% 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:

0095 CALVO & MATEYKA
ROBERT W BUTLER
1517 E 20TH ST PO BOX 1384
GRANITE CITY, IL 62040

0180 EVANS & DIXON LLC
JAMES M GALLEN
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Sylvia Travis
Employee/Petitioner

v.

Gateway Center
Employer/Respondent

Case # **08** WC **45487**

Consolidated cases: __

14IWCC0076

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Granada**, Arbitrator of the Commission, in the city of **Collinsville**, on **11/30/12**. After reviewing all 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 **Liability for TTD and medical expense**

14IWCC0076

FINDINGS

On **8/10/08**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$26,493.48**; the average weekly wage was **$509.49**.

On the date of accident, Petitioner was **44** 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 **$38,211.46** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$38,211.46**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $339.66/week for 112 3/7 weeks, commencing 10/1/08 through 10/27/10, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $38,211.46 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $335.00, subject to the Fee Schedule, as provided in Sections 8(a) and 8.1 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $305.69/week for 97.925 weeks, because the injuries sustained caused the 15% loss of each arm, and 10% loss of each hand as provided in Section 8(e) of the Act. Respondent is entitled to a credit of 7.5% loss of the left arm from a prior claim, thereby reducing Petitioner's award on the left arm to 7.5% loss of use.

Respondent shall pay the Petitioner compensation that has accrued from **10/28/10** through **11/30/12**, 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

4/24/13
Date

MAY - 1 2013

14IWCC0076

Findings of Fact

Petitioner was employed by Respondent as a Housekeeping Supervisor beginning in early 2005. Her primary responsibility was to clean and to prepare and monitor the facilities for conventions and meetings. Her duties included vacuuming, sweeping, mopping, dusting, wiping, washing windows, emptying trash, scrubbing floors and tables, cleaning restrooms and any other activity need to keep the facilities presentable. As part of her duties she would monitor events by maintaining restrooms and trash removal. During events she would generally clean other parts of the facility and just check in from time to time. She was typically the only one working but the Respondent had several part time employees who helped with large events. While she had some supervisory duties, this was a very small percentage of her work.

Petitioner noticed that she was really tired one day while washing windows. She told one of the coordinators that her hand had swollen up severely. She also had tingling and things falling out of hands. Her hand also hurt and began to wake her up at night. Petitioner testified that these conditions came on while she spent two days buffing the floor in August 2008. Her right hand was really bad. Petitioner testified that the several days prior to August 10, 2008, she had been working buffing a large hall stripping and waxing the floors. She stated that she used a large industrial buffer and that the performance of that job increased her symptoms to where she went to see her doctor.

She first saw Dr. Dorothy Loderstedt on August 13, 2008. Dr. Loderstedt noted pain and numbness in the right upper extremity and hand, and ordered a right hand EMG/NCV performed August 25, 2008. The findings were consistent with mild right carpal tunnel syndrome. She treated Petitioner with anti-inflammatory medication and a right wrist split. On August 29, 2008 she referred Petitioner to see an orthopedic surgeon. In a note on December 9, 2008, Dr. Loderstedt opined that the history of heavy lifting, pushing & pulling at work were the causes of her carpal tunnel syndrome. She released Petitioner to light duty.

Petitioner attempted to return to work but was notified by the employer that it was not able to accommodate light duty. She began being paid TTD benefits October 1, 2008.

On December, 30, 2008, Dr. Khash Dehghan examined the Petitioner. He noted numbness and tingling in her upper extremity digits right worse than left. On exam, he found positive phalens and median compression test bilaterally and positive right sided tinels. He ordered a splint for the left wrist and surgery for the right wrist. He noted that if the splint did not help the left wrist that surgery would ultimately be necessary. He performed right carpal tunnel release surgery on March 9, 2009. On March 18, 2009, Dr. Dehghan noted Petitioner's complaints of numbness in her fingers improved but she complained that the left sided carpal tunnel was more noticeable. Dr. Dehghan ordered a left EMG study. On March 25, 2009 she reported continued numbness in her small and little fingers on the right side, and also numbness in the same fingers on the left side. Tinels over both cubital tunnels were positive. Splints were ordered for both elbows.

The left EMG conducted April 30, 2009 was positive for ulnar neuropathy but negative for carpal tunnel.

Petitioner returned to Dr. Dehghan on May 5, 2009. He opines on that date that "Ms. Travis's job was again reviewed with her. . . . She was advised that in my opinion, her job at Gateway Convention Center had contributed to and aggravated her bilateral carpal and cubital tunnel syndromes."

14IWCC0076

Dr. Dehghan performed a left carpal tunnel and left cubital tunnel release on August 3, 2009. She reported resolution of her left finger numbness and tingling on her August 11, 2009 visit. He ordered physical therapy on her hands and continued to keep her off of work.

On September 9, 2009, Dr. Dehghan noted continued numbness and tingling in her right small and ring fingers. He recommended surgery for the right carpal tunnel syndrome. Dr. Dehghan moved so the surgery was ultimately performed by Dr. Michael Beatty on December 8, 2009. Dr. Beatty and Dehghan were in the same office. He performed a release of right ulnar nerve. He continued her off work status.

On January 7, 2010, Dr. Beatty reported that Petitioner was "doing well regarding surgery, but her arms continue to bother her." She complained of numbness and tingling returning to her left elbow forearm area. Dr. Beatty ordered repeat EMGs which show left ulnar neuropathy. He recommended repeat elbow surgery.

Respondent sent Petitioner to Dr. Harvey Mirly for an IME on April 2, 2010. Dr. Mirly opined that "[w]ith regard to her current condition being causally related, she does report, and the job descriptions do support, vigorous use of the hands in her activities. She reports a lot of use of buffers, cleaning windows with an overhead pole, a lot of wiping, and I believe those are the types of activities that may contribute to the development of nerve compression injuries. . . ." Dr. Mirly notes that the testing performed on the Petititioner supported the diagnosis of right carpal tunnel and cubital tunnel syndrome, but do not support a similar diagnosis of carpal tunnel on the left side.

She returned to Dr. Beatty who surgically released the ulnar nerve in her left elbow on June 22, 2010. He released her to light duty beginning August 9, 2010. At 10 weeks postoperatively, she had complaints of discomfort in her shoulder region. Dr. Beatty referred her to Dr. Yadava who ordered some therapeutic exercises. She was released to full duty on November 10, 2010. Dr. Beatty released her from his care on November 17, 2010.

On August 18, 2011, Dr. Timothy Bradley performed a medical records review on behalf of the Respondent. He opined that based upon this review, Petitioner's carpal tunnel and cubital tunnel conditions were not related to her work activities. He cites National Institute for Occupational Safety and Health as his basis that said work did not cause her carpal tunnel syndrome. With regards to cubital tunnel he states that "there is no association known for occupational exposure". After this report was prepared, Respondent then scheduled Petitioner to see Dr. Bradley for an IME. Dr. Bradley after examining Petitioner reiterated his prior opinions regarding causation.

Petitioner attempted to return to her employment with Respondent upon her release from the doctor. She testified that she was not allowed to come back to work on a full time basis.

Dr. Beatty opined that the job duties performed by Petitioner caused or aggravated the conditions of bilateral carpal tunnel and cubital tunnel surgery. He further opined that the job activities and aggravation caused or necessitated the need for the carpal tunnel and cubital tunnel surgeries. Dr. Beatty last examined the Petitioner on March 6, 2012. She was working at this time as a home health nurse which she reported was much less physically demanding. She still described decreased sensation distribution of the medial antebrachial cutanious nerve on the left. She testified that now she gets occasional cramping in the left elbow region. She feels she has substantial loss of strength and estimates she can lift about 30 pounds when prior to the injury she occasionally moved much more with both arms. Her elbow is numb to the touch. Her hands fatigue quickly and her left elbow gets a sharp shooting pain occasionally. As a hobby she occasionally will make flower

arrangements. She reports that she has lost some sensation in her fingers and has a more difficult time gluing beads and other small items on her arrangements.

Respondent has paid all the medical bills with the exception of $335.00 to Dr. Beatty for his last follow up visit. Respondent has also paid all the temporary disability benefits from October 1, 2008 through October 27, 2010.

Based on the foregoing, the Arbitrator makes the following conclusions:

1. Petitioner sustained her burden of proof regarding the issue of accident. She credibly testified that she began noticing problems with her hands and arms while performing her duties on or around August 10, 2008, most notably after operating a floor buffing machine for 2 days. Her description of her job duties was credible and clearly depicted constant use of both hands and arms, which although may have been varied throughout the day, , ultimately lead to her complaints of her hands swelling, tingling, and losing sensation and grip strength after buffing floors for 2 days, 8 hours per day.

2. Petitioner's condition of ill-being is causally connected to her employment activities. The Arbitrator finds persuasive the opinions of Petitioner's treating physicians on this issue. Even Respondent's IME, Dr. Mirly provides support on the issue of causation favorable to the Petitioner. The opinions of Petitioner's various treating physicians and Respondent's IME, Dr. Mirly, outweigh those opinions of Respondent's second IME, Dr. Bradley, whose opinions on the issue of causation are clearly to the contrary.

3. Based on the findings above, Petitioner is entitled to TTD from October 1, 2008 through October 27, 2010. Respondent shall receive a credit for any TTD it has paid thus far toward the period in question.

4. Respondent shall pay any reasonable, related and necessary medical expenses incurred, subject to the fee schedule and in accordance with Sections 8(a) and 8.1 of the Act. This would include the outstanding medical expense from Dr. Beatty for $335.0.00

5. As a result of her injuries, Petitioner has sustained a 10% loss of use of each hand; 15% loss of use of her right arm; and 15% loss of use of her left arm – less a credit of 7.5% to the left arm from Petitioner's prior claim under case #99 WC 39563 – thereby reducing Petitioner's award for her left arm to 7.5% loss of use of the left arm.

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

Maria Diaz,
Petitioner,

vs. No: 09 WC 05887

14IWCC0077

Prairie Packaging,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) of the Act having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice and medical expenses, and being advised of the facts and law, clarifies 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).

After considering the entire record, the Commission clarifies the award of medical expenses and affirms and adopts the remainder of the Decision of the Arbitrator.

The Arbitrator ordered the following:
"Respondent is to pay to Petitioner reasonable and necessary medical expenses incurred pursuant to Sections 8 and 8.2 of the Act."

At hearing, Petitioner submitted unpaid medical bills which she claimed as reasonable and related to the accident as Petitioner's Exhibits 5 through 7. Respondent disputed liability for these bills and admitted it did not pay any amount through its group medical plan for which credit may be allowed under §8(j) of the Act. (AX1).

The Arbitrator neglected to quantify the reasonable and necessary medical expenses awarded in her order. The Commission clarifies the Arbitrator's order to specify all medical bills contained in Petitioner's Exhibits 5 through 7 are awarded. The Commission orders Respondent pay to Petitioner related, reasonable and necessary medical expenses contained in Petitioner's Exhibits 5 through 7 pursuant to Section 8(a) and 8.2 of the Act.

14IWCC0077

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the March 20, 2013 Decision of the Arbitrator is hereby clarified and otherwise affirmed or adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall pay to Petitioner reasonable and necessary medical expenses contained in Petitioner's Exhibits 5 through 7 pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is to authorize and pay for the prospective medical treatment as prescribed by Petitioner's treating physicians, Dr. Nassos and Dr. Morganstern, including the pre and post operative attendant care pursuant to Sections 8(a) and 8.2 of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: FEB 03 2014

drd/adc
o-11/5/13
68

Daniel R. Donohoo

Kevin W. Lamborn

Thomas J. Tyrrell

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

DIAZ, MARIA
Employee/Petitioner

Case# **09WC005887**

PRAIRIE PACKAGING
Employer/Respondent

14IWCC0077

On 3/20/2013, 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 0.11% 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:

2208 CAPRON & AVGERINOS PC
MICHAEL ROM
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

1872 SPIEGEL & CAHILL PC
MARTIN T SPIEGEL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Maria Diaz
Employee/Petitioner

v.

Prairie Packaging
Employer/Respondent

Case # 09 WC 05887

Consolidated cases: _____

14IWCC0077

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Chicago**, on **February 6, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0077

FINDINGS

On the date of accident, **6/26/08**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**14,710.28**; the average weekly wage was $**282.89**.

On the date of accident, Petitioner was **52** years of age, *married* with **0** dependent children.

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

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

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

ORDER

- The Respondent shall pay to Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of the injury pursuant to Sections 8 and 8.2 of the Act.
- Respondent is to authorize and pay for the prospective medical treatment as prescribed by Petitioner's treating physicians including the pre and post operative attendant care pursuant to Sections 8(a) and 8.2 of the Act.

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

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

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

Carolyn Doherty
Signature of Arbitrator

3/20/13
Date

ICArbDec19(b)

MAR 20 2013

FINDINGS OF FACT

Petitioner, a 52 year old factory worker, testified that she worked on Respondent's assembly line wrapping cups coming off a conveyor belt, packing boxes with cups and lifting the boxes onto a pallet. Petitioner began working for Respondent in May 2006. Petitioner testified that she works a 12 hour shift from 7 am to 7 pm, 5 days per week. Petitioner was allowed 2 15 minute breaks and one half hour lunch break. The boxes filled with cups weigh from 20 to 50 pounds and on average there were 20 boxes on a pallet. Petitioner testified that she filled about 6 pallets per shift. As a packer, Petitioner rotated duties. She testified that part of the day she packed and part of the day she inspected but that lifting was always involved in all of the assigned job duties.

Prior to June 2008, the records from Clearing Clinic indicate that Petitioner was at the clinic on 3/19/08 for a physical examination. The records contain a "Pre-placement exam" report dated 3/19/08 indicating that Petitioner passed her exam and could return to work after having "surgery" at some point earlier in January 2008. The surgery was not work related and did not result from an injury according to the medical records. Petitioner's family doctor, Dr. Cardenas, also released Petitioner to work full duty at that time in March 2008. PX 1. Petitioner was diagnosed as a diabetic in 2000 and takes medication for diabetes and blood pressure.

A record from Dr. Cardenas dated 6/5/08, indicates that he had seen Petitioner and issued a "rtw" under a "Dx Neuropathy" as of 6/11/08. Thereafter, Petitioner returned to MacNeal Occupational Health Services at Respondent's request for a physical examination on 6/9/08 and noted that she had been off for "left hand numbness" and that her last day worked was 5/27/08. PX 1. The Physical Examination form dated 6/9/08 indicates a normal exam of Petitioner's shoulders, elbows, wrists, hands and fingers.

At trial, Petitioner testified that she noticed pain in her left arm beginning 8 weeks before she reported the pain to Respondent on June 26 2008. Petitioner testified that on June 26, 2008, she notified her supervisor "Jason" of her pain and was sent to Clearing Clinic with Respondent's approval. Petitioner testified that she did not report the problems with her arm when she first noticed the problems 8 weeks earlier despite her thought that the pain was related to her job duties.

The Authorization for Treatment form from MacNeal dated 6/26/08 indicates that Petitioner was to be rendered "treatment for on-the-job injury to her "L-hand/neck." A handwritten notation also notes that "Prairie wants doctor to fully evaluate her to see if this is work related." The treatment was authorized by Jason Clayton at Respondent. On the occupational information form Petitioner indicated "my job consist of lifting heavy boxes and I hurt my left wrist it feels numb and pain goes to my neck." The date of injury is listed as 5/1/08. In the treatment notes of Dr. Orig Petitioner complained that "my job consist on lifting heavy boxes and I hurt my left wrist, feels numb and pain goes up to my neck." Under history of present illness it is noted, "this is the initial visit for Maria Diaz, a 52 year old female, whose primary complaint is pain located in the neck to left fingers. She considers it to be severe. It has been about 8 weeks since the

onset of pain. She has noticed that it s made worse by pt unsure. It is improved with pt unsure. Her pain level is 10/10." After examination and cervical x-rays the initial diagnosis was neck strain and it was noted that "the cause of this problem is probably related to work activities." PX 1. Petitioner's left shoulder lifting was limited to 5 pounds or less and no above shoulder level work was to be performed. PX 1.

The diagnosis of left shoulder strain was continued at the next visit on 7/2/08. Petitioner continued under work restrictions and her pain medication was continued. PT was recommended. As of 7/15/08, a cervical MRI was ordered to rule out disc herniation. Petitioner began physical therapy under a continued diagnosis of neck strain. She reported on the PT patient questionnaire that the injury occurred while "lifting 20 -40 lb boxes – put on a skid." PX 1. The cervical MRI of 7/25/08 showed no disc herniation but mild spondylosis of the cervical spine and small disc osteophytes at multiple levels. As of 7/30/08, Petitioner continued with PT and noted an improving pain level. Petitioner was prescribed one more week of PT and was to return to regular duty as of the next visit. Petitioner was in fact discharged from care on 8/8/08 and was returned to work regular duty.

On 10/17/08, Petitioner had and EMG of her left arm ordered by her family physician, Dr. Cardenas. PX 2. The EMG indicated left carpal tunnel syndrome. Petitioner continued to treat thereafter with Dr. Cardenas who noted positive Phalen and Tinel's signs on the left hand. Petitioner was released to restricted duty in November 2008 by Dr. Cardenas. Petitioner also underwent an injection to her wrist. PX 2.

On 3/2/09, Petitioner began treating with Dr. Nassos at Diversy Medical Center who diagnosed left carpal tunnel related to her work activity. He placed Petitioner on restricted work duty and eventually ordered left carpal tunnel release surgery due to the failure of conservative care. On 4/27/09, Dr. Nassos noted that Petitioner needed the surgery and that without it he would recommend an FCE with permanent restrictions. Petitioner testified that she was afraid to have the surgery at that time but eventually agreed to the surgery in June 2009. Petitioner thereafter was seen by Dr. Morgenstern at Diversy in April 2010. He also recommended surgery to her left hand. She treated with him through September 2010 at which time he advised Petitioner that she would have pain and permanent restrictions until she underwent the carpal tunnel surgery. PX 2. Dr. Morgenstern also noted that Petitioner's left carpal tunnel was the "direct result of the patient's work-related activities that initially developed approximately March 2008." PX 2. In his report dated July 9, 2012, he opined that Petitioner's activities "involved repetitive motion and repetitive motion is known to be a cause of carpal tunnel syndrome and aggravation of carpal tunnel syndrome." PX 4. Petitioner requests the surgery at trial.

Petitioner testified that she was laid off from Respondent in 2010 for productivity problems. At the time she was laid off, Petitioner was under permanent restrictions from Dr. Morgenstern of carrying, pushing and pulling no greater than 20 pounds with the left upper extremity and no repetitive motion to the left wrist and hand until the patient receives surgical intervention. PX 2. These restrictions are in place until the surgery is approved. PX 2, PX 4. Since that time she has by employed through temporary agencies. Petitioner testified that the work she performs today is different from her job with Respondent as she does not have to lift at work. Furthermore, she

changes job duties and locations. Petitioner works a few days per week and all jobs involve assembly work.

Her last left hand treatment was in 2010 with Dr. Morgenstern. Since last seeing Dr. Morgenstern she notices pain in her hand when lifting and testified that the pain increases with lifting or activity. Petitioner testified that if she does not use the left wrist she does not have pain. Finally, she testified that her pain is the same now as it was in 2008, 2009 and 2010.

Respondent submitted the reports of Section 12 examining physician, Dr. Vender. RX 1. In his report dated 2/1/10, Dr. Vender diagnosed Petitioner with bilateral carpal tunnel worse on the left after performing repeat electrodiagnostic studies. Based on Petitioner's complaints and on the objective and diagnostic findings, Dr. Vender agreed that surgery on the left was indicated. Petitioner testified that she has no symptoms on the right side and is not looking for right sided treatment. Dr. Vender asked for a video of Petitioner's job duties to determine if her duties involved forceful and exertional activities on a regular and consistent basis so as to causally relate her condition and her job duties. In his second report dated March 10, 2010, Dr. Vender noted that he reviewed a written job analysis and a video of the job duties at issue. Petitioner agreed the video depicted her job duties but noted that her lifting duties were not depicted. Dr. Vender determined that no forceful activities were demonstrated and that her job activities did not contribute to her carpal tunnel. RX 1.

CONCLUSIONS OF LAW

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

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? What was the date of accident? Was timely notice of the accident given to Respondent? Is Petitioner's current condition of ill-being causally related to the injury?

Based on a review of Petitioner's medical records, the first mention of left hand complaints is in early June 2008. A record from Dr. Cardenas dated 6/5/08, indicates that he had seen Petitioner and issued a "rtw" under a "Dx Neuropathy" as of 6/11/08. Thereafter, Petitioner returned to MacNeal Occupational Health Services at Respondent's request for a physical examination on 6/9/08 and noted that she had been off for "left hand numbness" and that her last day worked was 5/27/08. PX 1. The Physical Examination form dated 6/9/08 indicates a normal exam of Petitioner's shoulders, elbows, wrists, hands and fingers.

At trial, Petitioner credibly testified that she noticed pain in her left arm beginning 8 weeks before she reported the pain to Respondent on June 26 2008. Petitioner testified that on June 26, 2008, she notified her supervisor "Jason" of her pain and was sent to Clearing Clinic with Respondent's approval. Petitioner testified that she did not report the problems with her arm when she first noticed the problems 8 weeks earlier despite her thought that the pain was related to her job duties. The records from June 26, 2008 and subsequent thereto as summarized above all reflect Petitioner's left hand and arm complaints and the relation of those complaints to Petitioner's job duties. The Authorization for Treatment form from MacNeal dated 6/26/08

indicates that Petitioner was to be rendered "treatment for on-the-job injury to her "L-hand/neck." A handwritten notation also notes that "Prairie wants doctor to fully evaluate her to see if this is work related." The subsequent records are replete with job histories and work duty descriptions connecting Petitioner's complaints to her work for Respondent and specifically to her lifting of boxes.

The Arbitrator is mindful that Petitioner noticed the symptoms as early as May 1, 2008 and that the condition was not "reported" until June 26, 2008. However, Respondent was aware Petitioner was off work in May and early June 2008 for "left hand numbness" based on the return to work exam records from MacNeal at PX 1. Accordingly, the Arbitrator finds that Petitioner sustained repetitive trauma type injuries to her left hand which reasonably manifested on June 26, 2008, the first date she sought medical care for the condition with Respondent's knowledge that Petitioner attributed the condition to her work duties. Respondent requested that a full exam be given on that date to determine "if this was work related." PX 1. The Arbitrator finds that Respondent received timely and proper notice of the injury and of its relation to Petitioner's job activities.

Petitioner underwent conservative care for her left hand complaints while continuing to work light duty for Respondent. While working light duty, Petitioner wore a splint. Petitioner was given a diagnosis of left carpal tunnel as of October 2008 and then a surgical diagnosis in April 2009 after further diagnostic testing confirmed left carpal tunnel and conservative measures failed. The Arbitrator assigns greater weight to the opinion of Petitioner's treating physicians than to the opinion of Dr. Vender. Drs. Nassos and Morgenstern opined that Petitioner's condition was caused by the cumulative and repetitive nature of Petitioner's job duties for Respondent. Again, all of Petitioner's treating records buttress these opinions.

Based on the above and on the record in its entirety, the Arbitrator finds Petitioner sustained repetitive trauma to her left hand manifesting on June 26, 2008, that Respondent received proper and timely notice and that Petitioner's current condition of ill-being is causally related to her job for Respondent.

J. Were the 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?

Based on the findings of accident and causal connection, the Arbitrator further finds that Respondent is to authorize and pay for the prospective medical treatment prescribed by Drs. Nassos and Morgenstern to treat Petitioner's left hand carpal tunnel pursuant to Section 8(a) of the Act. The order of prospective treatment includes the prescribed surgery and the pre and post surgical attendant care.

Further, based on the findings of accident and causal connection, Respondent is to pay to Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of her condition pursuant to Sections 8 and 8.2 of the Act.

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 Other (explain)	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lisa Peppers,
Petitioner,

vs. NO: 08 WC 01934

14IWCC0078

Rockford School District #205,
Respondent.

DECISION AND OPINION ON REVIEW

A Petition for Review of the December 12, 2012 Arbitration Decision in case number 08 WC 1934 was filed by attorney Francis M. Brady of Brady, Connolly & Masuda, P.C. on or about January 10, 2013. The Petition for Review requested the Commission to review the Arbitration Decision and consider the issues of jurisdiction, medical expenses and whether the Arbitrator could order the Respondent in claim 08 WC 1934 to be reimbursed by the Respondent in case 96 WC 65881 for medical bills paid. The Decision of the Arbitrator is attached hereto and made a part hereof.

A consolidated hearing was held before Arbitrator Holland on November 14, 2012 for claims 96 WC 65881 and 08 WC 1934. Petitioner's claim 96 WC 65881 named Respondent Rockford Board of Education #205, represented by attorney Francis M. Brady of Brady, Connolly & Masuda, PC., and Petitioner's claim 08 WC 1934 named Respondent Rockford School District #205, represented by attorney Patrick Morris of Wiedner & McAuliffe, Ltd.

Arbitrator Holland issued separate decisions for claim 96 WC 65881 and claim 08 WC 1934 on December 12, 2012. In his Decision on claim 08 WC 1934, the Arbitrator found that Petitioner did sustain a injury on October 19, 2007 arising out of and in the course of her employment, but that her present condition of ill-being was not causally related to the injury sustained on that date. The Arbitrator found the October 19, 2007 work injury was a temporary aggravation of a pre-existing condition. He further found that only three medical bills in evidence were reasonable, necessary and related to the October 19, 2007 work injury, namely a

November 13, 2007 office visit with Dr. MacKenzie, a December 3, 2007 epidural steroid injection and flouroguide and a December 11, 2007 office visit with Dr. MacKenzie. The Arbitrator ordered Respondent to pay the sum of $1614.00 for the above mentioned necessary medical services as provided in Section 8(a) of the Act. The Arbitrator made further findings regarding claim 96 WC 65881 and ordered Respondent in claim 08 WC 1934 to reimburse Respondent in claim 96 WC 65881 for benefits provided to Petitioner.

The Commission has issued a separate Decision and Opinion on Review in response to a timely Petition for Review of the December 12, 2012 Arbitration Decision in claim 96 WC 65881. However, the Commission notes that an Arbitration Decision was entered in case 96 WC 65881 on June 9, 2003. The Arbitration Decision was not appealed and it became the final decision of the Commission on or about July 9, 2003. As such, Arbitrator Holland lacked jurisdiction to hear any subsequent evidence or make any subsequent findings regarding claim 96 WC 65881. The Commission, in separate Decision and Opinion on Review, has vacated Arbitrator Holland's December 12, 2012 Arbitration Decision in claim 96 WC 65881. As such, any findings the Arbitrator made regarding claim 96 WC in the December 12, 2012 Decision for claim 08 WC 1934 are void.

With regard to the current Petition for Review in claim 08 WC 1934 filed by attorney Francis M. Brady of Brady, Connolly & Masuda, P.C., the Commission makes the following findings:

Mr. Brady represented Respondent Rockford Board of Education #205 for claim 96 WC 65881. The only named Respondent in claim 08 WC 1934 is Rockford School District #205 and that party is represented by attorney Patrick Morris of Wiedner & McAuliffe, Ltd. The Commission notes that while the employer of Petitioner is in essence the same in both claims, the Respondents, insurers and counsel in claims 96 WC 65881 and 08 WC 1934 are different. The only Petition for Review in claim 08 WC 1934 was filed by Mr. Brady on or about January 10, 2013. Both Petitioner and Respondent in claim 08 WC 1934 have argued in their Statement of Exceptions that the December 12, 2012 Arbitration Decision should be affirmed and adopted by the Commission. The Commission finds that no party to the proceeding in claim 08 WC 1934 filed a timely Petition for Review of the December 12, 2012 Arbitration Decision. Therefore, the Commission lacks jurisdiction to issue a Decision and Opinion on Review.

The Commission notes that the Arbitrator made findings in his Decision for claim 08 WC 1934 regarding claim 96 WC 65881. As noted above, the December 12, 2012 Decision in claim 96 WC 65881 has been vacated by the Commission in a separate decision. Further, the Commission notes that it has jurisdiction to order only a named Respondent to pay benefits as provided for under the Act to a named Petitioner in the case before it. A Petitioner files his Application for Adjustment of Claim stating an injury was sustained on a specific date that arose out of and in the course of employment with a named Respondent in order to establish his rights under the provisions of the Act to recover compensation directly from the named party and, for attainment of that end, it is immaterial who is ultimately chargeable with payment of compensation for his injuries. (*See* QBE Insurance v. IWCC, 2013 Ill. App. (5th) 120336WC).

14IWCC0078

For the foregoing reasons, the Commission lacks jurisdiction to issue a Decision and Opinion on Review of the December 12, 2012 Arbitration Decision without a party to the proceeding bringing a timely Petition for Review. The Commission dismisses the Petition for Review filed January 10, 2013.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petition for Review filed January 10, 2013 is hereby dismissed. The Commission lacks jurisdiction to issue a Decision and Opinion on Review of the December 12, 2012 Arbitration Decision. All other issues moot.

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: FEB 0 3 2014

drd/adc
o-11/05/13
68

Daniel R. Donohoo

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PEPPERS, LISA
Employee/Petitioner

Case# **08WC001934**

ROCKFORD BOARD OF EDUCATION DISTRICT NO. 205
Employer/Respondent

14IWCC0078

On 12/12/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% 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:

2489 BLACK, JIM LAW OFFICE
BRAD A REYNOLDS
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

1120 BRADY CONNOLLY & MASUDA PC
FRANCIS M BRADY
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)
COUNTY OF Winnebago)

- [ ] 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

Lisa Peppers

Case # 08 WC 01934

Employee/Petitioner

v.

Rockford

Rockford Board of Education District No. 205
Employer/Respondent

14IWCC0078

An *Application for Adjustment 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 J. Holland, arbitrator of the Commission, in the city of Rockford, on November 14, 2012. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was the 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 the petitioner's employment by the respondent?

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

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

F. [x] 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. [x] Were the medical services that were provided to petitioner reasonable and necessary?

K. [ ] What amount of compensation is due for temporary total disability?

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

M. [ ] Should penalties or fees be imposed upon the respondent?

N. [ ] Is the respondent due any credit?

O. [ ] Other _____

14IWCC0078

FINDINGS

- On **October 19, 2007**, the 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 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 $ **17,160**; the average weekly wage was $ **330.00**.
- At the time of injury, the petitioner was **48** years of age, ***married*** with **0** children under 18.
- Necessary medical services ***have not*** been provided by the respondent.
- To date, $ **1,565.80** has been paid by the respondent for TTD and/or maintenance benefits.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $ **N/A**/week for _____ weeks, from _ through _____, which is the period of temporary total disability for which compensation is payable.
- The respondent shall pay the further sum of $ **1614.00** for necessary medical services, as provided in Section 8(a) of the Act. (see decision for findings on medical)
- The respondent shall pay $ **0** in penalties, as provided in Section 19(k) of the Act.
- The respondent shall pay $ **0** in penalties, as provided in Section 19(l) of the Act.
- The respondent shall pay $ **0** in attorneys' fees, as provided in Section 16 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.

Douglas J Holland

Signature of arbitrator

12-10-11
Date

DEC 12 2012

IN AND BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lisa Peppers, Employee/Petitioner, v. Rockford Board of Education; District No. 205, Employer/Respondent.	)	Case No. 08 WC 01934 14IWCC0078

DISPUTED ISSUES

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

The Arbitrator takes judicial notice of Petitioner's Exhibit 7, as well as First Respondent's Exhibit 1 which are the Illinois Industrial Commission Arbitration Decision regarding the nature and extent of injury, concerning Case No. 96 WC 65881 involving Petitioner, Lisa Peppers and Respondent, Rockford Board of Education; District No. 205. In a prior written Decision of the undersigned, the Petitioner was found to have sustained injury to her low back as the result of a work injury on September 19, 1996, while restraining a student in the course of her employment as a para-professional for the Respondent. See PX 7. It was noted in the Decision of the Arbitrator that Petitioner's then medical records offered into trial on the date of the hearing, May 14, 2003, demonstrated that the Petitioner had disc pathology in her low back and that surgical treatment of her complaints had been recommended by Dr. Fanscali. See PX 7. At the time of the initial Arbitration, the Arbitrator found that although surgery had been recommended, the Petitioner had not submitted to surgery but testified that is an option for her in the future. The Arbitrator awarded permanent partial disability (PPD) against the Respondent, in the amount of 15% permanent loss of use of the body as a whole, pursuant to Section 8(d)(2) of the Act. See PX 7.

The Petitioner continued to work for the Respondent after the parties' hearing on May 14, 2003 as a paraprofessional. At the time of the hearing, the Petitioner testified that she would experience periodic flare-ups of her low back pain since the injury and that she no longer lifts or moves heavy objects either at work or at home. The Petitioner continued working for the Respondent, following the hearing, and continued to experience periodic flare-ups, as demonstrated by her treatment records. The Petitioner testified in situations of flare-up that she would take medications and would schedule an appointment to get a spinal block. According to the Petitioner, her symptoms would generally improve until she experienced another flare-up.

Medical records demonstrate that the Petitioner was referred by her primary care physician, Dr. Kinigakis, for consultation with Dr. Sean McKenzie at ROA on account of

low back pain and pain radiating down her bilateral legs and feet. Right toe cramping was also reported. The initial consult with Dr. McKenzie was done on May 10, 2006. See PX 1. Petitioner received a lumbar epidural steroid injection by Dr. McKenzie on May 16, 2006. She was then seen in follow-up on July 21, 2006 with ongoing right-sided low back pain with a reported increase down the right leg with burning. Dr. McKenzie ordered an updated lumbar MRI. See PX 1. After review of the lumbar MRI, physical therapy was ordered. LESI and L5-S1 nerve block were then performed by Dr. McKenzie on August 28, 2006. By November 5, 2006, Ms. Peppers was reporting improvement in her symptoms, but still complaining of right calf pain. PX 1. There is no other medical treatment rendered for her low back symptoms in 2006.

Nearly a year later on July 9, 2007, the Petitioner saw her Rheumatologist, Dr. Danstill, for a non work-related condition, Crohn's disease. In the July 9, 2007 appointment with Dr. Danstill, he noted low back pain with radiculopathy and indicated she was to see Dr. McKenzie for consideration of LESI. PX 1. On July 13, 2007, the Petitioner was seen by Dr. McKenzie with bilateral calf burning from the knees to her foot, along with pain radiating to her bilateral thighs. See PX 1. The radiating pain was worse on the left than the right and her large toe was numb. See PX 1. Dr. McKenzie prescribed gabapentin and also prescribed an updated lumbar MRI. See PX 1. When seen again on August 1, 2007, there was no change in her symptoms. The diagnosis was lumbar radiculopathy. The plan was to perform LESI. See PX 1. On August 9, 2007, a lumbar epidural steroid injection was performed, which reportedly improved her symptoms by 10%, when she was re-examined on August 15, 2007. On September 12, 2007, a repeat LESI along with L5-S1 selective nerve block, were performed by Dr. McKenzie. See PX 1. On September 19, 2007, the Petitioner reported most of her low back pain was gone although she reported some residual pain in her right leg. The diagnosis remained lumbar radiculopathy. The plan was to reinject the Petitioner on an as-needed basis. PX 1.

Petitioner testified that she was working at the Maria Montessori for the Respondent as a paraprofessional when she sustained a new injury on October 19, 2007. The Petitioner testified she was setting up lunch tables, along with the students, in the lunch room. Petitioner explained several of the tables were broken and that she had to put weight on the tables to bring them down. Petitioner testified that as she placed weight on the table, that the table broke and she fell to the ground with the table, landing on her buttocks. The Petitioner testified that immediately after the incident, the 'fire' down her leg came back and that it was constant. The Petitioner testified that one time prior to October 19, 2007, she recalled a constant burning 'fire' down her leg.

According to medical records reviewed, Ms. Peppers was first seen by Dr. McKenzie on November 13, 2007. See PX 1. Dr. McKenzie noted a history that the Petitioner had reinjured her back when lifting a table on October 19, 2007, and that she felt shooting pain in her low back which radiated down her bilateral legs since the episode. See PX 1. At her first visit following the October 19, 2007 incident, Dr. McKenzie prescribed Lyrica and performed a repeat LESI. See PX 1. On December 3, 2007, the Petitioner was seen again by Dr. McKenzie, who performed a repeat LESI and selective nerve block at L5-S1. On December 11, 2007, the Petitioner was reporting that she felt better. The

diagnosis of lumbar radiculopathy remained the same. The plan was to continue her on Lyrica, and she was to return as needed. PX 1.

Subsequently, Respondent #1 and Respondent #2 could not come to an agreement, as to who was responsible for additional medical treatment. Petitioner was not then seen due to delay in authorization of medical treatment, until she was seen by Dr. Stephen Heim on May 2, 2008. When seen on May 2, 2008, the Petitioner gave a history of back pain in her lower extremities and she reported that in the intervening three (3) plus years since last seeing Dr. Heim, her symptoms had slowly intensified. It was primarily her lower extremity symptoms that troubled her to the greatest degree. See PX 3. The Petitioner did not report the October 19, 2007 specific injury to Dr. Heim when seen on May 2, 2008. See PX 3; Deposition Transcript pages 19-20. Dr. Heim obtained x-rays and compared them to x-rays that he had obtained of the Petitioner in January of 2005. After performing physical exam and considering the x-ray results, Dr. Heim's diagnosis was progressive Grade II L5-S1 Spondylolytic Spondylolisthesis with right greater than left L5 radiculopathy. See PX 3; Deposition Transcript page 21. Dr. Heim recommended an updated lumbar MRI as well as lumbar discogram, which were performed on August 18, 2008. The lumbar discogram was performed only at L3-4 and L4-5. These levels were tested because they needed to rule out these levels as being symptomatic. Dr. Heim testified that he already knew L5-S1 was a problem. See PX 3; Deposition Transcript pages 22-23. Based on discogram results, Dr. Heim recommended and subsequently performed a one (1) level lumbar fusion with instrumentation at L5-S1 on October 23, 2008 at Central DuPage Hospital. See PX 3; Deposition Transcript pages 22-23. Shortly after surgery, the Petitioner developed a high fever of 104 degrees and she developed a pulmonary embolism and pneumonia in her right lung. Dr. Heim testified those were complications of the lumbar surgery which he performed on October 23, 2008. See PX 3; Deposition Transcript pages 25-26. After completing doctor ordered rehabilitation, the petitioner was release to full-duty work by Dr. Heim on January 15, 2009. See PX 6.

Petitioner testified at the time of the hearing that the surgery performed by Dr. Heim resolved her 'fire' down her legs. The Petitioner testified she had an excellent outcome from lumbar surgery. The Petitioner testified that she has not seen Dr. Heim since 2008 when she was released. Petitioner did testify to some limitation regarding range of motion regarding her lumbar spine and noting some symptoms, especially in cold weather.

The Arbitrator finds that the Petitioner sustained her burden of proving an accident occurred that arose out of and in the course of her employment by the Respondent on October 19, 2007. Petitioner testified she was setting up lunch tables, along with students, when she sustained injury to her low back on October 19, 2007. Certainly, Petitioner was performing acts assigned to her within her job duties at the time of the incident.

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

Petitioner testified she reported the 10-19-07 injury to Sara Jones with Respondent in a timely fashion. No evidence was offered to the contrary.

F. Is the Petitioner's present condition of ill-being causally related to the October 19, 2007 injury?

Respondent #1 and Respondent #2 disagree as to which of Petitioner's work injuries was the cause of her low back L5-S1 instrumented fusion, performed by Dr. Heim on October 23, 2008. On the one hand, Respondent #1 argues that the October 19, 2007 injury was a permanent aggravation of a pre-existing condition and a contributing factor to the need for Petitioner's low back surgery, thus relieving them of further responsibility for Petitioner's low back condition. On the other hand, Respondent #2 argues that the October 19, 2007 injury was merely a temporary aggravation of a pre-existing condition, which does not relieve Respondent #1 of their obligation to pay for causally related medical treatment, necessitated by Petitioner's original September 19, 1996 work injury.

The Arbitrator has carefully considered the testimony of the Petitioner and her treating medical records, along with the expert opinions of Dr. Heim and Dr. Singh. For the reasons listed below, the Arbitrator finds Petitioner failed to sustain her burden of proving that her present condition of ill-being is causally related to the October 19, 2007 injury. Instead, the Arbitrator find the Petitioner's present condition of ill-being is causally related to Case No. 96 WC 65881.

Several reasons support the Arbitrator's finding that there is a causal relationship between Petitioner's low back treatment with Dr. Heim from May 2, 2008 through January 15, 2009, and the Case No. 96 WC 65881 injury. First and foremost, the Arbitrator notes that at the time of the original hearing between the parties; it was contemplated by the Petitioner's surgeon that she required low back surgery. Medical records confirm that the low back surgery contemplated at the time of the parties original hearing in 2003 was a lumbar fusion. Dr. Heim performed the same surgery contemplated by the Petitioner's treating physician in 2003, on October 23, 2008.

Second, Petitioner's treating medical records from ROA demonstrate significant and ongoing low back pain with radiculopathy and bilateral leg pain throughout the middle of 2006, as well as 2007. The Petitioner was seen as recently by Dr. McKenzie, as September 19, 2007, regarding her low back pain (exactly one month prior to the episode with the lunch table in October). On September 12, 2007, Dr. McKenzie performed an LESI and L5-S1 selective nerve block for the diagnosis of lumbar radiculopathy.

Third, the Arbitrator considers the opinion of Dr. Stephen Heim, who is the treating physician, and adopts it as credible and persuasive. Dr. Heim significantly did not record a history of the table incident from the Petitioner when he saw her on May 2, 2008. On the issue of causation, Dr. Heim testified that it was his opinion to a reasonable degree of medical certainty, that Ms. Peppers's symptoms and subsequent care were related to the injury of September 19, 1996, and not the injury of October 19, 2007. See PX 3; Deposition Transcript pages 26-27. When specifically asked by Respondent #1's counsel whether the October 19, 2007 incident was the explanation for the worsening in her condition between the dates Dr. Heim saw the Petitioner in 2005 and 2008, Dr. Heim acknowledged that it was possible, though he testified her plain x-ray progression and the

progression seen on the MRI of January 7, 2008 is much more consistent with the gradual progressive process than an acute one. See PX 3; Deposition Transcript pages 40-41. All this is to say that while Dr. Heim acknowledged the Petitioner's symptoms had worsened between May of 2008 and January of 2005 when he had last seen her, it was Dr. Heim's position that the worsening of her symptoms was best explained by a gradual degenerative process associated with the original injury, rather than an acute process caused by the October 19, 2007 work injury.

Forth, Respondent #1 arranged an IME exam with Dr. Kern Singh. See PX 4-5. In his original IME report, dated August 28, 2008, Dr. Singh diagnosed isthmic spondylolisthesis at L5-S1. See PX 5. Regarding causality and apportionment, Dr. Singh (who was retained by Respondent #1), testified he believed the patient sustained an aggravation of her pre-existing degenerative condition in September of 1996. He concurred with Dr. Heim's assessment and believed the patient would benefit from a posterior laminectomy with instrumented fusion at L5-S1. See PX 5. It should be noted that subsequent to his initial report, Dr. Singh did write a subsequent report where he opined that the October 19, 2007 injury was an aggravation of the pre-existing low back condition, caused by the original work accident. Thereafter, Dr. Singh wrote a third opinion finding the surgery Dr. Heim performed in October of 2008, was not related to either the September 19, 1996 work injury, nor the October 19, 2007 work injury, in contradiction to two (2) prior written reports he had authored for Respondent #1. Law of the case principles bind the Arbitrator to his prior ruling. Dr. Singh's suggestion that surgery done by Dr. Heim at L5-S1 regarding the Petitioner was not related to either work injury is incompatible with law of the case principles and is rejected by the Arbitrator.

J. Were the medical services that were provided to Petitioner reasonable and necessary?

The Arbitrator finds that Petitioner's October 19, 2007 work injury was merely a temporary aggravation of a pre-existing condition. The Arbitrator specifically finds that only three (3) medical visits with ROA are causally related to the October 19, 2007 work injury, as listed below:

- November 13, 2007 office visit to Dr.MacKenzie-$149.00
- December 3, 2007 epidural steroid injection $801.00, and flouroguide for $569.00
- December 11, 2007 office visit to Dr. MacKenzie-$95.00

The Arbitrator finds Respondent #2 is responsible for these three medical bills which Respondent #1 has already paid. Respondent #2 is ordered to reimburse Respondent #1 for only those 3 dates of service at ROA identified above. All other medical bills, which are causally related to Case No. 96 WC 65881, are the responsibility of Respondent #1. The Arbitrator has issued a separate decision concerning Case No. 96 WC 65881, identifying those medical bills for which Respondent #1 is responsible for paying, which remain unpaid at this time. The Arbitrator's decision in Case No. 96 WC 65881 also directs Respondent #1 to reimburse Respondent #2 for all other medical expenses, which

were paid by Respondent #2, that the Arbitrator finds are not causally related to the October 19, 2007 work injury.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lisa Peppers,
Petitioner,

vs. NO: 96 WC 65881

14IWCC0079

Rockford Board of Education #205,
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 jurisdiction, accident, medical expenses and whether the Arbitrator improperly directed reimbursement, and being advised of the facts and law, vacates the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Findings of Fact and Conclusions of Law

Petitioner filed an Application for Adjustment of Claim on or about December 17, 1996, alleging injury to her back, body as a whole and both legs in the scope and course of her employment for Respondent, Rockford Board of Education #205 on or about September 19, 1996. The claim was assigned case number 96 WC 065881. A final hearing was bifurcated and heard on May 14, 2003 and May 16, 2003 before Arbitrator Douglas Holland.

Arbitrator Holland issued a decision on June 9, 2003. The Arbitrator found Petitioner did sustain accidental injuries that arose out of and in the course of her employment and ordered Respondent to pay Petitioner $114.70/week for a period of 75 weeks as provided in Section 8(d)2 of the Act, because the injuries she sustained caused a 15% loss of use of Petitioner's body as a whole. The June 9, 2003 Arbitration Decision was not appealed and became the final decision of the Commission on or about July 9, 2003.

14IWCC0079

Despite the fact that a final decision had been entered in this case in 2003, Arbitrator Holland reheard case 96 WC 65881 on November 14, 2012 in consolidation with a pending claim, 08 WC 1934, Petitioner had set for hearing before the Commission. Arbitrator Holland then issued an Arbitration Decision in case 96 WC 065881 on December 12, 2012, awarding Petitioner additional medical benefits under Section 8(a) of the Act.

The Commission finds that Arbitrator Holland lacked jurisdiction to hear any evidence or make any findings in claim 96 WC 65881 after the Arbitration Decision in the case became the final decision of the Commission in July 2003. The Commission notes that no party to the proceeding has filed a Petition for Review under Section 8(a) of the Act to petition the Commission to review the case.

For the forgoing reasons, the Commission vacates the Arbitrator's December 12, 2012 decision in case 96 WC 065881. All other issues are moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 12, 2012 is hereby vacated for lack of jurisdiction.

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: FEB 0 3 2014

drd/adc
o-11/05/13
68

Daniel R. Donohoo

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PEPPERS, LISA
Employee/Petitioner

Case# **96WC065881**

ROCKFORD BOARD OF EDUCATION DISTRICT NO. 205
Employer/Respondent

14IWCC0079

On 12/12/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% 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:

2489 BLACK, JIM LAW OFFICE
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308 W STATE ST SUITE 300
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0560 WIEDNER & MCAULIFFE LTD
PATRICK J MORRIS
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)
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

Lisa Peppers
Employee/Petitioner

v.

Rockford Board of Education District No. 205
Employer/Respondent

Case # 96 WC 65881

Rockford

14IWCC0079

An *Application for Adjustment 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 J. Holland, arbitrator of the Commission, in the city of Rockford, on November 14, 2012. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was 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 amount of compensation is due for temporary total disability?

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

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Other _____

14IWCC0079

FINDINGS

- On **September 19, 1996**, the 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 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 $ **7,646.80**; the average weekly wage was $ **191.47**.
- At the time of injury, the petitioner was **37** years of age, *married* with **3** children under 18.
- Necessary medical services *have not* been provided by the respondent.
- To date, $ **0** has been paid by the respondent for TTD and/or maintenance benefits.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $ **N/A**/week for _____ weeks, from _ through _____, which is the period of temporary total disability for which compensation is payable.
- The respondent shall pay the petitioner the sum of $ _____/week for a further period of _____ weeks, as provided in Section _____ of the Act, because the injuries sustained caused _____.
- The respondent shall pay the petitioner compensation that has accrued from _____ through _____, and shall pay the remainder of the award, if any, in weekly payments.
- The respondent shall pay the further sum of $ **189,477.22** for necessary medical services, as provided in Section 8(a) of the Act.
- The respondent shall pay $ **0** in penalties, as provided in Section 19(k) of the Act.
- The respondent shall pay $ **0** in penalties, as provided in Section 19(l) of the Act.
- The respondent shall pay $ **0** in attorneys' fees, as provided in Section 16 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.

Douglas J Holland
Signature of arbitrator

12-10-12
Date

DEC 12 2012

IN AND BEFORE THE ILLINOIS
WORKERS' COMPENSATION COMMISSION

Lisa Peppers, Employee/Petitioner, v. Rockford Board of Education; District No. 205, Employer/Respondent.	)	Case No. 96 WC 65881 14IWCC0079

DISPUTED ISSUES

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

The Arbitrator takes judicial notice of Petitioner's Exhibit 7, as well as First Respondent's Exhibit 1 which is the Illinois Industrial Commission Arbitration Decision regarding the nature and extent of injury, concerning Case No.: 96 WC 65881 involving Petitioner, Lisa Peppers and Respondent, Rockford Board of Education; District No. 205. In a prior written Decision of the undersigned, the Petitioner was found to have sustained injury to her low back as the result of a work injury on September 19, 1996, while restraining a student in the course of her employment as a para-professional for the Respondent. See PX 7. It was noted in the Decision of the Arbitrator that Petitioner's then medical records offered into trial on the date of the hearing, May 14, 2003, demonstrated that the Petitioner has disc pathology in her low back and that surgical treatment of her complaints had been recommended by Dr. Fanscali. See PX 7. At the time of the initial Arbitration, the Arbitrator found that although surgery had been recommended, the Petitioner had not submitted to surgery but testified that is an option for her in the future. The Arbitrator awarded permanent partial disability (PPD) against the Respondent, in the amount of 15% permanent loss of use of the body as a whole, pursuant to Section 8(d)(2) of the Act.

The Petitioner continued to work for the Respondent after the parties hearing on May 14, 2003 as a paraprofessional. At the time of the hearing, the Petitioner testified that she would experience periodic flare-ups of her low back pain since the injury and that she no longer lifts or moves heavy objects either at work or at home. The Petitioner continued working for the Respondent, following the hearing, and continued to experience periodic flare-ups, as demonstrated by her treatment records. The Petitioner testified in situations of flare-up that she would take medications and would schedule an appointment to get a spinal block. According to the Petitioner, her symptoms would generally improve until she experienced another flare-up.

Medical records demonstrate that the Petitioner was referred by her primary care physician, Dr. Kinigakis, for consultation with Dr. Sean McKenzie at ROA on account of low back pain and pain radiating down her bilateral legs and feet. Right toe cramping was

also reported. The initial consult with Dr. McKenzie was done on May 10, 2006. See PX 1. Petitioner received a lumbar epidural steroid injection by Dr. McKenzie on May 16, 2006. She was then seen in follow-up on July 21, 2006 with ongoing right-sided low back pain with a reported increase down the right leg with burning. Dr. McKenzie ordered an updated lumbar MRI. See PX 1. After review of the lumbar MRI, physical therapy was ordered. LESI and L5-S1 nerve block were then performed by Dr. McKenzie on August 28, 2006. By November 5, 2006, Ms. Peppers was reporting improvement in her symptoms, but still complaining of right calf pain. There is no other medical treatment rendered for her low back symptoms in 2006. PX 1.

Nearly a year later on July 9, 2007, the Petitioner saw her Rheumatologist, Dr. Danstill, for a non work-related condition, Crohn's disease. In the July 9, 2007 appointment with Dr. Danstill, he noted low back pain with radiculopathy and indicated she was to see Dr. McKenzie for consideration of LESI. On July 13, 2007, the Petitioner was seen by Dr. McKenzie with bilateral calf burning from the knees to her foot, along with pain radiating to her bilateral thighs. See PX 1. The radiating pain was worse on the left than the right and her large toe was numb. See PX 1. Dr. McKenzie prescribed gabapentin and also prescribed an updated lumbar MRI. See PX 1. When seen again on August 1, 2007, there was no change in her symptoms. The diagnosis was lumbar radiculopathy. The plan was to perform LESI. See PX 1. On August 9, 2007, a lumbar epidural steroid injection was performed, which reportedly improved her symptoms by 10%, when she was re-examined on August 15, 2007. On September 12, 2007, a repeat LESI along with L5-S1 selective nerve block, were performed by Dr. McKenzie. See PX 1. On September 19, 2007, the Petitioner reported most of her low back pain was gone although she reported some residual pain in her right leg. The diagnosis remained lumbar radiculopathy. The plan was to reinject the Petitioner on an as-needed basis. PX 1.

Petitioner testified that she was working at the Maria Montessori for the Respondent as a paraprofessional when she sustained a new injury on October 19, 2007. The Petitioner testified she was setting up lunch tables, along with the students, in the lunch room. Petitioner explained several of the tables were broken and that she had to put weight on the tables to bring them down. Petitioner testified that as she placed weight on the table, that the table broke and she fell to the ground with the table, landing on her buttocks. The Petitioner testified that immediately after the incident, the 'fire' down her leg came back and that it was constant. The Petitioner testified that one time prior to October 19, 2007, she recalled a constant burning 'fire' down her leg.

According to medical records reviewed, Ms. Peppers was first seen by Dr. McKenzie on November 13, 2007. See PX 1. Dr. McKenzie noted a history that the Petitioner had reinjured her back when lifting a table on October 19, 2007, and that she felt shooting pain in her low back which radiated down her bilateral legs since the episode. See PX 1. At her first visit following the October 19, 2007 incident, Dr. McKenzie prescribed Lyrica and performed a repeat LESI. See PX 1. On December 3, 2007, the Petitioner was seen again by Dr. McKenzie, who performed a repeat LESI and selective nerve block at L5-S1. On December 11, 2007, the Petitioner was reporting that she felt better. The

diagnosis of lumbar radiculopathy remained the same. The plan was to continue her on Lyrica, and she was to return as needed. PX 1.

Subsequently, Respondent #1 and Respondent #2 could not come to an agreement, as to who was responsible for additional medical treatment. Petitioner was not then seen due to delay in authorization of medical treatment, until she was seen by Dr. Stephen Heim on May 2, 2008. When seen on May 2, 2008, the Petitioner gave a history of back pain in her lower extremities and she reported that in the intervening three (3) plus years since last seeing Dr. Heim, her symptoms had slowly intensified. It was primarily her lower extremity symptoms that troubled her to the greatest degree. See PX 3. The Petitioner did not report the October 19, 2007 specific injury to Dr. Heim when seen on May 2, 2008. See PX 3; Deposition Transcript pages 19-20. Dr. Heim obtained x-rays and compared them to x-rays that he had obtained of the Petitioner in January of 2005. After performing physical exam and considering the x-ray results, Dr. Heim's diagnosis was progressive Grade II L5-S1 Spondylolytic Spondylolisthesis with right greater than left L5 radiculopathy. See PX 3; Deposition Transcript page 21. Dr. Heim recommended an updated lumbar MRI as well as lumbar discogram, which were performed on August 18, 2008. The lumbar discogram was performed only at L3-4 and L4-5. These levels were tested because they needed to rule out these levels as being symptomatic. Dr. Heim testified that he already knew L5-S1 was a problem. See PX 3; Deposition Transcript pages 22-23. Based on discogram results, Dr. Heim recommended and subsequently performed one (1) level lumbar fusion with instrumentation at L5-S1 on October 23, 2008 at Central DuPage Hospital. See PX 3; Deposition Transcript pages 22-23. Shortly after surgery, the Petitioner developed a high fever of 104 degrees and she developed a pulmonary embolism and pneumonia in her right lung. Dr. Heim testified those were complications of the lumbar surgery which he performed on October 23, 2008. See PX 3; Deposition Transcript pages 25-26. After completing doctor ordered rehabilitation, the petitioner was release to full-duty work by Dr. Heim on January 15, 2009. See PX 6.

Petitioner testified at the time of the hearing that the surgery performed by Dr. Heim resolved her 'fire' down her legs. The Petitioner testified she had an excellent outcome from lumbar surgery. The Petitioner testified that she has not seen Dr. Heim since 2008 when she was released. Petitioner did testify to some limitation regarding range of motion regarding her lumbar spine and noting some symptoms, especially in cold weather.

Respondent #1 disputes their obligation to pay medical bills associated with the Petitioner's lumbar surgery and any medical treatment after October 19, 2007, on the grounds that the October 19, 2007 was an intervening accident, relieving Respondent #1 of their obligation to be responsible for Petitioner's medical needs as the result of Case No. 96 WC 65881. Respondent #2 argues that the October 19, 2007 incident was merely a temporary aggravation of a pre-existing condition, which did not resolve Respondent #1 of their obligation to pay for Petitioner's work-related future medical expenses, regarding her low back including the surgery done by Dr. Heim in October of 2008.

It is for the Arbitrator to determine whether the October 19, 2007 work injury described by the Petitioner involving the lunch table, relieves or absolves Respondent #1 from any obligation regarding Petitioner's future medical benefits after October 19, 2007.

After review of the testimony of the Petitioner, and in consideration of treating medical records, along with the opinions of Dr. Heim and Dr. Singh, the Arbitrator finds that Respondent #1 was responsible for the Petitioner's lumbar surgery performed by Dr. Heim on October 23, 2008 at Central DuPage Hospital. Specifically, the Arbitrator finds that the October 19, 2007 incident involving the lunch table was merely a temporary aggravation of a pre-existing condition. The Arbitrator finds that the Petitioner achieved MMI for the October 19, 2007 injury on December 11, 2007. The Arbitrator specifically finds that treatment dates November 13, 2007, December 3, 2007, and December 11, 2007, are causally related to the October 19, 2007 injury, and that Respondent #2 is responsible for payment of those medical bills only. All subsequent treatment is causally related to the September 19, 1996 work injury, including the lumbar surgery performed by Dr. Heim.

Several reasons support the Arbitrator's finding that there is a causal relationship between Petitioner's low back treatment with Dr. Heim from May 2, 2008 through January 15, 2009, and the Case No.: 96 WC 65881 injury. First and foremost, the Arbitrator notes that at the time of the original hearing between the parties; it was contemplated by the Petitioner's surgeon that she required low back surgery. Medical records confirm that the low back surgery contemplated at the time of the parties original hearing in 2003 was a lumbar fusion. Dr. Heim performed the same surgery contemplated by the Petitioner's treating physician in 2003, on October 23, 2008.

Second, Petitioner's treating medical records from ROA demonstrate significant and ongoing low back pain with radiculopathy and bilateral leg pain throughout the middle of 2006, as well as 2007. The Petitioner was seen as recently by Dr. McKenzie, as September 19, 2007, regarding her low back pain (exactly one month prior to the episode with the lunch table in October). On September 12, 2007, Dr. McKenzie performed an LESI and L5-S1 selective nerve block for the diagnosis of lumbar radiculopathy.

Third, the Arbitrator considers the opinion of Dr. Stephen Heim, who is the treating physician, and adopts it as credible and persuasive. Dr. Heim significantly did not record a history of the desk incident from the Petitioner when he saw her on May 2, 2008. On the issue of causation, Dr. Heim testified that it was his opinion to a reasonable degree of medical certainty, that Ms. Peppers's symptoms and subsequent care were related to the injury of September 19, 1996, and not the injury of October 19, 2007. See PX 3; Deposition Transcript pages 26-27. When specifically asked by Respondent #1's counsel whether the October 19, 2007 incident was the explanation for the worsening in her condition between the dates Dr. Heim saw the Petitioner in 2005 and 2008, Dr. Heim acknowledged that it was possible, though he testified her plain x-ray progression and the progression seen on the MRI of January 7, 2008 is much more consistent with the gradual progressive process than an acute one. See PX 3; Deposition Transcript pages 40-41. All this is to say that while Dr. Heim acknowledged the Petitioner's symptoms had worsened

between May of 2008 and January of 2005 when he had last seen her, it was Dr. Heim's position that the worsening of her symptoms was best explained by a gradual degenerative process associated with the original injury, rather than an acute process caused by the October 19, 2007 work injury.

Fourth, Respondent #1 arranged an IME exam with Dr. Kern Singh. See PX 4-5. In his original IME report, dated August 28, 2008, Dr. Singh diagnosed isthmic spondylolisthesis at L5-S1. See PX 5. Regarding causality and apportionment, Dr. Singh (who was retained by Respondent #1), testified he believed the patient sustained an aggravation of her pre-existing degenerative condition in September of 1996. He concurred with Dr. Heim's assessment and believed the patient would benefit from a posterior laminectomy with instrumented fusion at L5-S1. See PX 5. It should be noted that subsequent to his initial report, Dr. Singh did write a subsequent report where he opined that the October 19, 2007 injury was an aggravation of the pre-existing low back condition, caused by the original work accident. Thereafter, Dr. Singh wrote a third opinion finding the surgery Dr. Heim performed in October of 2008, was not related to either the September 19, 1996 work injury, nor the October 19, 2007 work injury, in contradiction to two (2) prior written reports he had authored for Respondent #1. Law of the case principles bind the Arbitrator to his prior ruling. Dr. Singh's suggestion that surgery done by Dr. Heim at L5-S1 regarding the Petitioner was not related to either work injury is incompatible with law of the case principles and is rejected by the Arbitrator.

In summary, the Arbitrator finds that the October 19, 2007 work injury does not relieve Respondent #1 of their obligation to pay work-related future medical treatment, concerning the Petitioner. The Arbitrator specifically find that all medical treatment after the parties' initial hearing on May 14, 2003 and prior to October 19, 2007 is causally related to Case No.: 96 WC 65881, and Respondent #1 is responsible for this treatment. The Arbitrator further finds Respondent #1 is not responsible for medical treatment rendered at ROA to the Petitioner concerning the October 19, 2007 work injury, but limits that treatment to the following visits: November 13, 2007, December 3, 2007, and December 11, 2007. The Arbitrator thereafter finds that Respondent #1 is responsible for the Petitioner's remaining medical treatment concerning her low back and including low back surgery done by Dr. Heim, as well as post-surgery complication which resulted in the Petitioner's hospitalization for a pulmonary embolism at OSF St. Anthony.

Respondent #2 offered Rx 1, which is a compilation of all medical bills and TTD that Respondent #2 paid with regards to the Petitioner after the October 19, 2007 work injury. The Arbitrator now orders Respondent #1 to reimburse Respondent #2 for all medical bills contained in Respondent #2's Exhibit 1, in the amount of **$181,846.47**. Respondent #1 is not required to reimburse Respondent #2 for TTD benefits paid by Respondent #2 to Petitioner following her low back surgery with Dr. Heim.

J. Were the medical services that were provided to the Petitioner reasonable and necessary?

The Arbitrator finds all medical services provided to the Petitioner were reasonable and necessary and causally related to her September 19, 1996 work injury, with the exception of the three (3) visits at ROA in November 2007 and December of 2007. Respondent #1 is ordered to pay Respondent #2 for all medical bills paid by Respondent #2, regarding the Petitioner, as demonstrated by Respondent #2's Exhibit 1 in the total amount of $181,846.47. Respondent #1 is further ordered to pay the unpaid medical bills, as listed below:

Medical Provider	Date of Service	Total Outstanding Balance
1. Central DuPage Hospital	8/18/2008	$7,630.75

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

☒ 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

Anthony Stanley,
Petitioner,
vs.

14IWCC0080

NO: 12 WC 4762

Wal-Mart,
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, permanent partial disability, medical expenses, 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 July 15, 2013 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: FEB 0 3 2014
KWL/vf
O-1/28/14
42

Kevin W. Lamborn

Daniel R. Donohoo

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0080

STANLEY, ANTHONY
Employee/Petitioner

Case# **12WC004762**

WAL-MART
Employer/Respondent

On 7/15/2013, 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:

2427 KANOSKI BRESNEY
KATHY A OLIVERO
2730 S MacARTUR BLVD
SPRINGFIELD, IL 62704

0560 WIEDNER & MCAULIFFE LTD
MATTHEW ROKUSEK
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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

14IWCC0080

Anthony Stanley
Employee/Petitioner

v.

Wal-Mart
Employer/Respondent

Case # 12 WC 04762

Consolidated cases: NA

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield/Urbana**, on **April 15, 2013 and May 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

14IWCC0080

FINDINGS

On **9/21/11**, 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 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 $ **27,360.71**; the average weekly wage was $ **547.21**.

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

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

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

Respondent shall be given a credit of $ **0.00** for TTD, $ **0.00** for TPD, $ **0.00** for maintenance, and $ **5,918.13** in other benefits for which credit may be allowed pursuant to Section 8(j) of the Act.

Respondent is entitled to a credit for any medical bills it has paid through a group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

- Petitioner failed to provide notice as required under Section 6(c) of the Act.
- Petitioner failed to prove he sustained an accident on September 21, 2011 that arose out of and in the course of his employment with Respondent.
- Petitioner failed to prove causal connection.
- Petitioner's 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.

Nancy Lindsay
Signature of Arbitrator

7-10-13
Date

JUL 15 2013

This case originally went to arbitration on April 15, 2013; however, proofs were not closed until May 17, 2013. The disputed issues are: accident; notice; causal connection; temporary total disability; medical expenses; and the nature and extent of Petitioner's injury. Witnesses testifying at arbitration included Petitioner; Rod Wooldridge; Derrick Thaxton; Melody Sharp; Phillip Crawford; and Dwayne Maglone.

The Arbitrator finds:

According to the Decatur Memorial Hospital records (PX 1) Petitioner went to the emergency room on January 19, 2011 regarding a right wrist sprain/strain. The triage note states that Petitioner noted the onset of right hand and wrist pain after working/lifting pallets for Respondent. Petitioner denied any known injury but remarked he had performed the same job for 11 years. Additional history regarding Petitioner's activities at the time of the onset was noted. On physical examination Petitioner denied any pain to his proximal forearm, elbow, upper arm or shoulder. X-rays of Petitioner's right hand were taken. Petitioner was given a thumb spica wrist brace to wear at work, along with medication, and told to report to DMH Corporate Health the next day. (PX 1)

On January 20, 2011 Petitioner completed an Associate Statement regarding an injury occurring on January 17, 2011. Petitioner was lifting pallets but unsure how the injury occurred. Petitioner reported it on January 20, 2011 to "Drew." (RX 8) Melody Sharp completed the Employer's First Report of Injury on that date. (RX 8 – 0003). According to Respondent's records, Petitioner received treatment at DMH Corporate Health and was given temporary work restrictions which Respondent was able to accommodate. (RX 8 – 0004 to 0006)

According to Respondent's "Call In Sheets" Petitioner was absent from work on August 26, 2011 due to illness/injury. (PX 9) Petitioner was late for work on August 28, 2011 due to illness/injury. (PX 9)

According to Dr. Jones' records Petitioner called the doctor's office on August 30, 2011, requesting an appointment for left shoulder pain. (RX 10 – 0008; PX 3) Petitioner reported that his symptoms began three days earlier and were not work-related. (RX 10 – 0008) Petitioner provided his group medical insurance information at that time. (RX 10 – 0008) An appointment was scheduled for September 15, 2011; however, Petitioner did not show up for that appointment or call to cancel. (RX 10 – 008 through 0013)

Petitioner called in absent on September 21, 2011 due to illness/injury. (PX 9, p. 4)

Petitioner presented at the emergency room at Decatur Memorial Hospital on September 22, 2011. (PX 1 pg. 18 PX 3, pp. 7-12) The triage note indicates Petitioner reported intermittent pain over the preceding two days. Petitioner stated he could move his arm without difficulty but experienced intermittent pain and noted that certain movements exacerbated the pain. The mechanism of injury was reportedly unknown. (PX 1 p. 18) Petitioner denied any trauma and only mentioned that he did a lot of overhead lifting at work. Petitioner noticed pain with

abduction/flexion of his left shoulder. (PX 1 pp. 14-21) Emergency room documentation also notes Petitioner stated the shoulder pain had been present on an intermittent basis for four days. On physical examination Petitioner was tender to palpation of the glenohumeral joint and had positive pain with resisted abduction/flexion of his left shoulder. Petitioner was diagnosed with a muscle strain and was released to return to work with restrictions. He was also given medication and a sling and told not to use his left arm for ten days at which point he could return to full duty work without any restriction if he felt well. (PX 1, p. 16)

On/about September 30, 2011 Petitioner applied for an FLMA leave of absence effective September 21, 2011 through October 1, 2011 due to Petitioner's left shoulder. The emergency room physician completed the healthcare provider statement. (RX 1)

On October 4, 2011 (a Tuesday), Petitioner again called Dr. Jones' office requesting an appointment. (RX 10 – 0020, PX 3, p. 13) Dr. Jones' records indicate that Petitioner was experiencing left shoulder pain and had been to DMH ER "last Wednesday," and the date of onset of symptoms was "last Wednesday." In the space where one would indicate whether the injury was work-related, the following was marked out – "Yes, WalMart." In its place was written, "No." (PX 3, p. 13; RX 10 - 0020) Petitioner was to call back with workers' compensation information. Petitioner did call back on October 6, 2011 and advised "will not be work comp." (PX 3, p. 13; RX 10- 0020)

Petitioner next sought treatment from Dr. Duncan, his primary care physician, on October 11, 2011. (PX 2 p. 1) Prior to that date, Petitioner had not seen Dr. Duncan since 2007. (PX 2 p. 4) Petitioner explained he had left shoulder pain, had been in the ER and had been told he had tendinitis. He denied any trauma but reported performing lots of overhead activities, including stocking shelves. Petitioner was instructed about shoulder exercises and the use of Aleve for pain.

A clinical information form was updated by Dr. Jones' clinical assistant on October 11, 2011, indicating that Petitioner did not sustain an injury. (RX 10 – 0032 through 0034; PX 3, pp. 25 - 27) No history of a work injury was recorded. (RX 10 – 0032 through 0034)

Dr. Jones first saw Petitioner on October 13, 2011, at which time Petitioner reported left shoulder pain for the past three weeks. (RX 10 – 0028; PX 3) No history of a work-related injury or description of Petitioner's job duties was documented on that visit. Petitioner did report pain which would awaken him if he rolled over onto his left side. (RX 10 – 0028 through 0030). On physical examination, Dr. Jones found weakness of Petitioner's supraspinatus with pain, weakness of external rotation without pain, and the presence of atrophy of the supraspinatus. Dr. Jones ordered an MRI of Petitioner's left shoulder (PX 3, pp. 22-23) In the interim, Dr. Jones diagnosed Petitioner with left shoulder pain. Petitioner indicated he did not need a note for work. The doctor's note indicates Petitioner's work status was full duty. (RX 10 – 0029; PX 3, p. 23)

An MRI of Petitioner's left shoulder was obtained on October 18, 2011, which suggested a full-thickness tear of the rotator cuff without retraction. (PX 1 pg. 24) Petitioner returned to Dr. Jones on October 27, 2011, with no change in his symptoms. (RX 10 – 0040) Following a review of the MRI, Dr. Jones recommended surgery. (RX 10 – 0040).

Petitioner returned on October 27, 2011, to discuss the results of the MRI (PX 3, p. 33-34). Dr. Jones diagnosed left rotator cuff sprain and strain and discussed with Petitioner the need for surgery noting Petitioner would call when ready to schedule surgery (PX 3, pp. 33-34)

The records of Dr. Jones reflect that Petitioner called on November 8, 2011, requesting surgery be scheduled after Thanksgiving and the date of November 28, 2011, was agreed upon. (PX 3, p. 31)

Dr. Jones admitted Petitioner to Decatur Memorial Hospital on November 28, 2011. (PX 1 pp. 31, 35) No mention of a work-related injury was documented in the history and physical. (RX 10 – 0047) Dr. Jones performed a debridement arthroscopy with arthroscopic subacromial decompression, and debridement of a partial thickness rotator cuff tear. (PX 1 p. 35) He discharged Petitioner with a post-operative diagnosis of left partial thickness rotator cuff tear with impingement. (PX 1 pg. 35; RX 10 – 0043)

Respondent faxed Dr. Jones' office a Certification of Health Care Provider for Associate's Serious Health Condition (FMLA) form on November 29, 2011 (PX 3, pp. 48-50).

Petitioner returned to Dr. Jones post-operatively on December 6, 2011. (RX 10 – 0059) Dr. Jones completed the leave of absence paperwork indicating Petitioner was unable to work and faxed it back to Respondent. (RX 10 – 0059; see also PX 3 and RX 2) Petitioner was wearing a sling and taking 4 pain pills a day (PX 3, p. 52-53). Dr. Jones prescribed different medication, physical therapy for Petitioner, and kept Petitioner off work (PX 3, pp. 51 - 53).

Petitioner's therapy was conducted at Decatur Memorial Hospital. (PX 1 pp. 41-62, PX 3, p. 53) Although Petitioner was given a Patient History form on December 15, 2011, which asked "When & how did the problem start?" Petitioner did not complete the form. (PX 1 p. 41) Petitioner was wearing a sling and taking 4 pain pills a day (PX 3, p. 52-53). The initial therapy evaluation reported Petitioner was seen on December 15, 2011, and noted Petitioner's subjective comments were "hands went numb after work – in September, worked up to surgery – stocks shelves at [Respondent], surgery November 28, 2011, and wearing sling and immobilizer." It was also noted that Petitioner had 'problems with his right shoulder [illegible] this past summer." (PX 1, p. 44)

On January 6, 2012, the Hartford contacted Dr. Jones' office requesting an attending physician statement of functionality in support of Petitioner's claim for short-term disability benefits. A decision on Petitioner's income replacement was pending until that information was received. (RX 10 – 0062; PX 3, p. 55) Dr. Jones completed and signed the form, checking "no" when asked "[i]s this condition due to illness or an injury that is work-related," and indicating that his condition was the result of "sickness" rather than injury or pregnancy. The completed form further noted Petitioner was unable to lift/carry above his shoulder, reach at waist/desk level with his left arm, or reach below waist/desk level with his left arm. (RX 10 – 0063).

Petitioner returned to Dr. Jones on January 17, 2012. Petitioner reported his shoulder was doing pretty good. (PX 3, pp. 62-63) Dr. Jones recommended Petitioner stop using the sling but continue physical therapy. Although Petitioner wanted to return to full duty Dr. Jones kept him

on light duty and Petitioner was given a work slip stating no use of the left arm. (PX 3, pp. 61, 62-63)

Petitioner signed his Application for Adjustment of Claim on February 3, 2012, alleging a left arm injury due to stocking shelves and unloading trucks. The alleged date of accident was September 18, 2011. (AX 2)

On February 7, 2012 Respondent's Personnel Manager, Melody Sharp, faxed several pages to "Eric" at CMI. The cover sheet states, "Eric – we have no claim on this – How do you want me to proceed? He had a claim 1-17-11 for his wrist." (RX 3 - 0002) Attached to the cover sheet is a 2/3/12 letter from Petitioner's attorney's office enclosing a copy of the Application for Adjustment of Claim which had been filed on Petitioner's behalf. (RX 3 – 0003) A copy of the Application was attached. (RX 3 – 0004 to 0006)

By February 16, 2012, Petitioner was ready for therapy to be over. He felt he had made huge improvements and was discharged. (PX 1, pp. 70-71)

On February 21, 2012 Ms. Sharp faxed a copy of the Initial Notice of Case Filing to Eric at CMI. Ms Sharp wrote, "Eric I received this today in the mail. It's from the associate I asked you about a week or 2 ago. We have no file on him that he ever reported this." (RX 4)

An Associate's Statement was completed February 23, 2012. Petitioner claimed he injured his left shoulder on September 18 or 19 at 6:45 a.m. lifting some cans and his "hands went numb, start early that night." Petitioner claimed a left shoulder injury. There were no witnesses and Petitioner acknowledged he did not report it. (RX 5)

Petitioner returned to Dr. Jones' office on February 28, 2012, with continued discomfort and reporting he was taking 2 pain pills per day. Petitioner also had "brown spots" on his shoulder (PX 3, pp. 73-74). On physical examination, Dr. Jones found slight discomfort with forward elevation and a well healed incision (PX 3, p. 73). Petitioner had completed his physical therapy. Dr. Jones refilled medications for Petitioner and again released Petitioner to light duty work with no overhead and no lifting more than 5 pounds (PX 3, pp. 74-75).

The records of Dr. Jones reported Petitioner was seen again on April 10, 2012, with left shoulder pain anteriorly (which Petitioner rated at 7/10 at worst) left shoulder pain with movement, and pain when lifting his arm (PX 3, pp. 95, 97-99). It was noted by Dr. Jones this was a disputed workers' compensation issue. Petitioner was again given medications and work restrictions of 15 pounds lifting, waist level work only, and limited overhead work (PX 3, p. 97, 95). The records of Dr. Jones reveal that Petitioner was last seen on May 17, 2012, at which time Petitioner was doing good but had some soreness in upper arm (PX 3, p. 105). On physical examination, Dr. Jones found full motion and he released Petitioner to return to regular work and return to his office as needed (PX 3, pp. 104-106, 104; RX 10).

On April 30, 2012 Petitioner signed his Application for Adjustment of Claim in 12 WC 04762, a claim involving an alleged right hand injury due to stocking shelves. Petitioner alleged an accident date of January 19, 2011. (RX 7)

In correspondence dated September 11, 2012, Respondent advised Petitioner's attorney that it was disputing notice for this claim. (RX 14) Specifically, Respondent's attorney asked "[w]ould you please identify to whom and when your client allegedly provided oral notice of this injury?" (RX 14 – 0002) Petitioner's attorney replied on September 17, 2012, that "Mr. Stanley has informed me that he initially reported the work accident to Phil . . . on or about September 18, 2011, and before he went to the emergency room at Decatur Memorial Hospital on September 22, 2011." (RX 15 – 0002)

The deposition of Dr. Tyler Jones was taken on March 13, 2013. (PX 4) Dr. Jones is a board certified orthopedic surgeon licensed in the State of Illinois. He has been practicing in the Decatur area for approximately ten years. His practice is focused on shoulders, knees, hips, and fractures (primarily hands and elbows).

Dr. Jones testified that he initially saw Petitioner on October 13, 2011. Prior to that visit, Petitioner had contacted Dr. Jones' office on August 30, 2011 and spoke to someone in the front office who answers the phone. On the form generated after that conversation it indicates Petitioner had an onset of complaints three days earlier but it was not work-related. There was also mention of Blue Cross Blue Shield. An appointment was scheduled for September 15, 2011, but Petitioner failed to appear for it.

Dr. Jones further testified that Petitioner again contacted his office on October 4, 2011, regarding some problems with left shoulder pain. Petitioner indicated he had been to the emergency room the previous Wednesday and the "date of injury/onset of symptoms" date was listed as "last Wednesday." The form further indicates that Petitioner called back on October 6, 2011 and indicated the visit would not be "work comp" and, therefore, a reference to the visit being work-related was marked out and the word "No" written in. According to Dr. Jones, the note taker was Lisa Barber, his nurse.

Dr. Jones also testified that Petitioner referred himself to the doctor. On his October 13, 2011, questionnaire/history form Petitioner reported he was experiencing left shoulder pain due to movement and lifting. Petitioner also provided information as to his occupation as a grocery stocker on the third page of the history form.

At the time of their initial visit on October 13, 2011 Dr. Jones also had the ER records from Petitioner's earlier September 22, 2011 visit. Dr. Jones could not recall how he received those records or whether he actually reviewed them. At most, he felt it was a possibility. When he actually saw Petitioner, Petitioner's chief complaint was a three week history of left shoulder pain. Petitioner reported he was right hand dominant and denied any history of trauma. Petitioner explained to the doctor that his left shoulder had begun hurting approximately three weeks earlier especially with "above head movement." Petitioner had received no treatment and noted the pain would wake him up if he rolled over onto his left side.

Dr. Jones testified that he examined Petitioner's left shoulder noting full motion but some weakness and discomfort through his rotator cuff, especially in the area of the supraspinatus, the muscle that raises one's arm. Dr. Jones further noted some atrophy in Petitioner's supraspinatus which suggested Petitioner had not been using the muscle for a longer period of time (beyond

that of three weeks). The atrophy would have taken some time to occur but it would not be acute in nature. Dr. Jones explained, however, that people can have non-painful rotator cuff tears and not seek treatment. Petitioner also had a positive impingement sign which is frequently seen when the rotator cuff is irritated. X-rays of Petitioner's shoulder revealed AC joint arthritis, a common finding associated with aging and consistent with Petitioner's age of 51. Petitioner glenohumeral joint, the main shoulder joint, looked good. In light of Petitioner's physical examination findings, Dr. Jones ordered the MRI which revealed a full thickness rotator cuff tear. Dr. Jones also explained that the MRI indicated the tendon had not retracted (or shrunk) and retraction is frequently seen when a rotator cuff tear has been present for awhile. However, he could not state the age of Petitioner's tear. The MRI did not show any fat having infiltrated into Petitioner's left shoulder so he did not believe Petitioner's tear was a "real chronic" one. No dye was inserted into Petitioner's shoulder at the time of the MRI and, therefore, one could not determine the extent of the tear. However, according to the operative report, Petitioner's tear was only partial and not full thickness. Dr. Jones could not explain why the MRI showed pathology in the infraspinatus muscle as opposed to the supraspinatus. According to Dr. Jones, "MRIs aren't foolproof." (PX 4, p. 19)

Dr. Jones further testified that Petitioner was treated conservatively at first but was not given any work restrictions. Petitioner then telephoned him that he would like to schedule surgery sometime after Thanksgiving. Surgery was performed on November 28, 2011. During surgery Dr. Jones found a partial thickness rotator cuff tear and some spurring on the undersurface of the AC joint. Petitioner's tendon was debrided so that the spurs were removed and flattened down thereby allowing the rotator cuff to have more room. The tear was in the supraspinatus. Petitioner was unable to work using his left arm for six weeks thereafter to allow for standard therapy and recovery.

Post-operatively Dr. Jones monitored Petitioner's condition noting Petitioner's progression with pain, motion, and physical therapy. As of February 22, 2012 Petitioner had met all of his therapy goals and was being discharged from the formal program to his home exercise program. As of February 28, 2012 Petitioner was reporting slight discomfort with forward elevation of his arm to which the doctor explained that full recovery could take up to a year. Petitioner was allowed to continue with a pain pill but it was reduced in strength. Work restrictions of no overhead activity and a 5 pound weight limitation were given. Dr. Jones also recalled Petitioner mentioning some brown spots on his shoulder but he really could not remember what they were all about. He thought he probably recommended a visit to his dermatologist.

Dr. Jones followed up with Petitioner on April 10, 2012. Petitioner described his shoulder pain as located anteriorly and rated a 7/10 at its worst. Petitioner reported pain with movement but that he was performing his home exercise program and taking Naprosyn rather than narcotic medicine for any pain. Petitioner also reported he was unable to work as a stocker for Respondent due to arm discomfort. They also discussed Petitioner's lack of formal physical therapy after February of 2012 because of Petitioner's disputed work comp issue. Petitioner was given Tramadol and a Medrol dose pack and Dr. Jones reiterated the need for compliance with the shoulder exercise program on a daily basis. Petitioner's work restrictions included 15 lb. waist level work and limited overhead activity. Dr. Jones recalled nothing more about the disputed work comp issue.

Dr. Jones testified that Petitioner returned to see him on May 17, 2012, at which time Petitioner described his shoulder as doing "good" with some soreness but he was only taking one Tramadol every four hours (Tramadol being a mild pain pill). Petitioner was performing his home exercises and had full motion on exam. Petitioner was released from care and told to call if he had any problems.

Dr. Jones described Petitioner's diagnosis as rotator cuff tear with impingement syndrome. During the deposition he was shown a written job description for a stocker's position as well as the records of the emergency room visit at Decatur Memorial Hospital noting information concerning the mechanism of injury to which Petitioner replied that he did a lot of overhead activity stocking shelves at work and recalled no trauma. (PX 4, p. 30) Dr. Jones was given a hypothetical question regarding the work duties Petitioner has performed as a stocker for Respondent since 1999 (unloading trucks that come in in the evening, taking the pallets of merchandise to the floor with a pallet jack, and unloading the merchandise on approximately 12 pallets every night and placing the merchandise on various shelves of the store of which, at least two of the shelves are at shoulder level if not above and where most of Respondent's Great Value brand merchandise is located on those top shelves and he may also have to rotate older stock off the shelf and replace it with newer stock so that the older stock is in the front – an activity done several hundred times an evening – and with weights ranging from a pound to up to 10 to 15 lbs), and a history of Petitioner having performed those duties as a stocker in August of 2011 when he noticed left shoulder pain, called the doctor's office, did not state that his injury was a work comp injury and an appointment was scheduled for September 15, 2011 which Petitioner failed to appear for and that Petitioner continued to work thereafter and on September 19, 2011 Petitioner was performing his stocker duties when he again noticed left arm/shoulder pain and mentioned it to several co-workers but continued to work and notice symptoms eventually going to the emergency room on September 22, 2011 and then calling Dr. Jones' office on October 4, 2011, seeing Dr. Duncan on October 11, 2011 and then presenting for care with Dr. Jones as understood by the doctor. With the foregoing in mind and assuming the foregoing as true, Dr. Jones opined the work duties were a contributing factor to Petitioner's shoulder pain. While he could not say whether the work duties caused the rotator cuff tear he could say the work duties were an aggravation of the rotator cuff tear. Dr. Jones explained that overhead activities would not cause pathology in everyone and other activities could contribute to an underlying rotator cuff. (PX 4, pp. 31-34) Based solely on what Petitioner reported to him, this was not a work injury but Dr. Jones did not know what occurred with Petitioner initially reporting it was a work injury at the time of the second intake form in his office, and then changing his mind (PX 4, pp. 53-54) Dr. Jones also opined the complaints of a rotator cuff tear as found on the MRI and during surgery, could be aggravated by any overhead activity including reaching up to get a cup of coffee, changing a light bulb, adjusting a mirror of the car, and putting on clothes, but not with everyday waist level activities (PX 4, pp. 54-55)

Dr. Jones opined Petitioner is on the smaller height size for a male and he knows what a stocker has to do to put merchandise on the shelves but does not necessarily know the amount of merchandise stocked, having been in Wal-Mart and other stores. However, he did not know how much of Petitioner's work duties required overhead work but also noted that pulling a pallet does not require overhead work (PX 4, p. 55 - 59) Dr. Jones opined that work duties at shoulder level

would aggravate Petitioner's condition and activities above shoulder level would significantly aggravate Petitioner's condition (PX 4, p. 58) Dr. Jones explained overhead activities are known to cause pathology within the shoulder that could include an impingement syndrome and a rotator cuff tear (PX 4, pp. 34-35) Dr. Jones did not have any records or information there were other activities Petitioner performed overhead other than work duties (PX 4, pp. 35-37) Dr. Jones explained that initially they didn't know this was a work injury or being filed under work comp. "So there are questions that we might have asked back then knowing that this was a work injury that we did not at that point." We didn't inquire into recreation and home. (PX 4, p. 35) Dr. Jones opined the treatment he rendered Petitioner was necessary, reasonable, and medically appropriate based on his expertise in orthopedics (PX 4, p. 37)

On cross-examination Dr. Jones testified that he obtained a history of injury from Petitioner when he first examined him; however, Petitioner did not report a work-related injury. (PX 4 p. 39) Petitioner also did not report that he was seeking treatment for a workers' compensation claim. (PX 4 p. 40) Dr. Jones testified that Petitioner never reported a work-related injury to him. (PX 4 pp. 41, 61)

Dr. Jones admitted completing the attending physician statement of functionality on January 6, 2012, and stating the injury was not work-related. (PX 4 p. 44) Throughout the entire treatment, "we treated him as not a work-related injury." (PX 4 p. 52) If the claim was reported as a work-related injury, he would have submitted the bills to the workers' compensation carrier not Petitioner's group medical insurance. (PX 4 p. 40)

According to Dr. Jones, Petitioner had spurring on his x-rays that was unrelated to his alleged injury, which could cause the rotator cuff tear. (PX 4 p. 46) These spurs were the result of arthritis, which caused his shoulder impingement. (PX 4 pp. 59-60)

Dr. Jones testified he saw Petitioner for the last time on May 17, 2012. (PX 4 p. 50) At that time, Petitioner had full motion in his shoulder. (PX 4 p. 50) He did not document any loss of strength, and confirmed that he would have documented any loss of strength in his record. (PX 4 pp. 50-51) He advised Petitioner to call his office if he had any further complaints, and confirmed that Petitioner had not done so as of the date of his deposition. (PX 4 p. 51)

At arbitration Petitioner testified that he has been employed by Respondent as a stocker for 13 years. Petitioner testified he works the overnight/third shift (10:00 p.m. – 7:00 a.m.) and his job duties include pulling pallets (weighing 300 – 400 lbs) off the trucks with a pallet jack, delivering them to the proper area in the store to be shelved, and stocking merchandise on the shelves. According to Petitioner there are typically six shelves per isle, and the top shelf is about 5'9" high, approximately one inch higher than Petitioner. He testified that he would stock the shelves overhead approximately two times per shift, and that 600 of the 1200 items he would stock would go on the top two shelves. He explained that he mostly stocked Great Value brand products, which were mostly on the top two shelves. Petitioner used both hands and arm to lift and place the merchandise on the shelves.

Petitioner denied having any left arm or shoulder complaints, injuries, or treatment before August of 2011. Petitioner testified that he first noted "a little" pain in his shoulder in August of

2011 while stocking cans of Great Value beans. Petitioner called Dr. Jones' office to schedule an evaluation. Petitioner testified he could not recall if he was asked if his injury was work-related when he called. Although an appointment was scheduled for September 15, 2011, he testified that he cancelled his appointment because his mother was ill. On cross-examination Petitioner testified he told Dr. Jones' office that his shoulder was work-related.

Petitioner testified that he reported his injury to Phil Crawford at 1:30 in the morning on September 18, 2011. He identified Mr. Crawford as Respondent's representative at trial. Petitioner testified that he told Mr. Crawford he did not think he was going to "make it" because his shoulder was really hurting to which Mr. Crawford told him there was nothing wrong with him and he should continue working. Petitioner testified that he said nothing further to Mr. Crawford regarding his shoulder. On cross-examination Petitioner agreed that he never told Mr. Crawford that he had a work-related shoulder injury. Rather, he told Mr. Crawford that his shoulder hurt.

Petitioner testified that he continued working and his shoulder continued to hurt. Petitioner called in on September 21, 2011 and reported he would not be working. Petitioner testified he then sought treatment at Decatur Memorial Hospital on September 22, 2011. After being released from the hospital, Petitioner testified he went to Respondent's personnel office and reported his injury to "Diane," who Petitioner believed was an assistant to Melody. Petitioner testified Diane asked if he was taking ten days off and he replied in the affirmative. On cross-examination Petitioner admitted he did not tell the emergency room physician he had a work-related injury.

Petitioner testified that Melody told him he would need to get paperwork from the doctor allowing him to return to work after his ten days were up. According to Petitioner Melody gave him a form to have completed by the doctor and Petitioner had the emergency room doctor fill it out. Petitioner testified he returned the completed form to Melody and then he reported to work. Petitioner was not wearing a sling when he returned to work and had no restrictions. Petitioner clocked in and went to the break room like he normally did. In the break room were the night managers, "Rod" and "Brian" and other stockers, including Dwayne Maglone. Rod asked Petitioner if it was workman's comp and explained that Petitioner should clock in if it was and go home if it wasn't. Petitioner returned to work and noticed his shoulder would hurt while working.

Petitioner testified that in early October of 2011 he returned to see Dr. Jones. When calling the office he told them he was a stocker. Petitioner thought he called the doctor's office to tell them his shoulder was workers' comp. Petitioner testified he also thought he called Melody and asked her if his shoulder was workers' comp and she said no. Petitioner testified his conversation with Melody occurred before he called Dr. Jones' office the second time and told the office who to bill (ie., that his visit would not be work-related). On cross-examination Petitioner testified that when he first saw Dr. Jones he not only told him he was a stocker for Respondent but that his shoulder was due to a work-related injury.

Petitioner next sought treatment from Dr. Duncan because he needed an annual check-up. Petitioner testified that he told the doctor about his left shoulder and what he was doing when he

noticed the complaints. On cross-examination Petitioner acknowledged that he did not report a work-related injury to Dr. Duncan at that time. He saw Dr. Duncan because he needed a primary care physician.

Petitioner testified that he requested paperwork from Ms. Sharp.

Petitioner further testified that he provided paperwork to Rod Woolridge in early October 11, 2011 and that Mr. Woolridge asked him whether his condition was "workers' compensation."

Petitioner further testified that he called the store and spoke to Ms. Sharp in October of 2011, and asked her whether his condition was work-related and that she said no.

Petitioner testified that he told Dr. Jones that he was a stocker and explained his job duties as a stocker when they initially met with one another. He also testified that he told Dr. Jones that his injury was work-related during his initial office visit. When asked if Dr. Jones was lying during his testimony, Petitioner was somewhat evasive but responded, "I couldn't say that about him like that."

Petitioner also testified that in February of 2012, he was contacted by Melody Sharp and asked to come in to fill out paperwork and to undergo a drug screen. He met with Derek Thaxton, an assistant manager, and Melody at that time. Petitioner identified the associate statement identified as Respondent's Exhibit 5 and explained that Mr. Thaxton filled it out after asking him questions. Petitioner then signed the form without reading it first. Mr Thaxton explained that if an associate asked for help completing the statement, he would read the question and record their response. He confirmed that he asked Petitioner "when did you report your injury," and that his response was "didn't." This is consistent with the associate statement signed by Petitioner. (RX. 5) After completing the form, he gave it back to Petitioner, who reviewed the form and signed it. Mr. Thaxton then signed the form in acknowledgement.

The next day, the store completed the Employer's First Report of Injury for this claim. (RX 6 – 0002)

Petitioner received a full duty release from Dr. Jones on May 17, 2012. He returned to his regular job duties following that date, and has not sought additional medical treatment since that date. Petitioner testified he has not returned to Dr. Jones because he had been busy and his mother died.

Petitioner testified that he still has a little soreness in his left shoulder. Petitioner denied any difficulty with his left shoulder when pulling pallets. Petitioner uses a heating pad daily and takes three to six Advil every four or six hours (Petitioner initially testified to six hours but on cross-examination said it was every four hours). Petitioner continues to work as a stocker for Respondent.

Petitioner testified he was "a little tired" as he worked the third shift the day before his arbitration hearing and then drove from Decatur to Springfield after getting off work at seven o'clock in the morning.

Dwayne Maglone testified on Petitioner's behalf. Mr. Maglone has been employed by Respondent for approximately 13 years, initially in the maintenance department for approximately 6 months, and then as a stocker on the third shift, and had been a supervisor for Respondent his first 3 years of employment. Mr. Maglone works with Petitioner on the third shift, but they work independently of one another in the aisles of the store, with Mr. Maglone working on displays. Mr. Maglone regularly works in the grocery department and is familiar with the Great Value products (Respondent's product brand) and stated the Great Value products are typically stocked next to the name brand version of the product, such that canned foods are stocked next to the Great Value canned foods on the shelves. In the juice aisle, all the Great Value brands are kept in the same area in that aisle.

Mr. Maglone testified that a meeting is held every evening when the overnight stockers report to work about 10:00 p.m. to inform them regarding work expectations and aisle assignements. Mr. Maglone identified Rod as a manager for the third shift and the person conducting the break room meeting for the stockers before Petitioner was off work for his surgery. Mr. Maglone could not identify the exact date the meeting with Rod occurred but he thought it was months before Petitioner's surgery. During that meeting, Rod asked Petitioner if his injury was work-related and Petitioner responded in the affirmative.

Phillip Crawford testified on behalf of Respondent. Mr. Crawford is employed by Respondent as a shift manager or co-manager and knows Petitioner as one of the overnight stockers. Mr. Crawford is familiar with Respondent's policy for reporting work-related injuries and stated the policy in September of 2011 to be if the employee had an injury, the employee is supposed to immediately report it to their immediate supervisor, an assistant manager of the store, then the immediate supervisor reports it on an incident report and if it is an accident where the employee needs medical care, then an accident report is completed by the associate and someone in management. Mr. Crawford stated if an employee were to report they hurt their shoulder and needed medical treatment, an accident report or an associate's statement would be completed, and not an incident report. Mr. Crawford indicated this policy is followed 100% of the time. Mr. Crawford identified the associate's statement as the accident report. Mr. Crawford acknowledged if the employee does not immediately report the accident, the employee has 45 days to report it, but was not certain what happens with Respondent's policy.

Mr. Crawford heard Petitioner testify that Petitioner reported his left shoulder injury to him on September 18, 2011. Mr. Crawford denied he had any conversation with Petitioner with regard to a work injury on September 18, 2011, because Mr. Crawford was working days at that time. Mr. Crawford indicated his hours of employment for days were 7:00 a.m. to 8:00 p.m., and he would not have reported to work earlier than 7:00 a.m. on September 18, 2011, and not at 1:30 a.m. Mr. Crawford went to days in April of 2011 and worked days until September of 2012, when he went to the overnight shift. Mr. Crawford indicated an overnight shift manager may be called in if another overnight shift manager did not report, but that had never happened, and he had never covered for another co-manager who was on vacation. Mr. Crawford could not really recall when he first learned of Petitioner's alleged work injury to the left shoulder but

thought it was when Respondent's attorney contacted him. Mr. Crawford denied Petitioner ever told him he had pain in his shoulder.

Mr. Crawford identified Rod Woolridge as a co-manager, and acknowledged Mr. Woolridge held that position in September of 2011. Mr. Crawford identified the store manager as the top management person, the co-manager or shift manager as the second management person, and then the assistant manager. Mr. Crawford thought Brian Pendergrass was the assistant manager for the overnight stockers in September of 2011 and that Mr. Pendergrass and Terry were assistant managers for the overnight stockers in January of 2011. Mr. Crawford identified Drew Hiteman as a co-manager. Mr. Crawford was not aware of any manager or supervisor in the personnel office by the name of Diane in September of 2011 to the present. Mr. Crawford was not aware of any employee by the name of Diane that worked for Respondent, but acknowledged other employees go into the personnel office to use the terminals for computer based learning.

Melody Sharp testified on behalf of Respondent. Ms Sharp presently works at Sam's Club and has been employed by Respondent for 21 years. Ms. Sharp knows Petitioner as Ms. Sharp worked at the same store as Petitioner from September of 1991 until July of 2012, and worked the hours of 8:00 a.m. to 4:30 p.m., Monday through Friday. Ms. Sharp had Saturdays and Sundays off and also took off days for personal reasons on occasion. Ms. Sharp did not review her schedule to see if she had taken off any time during the period of August of 2011 through May 2012.

Ms. Sharp was formerly the personnel manager for Respondent and her duties included hiring employees, handling insurance for employees, FMLA, safety and accidents and proceedings with Respondent's insurance company, and dealing with employees alleging work-related injuries. Ms. Sharp stated Respondent's policy for reporting a work-related injury to be even if the employee feels he or she does not need medical treatment at the time, anything needs to be documented and there are both accident reports and incident reports (the latter of which is used when the employee feels he or she does not need medical attention). Ms. Sharp indicated all employees are trained in this policy on day one and there is a workmen's compensation poster in the hallway outside the break room. Ms. Sharp also testified that if an employee came to her reporting a work-related injury she would document such in the employee's file and the employee would also complete the paperwork. Ms. Sharp further stated if an employee telephoned her and reported a work-related injury, she would document that and advise the employee to immediately come in and complete the paperwork. Ms. Sharp says that she does this 100% of the time. Ms. Sharp indicated that besides the associate's statement for a work injury, there is information inputted into the computer to Respondent's insurance carrier, CMI, such as shown in Respondent's Exhibit 8. Ms. Sharp stated she had not seen RX 8 but the report had her name on it. RX 8 contained information concerning Petitioner's work injury of January 2011. Ms. Sharp explained she inputs information into the computer 100% of the time contemporaneous with the completion of an accident report. Ms. Sharp stated the employee's supervisor does not fill out any separate report from the associate's statement.

Ms. Sharp was aware Petitioner reported some work-related injuries while working for Respondent, including an injury to his right hand on January 19, 2011 and an injury to his left

shoulder on September 21, 2011. Ms. Sharp believed she assisted Petitioner in the documentation concerning his leave of absence for the work accident of January 19, 2011. Ms. Sharp learned of Petitioner's accident of September 21, 2011, when she received paperwork from Petitioner's attorney as shown in Respondent's Exhibit 3 on or about February 7, 2012. After receiving this paperwork from Petitioner's attorney, Ms. Sharp made copies of the paperwork and faxed the paperwork to the adjuster at Respondent's insurance carrier and thought she also mailed the original paperwork to them. Ms. Sharp also pulled Petitioner's medical file to make certain she had not previously missed anything but did not find any incident or accident reports or any records suggesting Petitioner had reported a work-related injury. Ms. Sharp initially indicated if she had an accident report she would have sent the adjuster a fax saying there was no claim on this but if there was a claim, she would fax the claim number to the adjuster so he would know which one it was. When Ms. Sharp faxed the documents to the adjuster on February 7, 2012, there was no claim number entered in Respondent's system. Ms. Sharp also subsequently received a claim form from the Commission as shown in Respondent's Exhibit 4. After receiving the form from the Commission, Ms. Sharp again looked at her file to see if there was any claim for the left shoulder injury and did not find one. Ms. Sharp then sent the adjuster a copy of the form from the Commission as shown in Respondent's Exhibit 4. The adjuster did not instruct Ms. Sharp to open a claim at that time.

Ms. Sharp identified Respondent's Exhibit 5 as an associate's statement that is completed when an employee seeks medical attention, and noted RX 5 was completed on February 23, 2012 after Ms. Sharp had received the documents from Petitioner's attorney and the form from the Commission. Ms. Sharp indicated that another Employer's First Report of Injury was generated but she did not personally complete that form as it was prepared by Jason Farmer, the store manager.

Ms. Sharp did not think she spoke with Petitioner in October of 2011 about his alleged shoulder injury. Had she spoken with Petitioner in October of 2011, Ms. Sharp would have informed Petitioner he had 24 hours to fill out the paperwork. Ms. Sharp, as personnel manager, it is not her position to say whether an injury is work-related or not and acknowledged she does not have any medical and legal training and has not been trained in what is or is not an accident under the Illinois Workers' Compensation Act. Ms. Sharp denied she ever told Petitioner his injury was not work-related.

According to Ms. Sharp, Petitioner did complete FMLA paperwork for his shoulder injury and that paperwork provides an opportunity to indicate whether the condition is work-related. Ms. Sharp explained if an employee chooses to complete the FMLA paperwork and the employee has the time allowed, the employee's job is protected up to 12 weeks initially. Ms. Sharp stated Petitioner completed the FMLA paperwork and removed himself from the schedule. Ms. Sharp was not aware of any restrictions Petitioner had for his left shoulder the end of September of 2011 through the early part of October 2011, as she typically looks at the dates the employee is going to be gone from work, and did not remember seeing the reference in Respondent's Exhibit 1 Petitioner had a sling for his left upper extremity with no use of the left upper extremity for 10 days. Ms. Sharp did not know whose handwriting was on Respondent's Exhibit 1, but stated it was not her handwriting.

Ms. Sharp explained the FMLA forms have a question as to whether the requested medical leave is for pregnancy, workers' compensation, disability, or one's own serious health condition and Petitioner did not indicate on the FMLA form why Petitioner was on medical leave. Ms. Sharp indicated when she receives an FMLA form that does not have markings on it in appropriate areas she provides it to the store manager who decides to approve it or indicate if more information is needed. Ms. Sharp explained if an employee had checked under the family care leave section the option of parent that would be sufficient for completing the reason for leave request and the marking of a sub-box is sufficient but the employee would be questioned further if they thought it was not complete enough. Ms. Sharp did not recall Petitioner was questioned further about the FMLA form he submitted. Ms. Sharp identified the signature on page 3 of the form to be that of Drew Hiteman, a co-manager for the third shift.

Ms. Sharp testified that she has never had an assistant when she was in the personnel office but there had been two training coordinators in the personnel office who were not members of management but their names were not Diane or Wendy, but Lisa and Theresa. Ms. Sharp was not aware of any employee by the name of Diane but knows a co-manager by the name of Rod. Ms. Sharp noted all employees can go into the personnel office and complete training on the computers in the office.

Ms. Sharp further testified that any completed accident reports would have been in the Petitioner's file and Ms. Sharp did not find any. Ms. Sharp goes to the employee file whenever she is asked a question about or by an employee to make certain she is accurate in her responses. Ms. Sharp said Petitioner's file did not have a statement from his supervisor with respect to the accident Petitioner sustained in January of 2011. Ms. Sharp also testified that if Petitioner called her to inquire if there was a report of injury for September of 2011 in his file, Ms. Sharp would go to the file and look in it; however, Ms. Sharp did not remember receiving a call from Petitioner of that nature and she would have made a record of such a call and put that in Petitioner's file.

Derrick Thaxton testified on behalf of Respondent. Mr. Thaxton is employed by Respondent and has been at the store where Petitioner works for 11 years as an assistant manager and presently works the third shift, or the hours of 8:00 p.m. until 8:00 a.m. Mr. Thaxton held the position of nighttime assistant manager in September of 2011 and February of 2012. Mr. Thaxton became aware of Petitioner's alleged left shoulder injury when Petitioner came in and told Mr. Thaxton he needed to fill out some papers. Mr. Thaxton noted Respondent's policy for reporting accidents is for the employee to report it to the supervisor immediately but the employee can report it later that day. Mr. Thaxton noted when an employee reports an accident to him which does not require emergency medical assistance, he goes to the personnel office and obtains a file to complete or have the employee complete it, and he does this 100% of the time.

Mr. Thaxton stated that on February 23, 2012, he had just returned from vacation and was told to go to the personnel office because Petitioner was there, but did not know what time this occurred only that he was working days which are the hours of 8:00 a.m. until 8:00 p.m. Mr. Thaxton thought Rod or Jason had told him there was an associate in the personnel office that needed to speak with a member of management and he did not even know who the associate was until he went to the personnel office.

Mr. Thaxton stated Petitioner told him he needed to fill out a report for his shoulder and Mr. Thaxton asked Petitioner if he had talked with anyone yet, and Petitioner responded no, so Mr. Thaxton went and got a manila file folder that had blank associate statements in it, and gave Petitioner the statement and Petitioner chose to have Mr. Thaxton complete the statement which was RX 5. Mr. Thaxton explained that an incident report, an accident report, and an associate's statement are all the same thing, and said all of these forms are in one packet. Mr. Thaxton assumed Petitioner was hurt when Petitioner said it was an incident and knew he had the right form as Petitioner answered the questions. Mr. Thaxton explained that an incident report is used when something happened but it is fixed with a band-aid and an accident report is used when it is something more than a band-aid. Mr. Thaxton identified RX 5 as the form he completed for the Petitioner on February 23, 2012. He was unaware that Petitioner was not working at the time he met the Petitioner in the personnel office.

After Petitioner chose to have Mr. Thaxton complete the statement, Mr. Thaxton said he began on line 1 asking Petitioner each question and wrote down Petitioner's responses including spelling Petitioner's name, date of birth, height and weight, and the date and time of injury, which Petitioner indicated was September 18 or 19, 2011, at 6:45 a.m. Question 4 on the statement asked Petitioner if he had reported his injury and Petitioner's response was he did not. After completing the statement, Mr. Thaxton gave Petitioner the statement to read and asked Petitioner if there were any changes to the statement. Mr. Thaxton said Petitioner reviewed the statement after it was completed and then signed it, but did not know how long Petitioner to look over the statement as Mr. Thaxton got a Kleenex and came back to the table after 2-3 minutes Mr. Thaxton then signed the statement as a witness.

Mr. Thaxton said Petitioner would not have reported to him on February 23, 2012, as he was working days but an employee can speak to any member of management regardless. Mr. Thaxton did not recall Petitioner's responses to the questions without looking at the statement.

Mr. Thaxton testified that he did not question Petitioner about the answer to when was Petitioner injured in which Petitioner indicated it was early that night, around 6:45 a.m., and his hands going numb. Mr. Thaxton did not put "hands" in the section about what part of the body was injured to be consistent with what had been conveyed to him in paragraph 3. Mr. Thaxton did not specifically ask Petitioner if he had told anyone about the injury besides filling out the associate's statement. In responding to question 4, Mr. Thaxton wrote it was not reported immediately because it was thought to just be numb and indicated that was something Petitioner told Mr. Thaxton. Mr. Thaxton initially left blank the question whether Petitioner had any complaints but then wrote "still hurting."

Mr. Thaxton testified he could not remember if the statement had a section indicating whether the statement was completed by a party other than the injured associate, but then looked at the statement and saw a provision to that effect. Mr. Thaxton stated there had never been a personnel manager or training coordinator by the name of "Diane" during his employment at the store and he did not think there was any employee, department manager, assistant manager, co-manager, or store manager by that name. Mr. Thaxton did not review Petitioner's personnel file on February 23, 2012.

At this point in the arbitration proceedings, the case was bifurcated to allow for the testimony of Rod Woolridge. Mr. Woolridge is employed by Respondent and has been at the store where Petitioner works for 14 years. He has held the position of shift manager over the entire store for the last 7 years. Mr. Woolridge presently works days but worked the third shift in 2011, or the hours of 7:00 p.m. until 8:00 a.m. Mr. Woolridge knew Petitioner was an overnight stocker and, as such, normally stocked merchandise in the grocery aisles. Mr. Woolridge acknowledged there is a meeting every evening in the break room to address the duties of the employees for the evening, and the shift manager conducts the meeting.

Mr. Woolridge recalled a period of time in the fall of 2011 when Petitioner was not working as an overnight stocker and then returned to work as such. Mr. Woolridge thought Petitioner was absent during that time because Petitioner had lost a family member. Mr. Wooldridge was unaware Petitioner missed work during that time because of his left shoulder. Mr. Woolridge acknowledged Dwayne Maglone was an overnight stocker in the fall of 2011. Mr. Woolridge could not remember a meeting with the overnight stockers in the fall of 2011 when he asked Petitioner whether he had been off work for a work-related injury.

Mr. Woolridge explained Respondent's policy for reporting work accidents. According to Mr. Wooldridge if an employee reports an injury, the manager stops what he is doing, completes the paperwork, and gets the accident entered into the system. Mr. Woolridge indicated he does this 100% of the time. Mr. Woolridge knows Petitioner and was not aware Petitioner alleged a shoulder injury on September 18, 2011, and did not recall Petitioner reported the injury to him or about October 4, 2011. Mr. Woolridge stated if Petitioner had told him he had a work-related injury, he would have stopped what he was doing and retrieved the paperwork to fill out and entered it in the system. He also acknowledged he would have initially asked Petitioner if he had completed the appropriate paperwork. Mr. Woolridge never completed an accident report for Petitioner's injury on October 4, 2011.

Petitioner had several prior claims before the Illinois Workers' Compensation Commission which were resolved prior to this hearing. (RX 9) This includes a claim against Respondent for a January 19, 2011, injury to his right hand. (RX 7 – 0002)

The written job description for stocker describes the essential functions of the position to be maintaining merchandise presentation by stocking and rotating merchandise, removing damaged or out-of-date goods, setting up, cleaning, and organizing product displays, signing and pricing merchandise appropriately, securing fragile and high-shrink merchandise, and receiving and stocking merchandise throughout the facility The written job description further notes the physical activities required of a stocker require reaching overhead and below the knees, including bending, twisting, pulling, and stooping, and moving, lifting, carrying, and placing merchandise and supplies weighing less than or equal to 50 pounds without assistance. (PX 5)

Regarding the issues of Accident (A); Causal Connection (F); and Notice (E) the Arbitrator concludes:

Based on the evidence and testimony presented Petitioner failed to prove he sustained an accident on September 21, 2011, failed to prove that he gave timely notice of an accident; and failed to prove that his left shoulder condition of ill-being was causally connected to his employment with Respondent. This is based upon the credible testimony of Respondent's witnesses and the lack of corroboration in the medical records to support Petitioner's testimony. Petitioner's testimony was not credible as it was contrary to and inconsistent with the medical records and testimony of other witnesses.

As Petitioner had two prior claims before the Commission, and his January 19, 2011 injury occurred while in Respondent's employment approximately eight months prior to the current injury, the Arbitrator finds that Petitioner was familiar with Respondent's reporting requirements and knew how to report a work accident/injury.

The Arbitrator views the medical records in consideration of the long-standing legal principle, as expressed by the Supreme Court in Shell Oil v. Industrial Comm'n, that contemporaneous medical records are more reliable than later testimony because "it is presumed that a person will not falsify such statements to a physician from whom he expects and hopes to receive medical aid." 2 Ill.2d 590, 602 (1954). Petitioner admitted that he did not report a work injury during his initial evaluations at Decatur Memorial Hospital and with Dr. Duncan, which is supported by the records from both facilities. While Petitioner testified he reported his injury to Dr. Jones', his testimony was rebutted both by Dr. Jones' medical records and Dr. Jones himself.

While Petitioner claims an accident date of September 21, 2011, the significance of that date is unclear. Petitioner did not even work that day, having called in absent. While he testified that he called in because his shoulder hurt, nothing about that day (or Petitioner's testimony) explains how/why a repetitive trauma shoulder condition would have manifested itself that day. Petitioner denied any left shoulder problems before August of 2011. He then testified that he began to notice "a little" pain in his left shoulder while working during August. However, when he begins to treat for his shoulder problem, he gives various onset dates – August 27, 2011 and September 20, 2011 (see the ER record of September 22, 2011). He also described the pain as intermittent. While some of the records make reference to Petitioner's overhead lifting at work, the Arbitrator finds the references lacking in further details to allow her to conclude or infer that Petitioner was associating the onset of his symptoms with that activity. The Arbitrator also notes that Petitioner failed to provide any details to the physical therapist concerning when and how his shoulder problem began and Dr. Jones testified Petitioner never spoke of a work accident or injury.

Further, causation was not addressed in any of the medical records. Dr. Jones' completed a physician statement for the Hartford indicating the claim was not work-related. While he admitted in his deposition that Petitioner's symptoms could have been aggravated by the alleged activity, he also stated that any overhead activity would have aggravated the Petitioner's complaints. The only opinion supporting causation was based on a three and half page hypothetical and job descriptions solely provided by Petitioner's attorney and those facts were

not established at trial. Petitioner provided no testimony regarding anything occurring on September 19, 2011. Dr. Jones was clear that Petitioner did not report his job duties to him during his treatment and that he did not have a clear understanding of how often Petitioner would stock merchandise overhead. Finally, Dr. Jones testified "If you go purely by my medical record and my discussions with the patient it was not a work injury." (PX 4, p. 53) Dr. Jones could not testify as to how much of Petitioner's job duties require overhead work or how much of his job duties required overhead lifting. (PX 4 p. 56) He acknowledged job duties below shoulder level would not aggravate Petitioner's condition. (PX 4 p. 57)

Taken as a whole, such evidence is insufficient to prove a causal link between the Petitioner's employment and his claimed injuries, as the right to recover benefits cannot rest upon speculation or conjecture. County of Cook v. Industrial Comm'n, 68 Ill.2d 24 (1997) Additionally, the assumed facts presented to Dr. Jones during his deposition were, in fact, not true and accurate. Therefore, Dr. Jones' opinion is not persuasive. No other doctor provided an opinion on causal connection.

The Illinois Supreme Court has held that Section 6(c) of the Workers' Compensation Act prohibits any claims under the Act unless the employee gives notice of his injury within 45 days of the accident. Lambert v. Industrial Comm'n., 79 Ill. 2d 243, 247 (1980). The giving of notice to the employer within 45 days of the accident pursuant to section 6(c) of the Workers' Compensation Act is jurisdictional and a prerequisite of the right to maintain a proceeding under the Act. Ristow v. Industrial Comm'n, 39 Ill. 2d 410, 413 (1968). Mere knowledge that the Petitioner was having problems with her finger is not sufficient to establish proper notice for a workers' compensation claim. In White v. Industrial Comm'n, 374 Ill.App.3d 907 (2007), although the employer knew the Petitioner was injured before the date in question, the record did not show the appraisal of "industrial injuries." The Appellate Court held that the purpose of the notice requirement is to enable the employer to investigate the employee's alleged industrial accident. White, 374 Ill. App. 3d at 911.

Petitioner failed to give timely notice of his alleged accident to Respondent. In support of her decision, the Arbitrator notes: (1) Petitioner was familiar with Respondent's polices for reporting a work-related injury; (2) there is no contemporaneous documentation of a work-related injury in the medical records or Respondent's files; and (3) Respondent's witnesses directly rebutted Petitioner's allegation.

While Petitioner did miss some time from work in August and September of 2011 which were logged in as "illnesses/injuries," the call-in sheets do not establish notice as required under the Act. At a minimum, they do not state whether the absence is due to illness or injury nor do they provide sufficient details from which Respondent would have known a work accident (specific or repetitive) was being reported.

Petitioner is not new to workers' compensation claims, and is familiar with Respondent's policy for reporting work injuries, based on the fact that he had a prior work injury approximately eight months before this accident and promptly reported same. Furthermore, after Petitioner reported his prior accident to Respondent, the accident was documented in Respondent's files (RX 8). No such documentation exists for Petitioner's instant claim. There

was no accident report until February 23, 2012, after Respondent received Petitioner's Application for Adjustment of Claim (RX 5). Thereafter the associate statement was completed. Respondent then completed the First Report of Injury on February 24, 2011 (RX 6), which is consistent with Respondent's practices for Petitioner's prior injury.

None of the medical records presented suggest that Petitioner's injury was caused by his job duties. Petitioner himself testified that he did not report a work-related injury to Decatur Memorial Hospital or Dr. Duncan. The physical therapy records do not document a work accident. Although Petitioner claims that he told Dr. Jones his claim was work-related, that testimony was not supported in the medical records (PX 2, RX 10) and was directly rebutted by Dr. Jones' testimony. (PX 4 pg. 40) That Petitioner would report a work accident but not mention it in the medical records is contrary to both common sense and Petitioner's prior familiarity with workers' compensation procedure (ie., his conduct in January of 2011).

While investigating the claim, Respondent specifically asked Petitioner to identify to whom he reported his accident. (RX 14) Petitioner only identified "Phil" (Mr. Crawford) who, at arbitration, credibly rebutted Petitioner's testimony. Even if one assumes Petitioner spoke with Mr. Crawford as he claims, Petitioner admitted that he did not tell him about a work accident involving his shoulder. At most, he simply reported his shoulder hurt. That is not enough information to establish notice of a work accident had been given. All four of Respondent's witnesses denied any knowledge of Petitioner's alleged work injury prior to the receipt of Petitioner's Application for Adjustment of Claim.

Although Mr. Maglone testified for Petitioner, his testimony is not persuasive. Petitioner specifically chose to call Mr. Maglone rather than Mr. Woolridge, even though Mr. Maglone is not a supervisor and his knowledge of an alleged accident would not be sufficient to establish that Respondent had notice of an alleged work injury. Mr. Maglone could not recall when the alleged conversation between the Petitioner and Mr. Woolridge took place or any other detail from that conversation. Further, his testimony was directly rebutted by Mr. Woolridge.

Petitioner also testified that he spoke with "Diane" in Respondent's personnel office. He did not know her last name and "believed" she was an assistant to Melody Sharp. Melody Sharp credibly rebutted this testimony. The Arbitrator also finds that Petitioner did not give adequate or sufficient notice of a work-related accident to Melody Sharp in September or October of 2011 when they were communicating with one another regarding leave of absence paperwork.

The Arbitrator notes that prior to arbitration Petitioner never indicated he gave notice to anyone other than Mr. Crawford. While there may be no requirement that a claimant identify everyone to whom he gave notice prior to arbitration practicality suggests one would, especially if it would aid in the determination of the compensability of a claim and avoid litigation. The Arbitrator also finds quite significant the events of February of 2012 as documented by Respondent's records, including the faxes between Ms. Sharp and CMI and Petitioner's Associate's Statement dated February 23, 2012 in which he denied having ever reported an accident.

The Arbitrator finds that Respondent first learned of Petitioner's alleged injury upon receipt of the Application for Adjustment of Claim, which was, at least, 136 days[1] after the alleged injury. Accordingly, Petitioner's claim is denied for failure to provide proper notice under the Act.

In light of the foregoing, all other issues are moot. Petitioner's claim for compensation is denied and no benefits are awarded.

****

[1] (9/22/11 – 2/3/12 (date Petitioner signed Application))

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dennis E Sparn, Jr.,

Petitioner,

14IWCC0081

vs.

NO: 12 WC 2285

Belleville Area Special Services Cooperative,

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(s) of temporary total disability, medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 29, 2013 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 $21,900.00. 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: FEB 03 2014
KWL/vf
O-1/27/14
42

Kevin W. Lamborn

Daniel R. Donohoo

Thomas J. Tyrrell

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

14IWCC0081

SPARN JR, DNNIS E
Employee/Petitioner

Case# **12WC002285**

BELLEVILLE AREA SPEICAL SERVICES COOPERATIVE
Employer/Respondent

On 8/29/2013, 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 0.06% 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:

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

0560 WIEDNER & MCAULIFFE LTD
MARY SABATINO
1 N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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)

14IWCC0081

Dennis E. Sparn, Jr.
Employee/Petitioner

v.

Belleville Area Special Services Cooperative
Employer/Respondent

Case # 12 WC 2285

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 **Mt. Vernon**, on **7/11/13**. After reviewing all 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 ___

14IWCC0081

FINDINGS

On the date of accident, **8/17/10**, 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 $**$16,543.46**; the average weekly wage was $**472.67**.

On the date of accident, Petitioner was **39** 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 $**25,296.81** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**25,296.81**.

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

ORDER

Respondent shall authorize and make payment for medical treatment for the lumbar spine, including, but not limited to, the lumbar surgery recommended by Dr. Gornet.

Respondent shall pay for reasonable and necessary medical services identified in Petitioner's Exhibit 9 as provided in Section 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall be given a credit for amounts paid.

Respondent shall pay Petitioner temporary total disability benefits of $315.11/week for 149-2/7 weeks, commencing 9/1/10 through 7/11/13, as provided in Section 8(b) of the Act. Respondent shall be given credit for $25,296.81 or 79-1/7 weeks in TTD benefits paid.

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

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

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

Signature of Arbitrator

8/26/13
Date

ICArbDec19(b)

AUG 29 2013

FINDINGS OF FACTS

Petitioner, currently 42 years of age, worked for Respondent as an individual care aid, since 2007. The job involved assisting students with multiple disabilities. Prior to August 18, 2010, Petitioner performed all the aspects of his job, including but not limited to lifting students in and out of wheel chairs, frequent bending and lifting and chasing and carrying students. He experienced no low back or lower extremity problems prior to August 18, 2010.

On August 18, 2010, Petitioner worked specifically as an aid for a 260 pound autistic high school student. The job required physical restraints. Petitioner testified the job was as physically demanding as the other work he performed for Respondent. On that date, the student struck Petitioner from behind and drove him across two desks. Petitioner, while lying over a desk, reached around to try and restrain the student. Petitioner testified he developed low back pain with numbness and tingling down the back of his right leg to the foot. Petitioner denied similar symptoms prior to the accident. Petitioner completed accident reports August 18 and August 26, 2010 corroborating the accident and development of symptoms. (Px. 8 at 1-2). At the time of the accident, Petitioner also worked through the State of Illinois assisting an individual with special needs. The tasks included lifting, carrying, bathing and performing other hygiene for the child.

Following the accident, on August 30, 2010, Petitioner came under the care of a pain management physician, Dr. William Thom. He reported severe low back pain radiating down the right leg. (Px. 1 at 2). Petitioner did not show any significant pain behavior. On physical exam, Petitioner had decreased motor strength of 3/5 in the right lower extremity. He could not walk heal to toe. Petitioner had decreased sensation in the L4 and L5 dermatomes. Dr. Thom noted tenderness over the right lumbar paraspinal muscles and facets. (Px. 1 at 4). Dr. Thom ordered x-rays, prescribed Flexeril and placed Petitioner on light duty. (Px. 1 at 5). X-rays of the lumbar spine showed L5 PARS Defect and L5-S1 spondylolithesis. (Px. 2 at 1). An ultrasound of the SI joints showed joint effusion, left worse than right. (Px. 2 at 3).

Petitioners' symptoms and exam remained unchanged September 13 and 20, 2010. (Px. 1 at 6-13). Dr. Thom ordered a lumbar MRI that Petitioner underwent on September 22, 2010. It confirmed the L5 PARS Defect, L5-S1 spondylolisthesis and moderate to serve L5 nerve root foramen stenosis. (Px. 2 at 6). The EMG/NCS testing on that date was not significant for lumbar radiculopathy. (Px. 2 at 7-9).

Dr. Thom performed lumbar trigger point injections on September 30, 2010. (Px. 1 at 18). Because the symptoms did not significantly improve, Dr. Thom on October 4 and 11, 2010 ordered lumbar injections. (Px. 1 at 23, 27).

Dr. Thom opined the work accident at a minimum aggravated Petitioner's lumbar condition and the need for treatment. (Px. 1 at 27). He opined Petitioner was not malingering and the objective findings and films correlated with his complaints. (Px. 1 at 27). He stated surgery was not warranted at that point, but it could be evaluated in greater extent if conservative measures failed. (Px. 1 at 24).

On November 1, 2010, Dr. Thom performed a second set of trigger point injections. (Px. 1 at 29, 33). Petitioner underwent the first set of epidurals at L4-5 and L5-S1 on November 16, 2010. (Px. 1 at 36). On December 22, 2010, Dr. Thom performed an L5-S1 epidural. (Px. 1 at 42). Dr. Thom on January 25, 2011 performed facet injections at L3-4, L4-5 and L5-S1. (Px. 1 at 49). On February 15, 2011, Petitioner reported continued low back and right lower extremity symptoms. The exam remained unchanged. Dr. Thom recommended a lumbar discogram. (Px. 1 at 56-60). Dr. Thom performed a lumbar discogram on February 23, 2011. (Px. 1 at 61). There was concordant pain at L3-4 and L4-5 and the L5-S1 did not hold the pressure well. (Px. 2 at 10-12). Dr. Thom stated the patient was not anxious and the responses appeared reliable. (Px. 2 at 12-13). The post-discogram CT showed disruption present at L4-5, L5-S1 and S1-S2. (Px. 2 at 14). Dr. Thom on March 16, 2011 offered continued epidurals versus surgical consultation versus spinal cord stimulator. (Px. 1 at 65, 68). Petitioner opted for an injection that Dr. Thom performed at L3-4 on March 23, 2011. On April 13, 2011, Petitioner told Dr. Thom he had significant pain reduction from the injection. (Px. 1 at 69). He also reported the therapy improved his range of motion but not the pain. Dr. Thom raised the possibility of a spinal court stimulator and increased the Lyrica and Celebrex.

On June 6, 2011, Petitioner saw a surgeon, Dr. Robert Grubb. On exam, Petitioner had a positive straight leg raise at 70 degrees for low back pain. Dr. Grubb recommended a myelogram that Petitioner underwent on June 17, 2011. (Px. 5 at 1-2). Based upon that test and Petitioner's weight, Dr. Grubb did not feel that Petitioner was a surgical candidate at that time but that he should continue weight loss and physical therapy. (Px. 5 at 3).

Petitioner returned to Dr. Thom on August 15, 2011. Dr. Thom opined Petitioner should not return to work in a position that required work involving restraints of students. (Px. 1 at 78-82). He ordered an FCE. For treatment, he agreed Petitioner's weight put him at a disadvantage for surgery and that he should consider a spinal cord stimulator. (Px. 1 at 78, 82). The FCE took place on August 23, 2011. The examiner concluded Petitioner gave good effort and he could not return to his occupation full duty. (Px. 4 at 4). The examiner noted some submaximal effort with dexterity testing, but opined that was not related to the injury and most likely due to deconditioning. (Px. 4 at 2). On September 15, 2011, Dr. Thom, after reviewing the FCE, placed permanent restrictions of no lifting, pulling or pushing greater than 50 pounds, frequent rest breaks and sit/stand as needed. He noted Petitioner was painful for days afterward the FCE, suggesting an aggravation of pain with attempts at maximal effort. Dr. Thom stated Petitioner would likely require permanent medications. He again suggested a trial for the spinal cord stimulator in light of Petitioner's weight. (Px. 1 at 83)

Petitioner returned to Dr. Grubb September 26, 2011, who opined the trial spinal cord stimulator was reasonable. (Px. 5 at 4).

Petitioner saw Dr. Thom three more times October 13, 2011, November 14, 2011 and January 30, 2012 while awaiting approval of the temporary stimulator. (Px. 1 at 88, 94, 99). Petitioner testified Respondent never approved the stimulator or provided an explanation for not approving it. By the last visit, Petitioner reported increased symptoms since formal therapy stopped. Petitioner was performing his home exercise program. (Px. 1 at 99). On February 13, 2012, Dr. Thom referred Petitioner to Dr. Gornet. (Px. 1 at 103).

Petitioner told Dr. Gornet that he had low back, right buttock, groin and thigh pain along with right great toe numbness. On physical exam he had decreased EHL function and ankle dorsiflexion at 4/5. Straight leg raises were provocative for right buttock and leg pain at 45 degrees. (Px. 6 at 1). Dr. Gornet reviewed x-rays, the 6/17/11 CT myelogram and 2/23/11 discogram films. (Px. 6 at 2). Dr. Gornet diagnosed symptomatic L5-S1 spondylolithesis, discogenic L4-5 pain and possible L3-4 disc injury. (Px. 7 at 10). He ordered a lumbar MRI. (Px 6 at 2).

On February 28, 2012, Respondent had Petitioner examined by Dr. Daniel Kitchens pursuant to Section 12 of the Act. Dr. Kitchens opined Petitioners' symptoms were related to his obesity, degenerative disc disease and spondylolithesis. He opined Petitioner's current symptoms were not work related and Petitioner could work full duty. He agreed testing and treatment to date had been reasonable, necessary and causally related to the accident. (Rx. 3). Respondent terminated temporary total disability benefits following the IME.

An April 16, 2012 MRI showed the L5 PARS Defect, L5-S1 posterior disc bulge, annular tear and several foraminal encroachment, L4-5 annular tear and L3-4 annular tear. (Px. 6 at 4). Dr. Gornet opined the results were similar to the September 22, 2010 films. He recommended surgery, pending weight loss, and causally connected the need for it to the work accident. (Px. 6 at 5).

On July 16, 2012, Petitioner weighed 328 pounds. He weighed 334 pounds on October 15, 2012. Petitioner testified he ate poorly when his TTD benefits stopped. By February 11, 2013, he weighed 321 pounds. By May 16, 2013, he weighed 304 pounds. Petitioner testified as of trial he weighed 298 pounds, two pounds less than the target weight for surgery. Petitioner testified he ate healthier when he received food stamps.

Petitioner currently experiences low back pain radiating down the right upper extremity. He wants to undergo the surgery proposed by Dr. Gornet so he can return to work for Respondent or get a nursing job. Petitioner took nursing classes since he has been off work because he did not find other work within his restrictions.

Petitioner deposed Dr. Gornet August 30, 2012. Dr. Gornet testified Petitioner's physical exam finding of decreased EHL function at 4/5 was classic L5 radiculopathy. (Px. 7 at 7-8). He diagnosed symptomatic L5-S1 spondylolithesis, discogenic L4-5 pain and possible L3-4 disc injury. (Px. 7 at 10). He opined the current diagnoses were related to the work accident. (Px. 7 at 10). He recommended a new lumbar MRI because the first was not completely diagnostic. (Px. 7 at 11). He reviewed the April 16, 2012 MRI and interpreted L5-S1 right foraminal stenosis and L4-5 disc herniations. (Px. 7 at 11-12). He recommended, pending weight loss and decreased abdominal size, an L4-5 disc replacement and L5-S1 fusion. (Px. 7 at 12-14). He causally connected the need for surgery to the work accident because it aggravated a preexisting asymptomatic condition as well produced new structural disc injuries at L4-5 and L5-S1. (Px. 7 at 14). He has successfully operated on patients larger than Petitioner and felt Petitioner was motivated to lose weight. (Px. 7 at 15-16). On cross examination, Dr. Gornet explained the need for surgery is work related because the accident made the L4-5 and L5-S1 symptomatic. (Px. 7 at 23-24).

Respondent deposed Dr. Kitchens on October 23, 2012. Dr. Kitchens diagnosed lumbar degenerative disc disease, lumbarized sacral spine, spondylolithesis and obesity. (Rx. 3 at 10-11). He opined the diagnoses were not caused, aggravated, accelerated or exacerbated by the accident. (Rx. 3 at 12). He opined Petitioner did not need treatment related to the accident because he did not have lumbar radiculopathy. (Rx. 3 at 15). On cross examination, he admitted the testing and treatment up to his exam was reasonable, necessary and causally related to the accident. (Rx. 3 at 25). He refused to opine the surgery proposed by Dr. Gornet was unreasonable or unnecessary. (Rx. 3 at 38-39).

CONCLUSIONS OF LAW

1. Regarding the issue of causation, Petitioner has met his burden of proof. Petitioner has proven a medical causal relationship exists between his current lumbar condition and the August 17, 2010 work accident. In support of the conclusion, the arbitrator relies on the Petitioner's unrebutted testimony and the medical evidence. Prior to the work accident, Petitioner suffered from degenerative disc disease, L5 PARS defect, L5-S1 spondylolisthesis, and obesity. However, the conditions did not produce lumbar and right lower extremity symptoms. Petitioner's testimony supports he had no prior back problems in that he worked full duty in a heavy physical position for Respondent since 2007. The work accident at a minimum aggravated his lumbar condition resulting in low back pain and right lower extremity symptoms. The symptoms have not resolved. This is supported by medical records and Petitioner's credible testimony. Lastly, the opinions of Dr. Gornet and Dr. Thom are more credible than the opinion of Dr. Kitchens because they treated Petitioner on multiple occasions and the opinions are consistent with the chronology of events. Dr. Gornet, unlike Dr. Kitchens, reviewed all the diagnostic films and medical records.

2. Respondent is ordered to approve the surgery proposed by Dr. Gornet because it is reasonable, necessary and causally related to the accident. In support of the conclusion, the arbitrator relies on the Petitioner's treating medical records. Petitioner has objective findings on the imaging studies and physical exam findings by Dr. Gornet and Dr. Thom to support the disc injuries at L4-5 and L5-S1. He attempted conservative measures, but remains sufficiently symptomatic that he cannot return to his pre-injury classification. Further, the opinion of Dr. Gornet is more credible than the opinion of Dr. Kitchens. Dr. Gornet reviewed all the imaging studies and opined surgery is reasonable and necessary once Petitioner lost necessary weight. Petitioner reached his target weight. Dr. Kitchens could not opine the surgery proposed by Dr. Gornet is unreasonable and unnecessary, only that he would not do it. While Dr. Thom and Dr. Grubb did not recommend surgery, the recommendations were based in part on Petitioner's weight. Petitioner has lost the weight as recommended by Dr. Gornet in order to proceed with surgery.

3. Petitioner is entitled to TTD benefits from September 1, 2010 through July 11, 2013. In support of this conclusion, the arbitrator notes that Respondent terminated benefits on February 28, 2012 based upon the opinion of Dr. Kitchens that Petitioner could work full duty. The opinions of Dr. Thom and Dr. Gornet that Petitioner required restrictions related to the accident are more credible that the opinion of Dr. Kitchens. Respondent is entitled to credit for TTD benefits paid.

4. Petitioner is awarded medical expenses in Petitioner's Exhibit 9, subject to the medical fee schedule. This decision is based on the finding that the need for the treatment from Dr. Gornet and Dr. Thom is reasonable, necessary and causally related to the work accident. Respondent is entitled to credit for any medical expenses it has already paid.

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

Julius Encarnacion,

Petitioner,

vs.

14IWCC0082

NO: 10 WC 42530

State of Illinois, Department of Corrections,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's permanent 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 16, 2013 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: FEB 03 2014

Daniel R. Donohoo

David L. Gore

Mario Basurto

DRD:bjg
0-1/23/2014
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0082

ENCARNACION, JULIUS
Employee/Petitioner

Case# **10WC042530**

10WC004178

ILLINOIS DEPT OF CORRECTIONS
Employer/Respondent

On 7/16/2013, 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:

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

5165 ASSISTANT ATTORNEY GENERAL
JEANNINE SIMS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PKWY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

JUL 16 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

14IWCC0082

☐ 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

Julius Encarnacion
Employee/Petitioner

v.

Illinois Department of Corrections
Employer/Respondent

Case # **10** WC **42530**

Consolidated cases: **10WC4178**

An *Application for Adjustment 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 **March 15, 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

On **September 14, 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 **$57,199.05**; the average weekly wage was **$1,099.98**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$1,964.68** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,964.68**.

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 $733.32/week for 2.72 weeks, commencing September 22, 2010 through October 10, 2010, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $324.97, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $659.99/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

7/15/13
Date

ICArbDec p. 2

JUL 16 2013

Attachment to Arbitrator Decision
(10 WC 42530)

STATEMENT OF FACTS:

On September 14, 2010, Petitioner, Julius Encarnacion was employed as a tool and toxics control officer by Respondent, the Illinois Department of Corrections. The parties agree that on that date, Petitioner sustained an accident that arose out of and in the course of his employment by Respondent.

As part of his job duties, Petitioner was tasked with delivering chemicals from storage to various departments within Stateville Correctional Center. On September 14, 2010, Petitioner was making a delivery to the kitchen area of Stateville. When he arrived in the kitchen, Petitioner began looking for another employee who he had determined was in the dining hall. The door between the dining hall and the kitchen was heavy and made of steel. While Petitioner was standing near the door, an inmate opened the door which struck Petitioner in the head. After being struck, Petitioner blacked out and awoke in an ambulance on the way to the hospital.

Petitioner was taken via ambulance to Provena St. Joseph Medical Center. The emergency room records from Provena indicate that Petitioner had been struck in the head by a very heavy steel door. Petitioner underwent a CT scan of the brain, x-rays of the cervical spine and an ECG, which were all normal. Petitioner was diagnosed with a head injury, concussion and subdural hematoma. (PX 2).

On September 16, 2010, Petitioner followed up with Optima Medical Associates ("Optima"). At that time, Petitioner complained of left sided headaches. Due to the continuing complaints of pain, an orbital x-ray was performed which came back negative. Petitioner was again diagnosed with a concussion and was given medication for his headaches. (PX 1).

On September 20, 2010, Petitioner was seen again at Optima. Petitioner complained of headache over his left orbital area, light headedness and loss of balance. Petitioner was diagnosed with concussion with loss of consciousness, residual headache and altered balance. (PX 1).

Petitioner followed up at Optima on September 23, 2010. At that time, Petitioner was still having headaches despite the pain medication. It was also indicated that Petitioner had called the Optima medical benefit center but had no memory of doing so. An MRI was ordered due to persistent headache and an episode of amnesia. (PX 1).

On October 4, 2010, Petitioner underwent a MRI of the brain, the results of which were unremarkable. (PX 1).

Petitioner testified that he returned to work on October 11, 2010.

The parties in this claim agreed that Petitioner was temporarily and totally disabled from September 22, 2010 through October 10, 2010.

On November 9, 2010, Petitioner followed up at Optima. There it was noted that Petitioner had persistent, daily headaches and left ear pain. Petitioner was diagnosed with balance abnormality and chronic headaches. Petitioner was cleared to return to work at that time with no limitations. (PX 1).

Petitioner sought no further medical treatment for his head after November 9, 2010.

At trial, Petitioner testified that he continued to experience headaches for approximately one year after the accident. Petitioner stopped taking medication for his head approximately six months after his last appointment with Optima.

On the issue of the petitioner's average weekly wage, (G), the Arbitrator finds as follows:

The Arbitrator has reviewed Petitioner's pay records, as contained in Respondent's Exhibit 3 and has calculated Petitioner's average weekly wage as follows:

Period Ending	Gross	OT Premium	Weeks	Wage
9/16/2009	$2,342.50	$0.00		$2,342.50
10/1/2009	$2,342.50	$0.00		$2,342.50
10/16/2009	$3,892.36	$1,541.31		$2,351.05
11/1/2009	$2,342.50	$0.00		$2,342.50
11/16/2009	$2,342.50	$0.00		$2,342.50
12/1/2009	$3,268.72	$926.22		$2,342.50
12/16/2009	$6,068.92	$3,726.42		$2,342.50
1/1/2010	$3,311.64	$922.64		$2,389.00
1/16/2010	$2,389.00	$0.00		$2,389.00
2/1/2010	$2,389.00	$0.00		$2,389.00
2/16/2010	$2,171.82	$0.00		$2,171.82
3/1/2010	$2,389.00	$0.00		$2,389.00
3/16/2010	$3,528.82	$922.64		$2,606.18
4/1/2010	$3,344.59	$955.59		$2,389.00
4/16/2010	$2,718.51	$329.51		$2,389.00
5/1/2010	$3,311.64	$922.64		$2,389.00
5/16/2010	$3,048.03	$659.03		$2,389.00
6/1/2010	$2,974.80	$585.80		$2,389.00
6/16/2010	$5,003.13	$2,614.13		$2,389.00
7/1/2010	$3,406.09	$981.09		$2,425.00
7/16/2010	$4,097.31	$1,672.31		$2,425.00
8/1/2010	$4,008.12	$1,583.12		$2,425.00
8/16/2010	$2,659.12	$234.12		$2,425.00
9/1/2010	$2,670.27	$245.27		$2,425.00
Totals	$76,020.89	$18,821.84	52.00	$57,199.05

Days in Pay Period:	15-16
Normal Hours Per Day:	8.00
Days per Week:	5.00

TOTAL EARNINGS UNDER SECTION 10:	$57,199.05
NUMBER OF WEEKS AND PARTS THEREOF WORKED:	52.00
SECTION 10 AVERAGE WEEKLY WAGE:	$1,099.98
TEMPORARY TOTAL DISABILITY RATE:	$733.32

Based upon the above calculations, the Arbitrator hereby finds that Petitioner's average weekly wage was $1,099.98 pursuant to Section 10 of the Act.

On the issue of unpaid medical bills, (J), the Arbitrator finds as follows:

Prior to hearing in this case, the parties agreed that actual the amount of outstanding bills for each of Petitioner's consolidated claims would be agreed to by the parties and only the outstanding amount of medical would be requested by Petitioner. The parties have each submitted that a total of $324.97 in medical bills remains outstanding related to this claim.

The arbitrator hereby finds that there is no basis for dispute as to the causal relationship or reasonableness and necessity of the medical bills presented by Petitioner in this matter. Therefore, the Arbitrator hereby orders Respondent to pay unpaid medical bills as follows:

The Arbitrator has examined the bills entered into evidence as Petitioner's Exhibit 6 and has found the following unpaid bills to be causally related to Petitioner's May 5, 2009 work accident:

Provider	Beginning	Ending	Total Charges	WC Paid	Balance
Provena Health	9/14/2010	9/14/2010	$324.97	$0.00	$324.97
Balance			$775.72	$0.00	$324.97

Therefore, the Arbitrator hereby orders Respondent to pay reasonable and necessary medical services of $324.97, as provided in Sections 8(a) and 8.2 of the Act.

On the issue of the nature and extent of Petitioner's injury, (L), the Arbitrator finds as follows:

Petitioner in this matter suffered an acute head injury with loss of consciousness, causing a concussion, a subdural hematoma, impaired balance and persistent headaches. Petitioner's impaired balance lasted at least through his November 2010 treatment with Optima. Petitioner's headaches lasted for approximately one year after the accident.

Based upon the unrebutted testimony of Petitioner concerning his condition and the medical records entered into evidence in this case, the Arbitrator hereby finds that Petitioner sustained a loss of use of 5% of the person

as a whole and orders Respondent to pay petitioner $659.99 per week for 25 weeks pursuant to Section 8(d)2 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

Julius Encarnacion,
Petitioner,

vs.

14IWCC0083

NO: 10 WC 4178

State of Illinois, Department of Corrections,

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 the nature and extent of Petitioner's 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 16, 2013 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: FEB 0 3 2014

Daniel R. Donohoo

David L. Gore

Mario Basurto

DRD:bjg
0-1/23/2014
068

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0083

ENCARNACION, JULIUS
Employee/Petitioner

Case# **10WC004178**
10WC042530

ILLINOIS DEPT OF CORRECTIONS
Employer/Respondent

On 7/16/2013, 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:

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

5165 ASSISTANT ATTORNEY GENERAL
JEANNINE SIMS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PKWY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

JUL 16 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

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

14IWCC0083

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Julius Encarnacion
Employee/Petitioner

v.

Illinois Deparment of Corrections
Employer/Respondent

Case # **10** WC **4178**

Consolidated cases: **10WC42530**

An *Application for Adjustment 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 **March 15, 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

On **May 5, 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 **$57,774.60**; the average weekly wage was **$1,111.05**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$1,293.56** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,293.56**.

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

ORDER

Respondent shall be given a credit of **$1,293.56** for TTD, **$0** for TPD, and **$0** for maintenance benefits, for a total credit of **$1,293.56**.

Respondent shall pay Petitioner temporary total disability benefits of $740.70/week for 2.86 weeks, commencing June 3, 2009 through June 22, 2009, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for 15.375 weeks, because the injuries sustained caused the 7.5% 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

7/15/13
Date

JUL 16 2013

Attachment to Arbitrator Decision
(10 WC 4178)

STATEMENT OF FACTS:

On May 5, 2009, Petitioner, Julius Encarnacion was employed as a tool and toxics control officer by Respondent, the Illinois Department of Corrections.

Petitioner was employed by Respondent at Stateville Penitentiary. As a tool and toxics control officer, Petitioner's job primarily involved maintaining the facility's tools, which included the task of etching and engraving reference numbers into each new tool that the facility received. Prior to May 5, 2009, Petitioner testified that multiple facilities in the state corrections system had recently closed and the tools had all been transferred to Stateville, where Petitioner was tasked with engraving each new tool. Each department within Stateville had their own set of tools, which could number above 100 tools per department. Petitioner testified that there were many departments within Stateville for which tools were engraved, including carpenters, plumbers, electricians, refrigeration, motor pool and dietary.

Petitioner explained that while etching and engraving tools, he would hold each tool in his left hand and use an electric etcher with his right hand. The etcher vibrated "a lot." Petitioner felt the vibration from the etcher in both hands, causing his hands to shake during the engraving process. The vibration was caused by the metal tip of the engraver striking the metal tool. While engraving the tools, Petitioner would twist his left wrist to allow him to engrave each side of the tool. Each individual tool that Petitioner engraved would take anywhere from 10 to 15 minutes to complete and Petitioner would engrave approximately 50 to 100 tools per day.

Petitioner testified that as of May 5, 2009, he had personally completed the engravings on approximately 70% of the tools received during the facilities transition.

In addition to maintaining tools, Petitioner's job also involved delivering tools and various chemicals to anywhere in the facility that required them. Petitioner testified that for tool and chemical deliveries, he would come in and out of the tool control office many times per day. The door to the tool control office was made from steel. In order to open the door, Petitioner would use his left hand to turn a large Folger Adams key in the door and pull the door open in the same motion. Petitioner explained that he always used his left hand to open the door because he kept his radio on his right side and his keys on his left.

On May 5, 2009, Petitioner testified that he was going to open the steel door to the tool control office when he experienced numbness and tingling in his left hand. Petitioner also noticed that there was a lump in his left wrist at that time. Petitioner had never experienced numbness or tingling in his left hand or noticed a lump in his left wrist prior to May 5, 2009.

Petitioner immediately reported his injury to his superior, Major Torri, and was sent home from work.

On May 6, 2009, Petitioner was seen at The Optima Medical Associates by Dr. Brian Ragona who diagnosed a ganglion cyst of the left wrist and advised Petitioner to follow up with a hand specialist. (PX 1).

On May 8, 2009, Petitioner was seen by Dr. Alan Chen who noted the painful lump in Petitioner's left wrist. Petitioner testified that he was experiencing tingling and numbness in the left hand when he sought care with Dr. Chen. Dr. Chen diagnosed a left wrist ganglion cyst and recommended a surgical excision of the cyst. (PX 3).

On May 15, 2009, Dr. Chen drafted a correspondence in which he noted Petitioner's left wrist mass and discomfort. At that time, the mass had grown on the volar aspect of Petitioner's left wrist. Dr. Chen stated that although Petitioner did not have a specific injury, he often used his left wrist with significant force when closing prison doors, which were extraordinarily heavy. (PX 3). Dr. Chen again recommended excision of the cyst due to continued discomfort by Petitioner.

After seeing Dr. Chen on May 15, 2009, Petitioner reported the accident and his diagnosis to Respondent. Petitioner filled out an accident report, contained in Petitioner's Exhibit 5, in which Petitioner detailed that he was performing tool control at the time of his accident and that his accident occurred due to repetitive motion. (PX 5).

On June 1, 2009, a CMS medical report was filled out by Mary Kronenburger, a nurse practitioner from Optima Medical Associates, who noted that as of June 1, 2009, the mass on Petitioner's wrist had increased in size and that Petitioner required surgical excision of the cyst. (RX 4).

On June 2, 2009, Petitioner followed up with Optima Medical Associates. On that date, it was noted that Petitioner complained of numbness in the left thumb and had a ganglion cyst of the left radial area of the wrist. Petitioner was placed on an off work status until surgery was scheduled. It was specifically noted that Petitioner could not use his left hand due to neuropathy and that it would cause an unsafe condition at work. (PX 1).

Petitioner testified that he began off work as of June 2, 2009. However, on June 3, 2009 Petitioner signed a temporary total disability (TTD) request, stating that he requested TTD benefits beginning on June 10, 2009. (RX 4). At trial, Petitioner did not recall the details surrounding his signing of the TTD request, he testified that he "just signed it." Petitioner further testified that each time he received a work status report, including when he received the work status report on June 2, 2009 from Optima, he took it to Kenneth from Stateville, who is the other individual who signed Petitioner's TTD request form.

On June 12, 2009, Petitioner underwent a surgical excision of a left wrist ganglion cyst, performed by Dr. Chen. (PX 3).

Following surgery, Petitioner continued to follow up with Dr. Chen. On June 22, 2009, Petitioner was released by Dr. Chen to return to work at full duty as of June 23, 2009. Petitioner testified at trial that he did in fact return to work on June 23, 2009.

On July 27, 2009, Dr. Chen drafted correspondence to Respondent indicating the course of treatment Petitioner had undergone and that he was clear to work without restriction. (PX 3). Petitioner has received no further treatment for his left hand or wrist since July 27, 2009.

On March 2, 2011, Petitioner's medical records were reviewed by Dr. Jeffrey Coe. Dr. Coe testified in this matter on December 5, 2011. Dr. Coe is a board certified specialist in occupational medicine. (PX 7 @ 3). Dr. Coe reviewed all of Petitioner's medical records from March of 2009 through his release from medical care. (PX 7 @ 5). Dr. Coe noted Petitioner's job duties, including engraving with an engraving tool and opening and closing cell doors. (PX 7 @ 6). Based upon Petitioner's treatment records, comments within those records regarding the nature of Petitioner's work, and the development of Petitioner's left wrist condition, Dr. Coe opined that there was a causal relationship between Petitioner's work activities and the left wrist ganglion cyst, which required surgical excision. (PX 7 @ 10-11). Dr. Coe opined that Petitioner's work activities aggravated the breakdown at the tendon sheath of the left wrist, causing the development of the cyst. (PX 7 @ 11). He explained that the forceful repetitive gripping and performing fine movements while gripping, are the types of stressful activities that can cause or contribute to the breakdown in the tendon sheath and the development of the ganglion cyst that Petitioner began to note in May of 2009. These are also the types of work activities that Petitioner described to Dr. Chen on May 8, 2009, including repetitive forceful gripping to open and close heavy cell doors and engraving using an engraving tool. (PX 7 @ 12). Dr. Coe further testified that all medical treatment he had reviewed had been reasonable and necessary. (PX 7 @ 11-12).

On cross-examination, Dr. Coe testified that it is standard medical teaching in occupational medicine that work factors may be a cause of a ganglion cyst; either directly causing the cyst or aggravating a preexisting cyst and rendering it symptomatic. (PX 7 @ 14). Dr. Coe testified that he did not know how heavy exactly the door that Petitioner had to open and close was, nor how often he had to perform that task. However, Dr. Coe has seen other prison employees over the years and has learned that the prison doors are heavy, weighing more than a hundred pounds. (PX 7 @ 15). Dr. Coe's understanding of Petitioner's engraving duties was that he used a vibrating engraving tool and gripped it forcefully. (PX 7 @ 18).

On August 29, 2012, Petitioner underwent a Section 12 examination with Dr. James Williams. The doctor noted in his report that Petitioner was employed in tools and toxics for Stateville Correctional Center. Dr. Williams noted that Petitioner's employment involved stocking and lifting, as well as using his left hand to open his steel office door. Dr. Williams reviewed a job description provided by Respondent, which by Dr. William's description appears to be the same job description as contained in Petitioner's Exhibit 4. Petitioner also informed Dr. Williams that he engraved tools as part of his job. Dr. Williams stated that Petitioner did not suffer any acute injury and that he did not complain of any symptoms whatsoever at the time of the examination. In contrast to Dr. William's statement, Petitioner testified at hearing that he did tell Dr. Williams that he was experiencing numbness in his left hand. After reviewing records and examining Petitioner, Dr. Williams opined that the ganglion cyst was not causally related to his work duties. He stated that "I do not believe that patient's job duties, being that of turning keys or of closing prison doors, would have resulted in any ganglion cyst." Dr. Williams further opined that all care and treatment had been reasonable and necessary, but he did not believe it was related to any work accident. (RX 17). Dr. Williams was not deposed in this matter.

At trial, Petitioner testified concerning the current condition of his left wrist and hand. He stated that when the palm of his left hand is touched, he experiences tingling in the left and, up into his fingers. He explained that

although surgery helped him a lot, his left hand still feels very different than his right hand. Petitioner has experienced tingling in his left hand since May 5, 2009.

On the issues of whether an accident occurred that arose out of and in the course of Petitioner's employment with respondent, (C), and whether Petitioner's current condition of ill being is causally related to his work accident, (F), the Arbitrator finds as follows:

After reviewing all evidence and testimony in this matter, the Arbitrator hereby finds that Petitioner did sustain an accident that arose out of and in the course of his employment by Respondent on May 5, 2009 and that the current condition of ill-being in Petitioner's left wrist and hand is causally related to his May 5, 2009 work accident.

Although Petitioner did not sustain an acute trauma to his left wrist, the repetitive nature of his duties caused the development of a ganglion cyst which required surgical excision. At trial, Petitioner testified to the repetitive work he performed for Respondent. It was undisputed by Respondent that as of May 5, 2009, Petitioner had personally engraved new identification numbers onto 70% of the hundreds of tools transferred from other state facilities to Stateville in early 2009. While etching and engraving each tool, Petitioner explained that he would hold the tools in his left hand while he used an electric etcher with his right hand. The vibration from the etcher shook both of Petitioner's hands. Each of the hundreds of tools engraved by Petitioner would take anywhere from 10 to 15 minutes to complete. In addition, Petitioner would twist his left wrist during the engraving process to allow him to engrave each side of the tool. In addition to engraving tools, Petitioner would repeatedly enter an exit a steel door, using his left hand to twist a large key in the door and pull the door open.

Respondent in this case offered no evidence or testimony to dispute the job duties described by Petitioner. The job description produced by Respondent indicates that Petitioner's duties required the "use of hands for gross manipulation (grasping, twisting, handling)" for 6-8 hours per day and required the "use of hands for fine manipulation (typing, good finger dexterity)" for 2-4 hours per day. (PX 4).

During his deposition testimony in this matter, Dr. Coe opined that Petitioner's work activities aggravated the breakdown at the tendon sheath of the left wrist, causing the development of the cyst. (PX 7 @ 11). He explained that forceful repetitive gripping performing fine movements while gripping are the types of stressful activities that can cause or contribute to the breakdown in the tendon sheath and the development of the ganglion cyst that Petitioner began to note in May of 2009. These are also the types of work activities that Petitioner described to Dr. Chen on May 8, 2009, including repetitive forceful gripping to open and close heavy cell doors and engraving using an engraving tool. (PX 7 @ 12). Dr. Coe further testified that it is standard medical teaching in occupational medicine that work factors may be a cause of ganglion cyst; either directly causing the cyst or aggravating a preexisting cyst and rendering it symptomatic. (PX 7 @ 14).

Respondent in this case relies on the IME report of Dr. Williams who opined that Petitioner's cyst was not caused by his work duties. (RX 17). The Arbitrator is not persuaded by the opinion of Dr. Williams. The Arbitrator notes it appears the doctor ignored the details of Petitioner's work duties in coming to that conclusion. Although Dr. Williams notes that Petitioner's job included engraving tools and although he reviewed the Stateville job description that shows Petitioner performed gross manipulation for 6-8 hours per day and fine manipulation for 2-4 hours per day, Dr. Williams simply concluded, "I do not believe that patient's job duties, being that or turning keys or of closing prison doors, would have resulted in any ganglion cyst."

(RX 17). It is clear from the records in this case, along with Petitioner's undisputed testimony, that Petitioner's job duties included far more than turning keys and closing prison doors. It appears Dr. Williams, disregarded pertinent facts, specifically the extent of tool use and engraving performed by Petitioner, rendering his opinion unreliable.

Therefore, after reviewing all records and testimony in this case, the Aarbitrator finds that the opinion of Dr. Coe is more persuasive than the opinion of Dr. Williams and adopts the opinion of Dr. Coe regarding causation.

The Arbitrator further finds that Petitioner's accident in this matter did occur on May 5, 2009. The date of an accidental injury in a repetitive trauma compensation case is the date on which the injury manifests itself. *Peoria County Belwood Nursing Home v. Industrial Commisison*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). The manifestation of a repetitive trauma injury occurs when the fact of injury and its causal relationship to the claimant's employment would have become plainly apparent to a reasonable person. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (2006).

The unrebutted testimony of Petitioner was that he had never noticed the lump in his left wrist until May 5, 2009, nor had he ever experienced pain in his left wrist until he was opening the steel office door on May 5, 2009. Petitioner then immediately reported his accident and injury to his supervisor. Based on this information, it is apparent that Petitioner's injury manifested itself to him on May 5, 2009.

On the issue of Petitioner's earnings, (G), the Arbitrator finds as follows:

The Arbitrator has reviewed Petitioner's pay records as contained in Respondent's Exhibit 3 and has calculated Petitioner's average weekly wage as follows:

Period Ending	Gross	OT Premium	Weeks	Wage
5/16/2008	$3,725.08	$1,242.90		$2,482.18
6/1/2008	$4,200.54	$1,760.78		$2,439.76
6/16/2008	$4,689.97	$2,437.47		$2,252.50
7/1/2008	$2,252.50	$0.00		$2,252.50
7/16/2008	$3,859.15	$1,450.05		$2,409.10
8/1/2008	$3,391.83	$1,139.33		$2,252.50
8/16/2008	$4,427.58	$2,175.08		$2,252.50
9/1/2008	$4,116.83	$1,553.63		$2,563.20
9/16/2008	$4,124.99	$1,864.35		$2,260.64
10/1/2008	$4,738.30	$2,485.80		$2,252.50
10/16/2008	$4,738.30	$2,485.80		$2,252.50
11/1/2008	$3,226.11	$973.61		$2,252.50
11/16/2008	$3,806.01	$310.73		$3,495.28
12/1/2008	$3,806.13	$1,553.63		$2,252.50
12/16/2008	$3,702.47	$621.45		$3,081.02
1/1/2009	$2,317.29	$0.00		$2,317.29
1/16/2009	$3,229.72	$946.01		$2,283.71
2/1/2009	$4,178.03	$1,892.03		$2,286.00

2/16/2009	$3,757.55	$1,051.13		$2,706.42
3/1/2009	$2,916.68	$630.68		$2,286.00
3/16/2009	$2,580.32	$294.32		$2,286.00
4/1/2009	$2,874.63	$588.63		$2,286.00
4/16/2009	$2,286.00	$0.00		$2,286.00
5/1/2009	$2,601.34	$315.34		$2,286.00
Totals	$85,547.35	$27,772.75	52.00	$57,774.60

Days in Pay Period:	15-16
Normal Hours Per Day:	8.00
Days per Week:	5.00

TOTAL EARNINGS UNDER SECTION 10:	$57,774.60
NUMBER OF WEEKS AND PARTS THEREOF WORKED:	52.00
SECTION 10 AVERAGE WEEKLY WAGE:	$1,111.05
TEMPORARY TOTAL DISABILITY RATE:	$740.70

Based upon the above calculations, the Arbitrator hereby finds that Petitioner's average weekly wage was $1,111.05 pursuant to Section 10 of the Act.

On the issue of temporary total disability benefits, (K), the Arbitrator finds as follows:

The Arbitrator has reviewed all evidence and testimony in this matter and hereby finds that Petitioner was temporarily and totally disabled from June 3, 2009 through June 22, 2009.

On June 2, 2009, Petitioner was seen at Optima Medical Associates. There, it was noted that Petitioner had numbness in his left thumb. Petitioner was diagnosed with ganglionic cysts causing radial nerve compression and numbness in his left hand. At that time, Petitioner was told to remain off work until surgery was scheduled. It was noted in Petitioner's work status report that day that Petitioner could not use his left hand due to neuropathy, which would cause an unsafe work condition. (PX 1).

At trial, Petitioner testified on direct examination that he went off work as of June 3, 2009.

On cross-examination, Petitioner was presented with Respondent's Exhibit 4, which is an Employee Request for Temporary Total Disability Benefits form, signed by Petitioner. The form indicates Petitioner requested TTD benefits as of June 10, 2009 and states that a physician's statement was attached describing his medical status. (RX 4). It is clear Petitioner did not recall the details surrounding his signing of this form.

The Arbitrator notes that the medical records attached to Respondent's Exhibit 4 are from Mary Kronenburger, a nurse practitioner from Optima Medical Associates, and were filled out and signed on June 1, 2009. Ms. Kronenburger indicates that the mass on Petitioner's left wrist had increased in size as of June 1, 2009 and that Petitioner had been referred for surgical excision of the mass. She further indicates that Petitioner was experiencing pain and numbness in his left wrist and hand. As of June 1, 2009, Ms. Kronenbuger indicated that Petitioner could work without restriction and that Petitioner would require restrictions after surgery. (RX 4).

The Arbitrator specifically notes that the form filled out by Ms. Kronenburger on June 1, 2009 predates the off work status placed on Petitioner at Optima Medical Associates on June 2, 2009. At trial, Petitioner testified that each time he received a work status report, he would take the form to Kenneth, the workers' compensation coordinator for Stateville, whose signature appears on Respondent's Exhibit 4. Petitioner further explained that he would have taken the off work slip he received on June 2, 2009 to Kenneth.

Although the TTD request filled out by Petitioner indicates that TTD was requested as of June 10, 2009, it is clear to the Arbitrator that although Petitioner was cleared to return to work on June 1, 2009, the medical records show he was taken off work on June 2, 2009. Furthermore, the testimony of Petitioner that he was off work from June 3, 2009 through his return to work on June 22, 2009 is unrebutted by any testimony or evidence in this case.

Therefore, the Arbitrator hereby orders Respondent to pay Petitioner temporary total disability benefits of $740.70 per week for 2.86 weeks from June 3, 2009 through June 22, 2009 pursuant to Section 8(b) of the Act.

On the issue of the nature and extent of Petitioner's disability, (L), the Arbitrator finds as follows:

Petitioner in this case sustained a ganglionic cyst which caused radial nerve compression and numbness in his left hand and required surgical excision. (PX 1, 3).

At trial, Petitioner testified concerning the current condition of his left wrist and hand. He stated that when the palm of his left hand is touched he experiences tingling in the left, up into his fingers. He further explained that although surgery helped him a lot, his left hand still feels very different than his right hand. Petitioner has experienced tingling in his left hand since May 5, 2009.

Based upon the medical records and testimony in this case, the Arbitrator hereby finds that Petitioner has sustained a 7-1/2% loss of use of his left hand.

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

Jerald Burnett,
Petitioner,

14IWCC0084

vs.

NO: 07 WC 46312

Monterey Coal Company,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 12, 2013 is hereby affirmed and adopted.

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

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

DATED: FEB 0 3 2014

Daniel R. Donohoo

David L. Gore

Mario Basurto

DRD:bjg
0-1/23/2014
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0084

BURNETT, JERALD
Employee/Petitioner

Case# 07WC046312

MONTEREY COAL CO
Employer/Respondent

On 6/12/2013, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
P O BOX 335
SPRINGFIELD, IL 62705

14IWCC0084

STATE OF ILLINOIS)

COUNTY OF SANGAMON) SS.

☐ 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

Jerald Burnett
Employee/Petitioner

Case # **07 WC 46312**

v.

Consolidated cases: **N/A**

Monterey Coal Co.
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 **Springfield**, on **January 15, 2013 and April 15, 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: Statute of Limitations; Section 1(f); Whether Petitioner developed an occupational lung disease as a result of exposure in the course of his employment with Respondent.

FINDINGS

On **4-30-04**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner was last exposed to coal dust and fumes arising out of and in the course of his employment.

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

In the year preceding the injury, Petitioner earned **$55,817.05**; the average weekly wage was **$1073.40**.

ORDER

Petitioner failed to prove he developed an occupational lung disease as a result of exposure in the course of his employment with Respondent. Petitioner's claim for compensation is denied. 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.

Jerry Lindsay
Signature of Arbitrator

June 10, 2013
Date

ICArbDec p. 2

JUN 12 2013

Jerald Burnett v. Monterey Coal Company, 07 WC 46312

This case was initially tried on January 15, 2013 with proofs left open per the agreement of the parties. Proofs were closed on April 15, 2013. Two witnesses testified at arbitration: Petitioner and Larry Watson.

The Arbitrator finds:

Petitioner, born on September 16, 1944, was 68 years old on the date of arbitration. Petitioner testified that he quit school after the tenth grade. According to Petitioner, his family moved, he transferred to a new school and had trouble keeping up so he quit. Petitioner testified that he spent 35 years in the coal mine, fifteen of which was underground. Petitioner testified that he was regularly exposed to coal and silica dust, diesel exhaust, and roof bolting glue fumes while mining. Petitioner further testified that his last day of work at the coal mine was on April 30, 2004 at Respondent's Monterey Coal Company's #1 Carlinville Mine. Petitioner testified he was working as a top shop repairman specialist when he quit. According to Petitioner he quit mining because he could no longer perform his job properly due to shortness of breath. Petitioner testified he had intended to work until age 65, then changed his goal to 62, but quit earlier. Petitioner testified that a co-worker suggested retirement to him after observing Petitioner leaning on a broom to stay standing while sweeping. Petitioner testified that he hasn't looked for any work since retiring because of his work history, limited education, and difficulty breathing. Petitioner testified that he has no other skills beyond coal mining. He did perform some construction work for Respondent and a construction company.

Petitioner testified that he first noticed breathing problems in the late 1990's while trying to tighten bolts on a man trip. He had to tighten the bolts to the necessary specification of 350 pounds. Tasks such as installing and repairing pumps in the lake, as well as walking the stairs to the hoist house, also caused breathing problems. Petitioner testified he would lose his breath and have to stop what he was doing and sit down. His breathing problems were worse around heavier areas of rock and coal dust. Diesel fumes and roof bolting glue fumes also affected him. To lessen his dust exposure Petitioner bid into his surface mining maintenance job.

Petitioner further testified that he currently becomes short of breath walking a half of a block. Petitioner testified he can climb a half a flight of stairs before having to stop and rest. His breathing problems have worsened since their onset. Whenever he goes anywhere his wife drops him off at the door to limit his walking. Petitioner would not take a mining job if offered today. Petitioner testified that he doesn't think he has the lung capacity to do any work unless he could sit. He also felt he did not have the work skills for such a job.

Petitioner testified he was treated by Dr. Chopra for his breathing problems. He brought his breathing medications and his nebulizer to arbitration. He also uses Advair and Combivent inhalers. Petitioner testified that he began smoking cigarettes around age 16 or 17 and quit when he was 49, averaging a pack or a little more each day. He acknowledged other health problems including an irregular heartbeat, high blood pressure, and prostate cancer. Petitioner's prostate cancer was diagnosed 6-7 years ago, and he was recently told it has spread to his lungs. Petitioner was also treated for throat cancer about a year after he left mining.

Under the current National Bituminous Wage Agreement, Petitioner's Exhibit 8, Petitioner would be earning $27.41 per hour as a miner today.

Larry Watson testified on behalf of Petitioner. Mr. Watson has known Petitioner for 25-30 years. He and Petitioner worked at the same mine. Mr. Watson worked in the plant and Petitioner was across the tracks in

the shop. Mr. Watson saw Petitioner almost every day at work. He observed Petitioner huffing and puffing when he went to the shop for parts. He told Petitioner he should retire. Mr. Watson knew Petitioner had a hard time breathing. Mr. Watson noted one time that Petitioner had finished sweeping and was getting ready to shovel. He asked Petitioner if he was alright, and Petitioner told him he could not catch his breath. Mr. Watson stated that Petitioner had breathing issues prior to that time, "but there at [the] last it was bad."

Petitioner's medical history includes bilateral knee surgery (1972; 1981) from which Petitioner had osteoarthritis accompanied by pain, discomfort, and reduced range of motion throughout his life. (RX 1, p. 7) He had cataract surgery in 1991 and 1993. Petitioner underwent aortic bypass surgery to both legs to the femoral arteries in 1994. Petitioner had seven hernia repairs in 2002 and throat surgery for cancer of the throat in 2004. He was also treated for prostate cancer in 2005. (PX 1, dep. exhibit 2) Petitioner also introduced the records of Carlinville Area Hospital which note Petitioner's COPD, atrial fibrillation with reduced ejection fraction, a sleep study, arthritis, vocal cord cancer, and prostate cancer. (PX 7, e.g. p. 23, 31-33, 49-52, 54-57, 78, 85-86)

According to Dr. Chopa's records Petitioner had an episode of bronchial asthma in January of 2006 but thereafter he denied any problems with shortness of breath until late December when Petitioner began treating for exacerbations of bronchial asthma. (PX 6) During this time Petitioner was also examined at Carlinville Cardiology Clinic. Petitioner reported shortness of breath but "only at higher levels of activity [and not] with day to day normal activities." (PX 7, p. 53) It was noted that Petitioner has COPD "from prior tobacco abuse, and tobacco abuse is probably the reason for the leukoplakia that he has." (PX 7, p. 53) Petitioner underwent heart-related testing and studies during 2006. (PX 7)

Petitioner underwent treatment for throat cancer in 2007. During this time he denied any shortness of breath except for visits in April and December and he was diagnosed with acute sinusitis and early bronchitis (April) and COPD and acute bronchitis (in December). In October of 2007 Petitioner was examined by Dr. Chopra. Petitioner denied any shortness of breath. (PX 6, 7)

At his attorney's request Petitioner was examined by Dr. Glennon Paul on January 22, 2008. According to his report, Petitioner was being seen for a "Black Lung evaluation." Dr. Paul concluded Petitioner had coal workers' pneumoconiosis, emphysema, pulmonary fibrosis, and "all other diagnosis as listed above." (PX 1, dep. ex. 2)

Petitioner's medical records from Dr. Chopra were admitted into evidence. Petitioner denied any problems with shortness of breath when examined on January 25, 2008 and March 25, 2008. (PX 6)

Dr. Paul's deposition was taken on December 1, 2008.Dr. Paul is the Senior Physician at the Springfield Central Illinois Allergy and Respiratory Clinic. He is the Medical Director of St. John's Respiratory Therapy Department. Dr. Paul teaches internal medicine and pulmonology at the SIU Medical School. Dr. Paul has authored a book on asthma. He has examined miners for state and federal claims testifying predominantly for coal companies. Dr. Paul interprets about 5000 chest x-rays and pulmonary function tests each year. (PX 1, p. 6-8.

Dr. Paul reported that Petitioner was short of breath walking 1-2 blocks or climbing 1-2 flights of stairs. He gets wheezing, coughing, and increasing shortness of breath with an upper respiratory tract infection. Petitioner's medications were Advair, Combivent, Nasacort, and nebulizers with DuoNeb. Dr. Paul noted

Petitioner's smoking, mining, and medical histories. On physical exam Dr. Paul noted 2 plus wheezes and rhonchi on expiration. He felt Petitioner's chest film showed multiple small nodules throughout both lung fields with minimal fibrosis. Pulmonary function studies demonstrated a mild to moderate obstructive airways disease with a decreased diffusion capacity compatible with emphysema and pulmonary fibrosis. There was also a restrictive defect compatible with pulmonary fibrosis. Dr. Paul felt Petitioner had CWP, emphysema, and pulmonary fibrosis. (PX 1, Depo Exh. 2, Paul report).

Dr. Paul stated that Petitioner could not have further coal dust exposure without endangering his health. Petitioner's pulmonary diseases make him more vulnerable to upper respiratory infections and make recovery from them more difficult. Dr. Paul stated that Petitioner was on a significant amount of pulmonary medication. (PX 1, p. 25-26). Dr. Paul provided that Petitioner's pulmonary fibrosis was from his CWP, and his measured impairment on testing was due to his CWP and emphysema. Petitioner's CWP would have been present when he left the mines. (p. 29-30). Dr. Paul stated that Petitioner's clinical, radiographic, and physiologic abnormalities were secondary to all of his diagnoses. Petitioner's pulmonary impairment limits him to sedentary work. (p. 31-32).

On cross-examination Dr. Paul agreed that Petitioner had significant medical problems unrelated to mining. He felt Petitioner was obese, but not morbidly obese. (PX 1, p. 33-34). He agreed that Petitioner's cigarette smoking was significant and that cigarette smoking was the number one cause of emphysema in the country. (PX 1, p. 36) Petitioner's shortness of breath on exertion would be exacerbated by his decreased ejection fraction. (p. 37). Dr. Paul stated Petitioner was 70-75 pounds overweight, but this would have no effect on his pulmonary function results. His obesity would affect his feelings of shortness of breath. (p. 39). Dr. Paul explained how Petitioner's emphysema and fibrosis cause a decreased diffusing capacity. (p. 40). Dr. Paul provided that a lung condition can place an extra burden on heart function and vice versa. Petitioner's pulmonary diagnoses would make recovery from an acute heart event more difficult. (p. 46). Dr. Paul is not a B-reader.

Petitioner underwent a chest x-ray on August 3, 2009 at the request of Dr. Chopra in conjunction with Petitioner's complaints of a fever and cough. The findings included increased opacities at the bilateral lung bases which could be due to infiltrate given Petitioner's clinical history. He also had evidence of cardiomegaly. (RX 3)

At Respondent's request Dr. Peter Tuteur examined Petitioner on May 12, 2010. Dr. Tuteur is a pulmonologist who is the Director of the Pulmonary Function Lab at Washington University and an assistant professor of medicine. Dr. Tuteur's deposition was taken on January 27, 2011 (RX 1). Dr. Tuteur testified that Petitioner has had pain and discomfort associated with his osteoarthritis throughout his life. He further testified that Petitioner told him his stair climbing was limited because of pain and weakness in his knees and hips. (RX 1, p. 7) In terms of weight-bearing ambulation, Petitioner's advanced osteoarthritis was disabling. Dr. Tuteur noted that when Petitioner was not weight-bearing and riding a bicycle Petitioner was able to put forth an effort which approached normal for his age. Petitioner complained of knee pain while cycling.

With regard to heart problems, Dr. Tuteur noted nonischemic cardiomyopathy (ie., inadequate function to sustain an appropriate cardiac output). (RX 1, p. 9) He noted Petitioner had atrial fibrillation due to a reduced ejection fraction which was controlled with medication. Petitioner's cardiac issues would affect his exercise tolerance. (p. 8-10). Dr. Tuteur stated Petitioner's weight put him in the obese category.

Petitioner's physical exam on May 12, 2010 was normal. Petitioner's pulmonary function testing did not show restriction, but mild obstruction that did not improve with bronchodilator administration. Exercise

testing was normal. (p. 11-13) Dr. Tuteur noted Petitioner was taking two inhalers and Duoneb to improve airflow obstruction. (p. 13-14) Dr. Tuteur testified that Petitioner did not have CWP "of sufficient severity and profusion to produce clinical symptoms, physical examination abnormalities, impairment of pulmonary function or radiographic changes." He felt Petitioner had chronic bronchitis caused by smoking. (p. 14-15)

On cross-examination, Dr. Tuteur agreed that the lower limit of normal for a diffusing capacity is 70% and that Petitioner's diffusing capacity was 64% and then 70%. CWP can cause a reduction in the diffusing capacity due to the obliteration of the capillary beds by fibrosis. (RX 1, p. 18-19) Dr. Tuteur further testified that CWP causes scarring and fibrosis and the affected tissue cannot perform the function of normal healthy lung tissue. (p. 26-27). His recommendation for those with CWP is to avoid any further mine dust exposure. CWP progresses after exposure cessation 50% of the time, but that tends to occur in the first year, or at least the second year after exposure ends. It is possible to have CWP despite normal pulmonary testing and normal physical exams. The most common complaint of CWP victims is breathlessness. (p. 28-30)

Dr. Tuteur also agreed that pulmonary function testing will tell the type of any abnormality, but not its etiology which can be multifactorial. Restrictive and obstructive defects can be multi-factorial in etiology. Each can be aggravated by something other than what caused it. (RX 1, p. 35, 37). Chronic lung disease can put an extra burden on the functioning of the heart. There is no test to determine the cause of chronic bronchitis and obstruction. (p. 24)

Respondent introduced the October 13, 2010 x-ray interpretations of B-reader/Radiologist Dr. Wiot. Dr. Wiot read the chest film of May 12, 2010 as quality 1 and negative for CWP. He saw nothing but a slightly enlarged heart and mild rotatory scoliosis of the spine. (RX 2)

Petitioner periodically treated with Dr. Chopra throughout 2010 through April of 2012. On occasion Petitioner complained of some shortness of breath and other symptoms which the doctor diagnosed as exacerbations of bronchitis and/or COPD. Petitioner also saw the doctor for various other medical problems and complaints. (RX 3) Petitioner underwent another chest x-ray in June of 2011 for his bronchitis. The impression was "interstitial change in the lung bases consistent with fibrosis, stable since August 5, 2009. No acute infiltrates. Cardiomegaly with no evidence of CHF." (RX 3) Petitioner underwent another chest x-ray in September of 2011 due to complaints of shortness of breath. The interstitial changes were described as "stable." No acute infiltrates were noted. (RX 3)

Dr. Chopra authored a note to Petitioner's attorney on March 22, 2012, in which he indicated Petitioner has emphysema and chronic obstructive pulmonary disease which could be aggravated by coal mine exposure. He further stated petitioner was totally disabled and unable to be employed in any meaningful employment. (PX 6)

Petitioner met with Delores Gonzalez, a vocational rehabilitation counselor, on July 9, 2012. (PX 3)

Petitioner also offered the testimony and opinions of Delores Gonzalez, a vocational rehabilitation counselor. Her deposition was taken on October 3, 2012. Ms. Gonzalez is an independent contractor who works for the Social Security Administration. She works as a mentor/clinical educator for SIU Carbondale's Master's degree level students, and teaches vocational rehabilitation to students at SUI Carbondale and Maryville

University. In the past she also has worked with the Missouri Department of Rehabilitation Employment Services. (PX 3, p. 4-7)

On July 9, 2012 Ms. Gonzalez met with Petitioner and conducted vocational testing and reviewed medical records. Dr. Gonzalez elicited an occupational and educational history and performed a transferability of skills analysis. (PX 3, p.7-9) Ms. Gonzalez acknowledged she was not retained to try and find Petitioner a job or engage in any job finding activities or training. It was her understanding that after Petitioner quit working as a coal miner in April of 2004 he retired and had not worked since or tried to work since then. Ms. Gonzalez reviewed the depositions of Drs. Paul and Tuteur as part of her work-up. (p. 7-11) Ms. Gonzalez described Petitioner's limitations regarding shortness of breath. She noted that walking or any mild increase in activity causes shortness of breath. With overexertion he has a hard time getting air and gasps for breath at times. (PX 3, Depo Exh. 2, p. 2, Gonzalez report) Ms. Gonzales concluded that Petitioner had no transferable job skills outside of the mining industry. She felt he had significantly impoverished word, reading and spelling academic skills. He could not succeed in a clerical position and would have to learn new job kills though hands on job performance with verbal instruction. (Id., p. 15) Ms. Gonzalez concluded that Petitioner had a residual functional capacity for work at the unskilled sedentary level and could not do manual labor on a full time basis. If Petitioner was limited to sedentary work, it could earn him an entry level wage of $8.50 to $10.00 an hour. However, prospective employers would be unlikely to hire Petitioner and would favor younger, more work-ready individuals with higher academic skills who would not need accommodation. (Id., p. 17)

Petitioner introduced the deposition of his treating physician Dr. Chopra, taken on November 27, 2012. Dr. Chopra has practiced family medicine in Carlinville for 32 years. During this time he has treated many coal miners for COPD, asthma, bronchitis sinusitis, coal workers' pneumoconiosis (CWP), and lung cancer. He is affiliated with Carlinville Area Hospital. A chart showed has treated Petitioner since 2005, but he has taken care of him much longer. He followed Petitioner on a regular basis because of the number of problems he has. (PX 2, p. 7-9).

Dr. Chopra stated pneumoconiosis, along with bronchitis, emphysema, and asthma can all result in obstructive lung problems. He felt that Petitioner's breathing problems are related to these conditions, and that there is no way to take them apart in terms of contribution. Dr. Chopra stated that Advair and Symbicort were prescribed to prevent pulmonary exacerbations and Combivent and antibiotics were given for acute exacerbations. Prednisone was given if Petitioner did not respond to regular treatment. Dr. Chopra stated that Petitioner has COPD and chronic bronchitis with acute exacerbations. Petitioner's COPD includes emphysema, obstructive lung disease, asthma and possibly pneumoconiosis. (PX 2, p. 10-12). Petitioner should not be exposed to coal or hazardous conditions. He found Petitioner to be totally disabled from gainful employment. (p. 15).

Dr. Chopra stated that Petitioner has significant heart problems and is under the care of a cardiologist for coronary artery disease. He has had femoral bypass surgery for circulation issues. Petitioner is seeing oncologist Dr. Gionnone for his recent lung cancer. (PX 2, p. 15-16). A report from 2006 from Dr. Zuck noted an ejection fraction of 35% which will cause shortness of breath. Petitioner weighed 247 pounds at five foot eight. He was overweight by about 71 pounds. This condition would also cause shortness of breath. (p. 22-23).

Petitioner's lung cancer recently was diagnosed. In the past he had prostate and laryngeal cancer. (PX 2, p. 17). Dr. Chopra's records indicated a CT guided lung biopsy was done on September 14, 2012. Petitioner's

lung cancer was secondary to his prostate cancer. (p. 19). Petitioner also has had arthritis in his back and knees going back several years. (p. 25-26).

Petitioner introduced B-reader/radiologist Dr. Smith's January 4, 2013 interpretation of Petitioner's August 9, 2007 x-ray and August 31, 2012 CT scan. Dr. Smith interpreted the chest film as showing CWP category 1/1 in all lung zones. Dr. Smith concluded that the CT scan demonstrated diffuse pulmonary interstitial fibrosis with small opacities in all lung zones bilaterally, and had findings typical of simple CWP. (PX 4)

Respondent also introduced B-reader/Radiologist Dr. Shipley's March 1, 2013 review of the 08-31-12 CT scan. Dr. Shipley noted the absence of any upper zone predominant small or large rounded opacities suggestive of coal workers' pneumoconiosis. Dr. Shipley's formal impression was no CT findings consistent with coal workers' pneumoconiosis, moderately extensive basilar predominant fibrotic interstitial lung disease three lower lobe pulmonary nodules suspicious for malignancy, metastatic disease from an extra-thoracic primary or multifocal lung cancer. (RX 4)

The Arbitrator concludes:

Based upon the medical records and testimony, Petitioner does have an obstructive airways problem. Dr. Paul diagnosed emphysema and Dr. Tuteur diagnosed chronic bronchitis, both of which fall under the COPD umbrella. While the statute of limitations for coal workers' pneumoconiosis is five years, there is no variation of the general three year statute of limitations for occupational diseases for COPD. Further, the Arbitrator notes that Dr. Tuteur both wrote in his report and testified that Petitioner's chronic bronchitis is related to his cigarette smoking. Both Dr. Tuteur and Dr. Paul noted that Petitioner had a significant cigarette smoking history. Dr. Paul, Dr. Tuteur and Dr. Chopra all agreed that cigarette smoking was the number one cause of these obstructive diseases. Further, the Arbitrator notes that Dr. Zuck, Petitioner's cardiologist, indicated in a report to Dr. Chopra that Petitioner's COPD was from prior tobacco abuse. There is nothing in the records from the cardiologists to reflect a diagnosis of an occupational lung disease, or coal workers' pneumoconiosis. Although Dr. Chopra discussed coal workers' pneumoconiosis, there is no indication in his testimony or his records that he ever actually diagnosed Petitioner with the disease or how he arrived at such a diagnosis for Petitioner. Dr. Tuteur indicated that there was no evidence in his evaluation to support a diagnosis of coal workers' pneumoconiosis. The Arbitrator notes that his evaluation of Petitioner was somewhat more thorough than that performed by Dr. Paul. The Arbitrator also notes Petitioner's obesity, osteoarthritis, heart problems and cancer. The Arbitrator adopts the well qualified opinions and reports of Dr. Tuteur, Dr. Wiot, and Dr. Shipley in support of her decision.

Based upon the evidence presented, the Arbitrator concludes that Petitioner has failed to prove by a preponderance of the evidence that he developed an occupational lung disease as a result of any exposures in the course of his employment with the Respondent. Petitioner's claim for compensation is denied. No benefits are awarded.

All other issues are moot.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carol A. Parks,

Petitioner,

14IWCC0085

vs.

NO: 12 WC 10120

SimontonWindows,

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 accidident, causal connection, temporary total disability, medical expenses, permanent disability and evidentiary issues, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 7, 2013 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.

14IWCC0085

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $26,500.00. 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: FEB 03 2014

Daniel R. Donohoo

David L. Gore

Mario Basurto

DRD:bjg
0-1/23/2014
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0085

PARKS, CAROL A
Employee/Petitioner

Case# **12WC010120**

SIMONTON WINDOWS
Employer/Respondent

On 6/7/2013, 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 0.08% 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:

0157 ASHER & SMITH
CRAIG SMITH
1119 N MAIN ST PO BOX 340
PARIS, IL 61944

0143 CRAIG & CRAIG
GREGORY C RAY
PO BOX 689
MATTOON, IL 61938

14IWCC0085

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CAROL A. PARKS
Employee/Petitioner

v.

SIMONTON WINDOWS
Employer/Respondent

Case # **12** WC **10120**

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 **Brandon J. Zanotti**, Arbitrator of the Commission, in the city of **Urbana**, on **April 18, 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: Should Petitioner's *Petrillo* objection be sustained or overruled?

FINDINGS

On **October 13, 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 **$25,414.48**; the average weekly wage was **$488.74**.

On the date of accident, Petitioner was **43** 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 (see below).

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$8,919.66** for other benefits, for a total credit of **$8,919.66**.

Respondent is entitled to a credit for medical bills paid by its group carrier under Section 8(j) of the Act, and shall hold Petitioner harmless from all claims which may be made against her by virtue of the payments.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $325.83/week for 40 6/7 weeks, commencing December 30, 2011 through October 10, 2012, as provided in Section 8(b) of the Act. Respondent shall receive credit for $8,919.66 in non-occupational indemnity disability benefits paid.

Respondent shall pay Petitioner permanent partial disability benefits of $293.24/week for 75 weeks, because the injuries sustained caused the 15% loss of use to the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical services set forth in Petitioner's Exhibits 6 through 9, as provided in Section 8(a) of the Act, and subject to the medical fee schedule, Section 8.2 of the Act. Respondent is entitled to a credit for medical bills paid by its group carrier under Section 8(j) of the Act.

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

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

Signature of Arbitrator

06/03/2013
Date

ICArbDec p. 2

JUN - 7 2013

STATE OF ILLINOIS)
) SS
COUNTY OF CHAMPAIGN)

14IWCC0085

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CAROL A. PARKS
Employee/Petitioner

v. Case # 12 WC 10120

SIMONTON WINDOWS
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Carol Parks, testified that she has been an employee of Respondent, Simonton Windows, since 2004. On October 13, 2011, she was working on the patio door line, building doors. On that day, she was on the Rotox corner cleaner, trying to keep up with the welder. She was putting frames into the Rotox, which required her to pull the frames out and twist and turn. The frames were approximately eight feet by six feet in height and width. As she was putting frames into the Rotox machine and pulling them out, she testified that the frame got caught on a table which was uneven. As she pulled on the frame, she testified that she heard a "pop" in her left shoulder. At that time, she noticed that her shoulder stung, and as the day went on she told the Group Leader/Backup Supervisor, Eric Vice, about her injury. She testified that the next morning she had a headache, her neck was stiff, her neck hurt, her shoulder hurt from her shoulder to her fingertips, and there were sharp, stabbing pains.

Upon returning to work the next day, October 14, 2011, Petitioner prepared an Incident Report with her supervisor. (See Petitioner's Exhibit (PX) 12). On October 14, 2011, she also saw the plant nurse, Tod Brewer, who noted in his records that Petitioner "was trying to keep up c the welder, doing rotox corner cleaner job. Sts frames were getting caught on tables due to different ht. Sts was moving frames that are est to be 4 to 5 pounds, but awkward in size. Thought was simple strain while @ work p work ↑ pain." Nurse Brewer noted the chief complaint was left chest wall and shoulder strain and further noted increased pain with range of motion to left upper extremity. (PX 12).

Petitioner continued to work with instructions from Mr. Brewer that she self-monitor her activities at work to reduce the risk of injury irritation. (PX 12). Mr. Brewer had Petitioner sign an Authorization for Medical Records and Communication Release for the medical treatment he provided to Petitioner. (RX 2). He noted that Petitioner was complaining of increased pain, with range of motion to the left upper extremity, and noted that he would re-check Petitioner on October 17, 2011. On October 17, 2011, Mr. Brewer noted that he was setting up an appointment with Dr. Jeffrey Brower, Respondent's company doctor, on October 18, 2011. (PX 12).

On October 18, 2011, Petitioner saw Dr. Brower, who urged her to see her physician. Dr. Brower placed Petitioner on restrictions consisting of: (1) no pushing, pulling 20 pounds; (2) no lifting over 10 pounds; and (3) no overhead activity. (PX 12).

Petitioner saw her family physician, Dr. Reid Sutton, on October 19, 2011. Dr. Sutton recommended a MRI of her left shoulder and left anterior chest, indicating that a muscle tear was a possibility. (PX 1).

The MRI was performed on October 20, 2011, and the radiologist's impression was as follows: "The palpable mass appears to be a large lipoma. There appears to be shoulder peritendinitis or intrasubstance rotator cuff tear as described." (PX 2). Dr. Sutton referred Petitioner to Dr. Gary Ulrich, an orthopedic surgeon at UAP Clinic in Terre Haute, Indiana. (PX 3).

On November 17, 2011, Petitioner was seen by Billie Bonebrake, NP. Ms. Bonebrake noted that Petitioner "is being seen and evaluated for her left shoulder pain....after she was finishing a frame after the clean...she felt like somebody had punched her in the shoulder. She has not had any pain or problems with her shoulder into [*sic*] this time. Since his [*sic*] injury he [sic] she's had quite a bit of pain and difficulty with range of motion." The nurse also noted that Petitioner had a lipoma that was present on the front part of her chest on the side of her shoulder. She stated that Petitioner had this for about 10 years. It was reported that since the accident, the lipoma got larger. On physical examination, it was noted that abduction was more difficult to about 90 degrees, and Petitioner had 3/5 rotator cuff strength. Hawkins testing was positive, and positive impingement was noted. It was Nurse Bonebrake's impression that Petitioner had left shoulder pain, left shoulder impingement, and left anterior chest lipoma. On that date, Petitioner was given work restrictions and a follow-up appointment with Dr. Ulrich on November 22, 2011. (PX 3).

Petitioner saw Dr. Ulrich on November 22, 2011, and he noted that she was there for her left shoulder. He further stated that she had two issues. His physical exam on that date revealed signs of impingement syndrome in grading of three over five strength; also, she had subacromial crepitus, no instabilities, and anterior chest lipoma. (PX 3; PX 13, p. 8). His impression was impingement syndrome of Petitioner's left shoulder, and lipoma chest wall. (PX 13, p. 8). It was the doctor's recommendation that the lipoma removal by general surgery service and arthroscopic subacromial decompression be performed at one time. He then set up an appointment for Petitioner to see Dr. Tisinai, a general surgeon, to initiate surgical coordination procedures. (PX 3; PX 13, p. 9).

On December 13, 2011, Petitioner was seen by Dr. Karen Tisinai, who noted that Petitioner had a lipoma, left chest, times one to two years, a torn rotator cuff left shoulder since October 2011, and that the shoulder was "work comp." Dr. Tisinai further noted in her reports that Petitioner was scheduled to have a left rotator cuff repair with Dr. Ulrich, and that he has asked that Dr. Tisinai see Petitioner for excision of the mass under the same anesthesia. (PX 3).

On December 30, 2011, Petitioner underwent two surgeries, which consisted of arthroscopic acromioplasty, arthroscopic distal clavicle excision, and excision of submuscular lipoma from the upper left chest wall. Dr. Ulrich's pre-operative and post-operative diagnosis was chronic impingement of the left shoulder, and Dr. Tisinai's pre-operative and post-operative diagnosis was submuscular lipoma. (PX 4). Following surgery, Petitioner saw Dr. Tisinai on January 10, 2012. Dr. Tisinai noted that Petitioner

was feeling well with no complaints. Her surgical site was clean, dry, and intact, with no signs of redness, swelling, drainage, or infection. Dr. Tisinai's impression of Petitioner on this date was noted as "healed and released," and the doctor told Petitioner to return or call the office as needed. (PX 16). Petitioner testified that she did not return to Dr. Tisinai for any further treatment following her post-operative visit on January 10, 2012.

Following surgery, Dr. Ulrich referred Petitioner to Paris Community Hospital Physical Therapy Department for range of motion and strengthening therapy. Petitioner continued physical therapy from January 4, 2012 until March 22, 2012. (PX 5).

Petitioner followed-up with Dr. Ulrich's office on January 12, 2012. It was noted at that appointment that Petitioner was still in pain, her sutures were removed, and she was going to be weaned out of sling that week, with follow-up in four weeks. Petitioner then followed up with Dr. Ulrich on February 2, 2012. His notes indicated under "Vital Signs" that Petitioner was still in pain, and she was improving her motion. Dr. Ulrich recommended that Petitioner continue physical therapy strengthening and continued to restrict her from work. Petitioner was next evaluated by Dr. Ulrich on March 1, 2012. It was noted that she was still having pain and some spasms in her left shoulder. The doctor's exam revealed that Petitioner had para trapezial spasm. His recommendations were for functional rehabilitation, usage of a TENS unit, and for her to remain off work and re-check in a month. (PX 3).

Petitioner was next seen by Dr. Ulrich on March 29, 2012. He noted that she had full range of motion, mild impingement, and no weakness, and released Petitioner to return to work on April 2, 2012. (PX 3).

Petitioner stated that upon delivering Dr. Ulrich's work restriction to Respondent, she was told by Kim Ashby, HR Director, and Tod Brewer, the plant nurse, that it was too early for her to return after her surgery, and that she would need to see Respondent's company doctor, Dr. Brower. Petitioner testified that it was also Dr. Brower's opinion that she should not return to work, and he noted in his office records that he thought that she should continue her home exercises, and he would recommend that she remain off work until she was more comfortable. (PX 12). Dr. Brower told Petitioner that her shoulder surgery would take anywhere from six months to one year for her to recover, and he filled out long-term disability papers, and continued to restrict Petitioner's work. Petitioner next saw Dr. Brower on May 1, 2012, where he recommended that she continue her home exercises; he thought that she was making slow progress. He further noted that he had filled out disability papers for her that would be in effect for the following three months. (PX 12).

Petitioner was next seen on August 7, 2012, this time by Dr. Brower's nurse practitioner, Tonya Heim. Nurse Heim noted in her records that Petitioner would remain on temporary disability at that time, and that she would discuss with Dr. Brower and see if he would like to have her return again in two weeks. (PX 12).

On August 21, 2012, Dr. Brower saw Petitioner for a "fit for duty" evaluation. At that time, he encouraged Petitioner to continue her home exercises to maintain her motion and strength, and reported that he would keep her off work for another six weeks and see her back at that time. (PX 12).

Petitioner followed-up with Dr. Brower on October 2, 2012. His note states that she was there for "fit for duty" follow-up evaluation. He recommended a functional capacity evaluation (FCE) prior to her

returning to work. (PX 12). On October 10, 2012, a FCE was performed. The FCE was set up by Dr. Brower, and the diagnosis on the FCE was S/P left subacromial decompression, with a date of injury listed as October 2011. The FCE summary states: "The worker, Carol Parks, was referred to this facility per Dr. Jeffrey Brower, with the diagnosis of S/P left subacromial decompression to undergo an FCE on this date. The worker was employed as a patio door laborer for Simonton Window. . ." (PX 15). The therapist's opinion was that Petitioner could function on a full-time basis as follows:

- Lifting/Carrying – 37# floor to waist, 40# 12" to waist, 30# waist to shoulder, 25# shoulder to overhead occasionally
- Pushing/Pulling – Pushing 73.4# of force and pulling 81.6# of force occasionally
- Sitting/Standing/Walking – Unrestricted
- Climbing – Unrestricted
- Reaching/Gripping/Fine Motor – Reaching forward constantly, overhead frequently; Gripping and fine motor is unrestricted
- Lower Level Positions/Movements – Unrestricted.

(PX 15).

Petitioner testified that she did not return to work in October 2012 due to undergoing a medical procedure which is not related to the injury at issue. She returned to work on January 14, 2013, with restrictions as noted on the Simonton Return to Work Form. (PX 14).

Petitioner testified that she currently continues to notice pain in her shoulder. She testified that she does not work on patio doors anymore, but has been transferred to a different line because the doors are too bulky on the patio door line. She is currently working with restrictions of no lifting, pushing, and pulling more than 35 pounds. Petitioner also testified that she continues to use the TENS unit which was provided to her following her left shoulder surgery. Petitioner also currently takes over-the-counter medications and Vicodin for the pain.

Dr. Ulrich testified that when he examined Petitioner on November 22, 2011, his exam revealed signs of impingement syndrome and a grading of 3/5 strength. The doctor also reported that she also had subacromial crepitance; no instabilities; and anterior chest lipoma. His diagnosis was impingement syndrome of the left shoulder, lipoma chest wall. (PX 13, p. 8). Dr. Ulrich opined that Petitioner's work injury of October 13, 2011 could have caused the impingement syndrome. (PX 13, pp. 8-9). Dr. Ulrich further opined that Petitioner's work injury was a causative factor in his recommendation for her to have surgery. (PX 13, p. 9).

Prior to surgery, x-rays were performed, where a change was noted about the acromion process, which was most likely causing some spurring. (PX 13, p. 18). During his surgery, Dr. Ulrich found Petitioner had Type 3 acromium, which he reduced to Type 1 acromium. (PX 13, p. 18). Dr. Ulrich further opined that the spurring he noted in surgery could have been exacerbated by Petitioner's work. (PX 13, pp. 18-19). During his surgery, Dr. Ulrich also removed eight millimeters of the distal clavicle, which he felt was part of the impingement syndrome process. (PX 13, p. 19). He further opined that Petitioner's pain complaints could have been caused by her Type 3 acromium. (PX 13, p. 20). Dr. Ulrich stated that Petitioner's history of fibromyalgia was not a factor in Petitioner's case. (PX 13, p. 22). Dr. Ulrich further opined that Petitioner's lipoma and the pain in her shoulder joint were two separate entities,

and he did not think that Petitioner could have confused the symptoms because he diagnosed them and treated them as two separate entities. (PX 13, p. 26).

Petitioner offered into evidence a series of medical bills she claims she incurred as a result of the alleged work injury. (See PX 6-9). The parties stipulated on the record that should Petitioner prevail on the present claim, that Respondent should be given applicable credit pursuant to Section 8(j) of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq.* (hereafter the "Act"), and further that Respondent would in that case hold Petitioner harmless from any claims for payment made on those bills. The parties also stipulated that should Petitioner prevail, Respondent would reimburse her for all related out-of-pocket medical expenses incurred as a result of the claim at bar.

CONCLUSIONS OF LAW

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

Based upon the evidence presented at trial, the Arbitrator concludes that Petitioner established that she sustained an injury that arose out of and in the course of her employment by Respondent. Petitioner testified that while working on the Rotox frame cleaner, she was trying to keep up with the welder, and was pushing and pulling large awkward frames out of the corner cleaner when the frames would get caught on the tables, which were uneven. While attempting to lift the frame out of the corner cleaner, she noticed pain in her left shoulder and upper chest muscle. Both Petitioner's Incident Report and the Supervisor's Investigation Report indicate that Petitioner was moving/lifting frames to the corner cleaner when the large frames got caught between the tables due to tables being uneven. Petitioner told her supervisor, Eric Vice, that she had hurt her shoulder on the day of the accident. On the following day, October 14, 2011, both Petitioner and her Supervisor prepared an Incident Report and a Supervisor's Investigative Report. (See PX 12).

Petitioner was then seen by the plant nurse, Tod Brewer, on October 14, 2011, were he noted that her chief complaint was left chest wall and shoulder strain, with site of pain being upper left chest wall, neck, and left shoulder.

There is no evidence that Petitioner had any prior problems with her left shoulder. Medical records show that she received treatment for pain to her left shoulder and chest wall from the plant nurse and her family physician, Dr. Sutton, following her accident.

Dr. Sutton recommended a MRI, which was performed on October 20, 2011. The MRI revealed a palpable mass which appeared to be a large lipoma and left shoulder peritendinitis or intrasubstance rotator cuff tear. (PX 2). Following the MRI results, Dr. Sutton referred Petitioner to Dr. Ulrich, an orthopedic surgeon. Petitioner's examinations on November 17 and November 22, 2011, noted that she had pain in her left shoulder to her neck, and that her pain increased with range of motion to the left upper extremity, that reaching behind the back increased the pain, that a sharp pain occurred with lifting the left shoulder, that abduction was difficult, a 3/5 rotator cuff strength, positive Hawkins testing, positive impingement, and positive subacromial crepitance. (PX 3 and 13). Following Petitioner's appointment with Dr. Ulrich on November 22, 2011, he recommended that she undergo surgery to her left shoulder, and while under general anesthesia have her lipoma removed by general surgery. (PX 3, 13, and 16).

The Arbitrator finds that Petitioner was a credible witness. Her testimony was corroborated by the medical records in evidence. She openly testified in a forthcoming manner, including during her cross-examination testimony. She appeared to be endeavoring to tell the full truth during her entire testimony.

The Arbitrator finds that the above evidence shows that Petitioner sustained an accidental injury to her left shoulder while working for Respondent on October 13, 2011.

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

On the issue of causation, there are two conflicting medical opinions. Respondent's company doctor, Dr. Brower, believes that Petitioner did not sustain a left shoulder strain, nor did she sustain any discrete injury to her left shoulder on October 13, 2011. Petitioner's treating physician, Dr. Ulrich, testified that there was a relationship between his diagnosis of impingement syndrome and her work injury. Furthermore, he opined that her work injury was a causative factor for the surgery he performed on December 30, 2011, consisting of arthroscopic acromioplasty and arthroscopic distal clavicle excision. The Arbitrator believes that the factual chain of events and the surgical findings support Petitioner's claim of causality.

Dr. Brower testified that he is board-certified in family medicine, and is not board-certified in occupational medicine. He has a contract with Respondent, wherein he travels to the plant to provide medical services to employees for non-occupational and occupational conditions. He felt that he had a physician/patient relationship with Petitioner. He did not recall whether he had reviewed the Incident Report prepared by Petitioner; he was not provided with, nor did he review any of the UAP Clinic/Dr. Ulrich records, and if he did, he could not remember reviewing them. Dr. Brower also testified that he is not holding himself out to be an orthopedic surgical expert. Dr. Brower opined that in October and November of 2011, he could not find any clinical findings to support that Petitioner had ongoing shoulder symptoms. (RX 1). However, during the same period of time, Dr. Ulrich noted that Petitioner had pain in her left shoulder to neck, abduction difficulty to 90 degrees, 3/5 rotator cuff strength, positive Hawkins, positive impingement, and positive subacromial crepitance. (See PX 3 and 13). Dr. Brower could not explain why Dr. Ulrich's office found positive Hawkins in two exams on November 17, 2011 and November 22, 2011, when he could not find the same positive seven days later when he saw Petitioner. (RX 1).

Dr. Brower, board-certified in family medicine, has admitted that he is not an orthopedic expert. Dr. Ulrich is a board-certified orthopedic surgeon and is a member of the American Academy of Orthopaedic Surgeons, American Osteopathic Academy of Orthopaedics, Past President of Sports Medicine Section – American Osteopathic Academy of Orthopaedics, and current President of American Osteopathic Association. (PX 13 – CV). Therefore, while Dr. Brower is qualified to address medical issues and opinions, the Arbitrator believes that Dr. Ulrich is better qualified to give a medical opinion concerning orthopedic care and treatment of Petitioner.

In order to sustain her burden of proof, Petitioner must show that her accident was the cause of her resulting injury. Having found that the accident did occur, the Arbitrator believes Petitioner has sustained 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?

The care and treatment Petitioner received from Dr. Ulrich represents reasonable and necessary treatment for her work injury of October 13, 2011. Respondent shall pay reasonable and necessary medical expenses of $34,741.85, as provided in Sections 8(a) and 8.2 of the Act, as reflected in Petitioner's Exhibits 6, 7, 8, and 9. Respondent is entitled to credit for any amounts paid on the awarded bills, either directly or through a group policy that falls within the purview of Section 8(j) of the Act. To the extent that Section 8(j) credit exists, Respondent shall keep Petitioner safe and harmless from any or all claims or liabilities that may be made against her by reason of having received such payments pursuant to Section 8(j) of the Act.

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

Petitioner's testimony and the medical records of Dr. Ulrich and Dr. Brower indicate that Petitioner was temporary and totally disabled from December 30, 2011 through October 10, 2012, representing 40 6/7 weeks. Petitioner is entitled to receive 40 6/7 weeks of temporary total disability (TTD) payments. Respondent is entitled to a credit of $8,919.66 by reason of non-occupational indemnity disability benefits which were paid to Petitioner. (See Arbitrator's Exhibit 1).

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

On the issue of nature and extent of the injury, the Arbitrator must refer to Section 8.1b of the Act. The parties stipulated that neither side would submit AMA Impairment Reports pursuant to Sections 8.1b(a) and (b)(i) of the Act. This factor is hereby waived.

Concerning Section 8.1b(b)(ii) of the Act, Petitioner has testified that she no longer works on the patio door line due to her restrictions. She returned to work for Respondent on January 24, 2013, under the following restrictions:

- Lifting/Carrying – 37# floor to waist, 40# 12" to waist, 30# waist to shoulder, 25# shoulder to overhead occasionally
- Pushing/Pulling – Pushing 73.4# of force and pulling 81.6# of force occasionally
- Sitting/Standing/Walking – Unrestricted
- Climbing – Unrestricted
- Reaching/Gripping/Fine Motor – Reaching forward constantly, overhead frequently; Gripping and fine motor is unrestricted
- Lower Level Positions/Movements – Unrestricted. (See FCE, PX 15).

Taking into account Petitioner's work restrictions in the context of her occupation, the Arbitrator gives ample weight to this factor.

With regard to Section 8.1b(b)(iii) of the Act, Petitioner was 43 years old at the time of her injury. (See Arbitrator's Exhibit 1). The Arbitrator considers Petitioner to be a somewhat younger individual and concludes that Petitioner's permanent partial disability (PPD) will be moderately greater than that of an older individual because Petitioner will have to live with the consequences of the injury for a longer period of time. The Arbitrator places some weight on this factor.

The Arbitrator next turns to Section 8.1b(b)(iv) of the Act. While permanent restrictions were established by the FCE and Respondent's company doctor, Dr. Brower, there was no evidence submitted to show any impairment in Petitioner's future wage earning capabilities. Accordingly, no weight is given in regard to this factor.

With regard to Section 8.1b(b)(v) of the Act, Petitioner's accident caused a strain/sprain of her left shoulder, resulting in impingement. She underwent arthroscopic surgery as a result of this condition, including an acromioplasty and a distal clavicle excision. She credibly testified that she continues to have pain in her left shoulder, decreased range of motion, loss of strength, and continues to use a TENS unit and take pain medication. Great weight is given to this factor.

Based on the factors set forth in the Act, the Arbitrator finds that Petitioner has sustained a 15% loss of use to the person as a whole pursuant to Section 8(d)2 of the Act, and is awarded permanent partial disability benefits accordingly.

Issue (O): Should Petitioner's *Petrillo* objection be sustained or overruled?

Petitioner objected to Dr. Brower's testimony concerning the care and treatment of Petitioner based upon *Petrillo v. Syntex Laboratories, Inc.*, 148 Ill. App. 3d 581, 499 N.E.2d 952 (1st Dist. 1986). The record indicates that Dr. Brower provides medical services to Respondent and also medical services/treatment to its employees, such as Petitioner. Tod Brewer, Respondent's company nurse, stated that he had Petitioner sign a medical authorization form covering his treatment. The record does not indicate whether said Authorization for Medical Records and Communication Release was also signed with the purpose of covering Dr. Brower's treatment. (See RX 2).

Respondent's counsel wrote a detailed letter asking Dr. Brower to comment on medical treatment provided, causal connection, accident, and permanency. (RX 1, Dep. Exh. 2). Dr. Brower stated that Petitioner was not aware that he was giving an opinion on whether she had a work injury or not, and did not get her permission or waiver for him to give his testimony. (RX 1, p. 56).

While the record before the Arbitrator does not show whether Dr. Brower advised Petitioner that the Authorization for Medical Records and Communication Release she signed on October 14, 2011 would also cover his medical care and treatment of her, the Release could be interpreted as covering his medical treatment of Petitioner. (See RX 2). Therefore, the Arbitrator overrules the *Petrillo* objection, and allows Dr. Brower's testimony.

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

Royce McCain,

Petitioner,

14IWCC0086

vs.

NO: 10 WC 45985

Kellermeyer Buidling Services, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, prospective medical care and vocational rehabilitation, 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 24, 2013 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.

14IWCC0086

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 $4,500.00. 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: FEB 0 3 2014

DRD:bjg
0-1/23/2014
68

Daniel R. Donohoo

David L. Gore

Mario Basurto

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

14IWCC0086

McCAIN, ROYCE
Employee/Petitioner

Case# **10WC045985**

KELLERMEYER BUILDING SERVICES INC
Employer/Respondent

On 5/24/2013, 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 0.08% 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:

BROWN & BROWN
RICHARD E SALMI
5440 N ILLINOIS ST SUITE 101
FAIRVIEW HTS, IL 62208

0238 LAW OFFICES OF WOLF & WOLFE
PATRICK R GRADY
25 E WASHINGTON SUITE 700
CHICAGO, IL 60602

14IWCC0086

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)

Royce McCain
Employee/Petitioner

v.

Kellermeyer Building Services. Inc.
Employer/Respondent

Case # 10 WC 45985

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on April 24, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, October 29, 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 $5,634.01; the average weekly wage was $331.41.

On the date of accident, Petitioner was 36 years of age, single with 3 dependent child(ren).

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

Respondent shall be given a credit of $12,689.42 for TTD, $0.00 for TPD, $0.00 for maintenance, and $1,325.76 for other benefits, for a total credit of $14,015.18.

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

ORDER

Respondent shall pay for reasonable and necessary medical services as identified in Petitioner's Exhibit 15 for medical services provided on or before December 5, 2011, but not thereafter, 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 for 57 5/7 weeks at the rate of $319.00 per week commencing October 29, 2010, through December 7, 2011, as provided in Section 8(b) of the Act. As stated in the Conclusions of Law attached hereto, Petitioner failed to prove he is entitled to any additional temporary total disability benefits or maintenance benefits.

As stated in the Conclusions of Law attached hereto, Petitioner failed to prove he is entitled to prospective medical treatment 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.

William R. Gallagher, Arbitrator
ICArbDec19(b)

May 17, 2013
Date

MAY 24 2013

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on October 29, 2010. According to the Application, Petitioner slipped on soap on a floor and sustained injuries to the low back and body as a whole. This case was tried as a 19(b) proceeding and Petitioner sought an order for payment of medical bills, temporary total disability/maintenance benefits, vocational services and prospective medical treatment. Respondent disputed liability on the basis of causal relationship. There is also a dispute regarding the computation of the average weekly wage.

Petitioner was employed by Respondent as a head custodian and, on October 29, 2010, he was cleaning the men's restroom at Kohl's department store in Fairview Heights, Illinois, when he slipped on some liquid soap on the floor which caused him to fall. When Petitioner fell, he struck his head on a sink and landed on his right side. One of Kohl's employees assisted Petitioner to the employee's break room and Petitioner contacted Respondent by telephone and was directed to go to Concentra.

Petitioner testified that he customarily worked 38 1/2 hours per week for Respondent. At trial, a wage statement was tendered into evidence by Respondent for Petitioner's earnings from June 27, 2010, through October 23, 2010, a period of 17 weeks. The number of hours worked by Petitioner per week varied from a low of 23.75 hours for the week of August 29 through September 4, 2010, to a high of 42.75 hours for the week of August 22 through August 28, 2010. Petitioner's total gross pay for this period of time was $5,634.01. At trial, Petitioner did not testify about whether he missed time or days from work, only worked partial weeks, etc.

The primary disabling injury claimed by Petitioner as a result of the accident of October 29, 2010, was to his low back. Petitioner previously sustained a work-related low back injury while working for a different employer which ultimately required three surgical procedures to the low back. The medical records regarding these prior surgeries were received into evidence at trial. Dr. David Raskas performed the three prior surgical procedures on Petitioner, the first of which took place on December 3, 2007. On that date, Dr. Raskas performed a microdiscectomy and laminotomy at L5–S1 on the left side. On March 18, 2008, Dr. Raskas performed the second surgery on Petitioner consisting of a complete discectomy and fusion with metal hardware at L5–S1. On September 3, 2008, Dr. Raskas performed the third surgical procedure on Petitioner, consisting of a revision laminectomy and microdissection at L5–S1. Petitioner remained under Dr. Raskas' care following the surgeries and, at one point, Dr. Raskas did suggest that Petitioner have a dorsal column stimulator surgically implanted; however, Petitioner declined to have that surgical procedure performed.

When Dr. Raskas saw Petitioner on March 25, 2009, he opined that Petitioner had permanent restrictions of no lifting, pushing, pulling over 20 pounds or repetitive bending, turning or twisting at the waist. He further noted that Petitioner needed to change positions of sitting or walking every 15 minutes and that Petitioner could work four hours a day, five days a week. At trial, Petitioner testified that it was his understanding that the work restrictions imposed by Dr. Raskas were only in reference to the work he did for the prior employer. Petitioner settled that prior workers' compensation case as a pro se for approximately $107,000.00.

Petitioner returned to work in February, 2010, and was hired to work as a custodian by Eurice Cleaning Services, and he worked in that capacity at a Kohl's department store. Petitioner's job duties included buffing, vacuuming and mopping floors, cleaning windows and dressing rooms, sweeping the parking lot, collecting/disposing of trash, etc. Respondent subsequently took over the contract providing custodial services at Kohl's and Petitioner was hired by Respondent as the head custodian. Petitioner's job duties were similar to what they had been previously, but he testified that he also used a floor scrubber and was required to stock the supply room and bathrooms. Petitioner testified that the heaviest work he had to perform was when he had to lift the scrubber which weighed about 30 pounds, to access the floor area behind the toilets. Petitioner stated that he was able to perform all of the aforementioned job duties.

When Petitioner went to Concentra following the accident of October 29, 2010, he was seen by Dr. Gary Gray. When seen by Dr. Gray, Petitioner described his low back pain as being 8.5/10. On examination, Dr. Gray noted inconsistencies in Petitioner's responses when he performed the straight leg raising test between the supine and sitting positions. Dr. Gray opined that Petitioner had sustained some contusions and a muscular strain of the right lower extremity and released him to return to work. Several hours later, Petitioner contacted Dr. Gray by telephone and stated that he could not return to work and wanted to go to the ER. Petitioner went to the ER of Memorial Hospital on November 1, 2010, was x-rayed, diagnosed with a lumbosacral strain and discharged.

On November 4, 2010, Petitioner sought treatment from Dr. Miguel Granger, complaining primarily of low back pain. The range of motion of the back was limited so Dr. Granger authorized the Petitioner to be off work and referred him to Dr. Daniel Schwarze, an orthopedic surgeon.

Petitioner was seen by Dr. Schwarze on December 16, 2010, and he diagnosed Petitioner with right sciatica and a lumbosacral strain and prescribed physical therapy. Dr. Schwarze saw Petitioner again on January 13, 2011, and noted that straight leg raising was positive on the right; however, muscle strength testing and light touch sensation were both inconsistent. At that time, Petitioner requested to be reevaluated by his former spine surgeon Dr. Raskas. On January 31, 2011, Petitioner was seen by Dr. Granger who referred him to Dr. David Kennedy, a neurosurgeon.

At the direction of the Respondent, Petitioner was examined by Dr. James Doll, a physiatrist, on January 10, 2011. At that time, Petitioner complained of low back pain as being 7–8.5/10 and initially denied any prior low back problems but subsequently admitted having an L5–S1 spine fusion in 2007. Dr. Doll examined Petitioner and reviewed various medical records provided to him by the Respondent. Dr. Doll noted that Petitioner complained of low back pain with radiation down the right leg with diffuse numbness throughout the right leg without any particular pattern. Dr. Doll's findings on clinical examination were benign and the results of the diagnostic procedures he reviewed did not reveal any objective abnormalities associated with the injury of October 29, 2010. Dr. Doll recommended a period of physical therapy and stated that some work restrictions were appropriate during the time he was being so treated. Dr. Doll did not believe that any surgical intervention or injections were indicated.

On February 24, 2011, Petitioner was seen by Dr. David Kennedy. On examination, straight leg raising was equivocally positive on the right side and Dr. Kennedy diagnosed Petitioner with a lumbar strain with right sided sciatic features. He authorized Petitioner to remain off work and recommended a lumbar myelogram with a follow-up CT scan. On June 9, 2011, Petitioner had both of these diagnostic procedures performed on him. The lumbar myelogram revealed that the right L5 nerve root sheath was noted to fill to a lesser degree than the left L5 nerve root sheath. Dr. William Baber, the radiologist who performed the myelogram, noted that the asymmetric filling might be due to previous surgery but that impingement related to L4–L5 disc pathology could not be ruled out. Dr. Kennedy performed a selective nerve root block at L5–S1 on the right side on September 30, 2011. He subsequently referred Petitioner to Dr. Barry Feinberg, who performed epidural injections to Petitioner on both October 26 and November 17, 2011. Petitioner testified that he only experienced some temporary relief following these injections.

Dr. Kennedy saw Petitioner again on December 13, 2011, and noted that Petitioner had undergone the injections but experienced no lasting relief of pain. He opined that he did not feel that anything further could be done. He described Petitioner's range of motion of the back as being "fairly good" but that Petitioner felt that his pain precluded him from performing normal activities. He recommended that Petitioner undergo a functional capacity evaluation (FCE) to determine permanent restrictions. Dr. Kennedy's records of that date did not contain any statement that he was making any sort of surgical recommendation to the Petitioner.

At the direction of the Respondent, Petitioner was examined for the second time by Dr. Doll on December 5, 2011. Dr. Doll examined Petitioner and he reviewed both additional medical records and a surveillance video of the Petitioner that was obtained on October 26, and October 27, 2011. At that time, Petitioner complained of continued low back pain with right leg symptoms and stated that his pain was 8/10. On examination, Dr. Doll could not perform a straight leg raising test because of Petitioner's complaints of severe pain at any degree of elevation. In his review of the surveillance video, Dr. Doll noted that Petitioner engaged in numerous activities inconsistent with his complaints of severe low back pain. Specifically, Dr. Doll observed the Petitioner standing, descending stairs, and walking without any apparent difficulties other than a mild trace antalgic gait favoring the right leg. Dr. Doll opined that Petitioner was at MMI as of December 5, 2011, and that no further medical treatment was required.

As noted above, video surveillance of the Petitioner was obtained on October 26, and October 27, 2011, and a DVD of the surveillance was tendered into evidence at trial. On the video obtained on October 26, 2011, Petitioner was observed getting in and out of a vehicle, walking on a balcony while talking on a cell phone and going up/down stairs, performing all of these activities without any observable difficulties. In the video of October 27, 2011, Petitioner walked up the stairs with a slight limp that was not present the day before; however, Petitioner looked directly at the camera during this time although, at trial, Petitioner denied having observed the person obtaining the video.

On March 2, 2012, Benedicte Hanquet, a physical therapist, performed a functional capacity evaluation (FCE) of Petitioner at the request of Dr. Kennedy. She observed that Petitioner was making a full physical effort and opined that he could not return to work as a janitor. She

recommended work restrictions of no lifting over 31 pounds, no frequent lifting, carrying of 21 pounds only occasionally, and limitations on standing and stooping. Subsequent to the FCE, Hanquet reviewed the videos and opined that Petitioner's activities were consistent with restrictions she imposed. Although he did not examined the Petitioner again, Dr. Kennedy reviewed the FCE and imposed work restrictions of no lifting over 30 pounds and only occasional bending, twisting or stooping.

At the direction of counsel, Petitioner was evaluated by Frank M. Trares, a rehabilitation counselor on May 21, 2012. Trares was informed of Petitioner's back condition and work restrictions and he made some recommendations to Petitioner as to how to secure employment in a self–directed job search. No formal rehabilitation or re-training plan was recommended by Trares. At trial, Petitioner tendered into evidence job search logs regarding his self–directed job search which, to date, has been unsuccessful.

In correspondence dated September 13, 2012, from Dr. Kennedy to Petitioner's counsel, he advised that Petitioner had nerve root compression and had temporary relief from the nerve root block at L5–S1 and that the pain was caused by pressure on the S1 nerve root as a result of the fall. Dr. Kennedy was deposed on March 20, 2013, and his deposition testimony was received into evidence at trial. When deposed, Dr. Kennedy opined that the compression at the S1 nerve root was due to residual disc material from the fusion surgery and that Petitioner probably dislodged a piece of the disc material at the time of the fall of October 29, 2010. Although Dr. Kennedy had not made a prior surgical recommendation in his medical records, when he was deposed he made the recommendation that Petitioner undergo a surgical procedure consisting of a foraminotomy at L5–S1 on the right side. In explaining the statement made in his medical record of December 13, 2011, that the resulting further that could be done for Petitioner, Dr. Kennedy testified that this comment was meant to be limited to further pain relief procedures such as injections.

Benedicte Hanquet was deposed on June 8, 2012, and her deposition testimony was received into evidence at trial. Her testimony was consistent with the FCE report she prepared and she reaffirmed her opinions as to Petitioner's work restrictions. In regard to the surveillance video, Hanquet agreed that she could not determine if the Petitioner was in pain and that it appeared as though the Petitioner was aware of the fact that he was under surveillance.

Dr. Doll was deposed on April 23, 2013, and his deposition testimony was received into evidence at trial. Dr. Doll's testimony was consistent with his medical reports and he reaffirmed his opinion that Petitioner was at MMI as of the date of his examination of December 5, 2011, and that no further treatment was required. In reaffirming his opinions, Dr. Doll noted the lack of objective findings on examination, inconsistencies noted during both his examinations as well as other physicians, and the marked inconsistencies of Petitioner's significant back complaints of 8/10 and his observation of the Petitioner in the surveillance video. Dr. Doll also opined that the lesser filling of the L5 nerve root sheath was not caused by the accident of October 29, 2010, and that there was not any residual disc material dislodged as result of the accident of October 29, 2010. He based this upon his review of Dr. Raskas' surgical report which stated that all disc material had been removed as well as the fact that the nerve block at L5–S1 provided Petitioner with little or no relief of his claimed symptoms.

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 not causally related to the accident of October 29, 2010.

In support of this conclusion the Arbitrator notes the following:

The Arbitrator concludes that Petitioner was not a credible witness on his own behalf. Initially, the Arbitrator notes Petitioner's claim that he was symptom free following his prior three back surgeries and had no work restrictions prior to October 29, 2010, is contrary to the medical evidence. At trial, Petitioner repeatedly stated that the work restrictions previously imposed on him by Dr. Raskas only applied to the job that he performed for his prior employer. This statement is illogical and defies common sense.

The Arbitrator watched the surveillance video and noted that Petitioner was able to get in and out of a vehicle, walk on a balcony while talking on a cell phone, and go up/down stairs without any readily observable difficulties. The Arbitrator concludes that this is inconsistent with Petitioner's complaints of severe low back pain.

The Arbitrator finds the opinion of Dr. Doll to be more credible than that of Dr. Kennedy. Dr. Doll's opinion that there was no dislodged disc material at L5–S1 as a result of the accident of October 29, 2010, is credible and consistent with the surgical report of Dr. Raskas. Further, Dr. Doll noted the lack of objective findings on examination and various inconsistencies observed during his examination of Petitioner as well as examinations by other physicians. Dr. Doll also reviewed the video and opined that Petitioner's observed activities were inconsistent with his claim of being in severe pain.

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

The Arbitrator concludes that Petitioner had an average weekly wage of $331.41.

In support of this conclusion the Arbitrator notes the following:

The wage statement tendered into evidence was for a period of 17 weeks, from June 27 through October 23, 2010, with a total earnings of $5,634.01. Petitioner testified that he customarily worked 38 1/2 hours per week; however, the number of hours Petitioner worked indicated in the wage statement varied between 23.75 and 42.75 hours per week. There is no other evidence in the record regarding this issue. Accordingly, the Arbitrators unable to determine if Petitioner, in fact, worked a lesser number of weeks or portions thereof than the 17 weeks indicated in the wage statement.

The Arbitrator hereby finds the average weekly wage to be $331.41, $5,634.01 divided by 17 weeks.

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 up to the time he was found to be at maximum medical improvement was reasonable and necessary and that Respondent is liable for payment of the medical bills associated therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 15 for medical services provided on or before December 5, 2011, but not thereafter, as provided by Sections 8(a) and 8.2 of the Act subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

As noted herein, Dr. Doll examined Petitioner on December 5, 2011, and opined that Petitioner was at MMI as of that date and not in need of any further medical treatment.

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

The Arbitrator concludes that Petitioner is not entitled to prospective medical treatment. In support of this conclusion the Arbitrator notes the following:

As stated herein, the Arbitrator found the opinions of Dr. Doll to be more credible than those of Dr. Kennedy and Dr. Doll has opined that Petitioner is not in need of additional medical treatment. The Arbitrator also notes that Dr. Kennedy did not make any sort of surgical recommendation until the time he was deposed and no such recommendation is contained anywhere in his treatment records.

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

The Arbitrator concludes that Petitioner is entitled to temporary total disability benefits for 57 5/7 weeks commencing October 29, 2010, through December 7, 2011.

The Arbitrator concludes that Petitioner is not entitled to either temporary total disability or maintenance benefits subsequent to December 7, 2011.

In support of these conclusions the Arbitrator notes the following:

As is noted herein, Petitioner was found to be at MMI by Dr. Doll of December 5, 2011.

Petitioner is not entitled to maintenance benefits because he failed to prove that the injury of October 29, 2010, resulted in a reduction of his earning capacity. The Arbitrator also notes that subsequent to the prior back injury and fusion procedure, Dr. Raskas imposed more significant work restrictions on Petitioner than those that were imposed by Dr. Kennedy in March, 2012.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Feliciano Italiano,

Petitioner,

vs. NO: 09 WC 21532
14 IWCC 087

Rausch Construction,

Respondent.

ORDER OF RECALL UNDER SECTION 19(f)

A Petition under Section 19(f) of the Illinois Workers' Compensation Act to Correct Clerical Error in the Decision of the Commission dated February 5, 2014, having been filed by Respondent herein. Upon consideration of said Petition, the Commission is of the Opinion that it should be granted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision and Opinion on Review dated February 5, 2014 is hereby vacated and recalled pursuant to Section 19(f) for a clerical error contained therein.

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

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: MAR 14 2014
TJT:yl
51

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FELICIANO ITALIANO,

Petitioner,

vs.

NO: 09 WC 21532
14 IWCC 087

RAUSCH CONSTRUCTION,

Respondent.

CORRECTED DECISION AND OPINION ON REMAND
FROM THE APPELLATE COURT OF ILLINOIS
FIRST DISTRICT
WORKERS' COMPENSATION COMMISSION DIVISION

This case comes before the Commission on remand from the Appellate Court of Illinois, First District, in case number 10 L 051017. On January 10, 2010, Arbitrator Black issued a decision finding that Petitioner failed to prove he suffered an accident arising out of and in the course of his employment with Respondent and did not award any benefits. On February 2, 2010, Petitioner filed section 19(e) special interrogatories asking the Commission five questions. On review, a majority of the Commission affirmed and adopted the Arbitrator's opinion, with one Commissioner dissenting. The Commission issued its decision on June 14, 2010. Petitioner then filed a motion with the Circuit Court on August 19, 2010, to set aside the Commission's decision and remand the case to the Commission with instructions to make findings in response to the section 19(e) interrogatories. The Circuit Court denied the motion on October 27, 2010. The Circuit Court heard the case and affirmed the Commission decision on April 6, 2011.

Petitioner timely appealed his case to the Appellate Court, which reversed and remanded it to the Commission on September 11, 2012. The Appellate Court held:

> Where the objective medical evidence established that the claimant sustained an injury and the sole causation opinion attributed the claimant's condition to the repetitive motions of his work, the Commission's decision that the claimant did not sustain injuries that arose out of and in the course of his employment is against the manifest weight of the evidence.

Petitioner filed a timely Petition for Review under §19(b-1) on November 13, 2009. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Appellate Court found the following facts:

Petitioner worked as a union cement mason for about 10 years as of his claimed injury in 2009. In October 2007, Petitioner began working for Respondent as a cement finisher foreman where he replaced sidewalks and handicap ramps.

Petitioner testified that on May 6, 2009, he noticed numbness in his hands up to his elbows and sharp pain in both shoulders as he was using a 12-inch grinder to grind a wall. Petitioner had been using a 15 to 20 pound grinder for four hours that day when he reported the pain. Petitioner added that he had to hold the grinder with two hands. Petitioner testified that he told his supervisor, Matt Kovalsky, about the pain and numbness. As of May 6, 2009, Petitioner had been grinding cement for about a week.

Petitioner testified that he had experienced similar pain symptoms in the fall of 2008 but did not report his issue or seek medical treatment. Petitioner explained he did not report his pain because in his "line of work, you get a lot of stress in your arms and legs and back, and I don't know if it was an injury or just because I was working so many hours and my body don't [sic] recuperate." In November 2008, Petitioner stopped working as part of a general lay off and his pain symptoms ceased while he was not working. However, when Petitioner returned to work in April 2009, the pain also returned. Petitioner continued to work until May 6, 2009, when he experienced so much pain that it interfered with his ability to work. Petitioner then reported his pain.

Respondent presented two witnesses who both testified they did not observe Petitioner showing any indication of pain while working. Bernadino Villasenor testified that he worked for Respondent for 25 years and was the operations manager. While he infrequently spoke to

Petitioner, Mr. Villasenor testified that Petitioner never mentioned any pain in his wrists or shoulders. Mr. Villasenor added that during his regular visits to the job site, he never noticed any indication that Petitioner was in pain or uncomfortable in any way. Mr. Kovalsky also testified at the hearing. He is a project manager for Respondent and saw Petitioner at least once a day. Before Petitioner reported his pain complaints on May 6, 2009, Mr. Kovalsky testified Petitioner never complained of numbness in his arms or wrists and never appeared to be in pain or discomfort while working.

When Petitioner reported his symptoms to Mr. Kovalsky, they discussed the origin of them. Mr. Kovalsky testified that when questioned, Petitioner denied hurting himself on the job. Mr. Kovalsky added that he told Petitioner that if he hurt himself at work, Petitioner needed to go to the clinic to be examined but Petitioner refused. Yet, during cross examination, Mr. Kovalsky admitted that he may have told Petitioner there was no need for him to go to the clinic. He also admitted to sending the following email to Mr. Villasenor on May 7, 2009:

> I told him that typically for an injury, [Respondent] will either send you to Concentra or the emergency room. Seeing that this was not an emergency, there was really no reason for him to go. He asked me if this was something that [Respondent] would pay for or if he had to go through his own insurance. I replied with I don't know.

Petitioner did not return to work after May 6, 2009, through the date of the arbitration hearing. His treating physicians continually wrote Petitioner off work or gave him light duty restrictions. Petitioner was told he was not needed at work on May 7, 2009. Mr. Villasenor testified about a telephone conversation he had with Mr. Kovalsky on May 6, 2009. Mr Kovalsky asked Mr. Villasenor if Petitioner was needed at work the next day, to which Mr. Villasenor replied no based on the weather forecast. Mr. Kovalsky then called Petitioner that evening to tell him that they would not be pouring concrete the next day and Petitioner was not needed at the work site. Mr. Kovalsky admitted on cross examination that other cement masons worked on May 7, 2009, but Petitioner was not needed. Mr. Villasenor also admitted on cross examination that typically the foreman worked if other cement masons were working.

Petitioner returned to the work site on May 7, 2009, asking Mr. Kovalsky if he could fill out an accident report. Mr. Kovalsky would not allow Petitioner to fill one out because they are to be completed immediately after an accident when an employee is injured on the job. Instead, Mr. Kovalsky gave Petitioner an incident report to fill out, which is to make a record of "an incident that may or may not have occurred on the job." Petitioner filled it out and wrote that he sustained a shoulder injury on May 6, 2009 due to the repetitive motion of grinding and chipping concrete.

Petitioner first sought medical treatment on May 7, 2009, with Dr. Marcotte, his primary care physician. Petitioner told Dr. Marcotte that he was a cement finisher and his job required

repetitive motions that strained his back and arms. Dr. Marcotte wrote in his initial report that Petitioner was seen for complaints of bilateral shoulder pain and that Petitioner had been performing the "same job over and over," which caused him pain radiating down into his hands. Dr. Marcotte diagnosed Petitioner with bilateral acromioclavicular strain and probable carpal tunnel syndrome bilaterally. Petitioner underwent an electromyogram on May 19, 2009. Dr. Bhasin wrote in his report that "the electrophysiological data obtained today is suggestive of bilateral median mononeuropathy at rest secondary to carpal tunnel syndrome, mainly by wrist-palm technique criteria only."

Dr. Marcotte saw Petitioner again on May 27, 2009. He noted that Petitioner still suffered from numbness and tingling in his first three fingers – his thumb and two fingers – on his hands bilaterally, and pain in his shoulders. Dr. Marcotte wrote that while Petitioner's symptoms had significantly improved, when Petitioner lifted his arms straight up or over his head, the pain returned. He diagnosed Petitioner with bilateral carpal tunnel syndrome and AC joint strain, and referred Petitioner to Dr. McComis, an orthopedic surgeon. Petitioner first visited Dr. McComis on June 1, 2009; he diagnosed Petitioner with bilateral carpal tunnel syndrome and recommended bilateral carpal tunnel release surgery.

Petitioner then treated with Dr. Corcoran on June 24, 2009. Petitioner underwent x-rays and Dr. Corcoran wrote both shoulders showed type II and type III acromion with mild AC arthrophy. He then diagnosed Petitioner with bilateral rotator cuff tendonitis and bilateral carpal tunnel syndrome. Dr. Corcoran recommended Petitioner attend physical therapy to treat his rotator cuff tendonitis. He also recommended Petitioner have carpal tunnel release surgery on the right side first, as it was worse than the left. Once that side healed, Petitioner should have surgery on the left side. Dr. Corcoran performed right open carpal tunnel release surgery on Petitioner on June 29, 2009.

Dr. Rubinstein then treated Petitioner on July 29, 2009. His impression was that Petitioner suffered from bilateral carpal tunnel syndrome and bilateral rotator cuff tendonitis. Dr. Rubinstein also wrote in his notes that "in view of the repetitive motion activities of cement finishing which also involve a significant amount of forceful pushing and pulling, it would be my opinion that these problems are related directly to his workplace activities." Dr. Rubinstein performed Petitioner's left carpal tunnel release surgery on September 17, 2009.

At the arbitration hearing, senior investigator Daniel Lindblad testified for Respondent and Respondent submitted his video surveillance into evidence. Mr. Lindblad testified he has specific recollection of Petitioner because he observed so much activity during the surveillance, which he conducted over several days. The first day of surveillance, June 5, 2009, Mr. Lindblad testified he observed Petitioner running errands, pushing a shopping cart and carrying shopping bags. Mr. Lindblad then saw Petitioner return to his residence, where he removed two trailer tires from the back of his vehicle, jacked up the trailer and then changed the tires. He added that Petitioner did not appear to struggle while doing this. Finally, Mr. Lindblad observed Petitioner

remove a case of water from his vehicle, lift it onto his left shoulder and carry it into his residence.

Mr. Lindblad conducted surveillance again on June 8, 2009. He observed Petitioner load two "full size" suitcases into his car, drive to a church, remove two pieces of luggage from another car and place the luggage into his car. When Petitioner arrived at the church camp near Indianapolis, Mr. Lindblad saw Petitioner take the luggage out of his vehicle. Petitioner put one piece of luggage on his shoulder and carried the other pieces to the entrance. Mr. Lindblad observed Petitioner for a final time on August 14, 2009, when Petitioner was hosting a yard sale. Mr. Lindblad testified he saw Petitioner manually open his garage door and remove various items, such as tables, closet doors, lamps, large plastic containers, a large table umbrella and wood. Petitioner then set up the items and lifted them to show people.

Petitioner testified his medical treatment resolved his symptoms and pain. Petitioner testified he last worked for Respondent on May 6, 2009. While his pain began subsiding in late May or early June 2009, Petitioner stated his numbness did not decrease until he had surgery. He testified that before his surgeries, he found it difficult to perform daily tasks due to his hand numbness. Petitioner testified the surgery was successful in relieving the pain and symptoms in his hands. Petitioner added that the pain in his shoulders made it difficult to lift things. However, after completing a course of physical therapy, his shoulder pain resolved.

Based on the facts above, the Commission finds that Petitioner proved he sustained an accident arising out of and in the course of his employment with Respondent and that Petitioner's condition of ill being is causally connected to the work related accident. We further award Petitioner medical expenses and temporary total disability benefits. We decline to award Petitioner penalties and attorneys' fees.

Per the Appellate Court's statement of facts and directive in its holding, the Commission finds that Petitioner proved he suffered a work related accident. The Appellate Court found that "based on [Petitioner's] testimony and the treating notes of Dr. Marcotte, Dr. Bhasin, Dr. McComis, Dr. Corcoran, and Dr. Rubinstein, there is clear, indisputable evidence that [Petitioner] suffered from an injury to his shoulders, arms and hands." The Court noted that because nature and extent were not at issue, the surveillance evidence presented by Respondent was meant to suggest Petitioner did not suffer an accident at all. However, the Court pointed out that the medical evidence was completely uncontradicted as Respondent failed to present at medical evidence to rebut Petitioner's claim. The Appellate Court also found Petitioner's injury arose out of and in the course of his employment. The Court noted Petitioner traced his repetitive trauma injury to a "specific moment of collapse of his physical structure" on May 6, 2009, when the pain in his shoulders and the numbness in his hands became so severe it interfered with his ability to work. The Court again stressed that Petitioner's testimony and the consistent medical evidence were not negated.

In addition to finding that Petitioner proved he suffered a work related accident, we hold that his condition of ill being is causally connected to his work injury. Petitioner reported his injury on the day he was no longer able to work due to the pain and numbness in his hands and shoulders. Petitioner sought medical treatment with his primary care physician the next day. Petitioner then continually treated his conditions until he no longer experienced the same pain. Petitioner underwent bilateral carpal tunnel release surgery and post operative physical therapy for his wrists and physical therapy for his shoulders. These treatments significantly helped Petitioner as he is now pain free.

Further Petitioner's symptoms significantly subsided when he was not working for Respondent. Petitioner testified that he experienced similar symptoms when he worked through October 2008. Once Petitioner stopped working those symptoms subsided. He testified that he did not begin experiencing such symptoms until he returned to work in April 2009. That Petitioner only experienced pain in his shoulders and numbness in his hands while he was working his manual labor job strongly supports his condition being causally connected to his work. Like other manual laborers, Petitioner attempted to work through the pain and believed it was just soreness from the job and not an actual injury. Once Petitioner sought treatment, it became clear that he suffered from bilateral carpal tunnel syndrome and bilateral rotator cuff tendonitis due to his work for Respondent. After Petitioner stopped working due to his pain and numbness, his symptoms steadily improved with medical treatment. Petitioner eventually experienced full resolution of his symptoms, pain and numbness. Moreover, Respondent offered no other reason as to why Petitioner experienced such pain.

Furthermore, Dr. Rubinstein provided the only causation opinion of record. On July 29, 2009, Dr. Rubinstein wrote in his notes that "in view of the repetitive motion activities of cement finishing which also involve a significant amount of forceful pushing and pulling, it would be my opinion that these problems are related directly to his workplace activities." Petitioner's testimony as to his work, the onset of his symptoms, their improvement with time off work and ultimate recurrence and progression is consistent with his medical records. No contrary evidence was presented. Respondent did not offer any causation evidence that contradicted Dr. Rubinstein's opinion that causation existed.

Because Petitioner was able to work before the May 2009 manifestation date with minimal to no complaints of pain, suffered a work related accident, reported the accident on the same day, continually sought medical treatment and improved with such treatment, we find that Petitioner's condition of ill being is causally connected to his work related injury.

The Commission finds that Petitioner's average weekly wage is $2,098.35. We included Petitioner's overtime hours in the average weekly wage calculation as he regularly worked overtime. Petitioner testified on May 6, 2009, he worked as a finisher foreman and as such was responsible to finish the work, even if the work day exceeded 8 hours. He added that his

overtime was required. Based on Petitioner's hourly wages and the pay stubs submitted, we hold that his average weekly wage is $2,098.35.

We award Petitioner temporary total disability benefits for 32 weeks. Petitioner's repetitive trauma injury manifested itself on May 6, 2009, and he sought medical treatment on May 7, 2009. Dr. Marcotte gave Petitioner light duty work restrictions as of that visit. Petitioner then continually received off work or light duty restrictions from Dr. Marcottee, Dr. Corcoran and Dr. Rubinstein. Petitioner returned to work on December 16, 2009. He is entitled to temporary total disability benefits of $1,231.41 per week for 32 weeks, representing the time period from May 7, 2009 through December 16, 2009.

The Commission further awards Petitioner medical expenses. Petitioner's medical treatment was reasonable and necessary, and not excessive. Petitioner visited several doctors, underwent surgery and participated in physical therapy. This treatment greatly benefitted Petitioner as he testified he no longer feels pain or numbness in his shoulders or hands. Petitioner is awarded his medical bills totaling $37,276.32, per the medical fee schedule.

Finally, we decline to award Petitioner penalties or attorneys' fees. Respondent did not behave in an unreasonable or vexatious manner when it failed to pay Petitioner medical expenses or temporary total disability benefits. It relied on the Arbitrator's January 10, 2010, decision finding Petitioner did not prove he sustained a work related accident. Respondent reasonably relied on the Arbitrator's decision and hence penalties and fees are not awarded.

For the reasons stated above, the Commission finds Petitioner proved he suffered an accident arising out of and in the course of his employment and his condition of ill being is causally related to his work accident. We therefore award Petitioner temporary total disability benefits and medical expenses.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is reversed as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner proved he suffered a repetitive trauma accident arising out of and in the course of his employment with Respondent and that his condition of ill being is causally connected to that work related accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's average weekly wage is $2,098.35.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,231.41 per week for a period of 32 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 shall pay to Petitioner the sum of $37,276.32 for medical expenses under §8(a) and §8.2 of the Act.

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

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

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

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: MAR 14 2014
TJT: kg
O: 8/19/13
51

Thomas J. Tyrrell

Daniel R. Donohoo

Kevin W. Lamborn

STATE OF ILLINOIS)BEFORE THE ILLINOIS WORKERS' COMPENSATION
) SS COMMISSION
COUNTY OF CHAMPAIGN)

Bradford Craig,
Petitioner,

vs. NO. 08 WC 11812

Prairie Material sales, Inc., d/b/a Prairie Central,
Respondent,

ORDER OF RECALL UNDER SECTION 19(f)

A Petition under Section 19(f) of the Illinois Workers' Compensation Act to Correct Clerical Error in the Decision of the Commission dated December 9, 2013, having been filed by Respondent. Upon consideration of said Petition, the Commission is of the Opinion that it should be granted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision dated December 9, 2013 is hereby vacated and recalled pursuant to Section 19(f) for clerical error contained therein. The parties should return their original Orders to Commissioner Mario Basurto.

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

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: MAR 19 2014

Mario Basurto

Michael J. Brennan

David L. Gore

MB/mam
43

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FELICIANO ITALIANO,

Petitioner,

vs. NO: 09 WC 21532

RAUSCH CONSTRUCTION,

14IWCC0087

Respondent.

DECISION AND OPINION ON REMAND
FROM THE APPELLATE COURT OF ILLINOIS
FIRST DISTRICT
WORKERS' COMPENSATION COMMISSION DIVISION

This case comes before the Commission on remand from the Appellate Court of Illinois, First District, in case number 10 L 051017. On January 10, 2010, Arbitrator Black issued a decision finding that Petitioner failed to prove he suffered an accident arising out of and in the course of his employment with Respondent and did not award any benefits. On February 2, 2010, Petitioner filed section 19(e) special interrogatories asking the Commission five questions. On review, a majority of the Commission affirmed and adopted the Arbitrator's opinion, with one Commissioner dissenting. The Commission issued its decision on June 14, 2010. Petitioner then filed a motion with the Circuit Court on August 19, 2010, to set aside the Commission's decision and remand the case to the Commission with instructions to make findings in response to the section 19(e) interrogatories. The Circuit Court denied the motion on October 27, 2010. The Circuit Court heard the case and affirmed the Commission decision on April 6, 2011.

Petitioner timely appealed his case to the Appellate Court, which reversed and remanded it to the Commission on September 11, 2012. The Appellate Court held:

> Where the objective medical evidence established that the claimant sustained an injury and the sole causation opinion attributed the claimant's condition to the repetitive motions of his work, the Commission's decision that the claimant did not sustain injuries that arose out of and in the course of his employment is against the manifest weight of the evidence.

Petitioner filed a timely Petition for Review under §19(b-1) on November 13, 2009. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Appellate Court found the following facts:

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Petitioner testified that on May 6, 2009, he noticed numbness in his hands up to his elbows and sharp pain in both shoulders as he was using a 12-inch grinder to grind a wall. Petitioner had been using a 15 to 20 pound grinder for four hours that day when he reported the pain. Petitioner added that he had to hold the grinder with two hands. Petitioner testified that he told his supervisor, Matt Kovalsky, about the pain and numbness. As of May 6, 2009, Petitioner had been grinding cement for about a week.

Petitioner testified that he had experienced similar pain symptoms in the fall of 2008 but did not report his issue or seek medical treatment. Petitioner explained he did not report his pain because in his "line of work, you get a lot of stress in your arms and legs and back, and I don't know if it was an injury or just because I was working so many hours and my body don't [sic] recuperate." In November 2008, Petitioner stopped working as part of a general lay off and his pain symptoms ceased while he was not working. However, when Petitioner returned to work in April 2009, the pain also returned. Petitioner continued to work until May 6, 2009, when he experienced so much pain that it interfered with his ability to work. Petitioner then reported his pain.

Respondent presented two witnesses who both testified they did not observe Petitioner showing any indication of pain while working. Bernadino Villasenor testified that he worked for Respondent for 25 years and was the operations manager. While he infrequently spoke to Petitioner, Mr. Villasenor testified that Petitioner never mentioned any pain in his wrists or shoulders. Mr. Villasenor added that during his regular visits to the job site, he never noticed any indication that Petitioner was in pain or uncomfortable in any way. Mr. Kovalsky also testified at

the hearing. He is a project manager for Respondent and saw Petitioner at least once a day. Before Petitioner reported his pain complaints on May 6, 2009, Mr. Kovalsky testified Petitioner never complained of numbness in his arms or wrists and never appeared to be in pain or discomfort while working.

When Petitioner reported his symptoms to Mr. Kovalsky, they discussed the origin of them. Mr. Kovalsky testified that when questioned, Petitioner denied hurting himself on the job. Mr. Kovalsky added that he told Petitioner that if he hurt himself at work, Petitioner needed to go to the clinic to be examined but Petitioner refused. Yet, during cross examination, Mr. Kovalsky admitted that he may have told Petitioner there was no need for him to go to the clinic. He also admitted to sending the following email to Mr. Villasenor on May 7, 2009:

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tunnel syndrome bilaterally. Petitioner underwent an electromyogram on May 19, 2009. Dr. Bhasin wrote in his report that "the electrophysiological data obtained today is suggestive of bilateral median mononeuropathy at rest secondary to carpal tunnel syndrome, mainly by wrist-palm technique criteria only."

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At the arbitration hearing, senior investigator Daniel Lindblad testified for Respondent and Respondent submitted his video surveillance into evidence. Mr. Lindblad testified he has specific recollection of Petitioner because he observed so much activity during the surveillance, which he conducted over several days. The first day of surveillance, June 5, 2009, Mr. Lindblad testified he observed Petitioner running errands, pushing a shopping cart and carrying shopping bags. Mr. Lindblad then saw Petitioner return to his residence, where he removed two trailer tires from the back of his vehicle, jacked up the trailer and then changed the tires. He added that Petitioner did not appear to struggle while doing this. Finally, Mr. Lindblad observed Petitioner remove a case of water from his vehicle, lift it onto his left shoulder and carry it into his residence.

Mr. Lindblad conducted surveillance again on June 8, 2009. He observed Petitioner load two "full size" suitcases into his car, drive to a church, remove two pieces of luggage from

another car and place the luggage into his car. When Petitioner arrived at the church camp near Indianapolis, Mr. Lindblad saw Petitioner take the luggage out of his vehicle. Petitioner put one piece of luggage on his shoulder and carried the other pieces to the entrance. Mr. Lindblad observed Petitioner for a final time on August 14, 2009, when Petitioner was hosting a yard sale. Mr. Lindblad testified he saw Petitioner manually open his garage door and remove various items, such as tables, closet doors, lamps, large plastic containers, a large table umbrella and wood. Petitioner then set up the items and lifted them to show people.

Petitioner testified his medical treatment resolved his symptoms and pain. Petitioner testified he last worked for Respondent on May 6, 2009. While his pain began subsiding in late May or early June 2009, Petitioner stated his numbness did not decrease until he had surgery. He testified that before his surgeries, he found it difficult to perform daily tasks due to his hand numbness. Petitioner testified the surgery was successful in relieving the pain and symptoms in his hands. Petitioner added that the pain in his shoulders made it difficult to lift things. However, after completing a course of physical therapy, his shoulder pain resolved.

Based on the facts above, the Commission finds that Petitioner proved he sustained an accident arising out of and in the course of his employment with Respondent and that Petitioner's condition of ill being is causally connected to the work related accident. We further award Petitioner medical expenses and temporary total disability benefits. We decline to award Petitioner penalties and attorneys' fees.

Per the Appellate Court's statement of facts and directive in its holding, the Commission finds that Petitioner proved he suffered a work related accident. The Appellate Court found that "based on [Petitioner's] testimony and the treating notes of Dr. Marcotte, Dr. Bhasin, Dr. McComis, Dr. Corcoran, and Dr. Rubinstein, there is clear, indisputable evidence that [Petitioner] suffered from an injury to his shoulders, arms and hands." The Court noted that because nature and extent were not at issue, the surveillance evidence presented by Respondent was meant to suggest Petitioner did not suffer an accident at all. However, the Court pointed out that the medical evidence was completely uncontradicted as Respondent failed to present at medical evidence to rebut Petitioner's claim. The Appellate Court also found Petitioner's injury arose out of and in the course of his employment. The Court noted Petitioner traced his repetitive trauma injury to a "specific moment of collapse of his physical structure" on May 6, 2009, when the pain in his shoulders and the numbness in his hands became so severe it interfered with his ability to work. The Court again stressed that Petitioner's testimony and the consistent medical evidence were not negated.

In addition to finding that Petitioner proved he suffered a work related accident, we hold that his condition of ill being is causally connected to his work injury. Petitioner reported his injury on the day he was no longer able to work due to the pain and numbness in his hands and shoulders. Petitioner sought medical treatment with his primary care physician the next day. Petitioner then continually treated his conditions until he no longer experienced the same pain. Petitioner underwent bilateral carpal tunnel release surgery and post operative physical therapy

for his wrists and physical therapy for his shoulders. These treatments significantly helped Petitioner as he is now pain free.

Further Petitioner's symptoms significantly subsided when he was not working for Respondent. Petitioner testified that he experienced similar symptoms when he worked through October 2008. Once Petitioner stopped working those symptoms subsided. He testified that he did not begin experiencing such symptoms until he returned to work in April 2009. That Petitioner only experienced pain in his shoulders and numbness in his hands while he was working his manual labor job strongly supports his condition being causally connected to his work. Like other manual laborers, Petitioner attempted to work through the pain and believed it was just soreness from the job and not an actual injury. Once Petitioner sought treatment, it became clear that he suffered from bilateral carpal tunnel syndrome and bilateral rotator cuff tendonitis due to his work for Respondent. After Petitioner stopped working due to his pain and numbness, his symptoms steadily improved with medical treatment. Petitioner eventually experienced full resolution of his symptoms, pain and numbness. Moreover, Respondent offered no other reason as to why Petitioner experienced such pain.

Furthermore, Dr. Rubinstein provided the only causation opinion of record. On July 29, 2009, Dr. Rubinstein wrote in his notes that "in view of the repetitive motion activities of cement finishing which also involve a significant amount of forceful pushing and pulling, it would be my opinion that these problems are related directly to his workplace activities." Petitioner's testimony as to his work, the onset of his symptoms, their improvement with time off work and ultimate recurrence and progression is consistent with his medical records. No contrary evidence was presented. Respondent did not offer any causation evidence that contradicted Dr. Rubinstein's opinion that causation existed.

Because Petitioner was able to work before the May 2009 manifestation date with minimal to no complaints of pain, suffered a work related accident, reported the accident on the same day, continually sought medical treatment and improved with such treatment, we find that Petitioner's condition of ill being is causally connected to his work related injury.

The Commission finds that Petitioner's average weekly wage is $2,098.35. We included Petitioner's overtime hours in the average weekly wage calculation as he regularly worked overtime. Petitioner testified on May 6, 2009, he worked as a finisher foreman and as such was responsible to finish the work, even if the work day exceeded 8 hours. He added that his overtime was required. Based on Petitioner's hourly wages and the pay stubs submitted, we hold that his average weekly wage is $2,098.35.

We award Petitioner temporary total disability benefits for 32 weeks. Petitioner's repetitive trauma injury manifested itself on May 6, 2009, and he sought medical treatment on May 7, 2009. Dr. Marcotte gave Petitioner light duty work restrictions as of that visit. Petitioner then continually received off work or light duty restrictions from Dr. Marcottee, Dr. Corcoran and Dr. Rubinstein. Petitioner returned to work on December 16, 2009. He is entitled to

temporary total disability benefits of $1,231.41 per week for 32 weeks, representing the time period from May 7, 2009 through December 16, 2009.

The Commission further awards Petitioner medical expenses. Petitioner's medical treatment was reasonable and necessary, and not excessive. Petitioner visited several doctors, underwent surgery and participated in physical therapy. This treatment greatly benefitted Petitioner as he testified he no longer feels pain or numbness in his shoulders or hands. Petitioner is awarded his medical bills totaling $37,276.32, per the medical fee schedule.

Finally, we decline to award Petitioner penalties or attorneys' fees. Respondent did not behave in an unreasonable or vexatious manner when it failed to pay Petitioner medical expenses or temporary total disability benefits. It relied on the Arbitrator's January 10, 2010, decision finding Petitioner did not prove he sustained a work related accident. Respondent reasonably relied on the Arbitrator's decision and hence penalties and fees are not awarded.

For the reasons stated above, the Commission finds Petitioner proved he suffered an accident arising out of and in the course of his employment and his condition of ill being is causally related to his work accident. We therefore award Petitioner temporary total disability benefits and medical expenses.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is reversed as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner proved he suffered a repetitive trauma accident arising out of and in the course of his employment with Respondent and that his condition of ill being is causally connected to that work related accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's average weekly wage is $2,098.35.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,231.41 per week for a period of 32 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 shall pay to Petitioner the sum of $37,276.32 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired

14IWCC0087

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: FEB 0 5 2014
TJT: kg
O: 8/19/13
51

Thomas J. Tyrrell

Daniel R. Donohoo

Kevin W. Lamborn

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Buenaventura Colon,

Petitioner,

14IWCC0088

vs. NO: 10 WC 03925

Lee Auto Parts,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of TTD and PPD and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Decision of the Arbitrator only to the extent that it increases the awarding PPD benefits to 4% loss of a person as a whole, finding this action appropriate given the injuries Petitioner sustained to his cervical and lumbar spine and complained of residual symptoms. The Commission declines to award greater benefits under Section 8(d)2 of the Act after viewing surveillance footage of Petitioner engaged in activities without any evidence of significant impairment.

The Commission notes the parties stipulated to the awarded TTD and medical benefits and finds no justification to disturb the stipulation.

The Commission affirms and adopts all other aspects of the Decision of the Arbitrator

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $214.43 per week for a period of 20 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 4% loss of a person as a whole.

14IWCC0088

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: FEB 0 5 2014
KWL/mav
O: 12/17/13
42

Kevin W. Lamborn

Daniel R. Donohoo

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0088

COLON, BUENAVENTURA
Employee/Petitioner

Case# 10WC003925

LEE AUTO PARTS
Employer/Respondent

On 3/20/2013, 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 0.11% 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:

2986 PAUL A COGHLAN & ASSOC PC
15 SPINNING WHEEL RD
SUITE 100
HINSDALE, IL 60521

4412 ACCIDENT FUND HOLDINGS INC
GRACE DiGERLANDO
200 W MADISON ST SUITE 3850
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 14IWCC0088

Buenaventura Colon
Employee/Petitioner

v.

Lee Auto Parts
Employer/Respondent

Case # **10** WC **03925**

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 **Arbitrator Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **1/8/13**. After reviewing all 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 **9/16/09**, 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 $**11,150.36**; the average weekly wage was $**214.43**.

On the date of accident, Petitioner was **18** 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 $**457.14** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**30,641.15** for medical benefits, for a total credit of $**31,098.29**

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

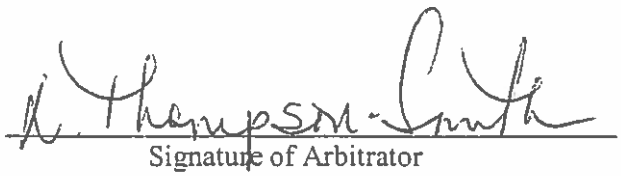
ORDER

The Petitioner has not proven, by a preponderance of the evidence, that his condition of ill-being, subsequent to April 1, 2010, is causally connected to the injury of September 16, 2009. The Arbitrator denies all medical benefits subsequent to April 1, 2010, pursuant to the Act.

The Respondent shall pay Petitioner $213.33 for 10 weeks as permanent partial disability, as the injuries sustained have caused 2% loss of use of a man, pursuant to 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

March 18, 2013

MAR 20 2013

FINDINGS OF FACT:

The disputed issues in this matter are: 1) causal connection; 2) medical bills; and 3) nature and extent.

Petitioner's prior medical history is significant for bilateral pars intra-articularis at L5-S1 defect without spondylolisthesis; a red, swollen itchy left eye; and contusion of the right knee. In addition, the petitioner has a history of chest pain and cardiac consultation going back to February of 2002. *See,* notes of Dr. Carmen Sierra dated January 19, 2009; March 19, 2009, & September 8, 2009, in PX4.

On January 8, 2013, the petitioner testified that he is 21 years old and is currently employed as a "parts" sales manager for Auto Zone; where he has worked for the past three (3) years. He further testified that he was a high school graduate and had attended eight (8) months of automotive schooling, at Lincoln Technical College.

The petitioner testified that, on September 16, 2009, he was eighteen (18) and employed by Lee Auto Parts ("Respondent") as a driver. While making his last delivery on September 16, 2009, his vehicle was struck on the passenger's side, by an oncoming vehicle when he was making a left hand turn; and it flipped over. The petitioner testified that paramedics cut him out of his vehicle and he was taken to the Glenbrook Hospital following his accident. X-rays were taken of his left elbow, left femur and his chest. They were all negative and he was given a prescription for Hydrocone. His primary diagnosis was Cervicalgia with spasm of muscle; and lumbago. *See,* PX4.

He further testified that he returned to work for the respondent approximately two (2) weeks after his accident and continued to work for approximately four more months. Since his injury, the petitioner testified that he had problems with lifting, but Flexeril helped a little.

The petitioner testified that it has been recommended that he undergo a fusion, but he was undecided about proceeding with surgery as it could make him worse. The petitioner testified that he had never completely stopped taking medications between 2009 and 2013 and that he currently took Tylenol and Naproxen and that Dr. Sierra was prescribing his Naproxen. The petitioner testified that physical therapy helped his neck but that he could not lift more than ten (10) pounds as it put too much pressure on his lower back. He testified that he utilized a back

belt and could no longer play basketball, football or run. The petitioner testified that he took Tylenol at work and it relieved his pain and allowed him to sit and stand longer.

The petitioner recalled being examined by Dr. Andersson in April of 2010 and that he was examined for approximately twenty-five (25) minutes. The petitioner testified that Dr. Andersson also examined him in October of 2011 and that examination lasted approximately five (5) minutes.

On cross-examination, the petitioner testified that he quit his job with the respondent company in March of 2010 to accept a position as an usher at U.S. Cellular Field, where he worked for approximately 3 months. He then went to work for Auto Zone. He testified that his hours, while working at U.S. Cellular Field, varied dependent upon the game schedule, but he generally worked four (4) to five (5) hours per week. He testified that his job as an usher required him to stand and walk at all times. The petitioner further testified that he had not sought treatment with any physicians other than Drs. Sierra, Pahwa, Vargas, Riera, and Erickson, relative to his accident of September 16, 2009. He testified that he had group medical insurance and has had it from 2009 through the date of this trial.

On cross-examination, the petitioner testified that upon examination by Dr. Andersson, he answered all of his questions honestly and advised Dr. Andersson of his complaints. He testified that he was aware that in April of 2010, Dr. Andersson recommended that he undergo an additional period of physical therapy, at a facility other than the Rehab Team. The petitioner testified that he did not attend physical therapy between March of 2010 and July of 2011 and that he was aware that Dr. Andersson did not believe that he required a fusion.

In addition, on cross-examination, the petitioner testified that his pain was currently in his back. He testified that he had a civil suit pending regarding the motor vehicle accident of September 16, 2009. The petitioner testified that he currently took two (2) Tylenol at a time, which would relieve his pain for three (3) to four (4) hours and allow him to sit or stand for four (4) to five (5) hours.

On re-direct examination, the petitioner testified that he did not attend additional therapy after his examination with Dr. Andersson in April of 2010 because the workers' compensation carrier would not authorize it and that his group insurance carrier would not pay for his treatment because his injury was work related. On re-cross examination, the petitioner testified that he only attempted to undergo physical therapy at the Rehab Team and no other facility, between March of 2010 and July of 2011.

On September 17, 2009, he presented to Saints Mary and Elizabeth Medical Center (the "Center"), complaining of pain from his neck to his buttocks. He also testified that he had

sustained minor cuts and bruises to his arm, but they resolved without issue. The petitioner was seen by Dr. Sierra, who referred him to Dr. Pahwa; who diagnosed him as having cervical, lumbar and coccyx strains. *See*, PXs 4 & 8.

On September 20, 2009, the petitioner was evaluated at the Center's emergency room. He complained of numbness and pain in the left arm and neck. The petitioner was diagnosed as having cervical radiculopathy. It was noted that he was allergic to Naproxen. *See*, PX7.

On September 29, 2009, the petitioner underwent a cervical MRI, which exhibited reversal of the cervical lordosis, which "could be seen in muscle spasm." No structural derangement was otherwise noted and there were no herniated discs or fractures. *See*, PX4.

On October 2, 2009, Petitioner presented to Dr. Carmen Sierra for modalities of cervical/lumbar traction. Dr. Sierra stated that Petitioner had recovered sufficiently to return to light/regular work duties. *See,* Disability Certification dated October 2, 2009 in PX4. Dr. Sierra ordered physical therapy for the petitioner at Rehab Team Physical Therapy.

On October 8, 2009, petitioner presented to Dr. Mohammed Ibrahim, for physical therapy, to treat Petitioner's low back pain (lumbago), cervicalgia and muscle spasm. Petitioner returned for physical therapy from October through the end of April, 2010 and was placed on limited duties, with restrictions of lifting no more than 10 pounds and sitting/driving for no more than four hours.

Petitioner was again referred to Dr. Pahwa on October 29, 2009; and also Petitioner returned for a follow-up to Dr. Sierra on November 12, 2009 with continued complaints of back pain.

Petitioner presented to the Center on December 10, 2009, for lumbar x-rays. Reportedly, the x-rays exhibited bilateral spondylosis at L5 without evidence of spondylolisthesis, the same findings were noted on a prior lumbosacral study of January 19, 2009, i.e. the x-ray results from January 19, 2009 reportedly exhibited L5-S1 spondylolisthesis with no significant spondylolisthesis and a bilateral pars intra-articularis at L5-S1. *See*, PX4.

On February 2, 2010, the petitioner was evaluated by Dr. Prem Pahwa, complaining of pain in the back and right knee and "some stiffness" in the neck. Upon examination, the petitioner was noted to have mild tenderness in the lumbosacral area. Back motions were noted to be "fairly good." Straight leg raise was to 75 degrees bilaterally and his Lasegue sign was negative. There was no weakness of the lower extremities, no sensory deficit and reflexes were present at the knees and ankles. Lumbar x-rays dated December 10, 2009 were reviewed. Dr. Pahwa diagnosed the petitioner with a lumbosacral strain with pre-existing spondylolysis at L5. A right knee MRI was prescribed. *See,* PX 4; RX 1.

Petitioner returned for physical therapy re-evaluation on December 24, 2009; a plan of care was set and he continued with treatment. Respondent recommended that the petitioner find an orthopedic doctor on January 5, 2010. At this time, he was on light duty.

Petitioner presented to Dr. Prem Pahwa on February 2, 2010, describing pain in his back and right knee and stiffness in his neck. Dr. Pahwa diagnosed petitioner with a lumbosacral strain with pre-existing spondylolysis at L5. He recommended an MRI of the right knee to determine where pain was coming from.

On February 25, 2010, the petitioner was ordered to continue physical therapy and re-evaluation. Petitioner tested positive for the cervical compression test and the Lasegue test, indicating nerve root irritation/inflammation and a lumbar lesion.

An MRI of petitioner's right knee was performed at the Center on March 13, 2010; the results of which were normal.

On April 1, 2010, Petitioner presented for an IME with Dr. Gunnar Andersson, at the request of the respondent. Dr. Andersson concluded at that time that petitioner was suffering from cervical and lumbar contusions and recommended that the petitioner's physical therapy plan be revised.

The petitioner attended physical therapy at Rehab Team from October of 2009 to April 17, 2010. The last Progress/Treatment Note from Rehab Team dated April 17, 2010, notes that the petitioner had returned the "demo of home exercise program correctly and independently." It was noted that the "Long Term Goal" of ambulation was improved to the "maximal level of function" and had been met. *See*, PX6.

There was a six-month gap in treatment. Then on October 14, 2010, the petitioner was seen by Dr. Sierra relating to low back pain. X-rays were taken and reported to be normal. On October 21, 2010, 200 mg of Advil, 2 times per day was prescribed by Dr. Sierra. *See,* PX4.

Then there is an eight (8) month gap in treatment. On July 14, 2011, Dr. Rogelio Riera evaluated the petitioner, reporting the same mechanism of injury and complaining of "off and on" neck pain. Examination of the neck revealed pain on palpation at the insertion of the para-cervical muscles; with some limitation of flexion and extension, due to pain. There was minimal pain on palpation of the lumbar area and no muscle spasm. Motor and sensory skills of the lower extremities and deep tendon reflexes were normal. Dr. Riera diagnosed the petitioner with "chronic back pain, possibly related to injuries that he suffered years back and sprain/strain of the lumbar spine." *See,* PX5.

On July 19, 2011, the petitioner underwent a lumber MRI, which exhibited bilateral non-displaced pars defect at L5-S1; with minimal disc bulging at that level with no stenosis or misalignment. The petitioner also underwent a cervical MRI on that date, which exhibited straightening of the cervical spine. *See*, PX5.

On July 21, 2011, the petitioner returned to Dr. Riera and an EMG and physical therapy were prescribed. On July 26, 2011, the petitioner underwent EMG/NCV studies, which exhibited mild right L5-S1 radiculopathy. *See*, PX5.

On August 18, 2011, Dr. Riera reviewed the EMG/NCV study, which revealed mild right L5-S1 radiculopathy. Due to said findings as well as petitioner's persistent pain, he was referred to Dr. Vargas, a pain specialist. Physical therapy and Flexeril were prescribed. *See*, PX5.

On August 19, 2011, the petitioner attended therapy at Premier Physical Therapy. It was noted that he transferred his care to that clinic for "convenience reasons" due to the facility's location in relation to his home and to avoid missing time from work. *See*, PX5.

On August 31, 2011, Petitioner presented to Dr. Axel Vargas, a pain management doctor, at the Gold Coast Surgicenter; a facility associated with Michigan Avenue Medical Associates, on referral from Dr. Riera. Petitioner described his pain as "electric-like shooting" which began in his mid and distal lower back and then radiated down his right buttock and lower extremity. Petitioner also reported having stiffness in his neck. Dr. Vargas concluded that Petitioner might be suffering from mild lumbosacral spondylosis and minimal disc disease; which may be causing radicular symptoms. Dr. Vargas administered an epidural steroid injection at this time and Petitioner was advised that he could work in a full duty capacity.

On September 14, 2011, the petitioner again presented to Dr. Axel Vargas and was assessed as having lumbar radiculopathy. Dr. Vargas administered a nerve root block/transforaminal epidural steroid injection. Between September 14, 2011 and October 26, 2011, the petitioner underwent three transforaminal lumbar epidural steroid injections at L5-S1. On November 9, 2011, Dr. Vargas referred the petitioner to Dr. Erickson. *See*, PX5.

Petitioner returned to Dr. Gunnar Andersson on October 25, 2011, for an IME re-evaluation. Petitioner indicated that he had returned to employment but was still experiencing low back pain. Dr. Andersson concluded that petitioner's condition was not work related and stated that Petitioner's treatment up through April of 2010 was reasonable and necessary but that any treatment afterwards is not related. The doctor released Petitioner to return to work in a full duty capacity and advised that no further treatment was necessary.

Petitioner followed up with Dr. Vargas on October 26, 2011, for a repeat steroid injection. On November 9, 2011, Petitioner returned to Dr. Vargas who again recommended a discogram and referred petitioner to Dr. Robert Erickson, a neurosurgeon.

On November 16, 2011, Dr. Erickson recommended that a diagnostic discography be performed. On November 30, 2011, the petitioner underwent a L3-S1 provocative lumbar discogram and post-discography CT. The discogram showed that petitioner had a nuclear cavity degeneration with disc protrusion and associated annular tear. The post-operative CT Scan showed grade 3 tears at L3-4 and L4-5 as well as a grade 4 tear at L5-S1. On December 5, 2011, Dr. Erickson recommended that the Petitioner proceed with an instrumented fusion at L5-S1. *See,* PX5.

Petitioner returned to Dr. Vargas on December 7, 2011, and according to his report, the discography confirmed that the origin of most of the petitioner's pain was stemming from the L5-S1 segment of his back. At that time, Dr. Vargas again indicated that the petitioner was capable of full duty work and did not need therapy. He stated petitioner should consider undergoing a surgical decompression or intra-distal disc decompression with respect to the L5-S1 radicular symptoms. Petitioner was advised to return to Dr. Erickson.

On December 9, 2011, Petitioner presented to Dr. Robert Erickson and he concluded that Petitioner should undergo a right-sided L5-S1 fusion and attributed his condition and need for surgery to his car accident on September 16, 2009.

Dr. Erickson, the treating board-certified neurosurgeon, testified by way of evidence deposition that the petitioner was a candidate for an L5-S1 fusion and that this surgery, as well as all of the aforementioned medical treatment and therapy, was related to the work accident. Dr. Erickson relied on the discogram findings as well as a "small disruption seen on the MRI. He also reviewed Respondent's IME report and the opinions of Dr. Anderson; as well as the surveillance video report of the petitioner. Dr. Erickson testified that Dr. Anderson's basis for opining there was no need for surgery was "nonsensical." As for the surveillance performed, Dr. Erickson testified that the video showed what the petitioner told him he was doing on a daily basis and that it did not present new information or change his recommendations for surgical intervention. *See*, PX2 at pgs. 14-15.

Respondent's IME physician Dr. Anderson, a board certified orthopedic physician, specializing in back and neck disorders, also testified by way of evidence deposition. Dr. Anderson testified that he examined the petitioner on April 1, 2010 and had reviewed records from Glenbrook Hospital, the Center and Dr. Pahwa. He also testified that upon examination, Petitioner walked normally but slowly and had a normal posture and opined that the petitioner did not sustain any permanent disability as a result of the subject accident; no longer had symptoms from the subject accident; did not require further treatment or surgery and had reached maximum

medical improvement ("MMI"). He thought that the petitioner's medical treatment had been reasonable and necessary up to the point when he examined him, i.e. April 2010. Petitioner had returned to work and had not had any treatment in approximately fifteen (15) months.

Two dates of surveillance conducted of the petitioner in 2012 were admitted into evidence. The surveillance footage is approximately 1 hour and 25 minutes long and exhibits the petitioner working on an automobile, carrying an infant in an infant carrier, walking, bending, lying on the ground, kneeling, squatting, utilizing tools, using a manual jack, etc. *See*, RX Group 3.

14IWCC0088

CONCLUSIONS OF LAW:

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

The burden lies with the claimant to establish the elements of his right to compensation. *Wal-Mart Stores, Inc. v. Industrial Comm'n,* 326 Ill.App.3d 438, 443, 761 N.E.2d 768, 773, 260 Ill.Dec.585, 590 (4th Dist. 2001) (citing *Nabisco Brands, Inc. v. Industrial Comm'n,* 266 Ill.App.3d 1103, 1106, 204 Ill.Dec. 354, 641 N.E.2d 578, 581 (1994)). This includes the burden of proving the existence of a causal relationship between the injury and the condition of ill-being. *See, Beattie v. Industrial Comm'n,* 276 Ill.App.3d 446, 449, 657 N.E.2d 1196, 1199, 212 Ill. Dec. 851, 854 (1st Dist. 1995). The mere existence of testimony does not require its acceptance. *See, Bernard v. Industrial Commission,* 25 Ill.2d 254, 184 N.E.2d 864 (1962).

After weighing the evidence in this case, the Arbitrator concludes that the petitioner established that he sustained lumbar, cervical and coccyx contusions and strains that arose out of and in the course of his employment with the respondent, on September 16, 2009. In forming this opinion, the Arbitrator relies upon the medical records and the opinion of Dr. Gunnar Andersson. The Arbitrator finds that the petitioner has failed to prove, by a preponderance of the evidence, a causal connection between his medical condition subsequent to April 1, 2010; and his injury of September 16, 2009; and therefore finds that the petitioner's recommended need for a L5-S1 fusion, is not causally related to his injury of September 16, 2009; and that such a procedure, is not reasonable or necessary.

Between September 16, 2009 and April 2, 2010, the petitioner was evaluated at the emergency room, by his family physician, Dr. Sierra; also by an orthopedic surgeon, Dr. Pahwa and by the IME orthopedic surgeon, Dr. Gunnar Andersson. The emergency room records confirm a diagnosis of arm and leg pain. Drs. Sierra and Andersson's records confirm a diagnosis of cervical, coccyx and lumbar sprains and Dr. Pahwa's records confirm a diagnosis of a lumbosacral strain. There is also some evidence of pre-existing L5 spondylosis contained within the medical records. The Arbitrator notes that despite multiple examinations and diagnostic tests, for several months, the petitioner was not diagnosed with anything more significant than contusions and strains; and no invasive treatment was recommended.

Subsequent to April of 2010, the petitioner did not seek medical treatment for an extended period. Per his testimony, the petitioner claimed that he failed to seek any such follow-up treatment because it was denied and his group carrier would not authorize it. The petitioner's testimony is not supported by the medical records submitted into evidence. The petitioner admitted that he was aware that Dr. Andersson recommended that he cease obtaining physical therapy with the Rehab Team and attend therapy at another facility. The petitioner testified that

he did not attempt to attend therapy at any facility other than the Rehab Team until July of 2011, in excess of one year after Dr. Andersson's recommendation.

Other than his examination with Dr. Andersson on April 1, 2010, the medical records evidence that the petitioner did not see a physician again until September 24, 2010; when he was evaluated by Dr. Sierra regarding rashes. Dr. Sierra's report of September 24, 2010, does not note any lumbar or cervical issues.

On October 21, 2010, Dr. Sierra's notes evidence that the petitioner complained of back pain and 200 mg of Advil was prescribed. No further treatment was recommended by Dr. Sierra and, per the subpoenaed records, the petitioner did not seek additional medical treatment nor was any treatment recommended until July 14, 2011; when he was evaluated by Dr. Riera. The Arbitrator notes that the Commission has previously denied benefits based upon a lack of causal connection when there is a significant delay in receiving treatment or a significant gap in treatment. *See, Gonzalez v. J.F. Daley International,* 94 WC 23862, 99 IIC 3121; *Bauer v. E M Wiegman* 98 WC 39838, 02 IIC 0839; *Mercado v. Trak Auto,* 99 WC 61550, 02 IIC 0412; *Day v. Danville Housing Authority* 10 WC 22490, 11 I.W.C.C. 0537. The Arbitrator finds that the petitioner's gaps in treatment from April 1, 2010 through October 14, 2010; and from October 21, 2010 through July 11, 2011; and again from December 9, 2011 through the date of trial to be significant and inexplicable as the petitioner is attempting to related to his current condition of ill-being to the subject accident.

The Arbitrator notes that the recommendation for additional medical treatment, including a lumbar fusion, came after nearly approximately a year-long gap in medical treatment. The Arbitrator notes that a recommendation for a lumbar fusion was not made until the petitioner underwent a lumbar discogram in November of 2011, more than two years after the petitioner's date of injury. Said recommendations also came after the petitioner had returned to full duty work and had been working in such capacity for two different employers, for approximately a year and a half.

Additionally, said recommendations were made in the face of "normal" neurological examinations and diagnostic tests. Per Dr. Erickson's testimony, the petitioner's neurological examination was "very good" and the recommendation for fusion was being made for "surgical pain treatment, in essence." If the petitioner was not symptomatic, Dr. Erickson testified that he would not perform a fusion and again, the fusion was for pain treatment. The Arbitrator notes that Dr. Andersson also cautioned against performing a fusion on an individual as young as the petitioner without a very specific indication and Dr. Erickson also testified that fusions are not often performed on individuals under the age of twenty-five (25). In addition, the Arbitrator takes notice of Petitioner's previous medical history, which is significant for bilateral pars intra-articularis at L5-S1 defect without spondylolisthesis.

The Arbitrator finds the opinions of Dr. Andersson to be more compelling than that of Dr. Erickson. Furthermore, she finds Dr. Andersson's opinions to be more persuasive than those of Drs. Riera and Vargas.

In accordance with Dr. Andersson's opinions, the Arbitrator finds that the petitioner reached a state of MMI without need for additional treatment, by late April or early May of 2010. Dr. Andersson took specific note of the petitioner's gaps in medical treatment and testified that the petitioner's pain complaints in October of 2011 were different than those he reported upon examination in April of 2010. Dr. Andersson testified that in October of 2011, the petitioner complained of "pain from the neck to the lower back and that pain was the worst possible." Additionally, 5 pain diagrams completed at the Michigan Avenue Medical Associates, between September 14, 2011 through December 7, 2011, evidence the petitioner having pain and/or numbness from the base of his skull to the base of his spine and down the front and sides of his bilateral legs from the upper thigh region to the ankles. Dr. Andersson testified that the petitioner's pain complaints did not match any known spine disorder and he believed the petitioner was malingering. Furthermore, Dr. Andersson testified that he did not believe the petitioner's pain was emanating from L5-S1 and believed it would be a "mistake" to perform a fusion on the petitioner.

The Arbitrator also notes that critical to the determination of causal connection is the petitioner's credibility and the weight of his testimony depends upon the same. Once the petitioner's credibility is questioned, the concept of truthfulness becomes critical. The Arbitrator notes that compensation has been denied by the Commission and affirmed by the Courts in numerous instances, when the claimant's credibility was suspect and contemporaneous medical histories conflicted with and/or failed to corroborate the claimant's testimony. *See, Elliott v. Industrial Commission*, 303 Ill.App.3d 185, 707 N.E.2d 228 (1999); *McRae v. Industrial Commission*, 285 Ill.App.3d 448, 674 N.E.2d 512 (1996); *Banks v. Industrial Commission*, 134 Ill.App.3d 312, 480 N.E.2d 139; *Luby v. Industrial Commission*, 82 Ill.2d 353, 412 N.E.2d 439 (1980). Furthermore, when an Arbitrator finds that a petitioner has not been truthful on a particular issue, the Arbitrator may then find the petitioner is not credible as to other issues. *See, Parro v. Industrial Commission*, 167 Ill.2d 385, 657 N.E.2d 882 (1995).

Although the Arbitrator has already provided several bases for finding that the petitioner's condition, subsequent to April 1, 2010, was not causally related to his work injury, the Arbitrator notes certain significant discrepancies in the petitioner's testimony and his medical records; which calls the petitioner's credibility into question.

At the time of trial, the petitioner testified that his current medications were Tylenol and Naproxen and that his Naproxen was being prescribed by Dr. Sierra. He further testified that he had not been medication free since the date of his injury. Subpoenaed medical records from Dr.

Sierra, the Glenbrook Hospital, the St. Mary and Elizabeth Medical Center and the Gold Coast Surgery Center all state that the petitioner is allergic to Naproxen. Additionally, there are no prescriptions contained within Dr. Sierra's subpoenaed records subsequent to October of 2010 when 200 mg of Advil was prescribed for the petitioner. The only other prescription contained within the records is a prescription for Advil and Flexeril written by Dr. Riera on August 18, 2011. The Arbitrator finds it incredible that the petitioner's primary care physician would prescribe a medication, i.e. Naproxen, that the petitioner's medical records clearly stated that he is allergic to and that said prescription would not be contained within his medical records. Although the Arbitrator believes it is probable that the petitioner takes over the counter Tylenol on occasion, she questions his testimony regarding his use of Naproxen.

The petitioner testified that following his motor vehicle accident on September 16, 2009, he was removed from his vehicle by paramedics. Medical records from the Glenbrook hospital state that the petitioner self extracted from his vehicle; they reflect a history that the petitioner climbed out of the window of his vehicle, laid on the ground, and waited for help. Again, the petitioner's credibility is called into question.

The Arbitrator notes that Dr. Erickson's records and his testimony reflect that according to the petitioner, he was limited to brief periods (i.e. five minutes) of standing, walking and sitting. Dr. Erickson also testified that the petitioner had to work in "very brief spurts." The petitioner testified that he was not capable of lifting more than ten (10) pounds, as it put too much pressure on his lower back. The petitioner did testify that he could sit or stand for 4 or 5 hours, if he took Tylenol. The Arbitrator notes that surveillance footage of the petitioner, taken in 2012, evidences him being capable of lifting more than ten (10) pounds, that he is clearly capable of walking and standing for more than five minutes at a time; and that he is capable of working for more than a "brief spurt." The Arbitrator notes that the surveillance footage evidences the petitioner being far more physically capable than his treating physician was led to believe.

The Arbitrator finds that the petitioner failed to prove, by a preponderance of the evidence, that his condition of ill-being subsequent to April of 2010, is causally related to his injury of September 16, 2009. The Arbitrator relies on the testimony of Dr. Andersson and the treating records of Drs. Sierra and Pahwa and finds that the petitioner sustained lumbar, cervical and coccyx strains and contusions as a result of his injury of September 16, 2009. In reaching this conclusion the Arbitrator also takes special notice of the following: 1) the petitioner missed two weeks and one day of work following his accident; 2) the petitioner returned to full duty work and continued working, in a fill duty capacity full duty through the date of his trial, i.e., the evidence reflects that the petitioner was only authorized off work for ten (10) days and was placed on light duty restrictions for a brief period of time; 3) the significant gaps in medical treatment; 4) the inconsistencies contained within the petitioner's testimony and the evidence presented at trial; and, 5) the surveillance footage of the petitioner wherein *inter alia*, he is

fixing a car bending over in the hood, for four to five minutes at a time; laying on the ground under the car for four to five minutes and getting out-from-under the car with no apparent distress. After reviewing the evidence in its entirety, the Arbitrator adopts the opinions of Dr. Andersson and finds no causal connection between the petitioner's condition of ill being subsequent to April 1, 2010 and his injury of September 16, 2009.

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

The petitioner claims that he is entitled to payment of outstanding medical charges in the amount of $54,185.83 for services received from 1) Gold Coast Surgicenter, Michigan Avenue Medical Associates; 2) Archer Open MRI, River North Pain Management Consultants; 3) Premier Therapy; 4) Gray Medical, Preferred Open MRI; and 5) Way Hoo Det Med, SC. The Arbitrator notes that the aforementioned services were incurred by the petitioner subsequent to April 1, 2010. As the Arbitrator finds that there is no causal connection between the petitioner's condition of ill being subsequent to April 1, 2010 and his injury of September 16, 2009, the Arbitrator finds that the respondent is not liable for the payment of the aforementioned medical services.

The invoice from the Rehab Team submitted into evidence at the time of trial reflected a balance of $14,035.00 and the parties stipulated that the respondent had paid $12,373.23 of this invoice and that the respondent believed that Rehab Team's invoice had been paid, in its entirety pursuant to the fee schedule. The parties stipulated that if any portion of Rehab Team's remaining invoice of $1,661.77 remains due and owing. Per the fee schedule the respondent will be liable for the payment of the same.

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

After weighing the evidence in this case, the Arbitrator concludes that the petitioner established that he sustained lumbar, cervical and coccyx contusions and sprains that arose out of and in the course of his employment with the respondent on September 16, 2009. In forming this opinion, the Arbitrator relies upon the opinion of Dr. Gunnar Andersson and the petitioner's medical records. The Arbitrator finds that the petitioner sustained permanent partial disability to the extent of 2% loss of use of a man pursuant to Section 8(d)(2) of the Act. Therefore, the petitioner is entitled to receive a total of ten (10) weeks of permanent partial disability benefits at $213.33 per week.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeff Whitley,

14IWCC0089

Petitioner,

vs.

NO: 11 WC 44162

City of DuQuoin,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 16, 2013 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: FEB 05 2014
KWL/vf
O-1/14/14
42

Daniel R. Donohoo

Thomas J. Tyrrell

DISSENT

I respectfully dissent from the majority's decision affirming and adopting the Arbitrator's decision. I respectfully find that the Arbitrator failed to explain the relevance and weight of the factors for determining the level of permanent partial disability per Section 8.1b.
Pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b (b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerate factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factor used in addition to the level of impairment as reported by the physician must be explained in a written order.

In applying this standard to Petitioner's claim, the Arbitrator awarded Petitioner 25% MAW and noted as follows:

(i): Dr. Petkovich assessed P's level impairment as 9% person as a whole per AMA guidelines.

(ii): Petitioner is employed as a supervisor in water and sewer dept, which is same job he held before.

(iii): Petitioner was 40 years old as of the date of loss.

(iv): Petitioner has returned to his pre-injury job, and no evidence of loss of earning capacity.
(v): Petitioner sustained a C5-6 disc herniation which was addressed via cervical spine fusion at C5-6.
The Arbitrator noted that Petitioner had cervical spine fusion, followed by physical therapy and rehabilitation, then return to work, regular duty, and that an award of 25% man as a whole was warranted. However in reaching his conclusion on nature and extent, the Arbitrator failed to discuss and explain the weight of the factors used in addition to the level of impairment reported by Dr. Petkovich.
Accordingly, I would find these relevant factors and assign weight as follows:

Under subsection (i), only one Section 8.1b report was tendered into evidence. This report authored by Dr. Petkovich, found Petitioner's AMA rating to be 9% impairment of whole person; this evidence is uncontroverted and should be assigned significant weight;

Under subsection (ii), Petitioner was employed as a water & sewer supervisor performing strenuous laboring duties and supervising others. He returned to those same work duties, but with permanent work restrictions of no lifting over 70 lbs per his functional capacity

evaluation and per his surgeon, Dr. Fonn; Petitioner testified that he requires assistance with heavy weights at times; Petitioner's testimony as to his work duties before and after his accident is uncontroverted and corroborated in the medical records: Petitioner is capable of a full duty return to work but with permanent weight restrictions; accordingly, Petitioner's job should have some weight in determining his level of PPD as his condition has somewhat affected his ability to work in a full duty capacity as a working supervisor, and minimal increase in PPD is warranted as Petitioner is able to perform his full duty work albeit with permanent weight lifting restrictions;
Under subsection (iii), there is no dispute Petitioner was 40 years old on the date of accident, this should be assigned some weight as Petitioner is a relatively younger individual, and sustains a PPD moderately greater than that of an older individual because Petitioner will have to live with effects of his injury for a longer period of time.

No evidence was introduced by either party regarding Petitioner's future earning capacity, subsection (iv). Petitioner testified that he returned to his prior position after being released to full duty work by Dr. Fonn. Accordingly no weight should be assigned to this factor as there is no evidence of any impact whatsoever on Petitioner's future earning capacity.

Finally, the treating medical records reflect that Petitioner underwent conservative medical treatment prior to the C5-6 anterior microdiscectomy. Thereafter, Petitioner's cervical condition gradually improved through July 18, 2012, when he was released to full duty work by Dr. Fonn. In conjunction with that release to full duty Petitioner underwent an FCE which placed him at the medium to heavy physical demand level, consistent with his usual occupation; As of Petitioner 's last office visit with Dr. Fonn on July 18, 2012, it was noted Petitioner's exam was unchanged from his prior visit and office exam of June 20, 2012 wherein it was revealed that Petitioner had made good progress in physical therapy, and had increased mobility significantly with substantial reduction in pre-op symptoms; there were normal neurological findings; and Petitioner was pleased with his progress. Petitioner has worked a full duty position since his release on July 18, 2012 and incurred no further medical care since then, that being a period of 9 months. Respondent's section 12 exam conducted on November 8, 2012, found mildly limited cervical spine range of motion consistent with his surgery, Petitioner also had reduced grip strength on the right compared to left, and some decreased sensation to pinprick along volar aspect of Right thumb and radial aspect of the right index finger.

Petitioner testified that he is able to perform his job but notices more difficulty now while lifting things over his head, reduced strength in his dominant right arm, and that he has to watch what he does now. Additionally, there is decreased right hand grip strength and continued numbness in his right thumb, pointer finger, and arm. Petitioner's testimony at trial is uncontroverted, and the Commission should find Petitioner to be credible given the consistency of his testimony with his contemporaneous reports of symptomatology made to both his treating physician, Dr. Fonn, and Respondent's Section 8.1b physician, Dr. Petkovich. Thus, there is credible evidence of some ongoing disability which is corroborated by the treating medical records and should be assigned significant weight.

Based on the record as a whole and in consideration of the factors enumerated in Section 8.1b which requires a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, I would find that Petitioner sustained permanent partial disability to the extent of 17.5% loss of use of the person as a whole pursuant to Section 8(d) (2) of the Act.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0089

WHITLEY, JEFF
Employee/Petitioner

Case# 11WC044162

THE CITY OF DuQUOIN
Employer/Respondent

On 5/16/2013, 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 0.08% 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:

2138 LAW OFFICE OF BRIAN K ZIRKELBACH
1100 WALNUT
PO BOX 687
MURPHYSBORO, IL 62966

0180 EVANS & DIXON LLC
MARILYN C PHILLIPS
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

14IWCC0089

Jeff Whitley
Employee/Petitioner

v.

City of DuQuoin
Employer/Respondent

Case # **11** WC **44162**

Consolidated cases: **none**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Joshua Luskin**, Arbitrator of the Commission, in the city of **Herrin**, on **April 16, 2013**. By stipulation, the parties agree:

On the date of accident, **October 13, 2011**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$53,093.88**, and the average weekly wage was **$1,021.04**.

At the time of injury, Petitioner was **40** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of **$19,290.41** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$19,290.41**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $**612.62** per week for **125** weeks, because the injuries sustained caused 25% loss of use of petitioner's body as a whole as provided in Section **8(d)(2)** of the Act.

Respondent shall pay Petitioner compensation that has accrued from July 18, 2012 (MMI) through the present, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

May 14, 2013
Date

MAY 16 2013

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JEFF WHITLEY,	)	
	)	14IWCC0089
Petitioner,	)	
	)	
vs.	)	No. 11 WC 44162
	)	
THE CITY OF DUQUOIN,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

The petitioner is a water and sewer department supervisor for the respondent. As part of his job, he helps repair water main leaks and landscaping. He injured his cervical spine on October 13, 2011, when a backhoe he was driving got stuck in mud, causing him to strike his head on the top of the cab. Accident was not disputed.

The petitioner testified that after the accident he experienced progressive pain from his neck into his right arm. An MRI of the cervical spine found a right-side disc herniation at C5-6 with nerve compression. PX1. The petitioner saw a neurosurgeon, Dr. Fonn. See generally PX2. After epidural injections were not successful in relieving the symptoms, Dr. Fonn performed C5-6 cervical fusion surgery on January 6, 2012.

The petitioner underwent postoperative physical therapy. On July 3, 2012, a functional capacity evaluation found the petitioner able to perform medium to heavy work, consisntent with his usual occupation. PX3. On July 18, 2012, Dr. Fonn released the petitioner to return to work per the FCE and placed him at MMI. PX2.

The respondent secured an AMA ratings report from Dr. Petkovich, an orthopedic surgeon, on November 8, 2012. See generally RX1. Following examination, Dr. Petkovich assessed the claimant with an AMA impairment rating of 9%.

The parties agreed that medical bills and temporary disability benefits had been paid. The petitioner testified that he was off work following the accident until May 20, 2012, when he returned to work. At the time of trial, he had resumed work in his pre-injury job capacity. He described some subjective limits due to perceived weakness in his right arm, but acknowledged that he was performing his regular job duties without changes to the job requirements.

OPINION AND ORDER

Pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b(b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records.

Applying this standard to this claim, the Arbitrator notes as follows:

(a) Dr. Petkovich assessed the claimant's level of impairment as 9% pursuant to the AMA guidelines of permanent impairment;

(b) The petitioner works as a supervisor in the water and sewer department. This is the same job he held before the injury;

(c) The petitioner was 40 years old at the time of the injury;

(d) The petitioner has returned to his preinjury occupation and there was no evidence presented indicating loss of earning capacity;

(e) The petitioner sustained a C5-6 disc herniation which was addressed via cervical spine fusion at C5-6.

The petitioner's work-related accident resulted in cervical spine fusion surgery; following physical therapy and rehabilitation, he returned to his regular job duties. Considering the enumerated factors and the evidence submitted, the arbitrator finds that as the petitioner has reached maximum medical improvement, the respondent shall pay the petitioner the sum of $612.62/week for a further period of 125 weeks, as provided in Section 8(d)2 of the Act, as the injuries sustained caused permanent loss to the petitioner's whole body to the extent of 25% thereof.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Donald Michael Malcolm,

Petitioner,

14IWCC0090

vs.

NO: 11 WC 20668

Pickneyville Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, prospective medical care, temporary total disability benefits, and permanency, 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.

After a complete review of the record, the Commission finds that while Petitioner's left knee condition was not caused by the August 25, 2010 accident, it was aggravated by the work accident to the point where Petitioner required surgical treatment. The Commission notes that the record indicates that Petitioner did not suffer from any left knee pain or problems prior to August 25, 2010. The Commission further notes that Petitioner's history of the accident has been consistent throughout, as have been his complaints of ongoing left knee pain following the August 25, 2010 accident. (PX2,PX4,RX6) The February 14, 2011 left knee MRI, taken after Petitioner came under the care of Dr. Freehill, showed moderate diffuse patellofemoral chondromalacia with mild contusion or inflammation of the adjacent Hoffa's fat pad, mild semimembranosus tendinosis with a 9mm soft tissue ganglion at its tibial insertion, and minimal Baker's cyst. (PX5) The Commission finds that while these findings are degenerative in nature, as noted by Respondent's Section 12 examiner, Dr. Kostman (RX6), they were clearly asymptomatic until the August 25, 2010 accident.

During her November 29, 2011, evidence deposition, Dr. Freehill explained that "[r]ecalcitrant femoral pain that does not get better after extensive treatment I think is, you know, indicates that you should do surgery. My thinking is that his causation occurred from his injury. I have no knowledge of prior antecedent knee pain before his injury. So my thought would be he had this twisting injury and a fall causing him to have knee pain." (PX8-pg.16) Dr. Freehill then corrected part of her testimony by acknowledging that the accident did not involve a fall and still found the work accident to be the basis for Petitioner's need for surgery. (PX8-pg.17) At her August 21, 2012 evidence deposition, Dr. Freehill explained, in more detail, why Petitioner's condition is causally related to the August 25, 2011 accident: "the injury that he sustained did not cause the medial plica. Medial plica is something that occurs. It's an anatomic variable, and it is not caused by trauma, but pain in the knee is more subjective, and he had no prior pain. He described an injury that occurred, and then he developed this pain syndrome. I think there's certainly evidence on his trochlea, which is the femoral side, where there was injury or damage there. I can't tell, again, if this is degenerative or if it's actually traumatically related, but I can say, based on the medical certainty, that he had damage that was consistent with his symptoms. He had symptoms that occurred after the injury. So, based on my experience, the injury probably caused the symptoms." (PX9-pg.11-12) On cross-examination, Dr. Freehill testified that she was not attributing Petitioner's chondromalacia to the August 25, 2010 accident, but was attributing Petitioner's symptomatology from the chondromalacia and knee pain "that's unremitting" to the accident "based on his injury." (PX9-pg.19)

The Commission notes that all three doctors involved in this case (Dr. Chow, Dr. Freehill, and Dr. Kostman) agree that Petitioner's left knee condition pre-existed the August 25, 2010 accident. As noted above, the left knee MRI shows degenerative changes in the left knee. However, the Commission notes that the record supports Dr. Freehill's finding that the accident caused the pre-existing condition to become symptomatic. As previously noted, Petitioner did not suffer from any left knee problems prior to August 25, 2010. Following the accident, Petitioner continued to have left knee pain and did not receive substantial relief from that pain until he underwent left knee surgery on January 9, 2012. (PX1,PX7,T.18-19) The Commission does not feel that Petitioner's ability to continue working full duty, as well as hunt, following the August 25, 2010 accident indicates that Petitioner did not continue to have left knee pain following the work accident. The Commission also notes that while Petitioner testified that he still has occasional left knee pain, he also testified that his current occasional pain does not compare to the pain he had following the August 25, 2011 accident and prior to his January 9, 2012 surgery. (T.18-19) Therefore, based on the overall record, the Commission finds that Petitioner has established that his left knee condition following the August 25, 2011 accident and the need for surgery are causally related to the August 25, 2010 work accident.

Based on the above finding, the Commission finds that Petitioner is entitled to payment of his outstanding medical bills for treatment of his left knee, totaling $20,961.96. The Commission further finds that Petitioner was temporarily totally disabled from January 9, 2012 through January 17, 2012. However, based on Section 8(b) of the Act, payment of temporary total disability benefits shall begin on the fourth day of such temporary total incapacity when the period of temporary total disability exceeds three day, but does not surpass thirteen days. Therefore, the Commission finds that Petitioner is entitled to temporary total disability benefits for 6/7 week, from January 12, 2012 through January 17, 2012.

Regarding permanency, the Commission notes that Petitioner has had an excellent recovery from surgery and that he has returned to work, full duty. The Commission further notes that Petitioner testified that his left knee now bothers him only "once in a while." (T.19) Based on the totality of the evidence, the Commission finds that Petitioner has established a loss of 10% loss of use of the left leg.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on February 13, 2013, 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 $933.87, in temporary total disability benefits, from January 9, 2012 through January 17, 2012, less the three day waiting period, 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 $20,961.96 for medical expenses under Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 21.5 weeks, as provided in Section 8(e)(12) of the Act, for the reason that the injuries sustained caused the 10% 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.

DATED: FEB 10 2014
DRD/ell
o-01/23/14
68

Daniel R. Donohoo

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

14IWCC0090

MALCOLM, DONALD MICHAEL Case# **11WC020668**
Employee/Petitioner

PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

On 2/13/2013, 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 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1580 BECKER SCHROADER & CHAPMAN PC
TODD J SCHROADER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0558 ASSISTANT ATTORNEY GENERAL
FARRAH L HAGAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

FEB 13 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

14IWCC0090

☐ 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

Donald Michael Malcolm
Employee/Petitioner

v.

Pinckneyville Correctional Center
Employer/Respondent

Case # 11 WC 20668

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Herrin**, on **November 19, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 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* sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned **$84,982.00**; the average weekly wage was **$1,634.27**.

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

Respondent is entitled to a credit for all payments made by group under Section 8(j) of the Act.

ORDER

Petitioner sustained a left knee strain from the accident of August 25, 2010. As such, Petitioner is entitled to 5% loss of use of the left leg under Section 8(e) of the Act.

Respondent shall pay Petitioner the sum of **$669.64**/week for a further period of **10.75** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused: **5% loss of use of the left leg.**

Respondent shall pay for reasonable and necessary medical bills as outlined in Petitioner's Exhibit #11 from the date of accident to April 12, 2011. The medical bills incurred after April 12, 2011, are found not related to the accident of August 25, 2010. Respondent shall receive a credit for all medical bills previously paid, including any bills paid by group health. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. The dates of service after April 12, 2011, are found not related.

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

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

Signature of Arbitrator

2/5/13
Date

FEB 13 2013

14IWCC0090

Findings of Fact

Petitioner is a 49 year-old correctional major at Pinckneyville Correctional Center. Petitioner alleged a date of accident of August 25, 2010, for injuries sustained to his left knee as a result of escorting a combative inmate to segregation. The case proceeded to hearing on all issues before Arbitrator Gerald Granada on November 19, 2012. The issues at trial were causation, medical bills, temporary total disability benefits, and nature and extent.

On September 2, 2010, Petitioner was seen at Dr. Chow's office. Petitioner stated that both ECTR's had been successful. The tingling and numb sensation had gone away. Petitioner was fully recovered. He had nice strength without difficulty. Petitioner was released from the office. Petitioner was to return only when needed.

On September 9, 2010, Petitioner presented to Dr. James Chow at James Chow, M.D., LTD d/b/a Orthopaedic Center of Southern Illinois for an orthopedic evaluation regarding the left knee. Petitioner reported that he injured himself while on duty on August 25, 2010. Petitioner reported that he wrestled an inmate back into the cell. The hands were cuffed, and inmate was resistant, so Petitioner had to force him to go into the cell. After that, Petitioner reported he experienced pain in the left knee joint. Petitioner reported that the pain persisted for the last two weeks. Petitioner reported that he had a right ACL injury two years ago after falling out of a tree. He did not have surgery. Petitioner reported that the left knee never had any problems in the past. Petitioner had no tenderness in the joint line. Petitioner pointed towards the medial side of the patella. Forcing the knee joint to full extension did not create pain. McMurray's examination was negative. Lachman's sign, pivot test, reversed pivot test were negative. Pressing the patella against the femoral condyle did not create crepitation or pain. Petitioner reported that he had an ACL injury in the right knee that Dr. Freehill had previously evaluated and suggested surgery, and Petitioner decided to go without the surgery. Dr. Chow noted that following the examination for the left knee joint, his concern was soft tissue injury. There was no joint instability and no signs of internal derangement of the knee joint. Dr. Chow recommended time to see how it goes. Petitioner continued to work full duty, and Dr. Chow believed he could continue his work. Petitioner was to follow-up in three weeks.

On September 25, 2010, Petitioner returned to Dr. Chow. Petitioner reported that the pain in his left knee was still present at the superior medial corner of the medial femoral condyle. Range of motion was quite free. The swelling had gone down. Petitioner had pain in the superior medial corner of the medial side of the patella at the medial femoral condyle. There was a little crepitation able to be palpated with pain. After the examination, it was believed that Petitioner may have right now been suffering from plica issues in the left knee. Conservative treatment was recommended.

On October 6, 2010, Petitioner presented to Physical Rehabilitation Center for physical therapy of his left knee.

On October 14, 2010, Petitioner returned to Dr. Chow. Petitioner reported that he had pain down the left knee. Dr. Chow believed it was plica pain. Dr. Chow noted that this was getting somewhat better. Movement of the knee joint was quite free. The swelling had gone down. Petitioner was able to ambulate. Petitioner was to return in one month for follow-up. Petitioner told Dr. Chow that he had been climbing trees. Dr. Chow noted that no wonder the knee was irritated a little bit. Dr. Chow told Petitioner to lighten up his activities.

On November 16, 2010, Petitioner returned to Dr. Chow. His left knee pain continued. Dr. Chow noted that this was like plica syndrome at the anteriomedial side of the left knee. Dr. Chow noted that he was able to palpate the plica and this bothered Petitioner. Petitioner was given anti-inflammatory medication.

On February 1, 2011, Petitioner presented to Dr. Angela Freehill for a chief complaint of left knee pain. Petitioner reported that he was wrestling an inmate back into his cell on August 25, 2010, when he sustained injuries to his left knee. Petitioner reported that he experienced pain to his left knee. He saw Dr. Chow who recommended conservative management. Petitioner reported that his knee was not getting better. He was still having pain at the anterior medial aspect of the kneecap. He had no pain posteriorly. He had no instability. Petitioner had no effusion in the knee. He exhibited full extension and flexion to 120 degrees. Petitioner had tenderness to the medial facet to the patella. He had a medial patellofemoral ligament that was sore. Dr. Freehill could palpate a reproducible popping sensation in the knee. X-rays obtained in September were reviewed which showed no evidence of arthritis. He did have irregularity of the patellofemoral joint specifically on the sunrise view. Dr. Freehill's impression was that Petitioner had either medial plica syndrome or possibly medial meniscus changes. Dr. Freehill recommended a MRI of the knee.

On February 14, 2011, Petitioner underwent a MRI of the left knee which revealed the following: 1) moderate diffuse patellofemoral chondromalacia with mild contusion or inflammation of the adjacent Hoffa's fat pad; 2) mild semimembranosus tendinosis with a 9 mm soft tissue ganglion at its tibial insertion; and 3) minimal Baker's cyst.

On March 1, 2011, Petitioner returned to Dr. Freehill for follow-up for his left knee. Examination reviewed a small effusion in the knee. He was tender right at the medial facet of the patella and medial plica region. Dr. Freehill reviewed the MRI which revealed no evidence of meniscus tear. Petitioner had some inflammation of Hoffa fat pad as well as the medial patellofemoral ligament right at the insertion at the medial facet of the patella. Petitioner was given a cortisone injection. Dr. Freehill's impression was left knee medial plica syndrome and inflammation. Petitioner was started on Naprosyn. Petitioner was started physical therapy. He was to return in six weeks for a clinical check. Petitioner was to continue working normal duty at work.

On March 8, 2011, Petitioner presented to physical therapy for a chief complaint of left knee pain, mostly in the medial patella region. Petitioner reported minimal swelling to the knee and 0/10 pain at rest with occasional sharp popping in the knee/calf area rated 5/10. Petitioner reported pain was worse with standing after prolonged sitting and ascending and descending stairs. Observation of the left knee revealed no swelling.

On March 10, 2011, Petitioner presented to physical therapy and reported no pain for his left knee.

On March 15, 2011, Petitioner presented to physical therapy. He reported some increasing pain yesterday with his left knee. He reported that he did a lot of yard work on Sunday, bending over to do the work. Petitioner reported that he also went fishing that day and while he was walking, he tripped and fell. He rated his left knee pain as a 3/10 on the pain scale.

On March 22, 2011, Petitioner reported to the physical therapist that he was having increased pain with prolonged sitting, reaching 2-3/10.

On April 12, 2011, Petitioner returned to Dr. Freehill. Petitioner reported that the injection made him pain free for about a week. Petitioner reported that his knee pain had recurred. He reported pain at the anteromedial aspect of the knee. It bothered him when he has his knee bent for long periods of time. It does not bother him at nighttime. Petitioner wanted to do the most aggressive thing to try and get rid of his pain. Examination revealed small effusion in the knee and tenderness at the medial facet of the patella as well as the medial plica region. Petitioner was assessed with left knee medial plica syndrome and patellofemoral pain which was

unresponsive to conservative management. Dr. Freehill noted that at that point, the only more aggressive option remaining was surgical arthroscopy with plica excision and debridement of the knee patellofemoral lesions. Dr. Freehill noted that they would submit the surgical request to workers' compensation.

On July 13, 2011, Petitioner was seen by Dr. W. Chris Kostman for an independent medical examination for his left knee. Petitioner reported that he may favor his left knee due to his prior right knee injury from 2008 which resulted in an ACL tear after falling from setting up a tree stand. Dr. Kostman diagnosed Petitioner with a left knee strain following a twisting injury. Dr. Kostman opined that Petitioner's current knee condition was related to his underlying patellofemoral degenerative arthritis and chondromalacia and to a lesser degree the medial joint line degenerative change. Petitioner reported that he continued to climb trees, both with a tree climbing pole as he described to assist him in climbing trees and also up ladders for deer hunting as recently as November of last year. He reported no difficulty when climbing for his recreational activities. Dr. Kostman believed treatment could be directed to Petitioner's underlying degenerative arthritis. Dr. Kostman opined that there was no evidence of a patellofemoral plica, and he did not believe Petitioner's findings were consistent with patellofemoral plica. Dr. Kostman did not recommend any further treatment from the August 25, 2010, incident. Dr. Kostman placed Petitioner at maximum medical improvement with respect to the incident of August 25, 2010.

On November 29, 2011, Petitioner returned to Dr. Freehill. Petitioner wanted to proceed with surgery under his own insurance.

On December 20, 2011, Petitioner returned to Dr. Freehill with left knee pain. He had left knee medial plica as well as medial meniscus pain. Surgery was denied by workers' compensation, and Petitioner wanted to proceed with surgery through his own insurance. Dr. Freehill recommended a surgical arthroscopy, partial medial meniscectomy as well as possible medial plica excision. Petitioner was to return one week after surgery.

On January 9, 2012, Dr. Freehill performed surgery on Petitioner's left knee at Good Samaritan Regional Health Center. The operation was a left knee arthroscopy, left knee arthroscopic medial plica excision and left knee arthroscopic trochlear groove chondroplasty. The post-operative diagnoses included a large fibrous band-like medial plica; Grade 3 chondromalacia of the trochlea and Grade 1 chondromalacia of the patella. There was no evidence of medial meniscus tear.

On January 17, 2012, Petitioner returned to Dr. Freehill. He was one week status post left knee arthroscopy and arthroscopic medial plica excision and trochlear groove chondroplasty. He was doing well. He was not having any great deal of difficulty. Dr. Freehill noted that Petitioner had Grade IV chondromalacia of the trochlea. Petitioner was to return in one month for a clinical check. Physical therapy was ordered. Petitioner was returned to regular duty as of January 18, 2012.

On January 18, 2012, Petitioner underwent a duplex Doppler venous ultrasound of the left lower extremity for left lower extremity swelling. The testing was unremarkable for deep venous thrombosis.

On February 17, 2012, Petitioner returned to Dr. Freehill five weeks status post surgery to his left knee. He was doing well. He was having no pain. Petitioner had been doing some remodeling of his house and having not as much difficulty with that either. Petitioner was to continue on home exercise program. He was doing really well. Petitioner was to do activities as tolerated. He was to return on a p.r.n. basis.

On March 7, 2012, Dr. Kostman's deposition was taken. Dr. Kostman noted that the September 9, 2010, note from Dr. Chow did not revealed anything on physical exam findings to reveal a plica syndrome. Specifically, Dr. Kostman testified that Dr. Chow's note did not note patellofemoral pain on exam. Dr. Kostman noted that x-rays were taken at his office which revealed degenerative change to the patellofemoral joint.

On May 23, 2012, Dr. Kostman reviewed additional medical records from Dr. Freehill, including the operative report of January 9, 2012. Dr. Kostman opined that after reviewing the additional medical records, he did not believe the need for surgery was related to the claim of August 25, 2010. Dr. Kostman noted that the findings during arthroscopy of 1/9/12 included medial plica and chondromalacia of the trochlea groove, which he believed were unrelated to the incident of August 25, 2010. Dr. Kostman did not believe that Petitioner's exam findings were consistent with or his imaging studies were consistent with patellofemoral plica. Therefore, he did not agree with Dr. Freehill's surgical recommendation.

Petitioner continued to work following the August 25, 2010, incident. He only missed nine days of work following the surgery in January 2012.

Therefore, the Arbitrator concludes the following:

1. Petitioner's left knee strain is related to the incident on August 25, 2010. As such, Petitioner is entitled to 5% loss of use of the left leg under Section 8(e) of the Act. Petitioner's plica syndrome and chondromalacia are not related to the August 25, 2010, incident at work. The surgery performed by Dr. Freehill is not related to the August 25, 2010, incident at work. The Arbitrator found the medical records from Dr. Chow and the opinions of Dr. Kostman persuasive in this regard.

2. Respondent shall pay for reasonable and necessary medical bills as outlined in Petitioner's Exhibit #11 from the date of accident to April 12, 2011. The medical bills incurred after April 12, 2011, are found not related to the accident of August 25, 2010. Respondent shall receive a credit for all medical bills previously paid, including any bills paid by group health. Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. The dates of service after April 12, 2011, are found not related.

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

Kenneth R. Wentz,

Petitioner,

vs.

NO: 10 WC 01279
14 IWCC 0091

Truck Centers Inc.,

Respondent.

CORRECTED 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 penalties and attorney's fees, modifies the Decision of the Arbitrator as stated below, and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes that the Arbitrator denied Petitioner's Petition for Penalties and Attorney's Fees, finding that Respondent's termination of Petitioner's weekly benefits on February 29, 2012, was not unreasonable or vexatious. The Arbitrator noted that Petitioner had admitted at hearing that he had driven to Wyoming "for the sole purpose of alleviating apparent boredom." (Arb.Dec.7,T.36-37) This contradicted Petitioner's earlier testimony that he drives only when necessary. (T.34-35,62) However, the Commission notes that Petitioner's undisputed testimony also shows that Petitioner's job required him to have a CDL license and B license, not just a basic driver's license, in order to perform his job for Respondent. (T.15-16) The Commission finds that Petitioner's ability to pass a basic driver's license vision test for a basic driver's license test in January 2012 does not mean the medical restriction on his driving had been lifted or that Petitioner can or has regained his CDL license. More importantly, the Commission finds that Petitioner's ability to pass a basic vision test for a driver's license does not mean that Petitioner's visual impairment has changed in any way.

As noted by Petitioner in his Statement of Exceptions and Supporting Brief, the "fact that

Petitioner had a valid driver's license does not negate the medical opinions that because of his permanent vision loss Petitioner cannot return to his job as a commercial driver." (Petitioner's Brief,pg.16) The Commission also notes that there are no restrictions on Petitioner's driving his personal vehicle. Based on the above, the Commission finds Respondent's decision to terminate Petitioner's benefits based on Petitioner's getting his driver's license erroneous, but not unreasonable or vexatious. Therefore, the Commission awards penalties pursuant to §19(l) of the Act. As explained by the Illinois Supreme Court in *McMahan v. Industrial Commission*, 182 Ill.2d 499, 515 (1998),

> "The additional compensation authorized by section 19(l) is in the nature of a late fee. The statute applies whenever the employer or its carrier simply fails, neglects, or refuses to make payment or unreasonably delays payment 'without good and just cause.' If the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay, an award of the statutorily specified additional compensation is mandatory."

As explained above, Petitioner's ability to renew his regular driver's license is not, in the Commission's view, a "good and just cause" to terminate Petitioner's weekly benefits since what Petitioner required to work was a CDL license, not the regular driver's license he obtained. Furthermore, as previously noted, Petitioner has not been restricted from driving, even though his doctor has recommended that he not do so. Therefore, the Commission reverses the Arbitrator's denial of Petitioner's Petition for Penalties and Attorney's fees and awards penalties under §19(l) from February 25, 2012 through September 25, 2012, the date of hearing, totaling $6,390.00.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on November 1, 2012, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $206.67 per week for a period of 21-6/7 weeks, from May 14, 2009 through October 27, 2009, 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 $461.78 per week for a period of 151-4/7 weeks, commencing October 28, 2009, through September 25, 2012, the date of hearing, and then ongoing for life, as provided in §8(f) of the Act, because he is permanently and totally disabled, and said payment shall continue weekly so long as Petitioner remains permanently and totally disabled.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay

reasonable and necessary medical expenses, as provided in §8(a) and §8.2 of the Act. (See Memorandum of Decision of Arbitrator and Petitioner's Exhibit 15 for detailed analysis thereto.)

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner $6,390.00, pursuant to §19(l) of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 6 2014
DRD/ell
o-01/23/14
68

Daniel R. Donohoo

David L. Gore

Mario Basurto

State of Illinois)
)ss.
County of Madison)

Before the Illinois Workers' Compensation Commission

Kenneth R. Wentz,
Petitioner,

vs.

No. 10WC01279
14IWCC0091

Truck Centers, Inc.,
Respondent.

ORDER

The Commission on its own Motion recalls the Decision and Opinion on Review of the Illinois Worker's Compensation Commission under Section 19(f) of the Act for the above-captioned case dated February 10, 2014.

The Commission is of the opinion that the Commission's Decision and Opinion on Review should be recalled and corrected due to a clerical error. The order regarding the Rate Adjustment fund was omitted and the description box on the decision was incorrectly marked "None of the Above" instead of "Rate Adjustment Fund".

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision and Opinion on Review dated February 10, 2014 is hereby recalled and a corrected decision issued simultaneously. The parties should return the February 10, 2014 decisions to Commissioner Michael J. Brennan.

Dated: FEB 2 6 2014

Daniel R. Donohoo

David L. Gore

Mario Basurto

DRD:bjg
0-1/23/2014
052

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

Kenneth R. Wentz,

Petitioner,

14IWCC0091

vs.

NO: 10 WC 01279

Truck Centers Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of penalties and attorney's fees, modifies the Decision of the Arbitrator as stated below, and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes that the Arbitrator denied Petitioner's Petition for Penalties and Attorney's Fees, finding that Respondent's termination of Petitioner's weekly benefits on February 29, 2012, was not unreasonable or vexatious. The Arbitrator noted that Petitioner had admitted at hearing that he had driven to Wyoming "for the sole purpose of alleviating apparent boredom." (Arb.Dec.7,T.36-37) This contradicted Petitioner's earlier testimony that he drives only when necessary. (T.34-35,62) However, the Commission notes that Petitioner's undisputed testimony also shows that Petitioner's job required him to have a CDL license and B license, not just a basic driver's license, in order to perform his job for Respondent. (T.15-16) The Commission finds that Petitioner's ability to pass a basic driver's license vision test for a basic driver's license test in January 2012 does not mean the medical restriction on his driving had been lifted or that Petitioner can or has regained his CDL license. More importantly, the Commission finds that Petitioner's ability to pass a basic vision test for a driver's license does not mean that Petitioner's visual impairment has changed in any way.

As noted by Petitioner in his Statement of Exceptions and Supporting Brief, the "fact that

Petitioner had a valid driver's license does not negate the medical opinions that because of his permanent vision loss Petitioner cannot return to his job as a commercial driver." (Petitioner's Brief,pg.16) The Commission also notes that there are no restrictions on Petitioner's driving his personal vehicle. Based on the above, the Commission finds Respondent's decision to terminate Petitioner's benefits based on Petitioner's getting his driver's license erroneous, but not unreasonable or vexatious. Therefore, the Commission awards penalties pursuant to §19(l) of the Act. As explained by the Illinois Supreme Court in *McMahan v. Industrial Commission*, 182 Ill.2d 499, 515 (1998),

> "The additional compensation authorized by section 19(l) is in the nature of a late fee. The statute applies whenever the employer or its carrier simply fails, neglects, or refuses to make payment or unreasonably delays payment 'without good and just cause.' If the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay, an award of the statutorily specified additional compensation is mandatory."

As explained above, Petitioner's ability to renew his regular driver's license is not, in the Commission's view, a "good and just cause" to terminate Petitioner's weekly benefits since what Petitioner required to work was a CDL license, not the regular driver's license he obtained. Furthermore, as previously noted, Petitioner has not been restricted from driving, even though his doctor has recommended that he not do so. Therefore, the Commission reverses the Arbitrator's denial of Petitioner's Petition for Penalties and Attorney's fees and awards penalties under §19(l) from February 25, 2012 through September 25, 2012, the date of hearing, totaling $6,390.00.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on November 1, 2012, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $206.67 per week for a period of 21-6/7 weeks, from May 14, 2009 through October 27, 2009, 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 $461.78 per week for a period of 151-4/7 weeks, commencing October 28, 2009, through September 25, 2012, the date of hearing, and then ongoing for life, as provided in §8(f) of the Act, because he is permanently and totally disabled, and said payment shall continue weekly so long as Petitioner remains permanently and totally disabled.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical expenses, as provided in §8(a) and §8.2 of the Act. (See Memorandum of Decision of Arbitrator and Petitioner's Exhibit 15 for detailed analysis thereto.)

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

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$6,390.00, pursuant to §19(l) of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 10 2014
DRD/ell
o-01/23/14
68

Daniel R. Donohoo

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0091

WENTZ, KENNETH R
Employee/Petitioner

Case# **10WC001279**

TRUCK CENTERS INC
Employer/Respondent

On 11/1/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.16% 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:

4599 SCHUCHAT COOK & WERNER
CLARE R BEHRLE
1221 LOCUST ST 2ND FL
ST LOUIS, MO 63103-2378

2250 LAW OFFICES OF STEPHEN LARSON
RHONDA KATTLEMAN
940 W PORT PLZ SUITE 208
ST LOUIS, MO 63146

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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

KENNETH R. WENTZ
Employee/Petitioner

v.

TRUCK CENTERS, INC.
Employer/Respondent

Case # 10 WC 1279

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 **Brandon J. Zanotti**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 25, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **01/29/09**, 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 **$13,000.00**; the average weekly wage was **$250.00**

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

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

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

Respondent shall be given a credit of **$48,514.46** for TTD, maintenance and permanency, for a total credit of **$48,514.46**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act. Respondent agreed to be responsible for causally related medical bills pursuant to the fee schedule. The parties agreed that Section 8(j) rights were not waived by Respondent.

ORDER

Respondent shall pay reasonable and necessary medical services, as provided in Section 8(a) of the Act, and subject to the medical fee schedule, Section 8.2 of the Act. (See Memorandum of Decision of Arbitrator and Petitioner's Exhibit 15 for detailed analysis thereto).

Respondent shall pay Petitioner temporary total disability benefits of $206.67/week for 21 6/7 weeks, commencing May 14, 2009 through October 27, 2009, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner $461.78 per week, for life, for 151 4/7 weeks, commencing on October 28, 2009, through the date of hearing, September 25, 2012, and ongoing, as provided by Section 8(f) of the Act, because he is permanently and totally disabled, and said payment shall continue weekly so long as Petitioner remains permanently and totally disabled.

Penalties and attorneys' fees pursuant to Sections 19(k) and 16 of the Act are hereby denied.

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

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

Signature of Arbitrator

11/01/2012
Date

NOV - 1 2012

14IWCC0091

STATE OF ILLINOIS)
)SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KENNETH R. WENTZ
Employee/Petitioner

v. Case # 10 WC 1279

TRUCK CENTERS, INC.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Respondent, Truck Centers, Inc., is a dealership which specializes in the sales of commercial trucks and tractor trailers. Petitioner, Kenneth R. Wentz, was working for Respondent as a casual driver when on January 29, 2009, he was walking across the dealership when a matt he stepped on slipped out from under him because of a wet floor. He fell, injuring his left shoulder. Petitioner began treating with Dr. Markenson, a physician who has treated him in the past for orthopedic problems. Dr. Markenson diagnosed a left rotator cuff tear and recommended surgery.

Prior to his work injury, Petitioner was thought to have a medical condition, a bleeding disorder, called Von Willibrands Disease. Because of a concern with proceeding to surgery with this condition, Dr. Markenson consulted with Dr. Gu at St. Louis Oncology Associates. It was recommended that Petitioner be given a medication, Factor VIII, to try to counter-act any excessive bleeding Petitioner might have from surgery as a result of the Von Willibrands Disease. Factor VIII is designed to provide a clotting agent.

Petitioner continued to work with Respondent until Dr. Markenson performed rotator cuff surgery on Petitioner's left shoulder on May 14, 2009 at St. Anthony's Medical Center. (Petitioner's Exhibit (PX) 6). When Petitioner woke up from surgery he testified he could not see – his vision was lost. He ultimately came to understand that the Factor VIII medication he was given led to a stroke which affected the part of his brain relating to his eyesight. Shortly after the surgery, he had a second stroke. Following the second stroke, his central vision returned but he was left without peripheral vision in both eyes. Following the initial surgery, Petitioner had to make four visits to St. Elizabeth's Hospital on May 27, 2009, May 31, 2009, June 21, 2009 and June 24, 2009. (PX 10).

Petitioner has seen a number of eye doctors in reference to his lost vision. All of them have advised him that his vision loss is permanent and there is no additional medical treatment to bring it back. Dr. Joan Pernoud, Respondent's examining physician, recommended a pair of specialized glasses following his last visit to her. (PX 13). Petitioner did have these glasses made and he feels that they have helped him somewhat, especially with his headache problems. They have not, however, restored his vision. Petitioner admits that all of the doctors have advised him against driving.

Petitioner testified that he does continue to drive on a limited basis. He does so because he lives alone in a very rural area, surrounded by farms, in which there is no public transportation near him. He relies on neighbors and friends to help him with transportation, but when they are not available, he drives himself. He limits his driving and does not drive at night. He testified he drives around the area up to 50 miles only when necessary. An occasion when he drives is when he has to go to the store. He drove a couple of weeks prior to trial to pick up his new prescription glasses in Belleville, Illinois.

Petitioner drove to Wyoming in 2011. The trip took about four days and once he was there he turned around and came back. Petitioner testified that he did this because he was "bored to death." Petitioner testified that he has also occasionally ridden his motor cycle but it has been over a year since he rode it last. He testified that motorcycles have always been a hobby for him. Petitioner testified that he is always very concerned and nervous when he drives because of his lack of peripheral vision.

Following his surgery, Petitioner did not return to his driving job with Respondent. While the company was trying to determine if they had any permanent work to offer him, Petitioner worked in the office for four days filing invoices. Petitioner testified to the difficulties he had doing this work. He suffered from headaches and any reading he did took twice as long. No additional work, either temporary or permanent, was offered to Petitioner by Respondent. Petitioner has not worked for anyone else, nor has he looked for work with anyone else. He does not know what sort of work he can perform since his professional driving career is over. Petitioner no longer has a CDL, or commercial driver's license. and would not be able to pass the physical examination. He needs this to drive commercially. Petitioner has never been offered any transportation assistance by Respondent, nor has he ever been offered vocational assistance.

After Petitioner last worked for Respondent, he began receiving checks on a weekly basis. Initially, Respondent paid Petitioner at the temporary total disability (TTD) rate of $206.67. Starting on October 27, 2010, Respondent began paying Petitioner at the permanent total disability (PTD) rate of $461.78. (RX 1). Ronda Wesemann, Respondent's human resources director who handles workers' compensation matters, was called at trial by Petitioner and testified. After paying through February 24, 2012, Respondent terminated the weekly payments because Respondent learned Petitioner had passed his driver's test. Petitioner testified that he got his driver's license renewed in January 2012. Petitioner testified he had to renew his driver's license because he had to have some form of transportation.

Ms. Wesemann testified that she was aware Petitioner had limited vision following the incident with his surgery, but was not aware of the exact medical diagnosis. She testified that many conversations took place about returning Petitioner to work in some fashion, including driving, but that Respondent's attorney advised against returning Petitioner to work in a driving capacity. Ms. Wesemann testified that she and others with Respondent heard that Petitioner was driving and had a license after it was determined that he could no longer drive for a career, but that they did not hear this from Petitioner himself. She testified that once Respondent's insurance carrier learned Petitioner was indeed driving, his benefits were terminated.

Petitioner has been receiving social security disability benefits (SSDI) since approximately 1991 because of orthopedic problems with his legs. From 1991 until 2003, he did not work at all because of these physical problems. The SSDI benefits he receives is his sole amount of support in addition to a pension in the amount of $64.67 per month from a prior employer. He was receiving SSDI benefits before he began working for Respondent in 2003, and Respondent was aware of this fact. His SSDI benefits were the type that allowed him to work a certain number of hours each month. Petitioner was working with Respondent because he could not financially survive on his SSDI benefits and small pension alone. Since his workers' compensation payments were cut, Petitioner testified he has been under an extreme hardship. He cannot pay for his living expenses, his mortgage, or his taxes, and has had to borrow money from friends and family. He estimates he has borrowed approximately $7,000.00 so far, and he has been told that he has reached his limit in what he can borrow.

Petitioner never graduated high school and does not have a GED. All of his adult work life has been performing jobs such as mechanic and truck driver. He holds no specialized training or special certificates.

Petitioner testified that the shoulder surgery performed by Dr. Markenson was a success and he no longer has problems with pain and function in the shoulder as he did prior to the surgery. He does not believe that his left shoulder is limiting his ability to work; rather it is his vision problems. Petitioner complains of ongoing headaches ever since his stroke, as well as memory problems. It is very difficult for him to read and it takes him longer to read, and the longer it takes can result in headaches. He has to twist his head to the side to see, making it difficult to drive. Petitioner takes medications for his cholesterol levels and his gout, but does not take any pain medication in reference to his shoulder.

On October 27, 2009, Dr. Markenson noted Petitioner was doing quite well with his left shoulder with only some minor problems. On that date, he placed Petitioner at maximum medical improvement (MMI), and discharged Petitioner from his care. In reference to Petitioner's shoulder, Dr. Markenson said he could return to full duty employment. However, in letters to Travelers Insurance, he noted Petitioner's permanent loss of vision due to the stroke and told them that Petitioner will not be able to return to work permanently because of his loss of ability to drive due to the vision loss. (PX 1, letters dated 08/18/2009 and 10/27/2009).

Dr. Marshall Matz, a neurosurgeon, reviewed the case for Respondent and in his August 17, 2009 report opined that the transfusion of Factor VIII increased the coagulability of Petitioner's blood, which would increase the risk of having a vascular occlusion. He suggested the record be reviewed by a hematologist for a further opinion as to whether or not the stroke was related to the use of Factor VIII. He thought that if a hematologist concurred that the vascular occlusion was the result of the Factor VIII treatment then it would not be unreasonable to conclude the episode that led to the necessity for surgery was the incident that caused his neurologic deficit. Dr. Matz thought that if Petitioner still had his ataxia and visual field loss then that was a permanent outcome from his posterior cerebral artery occlusion. (PX 8).

Dr. Michael Ellison, a hematologist, reviewed the file for Respondent and concurred that there was a causal connection between the Factor VIII and postoperative stroke. So while the rotator cuff surgery did not cause the stroke, it did so indirectly by necessitating use of the Factor VIII (Humate-P). (PX 9).

Petitioner was examined by Dr. Michael Jones at Illinois Eye Surgeons on December 8, 2009. Following examination, Dr. Jones noted that Petitioner did not meet the requirements needed to drive. (PX 11). Petitioner was examined by Dr. Gary Vogel, an optometrist, on January 6, 2010. He discussed a prismatic system to try to improve peripheral vision, but stated that in Illinois the prismatic systems cannot be used to obtain a drivers license. Dr.Vogel opined that Petitioner should not drive, even if he could pass the driver's test. (PX 12).

Petitioner was sent to Dr. Pernoud of Pernoud Eye Institute for an examination on March 25, 2010. Following her examination, Dr. Pernoud reported that Petitioner had suffered a stroke during his rotator cuff surgery and the stroke was located in an area which is involved with the visual field and with eye movements. She diagnosed visual effects of stroke, "including significant side vision loss and extraocular muscle function restriction." She thought that Petitioner was not capable of driving or passing an Illinois drivers examination because of his severe visual field loss. In her opinion, Petitioner would only be capable of limited desk work. She reported that Petitioner's visual field was restricted so severely that "any work requiring movement will be very difficult and potentially dangerous." She found him to be at MMI and reported that there was no additional treatment for his condition. (PX 13).

Dr. Pernoud went on to state, "[i]t is significant that Mr. Wentz has lost his entire right field of vision, as well as most of his superior field of vision. In fact, the side vision loss very nearly approaches his central vision making it very difficult to track even a written page. It appears he has lost 75% of his field of vision in the right eye and 70% of his field of vision in his left eye. In addition, the inability to move his eyes fully to the right constitutes an additional 20% loss of visual function in my opinion. The cumulative loss of vision, including both his visual field and his loss of binocular function would constitute an 80% total visual impairment in this gentleman." (PX 13).

Dr. Pernoud examined Petitioner again on June 28, 2012. She found that Petitioner's side vision loss was actually very comparable to that of his previous examination on March 25, 2010. She found it notable that Petitioner now had a vertical muscle imbalance that caused him to have a muscle imbalance in all fields of gaze. This, she opined, was due to the visual field abnormality whereby it is very difficult for Petitioner to fuse his two eyes and is, therefore, work related. In answer to specific questions, she reported that the current work-related diagnoses were: stroke-like visual system damage due to an anesthesia complication causing profound side vision loss and eye muscle imbalance causing double vision and restriction in eye muscle movements to the side. She found that Petitioner was not able to perform the duties of his usual occupation and was permanently impaired from a visual standpoint. She went on to state that the most significant finding at the time of Petitioner's examination was an interval change from his past examination in that he had developed a hypertropia of the right eye requiring prismatic correction in his glasses, and implying that without his prismatic correction in his glasses, he suffers double vision in all fields of gaze. In summary, Dr. Pernoud reported that Petitioner's injury had left him with 100% visual impairment due to the brain damage to his visual system. (PX 13).

Dr. Pernoud authored a third letter dated July 18, 2012, evaluating Petitioner's impairment for a Worker's Compensation Rating according to Missouri Regulations, and what requirements are necessary for a Missouri Driver's License. She reported that Petitioner's central vision is good, that his side vision is limited but apparently good enough to pass the driver's test, and that his largest issue is double vision in all fields of gaze without prismatic glasses which equate to 100% impairment according to Missouri Regulations. However, with prismatic correction in his glasses, she reported that Petitioner is able to see a single image and would be able to drive. (PX 13).

Petitioner was examined by Stephen Dolan, a licensed vocational expert, on May 30, 2012. Mr. Dolan's deposition testimony was taken on September 6, 2012. (PX 14). Mr. Dolan determined Petitioner's residual vocational profile, which is a snapshot of Petitioner's current employability. He found Petitioner to be sixty-three years old, approaching retirement age, with a ninth grade education. Petitioner spells and does math at grade school levels, reads above the high-school level, and in the past fifteen years has only worked as a driver. In the more remote past, he worked as a mechanic and a service writer, and such skills are probably either forgotten or out of date. Petitioner cannot be on his feet for significant periods of time. He cannot sit for long periods of time without elevating his feet and cannot change from sitting to standing easily. Petitioner's vision is now 80% impaired. He has a very limited field of vision. Mr. Dolan opined that Petitioner would have difficulty performing even desk work because he has difficulty tracking a written page. (PX 14, pp. 24-25).

Mr. Dolan outlined what Petitioner's transferable skills were, i.e., skills that are picked up either through education or by job experience that can then be transferred to other types of jobs, or jobs that the person has not actually done. Mr. Dolan found the only skills Petitioner has that are transferable are commercial driving skills, and his restrictions would keep him from doing those types of jobs. (PX 14, pp. 25-26).

Mr. Dolan found that Petitioner is not employable, and testified, "...I really don't think that that's even a close call. I mean he hadn't been able to maintain a full-time job since 1991. He's been working part-time under the SGA level, and now, because of his visual problem, which is primarily a visual field problem, he can't do

even that type of simple driving job." (PX 14, p. 26). Mr. Dolan also opined that Petitioner "also can't do desk work, as the doctor said, because it would just take him too long to read material." (PX 14, p. 26). Mr. Dolan testified there was no employment that would be regularly and continuously available to Petitioner; in other words, there is no stable labor market available to Petitioner. (PX 14, p. 27).

Mr. Dolan testified that Dr. Pernoud's supplemental report of July 18, 2012, in which she states that with prismatic correction in his glasses, he would be able to see a single image and would be able to drive, did not change his vocational opinion. (PX 14, p. 28). He elaborated that obviously Petitioner somehow passed the Illinois drivers test, so there is nothing new about this information and vocationally, the requirements for driving your own vehicle are very different from the requirements of driving a commercial vehicle. (PX 14, pp. 28-29). Further, Mr. Dolan testified that Petitioner would not pass the CDL test for a commercial drivers license because he has too great of a vision loss. (PX 14, p. 29). Even if Petitioner could pass a commercial driver's test and had a personal license, according to Mr. Dolan, there is "absolutely zero" likelihood of an employer hiring Petitioner for a driving job. Mr. Dolan further testified that, "[a]ny employer who hired him [Petitioner] for a driving job really needs to be psychiatrically evaluated. I mean it would really be a crazy thing to do." (PX 14, p. 29). According to Mr. Dolan, there is nothing in Petitioner's background, training, education, along with his physical and visual problems that would make him a desirable employee to a potential employer. (PX 14, p. 29).

As stated, *supra*, Ronda Wesemann testified at trial. Ms. Wesemann has been the human resource manager with Respondent for thirteen years. In that role, she is responsible for taking care of workers' compensation cases. Ms. Wesemann testified that she was familiar with Petitioner's situation and involved in the decision making on the file. She was aware that Petitioner sustained an accident while working for Respondent for which he had shoulder surgery and was given a medication as a precaution which led to a stroke. She is also aware that as a result of the stroke he experiences serious vision problems and that experts hired by Respondent's insurance carrier (Travelers) connected the use of that medication to the stroke and vision loss.

Ms. Wesemann was aware that Travelers had sent Petitioner a couple of times to see Dr. Pernoud, an eye specialist. Ms. Wesemann was asked whether she was aware that Dr. Pernoud found permanent significant side vision loss and problems with muscle function in Petitioner, to which Ms. Wesemann responded that she was not sure of the details but knew that Petitioner had vision limitations. Ms. Wesemann was aware that Petitioner was permanently impaired from a visual standpoint.

Ms. Wesemann testified that she was aware that no permanent job had been offered to Petitioner. She was aware that Petitioner was receiving weekly checks until they were stopped. When asked why the benefits were stopped, she said she had no decision-making authority in stopping the payments and that the reason for terminating the payments was because Respondent learned Petitioner had renewed his driver's license. She said that Respondent was considering offering Petitioner a part-time driving position in which he would drive a van and would not be required to have a CDL license. The driving position had "not yet" been offered and she agreed that offering such a job was against the advice of Respondent's attorney.

On February 29, 2012, Diana Johnson from Travelers Insurance Company sent a letter advising that weekly benefits were being terminated. The letter states that Travelers had voluntarily paid Petitioner at the permanent total disability rate for some time, not based on the injuries to his shoulder, but for the loss of vision. She wrote that they confirmed that on January 17, 2012, Petitioner was able to procure a drivers' license which is valid through April 16, 2016. Based on this information, she wrote, the basis for payments is no longer valid and "effective immediately, weekly benefit payments are terminated." She requested Petitioner's attorney to contact her attorney to discuss resolution of the claim based solely on the shoulder. (RX 2; PX 16).

Petitioner's attorney wrote Respondent's attorney on March 8, 2012, regarding the termination of benefits. She pointed out that Petitioner had lost a significant portion of his vision because of the medication

given as a result of his shoulder surgery. She pointed out that Petitioner could no longer qualify for his professional driving and has never maintained the position that he does not drive, and while it is recommended that he should not drive, he has to because he has no one to drive for him. She stated the actions were short sided as, to date, Travelers had not been asked to provide a personal driver for Petitioner. She demanded benefits be reinstated and if they believed Petitioner could return to some form of employment that they provide vocational assistance. (PX 16). Respondent extended an advance against permanency in the amount of $2,066.70 in July 2012. Petitioner testified that this advance helped, but did not alleviate his hardships due to the lack of payments.

CONCLUSIONS OF LAW

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?

Based on the foregoing, Petitioner is entitled to receive from Respondent compensation for bills pursuant to Section 8(a) and 8.2 of the Act. Petitioner is awarded those bills set forth in Petitioner's Exhibit 15, and Respondent shall have the appropriate credit for any bills paid by it, if any. Therefore, Petitioner is awarded the sum of $322.24 from All About Eyes, $82,507.32 from St. Elizabeth's Hospital, $56,206.53 from St. Anthony's Medical Center, $70.00 from Drs. Kraemer and Vogel, $10,714.32 from Tesson Heights Orthopaedics, $2,120.00 from Radiology Consultants, $155.00 from Illinois Eye Surgeons, $601.00 from Cardiology Consultants, $2,124.00 from Midwest Emergency, $5159.94 from SLUcare, $765.00 from St. Louis Oncology Associates, $2,124.00 from Midwest Emergency Department, $35.00 from Vascular & Hand Surgery, $640.00 from Dr. Panduranga Kini, $2,156.00 from Medstar Ambulance, $30.00 from Metro Cardiology Group, and $360.00 from Metropolitan Neurology. All such awarded sums shall be paid as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $35,605.25 for medical benefits that have been paid.

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

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

There is no dispute that Petitioner sustained an accidental injury on January 29, 2009, when he slipped and injured his left shoulder. There is additionally no dispute that he suffered complications from his work-related surgery that resulted in a permanent vision loss. While his shoulder does not impact his return to work, his vision loss does.

Petitioner alleges he was temporarily and totally disabled from May 14, 2009 through October 27, 2009, and that he is permanently and totally disabled from October 28, 2009 through the present. Respondent agrees with the period of TTD, but disputes that Petitioner is permanently and totally disabled.

Because of his permanent vision loss, Petitioner cannot return to his job as a commercial driver. Additionally, according Dr. Pernoud, Respondent's examining physician, Petitioner would only be capable of limited desk work and his visual field is restricted so severely that any work requiring movement will be very difficult and potentially dangerous.

Mr. Dolan, a vocational expert, evaluated Petitioner and concluded from his testing, review of materials, and based upon his age, education, work experience and restrictions, that Petitioner no longer had reasonable access to a stable labor market.

Respondent has not offered a job to Petitioner, nor has it provided vocational assistance. Additionally, Respondent has not provided any evidence that there is some kind of suitable work that is regularly and continuously available to Petitioner.

The Arbitrator finds that Petitioner was temporarily and totally disabled for 21 6/7 weeks from May 14, 2009 through October 27, 2009, and awards TTD benefits for that period of time in the amount of $4,517.22 (21 6/7 x $206.67). The Arbitrator finds that Petitioner's condition was permanent when Dr. Markenson released him from his care on October 27, 2009.

The Arbitrator finds that Petitioner is permanently and totally disabled pursuant to Section 8(f) of the Act, and awards the sum of $461.78 per week, for life, for 151 4/7 weeks ($69,992.65), commencing on October 28, 2009 through the date of hearing, September 25, 2012, and ongoing, which is the period of PTD for which compensation is payable. Respondent shall pay Petitioner the remainder of the award in weekly payments.

Respondent shall have credit for all amounts paid to Petitioner on account of said work injury. Respondent has paid $48,514.46 for weekly payments in the form of TTD, maintenance and PTD benefits. Therefore, Respondent owes Petitioner $25,995.41 in back benefits. Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, as provided in Section 8(g) of the Act.

Issue (M): Should penalties or fees be imposed upon Respondent?

Petitioner alleges he is owed penalties and attorneys' fees under Section 19(k) and Section 16 of the Act because Respondent acted in an unreasonable and vexatious manner in terminating his benefits in early 2012. The Arbitrator denies to award penalties and attorneys' fees in this matter. Petitioner's benefits were terminated after Respondent learned Petitioner was granted a driver's license and was known to be driving. Petitioner himself admitted that he drove, alone, to Wyoming for the sole purpose of alleviating apparent boredom. The Arbitrator does not find Respondent's actions in this regard to be unreasonable and vexatious, and therefore denies Petitioner's request for penalties and attorneys' fees.

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

MAURICE JENKINS,

Petitioner,

14IWCC0092

vs.

NO: 05 WC 48316

WALSH CONSTRUCTION,

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 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 is a Master Carpenter. He was working on the Dan Ryan Expressway on October 17, 2005. While working, he was hit in the head with a piece of lumber that was nine feet above him. The next thing he remembers is waking up and asking others what had happened. He was told he was hit in the head.

2. Petitioner treated at Concentra Medical Center that same day, but was allowed to return to his normal work duties.

3. Over the next 2 days, Petitioner complained of head pain, amnesia, blurred vision, light

headedness and disorientation. His work status was modified on October 19, 2005, and he was ordered not to work in a safety sensitive position.

4. Subsequently, On October 21, 2005, Petitioner was asked by Respondent to work one of the known safer areas of a construction site, in keeping with his modified restrictions. However, Petitioner refused, got into an altercation with Respondent's agents, and was terminated for insubordination.

5. Petitioner's post-accident treatment records continuously noted symptoms such as psychosis, seizures, dizziness, hallucinations and schizophrenia.

6. Dr. Schrift began treating Petitioner in November 2006. He diagnosed him with complex partial seizures, a form of epilepsy. Dr. Schrift noted that, prior to the accident, Petitioner wrote songs and played instruments. Petitioner now describes difficulty doing these things. Dr. Schrift opined that this was consistent with mood and anxiety disorders related to epilepsy.

7. Petitioner testified that he was first diagnosed with a seizure disorder when he was a teenager. His girlfriend testified that he has had epilepsy since childhood, and that he began having seizures at a young age after a childhood fight with his brother.

8. A Dr. Rossi testified that he was unable to establish a start to Petitioner's seizure disorder. Thus, he opined that no permanent injury resulted from the accident in question.

9. Respondent had Petitioner's medical records reviewed by Dr. Zollman, who opined that Petitioner suffered a mild traumatic brain injury/concussion. He opined that Petitioner's symptoms lasted for about one month. Dr. Zollman also noted that Petitioner had suffered brain injuries since childhood. He suffered a second brain injury in February of 2004, and a third in April of 2006. He opined that the work accident in question was not the reason for any current disabilities Petitioner may suffer from. Other premorbid conditions (such as epilepsy) are the likely cause. Dr. Zollman noted that only 10-15 percent of people have persistent symptoms after a mild brain injury.

10. Character witnesses suggested that Petitioner was mild mannered, likable and a good role model prior to the accident in question. They indicate that they have noticed a change in Petitioner's demeanor since the accident.

11. Petitioner acknowledged his pre-accident history of 13 arrests, 5 of which were felonies and 8 misdemeanors. He attributed this to false information, the "dumbness" of police and his childhood environment in the projects, which forced him to defend himself.

12. Dr. Zollman noted a series of pre-accident altercations involving Petitioner, including a

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1997 domestic incident with a previous girlfriend.

13. In the 18 months prior to Arbitration, Petitioner stated that his condition had improved, as he has been prescribed steady medication by Dr. Schrift.

14. Dr. Schrift stated that patients are occasionally non-compliant with taking medication due to the side-effects. However, he stated that Petitioner has generally been compliant.

15. Dr. Zollman noted that treatment records indicate Petitioner suffered from seizures when he missed doses of his medication.

The Commission affirms the Arbitrator's rulings on the issues of accident, causal connection, medical expenses and permanent partial disability.

The Commission, however, modifies the Arbitrator's ruling on temporary total disability.

Due to Dr. Zollman's opinion that Petitioner's brain injury was accompanied by symptoms lasting one month, the Commission modifies the temporary total disability (TTD) award, and awards Petitioner four (4) weeks of TTD benefits.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent is liable for 4 weeks of temporary total disability benefits (October 21, 2005 through November 17, 2005).

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:
O:12/12/13 FEB 10 2014
DLG/wde45
45

David L. Gore

Mario Basurto

Michael P. Latz

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

JENKINS, MAURICE
Employee/Petitioner

Case# **05WC048316**

14IWCC0092

WALSH CONSTRUCTION
Employer/Respondent

On 3/22/2013, 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 0.11% 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:

2830 THE MARGOLIS FIRM PC
CHARLES J CANDIANO
55 W MONROE ST SUITE 2455
CHICAGO, IL 60603

1622 HINSHAW & CULBERTSON LLP
ROBERT J FINLEY
221 N LASALLE ST SUITE 300
CHICAGO, IL 60601

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION CORRECTED DECISION

Maurice Jenkins
Employee/Petitioner

v.

Walsh Construction
Employer/Respondent

Case # **05** WC **48316**

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 Richard Peterson on June 27, 2011; August 1, 2011; August 26, 2011; and Lynette Thompson-Smith, on December 6, 2011; October 30 and October 31, 2012, Arbitrators of the Commission, in the city of Chicago. After reviewing all of the evidence presented, Arbitrator Thompson-Smith 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

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On **10-17-05**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$73,840.00**; the average weekly wage was **$1,420.00**

On the date of accident, Petitioner was **41** 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 is entitled to a credit of $20,281.99; $5,278.67 for medical payments and $15,003.32 for union disability payments, pursuant to Section 8(j) of the Act.

ORDER

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $946.66/week for 365 3/7 weeks, commencing 10-21-05 through 10-31-12, as provided in Section 8(b) of the Act.

Medical benefits
Respondent shall pay the outstanding, reasonable and necessary medical services up to $154,358.90 directly to the service providers, pursuant to Sections 8(a) and 8.2 of the Act.

Permanent Total Disability
Petitioner has not proven that he is permanently, totally disabled therefore Respondent shall pay Petitioner benefits of $591.77/week for 250 weeks as the injury has resulted in 50% loss of use of a man as a whole, as provided in Section 8(d)2 of the Act.

Penalties and attorney's fees
No penalties or attorneys fees are awarded.

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

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

Signature of Arbitrator

March 22, 2013

MAR 22 2013

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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 nature and extent. *See*, AX1.

Mr. Maurice Jenkins, hereafter referred to as (the "Petitioner"), worked for Walsh Construction Company hereafter referred to as (the "Respondent") in the capacity of a union carpenter. On October 17, 2005, a co-worker dropped a two-foot piece of oak lagging board, from approximately fifteen (15) to twenty (20) feet above. The board hit the left front brim of Petitioner's hardhat, knocking off and bending his corrective lens glasses. Walsh Safety Manager, James Conway, investigated the accident and prepared the first report of injury. Mr. Conway drove Petitioner to the occupational clinic at Concentra where the doctor took a history. i.e., "The patient states that he had a piece of wood fall from about 15 feet onto his head. He did have a hard hat on. The incident happened three (3) hours ago, and he still feels a little foggy. He is concerned with further damage. The pain is located on the left forehead". The pain was described as aching, ill defined and non-radiating. The doctor further noted that Petitioner's symptoms were exacerbated by working and he could not identify any alleviating factors. The petitioner denied loss of consciousness, dizziness, headache, nausea, vomiting, neck pain, paresthesias, bleeding, and had a full recollection of the event. The physical examination of his head revealed no ecchymosis or sinus tenderness or soft tissue swelling. Tenderness at the left forehead directly about the eyebrow was noted. The doctor diagnosed a face/scalp contusion. He was taken off work for the rest of his shift, given a prescription for Ibuprofen; and instructed to return the next day for a follow-up evaluation. *See*, PX5 & RX A, B.

On October 18, 2005, Petitioner returned to the doctor's office with complaints of sporadic head pain and amnesia. Petitioner stated that his head took the brunt of the hit when a piece of oak wood weighing approximately 25 pounds fell approximately 25 feet, hitting him on the front of his helmet. Since then he stated that he was having shooting pains in his head, slight sporadic blurred vision in his left eye and temporary memory loss. Petitioner denied loss of consciousness, neck or back pain. While at the

doctor's office, he began to demonstrate confused behavior; wandering around the office and not answering simple questions. Concentra transported him by ambulance to the emergency room of Mercy Hospital ("Mercy"), where he continued to make complaints of left forehead tension and shocks, confusion, and memory loss. He gave a history of wood falling 20 feet and hitting his hard hat. His physical examination was normal and the review of systems was negative, including alert and oriented signs; no posterior midline cervical spine tenderness, there was a normal level of alertness; there was no focal neurological deficit, and no painful distracting injuries. The examining physician at Mercy did not record any apparent physical injury; there was no bruising, scabs or scratches. Diagnostics films and tests were negative and he was given Tylenol for pain to his forehead and left eye. *See,* PX1 & 2.

On October 19, 2005, Petitioner again presented to Concentra, complaining of light-headedness and disorientation. He stated that he could not remember certain events that had happened yesterday; however, he remembered the traumatic event that caused the accident. He complained about "being no better at his job" though he had not worked since the day of the accident. The only physical finding on examination was tenderness above his left eyebrow. Petitioner was prescribed Ibuprofen and his work activity status was modified, i.e. he was ordered not to function in a safety sensitive position. Petitioner returned to work with his restrictions and was terminated for insubordination; after becoming aggressive with his supervisor and refusing to work in a certain area that the respondent states was within his restrictions. *See,* PX5.

On October 20, 2005, the doctor's continued diagnosis was contusion of the face, scalp and neck with the petitioner being in no acute distress. The CT scan of Petitioner's head was read as normal; his prescription was continued and he was advised to return on an urgent basis if the symptoms worsened.

On October 27, 2005, the Petitioner still reported headaches and stated that he was given Vicodin at the emergency room, which helped the pain. The doctor noted that the petitioner was taking his prescribed medications but still had pain located on the frontal scalp. He again denied loss of consciousness, dizziness and nausea. The Arbitrator

notes that the doctor states that "He still feels like he is "slower" and does not work or think as fast as he did before he was hit on the head. Patient has been working within the duty restrictions". The Arbitrator further notes that from testimony at trial, the petitioner was not working for Respondent, at this time. On this date, the petitioner was released from medical care and no further visits were authorized. *See*, PX5.

On February 17, 2007, the petitioner presented to Dr. Michael J. Schrift and the doctor noted that the petitioner has epilepsy with post concussion syndrome and a history of cerebrovascular disease, traumatic brain injury, and epilepsy; and exhibits paranoia and depression, which he claims, is because he cannot resume working. *See*, PX8.

Approximately one (1) year later, on February 27, 2008, the petitioner was admitted to the locked psychiatric unit of Jackson Park Hospital and place on close observation and medicated. He was expected to stay for approximately two (2) weeks. *See*, PX 7.

On March 19, 2008, the petitioner is diagnosed as having bipolar disorder with seizure disorder. *See*, PX6.

On May 23, 2008, Petitioner presented with auditory hallucinations, violent behavior and paranoia. He feared that his mother and brother were trying to kill him. He stated that his paranoia started after he was hit on the head while working in 2005 and he discussed having seizures and passing out. He stated that he finished high school without many problems and had been "in construction since age 19". The doctors' impressions were: since memory dysfunction is the most common cognitive impairment reported after a head injury and Petitioner's performance in memory related tasks was in the average range; there was no indication of such an experience. They also stated that informational processing speed also tends to decrease, as a result of a head injury and the petitioner did not demonstrate significant speed deficits in tasks involving processing information. The doctor's assessment was that petitioner exhibited a significant change in his personality, which was likely caused by his history of head trauma, although he did not delineate the significant traumatic events in Petitioner's

history. Petitioner was diagnosed as having schizophrenia/paranoia psychosis. *See,* PX3.

Witness by Deposition: Dr. Felise Zollman

Dr. Felise Zollman, the respondent's independent medical examiner, testified on two (2) occasions, January 27, 2010 and March 10, 2010. She did not physically examine the petitioner but rather reviewed his medical records. They indicated that he had been having seizures since 1993 and was hospitalized in August of 2003. The history provided at that time was that the petitioner had had an old head trauma as a child and that he had not been taking his seizure control medication, i.e. Dilantin; which put him at a greater risk for having seizures. She opined that "the symptoms that Petitioner complained of, after the accident, appeared to have resolved within one month, because it is not the nature of a mild traumatic brain injury, typically, to cause the type of significant impairment that would keep someone out of work for an extended amount of time". She reviewed Petitioner resulting brain injuries from a motor vehicle accident on February 2, 2004. She also testified that the petitioner's aggression and behavioral changes that resulted in his termination from work may be related to the work accident but because the petitioner had prior arrests for assault, etc. he seemed to exhibit a pattern of periodic, aggressive behavior. She also reviewed a forensic, psychiatric report from a Dr. Nadkarmi, which had been ordered by the Court to determine if the petitioner was competent to stand trial. The Arbitrator notes that this report was not produced as an exhibit to Dr. Zollman's deposition and therefore was unavailable for the Arbitrator's review. The Arbitrator also notes that on October 28, 2007, the petitioner was recorded fighting with an individual in a fast food restaurant then assaulting a police officer who was apparently called to the scene. The petitioner and two officers were in a struggle, which lasted approximately five (5) minutes, before both officers were able to subdue him. The petitioner was subsequently arrested and the Arbitrator can only presume that these were the circumstances for which this report was ordered. Dr. Zollman also reviewed Dr. Nettem's records of February 7, 2006, when Petitioner presented for a physical examination, which history states that the petitioner denied any complaints and upon examination stated that his last seizure was two months prior and

was awake, alert and under no distress. The doctor ordered blood work. On February 10, 2006, upon examination, the petitioner again presents with no complaints and Dr. Zollman testifies that on this date, the petitioner reported no further symptoms which would be reasonably related to a brain injury, i.e. no report of headache, memory loss, confusion etc. On cross-examination, the doctor testified that once a person has had three or more brain injuries or concessions, the risk of cumulative residual impairment increases. In the doctor's continuing deposition, taken on March 10, 2010, she testified that upon the petitioner initial diagnosis of epilepsy, which occurred around age four and a history of him moving toward cognitive and neuropsychiatric issues; this condition was manifested by intermittent behavioral problems; and she opined that his medical records reflected that he had been diagnosed as having a thought disorder, i.e., schizophrenia, rather than a mood disorder, i.e. bipolar disorder. She also reviewed Respondent's Exhibit 31, attached to the first deposition, which is a report from Madden Mental Health Center which diagnosed Petitioner as having 1) mood disorder; 2) epilepsy, 3) history of injury; and 4) interpersonal problems, testifying that those doctors obviously disagreed with her opinion, as they stated that the petitioner initial problem was a mood disorder. *See,* PX55, RXs E, pgs. 30-58, 77-87; F, pgs 5-12; 21-28; & K.

Dr. Zollman further testified that the blow to Petitioner's head was "quite possibly" responsible for the uncharacteristic irritability displayed by Petitioner in the days following his accident, which served as the Respondent's basis for terminating Petitioner's employment due to insubordination. *See*, RXs F& E. Dr. Zollman opined that statistically, individuals who sustain a concussion such as that sustained by the petitioner, would generally be expected to have their symptoms completely resolve within 10-14 days. Dr. Zollman reviewed the records of Dr. Munoz who treated Petitioner for approximately one month post-accident for symptoms, which included persistent severe headaches and memory loss. Dr. Zollman also testified that approximately 10 to 15% of people, who have a mild traumatic brain injury, would also have persistent symptoms, i.e., post-concussive syndrome. *See*, RX41.

Witness by Deposition: Dr. James L. Reilly

After a stringent direct examination by Respondent's attorney, the following facts were elicited: that Dr. James L. Reilly, assistant professor at the University of Illinois. Department of psychiatry was non-board certified. He performed a clinical evaluation of Petitioner, on April 24, 2007, upon request of Dr. Schrift. His report concluded that the petitioner has a persistently elevated anxiety, as a result of his work site accident of October 17, 2005. This conclusion was based upon Dr. Reilly's interviews with the Petitioner, his mother and his girlfriend, Ms. Fay Hopkins; and the information that the petitioner provided in the neuropsychological history questionnaire as well as his interpretation of data that the petitioner provided on a number of clinical testings, including but not limited to a MMPI. The doctor only reviewed medical records that were post-accident i.e., from October 17, 2005 through April 24, 2007; and did consider pre-existing conditions i.e., anxiety disorder or similar types of complaints based on the Petitioner's integrative history. He concluded, on the available information, that it did not seem likely to him that the pre-existing issues were relevant. In addition, the doctor testified that there is a strong degree of likelihood that there was an association between the emergence of Petitioner's anxiety symptoms and his accident. The doctor admitted that statistically speaking, the petitioner's anxiety could be a function of his epilepsy and the stress of him being unemployed. He also testified that Petitioner's score on the MMPI-2 tests under the lie scale was 74, which indicated upwards of two standard deviations above normal and would be considered elevated; and that most of petitioner's additional scores were elevated. The doctor further testified that those scores, taken with his responses across all of the scales, did not invalidate his profile and that the petitioner's tests indicated that he was not demonstrating sub-optimal performances on these tests or that he was malingering. *See,* RX H, pgs 8-78.

Witness by Deposition: Dr. Marvin Rossi

Dr. Rossi testified, after reviewing Petitioner's medical records that he could not established a baseline for the petitioner's seizure disorder. *See* RX G.

Witness at hearing: Ms. Faye Hopkins

The Commission heard testimony from Petitioner's companion, Faye Hopkins. Ms. Hopkins testified in August 2011, that she had known Petitioner, well, since they met in 2002. She further testified that she had daily telephone conversations with Petitioner and that they would go out or spend time with one another at least two (2) to three (3) days per week. Ms. Hopkins testified that she never witnessed Petitioner exhibit violent behavior prior to the accident, nor did she ever witness him lapse into extended states of depression, until after his injury. Ms. Hopkins testified that within three (3) to four (4) days of his accident, Petitioner began exhibiting cognitive difficulties, uncharacteristic aggression; and he was short tempered. Ms. Hopkins also testified that since his accident she has observed Petitioner complain of constant fatigue, to be inarticulate in his speech, to have balance issues; and to have a tendency to "zone" or seem to be staring into space.

Witness at hearing:

The Commission heard testimony from Mr. Joe Payne. Mr. Payne testified that he has known Maurice Jenkins for many years. Mr. Payne further testified that in 2001, he was working as a union Carpenter in Chicago and that he worked on jobs, side-by-side, with Petitioner for Scandinavia Construction Company. Mr. Payne testified that Petitioner had the reputation in the trade community for being dependable and a very hard worker. Mr. Payne also testified that he personally observed Petitioner as being a competent carpenter and a very hard worker. Mr. Payne also testified that Petitioner always exhibited what he termed as an outstanding, bubbly personality and that the petitioner's personality had changed after the accident. On cross-examination, the witness testified that he was arrested for robber and spent eighteen (18) months in a state penitentiary, in 1987-1988.

Witness at hearing:

The Commission also heard testimony from Mr. Darrell Jacobson. Mr. Jacobson testified that he had known Petitioner since the two of them went through high school

together as close friends. As they were growing up, Mr. Jacobson testified that Petitioner and he were among the biggest kids in their class, which made them targets for other young men who were trying to prove themselves. This situation resulted in a number of fistfights. Petitioner testified that he was frequently challenged to fight as a young man and that these altercations resulted in multiple contacts with law enforcement, though he was never charged with any crime on those occasions.

Mr. Jacobson testified that he loved the petitioner "like a brother" and always enjoyed his company but that since the accident, Mr. Jacobson literally "cannot stand to be in his company because of the change in Petitioner's personality." When asked to elaborate, Mr. Jacobson explained that Petitioner is nothing like his former self and that he used to be an "easy going, nice guy." Mr. Jacobson testified that "now Petitioner is so confrontational and has such a short fuse that it is virtually impossible to go out in public with him."

Witness at hearing:

The Commission heard testimony from Mr. Gerald Hamilton, a retired homicide detective, who is a 30-year veteran of the Chicago Police Department. Mr. Hamilton testified that he owned two of the three homes on the block when Petitioner's family moved into the third home, sometime in 1979. Mr. Hamilton further testified that he was not just a neighbor to Petitioner and his family but they were like family. Mr. Hamilton demonstrated an intimate familiarity with Petitioner's family including the names and ages of his family members, his awareness that Petitioner's mother died from cancer, and his attendance at her funeral. Mr. Hamilton also testified that throughout the time he was a neighbor and close friend of Petitioner's family, he fostered a number of youths. Mr. Hamilton further testified that the boys he fostered when Petitioner was in his teens, were the same age as Petitioner. Mr. Hamilton testified that his foster children and Petitioner would often engage in activities together such as playing basketball or softball. Mr. Hamilton explained that these joint activities provided still additional opportunities for Mr. Hamilton to observe Petitioner, as he was growing up. Mr. Hamilton described Petitioner as a nice young man, a good person and

someone whose entire family looked up to as a role model because he had risen above poverty, learned a trade and was earning a good living.

Witness at hearing:

Treating neuro-psychiatrist, Dr. Michael Shrift, testified that Dr. Zollman's assertions were reasonable assuming a healthy brain and no prior injuries, which assumption was entirely unwarranted in the case of Petitioner. In his testimony, Dr. Schrift emphasized that Petitioner did not have a healthy brain at the time of the accident. Various radiographic studies performed contemporary to the accident disclosed an old injury. Dr. Schrift testified that those studies memorialized a distant event, which had caused the death of certain brain cells and thereby compromising Petitioner's brain, making his brain more vulnerable to injury. Dr. Schrift testified that traumatic brain injury is cumulative in nature and explained that Petitioner's pre-existing epilepsy, alone, is evidence that he did not have a healthy brain at the time of the accident. Dr. Schrift further testified that Petitioner's assertion that his seizure disorder was controlled prior to the incident on October 17, 2005, but much less so after the accident, is entirely consistent with the medical science.

Dr. Schrift further testified that certain brain structures are several feet long and extend from the brain throughout the length of the spinal cord. Dr. Schrift explained that when someone suffers a blow to the head, there is a very rapid acceleration and concomitant deceleration, which can cause a shearing effect, damaging these long structures. Dr. Schrift further explained that the structures cannot heal or regenerate once they are gone. In further support of Dr. Shrift's opinion that Petitioner sustained additional damage to his brain on October 17, 2005, which continues to contribute to his present state of ill being, Dr. Schrift discussed various radiographic studies performed shortly after the accident, which demonstrated multiple localized areas of hypo-perfusion (reduced blood flow) in the cortex of Petitioner's brain. These areas included the dorso-lateral prefrontal cortex, the orbito-frontal areas and temporal lobes. Dr. Schrift explained that these areas are additionally prone to traumatic injury because, the cranium supports these areas of the brain by means of a bone shelf. And when there is

trauma to the area of the forehead, Dr. Schrift explained that the brain slams against this hard bony shelf, causing injury to the brain. The doctor testified that this was the mechanism of injury that the petitioner had suffered. Dr. Schrift testified that these areas of the brain are responsible for executive functioning, which includes such things as decision-making, the ability to plan, the ability to focus one's attention and the ability to conduct one's self in accordance with societal norms.

The Arbitrator viewed security video from a restaurant that Petitioner patronized on October 28, 2007. *See,* PX55. The video depicts Petitioner standing in the lobby of a take-out restaurant, holding a briefcase, and then he suddenly appears to be hoarding ketchup packets. Without apparent provocation or motive, Petitioner begins fighting with patrons and eventually fighting with responding law enforcement officers. This incident gave rise to felony charges of battery on law enforcement. Dr. Shrift was present in the hearing room for the viewing of this video and he explained that Petitioner was experiencing what Dr. Schrift called postictal psychosis. Dr. Schrift explained that Petitioner's seizure activity is responsible for postictal psychosis, which is characterized as auditory and visual hallucinations, delusions, paranoia, affect change, and aggression, which can last for hours or days. Many of these characteristics are clearly visible in the video, as pointed out by Dr. Shrift during his direct examination. There is no evidence that Petitioner ever experienced such a state, prior to his work injury of October 17, 2005.

Witness at hearing:

Mr. Maurice Jenkins

A review of that transcript of the petitioner's testimony was not very helpful. On only two occasions did he answer questions with some clarity, which was when he was asked if he was a "fun-loving and easy going guy" prior to the accident and some of the questions regarding his arrests. *See,* Tr. of August 26, 2011, pgs. 39-44. The rest of the transcript shows a petitioner who has either loss most of his memory regarding this accident and his subsequent medical treatment; or one who is skillful in evading answers to questions he does not wish to answer. However, the Arbitrator notes that

she had three (3) pre-trials with both attorneys and the petitioner and his uncle; and finds that the Petitioner, while obviously in a deteriorated mental and physical state; was able to express himself with decorum and explain his situation, as he sees it. In addition, on a later date, he testified more coherently. *See*, Tr. of October 30, 2012.

CONCLUSIONS OF LAW 14IWCC0092

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

Under the provisions of the Illinois Workers' Compensation Act (the "Act"), the Petitioner has the burden of proving, by a preponderance of credible evidence, that the accidental injury both arose out of and occurred in the course of employment. *Horath v. Industrial Commission*, 96 Ill. 2d 349, 449 N.E. 2d 1345 (1983). An injury arises out of the Petitioner's employment if its origin is in the risk connected with or incidental to employment so that there is a causal connection between the employment and the accidental injury. *See, Warren v. Industrial Commission*, 61 Ill. 2d 373, 335 N.E. 2d 488 (1975). *See also, Technical Tape Corp. v. Industrial Commission*, 58 Ill.2d 226 (1974). The mere fact that the worker is injured at a place of employment will not suffice to prove causation. The Act was not intended to insure employees against all injuries. *See, Quarant v. Industrial Commission*, 38 Ill. 2d 490, 231 N.E. 2d 397 (1967). The burden is on the party seeking an award to prove, by a preponderance of credible evidence, the elements of the claim; particularly the pre-requisite that the injury complained of arose out of and in the course of employment. *See, Hannibal, Inc. v. Industrial Commission*, 38 Ill. 2d 473, 231 N.E. 2d 409, 410 (1967).

The Arbitrator finds from a review of the record and testimony of the witnesses that Petitioner did have an accident that arose out of and in the course of his employment.

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

In making a claim under the Workers' Compensation Act, (the "Act"), an employee bears the burden of proving all of the elements of his case including the extent and permanency of his injury. 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). Moreover, it is the province of the Commission to decide questions of causation, and to resolve conflicting medical

evidence. *See, Steve Foley Cadillac v. Industrial Comm'n,* 283 Ill. App. 3d 607, 610 (1998).

A careful review of Petitioner's medical records demonstrates that prior to the work accident, he had a childhood trauma to his head which subsequently resulted in him acquiring an epileptic condition. He also suffered additional injuries to his head in a motor vehicle accident in February of 2004. However, there is unrebutted testimony from several witnesses, including the petitioner that he was working in a full duty capacity, as a union carpenter, for several years before the work accident and was apparently able to work compatibly with his co-workers and supervisors. There is also unrebutted testimony that the petitioner's personality changed after the accident and while some of the witnesses who testified for the petitioner also testified that they had been incarcerated early on in their lives, the Arbitrator finds that their testimony regarding the change in the petitioner's personality, after the accident, to be credible. The Arbitrator also notes that the petitioner has had accidents, since the work accident; stemming from his failure to take anti-seizure medication as well as "run ins" with law enforcement as a result of anti-social behavior; which may well be because of his failure to take prescribed medications. Currently, Dr. Schrift has testified that he believed that Petitioner's epilepsy was exacerbated by the accident becoming more frequent and intense. However, the doctor was not aware of and had not reviewed the petitioner's medical records from him falling and hitting his head in April of 2006 and was also unable to review any of petitioner's medical records prior to the accident therefore was not able to establish a baseline condition of petitioner head injuries. 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). In addition, 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). Here, the petitioner was admittedly not in perfect health but was able to work at a complex job and maintain a decent lifestyle. He has not worked since the accident and has had intervening accidents since that time, according to his doctor, due to the exacerbation of his epileptic condition, which has resulted in elevated seizure activity. In addition, he is now exhibiting anti-social behaviors toward total strangers, resulting in him being hospitalized and/or incarcerated, which he apparently was not doing while he was working as a union carpenter. The Arbitrator finds that the petitioner's current condition of ill-being is causally related to 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?

The respondent has not provided all reasonable and necessary services or paid for them. The remaining bills are as follows:

UIC Department of Psychiatry Medical Bill

Charges	Date of Service	Fee Schedule Amount
$90.00	08-10-06	($106.88)
$90.00	08-12-06	($85.02)
$150.00	08-14-06	($142.64)

Charges	Date of Service	Fee Schedule Amount
$350.00	11-10-06	($212.54)
$130.00	12-19-06	($107.86)

$130.00	01-03-07	($107.86)
$130.00	01-17-07	($107.86)
$130.00	03-30-07	($107.86)
$130.00	04-17-07	($107.86)
$750.00	04-24-07	($570.00 POC76)
$1,250.00	04-24-07	($950.00 POC76)
$130.00	05-03-07	($107.86)
$130.00	05-17-07	($107.86)
$130.00	07-23-07	($107.86)
$130.00	09-07-07	($107.86)
$130.00	10-23-07	($107.86)
$130.00	12-18-07	($107.86)
$55.00	01-11-08	($109.98)
$55.00	01-24-08	($109.98)
$55.00	02-04-08	($109.98)
$55.00	02-15-08	($109.98)
$55.00	06-20-08	($109.98)
$80.00	08-19-08	($129.98)
$76.00	09-12-08	($129.98)
$76.00	10-08-08	($129.98)
$76.00	11-11-08	($129.98)
Charges	Date of Service	Fee Schedule Amount
$76.00	03-17-09	($136.96)
$76.00	04-14-09	($136.96)

$76.00	06-20-09	($136.96)
$76.00	08-12-09	($136.96)
$71.00	10-20-09	($136.96)
$71.00	11-18-09	($136.96)
$71.00	03-29-10	($134.93)
$71.00	04-19-10	($134.93)
$71.00	06-02-10	($134.93)
$71.00	07-15-10	($134.93)
$71.00	09-21-10	($134.93)
$71.00	11-04-10	($134.93)
$71.00	01-03-11	($136.29)
$71.00	02-07-11	($136.29)
$71.00	03-02-11	($136.29)
$71.00	04-25-11	($136.29)
$71.00	05-31-11	($136.29)
$29.20	05-20-11	($ 29.20)
$21.00	05-20-11	($ 21.00)
$1,112.00	05-20-11	($1,170.06)
$877.00	05-20-11	($666.52)
$37.65	05-20-11	($37.65)
$88.00	05-20-11	($88.00)
$184.00	05-24-11	($105.52)
$164.00	05-24-11	($44.83)
$146.00	05-24-11	($47.39)

$24.00	05-24-11	($15.74)
Charges	Date of Service	Fee Schedule Amount
$120.00	05-24-11	($77.59)
$97.00	05-31-11	($136.29)
$104.00	07-06-11	($136.59)
$158.00	09-07-11	($64.39)
$135.00	09-07-11	($31.84)
$26.00	09-07-11	($11.02)
$104.00	09-07-11	($95.40)
$104.00	11-09-11	($95.40)
$203.00	11-15-11	($115.96)
$197.00	11-15-11	($73.86)
$26.00	11-15-11	($11.02)
$129.00	11-15-11	($54.31)
$39.00	11-15-11	($39.00)
$39.00	11-15-11	($39.00)
$104.00	03-19-12	($97.22)
$158.00	03-20-12	($54.73)
$135.00	03-20-12	($37.34)
$26.00	03-20-12	($14.81)
$72.00	03-20-12	($38.30)
Charges	Date of Service	Fee Schedule Amount
$104.00	05-14-12	($97.22)
$109.00	08-09-12	($97.22)

Total $10,150.63

City Of Chicago EMS Medical Bills

Emergency Care calculated at POC76

Charges	Date of Service	Fee Schedule Amount
$299.00	10-18-05	($227.24)
$465.00	06-04-07	($353.40)
$521.00	06-21-07	($395.96)
$505.00		($383.80)

Total $1,432.16

UIC Pathology Medical Bills

Charges	Date of Service	Fee Schedule Amount
$36.00	09-26-06	($125.59)
$284.00	12-05-06	($870.00)
$83.00	01-03-07	($220.14)

Total $403.00

Foundation For Emergency Services Medical Bill St. Bernard Hospital

Charges	Date of Service	Fee Schedule Amount
$208.00	05-22-08	($199.97)

Total $199.97

Radiological Physicians, Ltd Medical Bill Mercy Hospital

Charges	Date of Service	Fee Schedule Amount
$151.00	04-13-06	($138.86)

Total $138.86

Pathology Consultants Medical Bill

Charges	Date of Service	Fee Schedule Amount
$58.00	04-13-06	($171.58)

Total $58.00

Crandon Emergency Physicians (South Shore Hospital) Medical Bill

Charges	Date of Service	Fee Schedule Amount
$386.00	10-28-07	($294.16)

Total $294.16

AMIC Advanced Medical Imaging Center Medical Bill

Charges	Date of Service	Fee Schedule Amount
$1,452.00	04-27-06	($1,246.93)

Total $1,246.93

Anil Gulati. M.D. Neurologist Medical Bill

Charges	Date of Service	Fee Schedule Amount
$275.00	06-22-06	($283.39)
$125.00	07-20-06	($82.18)
$125.00	08-02-06	($82.18)
$150.00	04-10-07	($124.64)

Total $564.00

UIC Hospital Medical Bills

Charges	Date of Service	Fee Schedule Amount
$2,622.00	08-03-06	
	08-04-06	

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	08-09-06	
	08-11-06	
	11-21-06	
	02-23-07	($1,751.42)
$11,000.00	08-04-06	
$500.00	08-04-06 to 08-14-06	
$10,200.00	08-04-06 to 08-14-06	(ROOM)
$83.15	08-04-06 to 08-14-06	(DRUGS)
$393.05	08-04-06 to 08-14-06	(DRUGS)
$73.50	08-04-06 to 08-14-06	(DRUGS)
$328.00	08-04-06 to 08-14-06	
$897.00	08-04-06 to 08-14-06	
$147.00	08-04-06 to 08-14-06	
$90.00	08-04-06 to 08-14-06	
$1,273.00	08-04-06 to 08-14-06	
$415.00	08-04-06 to 08-14-06	
$612.00	08-04-06 to 08-14-06	
$201.00	08-04-06 to 08-14-06	
$1,172.00	08-04-06 to 08-14-06	
$87.00	08-04-06 to 08-14-06	
$2,593.00	08-04-06 to 08-14-06	
$949.55	08-04-06 to 08-14-06	(POC65)
$5,336.00	08-04-06 to 08-14-06	(DRUGS)
$90.00	08-12-06	($102.97)

$150.00	08-14-06	($163.42)
$458.00	09-26-06	
$111.00	09-26-06	($159.64)
Charges	Date of Service	Fee Schedule Amount
$347.00	09-26-06	
Charges	Date of Service	Fee Schedule Amount
$35.00	11-06-06	
$4,769.80	11-21-06	
$3,407.00	11-21-06	
$1,438.00	12-05-06	
$57.00	12-12-06	($91.63)
$57.00	12-12-06	($91.63)
$607.60	01-03-07	
$434.00	01-03-07	
$40.00	02-23-07	
$128.00	02-23-07	
$594.00	02-23-07	
$466.00	02-23-07	
$130.00	09-07-07	(Meds)
$130.00	10-23-07	(Meds)
$130.00	12-18-07	(Meds)
$422.00	12-23-07	
$75.00	01-11-08	($57.00)
$75.00	01-24-08	($57.00)

$75.00	02-04-08	($57.00)
$75.00	02-15-08	($57.00)
$174.00	02-05-08	
$53.00	04-01-08	($40.28)
$110.41	04-01-08	

Charges	Date of Service	Fee Schedule Amount
$75.00	06-20-08	($57.00 POC76)
$75.00	07-04-08	($57.00 POC76)
$84.00	08-19-08	($63.84 POC76)
$416.00	09-10-08	($316.16 POC76)
$84.00	09-12-08	($63.84 POC76)
$84.00	10-08-08	($63.84 POC76)
$84.00	11-11-08	($63.84 POC76)
$84.00	03-17-09	($63.84 POC76)
$95.00	07-07-09	($77.96)
$1,507.00	07-07-09	($860.74)
$216.00	03-29-10	($162.97)
$89.00	04-19-10	($134.93)
$89.00	06-02-10	($134.93)
$97.00	09-21-10	($134.93)
$97.00	11-04-10	($134.93)
$268.00	01-03-11	($203.65)
$97.00	02-07-11	($136.29)

$97.00	03-02-11	($136.29)
$97.00	04-21-11	($136.29)
$97.00	04-25-11	($136.29)
$2,164.85	05-20-11	($1,476.72
$638.00	05-24-11	($291.07)
$244.00	05-24-11	($150.97)
$97.00	05-25-11	($136.29)
$97.00	05-31-11	($136.29)

Total $57,583.20

Cottage Emergency Physicians (Jackson Park Hospital) Medical Bills

Charges	Date of Service	Fee Schedule Amount
$535.00	07-29-06	($442.09)
$386.00	10-28-07	($283.39)

Total $725.48

Northwestern Medical Faculty Foundation Medical Bills

Charges	Date of Service	Fee Schedule Amount
$24.00	04-30-06	($24.00)
$228.00	04-30-06	($322.50)
$500.00	04-30-06	($474.84)
$6.00	05-01-06	($6.00)
$218.00	05-01-06	($172.87)
$194.00	05-01-06	($165.31)
$385.00	05-01-06	($330.62)

Total $1,401.64

Maurice Jenkins
05 WC 48316

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Jackson Park Hospital Medical Bills

Charges	Date of Service	Fee Schedule Amount
$1,247.00	11-08-05	($1,247.00)
$610.50	02-08-06	($301.61)
$901.00	07-20-06	($362.64)
$180.00	07-29-06	($259.96)
$12,840.00	07-29-06	
	07-31-06	($9,758.40)

Charges	Date of Service	Fee Schedule Amount
$500.00	07-30-06	($409.03)
$325.00	07-30-06	($200.26)
$4,021.30	10-28-07	($3,056.18)
$124.10	01-04-08	($124.10)
$137.00	01-04-08	($124.10)
$124.10	01-16/12	($124.10)
$153.00	01-17-08	($153.00)
$2,976.42	01-08-08	($2,262.07)
$308.00	12-14-08	($234.08)
$8,249.48	02-27-08	($6,269.60)
$831.00	01-27-09	($437.94)
$63.68	02-28-09	
$5,859.48 1	2-22-07 thru	
	12-26-07	($5,859.48)
$349.00	08/21/10	($265.24)

$415.00	08-21-10	($207.59)
$169.00	12-29-08	($82.89)
$169.00	02-10-09	($82.89)
$1,274.00	02-17-09 thru 02/27/09	($573.15)
$357.00	03/06/09	($242.32)
$332.00	08/23/09	($252.32)

Total $32,953.33

Friedell Clinic Medical Bills (treatment rendered at Jackson Park Hospital)

Charges	Date of Service	Fee Schedule Amount
$35.00	11-08-05	($35.00)
$224.00	02-07-06	($136.03)
$224.00	02-10-06	($136.03)
$224.00	04-14-06	($136.03)
$224.00	04-24-06	($136.03)
$224.00	05-15-06	($136.03)
$224.00	06-23-06	($136.03)
$224.00	07-03-06	($136.03)
$35.00	07-29-06	($53.84)
$70.00	07-30-06	($107.68)
$164.00	07-31-06	($165.31)
$422.00	12-23-07	($165.31)
$137.00	01-04-08	($143.98)

$124.10	01-04-08	($94.31 POC76)
$124.10	01-16-08	($94.31 POC76)

Total $1,747.14

Mercy Medical Bills

Charges	Date of Service	Fee Schedule Amount
$698.00	10-22-05	($698.00)
$1,497.86	11-07-05	($1,497.86)
$2,000.00	04-13-06	($1,520.00)
$1,600.00	09-16-09	($963.35)

Total $4,679.21

Mercy Physician Billing

Charges	Date of Service	Fee Schedule Amount
$34.00	04-14-06	($53.84)

Total $34.00

Foundation For Emergency Services Medical BillBademosi Adebayo, M. D.

Charges	Date of Service	Fee Schedule Amount
$208.00	05-22-08	($199.97)

Total $199.97

McHenry Laboratory Services

Charges	Date of Service	Fee Schedule Amount
$50.50	07-20-06	($125.59)
$75.00	07-29-06	($75.00)
$89.10	07-30-06	($53.50)

Total $179.00

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Provident Hospital

Charges	Date of Service	Fee Schedule Amount
$160.00	12-09-07	($160.00)

Total $160.00

Medco (Pharmacy)

Charges	Date of Service	Fee Schedule Amount
$222.18	06-02-07	($222.18 Meds)

Total $222.18

UIC Radiology

Charges	Date of Service	Fee Schedule Amount
$385.00	08-04-06	($456.07)
$195.00	11-21-06	($299.02)

Total $580.00

Walgreens

Charges	Date of Service	Fee Schedule Amount
$3,495.05	12-20-06 to Present	($3,495.05)

Total $3,495.05

South Shore Hospital

Charges	Date of Service	Fee Schedule Amount
$144.00	10-28-07	($144.00 Meds)
$38.00	10-28-07	($38.00 Meds)

$349.00	10-28-07	($265.24 ER)

Total $447.24

Park House Medical Center

Charges	Date of Service	Fee Schedule Amount
$3,190.32	03-05-08	($3,190.32 Amount paid by DHS)

Total $3,190.32

John J. Madden Mental Health Center Medical Bills

Charges	Date of Service	Fee Schedule Amount
$5,412.00	05-23-08 thru 06-03-08	($5,412.00 Amount Paid By DHS)

Total $5,412.00

John H. Stroger Hospital

Charge	Date of Service	Fee Schedule Amount
$611.40	12-21-07	($464.66 ER)
$110.00	12-21-07	($83.60 ER)

Total $548.26

Rush University Medical Center

Charge	Date of Service	Fee Schedule Amount
$689.50	06-05-08	($524.02 ER)

Total $524.02

Thresholds

Charge	Date of Service	Fee Schedule Amount

$695.40	12-22-07	($528.50 POC76)
$154.63	12-27-07	($117.51 POC76)
$22.09	12-28-07	($16.78 POC76)
$44.18	01-02-08	($33.57 POC76)
$278.16	02-27-08	($211.40 POC76)
$115.86	03-03-08	($88.05 POC76)
$19.31	03-05-08	($19.31 Meds)

Total $1,015.12

Ambulance Transportation Inc (Transport from Stroger to Thresholds)

Charge	Date of Service	Fee Schedule Amount
$169.00	12-22-07	(POC76 Charge $128.44)
$550.00	12-22-07	($367.70)
$109.14	05-23-08	(POC76 - $82.94)
$214.21	05-23-08	($374.94)

Total $793.29

Community Mental Health Billing

Charge	Date of Service	Fee Schedule Amount
	12-23-07	($107.86)
	12-24-07	($107.86)
	12-26-07	($107.86)
	12-27-07	($169.63)
	02-27-08	($249.96)
	02-28-08	($109.98)
	02-29-08	($109.98)

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	03-02-08	($109.98)
	03-03-08	($109.98)
	03-04-08	($109.98)
	03-05-08	($172.97)
$90.10	06-16-08	($68.47 - POC76)
$36.04	06-16-08	($27.39 - POC76)
$66.60	10-15-08	($50.61 - POC76)
$16.65	10-21-08	($12.65- POC76)

Total $1,625.16

Northern Illinois Clinical Lab - Vuckovic Gradimir

Charge	Date of Service	Fee Schedule Amount
$32.00	12-23-07	($32.35)
$46.00	01-08-08	($39.98)
$11.50	01-17-08	($86.04)
$20.50	02-27-08	($32.33)
$11.50	02-28-08	($58.99)
$11.50	02-29-08	($58.99)

Total $126.98

Advance Ambulance

Charge	Date of Service	Fee Schedule Amount
$72.00	03-05-08	($54.72 POC76)
$30.00	03-05-08	($22.80 POC76)

Total $77.52

Dr. V R Kuchipudi 3101 Maple Ave, Brookfield, IL 60513

Charge	Date of Service	Fee Schedule Amount
$195.00	03-10-08	($148.20 - POC76)
$100.00	03-21-08	($76.00 - POC76)

Total $224.20

NICL Laboratories Propath - Jackson Park Hospital

Charge	Date of Service	Fee Schedule Amount
$92.40	03-19-08	($87.73)
$95.50	03-19-08	($58.99)
$61.11	03-19-08	($64.84)
$37.30	03-19-08	($43.39)
$80.20	03-19-08	($107.99)
$87.72	03-19-08	($163.00)
$15.00	03-19-08	($9.28)

Total $422.33

Dr. John Tulley 1801 W Taylor St Ste 3C, Chicago, IL 60612.

Charge	Date of Service	Fee Schedule Amount
$44.71	04-01-08	($96.98)

Total $44.71

Dr. Donna Bergen, 1725 West Harrison Street Suite 1118, Chicago (Rush)

Charge	Date of Service	Fee Schedule Amount
$152.95	06-05-08	($301.95)

Total $152.95

Meeni Pharmacy

Charge	Date of Service	Fee Schedule Amount

$462.67		($462.67 Meds)

Total $462.67

Osco Drug Pharmacy

Charge	Date of Service	Fee Schedule Amount
$440.24		($440.24 Meds)

Total $440.24

Jacobs Health Care Systems

Charge	Date of Service	Fee Schedule Amount
$366.61		($366.61 Meds)

Total $366.61

Advocate Health and Hospital

Charge	Date of Service	Fee Schedule Amount
$450.00	06-29-06	($342.00)

Total $342.00

Rajiv Kandala MD - (Jackson Park ER)

Charge	Date of Service	Fee Schedule Amount
$600.00	07-29-06	($456.00)
$500.00	07-30-06	($380.00)
$450.00	07-31-06	($342.00)
$300.00	08-01-06	($228.00)

Total $1,406.00

Shahida Ahmad, MD. IMG 2315 E 93rd St Ste 320, Chicago, IL60617

Charge	Date of Service	Fee Schedule Amount

$125.00	06-29-06	($170.04)

Total $125.00

K. What temporary benefits are in dispute?

Petitioner is due temporary total disability benefits from 10-21-05 through 10-31-12, as provided in Section 8(b) of the Act.

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

Petitioner has not proven that he is permanently, totally disabled. Respondent shall pay Petitioner benefits of $591.77/week for 250 weeks as the injury has resulted in 50% of use of a man as a whole, as provided in Section 8(d)2 of the Act.

M. Should penalties or fees be imposed upon Respondent?

The purpose of penalties is to expedite the compensation of industrially injured workers and penalize employers who unreasonably, or in bad faith, delay or withhold compensation due employees. *See, Avon Products. Inc. v. Industrial Comm'n*, 82 Ill. 2d 297, 301, 412 N.E.2d 468 (1980). Penalties should not be imposed when an employer reasonably believed an employee was not entitled to compensation. It is not enough, however, to assert an honest belief that the employee's claim is invalid; the employer's belief is honest only if the facts, known to a reasonable person in the employer's position, would justify non-payment of compensation *See, Board of Education of the City of Chicago v. Industrial Comm'n*, 93 Ill. 2d 1, 9, 442 N.E.2d 861 (1982). Moreover, the burden is on the employer to show that its refusal to pay was objectively reasonable. *Miller v. Industrial Comm'n*, 255 Ill. App. 3d 974, 980, 627 N.E.2d 676 (1993). Whether the employer's conduct justifies the imposition of penalties is to be considered in terms of reasonableness. *See, Electro-Motive Division v. Workers' Compensation Commission*, 190 Ill. Dec. 276; 621 N.E. 2d 145 (Ill. App. 1st Dist. 1993). *See also, Clark v. Workers' Compensation Commission*, 218 Ill. App. 3d. 116, 116 Ill. Dec. 13, 578 N.E.

14IWCC0092

2d 140 (1991), *McKay Plating Company v. Workers' Compensation Commission*, 91 Ill. App. 2d., 98, 62 Ill. Dec. 929, 437 N.E. 2d, 617, 623 (1982). Whether the employer has acted responsibly in refusing to pay benefits is to be decided on a case by case basis and is a question of fact. *See, Electro-Motive Division v. Workers' Compensation Commission, id.* Further, in determining whether delay in payment of workers' compensation has been unreasonable or vexatious so as to authorize imposition of a penalty, regard must be given to the circumstances attending the delay, nature of the case and the relief demanded; also to the question of whether the rights of the claimant have been prejudiced by that delay. *See, Board of Education of City of Chicago v. Workers' Compensation Commission*, 39 Ill. 2d 167, 233, N.E. 2d 362 (1968). Neither penalties nor attorneys' fees will be awarded in this matter.

N. Is Respondent due any credit?

Respondent is entitled to a credit of $20,281.99; $5,278.67 for medical payments, under Section 8 (a) of the Act; and $15,600.02 for union disability payments, under Section 8(j) of the Act.

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

Gayelynn Lohman,

Petitioner,

14IWCC0093

vs.

NO: 11 WC 42156

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 19, 2013 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.

14IWCC0093

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,600.00. 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: FEB 1 0 2014

David L. Gore

Daniel R. Donohoo

Mario Basurto

DLG/gal
O: 1/23/14
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0093

LOHMAN, GAYELYNN
Employee/Petitioner

Case# 11WC042156

CATERPILLAR INC
Employer/Respondent

On 2/19/2013, 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 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0767 PETE SULLIVAN & ASSOC PC
LAURA L GRAY
124 S W ADAMS ST SUITE 340
PEORIA, IL 61602

2994 CATERPILLAR INC
MARK FLANNERY
100 N E ADAMS ST
PEORIA, IL 61629-4340

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 14IWCC0093

GAYELYNN LOHMAN,
Employee/Petitioner

v.

CATERPILLAR, INC.,
Employer/Respondent

Case # 11 WC 42156

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 H. Pulia**, Arbitrator of the Commission, in the city of **Peoria**, on **1/25/13**. After reviewing all 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 _____

14IWCC0093

FINDINGS

On **9/8/11**, 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 *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$31,282.90**; the average weekly wage was **$625.66**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$2,624.00** in non-occupational indemnity disability benefits, for a total credit of **$2,624.00**.

Respondent is entitled to a credit of **$00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $417.11/week for 16-5/7 weeks, commencing 9/8/11 through 1/22/12, as provided in Section 8(b) of the Act.

Respondent shall pay the unpaid bill of Dr. Kancius in the amount of $775.00as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $375.40/week for 25.05 weeks, because the injuries sustained caused the **10% loss of the left foot and 5% loss of the right foot**, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

2/8/13
Date

ICArbDec p. 2

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 45-year-old parts specialists alleges she sustained an accidental injury to her bilateral feet due to repetitive work activities that arose out of and in the course of her employment with respondent and manifested itself on 9/8/11. Petitioner works in FPS Bay 19 in the Morton facility. She testified that she had worked in the Bay 19 area for almost 3 years prior to the alleged date of accident and wore steel toe shoes mandated by respondent. Her duties included taking parts out of damaged packaging and placing them in good packaging. Petitioner then carried the parts or pushed them down the conveyor belt about 20 to 25 feet, to the banding process area. She then would go to the computer to determine where the parts were to be distributed.

She testified that the floor underneath the packing area is primarily cedar blocks. As petitioner walked up and down along the conveyor belt she walked on cedar blocks. Petitioner's typical workday was eight hours, and she performed her packaging duties approximately 6 of the 8 hours. Petitioner testified that she also used a fork lift about two hours a day and spent the remainder of the day at her workstation. About 1 hour and 45 minutes of the time she spent at her workstation she was standing in front of the computer, processing information.

Petitioner testified that prior to 9/8/11 she worked in this job for 7 ½ years, in Morton and Mosville. Throughout this time petitioner testified that she walked on concrete and cedar block floors. Petitioner testified that the repackaged boxes she carried weighed up to 49 pounds, and any box that weighed more than 50 pounds had to be moved with a hoist. During the 2 to 3 years preceding the date of injury petitioner testified that the weight of the boxes she would move weighed on average between 20 and 40 pounds. Petitioner moved on average between 20 and 69 boxes a night depending on what material was in the packages.

Petitioner testified that in the area where she worked about 50% of the cedar blocks were uneven. She stated that one area where she would stumble, the cedar blocks were ¼ inch higher than the concrete. She also stated that some of the cedar blocks were recessed. Petitioner stated that the floor was not always level and the wood would swell if oils got into it.

On 9/8/11 as petitioner was processing the parts she felt extreme pain in the left heel of her left foot. Petitioner felt this pain while she was walking along the path of the conveyor on the uneven cedar blocks. She testified that she was limping. Petitioner reported her complaints to Paul Chetty, her immediate supervisor, before going to the doctor.

On 9/8/11 petitioner presented to Dr. Christine Kancius at Midwest Podiatry Group. Petitioner's chief complaint was pain in both of her heels. Petitioner described the condition as 6+ weeks sudden onset, with a sharp shooting quality and extreme severity. She reported that the pain was located at the plantar aspect of both

the left and right heel. The left heel was more painful than the right. She stated that her pain was made better with resting and soaking her feet. She further stated that her pain was worse upon rising in the morning and with weight-bearing. Petitioner reported that she noticed pain when she first got up in the morning and after standing up after periods of rest throughout the day. Petitioner denied any history of gout or rheumatoid arthritis. She also denied any history of a heel injury or trauma. Petitioner reported that her past medical history included foot and leg cramps. Petitioner was examined and her diagnosis was plantar fasciitis bilateral, and painful foot bilateral. Dr. Kancius injected the plantar aspect of the left heel at the level of the inferior calcaneal tubercle. A varus low dye rest strapping with longitudinal arch pad was applied to her left foot. Petitioner was counseled with regards to plantar fascia care. She was instructed to begin plantar fascia and gastrocsoleus stretching exercises for relief of her heel pain. She was also instructed to apply ice to the heel 15 to 20 minutes after stretching. Petitioner was restricted from weight-bearing without wearing shoes.

On 9/28/11 petitioner returned to Dr. Kancius. Petitioner reported that she had no improvement following the shot. Dr. Kancius suggested that petitioner wear an air cast for 4 to 6 weeks. She also authorized petitioner off work for a week to rest her foot and get used to the cast. Dr. Kancius's treatment recommendations remained the same. Petitioner remained restricted from weight-bearing without wearing shoes. She was also given a prescription for an air cast.

On 10/5/11 petitioner followed up with Dr. Kancius. Petitioner noted great improvement over the last several weeks while wearing the air cast. Dr. Kancius recommended that petitioner continue to wear the air cast for two more weeks. Thereafter she would consider weaning petitioner off the air cast.

On or about 10/7/11 petitioner completed an application for disability benefits. The form indicated that her injury occurred, or condition or sickness began on 08/01/11 and that she began missing work because of the sickness, injury or surgery on 09/28/11.

On 10/19/11 petitioner returned to Dr. Kancius. Petitioner again noted great improvement over last several weeks. Dr. Kancius recommended that petitioner continue to wear the air cast for two more weeks before beginning to wean her out of the cast. She also advised petitioner to make sure she bends her ankle daily.

On 11/2/11 petitioner returned to Dr. Kancius. She reported some discomfort in the heel. As a result, Dr. Kancius recommended that petitioner remain in the cast for two more weeks. On 11/16/11 Dr. Kancius recommended that petitioner gradually work herself out of the cast over the next two weeks and into a supportive tennis shoe. She recommended fabricating functional foot orthotics. Treatment consisted of biomechanical evaluation and plaster casting for functional foot orthotics. On 11/30/11 petitioner noted that she

had been unable to make a transition out of her cast and was still having pain in the foot. Since her orthotics were not yet ready Dr. Kancius told petitioner to continue with the air cast until the orthotics could be fitted. Dr. Kancius authorized petitioner off work for two more weeks.

On 12/12/11 petitioner followed up with Dr. Kancius. Petitioner was given orthotics with instructions to break them in slowly. Dr. Kancius told her that if she had any flareups she was to go back into her cast. Petitioner was authorized off work for three additional weeks in order to adjust to her orthotics. On 1/4/12 petitioner reported that she was still having some difficulty with her heel and getting used to her orthotics. Dr. Kancius told petitioner to gradually increase the time she stands in the orthotics. Petitioner was continued off work for an additional two weeks. On 1/16/12 petitioner reported that she was doing better with the orthotics. She indicated that she is going to increase her time wearing them in her work boots before she goes back to work on 1/23/12.

Petitioner testified that she returned to work on 1/23/12. When she returned to work petitioner noticed that respondent placed mats in various areas along the concrete and cedar blocks running along the conveyor belt in her work area. She also noted glue on some of the cedar blocks. Petitioner testified that these mats were not present before the alleged injury on 9/8/11.

On 2/1/12 petitioner noted that she was doing better with her left heel, but now she had mild plantar fasciitis of the right heel. She reported that she had been working for about two weeks and the pain was now located at the plantar aspect of the right heel. She stated that the pain is made better with resting her feet and worse with weight-bearing. Petitioner reported that she notices pain when first getting up in the morning and when standing up after periods of rest throughout the day. An examination revealed +3/10 pain on palpation of the plantar aspect of the left heel; no evidence of systemic inflammatory disease; no evidence of cellulitis; and no evidence of infection. There was +6/10 pain on palpation of the plantar aspect of the right heel. Dr. Kancius diagnosed plantar fasciitis of the left foot, plantar fasciitis of the right foot, and painful foot bilateral. Petitioner was prescribed Mobic and was told to continue with her orthotics.

On 4/26/12 Dr. Kancius drafted a letter to petitioner's attorney, Laura Gray. Dr. Kancius stated that petitioner had been a patient in her office since 9/8/11, and her initial complaint was pain in the bottom of her left foot. She also noted that petitioner told her that the right foot hurt, but not as bad. She noted that petitioner had reported that the pain had been going on for approximately 6 weeks. Dr. Kancius noted that after her initial exam she explained to petitioner that she had plantar fasciitis. Dr. Kancius noted that she treated it with an injection of celestone and lidocaine, padding and strapping of the foot, exercises, anti-inflammatories, rest and elevation when possible, and finally putting her in an air cast followed by custom orthotics. Dr. Kancius noted

that she authorized petitioner off work from 10/19/11 there 1/23/12, and that petitioner was improving when she last saw her on 2/1/12. Dr. Kancius was of the opinion plantar fasciitis is a very common problem. She could not say that petitioner's work environment caused her condition, but she was sure that it aggravated the problem. Without a specific injury, which petitioner denied, Dr. Kancius noted that there was no way to confirm what caused her plantar fasciitis.

On 6/27/12 petitioner underwent a section 12 examination performed by Dr. Ira Kornblatt at the request of the respondent. Petitioner reported spontaneous onset of bilateral, but mainly left-sided heel pain beginning approximately 8/1/11, when she complained of spontaneous onset of pain six weeks previously. She reported that she first noticed the pain when getting up in the morning and after standing up after periods of rest throughout the day. Petitioner stated that she was initially treated with a steroid injection to the left heel and stretching exercises. However due to ongoing symptomatology she was placed in a cast, supportive tennis shoes, and then orthotics in January 2012. She stated that on 1/23/12 she returned to her normal job activities after missing approximately 4 months of work. Petitioner reported that in February 2012 she complained of increased symptomatology regarding the right heel, for which he was given nonsteroidal anti-inflammatory medications. Petitioner denied previous problems with either foot and stated that she had been employed by Caterpillar for the past seven years. Her chief complaint was ongoing complaints of plantar foot pain, bilateral feet. She stated that she had just returned from a two-week vacation in Rome and had no pain in either foot while in Rome. However, upon returning to work the day before she developed recurrent pain in both her feet, which she claimed was due to her steel toed shoes and uneven factory floor. She stated that she continues to take a nonsteroidal anti-inflammatory medication on a daily basis.

An examination of the right hindfoot revealed complaints of pain over palpation of the plantar fascia and its insertion to the heel. Examination of the left heel revealed similar findings with some tenderness at the plantar fascial insertion. No local swelling of either foot was noted. X-rays were taken of petitioner's feet. They were negative for fracture, dislocation, or significant arthritis. Additionally, there was no evidence of a plantar spur of either foot. Dr. Kornblatt was of the opinion that petitioner had low grade plantar fasciitis of bilateral feet. He was further of the opinion that there was no history of trauma and no history of repetitive activity that would likely lead to plantar fasciitis. As such, he opined that petitioner's job activities were not likely a cause or an aggravation of the spontaneous onset of plantar fasciitis which the claimant developed. Dr. Kornblatt was of the opinion that petitioner had reached maximum medical improvement for her condition of plantar fasciitis. He did not believe petitioner had any further ongoing symptomatology due to her low grade plantar fasciitis, but noted that she continued to take nonsteroidal anti-inflammatory medications. Dr. Kornblatt was of the opinion

that petitioner needed these medications for symptomatic measures. He saw no evidence of any work related activity or problems that resulted in her present symptomatology.

The deposition of Dr. Kancius, a podiatrist, was taken on August 9, 2012 on behalf of the petitioner. Dr. Kancius testified that petitioner told her that at work she was standing a lot and moving on hard concrete surfaces. When asked if petitioner's full-time work duties of standing or walking on concrete floor, more likely than not, significantly aggravated her feet conditions, Dr. Kancius opined that if you have plantar fasciitis and you do work on hard surfaces and stand all day long it does keep the condition aggravated. Dr. Kancius further opined that petitioner's work duties of standing at work more likely than not aggravated her plantar fasciitis condition. Dr. Kancius' opinion in February 2012 was that petitioner's prognosis was guarded. At that time Dr. Kancius noted that petitioner had improvement with the left foot, but her right foot was beginning to hurt a little bit. Dr. Kancius found petitioner's complaints of pain to be consistent with her diagnosis.

Dr. Kancius was of the opinion that most steel toed shoes provide very poor arch support especially when you have a plantar fascial band problem already. She did not believe that steel toed shoes were very good supportive shoes. Dr. Kancius was of the opinion that the problems with steel toed shoes is that they are not usually manufactured with a great deal arch support , and they are also restricted as far as what can go inside the steel toed shoe. As such, it is difficult sometimes to get orthotics into these type shoes.

On cross examination Dr. Kancius opined that the recognized causes of plantar fasciitis include weight gain, choice of poor shoes, standing on hard surfaces, and pregnancy. Dr. Kancius did not know what type of shoes petitioner wore outside of work. She also had no understanding of petitioner's activities outside of work with respect to standing on hard surfaces. Dr. Kancius noted that petitioner was 150 pounds and stood about 5'3" tall. She further noted that petitioner provided no history of any specific injury or trauma. Dr. Kancius testified that other than standing for extended periods of time at work she was not aware of any other duties petitioner had that might aggravate the plantar fascial band. Dr. Kancius was of the opinion that by 10/19/11 she noted no symptoms in petitioner's plantar aspect of the right foot and was of the opinion that petitioner's plantar fascia symptoms had resolved on the right. Dr. Kancius was of the opinion that the fluctuation of petitioner's right foot pain back and forth was probably due to using the right foot a little bit more when the left foot was more aggravated. Dr. Kancius testified that she completed the physician's section of petitioner's application for disability benefits that was dated 10/7/11. She testified at that on page 2, question#5, in her opinion the petitioner's disability was not related to her work at Caterpillar. On redirect examination, Dr. Kancius testified that it was her understanding that at that time the petitioner was not claiming any acute injury with regard to her

right or left heel pain. Dr. Kancius opined that petitioner's bilateral foot problems were aggravated by her work duties, specifically standing on concrete and uneven surfaces.

On 10/3/12 the evidentiary deposition of Dr. Ira Kornblatt was taken on behalf of respondent. Dr. Kornblatt is an orthopedic surgeon specializing in sports medicine. Dr. Kornblatt was of the opinion that plantar fasciitis can come on spontaneously, especially in middle-aged women. He did not believe that petitioner reported any type of work activity that would have caused her plantar fasciitis. Dr. Kornblatt testified that if he had a patient with plantar fasciitis that fails conservative treatment he would send them to a podiatrist for further treatment. Dr. Kornblatt was of the opinion that some of the recognized causes of plantar fasciitis are spontaneous onset that is more common in men than women and tends to be in patients who are 40 to 60 years old; obesity; people who stand in one position over an extended period of time; people with repetitive stress from climbing or jumping; and runners. Dr. Kornblatt stated that he had never seen anything in writing that steel toed shoes result in an increased incidence of plantar fasciitis. He further stated that he has never seen in literature that walking on a factory floor where there are a few uneven surfaces can cause the development of plantar fasciitis. Dr. Kornblatt testified that he did not know what flooring surfaces petitioner was working out when she was packing parts.

Dustin Wagoner, Safety and Security Manager at the Morton Plant for the last five and half years, was called as a witness on behalf of respondent. Wagoner testified that his duties include programs related to the safety and health of employees. Wagoner went to petitioner's work area on 1/22/13 and took photos and reviewed the area. He had not been to petitioner's work area before this date. He did not believe petitioner's work area was different on the date of injury than it was on 1/22/13. He was not aware of the floor being raised or lowered. He further testified that anti-fatigue mats were placed in the area to ease the impact on the worker's body. Wagoner did not know how long the cedar blocks in petitioner's work area were there. He indicated that cedar blocks were used because petitioner's line handled the heaviest blocks and would crack the concrete.

Respondent offered into evidence petitioner's post offer questionnaire. In the questionnaire petitioner denied that she ever had any type of foot problem including plantar fasciitis.

Petitioner testified that currently she is unable to wear heels, high boots, or flip-flops. She claims that she must buy expensive shoes that can accommodate orthotics. She stated that she cannot walk for long distances. She also reported difficulty doing her workouts. Petitioner stated that she wears orthotics in her work boots. Petitioner is no longer able to hike for more than an hour and a half, and cannot walk on uneven terrain when hiking. At home, petitioner is unable to stretch upward to reach the cupboards. Petitioner denied any pain in her feet for 10 years prior to the accident. Petitioner testified that the pain in her feet is equal and varies depending

on what type of activities she is doing. She said her pain level can get up as high as 8/10 or on a good day be as low as 4/10. To relieve her pain petitioner takes Aleve, soaks her feet, and uses a foot spa. Petitioner can no longer walk in her bare feet.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner is alleging an accidental injury to his bilateral hands and arms due to repetitive work activities that arose out of and in the course of his employment by respondent and manifested itself on 2/17/11.

As a general rule, repetitive trauma cases are compensable as accidental injuries under the Illinois Worker's Compensation Act. In Peoria County Belwood Nursing Home v. Industrial Commission (1987) 115 111.2d 524, 106 Ill.Dec 235, 505 N.E.2d 1026, the Supreme Court held that "the purpose behind the Workers' Compensation Act is best serviced by allowing compensation in a case … where an injury has been shown to be caused by the performance of the claimant's job and has developed gradually over a period of time, without requiring complete dysfunction.." However, it is imperative that the claimant place into evidence specific and detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

Since petitioner is claiming an injury to her bilateral feet due to repetitive work activities, in Illinois, recovery under the Workers' Compensation Act is allowed, even though the injury is not traceable to a specific traumatic event, where the performance of the employee's work involves constant or repetitive activity that gradually causes deterioration of or injury to a body part, assuming it can be medically established that the origin of the injury was the repetitive stressful activity. In any particular case, there could be more than one date on which the injury "manifested itself". These dates could be based on one or more of the following, depending on the facts of the case:

1. The date the petitioner first seeks medical attention for the condition;
2. The date the petitioner is first informed by a physician that the condition is work related;
3. The date the petitioner is first unable to work as a result of the condition;
4. The date when the symptoms became more acute at work;
5. The date that the petitioner first noticed the symptoms of the condition.

In the case at bar the petitioner presented unrebutted evidence that she works on a packing line along a conveyor belt. Petitioner has been performing this job for the past 7 ½ years. Petitioner is required to wear steel-toed shoes and carry items or push items down the conveyor belt. For a minimum of 6 hours per day petitioner walks up and down the conveyor belt on cedar blocks and repackages boxes weighing between 20 and 40 pounds. She testified that she repackages between 20-69 boxes a shift, depending in the product. In addition to standing on her feet alongside the conveyor belt on the cedar blocks, petitioner also spends a portion of the remaining 2 hours standing at her computer entering information to determine where the packages are going. Petitioner works 40 hours a week, with 40 minutes for lunch and break per day.

Petitioner testified that the cedar blocks that made up the ground she stood on were not all even. She stated that approximately 50% of them were uneven, and in one area where the cedar blocks were ¼ inch higher than the adjoining concrete she would stumble at times. Petitioner stated that some of the cedar blocks were recessed and that some of them may be swollen if oil spilled and got absorbed into the block.

Petitioner testified that after she returned to work on 1/23/12 following her initial treatment she noticed that anti-fatigued mats had been placed over some of the cedar blocks and gaps between some of the cedar blocks had been filled in. Wagoner testified that these changes were made while petitioner was off. He had no pictures of what the area looked like before 9/8/11, only those taken right before trial. Petitioner testified that these photos did not accurately depict the area on 9/8/11.

Petitioner testified that when she presented to Dr. Kancius on 9/8/11 she described the onset of pain as 6 weeks ago, with the pain worsening since then. She described the pain as severe, sharp and shooting. She stated that it was worse upon rising in the morning and with weight bearing. Although petitioner had complaints prior to 9/8/11 and had mentioned it to her employer prior to that date, 9/8/11 was the date on which her condition became more acute at work and the date she first sought medical treatment for the condition.

Petitioner also testified that while off work she went on vacation to Rome and had no problems. However, after returning to work and resuming her work duties, she developed recurrent pain in both her feet.

Based on the above, the arbitrator finds the petitioner sustained an accidental injury to her bilateral feet due to her repetitive work activities that arose out of and in the course of her employment by respondent, and manifested itself on 9/8/11.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

The Arbitrator adopts her findings of fact and conclusions of law contained above with respect to the issue of accident and incorporates them herein by this reference.

Dr. Kancius and Dr. Kornblatt offered opinions on the issue of causal connection. Dr. Kancius noted that petitioner's initial complaint was with respect to the bottom of both her feet, left worse than right. Dr. Kancius diagnosed plantar fasciitis and treated it with an injection of celestone and lidocaine, padding and strapping of the foot, exercises, anti-inflammatories, rest and elevation when possible, and finally putting her in an air cast followed by custom orthotics. Dr. Kancius was of the opinion plantar fasciitis is a very common problem. Although she could not say that petitioner's work environment caused her condition, she was sure that petitioner's work duties aggravated the problem.

Dr. Kornblatt was of the opinion that petitioner had low grade plantar fasciitis of bilateral feet. He was further of the opinion that there was no history of trauma and no history of repetitive activity that would likely lead to plantar fasciitis. As such, he opined that petitioner's job activities were not likely a cause or an aggravation of the spontaneous onset of plantar fasciitis which the claimant developed. Dr. Kornblatt saw no evidence of any work related activity or problems that resulted in her present symptomatology.

In her deposition Dr. Kancius, a podiatrist, noted that petitioner told her that at work she was standing a lot and moving on hard concrete surfaces. When asked if petitioner's full-time work duties of standing or walking on concrete floor, more likely than not, significantly aggravated her feet conditions Dr. Kancius opined that if you have plantar fasciitis and you do work on hard surfaces and stand all day long it does keep the condition aggravated. Dr. Kancius opined that petitioner's work duties of standing at work more likely than not aggravated her plantar fasciitis condition. Dr. Kancius was of the opinion that most steel toed shoes provide very poor arch support especially when you have a plantar fascial band problem already. She did not believe that steel toed shoes were very good supportive shoes. Dr. Kancius was of the opinion that the problems with steel toed shoes is that they are not usually manufactured with a great deal arch support , and they are also restricted as far as what can go inside the steel toed shoe. As such, it is difficult sometimes to get orthotics into these type shoes.

Although Dr. Kancius was of the opinion that the recognized causes of plantar fasciitis include weight gain, choice of poor shoes, standing on hard surfaces, and pregnancy, she opined that petitioner's bilateral foot problems were aggravated by her work duties, specifically standing on concrete and uneven surfaces.

Alternative, Dr. Ira Kornblatt, an orthopedic surgeon specializing in sports medicine was of the opinion that plantar fasciitis can come on spontaneously, especially in middle-aged women. He did not believe that petitioner reported any type of work activity that would have caused her plantar fasciitis. Dr. Kornblatt testified that if he had a patient with plantar fasciitis that fails conservative treatment he would send them to a podiatrist for further treatment. Dr. Kornblatt also noted that some of the recognized causes of plantar fasciitis are

spontaneous onset that is more common in men than women and tends to be in patients who are 40 to 60 years old; obesity; people who stand in one position over an extended period of time; people with repetitive stress from climbing or jumping; and runners. Dr. Kornblatt stated that he had never seen anything in writing that steel toed shoes result in an increased incidence of plantar fasciitis. He further stated that he has never seen in literature that walking on a factory floor where there are a few uneven surfaces can cause the development of plantar fasciitis. The arbitrator finds it significant that Dr. Kornblatt did not know what flooring surfaces petitioner was working out when she was packing parts.

Based on the above, as well as the credible evidence, that arbitrator finds the opinions of Dr. Kancius more credible than those of Dr. Kornblatt. The arbitrator finds it significant that Dr. Kancius knew petitioner's job duties and what surface she worked on. Alternatively, Dr. Kornblatt admitted that he did not know the flooring surface that petitioner worked on. Additionally, he admitted that if he had a patient with plantar fasciitis that fails conservative treatment he would send them to a podiatrist for further treatment. Based on these findings the arbitrator finds Dr. Kancius, a podiatrist, had a more complete description of petitioner's work duties, and as a podiatrist, had a better understanding of what activities cause, or aggravate plantar fasciitis.

The arbitrator adopts the opinions of Dr. Kancius over those of Dr. Kornblatt, and finds the petitioner has proven by a preponderance of the credible evidence that her bilateral feet conditions are causally related to the repetitive work activities she does for respondent.

J. WERE 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 adopts her findings of fact and conclusions of law contained above with respect to the issues of accident and causal connection and incorporates them herein by this reference.

Petitioner is claiming that respondent is liable for an unpaid bill in the amount of $775.00 for treatment rendered by Dr. Kancius. The arbitrator finds the respondent shall pay the unpaid bill from Dr. Kancius in the amount of $775.00 pursuant to Sections 8(a) and 8.2 of the Act.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

The Arbitrator adopts her findings of fact and conclusions of law contained above with respect to the issues of accident and causal connection and incorporates them herein by this reference.

Petitioner is alleging that she was temporarily totally disabled from 9/28/11 to 1/23/12. On 9/28/11 petitioner presented to Dr. Kancius. Dr. Kancius restricted petitioner from weight-bearing without wearing shoes, and issued a prescription for an air cast for her to wear. Respondent could not accommodate these

restrictions. On 11/16/11 Dr. Kancius instructed petitioner to gradually work herself out of the cast over the next two week and into a supportive tennis shoe. Again, respondent could not accommodate this restriction. Over the next month petitioner was fitted with orthotics. On 1/16/12 she reported that she was doing better with the orthotics, She also indicated that she was going to increase her time wearing them in her work boots before she went back to work on 1/23/12.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner was temporarily totally disabled from 9/28/11-1/22/12, a period of 16-5/7 weeks. The arbitrator finds the respondent is entitled to a credit for the non-occupational indemnity disability benefits paid in the amount of $2,624.00.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

The Arbitrator adopts her findings of fact and conclusions of law contained above with respect to the issues of accident and causal connection and incorporates them herein by this reference.

As a result of this injury petitioner underwent conservative treatment for both her feet that included an injection of celestone and lidocaine, padding and strapping of the foot, exercises, anti-inflammatories, rest and elevation when possible, air cast and custom orthotics for her left foot and exercises, anti-inflammatories, rest and elevation for the right foot.

Petitioner was released to her full duty job on 1/23/12. She testified that currently she is unable to wear heels, high boots, or flip-flops. She claims that she must buy expensive shoes that can accommodate orthotics. She stated that she cannot walk for long distances. She also reported difficulty doing her workouts. Petitioner stated that she wears orthotics in her work boots. Petitioner is no longer able to hike for more than an hour and a half, and cannot walk on uneven terrain when hiking. At home, petitioner is unable to stretch upward to reach the cupboards. Petitioner denied any pain in her feet for 10 years prior to the accident. Petitioner testified that the pain in her feet is equal and varies depending on what type of activities she is doing. She said her pain level can get up as high as 8/10 or on a good day be as low as 4/10. To relieve her pain petitioner takes Aleve, soaks her feet, and uses a foot spot. Petitioner can no longer walk in her bare feet. Despite these subjective complaints petitioner has not sought any further medical treatment.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner sustained a 5% loss of use of the right foot, and 10% loss of use of the left foot pursuant to Section 8(e) 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 AWW	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steve Devaney,

Petitioner,

14IWCC0094

vs.

NO: 12 WC 23465

Worldwide Music Services, LLC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner/Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, average weekly wage/benefits rates, temporary total disability, employment termination, and penalties & attorney fees and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation 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 FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 59 year old employee of Respondent, who described his job as managing director since September 2010 (for 1-3/4 years). Petitioner's immediate supervisor was F. Hayden Connor. Respondent was in the business of sheet music distribution and they did not have an Internet e-commerce presence. Petitioner testified that he was brought in to help manage Respondent and the two other companies in the same building. Petitioner

testified he had an employment agreement with Respondent which at some point was reduced to writing. Petitioner testified that they had exchanged a series of e-mails regarding the employment contract. Petitioner viewed PX 6 and identified it as a draft contract between Petitioner and Respondent that was finalized. Petitioner testified that the contract stated (Petitioner read from the terms of the contract) that 'your remuneration will start at $30,000 paid (PA) on September 15, 2010 with another $30,000 held in abeyance until it can be afforded from cash flow, and will be paid retroactively.' Petitioner testified that at some point the agreement was printed out and presented for his signature. Petitioner stated that he signed a final version of that agreement and gave it to Mr. Connor; that was the last time he saw it. Petitioner testified that the noted paragraph was contained in the final version he signed. Petitioner testified that he understood that his annual salary was $60,000 and that the $30,000 per year under the agreement was deferred compensation that was part of his regular earnings. Petitioner testified that his understanding was that his 2011 and 2012 salary was $60,000; split between $30,000 currently paid and $30,000 as deferred compensation. Petitioner testified it was Mr. Connor's idea to defer part of the compensation as Mr. Connor had approached Petitioner with the idea. Petitioner testified that Mr. Connor asked him to do that because at the time Respondent was moving or required to move out of the facility they were in and was short of cash. Petitioner helped Respondent move out and it was always his understanding that his earning for 2011 and 2012 was $60,000. Petitioner testified the $60,000 per year salary was exclusive, separate and apart from any sort of bonus or performance incentive.

- On the date of accident, June 21, 2012, Petitioner testified he was working that day and physically feeling fine; he had no problems with his left shoulder or arm at all. Petitioner had a prior left arm fracture when he was 12 years old but from then until June 21, 2012 he had no problems with his left arm. Petitioner testified that on that day they were moving boxes at Respondent as they were told by Mr. Connor. Petitioner understood the work he was doing was for the benefit of Respondent. Mr. Connor owned the building where Respondent was located. Petitioner testified that the building Mr. Connor took over was sold as is and was in deplorable condition. Petitioner testified that on June 21, 2012 when he was moving boxes he slipped on some stairs and fell. Petitioner stated that it was wet outside and the stairs may have been wet from workers moving the boxes in and out from the wet. Petitioner stated he was collecting boxes from the doorway in. Petitioner stated that as he was delivering boxes to someone (Jeff Hansel) at the top of the stairs and he slipped and immediately fell on his elbow which jammed into his shoulder and neck. Petitioner testified that he didn't have time to extend his arm to catch himself. Petitioner stated immediately after the fall he had severe pain. Petitioner reported to Northwestern Memorial Hospital ER the same day of the accident and testified he reported headache, left shoulder, left clavicle, and left arm pain. Petitioner stated that his pain got worse with movement and he had swelling in his left hand as well. Petitioner is left hand dominant. Petitioner had an x-ray at the ER which revealed a non-displaced

fracture at his left elbow. Petitioner had an x-ray of his left forearm that day which confirmed a radial head fracture in his left arm. Petitioner testified that the ER doctor recommended that he follow up with an orthopedic surgeon and he was placed in a sling. Petitioner reported the injury to Mr. Connor at Respondent. Petitioner stated Mr. Connor said not to worry as Respondent had WC insurance.

- Petitioner was seen by Dr. Merk, an orthopedic surgeon, at Northwestern on June 26, 2012. Petitioner testified he reported to the doctor that he had pain in his elbow and radiating down into his forearm. Petitioner stated the pain was from his neck down to his hand. Petitioner understood the doctor diagnosed a displaced fracture in the radial head. The doctor gave Petitioner a restriction of no lifting more than 3-5 pounds and told him to follow up in 4 weeks. Petitioner stated that he attempted to return to work on June 28, 2012 with the restriction but was unable to perform his functions. Petitioner testified that he did not report to work on June 29, 2012 because of the problems he had the prior day. Petitioner testified at that time Respondent was unable to accommodate his 3-5 pound restriction. Petitioner had contacted Dr. Merk's office June 28, 2012 regarding his attempt at returning to work and the problems with his dominant arm. Petitioner stated that the doctor recommended he stay off work. Petitioner testified that Mr. Connor was aware that Petitioner had tried to work and was unable to do so. Petitioner stated that he spoke to Mr. Connor in the office on June 28 at about 1:00pm. Petitioner stated he told Mr. Connor that since Petitioner was left handed, any functions he normally performed were impossible and Mr. Connor told Petitioner to go home. Petitioner testified at some point after June 28 he received his first TTD check for $549.45 and he understood that to be for the period of June 22-June 26, 2012. He received a second check for $769.23 for June 29-July 5, 2012. He received a third check for $659.34 for July 6-July 11, 2012. Petitioner testified that at some point after the accident and prior to July 8, 2012 he spoke to Mr. Connor regarding the wage reported to the insurance company. Petitioner testified that he had reported his wage to the insurance company as $60,000/year. Petitioner stated Mr. Connor said he had also spoken to the insurance company the same day as Petitioner; the conversation took place in the office with no one else present at about 1:00p.m. Petitioner stated Mr. Connor said he had confirmed what Petitioner told the insurance company regarding wages ($60,000/year).

- Petitioner returned to Dr. Merk on July 11, 2012. At that time Petitioner stated that he had numbness in his left little and ring fingers and reported difficulty writing because of the lack of control of his left hand. The doctor recommended starting occupational therapy and to follow up in 4 weeks. Petitioner did not begin the therapy at that time. Petitioner filed his Application for Adjustment of Claim on July 9, 2012. Sometime after July 18, 2012 he received a fourth TTD check for $769.23 for July 12-July 18, 2012. Petitioner stated that he had another conversation with Mr. Connor (about retaining an attorney and filing the WC claim); however, he did not recall the date of that phone

conversation. Petitioner testified about August 2, 2012 he was informed his TTD benefits would be reduced to $253.00 per week because of the information Mr. Connor provided to the WC insurance adjuster; Petitioner testified Mr. Connor provided that information to the adjuster after Petitioner retained an attorney. Petitioner testified in his conversation with Mr. Connor, Mr. Connor had stridently suggested that Petitioner not hire an attorney as it would impact him financially and that Petitioner should not do it. Petitioner stated that he did not learn of the TTD reduction until he received that check. At some point Petitioner had a conversation with Mr. Connor regarding the reduction; he did not recall the date but it was shortly after receiving that check. The conversation took place over the phone. Petitioner stated he asked what caused the reduction and Mr. Connor said he called the insurance company. Petitioner testified that Mr. Connor told him that he was going to lose financially and that he needed to reduce the amount Petitioner was getting paid. Mr. Connor said he sent the W-2's to the adjuster. Petitioner testified he had 2-3 phone conversations with Mr. Connor regarding retaining an attorney around the time he received the first TTD check, and from there on they communicated via e-mail. Petitioner testified he had a phone conversation with Mr. Connor regarding filing a WC claim but he did not recall when that happened but it was before his benefits were reduced. Petitioner stated Mr. Connor told him not to seek legal counsel or they would come after Respondent and he would lose money.

- Petitioner returned to Dr. Merk on August 8, 2012. Petitioner stated then the pain had not improved and that he was realizing more numbness in the 4th and 5th fingers in his left hand. Petitioner testified he then noted a shaking sensation when he attempted to use his left arm. Petitioner stated that the doctor gave him restrictions of no lifting over 5 pounds and to avoid repetitive activity with the left arm. Petitioner stated that the doctor also recommended physical therapy and to see a neurologist. Petitioner indicated Dr. Merk's treatment as an orthopedic surgeon was restricted to skeletal and the fracture itself and that Petitioner should get looked at by a neurologist regarding the reduction in movement, shaking and numbness. Petitioner stated that Dr. Merk referred him to Dr. Shepard regarding those issues. Dr. Merk did not release Petitioner to full duty work at that time and did not indicate that he was lifting Petitioner's restrictions. Petitioner testified that Respondent did not have light duty available for him at that time. Petitioner testified that on August 8, 2012 he was terminated by Respondent. Petitioner testified Mr. Connor, via e-mail, told Petitioner that he was upset and since Petitioner was not coming in that he should return the key to the building. Petitioner testified Mr. Connor did not explain why Petitioner was fired. Petitioner identified PX10 as a copy of the e-mail he received from Mr. Connor August 9, 2012 indicating that he wanted the key back. Petitioner viewed PX11 and identified it as an e-mail from August 1, 2012 regarding a phone message and about Petitioner not being allowed in the building without permission which Petitioner did not have from Respondent. Petitioner viewed PX12 indicating that Petitioner had picked up some personal things from Respondent and that if Petitioner did not pick up any other personal items Respondent would deem them as abandoned.

- Petitioner reported to Dr. Shepard on August 10, 2012 and advised the doctor about the numbness and tingling in Petitioner's hand since the fall. Dr Shepard diagnosed radiculitis and neuralgia and recommended an EMG (done 8/17/12) and MRI (done 8/27/12). Petitioner indicated that the EMG revealed a peripheral neuropathy and the MRI still showed the non-displaced fracture of the elbow with some edema/swelling. Petitioner stated that he followed up with Dr. Shepard on September 7, 2012 and P reported that he could not put his arm on anything hard due to the pain and that he was still having the tremors in his left arm. He was again diagnosed with peripheral neuropathy. Petitioner stated that the doctor wanted to continue seeing him every three months. Petitioner indicated on September 10, 2012 he became aware that Respondent had terminated his benefits due to the reason that Petitioner was self-employed and running his own business separate and aside from Respondent. Petitioner stated he had his own website business that had begun January 2012 which was located in his home. Petitioner indicated that Mr. Connor had been aware that he had started that business. Petitioner stated Mr. Connor had been sent an e-mail from Phil Smith, the vice president of sales for Respondent, about it in February; Petitioner had been copied on that e-mail. The e-mail indicated that Mr. Smith was curious as to who Music Professional Organization was (Petitioner's business). Petitioner testified it was communicated to them that the website was Petitioner's (business). Petitioner testified he had many subsequent conversations with them about that business (the first at the time of that e-mail). Petitioner had the conversation with Mr. Connor in the office with no one else present. Petitioner testified that he had explained what he was doing; collecting music professionals globally. Petitioner stated that Mr. Connor did not tell him anything. Petitioner testified that Mr. Connor was aware, in February 2012, that he was and doing his own business simultaneously while working at Respondent. Petitioner testified that Music Professionals Organization has four parts to it; music professionals, sheet music, instruments, and products and services. Petitioner stated that he gathered information about music professionals and how they relate and interrelate with the four items. He stated Music Professionals was a promotional services organization. If any instrument manufacturer wanted to promote their instrument to music professionals to use, Petitioner's company would be the conduit for that. Petitioner stated that Respondent sold sheet music to dealers and the only relationship they had in common was in the music industry. Petitioner did not consider his business in competition with Respondent.

- At hearing November 21, 2013, Petitioner agreed there had been prior testimony regarding benefits being terminated around September 2012. Petitioner testified Mr. Connor at no time expressed objection to Petitioner having his own business and working at Respondent. Petitioner testified at no time did he ever voluntarily resign from Respondent after his injury and at no time did he agree to work as an independent contractor for Respondent or for Mr. Connor after the injury. Petitioner testified that

Music Professional Organization has a website that appeared January 2012 and as of July he made it available to collect money for Alzheimer's research by donating money from the sale of pearls on the website to the Alzheimer Association.

- Petitioner returned to Dr. Merk, on September 11, 2012 and reported continuing numbness and tingling in his left hand. Petitioner testified Dr. Merk never gave him a full duty work release nor lifted Petitioner's restrictions regarding no repetitive motion of the arm or 3 to 5 pound lifting limitations. The doctor instructed Petitioner to continue therapy. Petitioner stated that he continued therapy up to the date of hearing. Petitioner testified that at no time did Respondent provide him with a job within the restrictions. Prior to the accident, Petitioner testified he never had any medical problems with his left arm or hand and he had not experienced numbness or tingling in his left arm or hand.

- Petitioner testified there are things that now cause him pain that he did not have before; like writing, typing, lifting. Petitioner testified that when he writes, his hand shakes uncontrollably. He indicated he loses strength and grip. Petitioner testified when he tries to lay his elbow on hard surfaces he gets severe pain in his elbow. Petitioner testified that activities of daily living causes him pain and he has difficulty sleeping because of pain that wakes him 3-4 times per night.

The Commission finds that on the date of accident, June 21, 2012, Petitioner testified he was working that day and physically feeling fine; he had no problems with his left shoulder or arm at all. Petitioner had a prior left arm fracture when he was 12 years old but from then until June 21, 2012 he had no problems with his left arm. Petitioner testified that on that day they were moving boxes at Respondent as they were told by Mr. Connor. Petitioner understood the work he was doing was for the benefit of Respondent. Mr. Connor owned the building where Respondent was located. Petitioner testified that the building Mr. Connor took over was sold as is and was in deplorable condition. Petitioner testified that on June 21, 2012 when he was moving boxes he slipped on some stairs and fell. Petitioner stated that it was wet outside and the stairs may have been wet from workers moving the boxes in and out from the wet. Petitioner stated he was collecting boxes from the doorway in. Petitioner stated that as he was delivering boxes to someone (Jeff Hansel) at the top of the stairs and he slipped and immediately fell on his elbow which jammed into his shoulder and neck. Petitioner testified that he didn't have time to extend his arm to catch himself. Petitioner stated immediately after the fall he had severe pain. Petitioner reported to Northwestern Memorial Hospital ER the same day of the accident and testified he reported headache, left shoulder, left clavicle, and left arm pain. Petitioner stated that his pain got worse with movement and he had swelling in his left hand as well. Petitioner is left hand dominant. Petitioner had an x-ray at the ER which revealed a non-displaced fracture at his left elbow. Petitioner had an x-ray of his left forearm that day which confirmed a radial head fracture in his left arm. Petitioner testified that the ER doctor recommended that he follow up

with an orthopedic surgeon and he was placed in a sling. Petitioner reported the injury to Mr. Connor at Respondent. Petitioner stated Mr. Connor said not to worry as Respondent had WC insurance. Petitioner reported to Dr. Merk, an orthopedic surgeon, at Northwestern June 26, 2012. Petitioner testified he reported to the doctor that he had pain in his elbow and radiating down into his forearm. Petitioner stated the pain was from his neck down to his hand. Petitioner understood the doctor diagnosed a displaced fracture in the radial head. The doctor gave Petitioner a restriction of no lifting more than 3-5 pounds and told him to follow up in 4 weeks. Petitioner stated that he attempted to return to work on June 28, 2012 with the restriction but was unable to perform his functions. Petitioner testified that he did not report to work on June 29, 2012 because of the problems he had the prior day. Petitioner testified at that time Respondent was unable to accommodate his 3-5 pound restriction. Petitioner had contacted Dr. Merk's office June 28, 2012 regarding his attempt at returning to work and the problems with his dominant arm. Petitioner stated that the doctor recommended he stay off work. Petitioner testified that Mr. Connor was aware that Petitioner had tried to work and was unable to do so. Petitioner stated that he spoke to Mr. Connor in the office on June 28 at about 1:00pm. Petitioner stated he told Mr. Connor that since Petitioner was left handed, any functions he normally performed were impossible and Mr. Connor told Petitioner to go home.

The medical records contradict Petitioner's testimony in regard to shoulder/neck causal connection. The medical records clearly show that Petitioner specifically denied neck pain in the ER as well as in other medical records. While there is indication of numbness and tingling of his left little and ring finger, there is also indication of similar numbness in his toes in his left leg which also clearly would not be related. Further, Petitioner filed the Application for Adjustment of Claim only claiming injury to his left arm with no indication of a left shoulder or neck injury. There is clear evidence of a causal connection to Petitioner's condition of ill-being regarding his left arm with the documented radial neck fracture. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence and herein, affirms and adopts the Arbitrator's finding as to causal connection, regarding only the left arm.

The Commission finds the Arbitrator calculated the Average weekly wage (AWW) based upon a salary of $30,000 with $30,000 held in 'abeyance' pending payment from cash flow with profit. The Commission finds from the evidence presented that the additional $30,000 was deferred income. Accordingly, the average weekly wage should have been calculated with the base annual salary of $60,000 for an AWW of $1,153.85; temporary total disability (TTD) rate of $769.22, and permanent partial disability (PPD) rate of $692.31. The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence, and herein, modifies the AWW to be $1,153.85.

The Commission finds the evidence and testimony clearly supports the duration of lost time here. Petitioner was clearly discharged by Dr. Merk to only return as needed as of September 11, 2012. Dr. Merk did not impose any permanent restrictions on Petitioner. While petitioner may

have seen Dr. Shepard after that point, at no time did Dr. Shepard impose any sort of restrictions on Petitioner. Petitioner was apparently capable of returning to full duty after Dr. Merk's release so no further TTD would be due beyond that point. The TTD rate, however, as noted above was in error. Based upon the correct AWW, the TTD benefit rate is, herein, modified to **$769.22 per week** for the awarded TTD period.

The Commission finds that there are clear issues that Respondent had to terminate TTD benefits. Regardless of the issue of termination, Respondent paid TTD, albeit based on the lower AWW and also advanced PPD. Petitioner failed to prove that Respondent acted in an unreasonable and vexatious manner to warrant entitlement to any penalties and attorney fees. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence and, herein, affirms and adopts the Arbitrator's finding denying penalties and attorney fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Average Weekly Wage is $1,153.85.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $769.22 per week for a period of 11-5/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation 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.

14IWCC0094

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,600.00. 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: FEB 10 2014
O: 12/12/13
DLG/jsf
45

David L. Gore

Michael P. Latz

Mario Basurto

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

14IWCC0094

DEVANEY, STEVE
Employee/Petitioner

Case# **12WC023465**

WORLDWIDE MUSIC SERVICES LLC
Employer/Respondent

On 6/4/2013, 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 0.08% 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:

0391 THE HEALY LAW FIRM
PATRICK ANDERSON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

2837 LAW OFFICES OF THADDEUS GUSTAFSON
ROBERT SABETTO
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 19(b)

14IWCC0094

STEVE DEVANEY
Employee/Petitioner

v.

WORLDWIDE MUSIC SERVICES, LLC
Employer/Respondent

Case # 12 WC 23465

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 **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **November 14 and 21, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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 14IWCC0094

On the date of accident, **June 21, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$19,817.20**; the average weekly wage was **$388.57**.

On the date of accident, Petitioner was **59** 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 **$4,518.25** for TTD, **$0** for TPD, **$0** for maintenance, **$1,012.00** for PPD (advance), and **$5,422.51** for other (medical) benefits, for a total credit of **$10,952.76**.

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

ORDER

Petitioner is entitled to **11-5/7** weeks of TTD benefits from **June 22, 2012** through **September 11, 2012** at a weekly rate of **$253.00** for a total of **$2,963.72**.

Petitioner's request for penalties and attorneys' fees is denied.

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

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

Signature of Arbitrator

June 3, 2013
Date

ICArbDec19(b)

JUN - 4 2013

ARBITRATION DECISION

I. Findings of Fact.

Petitioner testified that Respondent's owner, Hayden Connor, hired him as its managing director in September 2010. According to Petitioner, he was hired to manage Worldwide Music Services and two other companies located in the same building. Connor owned all three companies. Petitioner and Connor exchanged emails and ultimately reduced to writing an employment contract that Petitioner signed. Petitioner did not have a copy of the contract, but he testified that it contained terms similar to those in an email dated September 28, 2010. *PX6, RX5*. This email, which indicates that it is a "rough draft" to "review and fine tune," states as follows:

> "2. Your remuneration will start at $30,000 p[er] a[nnum] on September 15, 2010 with another $30,000 held in abeyance until it can be afforded from cash flow, and will be paid retroactively. These [sic] money must come from actual cash profits as opposed to book profits which include depreciation and good will." *PX6, RX5*.

Petitioner testified that he understood his annual salary to be $60,000, which consisted of $30,000 in regular earnings and $30,000 in what he called "deferred compensation." This "deferred compensation" was not a bonus or an incentive. Petitioner testified on direct exam that he earned $60,000 in 2010 and 2011. On cross exam, he was shown his W2s for 2010 and 2011 (*RX16*), which showed earnings of $8,427.12 and $25,012.00, respectively. Petitioner admitted that the W2s were accurate.

Connor agreed that he and Petitioner had reduced to writing an employment contract. He testified that Petitioner never returned such contract to him signed. Connor also agreed that Petitioner was eligible to receive an additional $30,000 under the employment contract. However, this additional amount was conditional on actual cash profits at the end of the year. It was not based on performance, and it was not triggered by any benchmarks. This additional amount was never paid because the company did not have enough cash profits in either 2010 or 2011.

Connor responded to a records subpoena issued by Counsel for Petitioner. *PX5, RX4.* Contained in the response is a wage statement form showing Petitioner's earnings from June 27, 2011 through June 21, 2012. *PX5, RX2, RX4.* The wage statement shows a wage reduction from $14.43/hour to $9.62/hour starting on July 4, 2011. Connor admitted that he did not complete the wage statement, but testified that his accountant or her assistant did. Also contained in the response is a typewritten September 20, 2010 fax transmission memo showing Petitioner's wage rate as "$14.43 (hr.)." *PX5, RX2.* Next to this is a handwritten notation "REDUCED 7/4/2011 to 9.62 (hr.)".

Petitioner admitted that his salary was reduced in July 2011. According to him, Connor promised to return him to the amount he was earning before the reduction at some undetermined point in the future. Connor testified that the reduction was company-wide, and he admitted that he intended to return all of his employees to what they were making when the company could afford it.

Petitioner testified that he slipped and fell on the stairs outside the doorway while helping a co-worker, Jeff Hansel, move boxes into Respondent's building on June 21, 2012. It was wet outside, and water had been tracked onto the stairs. Petitioner landed on his left elbow and, according to him, jammed it into his neck. Although Petitioner testified that the building was in "deplorable" condition, he admitted on cross exam that nothing was wrong with the stairs.

Petitioner noticed severe pain and sought medical attention. That same day, Petitioner reported to the Northwestern Memorial Hospital Emergency Room with complaints of headache, left clavicle pain, left shoulder pain, and left arm pain after falling at work when he was moving boxes on stairs. *PX2.* He denied neck pain. His pain was increased with movement and Petitioner had pain radiating down into his forearm with tingling of his third and fourth fingers, as well as swelling of his first finger. An x-ray revealed: (1) The distal humerus fat pads are displaced from a traumatic joint effusion. (2) A subtle nondisplaced fracture seen at the base of the radial head. Petitioner's left arm was placed in a sling and he was advised to follow up with an orthopedic surgeon. *PX2.*

On June 26, 2012, Petitioner saw Bradley Merk, M.D., an orthopedic surgeon. *PX1.* Dr. Merk noted that x-rays of Petitioner's clavicle, humerus, elbow, forearm and wrist were taken. After reviewing such x-rays, Dr. Merk opined: "The only abnormality is very subtle, cortical disc irregularity of the anterior aspect of the

radial head neck junction with associated fat pads." Dr. Merk noted that his pain seems to be improving and that Petitioner does not note any neurologic symptoms. Petitioner noted some pain mostly over the elbow radiating into the forearm predominantly with rotational motion. Dr. Merk diagnosed Petitioner with a minimally displaced radial head fracture, recommended progressive range of motion and stretching exercises, encouraged him to wean himself from the sling and to increase the use of his hand for activities of daily living, advised him to work under a 3-5 pound lifting restriction, prescribed over-the-counter medication and the use of ice and instructed him to follow up in four weeks. *PX1*.

Dr. Merk's June 28, 2012 record indicates that Petitioner telephoned the office. The note said that Petitioner "tried to work today but had problems as his injury is in his dominant arm." *PX1*.

Petitioner testified that on June 28, 2012, he reported to work but was unable to work the whole day. Petitioner testified that he told Connor that day that because he is left-handed, he found that any function that he normally performed with his left hand were nearly impossible. Petitioner testified that Connor then told him to go home. *PX1*.

Petitioner testified because of the problems he had on June 28, 2012, he did not report to work on June 29, 2012. Petitioner claimed that Respondent was not able to accommodate his 3-5 pound lifting restriction. Dr. Merk's June 29, 2012, record indicates Petitioner visited the office that date and reported that he performed neither social nor occupational activities of daily life. Although Petitioner testified that Dr. Merk told him to stay off work at that time, there is no mention of Petitioner's work status in the June 29, 2012 record. *PX1*.

On July 11, 2012, Petitioner returned to Dr. Merk with complaints of "numbness in his left small and ring fingers, as well as kind of just generalized muscle ..." He also complained that he feels like he has not been having good control of his left forearm and has had difficulty writing. Otherwise, he states his range of motion is improving. Dr. Merk wrote that they would get Petitioner set up with occupational therapy to start moving his elbow, start improving his range of motion and give him more confidence with his arm. He instructed Petitioner to follow up in four weeks for a repeat clinical and radiographic evaluation. He also reported having difficulty writing and decreased range of motion. *PX1*.

Petitioner testified that he did not begin occupational therapy at that time.

Petitioner testified that he completed an Application for Adjustment of Claim on July 9, 2012.

Petitioner returned to Dr. Merk on August 8, 2012, in follow-up status/post left radial neck fracture, treated non-surgically. The doctor notes that, in general, Petitioner is improved but still has pain, particularly at night for which he periodically takes Norco. He rates his average daily pain at about 5/10. He still lacks some mobility and feels some numbness over the distribution of his fourth and fifth digits that radiates into his arm a little bit. He also notes some numbness in his lateral toes. He also has some discomfort in the neck region, after the fall. He notes, also, that as he attempts to use his arm, he gets some shaking sensation. On examining Petitioner, Dr. Merk finds some decreased range of motion. However, he finds 5/5 motor strength, intact profusion, intact pulse and normal refill. Dr. Merk also notes decreased subjective sensation over the arm. X-rays revealed that his fracture is fully healed and in anatomic alignment. Dr. Merk noted that the doctor had previously prescribed physical therapy, but apparently Petitioner had some other health problems and did not attend the therapy. The doctor encouraged Petitioner to participate in physical therapy and thought it would improve Petitioner's range of motion and strength and function. With regard to the constellation of neurologic type symptoms, Dr. Merk recommended a neurology evaluation and referred him in that regard. Dr. Merk instructed Petitioner to follow up with him in 6 weeks and imposed a five-pound lifting restriction and advised him to avoid repetitive activity with that arm. *PX1*.

Once again, Respondent provided no light-duty work. Instead, that same day, Petitioner's employment with Respondent was terminated.

On August 10, 2012, Alan Shepard, M.D., a neurologist, saw Petitioner. *PX3*. Petitioner reported that about six weeks ago, he slipped on some water and fell. He did not have time to put his hand out to stop the fall. His left elbow broke his fall. Petitioner complained of numbness and tingling in the last two digits of his left hand and the last two toes on his left foot. Petitioner also has noticed a tremor. After the fall, he was diagnosed with Merkel Cell Carcinoma. Physical exam revealed decreased sensation in Petitioner's left hand in the ulnar distribution and decreased sensation of the left lateral S1 distribution on the left side. *PX3*. Dr. Shepard's assessment: neuralgia, neuritis, radiculitis, unspecified (729.2) and late effect of injury to nerve root(s), spinal plexus(es) and other nerves of trunk (907.3). Dr. Shepard also wrote: "The ulnar sensory nerve at the wrist likely is post traumatic, as is the foot. Doubt plexopathy, and the tremor I feel is also consistent with nerve issues." He recommended an NCV/EMG. *PX3*.

On August 17, 2012, Dr. Shepard noted that the EMG results suggest an ulnar neuropathy at the elbow. His plan was to obtain imaging (MRI) and begin therapy. *PX3*.

On August 27, 2012, Petitioner underwent an MRI, without contrast, of his left upper extremity. The radiologist's impression of the images is as follows: PROXIMAL LEFT FOREARM MEDIAN AND ULNAR NERVE EDEMA OVER A 7 CM. LENGTH, STARTING AT THE LEVEL OF THE RADIAL TUBEROSITY. NO COMPRESSING MASS, OR MUSCLE EDEMA OR FATTY ATROPHY IS VISUALIZED. NON-DISPLACED RADIAL NECK FRACTURE. *PX3*.

On September 7, 2012, Petitioner returned to Dr. Shepard and complained that he cannot put his arm on anything hard because it hurts, that he still has sensory loss in the left ulnar distribution and that his tremor persists. He also mentioned to Dr. Shepard that he is "getting chemo." Dr. Shepard noted that Petitioner has yet to start occupational therapy. Dr. Shepard reviewed the MRI, which showed edema from his fall of several months ago, and determined that Petitioner needed Lyrica and Neurontin. Dr. Shepard's assessment (729.2 & 907.3) remained the same. He noted that Petitioner would be seeing Dr. Merk. Dr. Shepard did not record a Return to Office date as he had with Petitioner's first two visits. *PX3*.

On September 11, 2012, Petitioner returned to Dr. Merk. The doctor noted that Petitioner is doing his own range of motion at home and has not attended physical therapy yet. He noted that Petitioner has seen Dr. Shepard and was started on Lyrica, but overall has not seen a difference. He continues to report neurological symptoms such as tingling and numbness in various parts of his body, particularly his left ulnar digits. *PX1*. X-rays revealed a healed radial head fracture. Upon examination, Dr. Merk found Petitioner to be in no apparent distress, alert and oriented x3, left upper extremity. He has near full range of motion in the left elbow. He is lacking maybe three to five degrees of supination and three to five degrees of extension, otherwise symmetric with his contralateral side. He is neurovascularly intact. He does have mildly decreased sensation in the ulnar two digits, however this is intact. He also has some pain associated with percussion of the ulnar nerve on the left. Otherwise, it is normal exam. Dr. Merk determined on this date that Petitioner's non-displaced left radial head fracture was radiographically and clinically healed. From that standpoint, Dr. Merk opined, "there is no more follow up with us necessary" and "at this time there are no ongoing orthopaedic issues" and he "can follow up on an as needed basis." Dr. Merk stated that Petitioner has some ongoing neurological issues, which we recommend he continue to manage with Dr. Shepard. *PX1*.

At the time of trial, Petitioner testified that writing, typing and lifting causes pain. He further testified that when he writes, his hand shakes uncontrollably. When he lifts things with his left arm, he drops them. When he puts his left elbow on a hard surface, he experiences pain in the elbow. Petitioner further testified that he has pain when he extends his left arm, and that he is awakened three to four times a night as a result of such arm pain.

A "Physical Demands Analysis", which was completed by Respondent, indicates Petitioner's job required him to lift 1-10 pounds frequently, and 11-50 pounds occasionally. His job also required occasional, fine manipulation grasping, reaching, and feeling, as well as frequent keying. Constant repetitive use of the hands was also required. According to this analysis, Respondent was not able to accommodate "transitional duty" work. *PX5*.

Petitioner admitted that he told Rebecca, the claims adjuster for Respondent's insurance carrier, that he earned $60,000 a year. Petitioner testified that at some point after the accident but before July 8, 2012, he had a telephone conversation with Connor in which Connor stated he also told the insurance carrier that Petitioner earned $60,000 a year. Petitioner also testified that Rebecca told him that Connor had verified his $60,000 salary.

Connor denied telling Rebecca that Petitioner earned $60,000 a year.

Petitioner testified that Connor paid him $5,000 before Petitioner sustained his accidental injury

Petitioner admitted that he began receiving TTD checks from Respondent's carrier after that time. Initially, the amounts of the checks were between $545.00 and $769.00. However, they dropped down to $253.00 per week in approximately August 2012.

A couple weeks after the last day he worked for Respondent, Petitioner and Connor met for coffee at a Starbucks to discuss how Petitioner was doing. Petitioner underwent surgery to remove a tumor from his groin around that time. According to Connor, Petitioner expressed an interest in working as an independent contractor rather than as an employee, and Connor invited him to submit a bid. Connor considered this to be a voluntary resignation. Petitioner denied that

he ever requested to work as an independent contractor or that he ever resigned, but emails in July and August 2012 show that he did submit two separate cost proposals to work for Respondent on a contract basis. *RX6, RX9*. Petitioner testified that on August 8, 2012, he was fired. Connor testified that he rejected Petitioner's bid to work as an independent contractor and did not consider him an employee anymore.

Petitioner started his own business, Music Professional Organization LLC ("M.P.O."), in early 2012. According to Petitioner, M.P.O. is a web-based promotional services organization that acts as a conduit for selling sheet music, musical instruments, and other music-related products and services. He registered M.P.O. with the Secretary of State on January 18, 2012. *PX8, RX13*. Petitioner ran his business from his home. Petitioner testified that the MPO website was operational in January, but a Facebook post from him on July 7, 2012 indicates that it "went live" on that date. *RX15*. Petitioner admitted that M.P.O.'s services were not offered for free, and that he operated M.P.O. with the intent to turn a profit. He testified that he told Connor about this business in February 2012, but Connor denied that he knew anything about it until after it went live in July 2012.

Rebecca Miranda, an Adjuster with Respondent's insurance carrier, issued a letter to Counsel for Petitioner by fax on September 10, 2012. In her letter, Miranda stated that she had determined Petitioner was running his own business and this disputed his entitlement to TTD.

In a note dated September 11, 2012, Dr. Merk stated that Petitioner's fracture had healed and he discharged him from care to return on an "as needed" basis. *PX1*. Although the doctor referenced ongoing neurological issues for which he referred Petitioner to Dr. Alan Shepherd, he did not impose any physical restrictions. Dr. Shepherd examined Petitioner on August 10, 2012; August 17, 2012; and September 7, 2012. *PX3, PX5*. None of Dr. Shepherd's notes contains any indication of physical restrictions.

II. Conclusions of Law

In support of the Arbitrator's Decision relating to Issue (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator makes the following conclusions of law:

It is axiomatic that a claimant bears the burden of proving all the elements of his claim to recover benefits under the Workers' Compensation Act. Ingalls Memorial Hospital v. Industrial Commission, 241 Ill.App.3d 710, 716 (1st Dist. 1993). His burden includes proving a causal connection between the work accident and his condition of ill-being. Lee v. Industrial Commission, 167 Ill.2d 77, 81 (Ill. 1995). Liability cannot rest on imagination, speculation, or conjecture. Illinois Bell Telephone Co. v. Industrial Commission, 265 Ill.App.3d 681, 685 (1st Dist. 1994).

It is undisputed that Petitioner sustained an accidental injury to his left elbow when he slipped and fell on the stairs while working for Respondent on June 21, 2012.

Petitioner testified that he also injured his left shoulder and neck.

The Arbitrator does not find Petitioner credible on this point.

The Arbitrator has carefully examined the initial emergency room records of Northwestern Memorial Hospital of June 21, 2012. These records document Petitioner's stated history of falling onto his left side and injuring his left arm. *PX2*. These records also document that Petitioner reported striking his head on a "door step." *PX2*. While the records do show that he complained of left shoulder pain that radiated into his fingers, they also show that he specifically denied any neck pain. *PX2*. X-rays confirmed a radial head fracture of the left elbow. *PX2*. X-rays of his left clavicle were unremarkable. *PX2*. Petitioner's diagnosis at the time of discharge was a radial head fracture of the left elbow. *PX2*. The records contain no diagnosis regarding the left shoulder or the cervical spine.

Petitioner followed up with Bradley R. Merk, M.D., beginning on June 26, 2012. *PX1*. The Arbitrator also has carefully examined Dr. Merk's records. Dr. Merk reviewed x-rays of Petitioner upper left extremity and noted: "the only abnormality is very subtle, cortical disc

irregularity of the anterior aspect of the radial head neck junction with associated fat pad." Dr. Merk's impression was a minimally nondisplaced radial head fracture of the left elbow. *PX1*.

On August 8, 2012, which is the date on which his employment with Respondent ended, he complained to Dr. Merk for the first time of numbness in his lateral toes, a shaking sensation in his left arm and some discomfort in the neck region after his fall. (Emphasis added.)

The Arbitrator also points out that on August 10, 2012, Petitioner reported to Dr. Shepard that after his fall, he was diagnosed with Merkel Cell Carcinoma. On September 7, 2012, Petitioner told the doctor that he was "getting chemo."

Dr. Merk's treatment through September 11, 2012 focused solely on Petitioner's left elbow. *PX1*.

The Arbitrator also has examined Dr. Alan Shepherd's records and finds that treatment focused on the left elbow. *PX3*. Dr. Shepherd mentioned Petitioner's foot and lumbar spine. Yet, but there is nothing to connect either of these body parts to his work injury. Petitioner did not allege injuries to either of these areas, anyway.

The Arbitrator finds, based on the medical records of Northwestern Memorial Hospital, Dr. Merk, and Dr. Shepherd, that Petitioner sustained a fracture of the radial head of the left elbow as a result of his accidental injury of June 21, 2012.

Other than a negative x-ray of the left clavicle on the date of accident, there is no evidence of any treatment for the left shoulder in the emergency room or anywhere else that would corroborate a left shoulder injury. Furthermore, the Petitioner specifically denied neck pain in the emergency room on the date of accident. On August 8, 2012, which is nearly seven weeks after the accident, Petitioner first voiced complaints of discomfort in his neck after his fall.

Indeed, Petitioner's own Application for Adjustment of Claim alleges injuries to his left arm only—not to his neck or any other body part. *RX1*. The evidence refutes Petitioner's claim that he sustained an accidental injury to his left shoulder and neck.

In support of the Arbitrator's Decision relating to Issue (G), what were Petitioner's earnings, the Arbitrator makes the following conclusions of law:

The Arbitrator has carefully examined Respondent's subpoena response, particularly the wage statement (*RX2*), the handwritten notation concerning Petitioner's wage reduction,and Petitioner's W2s (*RX16*). The Arbitrator has also carefully considered the testimony of both Steve Devaney and Frank Hayden Connor.

On cross-examination, Connor was asked about the email message that he sent Petitioner on July 15, 2012. (*RX6*) Such email message includes the following sentence: "As I explained, unfortunately I cannot pay you the $10,000 I owe you in back salary at this time." Connor testified that Petitioner would receive the $10,000 when the company was in a stronger financial position. Connor testified that the reduction in pay that he established was company-wide.

Language in the rough draft contract includes the following: " ... with another $30,000 held in abeyance until it can be afforded from cash flow, and will be paid retroactively. These [sic] money must come from actual cash profits ..."

The Arbitrator concludes that the payment of "another $30,000" was conditional.

Due to the downturn in the economy, and after the date on which the rough draft contract was sent out, Connor reiterated that he actually had to institute across-the-board salary *cuts*.

None of Respondent's financial statements were offered into evidence.

Petitioner argues that "another $30,000" was deferred compensation. In support of his argument, Petitioner cites a Commission case, Robert Hart v. State of Illinois, Dept. of Agriculture, 04 IIC 0254.

In Hart, claimant participated in a deferred compensation scheme in the year preceding the accident. Accordingly, the deferred compensation amount did not appear on his regular check. Claimant testified that he understood his deferred compensation to be part of his earnings. The Commission held that claimant's average weekly wage should include deferred

compensation. Because the State of Illinois was the Respondent, the case could not be appealed to the judiciary.

The Commission's holding in Hart is not precedent for the issue before the Arbitrator in this case.

The Arbitrator notes that Section 10 of the Worker's Compensation Act states, in relevant part, the following:

> The compensation shall be computed on the basis of the "Average weekly wage" which shall mean **the actual earnings of the employee** in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury, illness or disablement, excluding overtime and bonus, divided by 52; but if the injured employee lost 5 or more calendar days during such period, whether or not in the same week, then the earnings for the remainder of the 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted. Where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee actually earned wages shall be followed . . . (Emphasis added.)

Based on the facts and the law, the Arbitrator finds that Petitioner's average weekly is $388.57. Petitioner admitted that his earnings for 2010 and 2011 were accurately reflected in his W2s. Petitioner was paid a salary based on 40 hours a week, and his hourly wage rate was reduced from $14.43 to $9.62 starting on July 4, 2011. The Arbitrator arrives at this figure by adding up Petitioner's total earnings between June 27, 2011 and June 15, 2012 ($19,817.20) and dividing that figure by 51 weeks, which is the total number of weeks available in the Record. The Arbitrator excluded the week of June 18, 2012 because it includes the accident date, and is only four days (not five as indicated).

In support of the Arbitrator's Decision relating to Issue (L), what amount of compensation is due for temporary total disability, the Arbitrator makes the following conclusions of law:

Respondent argues that since M.P.O. (Petitioner's online business venture) "went live" on July 7, 2012, Petitioner is not entitled to TTD benefits.

Petitioner admitted that he paid someone to put together a website for M.P.O., and that the purpose of M.P.O. was to be a profitable promotional services company.

However, there is no evidence that M.P.O. generated any revenue for Petitioner, much less occasional wages.

Evidence that an employee has been or is able to earn occasional wages or to perform certain useful services neither precludes a finding of total disability nor requires a finding of partial disability. Zenith Co. v. Indus. Comm'n, 91 Ill.2d 278, 437 N.E.2d 628 (1982).

Petitioner lost time from June 22, 2012 until he attempted to return to work with restrictions on June 28, 2012. He worked part of the day on June 28, 2012 and went home. When Dr. Merk examined Petitioner on June 26, 2012, he had imposed a weight restriction of no lifting over 3-5 pounds. *PX1*.

On August 8, 2012, Dr. Merk imposed a five-pound lifting restriction and advised Petitioner to avoid repetitive activity with his left arm. *PX1*.

On August 8, 2012, when Frank Hayden Connor fired Petitioner, Petitioner still had light-duty restrictions.

> "Whether an employee has been discharged for a valid cause, or whether the discharge violates some public policy, are matters foreign to workers' compensation cases. An injured employee's entitlement to TTD benefits is a completely separate issue and may not be conditioned on the propriety of the discharge . . . the determinative inquiry for deciding entitlement to TTD benefits remains, as always, whether the claimant's condition has stabilized. If the injured employee is able to show that he continues to be temporarily totally disabled as a result of his work-related injury, the employee is entitled to TTD benefits." Interstate Scaffolding v. Illinois Workers' Comp. Comm'n, 236 Ill. 2d 132, 149, 923 N.E.266 (2010).

The Arbitrator finds that on September 11, 2012, Dr. Merk discharged Petitioner from his care and instructed him to return on as as-needed basis only. Dr. Merk did not impose any permanent work restrictions on Petitioner at that time.

The Arbitrator has carefully reviewed Dr. Shepard's records and finds that he never imposed work restrictions on Petitioner. In fact, he never mentioned Petitioner's work status at all.

Based on the foregoing, the Arbitrator finds that Petitioner is entitled to TTD benefits from June 22, 2012 through September 11, 2012.

In support of the Arbitrator's Decision relating to Issue (M), should penalties or fees be imposed upon Respondent, the Arbitrator makes the following conclusions of law:

Bona fide disputes existed as to Petitioner's earnings and the length of his temporary total disability. Therefore, the Arbitrator finds that neither penalties nor attorney's fees are warranted in this case.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laura Hurst,

Petitioner,

vs. NO: 11 WC 33874

14IWCC0095

Walmart Inc. Store #4529,

Respondent,

DECISION AND OPINION ON REVIEW

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

The Commission finds that Petitioner is entitled to temporary total disability payments from July 23, 2011 through July 29, 2011 and from August 20, 2011 through February 25, 2012.

The Commission adopts the findings of Dr. Grear about the type of work Petitioner was capable of doing. His testimony was more credible than the opinions of Dr. Hansoor. Dr. Grear felt that Petitioner could return to medium type work on January 8, 2012. (Respondent Exhibit 8 Pgs. 9-18)

The Commission finds that bona fide job offers of a desk job were made to the Petitioner on January 5, 2012 and January 19, 2012. These were job offers that Dr. Grear felt Petitioner could handle. (Respondent Exhibit 2)

Although there is some questions as to when and if the Petitioner received these letters there is no doubt that Petitioner had an in-person meeting with Denise Jernigan the co-manager of the Respondent on February 25, 2012. At this meeting, Ms. Jernigan gave the Petitioner a job offer consistent with the deskwork Dr. Grear felt she could handle. The Petitioner refused to accept this job offer. (Transcript Pgs. 79-81)

Therefore, the Commission finds that the Petitioner refused a job that she could have handled on February 25, 2012. Petitioner's temporary total disability benefits ends as of that date.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $220.00 per week for a period of 27 6/7 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 Respondent pay to Petitioner the sum of $44,486.24 for medical expenses under §8(a) and 8-2 of the Act. Respondent shall authorize the proposed L-3 and L-4 and L4-5 lateral lumbar fusion with allograft and the accompanying reasonable and necessary treatment until Petitioner reaches maximum medical improvement.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 1 1 2014

Charles J. DeVriendt

Michael J. Brennan

Ruth W. White

HSF
O: 12/10/13
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HURST, LAURA
Employee/Petitioner

Case# **11WC033874**

14IWCC0095

WALMART INC STORE #4529
Employer/Respondent

On 1/24/2013, 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 0.09% 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:

2221 VRDOLYAK LAW GROUP LLC
MEGAN WAGNER
741 N DEARBORN ST 3RD FL
CHICAGO, IL 60654

0560 WIEDNER & MCAULIFFE LTD
JUSTIN T SCHOOLEY
1 N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
) ss. 14IWCC0095
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

Laura Hurst
Employee/Petitioner

v.

Walmart, Inc. Store #4529
Employer/Respondent

Case # **11** WC **033874**

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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Geneva, Illinois** on **November 19, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **7/22/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$16,744.00**; the average weekly wage was **$322.00**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$3,017.15** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$3,017.15**.

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 **$220.00**/week for **66-1/7ths** weeks, commencing **7/23/2011** through **7/29/2011**, and from **8/20/2011** through **11/19/2012**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of **$44,486.24**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize the proposed L3-L4 and L4-5 lateral lumbar fusion with allograft and the accompanying reasonable and necessary treatment until Petitioner reaches maximum medical improvement.

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

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

Signature of Arbitrator

1/22/13
Date

JAN 24 2013

Findings of Fact:

Petitioner testified that on the date of accident, July 22, 2011, she was employed by Respondent as an unloader. She testified her job duties were to unload freight from the trucks which delivered merchandise to the store. She would unload the truck from a conveyor belt and stack the items on pallets and deliver them to the departments in the store so they could be stocked. She testified the boxes weighed any where from ounces to hundreds of pounds and there was no set weight limit. She testified the maximum she would lift by herself was about 50 pounds and she would have another person help her lift anything over 50 pounds, which is known as a "team lift." She testified each truck had to be unloaded in two hours maximum. She testified the manager on duty would time how long it took a team to unload each truck and if they could not unload a truck in less than two hours they would "get scolded." She testified trucks might carry an average of 1700 pieces and a team of about six people plus a supervisor would unload the truck. She testified her job consisted of anywhere between two to four hours of unloading. Petitioner testified that during the remainder of her shift she would sort merchandise into various departments and deliver items to such departments, help stock the floor, and clean the back area of the store.

The "unloader" job description submitted by Respondent indicates that the following are essential physical activities for the position: reaches overhead and below the knees, including bending, twisting, pulling, and stooping; grasps, turns, and manipulates objects of varying size and weight, requiring fine motor skills and hand-eye coordination; moves up and down a ladder; moves, lifts, carries, and places merchandise and supplies weighing less than or equal to 50 pounds without assistance; safely operates motor vehicles or other large power equipment. (Resp. Ex. 3) This job description further indicates employees must work overnight; move through narrow, confined, or elevated spaces; and move over sloping, uneven, or slippery surfaces. (Resp. Ex. 3) The description further indicates that an unloader must: maintain merchandise presentation by stocking and rotating merchandise, removing damaged or out of date goods, setting up, cleaning, and organizing product displays, signing and pricing merchandise appropriately, and securing fragile and high-shrink merchandise; maintain area of responsibility in accordance with Company policies and procedures by properly handling claims and returns, zoning the area, arranging and organizing merchandise/supplies, identifying shrink and damages, and ensuring a safe work environment; receive and stock merchandise throughout the facility and organize and maintain the backroom by following Company safety, cleaning, and operating procedures, utilizing equipment appropriately, setting up displays, maintaining modular integrity, receiving, sorting, staging, and delivering merchandise, and completing paperwork, logs, and other required documentation. (Resp. Ex. 3)

Petitioner testified that on July 22, 2011, she was unloading cases of gallons of iced tea, with some cases holding six gallons and some cases holding four gallons. Petitioner testified that after unloading five or six cases of iced tea she put a case down onto the pallet and as she came up she felt pain, popping, and a strange sensation down her leg. Petitioner testified this incident occurred at about 5:25 p.m. Petitioner testified she initially thought it was something she could work through, just a "kink." She testified she tried to work but the pain got progressively worse until she had to vomit. Petitioner testified that after vomiting, she realized she was actually hurt and at about 5:40 p.m. she decided to tell her supervisor, Rich. Petitioner testified that upon informing Rich he asked her to go ahead and work through it until lunchtime. Petitioner testified she continued to work to the best of her ability but was "very slow and mopey at that point." Petitioner testified that after lunch she reported to Rich's supervisor, Christina, and made an incident report. She testified Christina sent her home with instructions to go to the ER if she got any worse.

Petitioner testified that after leaving work on July 22, 2011 she went home and sat on a heating pad, tried to ice her injury, and tried to stay comfortable for the evening. Petitioner testified that by the next morning she was

still pretty hurt and she went and checked in at Walmart. She testified that the store manager, Dave, drove her to Silver Cross Emergency Room.

On July 23, 2011, Petitioner presented to Silver Cross Emergency Room. Records indicate her symptoms began "yesterday…when lifting boxes." (Pet. Ex. 1. p. 7) Petitioner's symptoms were aggravated with bending and alleviated with remaining still. (Pet. Ex. 1. p. 7) Dr. Joseph Cortez examined Petitioner and indicated: moderate pain of left low back; ROM was painful with flexion, extension; and muscle spasm in the left low back. (Pet. Ex. 1. p. 8) Dr. Cortez noted that the "problem is new" and indicated no prior back injuries. (Pet. Ex. 1. p. 11) Dr. Cortez diagnosed Petitioner with a back sprain; prescribed flexeril and tramadol; placed her off work for one day; and indicated she should follow up in 2-3 days with a private physician. (Pet. Ex. 1. p. 11) Petitioner's x-ray report of the lumbar spine notes that she had pain in the low back, more on left than right and radiating down her left leg and indicates discogenic changes at L4-L5 and mild disc space narrowing at L4-L5. (Pet. Ex. 1. p. 14) The X-Ray report further notes "if symptoms persist, an MRI of the lumbar spine may be obtained for further assessment." (Pet. Ex. 1 p. 14)

On July 26, 2011, Petitioner reported to Dr. James Niemeyer, Respondent's occupational doctor, at MedWorks Occupational Health. (Pet. Ex. 2. p. 3) Petitioner reported that on July 22, 2011 she was unloading boxes off a truck at work, using proper lifting mechanics and wearing her low back brace, but she injured her low back and was sent home due to pain. (Pet .Ex. 2. p 3) Petitioner's symptoms were pain in the small of her back radiating to left into buttocks then laterally to front of her thigh, with some parethesias in her left leg. (Pet. Ex. 2. p. 3) Dr. Niemeyer's exam indicated: ROM forward flex was to about 18 inches from top of toes before pain stopped her from going further; extension was full but painful at the extreme of motion; Patrick's test was positive on left negative on right; she had tenderness over SI joint; and discomfort in region where piriformis would coerce. (Pet. Ex. 2. p. 3) Dr. Niemeyer diagnosed Petitioner with a lumbosacral strain/sprain; prescribed tramadol, flexeril, and naproxen; recommended alternating ice and heat. (Pet. Ex. 2. p. 4) Dr. Niemeyer placed her off work for the next 3 days as "she tried to go back to work last night at a sedentary duty position but was unable to complete the course." (Pet. Ex. 2. p. 4)

On August 1, 2011, Petitioner followed up with Dr. Niemeyer and indicated her pain was better but that she still felt very stiff. (Pet. Ex. 2. p. 9) Dr. Neimeyer indicated she still had paraesthesis into the left thigh, which was quite bothersome to her. (Pet. Ex. 2. p. 9) Upon exam, Dr. Niemeyer noted ROM showed her forward flexion to about 6 inches from the top of her toes, which was an improvement, but that she stopped secondary to pain and tightness in the small of her back. Petitioner's extension was full but painful at the extreme of motion. Extension was more painful than flexion.Dr. Neimeyer made the same recommendations as he had on July 26, 2011 and recommended an MRI of the lumbar spine to determine if a disc bulge was present. He placed her back to work with sedentary restrictions of maximum lifting of 10 pounds with occasional carrying, pushing, or pulling objects weighing no more than 10 pounds with occasional walking and standing, and advised her to visit him if she had problems. (Pet. Ex. 2. p. 9, 10)

On August 2, 2011, Respondent offered Petitioner a position as a fitting room associate from 4 p.m. to 1 a.m. Petitioner accepted this position. (Resp. Ex. 6) Petitioner testified that her fitting room duties were to answer the phones and attend to the fitting room. Petitioner elaborated that some of her duties included locking and unlocking the doors to the fitting rooms; re-hanging clothing and putting it back on the floor; keeping the area clean; and sweeping the floor. She testified she had to bend to pick things up and that she was unable to do so, and that she was required to twist when placing items on racks. Respondent's job description for this position indicates the following physical activities are essential to the position: reach overhead and below the knees, including bending, twisting, pulling, and stooping; move, lift, carry, and place merchandise and supplies weighing less than 10 pounds without assistance; grasp, turn, and manipulate objects of varying size and weight, requiring fine motor skills and hand-eye coordination. The job description further states that fitting room associates must, among other duties, assist with locating merchandise; maintain the fitting room in

accordance with Company policies and procedures by properly handling claims and returns, zoning the area, arranging and organizing merchandise/supplies, and ensuring a safe work environment; and maintain the fitting room by folding and hanging clothing, returning merchandise to appropriate departments, and answer the phone for the entire facility. (Resp. Ex. 6)

On August 8, 2011, Petitioner returned to Dr. Niemeyer and indicated that she was stiffer than during the previous week. Petitioner's forflex regressed to 12 inches above her toes. Dr. Niemeyer maintained the same light duty restrictions, and again requested authorization for an MRI. (Pet. Ex. 2. p. 14) On this date, Petitioner again accepted the fitting room attendant position. (Resp. Ex. 1)

On August 15, 2011, Petitioner returned to Dr. Niemeyer who stated, "still have not heard anything about the approval for her MRI scan." Dr. Niemeyer later indicates in the record, "Again, we are waiting on the approval of the MRI scan so we can move forward with care and treatment." Petitioner indicated her symptoms remained unchanged. Dr. Niemeyer kept Petitioner on the same light duty restrictions. (Pet. Ex. 2. p. 15) On August 16, 2011, Petitioner again accepted the fitting room attendant position. (Resp. Ex. 5)

On August 23, 2011, returned to Dr. Niemeyer "complaining more and more about her low back pain." Dr. Niemeyer indicates Petitioner missed work "this past Saturday and Sunday due to increased pain. She is having a lot of spasms. She is trying to work at the sedentary duty job but she is unable to take her muscle relaxer or pain killers secondary to them making her drowsy." Dr. Niemeyer further noted the pain was all in the small of her back. He noted "I believe this is the third week in a row we have been requesting an MRI scan and it is yet to be approved or authorized." Upon exam, he noted she could only forward flex to 20 inches above her toes; extension was about 20% of normal of both provocative or centralized low back pain. Dr. Neimeyer indicated "I took her off work for the next week," and that she should be excused for work missed on August 20 and August 21, 2011. He also commented, "NEEDS MRI!" (Pet. Ex. 2. p. 18,19)

Petitioner testified that, following her duties as fitting room associate, she was having "so much pain; it was very difficult to do that [job]." Petitioner testified she told Dr. Niemeyer her medication interfered with her ability to perform the light duty job, as it caused extreme drowsiness and impaired her judgment. She testified it is against store policy to be "under the influence at work."

On August 26, 2011, Petitioner presented to Dr. Ravi Barnabas at Alivio Therapy and Chiropractic. Petitioner indicated to Dr. Barnabas that on July 22, 2011 she felt a pull and a pop in her lower back when unloading a heavy box weighing about 40 pounds. Petitioner rated her back pain at 7-8/10 and indicated it radiated down the left leg with tingling and numbness and at times her left leg felt weak. Dr. Barnabas' exam states: palpation revealed tenderness in the lumbosacral spine on both SI joints in L4-5-S1 area; forward flexion was 20; hyperextension was 15; right lateral bending was about 15 on the left and 25 on the right; straight leg test was positive on left at 30 degrees for pain, radiculopathy at the right side was 45. Additionally, Dr. Barnabas noted Patricks and Milgrams tests were positive. He noted Petitioner's gait had a limp, she was unable to perform the heel to toe walk due to her pain, and had spasms in her low back. He diagnosed Petitioner with acute lumbar strain/sprain; lumbar spine radiculitis; lumbar disc displacement; and lumbago. He recommended an MRI and continued Petitioner's pain medication prescriptions. (Pet. Ex. 3 p.4,5)

That same day, Petitioner underwent an MRI of the lumbar spine at Delaware MRI which was performed by Dr. Brian Fagan, MD, and revealed mild degenerative changes at L3-4 and L4-5 and mild narrowing of foramina bilaterally from diffuse disc bulge at L3-L4, with disc material abutting exiting nerve roots bilaterally in the far lateral foramina. (Pet. Ex. 4 p. 3)

On August 31, 2011, Petitioner began physical therapy ATI, at the referral of Dr. Barnabas. Petitioner indicated she felt a pop in her back when she was unloading several boxes weighing over 40 pounds each. The

notes further indicate Petitioner attempted light duty but had an increase in pain. Petitioner had intermittent back spasms and numbness in the left thigh. Petitioner rated her pain at rest as 5/10 and pain during activity at 8-9/10. Petitioner indicated she felt better when lying in a supine position. Petitioner indicated pain was worst when sitting and walking more than 10-15 minutes. She indicated her pain caused disruptions in her sleep. (Pet. Ex. 5 p. 3) Upon exam, Petitioner demonstrated significant tightness along the thoracic/lumbar areas; hip flexion was limited to 90 degrees due to pain; decreased ROM in the trunk and lumbar areas; decreased lumbar, core and LE strength; fair posture; palpable tenderness, spasm, and increased soft tissue tension over the thoracic/lumbar PSP; increased complaints with transfers and transitional movements; and radicular symptoms in the left leg. (Pet. Ex. 5 p. 7, 9) Petitioner's symptoms were noted to be consistent with a diagnosis of low back pain and radiculopathy. (Pet. Ex. 5 p. 9) Petitioner was prescribed physical therapy three times per week. (Pet. Ex. 5 p. 10)

Petitioner presented to Dr. Sue Harsoor, at the recommendation of Dr. Barnabas, on September 1, 2011. Petitioner relayed that she was injured at work when unloading boxes weighing 30-40 pounds and felt pain in her low back. Petitioner rated her pain at 8/10. Petitioner indicated her pain was worsened with prolonged walking and prolonged sitting and improved by lying flat. She noted Petitioner was able to perform all activities of daily living. Dr. Harsoor reviewed Petitioner's MRI and noted that it showed multilevel disc bulges, facet arthritis with mild foraminal narrowing at L3-4 with disc material abutting the exiting nerve roots. Dr. Harsoor diagnosed her with radiculopathy of the lumbar spine and myofascial pain. She advised Petitioner to continue physical therapy and to consider epidural steroid injections. (Pet. Ex. 6 p. 3-5)

On September 21, 2011, Kristin Swidergal, MPT, evaluated Petitioner's physical therapy progress at ATI. Ms. Swidergal noted Petitioner's pain was 8-9/10 at that time and averaged about 6/10. Petitioner demonstrated modest improvement in tissue pliability at thoracic and lumbar PSPs; guarded mobility with improved posture and increased cadence with ambulation; and she was able to lie prone but was still limited with standing and ambulating after 20-30 minutes. Ms. Swidergal noted Petitioner had left leg pain, weakness, and decreased flexibility but had minimally improved trunk flexibility. Petitioner's tolerance for activity improved but remained significantly limited by pain. Ms. Swidergal indicated Petitioner would be unable to work as an unloader with a medium-heavy lifting requirement. (Pet. Ex. 5. p. 18)

On September 22, 2011, Petitioner presented to Dr. Harsoor and indicated her pain was 9/10; the pain was constant/throbbing/shooting; radiated to left lower extremity; and caused numbness and muscle spasms. Petitioner noted her pain worsened with prolonged walking and sitting, but was better when lying flat. She noted Petitioner was able to perform all activities of daily living. Dr. Harsoor recommended L3-L4 epidural steroid injections and continued physical therapy. (Pet. Ex. 6 p. 7-9)

On October 3, 2011, Ms. Swidergal evaluated Petitioner's physical therapy progress at ATI. Petitioner rated her pain as 5/10 average.Ms. Swidergal noted Petitioner had decreased tension and sensitivity to the L/S area; slow cautious mobility, especially with change of position; walking tolerance of 15-20 minutes, standing tolerance of 15-20 minutes, sitting tolerance of 15 minutes which increased with use of hot or cold packs or being in a reclined seated position. Ms. Swidergal noted Petitioner had left leg pain, weakness, and decreased flexibility and minimally improved trunk flexibility. Petitioner's tolerance for activity remained significantly limited by pain. Ms. Swidergal indicated Petitioner would be unable to work as an unloader with a medium-heavy lifting requirement. (Pet. Ex. 5. p. 23)

On October 11, 2011, Dr. Harsoor performed an L3-L4 lumbar epidural steroid injection with trigger point injections at Rogers One Day Surgery on Petitioner. (Pet. Ex. 6. P. 12-14)

On October 17, 2011, Ms. Swidergal evaluated Petitioner's physical therapy progress at ATI. Petitioner noted she no longer had the "grabbing pain," and she thought the injection worked. She noted she still felt the

left leg was weaker than the right and still had difficulty bending over to put on her socks and shoes. Ms. Swidergal noted she still had tenderness along the lumbar spine, and lumbar PSPs. Petitioner's mobility improved and she was able to undergo 90 minutes of therapy. Petitioner's walking/standing tolerance was 20-30 minutes and her sitting tolerance was one hour. Ms. Swidergal indicated improved tolerance for activity but it was limited by fatigue and weakness of the left leg. She noted Petitioner was unable to work as an unloader at medium-heavy lifting requirements. (Pet. Ex. 5. p. 27)

On October 20, 2011, Petitioner presented to Dr. Harsoor and indicated her pain was down to 3/10; however, she noted her left leg continued to be numb and weak. Petitioner noted her pain worsened with prolonged walking and sitting, but was better when lying flat. She noted Petitioner was able to perform all activities of daily living. Dr. Harsoor recommended an L3-L4 epidural injection to relieve leg pain, and kept Petitioner off work through November 11, 2011. (Pet. Ex. 6 p. 21-26)

On October 24, 2011, Petitioner presented to Dr. Barnabas indicating that, following the injection, her pain was down to 4/10. Upon exam Petitioner had slight tenderness on her bilateral SI joints; her left lateral flexion was reduced with mild pain, and she had Babinski's down going. Dr. Barnabas assessed Petitioner with lumbar disc disease, disc bulges, and spinal cord compression, and recommended continued physical therapy and injections. (Pet. Ex. 3. p. 18,19)

On November 9, 2011, Petitioner presented to Dr. Barnabas indicating her pain was about 4/10. On exam Petitioner's ROM was limited, mainly at the end of flexion and extension. Petitioner had tenderness into the left gluteus maximums and into the trochanteric bursal area and into the area of the tensor fascia lata. Petitioner was given EMS and hot packs and advised to continue her physical therapy. Dr. Barnabas kept Petitioner off work "until further notice." (Pet. Ex. 3. p. 20,21)

On November 11, 2011, Ms. Swidergal evaluated Petitioner's physical therapy progress at ATI. Petitioner noted that her pain improved, but it "tighten[ed] up on [her] every now and then" and she was awaiting approval for her second epidural injection. Petitioner provided that she was not ready to transition to work conditioning and sometimes her leg was still very weak. Petitioner indicated she was able to donn/doff her socks and shoes without pain but she still had difficulty when lifting more than 15 pounds to her waist. Ms. Swidergal noted she still had tenderness along the lumbar spine, and lumbar PSPs. Petitioner had proper lifting techniques, but had an altered gait with decreased step length and guarded posturing. Petitioner was able to undergo 90 minutes of cardio and weight machines. Petitioner's standing tolerance was 20-30 minutes without upper extremity support, walking tolerance was 20 minutes without upper extremity support, and she was able to lie in the prone position for 5 minutes without lower back pain. Ms. Swidergal indicated improved tolerance for activity but it was limited by fatigue and weakness of the left leg. Ms. Swidergal indicated Petitioner had improved lifting techniques but remained limited in her tolerance for weight. She further noted Petitioner was unable to work as an unloader at medium-heavy lifting requirements. (Pet. Ex. 5. p. 34)

On November 22, 2011, Petitioner underwent a Section 12 exam with Respondent's examiner, Dr. Michael Grear. (Resp. Ex. 8. dep #2) Petitioner testified Dr. Grear examined her for about 10 minutes. Dr. Grear's report indicated Petitioner injured her back on July 22, 2011 while lifting crates of product weighing 20-30 pounds. (Resp. Ex. 8. dep #2) Dr. Grear noted Petitioner had pain in the low back with radicular pain into the left lower extremity; was released from work; and had been treated conservatively since her injury. He noted she had physical therapy for three months with moderate improvement, which was most dramatic following her first epidural injection. Dr. Grear stated Petitioner was prescribed naprosyn, tramadol, and soma but that she "only takes medications sporadically because they make her too sleepy."(Resp. Ex. 8 dep #2) At Arbitration, Petitioner testified she told Dr. Harsoor that her medication was causing her to sleep up to 16 hours after one dose. Petitioner further testified that she told Dr. Grear that she and Dr. Harsoor determined she should only take her medications in the evenings, after she finished her physical therapy for the day.

Additionally, Dr. Grear noted Petitioner had numbness/tingling into left leg, which had dissipated. He indicated Petitioner's pain localized to low back. Dr. Grear indicated any prolonged periods of sitting or standing elicited discomfort. Dr Grear indicated, Petitioner "drove here today on her own."(Resp. Ex. 8. dep #2) At Arbitration Petitioner testified she was driven to the exam by a transportation service provided by the insurance adjuster. Dr. Grear's exam indicated Petitioner moved with caution from sitting to standing; had negative straight leg raising in sitting position, and dull symmetrical reflexes at the knee and ankle. He further indicated she had paraspinal muscle spasms with voluntary resistance to forward flexion, left and right lateral rotation, and hyperextension. Dr. Grear viewed Petitioner's x-ray studies and her August 26, 2011 MRI. Dr. Grear indicated they showed no evidence of any significant intrathecal pathology and that mild degenerative changes were noted throughout the lower lumbar spine with mild foraminal narrowing at L3 and L4. Dr. Grear diagnosed Petitioner with a lumbosacral strain with left radiculopathy which was causally related to the injury of July 22, 2011. Dr. Grear indicated Petitioner's prior treatment was reasonable and customary. He noted Petitioner's subjective complaints were lower back pain radiating into her left buttocks and his objective findings were trace paraspinal muscle spasm in the lower LS. Dr. Grear indicated Petitioner had no prior injuries or preexisting conditions. With regard to further treatment, he recommended continued use of nonsteroidal anti-inflammatory medicines and to be admonished to take the medicine on a regular basis. Dr. Grear stated Petitioner's muscle relaxant, Soma, had been causing difficulty with sleepiness, he thus indicated "an alternative muscle relaxant should be considered." (Resp. Ex. 8 dep #2) Petitioner testified Dr. Grear did not identify any muscle relaxants that were considered non-drowsy.

Dr. Grear determined Petitioner had not reached maximum medical improvement. Dr. Grear recommended completing the series of injections, based on Petitioner's improvement following her first epidural injection. Dr. Grear noted "formal physical therapy" should be terminated and a home exercise program should be pursued. Dr. Grear anticipated Petitioner should be able to reach MMI in about eight weeks and should return to work following the completion of steroid injections. At that time, he indicated she could not return to normal work activities and would be able to return to a modified activity for eight weeks, at which time an FCE could be obtained to identify any residual work restrictions. Dr. Grear indicated Petitioner should be restricted to deskwork. (Resp. Ex. 8. dep #2)

On November 23, 2011, Petitioner presented to Dr. Barnabas complaining of pain in her low back at 4/10. Petitioner's ROM was painful mainly upon flexion and extension, lateral flexion and rotation improved but tenderness was noted into the lumbar paraspinal muscles, mainly on the left side and in the lumbar spine, with Milgram's test eliciting pain. Dr. Barnabas recommended work conditioning and placed Petitioner off work for two more weeks. (Pet. Ex. 3. p. 2.)

On November 25, 2011, Ms. Swidergal evaluated Petitioner's physical therapy progress at ATI. Petitioner noted she had increased lower back pain. Petitioner indicated she was having difficulty reaching forward to don/doff her socks and shoes and had difficulty lifting overhead. Ms. Swidergal noted she still had tenderness with PSPs at the lumbar spine and tautness at the thoracolumbar fascia. Ms. Swidergal noted Petitioner had proper lifting techniques, but had difficulty lifting overhead. Petitioner's standing tolerance was 20-30 minutes without upper extremity support, walking tolerance was 20 minutes without upper extremity support, and she was able to lie in the prone position for 5 minutes without lower back pain. Ms. Swidergal indicated Petitioner had continued left leg weakness; decreased trunk mobility and LE flexibility, and limited endurance. Ms. Swidergal noted Petitioner had improved since her initial evaluation and could benefit from work conditioning to prepare for work as an unloader. Petitioner was discharged from therapy to begin work conditioning. (Pet. Ex. 5. p. 40)

On December 2, 2011, John Connell, ATC, evaluated Petitioner's work conditioning progress at ATI. Mr. Connell indicated that no job description was available but Petitioner worked as a Store Laborer for Walmart.

He indicated, "this is considered a medium physical demand level occupation (occasional lifting 50 pounds) according to the client interview and the Dictionary of Occupational Titles (922.687.058)." Mr. Connell noted her current lifting ability was "light." Petitioner reported increased lower back pain with trunk rotation as her main complaint as well as general muscle fatigue. A FCE was recommended upon completion which was targeted as December 23, 2011. (Pet. Ex. 5. p. 57)

On December 6, 2011, Petitioner presented to Dr. Barnabas at Alivio complaining of pain at 4/10. Petitioner's ROM was painful on flexion, extension, lateral flexion, and rotation. Petitioner received EMS and hot packs, was advised to continue therapy at ATI, and was placed off work for two more weeks. (Pet. Ex. 3. p. 29,30)

Petitioner also presented to Dr. Harsoor on December 6, 2011. She reported pain at 5/10 and requested left sided epidural injections to relieve her pain. Petitioner indicated pain worsened with prolonged walking and sitting but got better when lying flat. The notes indicated that Petitioner was able to perform all activities of dialing living. (Pet. Ex. 6 p. 28-30)

On December 9, 2011, Petitioner's work conditioning progress at ATI was evaluated by Mr. Connell. Mr. Connell noted Petitioner reported generally increased tolerance to exercises but continued to report sharp lower back pain with activities involving lumbar rotation. Petitioner's current estimated PDL was Light. Petitioner displayed good effort each day. (Pet. Ex. 5. p. 66)

On December 13, 2011, Petitioner presented to Dr. Harsoor complaining of pain at 6/10, with continued numbness and weakness in the left leg. Dr. Harsoor administered left transforaminal epidural injections at L4 and L5 with trigger point injections. Dr. Harsoor placed Petitioner off work until January 3, 2012 due to injection, muscle spasms, and back pain. (Pet. Ex. 6. p. 32-36)

On December 16, 2011, Petitioner's work conditioning progress at ATI was evaluated by Mr. Connell. Petitioner continued to report her main complaint was increased lower back pain with activities involving lumbar rotation and pain with prolonged standing and walking. Petitioner's current estimated PDL was Light to Medium. (Pet. Ex. 5. p. 75)

On December 21, 2011, Petitioner presented to Dr. Bermudez with complaints of soreness in her low back but indicating pain had diminished following injection. On examination Petitioner's ROM was painful at the end of flexion and extension with tenderness noted in the lumbar paraspinal muscles and the lumbar spine with increased pain and trigger points noted in the left side. Rotation increased Petitioner's pain. Petitioner received EMS, hot packs, soft tissue massage, ultrasound, and gentle mobilization. (Pet. Ex. 3. p. 31)

On December 26, 2011, Petitioner's work conditioning progress at ATI was evaluated by Mr. Connell. Mr. Connell noted Petitioner was able to progress her lifting tolerances, with an actual overhead lifting tolerance of 20 pounds for three repetitions. Petitioner continued to report her main complaint was increased lower back pain with activities involving lumbar rotation but also reported pain with squatting, prolonged standing and walking. Petitioner's current estimated PDL was Light to Medium. (Pet. Ex. 5. p. 86)

On January 2, 2012, Petitioner's work conditioning progress at ATI was evaluated by Mr. Connell. Mr. Connell noted Petitioner participated as instructed. Mr. Connell noted Petitioner was able to progress her lifting tolerances, with an actual overhead lifting tolerance of 24 pounds for two repetitions. Petitioner was able to lift 50 pounds from floor to chair for six repetitions and lift and carry 40 pounds for 100 feet. Petitioner continued to self-modify activities involving trunk rotation due to subjective complaints of lower back pain. Her PDL was Medium. Mr. Connell recommended discharge from the work conditioning program pending physician reevaluation noting that Petitioner met all functioning lifting tolerance goals and not showing any progression

of positional tolerances for several weeks. (Pet. Ex. 5. p. 95) Petitioner testified it took her about 35 minutes to lift 50 pounds six times during her January 2, 2012 work conditioning session. She testified that in her job as an unloader she would be expected to lift 50 pounds for six repetitions in about three minutes. She testified that she had to self modify her activities during this session due to her low back pain.

On January 3, 2012, Petitioner presented to Dr. Harsoor indicating her pain was down to 3/10, she indicated her left leg numbness and weakness were improving. She continued to have a stiff back. Petitioner indicated her pain worsened with prolonged walking and sitting but got better when lying flat. The notes indicated Petitioner was able to perform all activities of daily living. Petitioner indicated she had plateaued at therapy and that she would like to try another epidural injection. Petitioner indicated her treatments from the physical therapist had not helped her pain. Dr. Harsoor recommended another epidural injection per the IME recommendation. (Pet. Ex. 6. p. 42-44)

That same day, Petitioner presented to Dr. Bermudez. Petitioner complained of pain in her mid and low back at 3/10 and indicated she was attending work conditioning. Dr. Bermudez indicated that, per Dr. Harsoor, Petitioner should remain off work at that time and she was scheduled for an injection on January 13, 2012. Dr. Bermudez further states, "Per Dr. Harsoor, she wants the patient to stop work conditioning prior to getting the injection and she will determine when the patient will go back to work conditioning." On exam, Petitioner's ROM was painful mainly at the end of flexion and extension and she had tenderness throughout the thoracolumbar paraspinal muscles, mainly on the left side. (Pet. Ex. 3. p. 32)

On January 4, 2012, Petitioner's work conditioning progress at ATI was evaluated by Mr. Connell. Mr. Connell indicated Petitioner participated as instructed and had an actual overhead lifting tolerance of 24 pounds for two repetitions. Petitioner continued to self-modify activities involving trunk rotation due to subjective complaints of lower back pain. Petitioner's PDL was medium. Mr. Connell stated, "Petitioner was discharged from Work Conditioning Program by her physician at her follow up appointment." Mr. Connell discharged Petitioner. (Pet. Ex. 5. p. 98)

On January 5, 2012, a job offer was mailed to Laura Hurst, of "desk work," based on Dr. Grear's recommendations. The position offered stated: "to include (but is not limited to) the following: answering the phone." No job description was attached. The hours of the position would be from 4 p.m. to 1 a.m. (Resp. Ex. 7)

On January 10, 2012, Petitioner presented to Dr. Harsoor indicating her pain was about 5/10. Petitioner indicated pain worsened with prolonged walking and sitting. See Pet. Ex. 6 p. 46. Dr. Harsoor administered lumbar epidural steroid injections at L3-4 with trigger point injections, for Petitioner's lumbar disc herniation, and performed epidurography for Petitioner's lumbar radiculopathy. (Pet. Ex. 6 at 46-50)

On January 11, 2012, Petitioner presented to Dr. Harsoor with a continued pain rating of 5/10. Petitioner indicated pain worsened with prolonged walking and sitting. Dr. Harsoor placed her off work until January 30, 2012. (Pet. Ex. 6. p. 52-54)

On January 19, 2012, a job offer was mailed to Laura Hurst, of "desk work," based on Dr. Grear's recommendations. The position offered stated: "to include (but is not limited to) the following: answering the phone." No job description was attached. (Resp. Ex. 4)

On January 23, 2012, Petitioner presented to Dr. Harsoor and indicated her pain had decreased to 4/10 following injections. Petitioner indicated pain worsened with prolonged walking and sitting. Dr. Harsoor recommended a discogram, based on her having multiple disc problems. Dr. Harsoor noted that, as pain is still limiting her function, Petitioner would like to pursue further aggressive treatment. Dr. Harsoor referred

Petitioner to Dr. Barnabas to make a surgical referral. Dr. Harsoor placed Petitioner off work until February 30, 2012, due to pain. (Pet. Ex. 6 p. 55-58) On that same day, Dr. Bermudez referred Petitioner to Dr. Salehi for a surgical consultation. (Pet. Ex. 3 p. 33)

On February 14, 2012, Petitioner presented to Dr. Harsoor for an L3-4, L4-5, and L5-S1 lumbar discogram. Dr. Harsoor noted: moderate resistance at L3-4, L4-5 and L5-S1; dumb bell disc pattern was noted at all levels, with no leak. She further noted Petitioner's concordance of pain as follows: "patient had moderate pain of 7/10 at L4-5, and mild pain at L3-L4 and L5-S1." Dr. Harsoor determined Petitioner had 4/5 concordant pain at L4-L5 level and no concordance at L3-4 or L5-S1. Dr. Harsoor indicated Petitioner would be off work until surgeon's evaluation. (Pet. Ex. 6. p. 62-66)

That same day, Petitioner underwent a post-discogram CT scan of the lumbar spine with Dr. Sasan Pauyvar, M.D. Dr. Pauyvar indicated that at L4-L5, the injected contrast extended to the posterior third of the disc compatible with a grade III radial tear, with a borad based left foraminal disc protrusion with disc material causing moderate left foraminal stenoisis. Dr. Pauyvar further noted a slight amount of contrast extended into the left neural foramen due to a focal annular tear in that region. There was no associated central or right foraminal stenosis. (Pet. Ex. 9. p.3,4)

Petitioner testified that on February 25, 2012, she went to Walmart to turn in her off-work notes from Dr. Harsoor. At that time, she was presented with a job offer of "desk work," based on Dr. Grear's recommendations. The job offer stated: "to include (but is not limited to) the following: answering the phone." No job description was attached. The hours of the position were from 4 p.m. to 1 a.m. Petitioner refused the position and wrote "not refusing to work but I am off on workers comp so cannot work as of now [sic]." (Resp. Ex. 2)

Petitioner testified the job she was offered was to work in the fitting room and answer phones. Petitioner testified she told her manager Denise she was under her doctor's care and could not perform the job they were asking her to perform. She testified that at the time of the offer her pain was increased by prolonged sitting and prolonged standing and that the position most helpful to her pain was lying down or in a prone position with her knees up. Petitioner testified Denise did not indicate Petitioner would be able to lie down during the job.

On cross exam, Petitioner testified the February 25, 2012 offer was to answer phones at the fitting room, and that, although the written offer states "desk work" and previous written offers state "fitting room," "it is not a different job." Upon being questioned whether the "desk work" offer indicates that Dr. Grear released Petitioner to work, she responded, "Yes. But he's not my doctor." Upon being questioned why she didn't try going back to work, she responded, "at the time I could not." She was asked why she didn't want to try and work when work conditioning showed she could lift up to 50 pounds and had improved since January. Petitioner responded, "There was more to it than that. I could not twist. I cannot touch my toes. There is things I cannot do. I was able to do those things if you take them and look at them in that context. It's not the same as doing the job."

On Re-Cross, Petitioner was questioned as to what other duties she would have besides answering the phones, she responded, "The phone is located at the fitting room desk. I would be doing the fitting room."

On February 27, 2012, Petitioner presented to Dr. Harsoor complaining of continued back pain. Petitioner indicated pain worsened with prolonged walking and sitting. Petitioner indicated she would like to pursue further aggressive treatment as her lumbar discogram was significant for L4-5 concordant pain. Petitioner was placed off work pending surgical evaluation. (Pet. Ex. 6 p. 75-77)

On March 2, 2012, Petitioner presented to Dr. Sean Salehi. Petitioner filled out a medical history form and described her symptoms as follows: lower back pain, stiffness, spasms, numbness, loss of flexibility & ROM, and tenderness to touch. Petitioner indicated her symptoms were constant and she had not had similar symptoms previously. Petitioner noted sitting and standing made the pain worst and lying down made the pain better. She further noted twisting movements, stairs, cold weather, and staying in one position too long, also made pain worse. She noted heat and ice made her pain better. Petitioner noted she had pain, weakness and decreased ROM in her muscles/joints; and weakness, numbness, and tingling in her left hip and left leg. Petitioner noted her job was a truck unloader and she had medium and heavy duties, lifting 20-50 pounds and 50-100 pounds. Petitioner noted bed rest provided some relief, physical therapy provided some relief, injections provided some relief, and a brace provided no relief. Petitioner indicated her pain was 5/10 and was located at the lower back, radiating down the left leg. (Pet. Ex. 10 p. 3)

Dr. Salehi reported Petitioner was injured on July 22, 2011 when she was unloading cases onto a pallet in a bending/twisting motion and that after moving about the sixth case she felt a pinching/popping sensation that took her breath away. Dr. Salehi noted Petitioner underwent a course of physical therapy and had three epidural injections, which helped to bring her pain down. He noted that she underwent a course of work conditioning which served only to aggravate her pain. He noted extension worsens her pain, as well as any twisting motions or bending forward to pick up objects. The majority of her pain was constant low back pain with intermittent radiation down into the left leg, sometimes all the way to the foot. Petitioner had numbness in the left lateral thigh, and felt weak in the left leg but denied having any falls. (Pet. Ex. 10 p. 4)

Upon lumbosacral exam, Dr. Salehi noted lumbosacral tenderness and tenderness along the left posterior iliac crest with palpation. Petitioner's ROM: forward flexion to 40 degrees, hyperextension to10 degrees, right lateral bend to 20 degrees, and left lateral bend to 20 degrees. Dr. Salehi noted left sciatic notch tenderness. Upon motor exam, Dr. Salehi noted gait was antalgic and posture was mildly forward flexed. Petitioner had decreased sensation in the left lateral thigh and calf. (Pet. Ex. 10 p. 6)

Dr. Salehi reviewed Petitioner's August 26, 2011 MRI and determined Petitioner had two level disc disease at L3-4 and L4-5 manifested by slight height loss at L3-4 and slight T2 signal loss at both levels, with mild circumferential disc bulge without neural compression. He personally reviewed Petitioner's February 2, 2012 discogram CT and noted an annular tear at L3-4. He reviewed the lumbar discogram report and noted concordant pain at L4-5. (Pet. Ex. 10 p.7)

Dr. Salehi stated Petitioner's mechanical back pain was secondary to the annular tear at L3-L4 and disc degeneration at L4-5. The doctor noted the discgram showed concordant pain at L4-5, but he was also concerned about the degeneration at L3-4 based on the MRI. Dr. Salehi stated that, given the failed course of conservative care, he recommended surgical intervention in the form of an L3-4, L4-5 lateral lumbar fusion with allograft. At that time, Dr. Salehi felt Petitioner could return to work with desk work/light duty capacity with no lifting more than 20lbs, push/pull more than 35lbs., no repetitive bending or twisting at the waist and alternate between sit/stand every 30-45 minutes. She was to follow the restrictions until at least 6 months post-op. (Pet. Ex. 10 p. 7)

On April 20, 2012, Petitioner presented to Dr. Bermudez complaining of pain at 7-8/10, and stating she had difficulty sleeping due to pain and difficulty walking, standing, and climbing. On exam, Petitioner's ROM continued to be painful in all directions of flexion, extension, lateral flexion, and rotation with tenderness into the bilateral paraspinal muscles, and he noted a positive Milgram's test in the lumbar spine. Dr. Bermudez gave Petitioner EMS, hot packs, ultrasound, and soft tissue massage. (Pet. Ex. 3 p. 39)

On May 1, 2012, Petitioner underwent a second Section 12 examination with Dr. Grear. The doctor stated Petitioner had strained her lumbosacral spine in her July 22, 2011 work accident. Dr. Grear indicated patient

was treated with naprosyn, tramadol, and soma which made her sleepy and was discontinued. Dr. Grear stated Petitioner's first injection stopped her pain from radiating into her left leg but that the two subsequent injections provided no therapeutic benefit. He stated Petitioner no longer complained of pain down her leg, but continued to complain of pain in the lower lumbar spine. Dr. Grear reviewed Petitioner's MRI reports. He noted that the discogram revealed some radial tears at L4-5, but no significant extrusion of the disc material and no significant intrinsic pressure on the nerve roots and only mild foraminal stenosis without any clinical complaints of radicular pain. (Resp. Ex. 8. dep #3)

Dr. Grear's phsycial exam revealed Petitioner moved with guarded motion from sitting to standing, trace parspinal muscle spasm, and avoidance response with palpation diffusely throughout her lumbar spine. Petitioner had diminished forward flexion, left and right lateral rotation, hyperextension of approximately 20 degrees secondary to pain. Dr. Grear noted he had no current medical records to review except the CT discogram and his opinions were based on his own physical exam. Dr. Grear determined Petitioner's physical therapy, two epidural injections, and use of Norco, were reasonable and customary. He noted that she should try a nonsteroidal anti-inflammatory medicine. (Resp. Ex. 8. dep. #3)

Dr. Grear stated that, based on his exam and the records he reviewed, that the proposed treatment by Dr. Salehi, including the L3-4 and L4-5 lateral lumbar fusion with allograft was not reasonable and medically necessary. He stated that, based on the MRI and CT discogram, spinal fusion and laminectomy and discectomy in the absence of radicular symptoms would be improbable to result in significant benefit. Dr. Grear stated Petitioner had not yet reached MMI; however, he expected after good conservative management, weight loss, and a home exercise program she should be able to return to full time employment in a medium to light duty position, with no lifting more than 15 pounds from floor to waist and no lifting greater than 10 pounds from waist to above the shoulder level. He anticipated she would reach MMI within eight weeks. Dr. Grear stated Petitioner should be capable of working full time limited to deskwork with frequent ability to change positions. (Resp. Ex. 8. Dep. #3)

On May 29, 2012, Dr. Grear authored a supplemental report. The doctor indicated that his answers to the questions of May 1, 2012 had not changed, after reviewing "further medical records." (Resp. Ex. 8 dep. #4) The Arbitrator notes Dr. Grear did not indicate what medical records he reviewed.

On July 23, 2012, Dr. Salehi authored a report after reviewing Dr. Grear's May 1, 2012 IME report. Dr. Salehi noted that Dr. Grear's opinion was that, based on the MRI and CT discogram, he felt spinal fusion and laminectomy and discectomy in the absence of radicular symptoms would be improbable to result in significant benefit to the patient and that further interventional care and further physical therapy was not necessary. To this, Dr. Salehi responded that Petitioner had low back pain with intermittent radicular symptoms down the left leg into the foot, as indicated in his March 3, 2012 report. He noted she had lumbosacral and posterior iliac crest tenderness with positive left sciatic notch tenderness with decreased sensation in the left lateral thigh and calf. Dr. Salehi stated Petitioner's symptoms are discogenic in nature as a result of the annular tear at two lumbar discs. He stated there is a great deal of evidence in the neurosurgical literature supporting a fusion operation for the diagnosis of discogenic pain unresponsive to medical management, and to say otherwise is not to rely on medical evidence. Dr. Salehi further stated that, even regardless of whether she had lower extremity complaints, her MRI showed two level disc disease at L3-4 and L4-5 with slight height loss at L3-4 and T2 signal loss at both levels. He noted the discogram revealed an annular tear at L3-4 and confirmed Petitioner's source of pain. Lastly, he stated, as she failed conservative treatment and her present complaints had been present for a year since her injury, she is a surgical candidate in the form of an L3-4 and L4-5 lateral lumbar fusion. (Pet. Ex. 11 p. 9)

On July 30, 2012, Petitioner presented to Dr. Harsoor regarding pain at 5/10 in her low back along with numbness and tingling in her feet, which persisted during the prior four weeks. Petitioner indicated pain

worsened with prolonged walking and sitting.Dr. Harsoor noted Petitioner reported being "let go from work." Dr. Harsoor refilled Petitioner's Tramadol and restarted Petitioner's Naproxen prescription. (Pet. Ex. 6. p. 83-85) Dr. Harsoor's records include a blank "lumbar transforaminal injection" form. (Pet. Ex. 6. p. 86) Dr. Harsoor's bill for July 30, 2012, of $126.00, does not include a CPT code for an injection. (Pet. Ex. 6. p. 130) As such, considering no bill was created for an injection on this date, no injection was performed on this date.

On September 5, 2012, Petitioner presented to Dr. Harsoor complaining of persistent pain at 6/10 with numbness and tingling down into her feet. Petitioner indicated pain worsened with prolonged walking and sitting. Petitioner indicated "some acidity from Naproxen." Dr. Harsoor refilled Tramadol, Flexeril, and stopped Naproxen. (Pet. Ex. 6. p. 87-89) Again, Dr. Harsoor's records include a blank form for a lumbar transforaminal injection. (Pet. Ex. 6. p. 90) Dr. Harsoor's bill for September 5, 2012, for $126.00, does not include a CPT code for an injection. (Pet. Ex. 6. p. 131) Considering that no bill was created for an injection on this date, no injection was performed on this date.

On September 6, 2012, Dr. Salehi presented for a deposition. Dr. Salehi testified he specialized in neurological surgery and had been board certified since 2004. (Pet. Ex. 11 p. 4) He testified, to a reasonable degree of medical and surgical certainty that the injury of July 22, 2011, which involved bending, twisting, and lifting resulted in an aggravation of Petitioner's preexisting condition. He testified that the lateral lumbar fusion at L3-4 and L4-5 was the only thing which would help Petitioner. He provided that the recommendation was based on his clinical knowledge, knowledge of the literature, and correlation of the imaging findings. (Pet. Ex. 11 p. 11) He testified that lumbar strains typically resolve within six weeks and ongoing pain would be related to a different diagnosis. He testified Petitioner's conservative treatments were reasonable and necessary. (Pet. Ex. 11 p. 13) On cross, he testified that if a patient demonstrates physical demand level during work conditioning of a medium physical demand level that they would be able to perform medium level work if those activities were sustained and not just a burst of going up to a medium level, causing significant symptoms. (Pet. Ex. 11. p. 21, 22) Dr. Salehi testified Petitioner's degenerative disc disease was asymptomatic and the accident rendered it symptomatic, and she developed an annular tear on top of what she had before. (Pet. Ex. 11 p. 24, 25) Lastly, Dr. Salehi testified his bill had not been paid and that his office had a policy of requiring payment before seeing patients. (Pet. Ex. 11 p. 26)

On October 23, 2012 Dr. Grear presented for a deposition. Dr. Grear testified he became board certified in 1981 and practiced in general orthopedics and that he takes care of the back and operates on all joints but no longer operates on spines. (Resp. Ex. 8 p. 3-5) He testified that, at the time of his November 22, 2011 exam, he had medical records of Dr. Harsoor, physical therapy notes, and the radiographic study from Silver Cross Hospital. (Resp. Ex. 8 p. 10) Dr. Grear testified he was provided with Dr. Salehi's report and the work conditioning records prior to his May 29, 2011 IME addendum. (Resp. Ex. 8 p. 16) On cross, Dr. Grear testified lumbar strains typically resolve in six to twelve weeks and that six months is not unheard of. (Resp. Ex. 8 p. 18) Dr. Grear testified annular tears would never again become "normal." (Resp. Ex. 8 p. 22) Dr. Grear testified annular tears elicit inflammation in the surrounding tissues that leads to pain. Dr. Grear testified a fusion may be appropriate medical treatment to combat mechanical back pain. (Resp. Ex. 8 p. 22-24).

On October 29, 2012, Petitioner presented to Dr. Harsoor complaining of persistent low back pain at 5/10 and numbness and tingling down into her feet. Petitioner indicated pain worsened with prolonged walking and sitting. Dr. Harsoor noted Petitioner was awaiting surgical approval and she refilled Tramadol and recommended continuation of Flexeril and Elavil. Again, Dr. Harsoor's records include a blank form for a lumbar transforaminal injection. (Pet. Ex. 6. p.93-96) Dr. Harsoor's bill for September 5, 2012, for $126.00, does not include a CPT code for an injection. (Pet. Ex. 6. p. 132) The Arbitrator notes that, considering that no bill was created for an injection on this date, no injection was performed on this date. Likewise, Petitioner testified she did not undergo an injection at this time. Petitioner testified Dr. Harsoor placed her off work.

Petitioner testified that prior to July 22, 2011 she had not suffered any back injuries. She further testified that since her accident on July 22, 2011 she has not had any other injuries to her back. She testified that at arbitration that her back pain was a five on a scale of 1-10, due to the long commute. She testified she was driven to arbitration by her fiancé. Petitioner testified she cannot touch her toes, has a hard time shaving her legs, walking up and down stairs, sitting for long periods of time. She testified any twisting motion, like laundry causes pain. She testified it takes her an extremely long time to do the laundry and things that took her minutes now take her hours. She testified she does stretching exercises, uses exercise balls, lays on the floor, takes hot showers, alternates ice and heat for 20 minute intervals, and takes pain medication to relieve her pain.

Petitioner testified she wants to undergo the lumbar fusion recommended by Dr. Salehi. Petitioner testified she would be surprised if Dr. Harsoor's records indicated she was able to perform all activities of daily living.

On cross exam, Petitioner was questioned as to Dr. Salehi's recommendations regarding her work capabilities at his exam on March 2, 2012 and she responded she understood him to mean that she could perform desk work after her surgery. Petitioner testified she has low heels she wears if she is going to be sitting. She provided that she attempted to wear regular heels one day and it was "a totally bad idea." She took them off as soon as she could. However, she has occasionally tried to do it again. She testified she has learned to live with wearing flats and mostly flip flops since she cannot tie shoes and cannot reach her toes.

Respondent's witness Ms. Jernigan testified she is the co-manager of Walmart and has held the position for three years. She testified she handles workers' compensation claims. She testified she had employees who were taking medication for allergies, migraines, stomach aches, and acid reflux who were allowed to take their medication upon letting managers know about the medication and providing medical paperwork. She testified the deskwork offered to Petitioner is in the front cash office where she would be sitting at a desk, answering phones, and taking messages, and not working the fitting room. She testified she told Petitioner if she did not accept the February 25, 2012 offer she was accepting her termination. She also testified she saw Petitioner walking around the store in heels for about 30 minutes.

Ms. Jernigan testified it was store policy to include a job description with bona fide job offers, and job descriptions were attached when Petitioner was offered positions as unloader and as fitting room attendant. She testified she did not attach any job description on February 25, 2012 when she indicated to Petitioner she would be doing desk work. Further, she testified she would not allow an employee to take a medication that caused her to sleep for 15 hours. Ms. Jernigan admitted she had Dr. Grear's report in her possession at the time of the Februrary 25, 2012 light duty offer. She testified that on a busy day an unloader would be moving merchandise more than six times throughout an eight-hour day. Lastly, she testified that, regardless of how much weight was lifted in the unloading job, an unloader would be required to twist and bend.

On rebuttal testimony, Petitioner testified that on February 25, 2012, she was not told she would be working in the cash room but was told she would be working at the fitting room answering phones. She testified she was not told she would be accommodated with regard to drowsiness caused by her medication.

With respect to issue (F) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner testified, without rebuttal, that before the accident on July 22, 2011, she never previously injured her low back. She additionally testified, without rebuttal, that since the date of accident, she has not re-injured her low back. The medical records corroborate Petitioner's testimony.

The Arbitrator finds that Petitioner's testimony was credible and that she provided a consistent history of the accident. The Arbitrator finds it more likely than not that Petitioner's asymptomatic discs at the L3-4 and L4-5 levels were aggravated and became symptomatic after the lifting accident.

After hearing the testimonies of Petitioner and Denise Jernigan; reading the testimonies of Dr. Salehi and Dr. Grear; and reviewing the exhibits submitted, the Arbitrator hereby finds that Petitioner's present condition of ill-being with regard to her low back condition is causally related to the injuries sustained on July 22, 2011.

With respect to (J.) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services; and (K.) Is Petitioner entitled to any prospective medical care, the Arbitrator finds as follows:

Having reconciled that Petitioner's condition of ill-being is causally related to the accident herein, the Arbitrator hereby finds the medical services that were provided to Petitioner were reasonable and necessary.

Petitioner alleges several outstanding medical bills. The Arbitrator finds that Respondent has not paid all appropriate charges for the reasonable and necessary medical services, and therefore orders Respondent to pay the following amounts, as provided by Section 8.2:

Name of Provider	Total Bills	Dates of Service
Ex. 3: Dr. Ravi Barnabas	$2,881.57 (Alivio)	8/26/2011-6/4/2012
Dr. Ruben Bermudez	$342.38 (Herron)	
Ex. 4: Delaware Place MRI	$320.00	8/26/2011
Ex. 6: Dr. Sue Harsoor	$18,193.00	9/1/2011-10/29/2012
Ex. 7: Rogers Park One Day Surgery	$18,974.74	10/11/2011-2/14/2012
Ex. 8: Advanced Laboratory Services	$2,004.00	11/9/2011-4/17/2012
Ex. 9: Lakeshore Open MRI	$1,245.55	2/14/2012
Ex. 10: Dr. Sean Salehi	$525.00	3/2/2012
TOTAL:	**$44,486.24**	

Prospective medical services

Additionally, Petitioner testified at hearing that she wishes to undergo the L3-4, L4-5 fusion proposed by Dr. Salehi. The Arbitrator finds that Dr. Salehi's testimony was more persuasive than the testimony of Dr. Grear. The testimony and evidence presented support an order for the fusion, as Petitioner has (1) failed conservative treatment, and (2) her pain is discogenic in nature. Thus, the Arbitrator orders Respondent to authorize the proposed surgery and the necessary subsequent medical treatment until Petitioner reaches maximum medical improvement.

With respect to issue (K.) Is Petitioner entitled to temporary total disability, the Arbitrator finds as follows:

Temporary Total Disability compensation is provided for in section 8(b) of the Workers' Compensation Act, which provides, "[W]eekly compensation *** shall be paid *** as long as the total temporary incapacity lasts," which the Courts have interpreted to mean that an employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit. Further, the period during which a claimant is temporarily totally disabled is a question of fact to be resolved by the Commission. Archer Daniels Midland Co., 138 Ill. 2d at 118-19; McKay Plating Co. v. Industrial Comm'n, 91 Ill. 2d 198 (1982).

Dr. Harsoor placed Petitioner off work through the date of arbitration, November 19, 2012, due to her low back pain. No physical therapist ever indicated Petitioner was rehabilitated to the point of being able to return as an unloader. The records indicate that Petitioner continued to self modify activities involving trunk rotation due to lower back pain. It was this stagnation that indicated to the physical therapist that Petitioner should be released from work conditioning. The physical therapist did not indicate Petitioner was able to work full duty. Rather, the physical therapist indicated Petitioner's treating physician discontinued work conditioning in order to seek other methods of relieving Petitioner's pain. Further, Petitioner testified it took 35 minutes to lift 50 pounds six times during work conditioning, whereas her job as an unloader required her to lift 50 pounds six times in about three minutes. Additionally, her ability to "team lift" items weighing hundreds of pounds was never tested. Clearly she was incapable of returning to her position as an unloader.

Records indicate Petitioner told every doctor, including Drs. Barnabas, Harsoor, Salehi, and Grear, her pain was worst with prolonged sitting and best when lying down. Petitioner likewise testified. Petitioner's work conditioning did not test her ability to sit at a desk for eight hours. Work conditioning was geared toward achieving Petitioner's prior lifting, bending, twisting, and endurance abilities. An ability to lift 50 pounds has no bearing on the ability of an individual with a low back injury to sit in a chair for eight hours. Moreover, assuming Petitioner was offered the fitting room job on February 25, 2012, she would be required to perform intermittent bending, twisting, and lifting—activities which caused pain and were not authorized by Dr. Grear or Dr. Salehi. Petitioner testified her pain medication caused her to be drowsy to the point of sleeping up to 16 hours per day. Moreover, Ms. Jernigan admitted that, regardless of medications, employees would not be permitted to sleep on the job.

The Arbitrator further notes that on multiple occasions prior to January 3, 2012, it was noted Petitioner was able to perform all activities of daily living. Subsequent thereto the notes do not indicate whether Petitioner was able to perform all activities of daily living. However, the notes consistently note Petitioner complaining of persistent low back pain; numbness and tingling down into her feet; and her pain worsened with prolonged walking and sitting.

Thus, after hearing the testimony of Petitioner and Ms. Jernigan, reviewing testimony of Drs. Salehi and Grear, and reviewing the exhibits submitted, the Arbitrator hereby finds Petitioner was temporarily totally disabled from 7/23/2011 to 7/29/2011, and from 8/20/2011 (the day Dr. Niemega excused Petitioner from work) to 11/19/2012, for a period of 66-1/7ths weeks.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Flesner,
Petitioner,

vs.

NO: 11 WC 32917

14IWCC0096

Thomas G. Todd, Inc., d/b/a Nancy's Pizzeria,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection and medical expenses both incurred and prospective 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 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 Petitioner testified that he worked for the Respondent for 36 years. He has been manager of Nancy's Pizzeria for 16 years. His job duties are to make the dough and sauce. The flour comes in 50-pound bags. You put the flour into a bowl with water and then cut it up into 17-ounce pieces. The sauce comes in two cases per bag. There are six cans per case and they weigh a couple of pounds each. (Transcript Pgs. 8-11)

Petitioner further testified that he makes the dough everyday and the sauce every two days. (Transcript Pgs. 11-12)

Petitioner indicated that he would get a pinching or pulling and they would come and go at different times whether he was working or at home. When he would pick up the 50-pound bag of dough, once in a while he would feel a pulling sensation in the abdominal area. (Transcript Pgs. 13-14)

14IWCC0096

The Commission adopts the testimony of Dr. Coe over that of Dr. Palacci. Dr. Coe believed that a causal relationship existed between the repetitive pulling sensations Petitioner testified to and the umbilical hernia. (Petitioner Exhibit 5)

Therefore, the Commission finds that Petitioner has proven that his umbilical hernia was the result or was aggravated by the repetitive trauma the Petitioner was exposed to during his job as manager of Nancy's Pizzeria on June 1, 2011.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $250.00 for medical expenses under §8(a) of the Act and §8-2 and that Respondent is liable to pay for all related prospective treatment including surgery as proposed by Drs. Milgram and Popatopolous.

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 $5,000.00. 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:
121013 FEB 1 1 2014
CJD/hsf
049

Charles J. DeVriendt

Michael J. Brennan

DISSENT

The arbitrator wrote an excellent decision accurately describing the evidence upon which he based his decision. I agree with Arbitrator Falcioni's analysis and conclusions. I would affirm and adopt the arbitrator's decision.

With respect, I dissent.

Ruth W. White

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

FLESNER, DAVID
Employee/Petitioner

Case# **11WC032917**

THOMAS G TODD INC
Employer/Respondent

14IWCC0096

On 3/8/2013, 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 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK KOHEN
ADAM F RATHERS
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
MARK P RUSIN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC0096

David Flesner
Employee/Petitioner

Case # 11 WC 32917

v.

Consolidated cases:

Thomas G. Todd, 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 Arbitrator Falcioni, Arbitrator of the Commission, in the city of Geneva, on 2/22/13. After reviewing all 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 _____

14IWCC0096

FINDINGS

On the date of accident, 6-1-11, 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 not*** sustain an accident that arose out of and in the course of employment.

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

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

On the date of accident, Petitioner was N/A years of age, single, with 0 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 $0.00 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

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

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

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

Signature of Arbitrator

March 6, 2013
Date

ICArbDec19(b) p. 2

MAR 8 - 2013

In support of the Arbitrator's decision relating to (D) 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 facts:

Petitioner is the store manager for a Nancy's Pizza location. He alleges an accident on June 1, 2011. Petitioner did not testify as to involvement in any work accident or unusual event that date. He testified to being diagnosed with a hernia and that after June 1, 2011 he avoided heavy lifting as he did not want to injure himself. Petitioner did not offer into evidence any medical reports or medical records documenting care or treatment for a hernia condition on or about June 1, 2011. Petitioner did not offer any medical records into evidence which show he was restricted from performing any work activities on June 1, 2011 or thereafter. Petitioner acknowledged he continued working his normal position after June 1, 2011.

Petitioner testified that part of his job as a manager involved making dough and sauce. Petitioner did not testify his work activities in making dough and sauce were repetitive in nature. He admitted to making dough only once a day and sauce every two days. Petitioner stated making dough involved lifting a 50 pound bag of flour into a bowl, but did not indicate this was necessary more than once a day. Petitioner testified that making sauce involved lifting a case of cans which weighed about 25 pounds, but acknowledged he would not make sauce on a daily basis, but every other day. By Petitioner's own testimony, he would not have been required to lift a case of cans more than one time every two days. Petitioner did not testify to any other job duties of significance. He did not testify to any heavy job duties on a repetitive basis.

The medical records in evidence show Petitioner had visits with Dr. Papadopoulos, an internist, from November 16, 2010 through January 31, 2011. Petitioner testified he saw Dr. Papadopoulos to be evaluated for diabetes. However, according to Dr. Papadopoulos' records, Petitioner was first seen November 16, 2010, primarily due to foot pain. During the course of

the exam this date, Dr. Papadopoulos noted an umbilical hernia. The doctor's records do not indicate the hernia related to any work accident or work activity. The records do not indicate any specific treatment was rendered or prescribed for this condition. Dr. Papadopoulos did not authorize Petitioner off work on account of this condition or restrict his work capabilities.

Petitioner had further visits with Dr. Papadopoulos on November 30, 2010, December 27, 2010 and January 31, 2011, but no further mention is made of a hernia condition. There is no indication in Dr. Papadopoulos' further notes that Petitioner required further care on account of a hernia condition or that the hernia condition had any relationship to a work accident or work activities.

There is no further medical record of treatment in evidence until a visit with Dr. Milgram, Petitioner's primary care provider, on November 8, 2011. By history, Petitioner reported first noticing an umbilical hernia in December, apparently referring to December of 2010. Petitioner is 5'6" tall. Dr. Milgram noted Petitioner weighed 264 pounds on November 8, 2011. According to Dr. Papadopoulos' records, Petitioner weighed 248 pounds one year earlier in November 2010. Thus, Petitioner had gained 16 pounds in the past year. By history, Petitioner reported the hernia protrusion had gotten slightly bigger. He denied any sharp pains whatsoever. He reported only occasional discomfort, which Petitioner specifically denied was related to any physical activities. Petitioner did not report the hernia condition related to any work accident or work activities. Dr. Milgram diagnosed an umbilical hernia and advised Petitioner to see a surgeon for evaluation.

Petitioner has had further visits with Dr. Milgram throughout 2012 for various medical problems, but the doctor's records do not indicate petitioner has received additional treatment on account of a hernia condition.

At the request of Petitioner, Petitioner was examined by Dr. Coe on March 27, 2012. Dr. Coe stated a causal relationship existed between repetitive abdominal wall strain injuries suffered by Petitioner at work on June 1, 2011 and his hernia condition. However, Dr. Coe admitted the treating medical records do not support a contention that Petitioner's hernia condition is related to any work accident or work activities. (See PX 5, page 32). Further, the history obtained by Dr. Coe is inaccurate. Petitioner did not even testify as to involvement in any repetitive work activities or unusual event on June 1, 2011. Further, Dr. Coe admitted that Petitioner is obese with a significantly elevated body mass index. Dr. Coe admitted that obesity is a risk factor in the development of hernias and makes Petitioner prone to developing a hernia. (PX 5, page 27).

At the request of Respondent, Petitioner was examined by Dr. Palacci on August 23, 2012. Dr. Palacci examined Petitioner and reviewed pertinent medical records including those of Dr. Milgram and Dr. Papadopoulos. Dr. Palacci noted Petitioner was morbidly obese. Dr. Palacci stated Petitioner's large protuberant abdomen predisposed him to development of an umbilical hernia. Dr. Palacci stated the medical records did not support Petitioner's hernia condition related to any work accident or activities. The doctor noted Petitioner never reported a traumatic event and Petitioner's condition was likely secondary to his morbid obesity.

The Arbitrator finds Petitioner failed to prove he sustained accidental injuries which arose out of and in the course of his employment on June 1, 2011 and fail to prove his hernia condition is causally related to an alleged accident of June 1, 2011. Petitioner did not testify as to any work accident on June 1, 2011 or repetitive work activities which constitute a compensable work accident. The medical records do not support a contention that Petitioner sustained a compensable work accident. The medical records in evidence do not support Petitioner's allegation that his hernia condition is related to any work accident or work activities.

In fact, the records indicate Petitioner specifically advised the treating doctor that his abdominal discomfort was not related to any physical activities. The Arbitrator has reviewed the reports and testimony of both Dr. Palacci and Dr. Coe. The Arbitrator finds the opinions of Dr. Palacci more credible that Petitioner's hernia condition is not related to a work accident of June 1, 2011 or work activities. The claim for compensation is denied. All other issues are therefore 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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Popwoczak,

Petitioner,

vs.

NO: 07 WC 1995

14IWCC0097

Rite Way Tile & Carpet,

Respondent,

DECISION AND OPINION ON REMAND

This matter is before the Commission on Circuit Court Judge Patrick J. Sherlock's remand of the Commission's decision, which was issued on August 24, 2012. In that remand, the Judge affirmed the decision of the Commission in regards to penalties and fees under §19(k) and (l) and §16 attorneys' fees. The Judge also affirmed the Commission in regard to their finding of permanent partial disability. However, the Court reversed the Commission's finding that Petitioner's current condition of ill being was causally connected to the original accident of December 11, 2006 and further reverses the Commission's finding that Petitioner was entitled to temporary total disability payments from April 7, 2007 through February 7, 2011.

IT IS THEREFORE ORDERED BY THE COMMISSION based on the remand from Judge Patrick J. Sherlock that Respondent does not have to pay the Petitioner any temporary total disability payments under §8(b) of the Act as ordered by the Commission in the attached decision.

IT IS FURTHER ORDERED BY THE COMMISSION that based on the remand of Judge Patrick J. Sherlock there was no causal connection between the Petitioner's condition of ill being at the time of the second arbitration hearing and the accident, which occurred on December

14IWCC0097

11, 2006.The remainder of the attached decision is affirmed.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $26,000.00. 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: FEB 1 1 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
R: 12/4/13
049

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Popowczak,

Petitioner,

vs.

NO: 07 WC 1995

14IWCC0097

Rite Way Tile & Carpet,

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 causal connection, temporary total disability, permanent disability, credit and penalties and fees and being advised of the facts and law, reverses the Decision of the Arbitrator in regards to causal connection and increases the amount of temporary total disability due and owing the Petitioner as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator relied on the opinion of the independent medical examiner, Dr. Mather, in finding that Petitioner's current condition of ill being was not related to the original accident. (Respondent Exhibit 2)The Commission finds that this opinion runs counter to the Commission's previous decision affirming the finding that Petitioner suffered a strain and an aggravation of a pre-existing condition of spondylolisthesis. Therefore, Petitioner's current condition of ill being is causally connected to the original accident.

The Commission finds that Petitioner is entitled to temporary total disability until February 7, 2011. According to the Chicago Tribune and other internet media outlets it would appear Petitioner was able to perform some type of work. (Respondent Exhibit 7) Although Petitioner offered off work slips from Dr. Dam, it does not appear that the Doctor provided these work slips after actually examining the Petitioner. (Petitioner Exhibit 5)

14IWCC0097

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $455.52 per week for a period of 200 2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $409.97 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 loss of use to the person as a whole to the extent of 10%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $5,063.36 for medical expenses under §8(a) of the Act. Respondent shall further reimburse Petitioner for out of pocket expenses in the amount of $378.02

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 $39,300.00. The probable cost of the record to be filed as return to Summons is the sum of $35.00, payable to the Illinois Workers' Compensation Commission in the form of cash, check or money order therefor and deposited with the Office of the Secretary of the Commission.

DATED: AUG -7 2012

Charles J. DeVriendt

Yolaine Dauphin

Yolaine Dauphin

Ruth W. White

Ruth W. White

HSF
O: 6/26/12
049

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

VICKY PARAS,

Petitioner,

vs.

NO: 04 WC 59273

14IWCC0098

MOTOROLA, INC.,

Respondent,

DECISION AND OPINION ON REVIEW

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

The Commission notes that the Arbitrator's internet search was improper and beyond the evidence contained in the record. However, this error was harmless since this additional information was not necessary for the Arbitrator to reach the appropriate conclusions on the issues in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 17, 2013, 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:
o012214
CJD/se
049

FEB 11 2014

Michael P. Latz

Ruth W. White

DISSENTING OPINION

I respectfully dissent and find that the testimony of Petitioner was credible as were the causation opinions of Dr. Stamelos, Dr. Williams, and Dr. Chmell. Respondent's Section 12 Dr. Fernandez opined that Petitioner's job duties did not contribute to or aggravate her bilateral carpal tunnel syndrome (CTS) because he reviewed her job description and a video. However, his testimony does not seem to be based on the actual facts of this case. Petitioner's undisputed testimony was that the video was not representative of her work duties because it did not show "manual tune" or "repair." (T.24). "Manual tune" involved using small screwdrivers and required Petitioner to "turn [her] fingers all day long." (T.26). Petitioner testified that she spent 10 hours a day, 6 days a week doing that job and she noticed pain, numbness, and swelling in her hands while doing it. (T.21, 27). Petitioner also did other jobs including "laser trim," "pick and place," and "inspection and repair." (T.22).

Although the video shows the job of "laser trimming," Petitioner testified that she operated four machines at once while the video only showed workers doing one. (T.150). Petitioner testified that nobody else worked on four machines. (T.30). Petitioner testified that she also worked in the "receiver line," which is not shown on the video, and used a pneumatic screwdriver which involved applying 15 to 20 pounds of pressure. (T.67). Petitioner also testified that the video didn't show pliers being used to cut some of the circuit boards. The video only showed work on "the smallest boards." (T.149). When Petitioner was returned to work with light duty restrictions, she was put in "inspection" for only two weeks and then Respondent put her back in "manual tune." (T.39).

Petitioner credibly testified that her hands were hurting her and she had numbness in her fingers in 2001 but she thought it was related to her neck. (T.33). This is supported by the medical records and testimony of her treating physician, Dr. Stamelos, that Petitioner was

complaining of pain in her left hand and fingers along with numbness at that time. The first mention of right hand numbness and tingling was several months later on March 20, 2002, after Petitioner had been off work, and at a time when Dr. Stamelos noted that her neck and bilateral shoulder pain were getting better. This lends credibility to his testimony that Petitioner's complaints have been similar since the very beginning, including numbness and tingling in both hands (Px12 at 8) and that Petitioner has never stopped complaining about her hands (Id. at 13), but he was more focused on her cervical and shoulder problems because those were more serious (Id. at 42). He testified that Petitioner has double crush syndrome and that she is the "poster girl" for repetitive motion carpal tunnel disease. (Id. at 29). He is "positive" that Petitioner's work activities contributed to or caused her carpal tunnel. (Id. at 36).

Analyzing the testimony of Respondent's Dr. Fernandez in more detail, he testified that Petitioner's pain behavior was not significantly beyond her objective findings and that she does have a bad case of bilateral CTS with the right being much more severe than the left. (Rx7 at 12, 16). He did not believe that Petitioner's work duties, even if done for 27 years, would contribute to CTS and felt that her condition was "idiopathic." However, he did admit that her symptoms "manifested" while she did her job. (Id. at 20). Even though Petitioner's symptoms were worse when she was working, he did not believe that this meant there was a causal connection. On cross examination, he admitted that once someone has CTS, the symptoms can worsen over time even if they aren't working. He also admitted that if the job description and video were not all inclusive and she did, in fact, have to use vibratory tools, pinch/grasp, and press things into place, this would be important in his determination of causation. (Id. at 26). He opined that if Petitioner was exposed to heavy gripping, grasping, using tools on a repetitive basis, and certain vibratory tools, "of course those could be contributory factors considered causal to" CTS. (Id. at 29). He also opined that Petitioner absolutely needs surgery.

In my opinion, Dr. Fernandez's opinion is based on an incomplete understanding of Petitioner's job and should be discounted for that reason. Although the Arbitrator found the opinions of Petitioner's own doctors to be faulty for the same reason, she believed Dr. Fernandez because he viewed the video and reviewed the job description. However, as discussed above, this is immaterial when the video does not show all of Petitioner's job duties and particularly does not show the most strenuous ones.

In addition to Dr. Stamelos, Petitioner was examined by Dr. Williams who felt that there was a significant relationship between her work and her carpal tunnel syndrome. (Px13 at 13). Dr. Chmell also performed an examination and records review and agreed that there was a causal relationship. (Px14 at 17).

Based on the above and a review of the record as a whole, I would reverse the Arbitrator's decision on the issues of accident and causation and would find that Petitioner's bilateral CTS are causally related to the initial accident on October 10, 2001.

Charles J. DeVriendt

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

PARAS, VICKY
Employee/Petitioner

Case# **04WC059273**

02WC011336

14IWCC0098

MOTOROLA
Employer/Respondent

On 1/17/2013, 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 0.10% 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:

0006 LEO ALT
221 N LASALLE ST
SUITE 2014
CHICAGO, IL 60601-1407

1120 BRADY CONNOLLY & MASUDA PC
BEVERLY N MASUDA
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

14IWCC0098

☐ 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)

Vicky Paras
Employee/Petitioner

v.

Motorola
Employer/Respondent

Case # 04 WC 59273

Consolidated cases: 02 WC 11336

An *Application for Adjustment 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 G. Lammie**, Arbitrator of the Commission, in the city of **Chicago**, on **June 16, 2011** and the case was later re-assigned and proceedings were concluded by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Chicago**, on **June 12, 2012, July 24, 2012,** and **October 29, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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 **19(b), 8(a)**

FINDINGS

14IWCC0098

On the date of accident, **September 23, 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* 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 $**41,572.96**; the average weekly wage was $**799.48**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **no** dependent children.

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

Respondent shall be given a credit of $**58,095.91** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**58,095.91**.

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

ORDER

A consolidated hearing was held in Petitioner's consolidated cases. With the exception of the temporary total disability/maintenance benefits addressed in this decision, the Arbitrator denies any additional award beyond what was made in the Arbitrator's decision in Case No. 02 WC 11336 as a result of Petitioner's aggravating injury on September 23, 2004.

Temporary Total Disability/Maintenance Benefits

As explained more fully in the Arbitration Decision Addendum, the Arbitrator denies Petitioner's claim for temporary total disability or maintenance benefits after March 9, 2009 and orders that Respondent shall pay Petitioner two days of unpaid maintenance benefits for March 6, 2009 and March 9, 2009 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

January 16, 2013
Date

JAN 17 2013

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

Vicky Paras
Employee/Petitioner

v.

Motorola
Employer/Respondent

Case # **04** WC **59273**

Consolidated cases: **02** WC **11336**

FINDINGS OF FACT

The parties participated in a consolidated hearing on June 16, 2011 before Arbitrator Lammie at which time all live testimonial evidence was presented pursuant to Petitioner's Section 19(b) and Section 8(a) motion. Subsequently, these matters were reassigned to the undersigned Arbitrator to conclude the presentation of evidence and render a decision on the issues presented. The Arbitrator finds on the issues presented at trial as stated herein and notes the Arbitrator's concurrent decision rendered in Case No. 02 WC 11336.

Background

Vicky Paras ("Petitioner") testified that she emigrated from Greece in May of 1974 after completing the American equivalent of the first year of high school. June 16, 2011 Arbitration Hearing Transcript ("Tr. pp.") 11-12. Her primary language is Greek and she taught herself English. Tr. pp. 12-13. Petitioner is right-hand dominant. Petitioner's Exhibit ("PX") 5.

Petitioner was employed with Respondent since 1976 through her first date of accident[1]. Tr. pp. 10-12. Petitioner testified that her first job in the United States was with Respondent in Franklin Park[, Illinois] and that she worked with tiny crystals used in watches for a couple of years. Tr. pp. 12-14. Thereafter, Petitioner moved to Schaumburg[, Illinois] in 1978 and worked in parts and then in crystals. Tr. p. 14.

Petitioner testified that she never filed a workers' compensation claim prior to these claims, that she was never sick, and that she worked seven days a week. Tr. p. 15. She also testified that she was never treated for any neck, back, arm or hand condition prior to October of 2001, and that she never had occasion to go to Respondent's clinic or medical department. Tr. p. 15. Petitioner further testified that she did not know what carpal tunnel was prior to 2001 and that it was not until she came under the care of Dr. Stamelos that she understood that she might have carpal tunnel. Tr. p. 27.

On cross examination, Petitioner testified that she could not remember if she only claimed an injury to her left shoulder when she originally filed her workers' compensation claim in 2002, but also acknowledged that her original application for adjustment of claim filed by her prior attorney referred to an injury due to pushing and pulling, which resulted in injury to the left shoulder only. Tr. pp. 73-76; Respondent's Exhibit ("RX") 1. Petitioner's Amended Application for Adjustment of Claim dated March 16, 2004 reflects a pushing and pulling injury to the "left shoulder, neck, arms, hands, etc." RX2.

[1] While Petitioner testified that she worked through October of 1991, the Arbitrator notes that the undisputed date of accident is October 10, 2001. Arbitrator's Exhibit ("AX") 1.

Petitioner further testified on cross examination that her original application for adjustment of claim filed on March 16, 2004 by her prior attorney again referred to an injury sustained on October 10, 2001 due to pushing and pulling, resulting in injury to the left shoulder, neck, arms, and hands. Tr. pp. 115-116; RX2. On re-direct examination, Petitioner testified that her former attorneys filed an amended application on her behalf after she advised them of what her doctors had been telling her. Tr. pp. 140-142. Petitioner also testified that she did not remember exactly what she was doing on the date of injury; she was either in inspection or laser and she believed that she was in laser half of the day and elsewhere for the remainder of the day. Tr. p. 113. She further testified on re-direct examination that her pain was worse after her second injury in 2004 and that it was localized in the upper back, shoulder, and down to her hand. Tr. pp. 148-149.

The Arbitrator notes that no original or amended application for adjustment of claim in the Commission's files in both of Petitioner's cases reflect any injury sustained as a result of repetitive trauma.

Petitioner's Job Duties

Petitioner testified that she was originally assigned to "manual tune" and had been in that position for several years prior to 2001. Tr. pp. 17-21. This position was in the same department as "laser, pick and place, inspection and repair." Tr. p. 20. Petitioner estimated that she worked in manual tune 80% of the time, approximately 10 hours a day, 6 days a week. Tr. pp. 20-22. Petitioner testified that the majority of the remainder of her time was spent working as the "laser" person. Tr. pp. 22-23. Otherwise, Petitioner worked filling in other positions including "pick and place" and "inspection and repair." Tr. p. 23. On cross examination, Petitioner testified that prior to her injury in October of 2001 she also worked in an area called "manual kits." Tr. p. 76.

Petitioner testified that the "laser" position involved using another, more modern [computerized] machine; there she would move around a mouse with little buttons to make cuts into certain places on the board. Tr. pp. 27-28. While in this position, Petitioner testified that she noticed numbness, swelling, and that her hands were hurting. Tr. p. 27.

On cross examination, Petitioner testified that she would stand in front of a computer with a keyboard and tune small, thin circuit boards; to do this, she would take the circuit board out of one box, adjust the circuit board to match the [computer] screen, and then place the completed circuit board in another box. Tr. pp. 97-99. Petitioner testified that the circuit boards in the laser position are bigger than those in manual tune. Tr. pp. 100. She further testified that there are different lasering processes for different boards, but the four machines on which she worked were all the same. Tr. pp. 101-103.

Petitioner testified that she worked in laser approximately 8-10 hours per day, 4-5 days per week in 2002 and 2003. Tr. p. 106. Petitioner testified that Respondent's Exhibit 4 was not representative of what she did when she worked the laser position because it showed the employees operating less than four laser machines simultaneously like she did by going from one machine to another and "[j]umping like crazy, around." Tr. pp. 28-30, 150. Petitioner also testified that she only uses the mouse in this position. Tr. pp. 103-104.

Petitioner further testified that Respondent's Exhibit 4 did not show manual tune or repair or inspection. Tr. pp. 24-25, 137. Petitioner testified that manual tune involved using a small tool that was similar to a screwdriver on small circuit boards of differing sizes and that she would turn her fingers all day long around, forward, and backwards. Tr. pp. 26, 66, 104. Petitioner testified that she also worked with an air gun using 15-20 pounds of pressure to close transreceivers with the screws and later clarified that she did not use this tool while in manual

tune, but rather while she was in repairs. Tr. pp. 67-68, 105. Then she would input information into a computer that could either pass or reject the [circuit] board. Tr. p. 26.

Petitioner also worked in a quality control inspection job (a.k.a. FQA). Tr. pp. 107-108. Petitioner testified that she was seated in this position and that varying sizes and types of thin circuit board sheets would come down to her on a conveyor belt and she would use tools including a tweezers, brush, and pliers to inspect, clean, and place the circuit boards in a box. Tr. pp. 108-110. On re-direct examination Petitioner testified that the pliers she used were not reflected in Respondent's Exhibit 4 and that it only showed the smallest [circuit] boards. Tr. pp. 149-150.

Job Descriptions

Petitioner's line assembly operator job description in Respondent's microcircuits group dated September 22, 2004 reflects that an employee is rotated every two weeks. PX2. Some of the tasks that Petitioner performed required the following: (1) ability to assemble small components into ceramic substrates using tweezers (line assembly); (2) ability to sit and look at small parts under a microscope for eight hours a day (FQA); (3) ability to stand/sit for long periods of time (mostly sitting); and (4) ability to lift up to 15 pounds "(mostly related to fixtures - at the time [Petitioner] was working on Manual tuning and boards weighed about 1 to 2 pounds)[.]" *Id.* The time spent on each task depended on the job and was approximately 5 to 10 min. *Id.* The tools required to perform the job (both manual and power) included tweezers, a hand torque set 15 pounds, and tuning tools for the manual tuning position. *Id.* Petitioner was also required to be able to lift up to 15 pounds. *Id.* The Arbitrator notes that this job description appears to have been created in response to a request about Petitioner's specific job duties.

An internal job description analyzed as of December 28, 2005 and entitled "Physical Demand Documentation" delineates the functions and physical activities required by the FQA, pick and place, and laser trim positions. PX2; RX11. FQA is a quality assurance inspection position. *Id.* The purpose of the pick & place position is to place components on a circuit board. *Id.* The purpose of the laser position is to utilize a machine that automatically trims excess solder or other material from circuit boards. *Id.* All three positions have essential functions that include visual inspection, inspection with use of a powered microscope, utilizing tweezers/picks/fingers to place components onto circuit boards, and picking up trays of circuit boards (weighing approximately 5 to 8 pounds) to trim boards where the employee determines how many boards to place on the tray. *Id.* The physical requirements of the positions are as follows:

	Laser Trim	FQA	Pick & Place
Standing	Occasionally (30% or less of shift)	None	None
Sitting	Constantly (70% of shift)	Constantly (90% of shift)	Constantly (90% of shift)
Walking	Rarely (less than 5% of shift)	"	"
Lifting	Rarely (less than 5% of shift); lifts trays from rack that range in height from 42"-64" on rare basis & lifts trays of boards weighing 5-8 pounds as determined by the employee and how many boards the put on the tray	"	"
Carrying	Rarely (less than 5% of shift)	"	"
Pushing/	Rarely (less than 5% of shift);	"	"

pulling	pushes trays into fixtures with minimal force
Reaching	Infrequently (less than 10% of shift); transferring trays from the rack requires reaching down to 20" and up to 64"; placing boards in fixture requires reaching 15" from body at 42" height; activation button is 20" reach

Id. In addition, repetitive hand motions include bilateral simple grasping, firm grasping, and fine manipulation. *Id.* The use of picks and tweezers also requires fine manipulation as well as simple and firm grasping. *Id.* Holding trays and circuit boards requires grasping, but no repetitive fingering motions are required. *Id.*

October 10, 2001 Accident

Petitioner testified that on October 10, 2001, there were some people missing from the line. Tr. p. 16. Petitioner testified that she was assigned as the pick and place person, but since there was no one to pick up the heavy fixtures she pulled the fixtures from the bottom of the table and put them in a cart to carry them. Tr. p. 16; *see also* Tr. p. 80. Petitioner testified that the second time she pulled the fixtures to place them on the table she felt pain in her back "like I was stung with a hard pain[.]" Tr. pp. 16-17; *see also* Tr. pp. 139-140.

Petitioner further testified that one could either sit or stand depending on the size of the circuit boards and covers, some of which were big. Tr. pp. 81-82. Petitioner was unable to accurately describe the size or weight of these boards, but estimated that they were approximately 1' x 6" and approximately 1-1½" thick. Tr. pp. 82-84.

Petitioner testified that the circuit board would come to her on a conveyor belt and she would snap a part onto the circuit board. Tr. p. 83. She also testified that the circuit boards were copper on the bottom and green on the top, that the metal piece that she attached to the circuit board was the same size as the bottom of the circuit board, and that she would then place the circuit board back onto the conveyor belt to go forward on the line. Tr. pp. 85-86.

Petitioner testified she told her coworker about her injury and that her coworker told Petitioner's supervisor that her back was hurting. Tr. p. 17.

Respondent's Health Services Department & Alexian Brothers

Petitioner testified that she was referred to, and saw, the company nurse. Tr. pp. 17, 30-31. She also went to Respondent's clinic at Alexian Brothers a few times. Tr. pp. 30-31. The medical records reflect that Petitioner went to Alexian Brothers on October 15, 2001. PX4. At that time, Petitioner's restrictions included no lifting/carrying over 2 pounds with the left arm, limited pushing/pulling with the left arm, no limited strong grip/grasp/pinch with the left hand/arm, and no reaching/lifting above the left shoulder. PX4. Petitioner also saw a nurse at Respondent's Health Resources department on October 22, 2001, was sent to the clinic, and then returned to work with restrictions. PX1. Petitioner returned to the nurse on November 2, 2001 and was sent to the clinic at 8:15 a.m. PX1. The work restrictions ordered on October 22, 2001 and November 2, 2001 remained the same with the exception that Petitioner was further restricted from pushing/pulling over 5 pounds. PX4.

Stamelos Clinic

Petitioner testified that she then went to see Dr. Stamelos because he spoke Greek and that all of the treatment that she received from Dr. Stamelos in 2001 and 2002 was for her neck, hands, and arm; he was not treating her for any other purpose. Tr. pp. 31, 62, 88-89. At that time, Petitioner testified that she noticed numbness in her hand and fingers, especially on the left, and pain in her neck and hand. Tr. pp. 33. Petitioner also testified that she was laid off in 2001. Tr. pp. 31-32.

Petitioner testified that she continued to treat with Dr. Stamelos, and occasionally went to Respondent's medical department where they put ice on her shoulder and left hand. Tr. pp. 40-41.

Petitioner first saw Spiros Stamelos, M.D. ("Dr. Stamelos") on November 14, 2001. Tr. p. 88; PX5; PX12, p. 7. At that time, Petitioner reported an injury on October 10, 2001 "of the left shoulder because of repetitive usage. She works in the line resulting in over usage of the left arm." PX5; *see also* PX12, p. 8 (Dr. Stamelos testified that Petitioner attributed her injury primarily to repetitive hand work at Motorola). Petitioner reported that "[s]he was pushing and closing containers when she experienced [numbness, tingling, and pain radiating down to the first, second, and third digits of the left arm/hand] because of repetitive usage." PX5; *see also* PX12, pp. 42, 43-44. A handwritten history, presumably taken by Dr. Stamelos' staff, reflects that Petitioner "sts was pushing & clicking container in assembly line. Pt had repetitive assembly line motion which cause L shoulder pain." PX5.

Dr. Stamelos' records reflect only limited range of motion in the left shoulder and cervical spine, a very painful left shoulder, and paraspinal muscle spasms without any complaint of bilateral hand tingling, primarily on the left. *Id.* The medical records further reflect that Dr. Stamelos' note that Petitioner's x-rays showed a loss of lordosis in the spine. *Id.* Dr. Stamelos administered trigger point injections into the bilateral shoulders and cervical spine. PX5; PX12, p. 34. He ordered different prescription medications from the "inappropriate" ones prescribed at Alexian Brothers that gave Petitioner a rash. PX5. He ordered a left shoulder MRI, a cervical spine MRI, and an EMG/NCV of the left upper extremity "because of the radiation of the pain down the arm." PX5; *see also* Tr. pp. 34-35. Additionally, he ordered physical therapy because of Petitioner's radiating pain down into the left arm. PX5. Dr. Stamelos noted that "I do believe it is soft tissue in the form of impingement versus a rotator cuff injury and possible AC degeneration and possible labrum injuries." *Id.* Petitioner was placed off work by a chiropractor at the Stamelos clinic through November 28, 2001. PX5; *see also* PX12, p. 13.

On November 16, 2001, Petitioner reported diffuse neck pain, moderate pain radiating into the left shoulder, increased pain when lifting the left arm and bending the neck backwards, and headaches. PX5. Petitioner reported being pain free before and an onset of pain while she was working a repetitive job at Motorola on October 10, 2001, which she rated at a level of 7/10. *Id.* Dr. Stamelos noted that muscle relaxant and anti-inflammatories helped minimally as had a course of physical therapy, but that her pain had not improved significantly and that she had difficulty sleeping as well as performing tasks at home. *Id.* After an examination, Dr. Stamelos diagnosed Petitioner with chronic moderate cervical strain with associated mild myofascial pain syndrome and articular dysfunction of the C5-C6 and facet with left arm radiculopathy from suspected arthritic changes or the space occupying disc lesions at C4-C7 and cervicogenic tension headaches. *Id.* He ordered home exercises, a TENS unit for electrical stimulation, and chiropractic care. PX5; *see also* Tr. pp. 36-37. Petitioner returned to a chiropractor at Dr. Stamelos' clinic for continued chiropractic care and/or physical therapy throughout her treatment with Dr. Stamelos. PX5.

Petitioner underwent a cervical spine MRI on November 21, 2001. *Id.* At that time, Petitioner reported "left-sided neck pain radiating down the left arm since lifting and pulling injury at work October 10, 2001." *Id.* The interpreting radiologist noted a large left lateral herniated disc at C6-C7. *Id.* Petitioner underwent a left shoulder MRI on the same date and reported "[p]ain since lifting/pulling injury." *Id.* A different interpreting radiologist noted: (1) mild to moderate increased signal intensity involving the supraspinatus tendon anterodistally consistent with inflammation, degeneration, or contusion if trauma has occurred but no rotator cuff tear; (2) no labral-ligamentous complex tear; and (3) an approximately 1.4 x 1.0 cm circumscribed lesion involving the medial aspect of the humeral head most commonly representing a conjoined lesion/cortical chondroma. *Id.*

On November 28, 2001, Dr. Stamelos placed Petitioner off work through December 5, 2001 pending an orthopedic evaluation. PX5; *see also* Tr. pp. 89, 151-152.

On December 5, 2001, Petitioner returned to Dr. Stamelos complaining of left shoulder pain and neck pain causing headaches as well as numbness in the left hand in the second and third digits. PX5. No objective examination findings were noted at the time of this visit. *Id.*

On December 11, 2001, Petitioner underwent the recommended EMG/NCV to rule out left cervical radiculopathy versus a myofascial referral pattern. PX5. Specifically, Petitioner was being evaluated for her "complaints of neck pain and associated radiation of the pain with paresthesias into her left upper extremity since her work related pulling injury of October 10, 2001. She is referred to rule out a left cervical radiculopathy vs. a myofascial referral pattern." *Id.* The interpreting physician opined that Petitioner's study was abnormal, the EMG findings were consistent with left C7 radiculopathy, there was evidence of a mild-moderate median neuropathy at the left wrist, and evidence of the mild median sensory neuropathy at the right wrist. PX5; *see also* PX12, pp. 9-10.

On December 19, 2001, Dr. Stamelos reviewed Petitioner's MRI films and EMG/NCV test results and noted "[t]he impression" of left carpal tunnel syndrome, right carpal tunnel syndrome mild, and a herniated disc at C6-C7 on the left. PX5. At his deposition, Dr. Stamelos testified that Petitioner's C6-C7 nerve problem affected Petitioner's left upper extremity. PX12, pp. 10-11. Dr. Stamelos referred Petitioner for a neurology consult and ordered continued conservative management (i.e., chiropractic care). PX5. While he notes that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* Petitioner was placed off work through January 16, 2002[2]. *Id.*

On January 28, 2002, Petitioner was placed off work because she was "100% disabled from work until further notice." *Id.*

First Section 12 Examination – Dr. Skaletsky

On February 5, 2002, Petitioner saw Gary Skaletsky, M.D. ("Dr. Skaletsky") at Respondent's request. Tr. pp. 77-78; RX9. Dr. Skaletsky examined Petitioner and took a history from her, reviewed various treating medical records, and rendered opinions regarding Petitioner's cervical spine. RX9.

[2] While the Stamelos clinic note reflects a January 16, 2001 date, the date of Petitioner's visit was December 19, 2001. PX5. The Arbitrator notes that Petitioner's next appointment was scheduled for, and Petitioner's off work status was effective through, January 16, 2002.

Regarding the mechanism of injury, Petitioner reported that on October 10, 2001 she "was performing a function that she says required her to exert significant downward pressure with both upper extremities onto a metal part. This was done repetitively as the parts came past her on a conveyor belt. The purpose of this function was to snap or fit the metal part onto another piece of equipment. In doing so, she felt the immediate onset of pain in her neck radiating to the left upper extremity." *Id.* Petitioner also reported continuing work with increased symptomatology and numbness and weakness of the left upper extremity. *Id.*

Petitioner testified that she did not recall describing a job to Dr. Skaletsky where she worked on a conveyor belt snapping or fitting metal parts into another piece of equipment, but soon thereafter testified that this is what she did on "[t]hat day that I was hurting. That was the job I was hurting." Tr. pp. 78-79. Petitioner testified that this is the pick and place job. Tr. p. 79.

On examination, Dr. Skaletsky noted that Petitioner was uncomfortable, tilted her head toward the right, and held her left upper extremity flexed at the elbow and close to the body. PX9. Petitioner's neck had limited range of motion particularly in extension and turning to the right as well as tenderness and spasm to palpation of the left cervical, trapezius, and scapular muscles. *Id.* Petitioner's deep tendon reflexes were symmetrical and equal with no Babinski's signs or pathologic reflexes. *Id.* Petitioner's gait and station were normal although she kept her left arm relatively close to her body while walking, her strength was decreased rather diffusely in the left upper extremity which Dr. Skaletsky believed to be secondary to pain rather than true weakness, Petitioner's Romberg test was negative, and there was no sign of atrophy or fasciculation. *Id.* Petitioner's sensory examination was decreased on the outer aspect of the left upper extremity down to the level of the second and third fingers of the left hand. *Id.*

Ultimately, Dr. Skaletsky diagnosed Petitioner with a herniated nucleus pulposus on the left at C6-C7 with left cervical radiculopathy. *Id.* He recommended an anterior C6-C7 discectomy with interbody fusion and opined that Petitioner would reach maximum medical improvement 12 weeks postoperatively. *Id.* Dr. Skaletsky also noted his concern about causal connection. *Id.* Specifically, he noted the discrepancy between Petitioner's report of the mechanism of injury on the date of his examination and an October 15, 2001 note indicating that Petitioner was applying gentle pressure with her thumbs at the time of injury. *Id.* He also noted his review of a line assembly operator job description indicating the need to lift up to 15 pounds, use tweezers, and a hand torque set to 15 pounds. *Id.* Dr. Skaletsky further noted that if Petitioner was performing the latter job there was no causal connection between her injury and the diagnosis, whereas his opinion might change if she was performing a different job with different requirements at the time of injury. *Id.*

Continued Medical Treatment

On February 20, 2002, Dr. Stamelos noted Petitioner's "history of neck and *bilateral shoulder injuries*, work related, on 10/10/01." PX5 (*emphasis added*). However, Petitioner only reported neck and left shoulder, arm and/or hand symptoms during chiropractic care prior to February 20, 2002. *Id.* Petitioner did not report any traumatic injury to or symptomatology in the right shoulder, arm, or hand. *Id.* Petitioner complained of "[pain] in the neck and shoulders [that] continues" at a chiropractic visit on February 25, 2002. *Id.* On cross examination, Petitioner denied complaining only about neck pain and not pain in the hands. Tr. p. 120. Dr. Stamelos diagnosed Petitioner with a cervical strain, whiplash and radiculitis of the cervical spine. PX5. While he notes that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* He ordered continued conservative treatment and kept Petitioner off work. *Id.*

Petitioner sought treatment with Wesley Yapor, M.D. ("Dr. Yapor") on March 5, 2002. PX5; *see also* Tr. p. 89. At that time, she reported "that she was perfectly healthy and fine up until November of 2001." PX5. Petitioner

reported that she was working for Respondent where she "was working pain forth at a rather unusual high effort." *Id.* She further reported that "she began experiencing pain in the left upper extremity shortly thereafter.... [and] pain and increasing discomfort, especially in the index and middle finger of the left upper extremity...." *Id.* Dr. Yapor advised Petitioner that surgery was the most definitive way to treat her left upper extremity, but Petitioner reported that she had just started cervical traction which she wanted to continue and he advised that she should do so and return to him after traction was completed. PX5; *see also* Tr. p. 89. Petitioner testified that she refused the recommended surgery because she was afraid. Tr. pp. 89-90.

On March 20, 2002, Petitioner reported improved "neck pain and bilateral shoulder pain" and "numbness and tingling in the bilateral hands, left hand worse than right." PX5. Dr. Stamelos diagnosed Petitioner with cervical degenerative disk disease and a herniated disk at C5-C6. *Id.* While he notes that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* Dr. Stamelos also noted that "[e]ssentially, there is no change in the patient's condition." *Id.* He ordered continued conservative treatment for "cervical disc herniation with radiculopathy on the left at C6-7" and kept Petitioner off work. *Id.*

On May 20, 2002, Petitioner reported "neck pain, left shoulder pain, left wrist pain and right wrist numbness." PX5. While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination results are identified. PX5. Dr. Stamelos changed Petitioner's diagnoses to chronic pain syndrome, carpel tunnel syndrome, left shoulder pain and cervical spine pain, but again noted that "[e]ssentially, there is no change in the patient's condition." PX5. He ordered continued conservative treatment, noted that "wrist surgery for carpal tunnel release will be considered in the future[,]" and kept Petitioner off work. PX5; *see also* Tr. pp. 36-37, 90 and PX12, pp. 13-14.

On June 12, 2002, Petitioner reported "neck pain, left shoulder pain and bilateral wrist numbness and pain." PX5. While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* Dr. Stamelos changed Petitioner's diagnoses to chronic pain and disability, bilateral wrist numbness, and left shoulder pain, but again noted that "[e]ssentially, there is no change in the patient's condition." *Id.* He ordered continued conservative treatment "secondary to chronic pain[,]" and kept Petitioner off work. *Id.*

On August 7, 2002, Petitioner reported "neck pain." *Id.* While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* Dr. Stamelos changed Petitioner's diagnoses to "[c]ontinued cervical syndrome, chronic pain." *Id.* He again noted that "[e]ssentially, there is no change in the patient's condition." *Id.* He also noted that Petitioner was "awaiting for a return to work versus surgical intervention[, and that Petitioner] states that the medications are not helping her." *Id.* Dr. Stamelos kept Petitioner off work and scheduled a return visit in one week. *Id.*

On August 19, 2002, Petitioner reported "neck pain and numbness to the bilateral hands, right side worse then [sic] the left." *Id.* While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination results are identified, however he now noted that Petitioner's "condition" was improving. *Id.* He diagnosed Petitioner with cervical syndrome, ordered continued conservative treatment. *Id.* The work note, however, reflects that Petitioner's diagnoses are "cervical strain, radiculitis[.]" *Id.* Dr. Stamelos returned Petitioner to light duty work with a 5-pound lifting restriction beginning August 20, 2002. PX5; PX12, pp. 15, 45-46; *see also* Tr. pp. 89, 90-93, 151-153 (Petitioner testified that she was off work through this date per Dr. Stamelos' orders, but later testified that she could not recall if she was paid during this period of time or how long she was off work after Dr. Stamelos placed her off work).

At trial, Petitioner testified that she returned to work for Respondent in a light duty position in inspection for approximately two weeks as prescribed by Dr. Stamelos. Tr. pp. 37-38. The inspection position was easy and, while she used her hands, Petitioner testified that she did not lift or turn anything using her wrists. Tr. pp. 38-39. Then Petitioner testified that she was placed back in the laser and manual tune positions. Tr. pp. 39. At this time, Petitioner testified that she noticed that she got tired easily, her back was killing her, her shoulder was killing her, and her hand was killing her. Tr. pp. 39-40. On cross examination, Petitioner denied that Respondent accommodated her restrictions and testified that after one week she was "put on the line again" in her manual tune position. Tr. pp. 93-95.

On October 2, 2002, Petitioner returned to Dr. Stamelos and reported "bilateral hand pain and numbness, right side worse then [sic] the left[, and…] neck pain." PX5; PX12, p. 49. Petitioner also reported that she was working light duty. PX5. While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* Dr. Stamelos changed Petitioner's diagnoses to "[c]ontinued bilateral hand pain, carpal tunnel syndrome and cervical syndrome." *Id.* The work note, however, reflects that Petitioner's diagnoses are "cervical strain, radiculitis[.]" *Id.* He ordered physical therapy with a chiropractor "on an as needed basis[,]" and increased Petitioner's work restrictions to include sedentary work only and no lifting/pushing over 2 pounds. *Id.* The work note reflects that Petitioner was restricted from lifting/carrying over 5 pounds, pushing or lifting at all, and that she was to "continue" light sedentary work. *Id.* The prior work note, however, does not mention sedentary work. *Id.*

Petitioner did not seek medical treatment again for nine months until July 2, 2003. PX5; PX12, p. 16. On this date, Petitioner reported a work related injury on October 10, 2001 "when she was pushing some fixtures into a box resulting in pain in her neck." PX5. Dr. Stamelos noted Petitioner's visit with Dr. Yapor [presumably from March 5, 2001] "where the cervical syndrome was diagnosed not to mention the carpal tunnels and bilateral hand pain." *Id.* He also noted that Petitioner continued to have pain but was avoiding surgery or invasive treatment hoping that it would get better spontaneously, and that she continued to see Dr. Sotos [from his clinic] for noninvasive chiropractic care. *Id.* At his deposition, Dr. Stamelos testified that Petitioner had not yet had surgery and she wanted to continue with therapy and chiropractic treatment. PX12, p. 17.

Regarding her symptoms, Petitioner reported that she "still has neck pain, low-back pain and bilateral wrist pain and numbness." PX5. Dr. Stamelos does not identify any objective examination at the time of this visit. *Id.* Dr. Stamelos noted that Petitioner had been diagnosed with cervical syndrome, herniated discs in the neck, and chronic pain, but she had not responded well to conservative management. *Id.* He further noted that Petitioner would begin treatment at the clinic on a regular basis and that she was "going to probably end up having a carpel tunnel release as a starter since she is not improving all of this time." *Id.* He determined that Petitioner's large C6-C7 herniated disc of the left was causing radicular symptoms and her feeling of ill being. *Id.* He ordered continued restricted duty work and for her to return to the clinic "prn." *Id.* No objective examination findings were noted at the time of this visit. *Id.*

Petitioner did not seek medical treatment again for another eight months until February 25, 2004. PX5; PX12, pp. 17-18. On this date, Dr. Stamelos authored a narrative letter at Petitioner's request noting that she was "presently working in a light duty capacity" and that her restrictions were permanent. PX5; PX12 pp. 50-51. At his deposition, Dr. Stamelos testified that he "would just rather write it and get her off my back than argue with her." PX12, pp. 50-51. In his report, Dr. Stamelos stated that Petitioner was injured at work on October 10, 2001 "secondary to pushing a lot of weight resulting in a strain and injury to her cervical spine and shoulder. This resulted in severe neck pain, left shoulder pain, and left arm pain." PX5; *see also* PX12, pp. 17-18. He opined that Petitioner sustained a permanent injury in the neck and upper girdle that "necessitate either surgical indications at C5-C6 and C6-C7 or for her to modify her workload to accommodate the condition." PX5; *see*

also Tr. pp. 36-37. He noted that Petitioner had "opted for a modification of her work style and to work within her limitations." PX5. He recommended an evaluation and permanent work restrictions along with a permanent position that would accommodate herniated discs in her neck and left radiculopathy. *Id.*

At his deposition, Dr. Stamelos testified that he did not refer to Petitioner's carpal tunnel syndrome because he had to address Petitioner's neck first, which was the "central problem." PX12, pp. 52-53. He further testified that Petitioner injured herself secondary to pushing a lot of weight. PX12, p. 51. Dr. Stamelos qualified his response about the mechanism of Petitioner's injury by stating "[w]ell, that's what she said in Greek, maybe I misinterpreted. What she meant was repetitive motion. There is no Greek word for repetitive motion. Pushing a lot of weight or doing a lot of work, work with her hands of course." PX12, p. 51. He added, "I think there is weight involved, but I think she meant just an awful lot of work went through her hands, that would be a good way to describe it. [.... And, there] was lifting in her job. She said she had to lift some boxes after she filled them, but she said most of her work was doing repetitive motion. And somebody, I think, I don't remember, somebody I think it was this doctor who saw her, said she did like 3,000 maneuvers a day or something[, which was Petitioner's estimate to that doctor and probably to him as well.]" PX12, pp. 51-52.

On March 31, 2004, Petitioner returned reporting ongoing neck pain that was worse over the posterior aspect. PX5. Petitioner did not report pain in either arm or hand. PX5. Dr. Stamelos noted that Petitioner had a repetitive usage injury from Motorola that had been contested and that "[f]or some reason, they do not want her to have the surgery." *Id.* He ordered medications, injections therapy, diagnosed her with cervical syndrome related to her injury on October 10, 2001, and instructed her to return on an as needed basis. *Id.* No objective examination findings were noted at the time of this visit other than Dr. Stamelos' handwritten diagnosis of "cervical syndrome." *Id.*

Approximately three months later, on June 30, 2004, Petitioner returned to Dr. Stamelos. *Id.* He noted that she had carpal tunnel syndrome and needed surgery, low back pain, and cervical spine syndrome due to herniated discs at C5-C7 "all from an injury on October 10, 2001 at Motorola." *Id.* No objective examination findings were noted at the time of this visit other than Dr. Stamelos' handwritten diagnoses of "LBP/C-spine/HND [illegible]." *Id.*

September 23, 2004 Accident & Continued Medical Treatment

Petitioner testified that she was lifting boxes on September 23, 2004 and hurt herself and felt a sharp pain, again. Tr. p. 41. She returned to Dr. Stamelos on September 27, 2004 who placed her off work. Tr. pp. 41-42, 119-120. Petitioner testified that she did not receive workers' compensation benefits or temporary total disability benefits from September 24, 2004 through February 27, 2007. Tr. pp. 42-43.

Dr. Stamelos' records contain two different progress notes dated September 27, 2004. PX5. The first such note reflects Dr. Stamelos' notation that Petitioner returned after sustaining "a repetitive motion injury while working in the assembly line and pushing fixtures." *Id.* He noted that Petitioner developed radiculopathy which turned out to be herniated discs at C5-C6 and C6-C7, and despite conservative treatment, Petitioner's condition had worsened. *Id.* He ordered a physical therapy and surgical evaluation for the cervical spine by Dr. Alburno and further diagnostic testing, prescribed pain medication including Vicodin, ordered physical therapy, and placed Petitioner off work until further notice "[d]ue to excessive pain[.]" *Id.* No objective examination findings were noted at the time of this visit other than Dr. Stamelos' handwritten diagnoses of "cervical syndrome/HND C5 C6 C6 C7[.]" *Id.* Petitioner testified that on cross examination that she did not recall being referred by Dr. Stamelos to Dr. Alburno or being treated by him. Tr. p. 120. Dr. Stamelos' assessment was that Petitioner had

cervical syndrome with herniations from C5-C7 and radiation to the left from the shoulder down to the mid-upper arm. PX5. He noted that conservative management had failed. *Id.*

The second note dated September 27, 2004 reflects Dr. Stamelos' notation that Petitioner returned after an injury at work on September 23, 2004 with "quite significant" pain complaints of neck stiffness, pain, and radiculopathy "that has occurred since the time of the injury while working at Motorola. The radiculopathy and the pain were so severe that she had to get an emergency appointment to see me where I will try to treat her for these new symptoms that she has developed." *Id.* Dr. Stamelos noted that Petitioner had "some kind of history of neck problems in the past[, however], she has had no symptoms for a long time, and it seems to be a new occurrence based on the patient's history and the patient's presentation." *Id.*

On October 13, 2004, Petitioner returned to Dr. Stamelos and reported considering discoplasty with Dr. Alburno. *Id.* While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination[3] results are identified other than Dr. Stamelos' handwritten diagnosis of "cervical syndrome considering discoplasty [with] Dr. Alburno." *Id.* Dr. Stamelos diagnosed Petitioner with cervical syndrome, ordered a continuation of the "current course of management," and instructed Petitioner to return as needed. *Id.*

At his deposition, Dr. Stamelos testified on cross examination that Petitioner had no hand complaints on September 27, 2004 through November 17, 2004. PX12, pp. 54-55. He further testified that he did not treat Petitioner for carpal tunnel syndrome from the second half of 2004 through 2007, but he qualified his response by stating that he treated Petitioner for the more important cervical injury. PX12, pp. 55-56.

October 14, 2004 Incident Report

An Occupational Health Resources Injury and Illness Incident Report ("incident report") completed by Petitioner on October 14, 2004 reflects that when she returned to work after her 2001 injury she worked on the laser machines. Tr. pp. 116-119; PX3; RX3. Petitioner reported that after she returned to work from her 2001 injury she was placed to work on 4 laser machines despite having restrictions. PX3. The Arbitrator notes that the incident report originally reflected three laser machines but that was written over with the number four. *Id.* Petitioner further stated that she complained to Frank as of April 1, 2004 that he needed to move her. *Id.* According to the incident report, Frank asked Petitioner for other paperwork which she provided from her Dr. and he moved her, "but the damage was done and I was visiting the nurses offices for [illegible] often and he was complaining because I was going to the nurse for [illegible] something to relieve my pain so on Sept 23 I visit the office and told them I was going to the doctor after the nurses (Marylyn [illegible]) advised to visit my doctor[.]" *Id.*

On re-direct examination Petitioner testified that she completed the incident report after she was injured the second time noting that Frank, her supervisor, had given her regular work which was contrary to her doctor's restrictions. Tr. pp. 142-143. On re-cross examination, Petitioner testified that Frank put her back to her original position in manual tune. Tr. pp. 156-157.

The incident report reflects that the body parts affected included only the upper back and left arm. Tr. pp. 116-119; PX3; RX3. Petitioner testified that she gave this report to the nurse. Tr. p. 156. Upon questioning as to

[3] The Arbitrator notes that Dr. Stamelos' records contain a note from October reflecting that Petitioner was diagnosed with cervical disc herniation and that an examination was performed, however the day and year of the exam is unidentifiable and the signature appears to be by someone with the first name initial "K," which the Arbitrator infers is not Dr. Stamelos. PX5.

the exclusion of any reference in the incident report of injury of her hands, Petitioner testified that her English was not very good. Tr. pp. 118-119.

Continued Medical Treatment

Petitioner underwent another cervical spine MRI on October 6, 2004 as indicated by a history of "pain." PX5. On October 27, 2004, Petitioner began physical therapy at the Stamelos clinic for her neck pain. *Id.*

On November 17, 2004, Petitioner returned with a "cervical problem" including effacement and the disc herniation at C5-C6 with spurring resulting in cord compression and chronic cervical radiculopathy and cervical syndrome." *Id.* Dr. Stamelos noted that Petitioner was still considering discoplasty and that she was awaiting approval for the surgery. *Id.* Petitioner was to return to him as needed. *Id.*

Approximately four months later, on March 23, 2005, Petitioner returned to Dr. Stamelos and reported that she was not working. *Id.* Dr. Stamelos noted that Petitioner had cervical syndrome and a herniated nucleus pulposus. *Id.* While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* He ordered that Petitioner continue "with the current course of management" and scheduled a follow up in four weeks. *Id.*

On June 15, 2005, Petitioner returned to Dr. Stamelos, who noted that Petitioner suffered from cervical spine syndrome and that she needed physical therapy, which was being denied. *Id.* He also noted that Petitioner had low back pain, and that Petitioner could not work at that time. *Id.*

On September 26, 2005, Dr. Stamelos noted that Petitioner had cervical spine syndrome and that she needed nucleoplasty surgery. *Id.* While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* He referred Petitioner to Dr. Elborno for an evaluation and to schedule surgery at which he wanted to be present. *Id.* No objective examination findings were noted at the time of this visit. *Id.*

Second Section 12 Examination – Dr. Levin

On October 10, 2005, Petitioner underwent a second section 12 evaluation of the neck with Mark Levin, M.D. ("Dr. Levin"). Tr. pp. 120-121; RX10. Dr. Levin examined Petitioner and took a history from her, reviewed various treating medical records, and rendered opinions regarding Petitioner's cervical spine. RX10.

Petitioner gave Dr. Levin a history of her condition. *Id.* She reported working as a full-time cell phone assembler for Respondent for 27 years. *Id.* In 2001, she reported that she was lifting 50 lbs. every twenty minutes and began having neck pain. *Id.* Petitioner treated with Dr. Stamelos, underwent therapy and injections, and that it was recommended that she undergo a cervical fusion, but she was scared and did not undergo the surgery. *Id.* She also reported a temporary improvement while being off work for 6-7 months. *Id.* Petitioner opted to undergo continued therapy and pain management and she worked light duty until April of 2004 when she was returned to full duty work. *Id.* Again, Petitioner reported that in her full duty position she had to lift up to 50 pounds, but she did not specify how often she did so. *Id.* She also reported that after two months of full duty work she started having increased neck pain, saw the company nurse, and underwent some occupational therapy. *Id.* "By September 23, 2004 her neck pain gradually increased and she started getting numbness and tingling down her fingers, more on the left than the right." *Id.* Petitioner was placed off work and underwent some trigger point injections with Dr. Stamelos, who referred her to another doctor for surgery,

which she reported she was then ready to accept. *Id.* Finally, Petitioner reported developing pressure headaches. *Id.*

At the time of her examination, Petitioner complained of neck pain at a level of 7-8/10 with a sharp, constant burning sensation. *Id.* Petitioner reported pain greater on the left then on the right with pain radiating down her arms and "she feels like she drops items." *Id.* Petitioner reported headaches with weather changes, worsening neck pain when turning her neck to the right, minimal driving, and feeling "like she has lost the ability to move her arms behind her back." *Id.*

On examination of the neck, Petitioner complained of tenderness to palpation over the left cervical paraspinal muscles going into the left trapezius, no pain over the right cervical paraspinal muscles or the right trapezius, and pain over the medial border of the left scapula with slight tenderness over the medial border of the right scapula. *Id.* Petitioner had some slight discomfort to palpation over the thoracic spine us processes. *Id.* She was able to forward flex and touch her chin to within 1 inch of her chest and extend back to neutral. *Id.* Her right deviation was 45° and left deviation was 70°. *Id.* On examination of the upper extremities, Petitioner had tenderness over the right and left AC joint and left AC joint and diffuse discomfort over the entire left clavicle and to palpation of the left arm. *Id.* Petitioner's active range of motion in the shoulders was 170° bilaterally on forward flexion, 170° on right abduction, 160° on left abduction, internal rotation on the right to T5 and on the left to T10. *Id.* Petitioner's external rotation was 90° bilaterally and rotator cuff strength was 5/5 bilaterally. *Id.*

Dr. Levin diagnosed Petitioner with cervical spondylosis with secondary neck discomfort and loss of range of motion. *Id.* He noted that Petitioner did not give any one alleged work injury that was causing her discomfort but stated that this gradually became worse on September 23, 2004 causing her to be off work. *Id.* Dr. Levin noted that he did not have Petitioner's actual job description at the time of his report and that he had not reviewed actual films of certain diagnostic studies. *Id.*

Ultimately, Dr. Levin opined that Petitioner had no specific accident occurring on September 23, 2004 and noted that Petitioner described that it was increased work activities beginning in April of 2004 that made her symptoms worse. *Id.* Dr. Levin disagreed with the recommended discoplasty from pain management. *Id.* He noted that the procedure was not the standard of care currently used in orthopedics and that he would not recommend the procedure for Petitioner. *Id.*

Continued Medical Treatment

On November 30, 2005, Petitioner returned to Dr. Stamelos. PX5. At this visit, Dr. Stamelos noted that Petitioner "was inappropriate" at her last visit and that she needed a psychiatric referral to treat her for depression. *Id.* The Arbitrator notes that no such inappropriate behavior was noted in Dr. Stamelos' September 26, 2005 progress note. *Id.* Dr. Stamelos also referred to Petitioner's October 10, 2001 injury and Petitioner's reluctance to have surgery which she now wanted to undergo but had no financial means by which to do so. *Id.* He further noted that Petitioner had recently been evaluated by Dr. Mark Levin of Barrington Orthopedics who felt that she needed her workup and possibly surgery. *Id.* Petitioner reported being in pain and requested injection therapy, which he noted was indicative of a lot of pain because Petitioner was needle phobic. *Id.* The Arbitrator notes that no such phobia was mentioned on November 14, 2001 when Dr. Stamelos first provided injection therapy to Petitioner, or at any time thereafter until this date. *Id.* Dr. Stamelos diagnosed Petitioner with cervical disc syndrome and left radiculopathy with her hand being very weak and painful. *Id.* No objective examination findings were noted at the time of this visit. *Id.*

On July 31, 2006, Petitioner testified that she came under the care of Dr. Bauer as approved by Respondent. Tr. pp. 43-44, 121. Petitioner lists her occupation as laser operator in the new patient information form of the same date. PX6.

Petitioner saw Jerry Bauer, M.D. ("Dr. Bauer") and reported that she was a former machine operator for Respondent with recurrent lifting of 15 pounds. PX6. Dr. Bauer noted Petitioner's history that in 2001 "she was lifting boxes with heavy plates inside and she injured her left arm." *Id.* Petitioner reported problems in her left shoulder, radicular pain and numbness in her left arm, headaches, neck pain, and persistence of symptoms such that she had not worked since 2004. *Id.* Dr. Bauer also noted Petitioner's report of "left sided neck pain with radicular pain radiating down her left arm, hand and fingers with a burning sensation. Driving results in some numbness in her hands and she has to switch hands. Her hands also tend to fall asleep at night." *Id.*

On examination, Dr. Bauer noted that Petitioner had limited range of motion in the neck, tenderness along the left trapezius muscle, and a slightly reduced left triceps reflex and mild weakness of her finger extensors on the left. *Id.* Petitioner had reasonably good strength in both her arms and legs, positive bilateral Tinel's and Phalen's signs, and a positive Hoffman's and Trömner's sign on the right only. *Id.* Dr. Bauer's impression was that Petitioner had a "long history of persistent radicular pain in her left arm. She probably also has carpal tunnel syndrome." *Id.* He recommended repeat MRI of the cervical spine and a repeat EMG study to assess the degree of her radiculopathy and carpal tunnel syndrome. PX6; *see also* Tr. pp. 44-45. He also recommended cervical spine x-rays and a CT scan. PX6.

Petitioner underwent an MRI on August 31, 2006, which showed a small left foraminal disc herniation at the C6-C7 level that would be expected to result in a left C7 radiculopathy and very small midline disc herniations at the C3-C4 and C5-C6 levels. *Id.* A September 18, 2006 MRI showed mild degenerative changes of the lower cervical spine, but was otherwise unremarkable. *Id.*

Petitioner underwent a repeat EMG/NCV on September 8, 2006 that showed very severe right carpal tunnel syndrome on the right and mild left carpal tunnel syndrome. *Id.*

On September 20 and 21, 2006, Petitioner sought treatment with Dr. Bauer. *Id.* Dr. Bauer noted Petitioner's cervical MRI which revealed a small central disc herniation at C5-C6, and a herniated disc on the left at C7[4]. *Id.* Dr. Bauer noted that Petitioner's herniated disc on the left would account for her radiating left arm pain. *Id.* He further noted that Petitioner's EMG revealed bilateral carpal tunnel worse on the right than on the left and that Petitioner was symptomatic from the carpal tunnel syndrome. *Id.* Petitioner wanted to undergo carpal tunnel surgery first and Dr. Bauer referred Petitioner to Dr. Craig Williams. *Id*; *see also* Tr. pp. 121-122.

On October 5, 2006, Dr. Bauer noted that Petitioner called and indicated that she wanted to have her carpal tunnel surgery prior to having neck surgery. PX6. On cross examination, Petitioner denied telling Dr. Williams that she wanted surgery on her hands. Tr. pp. 121-122. She further testified that she did not see Dr. Williams until approximately 2 years later in May of 2008. Tr. p. 122.

[4] The Arbitrator notes that the interpreting radiologist noted that Petitioner also had a small central disc herniation at C3-C4 and that the herniated disc on the left was at C6-C7. PX5.

Third Section 12 Examination & Dr. Fernandez Deposition

On October 17, 2006, Petitioner underwent a third section 12 evaluation by John Fernandez, M.D. ("Dr. Fernandez"). Tr. p. 123; RX8. Dr. Fernandez submitted to a deposition on July 30, 2010. RX7. He is a board-certified surgeon in orthopedics, microsurgery, and hand surgery. *Id*, pp. 5-6.

Dr. Fernandez examined Petitioner and took a history from her. RX8; RX7, pp. 8-12. He did not examine Petitioner's neck or cervical spine. RX7, p. 25. Dr. Fernandez also reviewed certain treating medical records and diagnostic tests, a video depicting the activities of the FQA, pick and place, and laser trim positions, a job analysis entitled physical demand documentation. RX8; RX7, pp. 13-16; *see also* PX2. He rendered opinions regarding Petitioner's carpal tunnel syndrome. *Id.*

On cross examination, Dr. Fernandez testified that Petitioner's description of her job duties correlated with his review of the job video and physical demand analysis and that the accuracy of any job description given to him regardless of the source is important in forming his opinions. RX7, pp. 25-27. He further testified that the simple use of a vibratory air tool would not subject a person to developing carpal tunnel alone; it would depend on the type of tool and the force associated with the use of the tool. RX7, pp. 27-28. Additionally, Dr. Fernandez testified on cross examination that if Petitioner was hypothetically "exposed to heavy gripping, grasping, using tools on a repetitive basis, certain types of vibratory tools as you pointed out, of course those could be contributory factors considered causal to the carpal tunnel syndrome." RX7, pp. 28-29.

At the time of her examination, Petitioner reported that she began to notice discomfort in her hands in 2002. RX8; RX7, p. 8. She also reported neck and shoulder pain, but that her "major" complaints involved numbness and tingling primarily affecting the median nerve distribution right much greater than left. RX8 (quotations in original); RX7, pp. 8-9. The symptoms worsened at night and with activities including driving, and Petitioner reported that her pain and symptoms were at a level of 10/10. RX8; RX7, pp. 8-9. Dr. Fernandez noted that Petitioner was tearful during portions of her examination while speaking about her symptoms and that she did not seem to exhibit symptoms magnification or pain beyond her objective findings. RX8; RX7, p. 12. Petitioner did not report any elbow complaints. RX7, p. 10.

Dr. Fernandez testified that Petitioner related her complaints to her work activities and stated that her 2001 injury occurred at work and she was using her hand tuning tools all day long. *Id.*

Dr. Fernandez diagnosed Petitioner with bilateral wrist carpal tunnel syndrome, right greater than left. RX8. He opined that there was no causal relationship between her work and the development of her carpal tunnel syndrome even though she did the work for 27 years. RX8; RX7, pp. 16-17. He noted that Petitioner's tasks were repetitious, but they were also relatively varied with reference to what she did. RX8. Additionally, he noted that none of the activities involved significant gripping or grasping with significant force, the use of heavy tools, or significant hyperextension or hyper flexion for prolonged periods of time. *Id.* Dr. Fernandez further noted that carpal tunnel syndrome is a multifactorial disorder most commonly seen in females in Petitioner's age group, and that there was an additional risk from Petitioner's increased body mass index/weight. RX8; RX7, pp. 18, 20-21, 35. Finally, Dr. Fernandez noted that there was no doubt that Petitioner's symptoms may increase or worsen with exposure to any activities, including work activities, but that did not warrant a finding of causal relationship or aggravation effect from her work activities. RX8. He opined that Petitioner could work full duty without restriction, that she could keyboard and perform data entry, and that she was at maximum medical improvement unless she decided to proceed with further treatment. *Id.*

At his deposition, Dr. Fernandez testified that carpal tunnel syndrome was caused by excessive pressure on the nerve at the wrist which could be caused by many things including direct trauma although the vast majority of cases were idiopathic "meeting that there is no known single cause. It is multifactorial...." RX7, pp. 17-18. Certain job activities could aggravate or contribute to carpal tunnel syndrome including significantly repetitive activities requiring heavy forceful gripping and hyperflexion or hyperextension. RX7, pp. 18-19. In Petitioner's case, Dr. Fernandez testified that while Petitioner related her symptoms to her job activities because she would get symptoms with job activities the symptoms were a manifestation of her [pre-existing] condition. RX7, pp. 19-20. Dr. Fernandez also testified that there has never really been a proven association between repetitive activities such as keyboarding or data entry without associated force. RX7, pp. 19, 21. On cross examination, Dr. Fernandez testified that a person's genetic predisposition to developing carpal tunnel syndrome coupled with exposure to job activities that everyone agreed could cause carpal tunnel syndrome was insufficient to relate a carpal tunnel diagnosis with the job. RX7, pp. 30-31.

Regarding other factors unrelated to work activities, Dr. Fernandez testified that while carpal tunnel syndrome could progress on its own over time, if Petitioner's job was causing or contributing to her carpal tunnel syndrome then he would expect that Petitioner symptoms would have improved and not worsened while she was off work. RX7, pp. 21-23. On cross examination, Dr. Fernandez acknowledged that carpal tunnel syndrome could progress or deteriorate with or without work activities. RX7, pp. 24-25.

Continued Medical Treatment

On October 29, 2006, Petitioner returned to Dr. Stamelos who noted in a narrative letter that she was a patient "who experienced significant injury to both her wrists and to her cervical spine because of the strenuous work she was involved in working for Motorola." PX5. He noted that it was "well known that her job requires her to be repetitively lifting and grabbing that would be the job description of items in mechanical objects that Motorola builds[,]" that Petitioner was a long time employee of Respondent's and that she had been in good health until recently. *Id.* He also noted that "[d]uring the period of 10/10/01 to 09/23/04, she worked with pain and in September 2004, she was taken off work by me with a letter of medical necessity." *Id.*

Dr. Stamelos opined that Petitioner had known herniations of the cervical spine that were "aggravated by repetitive lifting bending and twisting[,]" that she undoubtedly needed future treatment and surgery, and that while Petitioner was "very appropriate" and her condition was "very subtle" it was also "very serious" because it would ultimately lead to problems in turning her neck and functioning. *Id.* In conclusion, Dr. Stamelos noted that he would "try to become familiar with the case and the terminology and be more than happy to assist [Petitioner's counsel] with deposition because of complexities and difficulties in this type of case, which I believe is a work related repetitive motion injury." *Id.*

On November 9, 2006, Petitioner was cleared for surgery by her insurance company and indicated to Dr. Bauer her wish to proceed with surgery. PX6.

On December 15, 2006, Petitioner returned to Dr. Bauer but was unable to proceed with surgery due to antibiotic treatment for a tooth and gum infection. *Id.* Dr. Bauer noted that Petitioner had persistent burning in pain in the left arm which had been refractory to conservative therapy for a long period of time. *Id.* He also noted that Petitioner had paresthesias in her hand which was related in part to her cervical herniated disc as well as her carpal tunnel syndrome. *Id.*

On February 27, 2007, Petitioner underwent surgery with Dr. Bauer at Advocate Lutheran General Hospital for cervical radiculopathy. PX7; PX6; *see also* Tr. pp. 44-45, 123. Specifically, Petitioner underwent an anterior

cervical discectomy at C5-C6 and C6-C7 with microscope assisted visualization and an anterior cervical interbody fusion at C5-C6 and C6-C7 with placement of hardware including a plate and screws. PX7.

Petitioner testified that she remained under the care of Dr. Bauer after the surgery and began receiving temporary total disability benefits. Tr. p. 46.

The medical records reflect Petitioner saw Dr. Bauer postoperatively. PX6. On February 27 and March 7, 2007, Petitioner underwent x-rays that showed good alignment of the cervical spine and hardware. *Id.* Petitioner also returned to Dr. Bauer postoperatively on April 11, 2007, at which time her x-rays continued to show good alignment. *Id.* He ordered physical therapy for the neck and placed Petitioner off work. *Id.*

On May 9, 2007, Petitioner saw Dr. Stamelos who diagnosed her with depression, referred her to a psychiatrist, and noted that she should return on an as needed basis. PX5.

Petitioner began postoperative physical therapy on May 16, 2007 at Athletico. *Id.*

On May 23, 2007, Petitioner returned to Dr. Bauer, underwent x-rays, and reported residual pain in the left arm which was much improved. PX6. He noted that Petitioner had a normal neurological exam, her wound looked fine, her bone graft, plate, and screws were all in good position, that she had good strength, sensation, and reflexes, and that she reported improved pain as compared to pre-surgical pain. *Id.* He ordered continued physical therapy, prescribed medication, ordered wrist splints, and scheduled a return visit in two months with a repeat x-ray at that time. *Id.*

On July 11, 2007, Dr. Bauer noted that Petitioner's x-rays revealed good positioning of the bone graft, plate, and screws. *Id.* On examination, he noted that Petitioner's wound looked fine, deep tendon reflexes were symmetrical, and that she still had some dysesthesias [pathology] in her left arm. *Id.* Petitioner reported that her neck pain worsened while she was in physical therapy and that she was unhappy with her physical therapy site, therefore she was switched to another one. *Id.* Dr. Bauer kept Petitioner off work in her former position, which he noted was not then available, and scheduled a follow up with x-rays in three months. *Id.*

Petitioner testified that she went to Greece at the end of July of 2007 through August until she returned the first week of September of 2007. Tr. pp. 47, 51. She testified that the purpose of her visit was to see her mother who was sick and to bring her back to the United States. Tr. pp. 47-49; *see also* PX6 (10/31/2007 Dr. Bauer note). Petitioner testified that she did not receive approximately eight weeks of temporary total disability benefits and that her benefits resumed at some point. Tr. pp. 49-53.

On October 31, 2007, Petitioner reported some stiffness down the back of her neck and occasional discomfort in the left arm. PX6. On examination, Dr. Bauer noted that Petitioner's wound looked fine, her deep tendon reflexes and sensation were intact, and she still had some paresthesias in her hands with a positive Tinel's sign which he believed were related to bilateral carpal tunnel syndrome. *Id.* Petitioner testified that Dr. Bauer discharged her from his care and referred her to Dr. Williams. Tr. pp. 54, 124. Indeed, regarding her neck, Dr. Bauer noted that Petitioner reached maximum medical improvement. PX6. He also referred Petitioner to Dr. Williams for carpal tunnel surgery evaluation. PX6; *see also* Tr. p. 54.

In response to correspondence from Petitioner's counsel, Dr. Bauer rendered a report dated November 14, 2007 stating that regardless of whether Petitioner attended her physical therapy she was not able to return to work in August 2007. PX6. In a separate note also dated November 14, 2007, Dr. Bauer noted his placement of Petitioner at maximum medical improvement and stated that if the insurance company wanted specific

restrictions regarding a return to work then Petitioner would need to undergo a functional capacity evaluation. *Id.*

On November 21, 2007, Dr. Bauer referred Petitioner for a functional capacity evaluation. Tr. p. 123.

On December 5, 2007, Petitioner underwent the recommended functional capacity evaluation ("FCE"). Tr. p. 124; PX5; PX6. Petitioner appeared 45 minutes late and reported that she had a work related injury to her neck on September 23, 2004, but "**refused to give the therapist any additional history.**" PX6 (**emphasis in original**). The FCE was invalid due to submaximal effort. *Id.* Petitioner failed 20 of 23 objective validity criteria and the results of the FCE did "not represent a true and accurate representation of [Petitioner's] overall physical capabilities and tolerances at this time." *Id.* The FCE evaluator found that Petitioner was capable of functioning at a higher category of work than the minimal level of sedentary work, which was indicative of 2-hand occasional lift/carry of four pounds from floor-to-waist level, exhibited as a result of the invalid test. *Id.* Petitioner was listed as employable. *Id.*

Psychiatric Treatment

On May 22, 2007[5], Petitioner saw Dale John Giolas, M.D. ("Dr. Giolas"), a psychiatrist, for an initial evaluation based on Dr. Stamelos' referral. PX5. At that time, he noted Petitioner's symptomatology in response to various stressors including "surgical, pain, unemployment" resulting from a work injury and he diagnosed Petitioner with major depressive disorder, single episode, severe without psychotic features. *Id.* Petitioner returned on July 5, 2007[6] and Dr. Giolas maintained his prior diagnosis. *Id.* He recommended a follow up in two months presumably after Petitioner returned from seeing "M" in Greece. *Id.* Petitioner returned to Dr. Giolas on October 4, 2007 and February 6, 2008. *Id.* At the latter visit, Petitioner reported more depression and was "tearful as she is dealing with mother dying of pancreatic Ca at home." *Id.*

Continued Medical Treatment & SSD Benefits

Petitioner testified that she applied for Social Security disability benefits on November 14, 2006 and was eventually approved on September 4, 2008. Tr. pp. 69-70; *see also* PX5 (2/4/08 Stamelos note).

On January 14, 2008, Dr. Bauer noted his review of Petitioner's FCE that was "inconclusive" and stated that he would, thus, be unable to provide reasonable activity level recommendations and possible restrictions for Petitioner. PX6.

On February 4, 2008, Petitioner returned to Dr. Stamelos who noted that she was status post fusion with residual problems, had chronic pain, carpal tunnel syndrome, depression, and residual radiculopathy, and was trying for disability. PX5. No objective examination findings were noted at the time of this visit. *Id.*

She returned three days later on February 7, 2008. *Id.* Dr. Stamelos reiterated that Petitioner was status post cervical fusion and discectomy, that she had been diagnosed with carpal tunnel syndrome and depression, and that she had residual radiculopathy and pain from her cervical spine with chronic pain. *Id.* He opined that Petitioner was "fully disabled for any kind of work since we have the implications of injury, surgery, and some shortcomings." *Id.* He noted Petitioner's age of 53, slight obesity, and difficulty using upper extremities, and

[5] There are two different notes dated May 22, 2007, one of which appears to be incomplete. PX5.

[6] There are two different notes dated July 5, 2007, one of which appears to be incomplete. PX5.

essentially opined that she was fully disabled requiring SSI disability benefits. *Id.* No objective examination findings were noted at the time of this visit. *Id.*

Petitioner was scheduled to see Dr. Bauer again on February 27, 2008, but she did not attend the appointment. PX6. Then, on March 18, 2008, Dr. Bauer responded to correspondence from Petitioner's counsel and advised that he was unable to provide any medical update since he had not seen Petitioner in over four months. *Id.*

Fourth Section 12 Examination

On March 24, 2008, Petitioner saw Dr. Levin a second time at Respondent's request. *See also* Tr. p. 124; RX10. Dr. Levin re-examined Petitioner and took a history from her, reviewed various treating medical records, and rendered opinions regarding Petitioner's cervical spine. RX10. At the time of her examination, Petitioner reported being unemployed since her termination by Respondent in September of 2006, undergoing physical therapy after her surgery through October of 2007, and some continued burning in the left arm and forearm which was constant but varied. *Id.*

On examination, Petitioner was able to forward flex to touch her chin to within 3 inches of her chest and extent back 10°, she had right deviation to 25° and left deviation to 30°, she was tender to palpation over the medial border of the left scapula with minimal tenderness over the right medial border of the scapula, and she had no cervical or thoracic spasm. *Id.* Petitioner's upper extremities revealed no pain to palpation over the AC or SC joints, active shoulder range of motion on forward flexion to 170° on the right and to 90° on the left, passive range of motion to 110° with pain, and abduction on the right to 140° and on the left to 90° with pain. *Id.* Internal rotation on the right was to L1 and to the lumbosacral junction on the left, external rotation was 90° bilaterally, and rotator cuff strength was 5/5 on the right and 5-/5 on the left. *Id.* Petitioner had a negative impingement sign on the right and positive impingement sign on the left which she reported was present for the prior three months. *Id.* She also had a positive Tinel's sign on the left and a negative Tinel sign on the right with normal wrist motion bilaterally. *Id.* Biceps reflexes were normal bilaterally and Petitioner had a negative Phalen's sign. *Id.* Pinprick sensation was decreased over the left arm but otherwise normal. *Id.*

Dr. Levin diagnosed Petitioner as being status post cervical discectomy and fusion at C5/6 and C6/7, and found that she was at maximum medical improvement. *Id.* He also noted that Petitioner had a new onset of some change in her shoulder range of motion which did not appear to be related to her work activities dating back to September of 2004. *Id.* Regarding her ability to work, Dr. Levin noted that Petitioner's functional capacity evaluation was invalid and that Petitioner was capable of doing more than sedentary work, however, based strictly on Petitioner's physical examination, he would restrict Petitioner from work above shoulder level due to the new onset of decreased shoulder range of motion and pain. *Id.*

Continued Medical Treatment

On April 16, 2008, Dr. Stamelos noted that Petitioner was status post cervical fusion, she had disc disease, depression, pain, and carpal tunnel syndrome although [surgery for] that had not yet been approved. PX5. He also stated that she had a "double crush injury," that she worked for Zenith Assembly with repetitive usage of her hand, and that she wanted to have surgery as soon as possible with workers' compensation insurance approval or through alternative insurance. *Id.*

At his deposition, Dr. Stamelos testified on cross examination that Petitioner's carpal tunnel syndrome was related to Petitioner's first accident despite the fact that she had not been treated for it for four years. PX12, p. 57. He testified that the fact that Petitioner had been off work for four years after September of 2004 did not

affect her carpal tunnel syndrome because it never goes away. PX12, pp. 57-58. He also testified that although Petitioner's carpal tunnel syndrome worsened while she was not working, that was due to the normal aging process and Petitioner's hormonal changes. PX12, pp. 57-58. Dr. Stamelos further testified this is why he believed Petitioner wanted "to have it fixed now, but [she didn't] want to pay for it, [she wanted] to get some compensation or something." PX12, p. 58.

Dr. Stamelos referred Petitioner to John Sarantopoulos, D.O. ("Dr. Sarantopoulos") for evaluation of a physical therapy rehabilitation potential status post fusion. PX5; PX8. No objective examination findings were noted at the time of this visit. PX5.

Dr. Williams – Second Opinion and Deposition[7]

On May 7, 2008, Petitioner saw Craig Williams, M.D. ("Dr. Williams") one time per Dr. Bauer's referral for complaints of bilateral hand numbness, worse on the right, tingling and left elbow pain. PX6; PX9; PX13. Petitioner reported being more symptomatic on the right side, experiencing constant numbness bilaterally, worse on the right, and burning dorsal forearm pain on the left. PX9; PX13, pp. 6-10. Among other examination findings, Dr. Williams noted normal bilateral wrist range of motion, tenderness over the left lateral epicondyle and radial tunnel, pain with resisted wrist extension that reproduced forearm burning and pain, and positive Tinel's, Phalen's, and Durkan signs bilaterally. *Id.* At his deposition, Dr. Williams testified that he did not see any evidence of thenar muscle wasting on either side and that if Petitioner told him when her elbow symptoms started, he did not record that in his records. PX13, pp. 9, 44. Dr. Williams' impression was that Petitioner had bilateral carpal tunnel syndrome and evidence of left lateral epicondylitis. PX9; PX13, p. 11. He recommended surgical intervention for the carpal tunnel syndrome and beginning with conservative treatment for the lateral epicondylitis. *Id.*

Dr. Williams submitted to a deposition on May 18, 2009. PX13. He is a board-certified orthopedic surgeon with a subspecialty in hand surgery. *Id*, p. 5.

Dr. Williams testified that he only saw Petitioner on one occasion, May 7, 2008. PX13, p. 5. He authored a report of the same date and a second narrative report, dated September 15, 2008 at Petitioner's counsel's request. PX13, p. 12. He reviewed various records prior to rendering his reports including the following: (1) Petitioner's December 11, 2001 EMG report; (2) Dr. Stamelos' treating record from May of 2002; (3) a letter between Dr. Bauer and Dr. Stamelos from October of 2007; (4) Petitioner's September 8, 2006 EMG; and (5) some of Petitioner's vocational information from Petitioner's counsel. PX13, pp. 26-28.

In response to a lengthy hypothetical question posed by Petitioner's counsel, Dr. Williams testified that Petitioner's carpal tunnel syndrome was related to her work activities based on his "experience with patients with similar activities and similar conditions, as well as [his] knowledge of the anatomy, pathophysiology of the hand." PX13, pp. 14-19. He also testified that a double crush syndrome refers to a neurologic condition in which there may be a compressive neuropathy of a nerve at two levels. PX13, p. 19.

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[7] The Arbitrator notes that Respondent's counsel objected to certain opinions rendered by Dr. Williams at his May 18, 2009 deposition pursuant to *Ghere* because his narrative reports did not encompass all of the issues raised during the deposition and, presumably, those extraneous opinions caught Respondent by surprise at the time of the deposition. PX13, pp. 20; *see also Ghere v. Industrial Comm.*, 278 Ill. App. 3d 840, 663 N.E.2d 1046 (4th Dist. 1996). By the date of hearing, however, and in light of *City of Chicago v. IWCC* and noting the Appellate Court's more recent reiteration of a *Ghere* objection analysis in *Mulligan v. IWCC*, the Arbitrator overrules Respondent's objections. *City of Chicago*, 387 Ill. App. 3d 276, 899 N.E.2d 1247 (1st Dist. 2009); *Mulligan*, 408 Ill. App. 3d 205, 946 N.E.2d 421 (1st Dist. 2011).

Ultimately, Dr. Williams opined that there was a "significant relationship between [Petitioner's] current diagnosis of the carpal tunnel syndrome and the work activities that she had performed at Motorola as described in the letter that [Petitioner's counsel] provided to [him] on July 31st, 2008." PX13, pp. 13-14. On cross examination he clarified that Petitioner's work activities contributed to, but did not cause, Petitioner's carpal tunnel syndrome. PX13, p. 32. Dr. Williams understood Petitioner's job to be in "manual tune" and to require "extensive use of small screwdrivers to screw or tighten components or manipulate components that she estimated was 3,000 times a day; that it required twisting and turning of her wrist, as well as the use of air vibrating tools..." and the use of a "tweezers-type tool" and "some portion of pulling and snapping items together and in place and then filling them in boxes that weighed up to about 50 pounds." PX13, pp. 14, 16.

On cross examination, Dr. Williams testified that carpal tunnel syndrome can have various causes and that the causes are multifactorial. PX13, pp. 31-32. In Petitioner's case, he opined that Petitioner's job duties contributed to her carpal tunnel syndrome and he noted a combination of contributing factors including the repetitious nature of Petitioner's activities as he understood them, the inflammation/thickening of the flexor tendons encroaching upon the carpal tunnel space, the "suggestion and evidence that the use of vibratory tools can also contribute" to carpal tunnel syndrome, and because continuous gripping, grasping, pinching, fine motor activity and forceful activities on a repetitive basis can contribute to carpal tunnel syndrome. PX13, pp. 32, 34-36. However, Dr. Williams acknowledged that he had no specific information about the vibratory air tool used by Petitioner, how she used the tool, or with which hand or both she used the air tool. PX13, pp. 28-29. With regard to the use of vibratory tools, Dr. Williams acknowledged that use alone was insufficient to contribute to carpal tunnel syndrome development and it depended on degree, exposure, and so forth. PX13, p. 35. Similarly, he testified that the use of vibratory tools, gripping, and grasping should be continuous or a significant component of the work activities. *Id.* Dr. Williams also acknowledged that he did not view any video depicting Petitioner's job duties and his assumption that Petitioner's position was full time based on the "report" that Petitioner performed "3,000 repetitions a day." PX13, p. 29.

Regarding factors unrelated to work activities, Dr. Williams acknowledged that there is an increased incidence of carpal tunnel syndrome in older persons, in postmenopausal women, and in heavier persons as a secondary mechanism influencing the carpal tunnel. PX13, pp. 37-38. He also explained that while Petitioner's carpal tunnel symptoms were reportedly worse on the left in 2001, her December of 2001 EMG showed that she was electrophysiologically slightly worse on the right. PX13, pp. 39-40; *but see* PX5 (EMG findings showed evidence of a mild-moderate median neuropathy at the left wrist and evidence of the mild median sensory neuropathy at the right wrist).

Dr. Williams was unable to explain whether that symptomatology stemmed from Petitioner's carpal tunnel syndrome or cervical condition or both, but he suspected that some of the left-sided hand symptoms stemmed from Petitioner's cervical condition that were relieved after her cervical surgery which then "unmasked" the right-sided carpal tunnel syndrome. PX13, p. 40. To explain why Petitioner's right-sided symptoms increased despite the fact that Petitioner had not worked since 2004, Dr. Williams testified that once a person has chronic flexor tendon thickening daily use would continue to irritate the condition and Petitioner's symptoms probably would have been worse had she continued to work. PX13, pp. 40-41.

Dr. Williams also testified that continuous or prolonged keyboarding activities "that are not in, you know, modest and intermittent levels can exacerbate your symptoms much the way that other things that I asked her about here, talking on the phone, sleeping... driving your car, blow drying your hair, all those things can exacerbate your symptoms." PX13, pp. 41-43. He suggested keyboarding should only be done in small bits and in moderation if necessary. PX13, p. 43.

Regarding lateral epicondylitis, Dr. Williams testified that symptoms developed particularly in middle age as was Petitioner at the time of her examination and that this pain would not be masked by a cervical condition because it is not in the same anatomical distribution. PX13, pp. 44-47. Finally, Dr. Williams testified that Petitioner was capable of some work activity in May of 2008. PX13, p. 45.

Continued Medical Treatment

Petitioner underwent the recommended physical therapy evaluation on May 23, 2008. PX6; PX8. Dr. Sarantopoulos recommended that Petitioner undergo updated cervical spine imaging, updated EMG/NCV of the upper extremities for cervical radiculopathy and upper extremity referral entrapment neuropathy, physical therapy to address cervical symptomatology, trigger point injections for treatment of myofascial pain, additional medication for pain control, and, if her symptoms did not improve, cervical epidural injections. *Id.* It was noted that Petitioner was unfit to work as an assembly line worker secondary to her current symptoms and medication necessity that caused drowsiness. *Id.*

Petitioner testified that her temporary total disability benefits stopped in 2008 and her last check was February 6, 2008 until her benefits resumed June 23, 2008 when she went to a vocational rehabilitation assessment at Respondent's request. Tr. pp. 154, 57.

Dr. Chmell – Independent Medical Examination & Deposition[8]

On June 14, 2008, Petitioner underwent an independent medical evaluation at her attorney's request with Samuel Chmell, M.D. ("Dr. Chmell"). PX10; Tr. p. 62. Dr. Chmell submitted to a deposition on July 9, 2009. PX14. He is a board-certified orthopedic surgeon. *Id*, pp. 4-5, 24.

Dr. Chmell reviewed various medical records provided to him prior to rendering his opinions including the following: (1) a November 21, 2001 Arlington Heights MRI report; (2) Dr. Sarantopoulos' December 11, 2001 report; (3) an October 6, 2004 Neuro Open MRI report; (4) an Advanced Radiology Professionals report dated August 31, 2006; (5) a Professional Neurological report dated September 16, 2004; (6) Dr. Bauer's February 27, 2007 surgical report; and (7) Advocate Lutheran General hospital's records regarding Petitioner's surgery. PX14, pp. 7, 25-26. Dr. Chmell did not have any of Petitioner's medical records from 2001 and he reviewed a summary of records from Petitioner's counsel's office for treatment from November 14, 2001 through February 7, 2008. PX10; PX14, pp. 7, 27.

Petitioner reported that her job regularly and repeatedly required her to use her hands manipulating fine tuners and that she performed repeated lifting and pulling of boxes and steel fixtures. PX10. She also reported that she had been "performing repetitive motion activities with her hands and wrists for 27 years, but even more significantly, for the last seven years she has been working on a line assembly for transceivers doing pretty much the same thing on a daily, weekly, monthly and yearly basis. She state[d] that she use[d] the same tweezers and screwdrivers to perform the same assembly functions on a Motorola transceiver." *Id.* Further, Petitioner reported that she was unable to perform her regular job and that while her physicians recommended a job with restrictions and limitations it had not been provided to her by Respondent. *Id.*

Regarding her injury in October of 2001, Petitioner reported that "she was repeatedly lifting and pulling 50-pound boxes of steel fixtures. She developed left shoulder and arm pain. The shoulder and arm pain worsened

[8] Respondent's counsel also made *Ghere* objections to certain opinions rendered by Dr. Chmell at his deposition. PX14, pp. 12-13. The Arbitrator overrules Respondent's objections. *See* Footnote Number 9.

and radiated up into her neck. She then developed pain and swelling in her hands and wrists which became associated with numbness and tingling." *Id.* Regarding her injury in September of 2004, Petitioner reported that she "sustained an injury to her cervical spine with lifting and straining. She developed a severe sharp pain at the base of her neck on the left side and this pain persisted and worsened. The pain radiated all the way down her left arm and became constant, severe, shooting, and burning in nature. She could not move her neck or her arm." *Id.*

On examination of the cervical spine, Petitioner had moderate reduction of the normal cervical lordosis, muscle spasm and tenderness of the cervical paraspinal muscles left side more prominent, a healed but slightly reddened and hypertrophic surgical scar, positive Spurling's test on the left, and diminished range of motion. *Id.* On examination of the hands, Petitioner had slight diffuse swelling of both hands/wrists, full range of motion in both elbows and forearms and the right shoulder, and diminished range of motion in the left shoulder. *Id.* Both wrists demonstrated tenderness at the area of the carpal tunnel. *Id.* Petitioner had a positive median nerve compression test in both wrists and mild thenar atrophy on the right only as well as a positive Tinel's sign along the median nerve in both wrists and a positive Phalen's sign on the right at 15 seconds and 25 seconds on the left. *Id.* At his deposition, Dr. Chmell acknowledged on cross examination that Petitioner did not complain about either of her elbows during his examination and that he made no findings regarding Petitioner's elbows. PX14, p. 27. He also testified that Petitioner had no thenar atrophy on the left. *Id.*

Dr. Chmell diagnosed Petitioner with the following: (1) traumatic aggravation of cervical degenerative disc disease; (2) cervical disc herniations at C5-6 and C6-7 status post surgery; (3) bilateral carpal tunnel syndrome; (4) bilateral double-pinch syndrome secondary to the first three diagnoses; and (5) and rotator cuff tendinosis left shoulder. *Id.*

Regarding her cervical spine, Dr. Chmell opined that Petitioner sustained a cervical spine injury on both dates of accident which required surgery, that her medical and surgical treatment was reasonable and necessary, and that Petitioner had passed the point of maximum medical improvement. PX10; PX14, pp. 8-10. Regarding her bilateral carpal tunnel syndrome and tendinitis of the left shoulder, Dr. Chmell opined that they were causally related to Petitioner's long-term repetitive motion trauma at work to the upper extremities. *Id.* He also opined that both work accidents "likely contributed causally to the bilateral carpal tunnel syndrome and the left shoulder tendinosis[,]" and that Petitioner had double-pinch syndrome where the nerve lesion in her cervical spine likely further aggravated Petitioner's median nerve problem at the carpal tunnel. *Id.* Ultimately, Dr. Chmell testified at his deposition that Petitioner's bilateral carpal tunnel syndrome was caused by both her cervical injury and her repetitive work activity. PX14, p. 29.

At his deposition, Dr. Chmell testified that Petitioner's left-sided symptoms from her double-pinch syndrome in the neck and left arm were so overwhelming that Petitioner's right-sided hand symptoms did not become prominent until after her neck surgery, which alleviated the left-sided symptoms. PX14, pp. 10-13. He further testified that Petitioner's bilateral hand symptoms would not have necessarily improved when she was inactive after her cervical surgery because her bilateral hand condition was permanent and sometimes there is no explanation why such a condition does or does not improve with inactivity. PX14, pp. 17-18. The Arbitrator notes that Dr. Chmell did not provide these explanations about Petitioner's cervical spine condition masking her hand or bilateral hand symptomatology in his report.

In his report, Dr. Chmell also recommended bilateral carpal tunnel release followed by a course of therapy on each side and reassessment thereafter for the degree of permanent partial impairment. PX10. Otherwise without surgery he opined that Petitioner was at maximum medical improvement. *Id.* At his deposition and in response to a lengthy hypothetical question posed by Petitioner's counsel, Dr. Chmell testified that Petitioner's

bilateral carpal tunnel syndrome was related to her work activities because, in general, "...repetitive motion trauma can cause carpal tunnel syndrome, first of all. And I believe that [Petitioner] was subjected to repetitive motion trauma in her job to the extent that, in her, it did cause it. And I have seen other people to where it's caused it in the same fashion." PX14, pp. 13-17.

Dr. Chmell also opined at his deposition about the propriety of Petitioner's vocational re-training to perform computer keyboarding. PX14, pp. 20-21. He testified that such training would not be appropriate because it was usually repetitive in nature and caused the same sorts of problems that Petitioner had experienced with her hands and wrists. *Id.* He further testified that Petitioner was not employable because of her hands and that appropriate jobs are not readily available for undereducated people where at least considerable usage of the hands is involved. *Id.* If Petitioner had the recommended carpal tunnel repair, however, he opined that Petitioner may or may not thereafter be employable. PX14, pp. 22, 30. The Arbitrator notes that Dr. Chmell did not provide these opinions in his report, there is no evidence that he reviewed any vocational rehabilitation documentation before he rendered any of his opinions, and there is no evidence that Dr. Chmell was asked to render opinions regarding Petitioner's prospective employability in his report. PX14, pp. 20-22; PX10.

Continued Medical Treatment

On July 30, 2008, Petitioner returned to Dr. Stamelos complaining of numbness and pain in the hand all this time "and has not been listen [sic] to." PX5. He reiterated that Petitioner needed a carpel tunnel release to reach maximum medical improvement and possibly return to some kind of employment although Petitioner was on disability because she had given up on any return to work due to the cervical fusion and associated pain. *Id.* He also noted that Petitioner still felt that she was disabled for any kind of work. *Id.* No objective examination findings were noted at the time of this visit. *Id.*

A "physical residual functional capacity questionnaire" was also completed on July 30, 2008 by a chiropractor noting Petitioner's then-current symptomatology and history of injury. *Id.* It appears that this questionnaire was provided to Dr. Stamelos and Petitioner's SSD benefits legal counsel. *Id.*

On September 15, 2008, Dr. Williams authored a second narrative report in which he ultimately opined that "there was a significant relationship between [Petitioner's] carpal tunnel syndrome and her work activities at Motorola." PX9; PX13 (Ex. 3). He was unable to definitively opine further on the relationship between Petitioner's left lateral epicondylitis condition and her work, if any. *Id.*

In a narrative letter dated January 12, 2009, Dr. Stamelos authored correspondence at Petitioner's request addressed to "to whom it may concern[9]" in which he reiterated that Petitioner had bilateral carpal tunnel syndrome as a result of repetitive usage that required surgery. PX5; PX12, p. 60. He further noted that Petitioner had been awaiting approval for surgery of this essential procedure which was necessary for her manual dexterity inability to function. PX5. In addition, he stated that Petitioner's condition was being aggravated by "the cold and the chronicity." *Id.* He noted the good suggestion that Petitioner go to school to learn computer work and do keyboarding and data entry, but that people with impaired median nerve function and hand pain would find it almost impossible to function on a computer. *Id.* Dr. Stamelos suggested a delay such schooling and, instead, recommended the bilateral carpal tunnel release surgery so that Petitioner could then be vocationally rehabilitated. *Id.*

[9] This correspondence also appears to have been sent to Petitioner's counsel. PX5.

Petitioner returned to Dr. Stamelos approximately one year and nine months later on October 4, 2010 complaining of bilateral wrist pain. *Id.* Dr. Stamelos diagnosed Petitioner with a cervical strain, whiplash and radiculitis of the cervical spine as well as bilateral carpal tunnel syndrome. *Id.* He prescribed Norco and Darvocet, ordered continued "conservative management," and instructed Petitioner to return on an as needed basis for a reevaluation. *Id.* While Dr. Stamelos notes that he evaluated Petitioner in the office, the only objective examination results identified are Petitioner's blood pressure and pulse levels. *Id.*

Approximately 13½ months later, on November 16, 2011, Petitioner returned to Dr. Stamelos' clinic. *Id.* Petitioner cervical spine fusion was noted, and she reported chronic pain. *Id.* Dr. Stamelos noted that Petitioner probably has carpal tunnel, and later noted that she definitely had bilateral carpal tunnel syndrome as proven by objective testing, and that she could not return to work because she had continued dysfunctions and inability. *Id.* Notably, Dr. Stamelos noted that Petitioner had a right-hand dysfunction and that she suffers from depression despite treatment with a psychiatrist[10]. *Id.* Dr. Stamelos opined that Petitioner continued to be disabled by both psychological and psychiatric problems and the physical impairment of her arms. *Id.* He also noted that Petitioner was obese and unable to function because of hand and upper extremity pain. *Id.* He further noted that there were enough problems to make her disabled but they would not treat all of her issues, they would continue to follow her closely "upon her wishes," and that she had not been in for treatment for a significant amount of time although she felt that she was not well and wanted to be under the treatment of a qualified doctor. *Id.* He referred Petitioner back to her neurosurgeon [Dr. Bauer] for the cervical spine and noted that they could treat her for carpal tunnel, but that Petitioner was reluctant. *Id.*

Vocational Rehabilitation - Vocamotive

Petitioner testified that she underwent a vocational rehabilitation assessment at Vocamotive on June 23, 2008 at Respondent's request with Mr. Belmonte. Tr. pp. 57, 124-125, 153-154, 205. Petitioner testified that they attempted to teach her how to use a computer, keyboard and mouse to look for a job. Tr. pp. 57-58. Vocamotive assisted Petitioner in applying for employment and she applied for employment by phone as well. Tr. pp. 58-59. Petitioner did not obtain any job interviews, but did speak with prospective employers over the phone. Tr. p. 59. Petitioner testified she was instructed by Vocamotive not to tell prospective employers that she had a back operation or that she could not use her hands. Tr. p. 59.

The record reflects assessment, progress and discharge reports from Vocamotive between August 6, 2008 and March 9, 2009. RX6. During that time, Petitioner left before the end of her session, she did not attend sessions, she failed to apply for job leads provided, she did not participate in recommended vocational rehabilitation activities for various reasons including reported effects of her medication on her abilities, she voiced her opinion that she could not perform the recommended activities or obtain employment, she did not complete some job logs, and she was otherwise selective in her cooperation for various reasons in recommended vocational rehabilitation activities. *Id.*

Joseph Belmonte ("Mr. Belmonte") is a certified rehabilitation counselor at Vocamotive. Tr. pp. 194-198; *see also* RX5. Mr. Belmonte testified that when a client, like Petitioner, is referred to him his practice is to contact the client and his attorney and schedule an initial interview at which time he takes a detailed history. Tr. pp. 202-204. Then, he reviews the client's medical information and thereafter issues an initial evaluation report.

[10] The treating psychiatrist is noted as Dr. Saulecky, who is noted as having committed suicide. PX5. The only other reference to Dr. Saulecky (or Dr. Solecki) in this record is contained in the deposition of Petitioner's vocational rehabilitation counselor, Ms. Entenberg, who testified that she reviewed an unidentified number of his treating records for Petitioner. PX15, pp. 14, 26.

Tr. p. 204. In accordance with his practice, Mr. Belmonte conducted an initial interview with Petitioner on June 23, 2008. Tr. p. 205.

Mr. Belmonte testified that he did state or suggest to Petitioner that she should not inform prospective employers of her medical problems. Tr. pp. 249-250. Petitioner testified that Mr. Belmonte advised her that he could only address her back issues. Tr. pp. 59-60. She also testified that she told Mr. Belmonte that she was having problems with her hands. Tr. pp. 60-61.

Mr. Belmonte rendered his initial evaluation report and concluded that Petitioner was prospectively employable and he identified specific job targets for Petitioner reflected more specifically on page 12 of his report including unskilled to low semiskilled occupations such as basic food preparer, laborer within a fast food restaurant, certain cashiering positions, some ticket taker positions, parking lot cashier, some light housekeeping occupations, etc. Tr. pp. 205-214. Mr. Belmonte also considered an invalid functional capacity evaluation report in rendering his opinions. Tr. pp. 215-216. With regard to Petitioner's prospective wages, and given Petitioner's very narrow work experience and the kind of jobs being targeted for her, he projected that Petitioner could earn between minimum wage and nine dollars per hour. Tr. pp. 217-218.

Mr. Belmonte testified that there was some difficulty in initially implementing Petitioner's rehabilitation plan due to communication difficulties, which were resolved, and he met with Petitioner again on September 15, 2008. Tr. pp. 219-220. Mr. Belmonte also testified about some of Petitioner's characteristics including that she was always "very direct" and "does not hesitate to express her opinion or state her position with regard to what she believes she wants or may be entitled to or what she may expect." Tr. pp. 220-221. Mr. Belmonte further testified that at Petitioner's initial interview she asked him why he believed he could get her a job if her employer [Respondent] was not going to take her back. Tr. pp. 221-222. He noted that Petitioner's question was not problematic in and of itself, but he did sense after his discussion with her that Petitioner "was in fact prospectively resistant to the process because of what she stated she felt she wanted from the process which was medical treatment and not vocational rehabilitation." Tr. pp. 222-223. Mr. Belmonte further noted that "[Petitioner] manifested from time to time clear frustration and some resistance to being on time or being present on days when we could [effectively] treat her, but which may not have been her preference. She ultimately did not [effectively] job search on days unless she was actually in the office working under our supervision." Tr. p. 223.

Petitioner submitted to additional educational and aptitude testing by Jim Boyd ("Mr. Boyd") at Vocamotive's request and he generated a report on which Mr. Belmonte relied. Tr. pp. 224-226. On cross examination, Mr. Belmonte testified that Mr. Boyd chose the tests to administer to Petitioner which included Woodcock Johnson, Roman III, and Tests of Achievement. Tr. p. 244. As a result, Mr. Boyd identified Petitioner's aptitudes as follows: letter word identification at 6.7 grade level; reading fluency at 5.8 grade level; story recall at 3.6 grade level; mathematical calculation at 10.8 grade level; math fluency at 13.0 grade level; spelling skills roughly $9^{th}/10^{th}$ grade; writing fluency just below 6^{th} grade; and passage comprehension in reading at 4.5 grade level. Tr. pp. 244-246.

Mr. Belmonte testified that his expectations of Petitioner were conveyed to Petitioner at her initial interview and throughout the vocational rehabilitation process. Tr. pp. 226-228. Petitioner was receptive to Vocamotive's offer for computer assistance to help her find a job, but Mr. Belmonte testified that their job search efforts were not directed at finding Petitioner a job utilizing computers. Tr. pp. 228-229.

Petitioner's vocational rehabilitation through Vocamotive ended on March 9, 2009. Tr. pp. 125-126, 229-231. Mr. Belmonte testified that during the course of his conversations with Petitioner he acknowledged her feelings

about the vocational rehabilitation process and that medical treatment was her priority, but iterated that their services would be to her benefit in either actually finding her a job or ultimately determining whether there was a stable labor market for her. Tr. pp. 230-231. He further testified that he regularly attempted to actively enroll Petitioner in their process, but by March 9, 2009, "it became apparent that she was not going to change the orientation and her attitude, and I felt that at that point that I had made every reasonable effort that was likely to produce any change in the stance, and I felt that I was ethically obligated to advise both her and the people that were paying the bill that I really didn't see that it was cost effective to continue to move forward." Tr. pp. 230-231.

More specifically, Mr. Belmonte testified that Petitioner "consistently stated that her objective was medical treatment, surgery for the arms." Tr. p. 231. He testified that he told Petitioner that despite her complaints, which he acknowledged, he had no objectively, medically identified impairment to work with; "[i]n other words, no doctor had ever said that she was impaired with regard to the carpal tunnel syndrome or whatever might be happening in the upper extremities. So it was never identified by a physician that she couldn't do A, B, or C as an example. And without that, I didn't have [any job targets] that I could determine could be taken off the table...." Tr. pp. 231-233. On cross examination, Mr. Belmonte did acknowledge that Petitioner's reports of difficulty holding objects, dropping objects, clasping her clothes, could prospectively create a problem keyboarding or doing computer work. Tr. p. 247. He further acknowledged the fact that prospective pending surgery could be a significant and potentially complicating factor [in finding employment] for an applicant. Tr. p. 247.

Mr. Belmonte also testified that, while Petitioner was aware of their expectation that she would job search on her own, she did not job search on days that she was assigned to do so other than when she was at the Vocamotive office and he discharged her from their rehabilitation program for this reason. Tr. pp. 235-237. On cross examination, Mr. Belmonte acknowledged Petitioner's report of traveling to prospective employers Hallmark and Red Roof Inn, but her visits were unsuccessful. Tr. pp. 262-263. He testified that on one occasion Petitioner stated to him that "she did not mind coming here because it would make her look good in court[,]" and he explained that this statement is notable in the bigger context of his discussions with Petitioner where her focus was that she wanted surgery, she did not believe that she was employable, she did not want to work in food preparation, be a cashier, or change the date of her schedule from Tuesday to Wednesday even if they required her to do so. Tr. pp. 238-239.

On cross examination, Mr. Belmonte also acknowledged that his December 15th report reflects that he told Petitioner that he could not give her a decision on how she should proceed given the fact that the reported carpal tunnel was not a part of the medical situation that Vocamotive was able to use in analyzing her restrictions. Tr. p. 256. Mr. Belmonte did ultimately receive a report from Dr. Stamelos in which he indicated that working on or using a keyboard was not appropriate for Petitioner given the fact that she needed carpal tunnel surgery. Tr. pp. 258-259. He also acknowledged that Dr. Stamelos' recommendation for carpal tunnel release surgery would make driving in very cold weather troublesome for Petitioner. Tr. p. to 61.

As of December 5, 2008, Petitioner keyboarded eight words per minute, she was not doing very well with it, and Vocamotive subsequently discontinued the training because her level of education and language proficiency would never have led them to the performance of a job by Petitioner requiring anything other than some elemental, utilitarian data entry. Tr. pp. 259-260. Mr. Belmonte clarified on re-direct examination that Vocamotive discourages computer-only job searches and that it is not an indicator in the applicant's success in finding a job. Tr. p. 269.

Mr. Belmonte testified that he did not inquire of Respondent whether they had any positions within Petitioner's restrictions because he operates under the assumption that those issues have already been explored and exhausted once she was referred to him for vocational rehabilitation services. Tr. pp. 266-267; *see also* Tr. pp. 268-269.

Petitioner testified that she was never reimbursed for travel expenses, mileage, or tolls to get to and from Vocamotive, although Petitioner requested it. Tr. p. 61; *see also* Tr. p. 252.

Vocational Rehabilitation – Rehabilitation Service Associates

At Petitioner's counsel's request, she also saw Susan Entenberg ("Ms. Entenberg") at Rehabilitation Service Associates on April 16, 2009. Tr. p. 62; PX11; PX15. Ms. Entenberg completed a report thereafter dated May 22, 2009 and testified at a deposition on March 8, 2011. PX11; PX15.

In her report, Ms. Entenberg noted Petitioner's report that she injured herself on September 23, 2004 while lifting a box and she felt a sharp pain in her neck and left arm. PX11; PX15, pp. 7-8. Regarding Petitioner's earlier injury, Ms. Entenberg notes that Petitioner stated "that she sustained an injury to her left upper extremity, neck on October 10, 2001 while under the employ of Motorola." PX11. Petitioner also reported that she could not turn knobs or perform fine movements with her hands, did not chop/peel/cut, could only write for 10 minutes, and could only be at a computer for 15 minutes. PX11; PX15, p. 9.

Ms. Entenberg testified that prior to reaching her opinions she met with Petitioner and obtained information, she reviewed Petitioner's medical records to determine her work restrictions and recommendations, and she reviewed vocational testing records. PX15, p. 10. Ms. Entenberg concluded that Petitioner was not a candidate for further vocational rehabilitation services in consideration of the factors delineated in *National Tea v. Industrial Comm.* whether or not she had bilateral carpal tunnel surgery, that there was no stable labor market for her, and that if she could perform the jobs listed by Vocamotive Petitioner would only be able to earn $8.80 per hour. PX11; PX15, pp. 11-15.

Ms. Entenberg also testified that she understood that Vocamotive was having Petitioner go "to the office to look for jobs and go on-line and job search" and perform "computer activity on a sustained basis" which was not appropriate given Petitioner's report that she could not be on a computer for any length of time, the symptoms in her hands, and the recommendation for bilateral carpal tunnel surgeries. PX15, pp. 11-13.

On cross examination, Ms. Entenberg admitted she met Petitioner only once and that she primarily works with Petitioners in workers' compensation cases. PX15, p. 16. Ms. Entenberg stated that she understood Petitioner's English, although she had to listen, and that Petitioner was a little excitable, frustrated, and a little upset at times throughout their assessment. PX15, pp. 17-18. Ms. Entenberg also stated that Petitioner "felt that she was not capable of working, that she could not work." PX15, pp. 19-20. Ms. Entenberg further stated that she relied on Dr. Bauer's restriction that Petitioner could perform only sedentary work, but she was unable to locate that medical record at the deposition and she admitted that Dr. Bauer's June 14, 2008 report stated that he could *not* conclude what activities Petitioner could or could not perform based on the invalid December 5, 2007 functional capacity evaluation results. PX15, pp. 23-24, 26-28. Finally, Ms. Entenberg acknowledged that the cashier and food preparation worker positions identified by Vocamotive were appropriate unskilled placement jobs for Petitioner. PX15, pp. 29-30.

Petitioner testified that she has continued to look for work after March of 2009 on her own by either submitting applications in person or calling over the phone. Tr. pp. 126-128. She applied for part-time position with jewel

in her neighborhood in Arlington Heights and she called a couple of prospective employers that she found in the newspaper including a hotel for a desk clerk position. Tr. pp. 128-130. She testified that she does not believe she can work with her hands, but she can answer a phone. Tr. p. 130.

Continued Medical Treatment

Petitioner testified that she saw Dr. Stamelos on October 4, 2010 and she believes she has seen him two or three times thereafter. Tr. p. 126. Petitioner understood that Dr. Stamelos' bill was not paid. Tr. p. 146. The Arbitrator notes that the parties have stipulated that if Dr. Stamelos' bill has been paid Respondent would receive credit for that payment. AX1; AX2; Tr. p. 148.

Dr. Stamelos' Deposition

Dr. Stamelos submitted to a deposition on April 17, 2009. PX12. He is a board-certified orthopedic surgeon. *Id*, p. 5.

Dr. Stamelos testified that Petitioner described doing many things at work that were manual, repetitive, and even lifting. PX12, p. 11. He testified that Petitioner reported using tools, screwdrivers, punches and assembling or snapping things together then putting them in a box or wrapping them up "or whatever it is and then at the end she had to put the box on a belt or something and put it on a skid." *Id.* Dr. Stamelos summarized that Petitioner had a variety of duties working the upper extremities and that she could not "work lifting and bending and twisting without the contributions of the shoulder, the neck and the hand." *Id.* On cross examination, Dr. Stamelos testified that his understanding of Petitioner's work was all based on what Petitioner told him. PX12, pp. 61-62. Dr. Stamelos added that "I have many Motorola patients in the past. So my experience with Motorola was repetitive usage of their extremities. But I never actually had a nurse visit me or somebody giving me a job description of [Petitioner's] work." PX12, p. 62.

Dr. Stamelos testified that Petitioner's initial complaints were cervical spine stiffness and pain, left shoulder pain, and tingling in both hands, primarily on the left. PX12, p. 7. On cross examination, Dr. Stamelos conceded that his November 14, 2001 note makes no mention of carpal tunnel condition or findings with regard to Petitioner's hands. PX12, pp. 38-40. He further conceded that his note of Petitioner's December 5, 2001 visit makes no mention of carpal tunnel although he explained that the C6/C7 innervates the same area of the hand that the carpal tunnel innervates and he did not have any specific objective testing of carpal tunnel at that time. PX12, p. 41.

On cross examination, Dr. Stamelos testified essentially that Petitioner's very large herniation at C6/C7 on the left was masking Petitioner's mild to moderate carpal tunnel syndrome through February 20, 2002. PX12, pp. 42-43. He also testified that Petitioner complained more about left-sided symptoms than right-sided symptoms through March of 2002. PX12, p. 48. Then, Dr. Stamelos further testified on cross examination that Petitioner was complaining more about right-sided symptoms in 2009, but qualified his response by stating that Petitioner's left-sided symptoms masked Petitioner's right-sided symptoms. PX12, p. 48.

Petitioner did not show Dr. Stamelos how she performed her work. PX12, pp. 11-12. Dr. Stamelos merely noted that Petitioner did thousands of maneuvers per day automatically according to her report. *Id.* Dr. Stamelos opined that various maneuvers performed repetitively by Petitioner is the "most consistent and accepted way to create carpal tunnel." PX12, pp. 12-13. Dr. Stamelos also testified that Petitioner never stopped complaining about her hands, but "[w]hen I took her off of work, her symptoms subsided, by [sic] her condition didn't improve." PX12, p. 13. On cross examination, Dr. Stamelos testified that he took Petitioner

off work even when her carpal tunnel syndrome was not improving because Petitioner had multiple orthopedic problems and a psychiatric problem. PX12, p. 59. He testified that he would not have necessarily taken Petitioner off work solely for the carpal tunnel syndrome and might have only restricted her work, but he also testified that "Dr. Bauer also had a lot to do with it." PX12, p. 60.

Dr. Stamelos testified Petitioner's neck and shoulder symptoms improved after her neck surgery, but "there has been a consistency to the symptoms of her hand. When she didn't work or didn't use her hand, the symptoms are not as strong but she still has difficulty with cold, when she sleeps, she has difficulty buttoning her buttons. In other words, the condition is ongoing and stagnant and nonimproving. In other words, the intensity of the symptoms worsened with her doing anything manual, but if she doesn't do anything, she doesn't get an improvement, she just has the carpal tunnel condition, primarily on left and some on the right." PX12, pp. 18-19.

To explain why Petitioner's carpal tunnel syndrome did not improve while she was away from her job, Dr. Stamelos testified about the deterioration of the ligaments, bones, and tendons in the carpal tunnel due to overuse, age, gender, and other factors such that "once you have carpal tunnel you cannot not have carpal tunnel." PX12, pp. 19-22. He further testified that while Petitioner "would have had carpal tunnel" given the type of work that she was doing at 20 years old, her carpal tunnel syndrome has nothing to do with her gender and normal hormonal changes at her age, but rather it was in addition to her predisposing factors. PX12, pp. 22-23. On cross examination, Dr. Stamelos acknowledged that there were many studies showing a peak of carpal tunnel symptomatology in women during menopause between 45 and 55 years of age, however he believed that there had not been any studies regarding Petitioner's particular body habitus (i.e., approximately 190 pounds and 5'3 tall) and the incidence of carpal tunnel. PX12, pp. 47-48. He also testified that the lack of surgical intervention for carpal tunnel syndrome could have had an impact on the severity of Petitioner's condition and that Petitioner continued to refuse such surgery through July of 2003. PX12, pp. 46, 49-50.

Regarding Petitioner's capability of returning to work, Dr. Stamelos testified that "it would have to be one of these special jobs that would be a job that would have to -- we do a functional capacity evaluation and she would just sit and watch a TV screen or an inspector or somebody, in other words where there is no use of the hand. And then there is issue of getting to work and coming home and there is an issue of cold versus warmth. In other words the hands are very sensitive to the cold, so it would have to be a designer job for her to work." PX12, p. 25.

In response to a lengthy hypothetical question posed by Petitioner's counsel, Dr. Stamelos testified that Petitioner was "the poster girl for repetitive motion carpal tunnel disease. There is no question in my mind that her condition, 3000 manual repetitive usage of her extremities a day, doing the work at Motorola, contributed and caused her carpal tunnel primarily in the left, but also on the right." PX12, pp. 25-29. He further testified that the same repetitive conditions that cause carpal tunnel can also cause lateral epicondylitis in some people and that the conditions were irreversible and could only be corrected with surgery. PX12, pp. 29-30. According to Dr. Stamelos, Petitioner did not know what carpal tunnel was until she saw him and that when he "told her about the surgery she was completely against it because she thought I was making it up." PX12, pp. 30-31. Ultimately, Dr. Stamelos testified that he was "positive" that Petitioner's work activities contributed or caused Petitioner's carpal tunnel. PX12, p. 36.

Dr. Stamelos opined that Petitioner could not return to a repetitive nature job at that time. PX12, p. 30. On cross examination, he clarified this opinion and testified that Petitioner would never be able to return to repetitive usage work without an operation. PX12, p. 46.

Dr. Stamelos opined that the vocational training that Petitioner was receiving for computer usage was inappropriate because Petitioner's carpal tunnel syndrome was a deterrent for manual work, data entry, or computer work. PX12, p. 30.

Elli Taylor

Elli Taylor ("Ms. Taylor") testified that Petitioner's counsel had previously represented her in a worker's compensation case against Respondent related to her left hand/thumb while working on a different line from Petitioner. Tr. pp. 159-160, 174. Ms. Taylor testified that her case was settled. Tr. p. 160.

Ms. Taylor testified that she worked in the same department as Petitioner for a long time. Tr. p. 160. She also viewed Respondent's Exhibit 4 and testified that it only partially accurately portrayed what Petitioner did at work. Tr. p. 161. Ms. Taylor testified that Petitioner worked a lot on laser, which was shown in a little bit of the video, but Petitioner also did a lot of work in manual tune and there were only a few people that could do that "[b]ecause it's very, very difficult." Tr. p. 161. Ms. Taylor observed approximately three or four other employees, including Petitioner, performing manual tune duties while Ms. Taylor worked for Respondent, but she did not ever perform manual tune duties after one unsuccessful attempt to do so. Tr. pp. 162-167, 170, 181-182.

Ms. Taylor testified that she observed Petitioner performing work on laser and operating about four machines. Tr. p. 170. She testified that she did not observe others operating four machines. Tr. p. 170. Ms. Taylor also testified that she observed Petitioner working in pick and place once in a while and very little "because it's one of the easier jobs." Tr. p. 172.

In addition, Ms. Taylor testified that everyone did FQA/inspection and that whenever there was a problem, such as an injury, Respondent would place the employee in inspection because it was easy and not hard on the neck or back or hands because the employee is looking at something through a magnifying glass to determine if all the parts are in their proper place. Tr. pp. 172-173.

On cross examination, Ms. Taylor testified that in 2001 she worked in the microcircuits department for approximately 3-4 years and her supervisor with Keith Lulik. Tr. pp. 176-177. Ms. Taylor testified that she was transferred and believed that she still worked in the same area, microcircuits, in 2004 for one year under another supervisor, Maria. Tr. pp. 177-178. Ms. Taylor was never supervised by Petitioner supervisor, Frank Neugebauer. Tr. p. 178.

Ms. Taylor also testified that while she was employed by Respondent she did laser trimming, pick and place, and FQA. Tr. p. 181. Ms. Taylor testified that FQA and pick and place are light jobs, but laser trim is not because the employee was standing—although she also testified that the employee is not really lifting anything. Tr. p. 182.

Additional Information

Petitioner testified that she was terminated from her position with Respondent and she has not worked since September 24, 2004 for any employer. Tr. pp. 55, 119. Petitioner testified that she has not received any other workers' compensation [benefits payments] other than those to which she testified at trial. Tr. p. 55.

Petitioner remains under the care of a primary care physician and occasionally sees Dr. Stamelos. Tr. p. 56. She also testified that she is ready willing and able to undergo the recommended carpal tunnel surgery. Tr. p. 61.

As of the date of her testimony, Petitioner testified that she is in pain and cannot sit or stand for more than a certain amount of time because of her back. Tr. pp. 63-64. She also testified that she lost the ability to move her body more than 40% and that she has to move her whole body to the left or to the right, that she has difficulty bending her head in the front or in the back to wash her hair, that she cannot lift herself from sleep (that she has to reach for something like the bed board in order to get up from the bed), that she suffers while it is raining, and that she is on pills. Tr. pp. 63-64.

With regard to her hands, Petitioner testified that they were numb, that she loses objects from her hands, that she sometimes lacks feeling in her hands when handling money, that her thumb is tingling like it is stuck, and that she cannot move her right thumb at all. Tr. pp. 64-65. She also testified that she experiences this in both hands, but that her right hand is worse. Tr. p. 65.

Petitioner can drive her van, but testified that she cannot sit for a long time and drives only for shopping and similar activities because of pain that "is killing her" in the upper thoracic lower cervical spine area. Tr. pp. 131-134.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above, and the Arbitrator's and parties' exhibits are hereby made a part of the Commission 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 the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

Cervical Spine and Left Arm Radiculopathy

The Arbitrator notes that the parties do not dispute causation regarding Petitioner's cervical spine injury stemming from either date of accident. Notwithstanding, the Arbitrator finds that Petitioner's cervical spine condition and the associated left arm radiculopathy is causally related to her undisputed accident on October 10, 2001 which was aggravated on the date of her second undisputed accident, September 23, 2004.

Petitioner's testimony about the traumatic mechanism of injury occurring on October 10, 2001 and her onset of symptoms is corroborated by record evidence, supported by contemporaneous and objective test results, and supported by objective clinical findings made by various treating physicians and independent medical examiners. Regarding her first accident, Petitioner testified that she felt a hard, stinging pain in her back when she pulled a box of fixtures while working on the pick and place assembly line. Regarding her second accident, Petitioner testified that she was lifting boxes on September 23, 2004 when she hurt herself and felt a sharp pain. Overall, the record corroborates Petitioner's testimony about these traumatic mechanisms of injury at trial as well as her symptoms from each date of injury through the date of her testimony at arbitration.

Furthermore, there is no evidence that Petitioner had any cervical spine injury, left shoulder injury, or left-sided symptoms radiating down to her mid-arm prior to her first accident. The record contains credible evidence that Petitioner's second accident aggravated her cervical spine condition—although Petitioner initially refused recommended surgical intervention for years—given Dr. Bauer's objective findings throughout his treatment of Petitioner particularly when viewed in light of the Section 12 opinions rendered by Drs. Skaletsky and Levin. While the Arbitrator notes that Petitioner's treating physician, Dr. Bauer, placed her at maximum medical improvement regarding her cervical spine condition on October 31, 2007, and that Dr. Levine also opined that Petitioner had reached maximum medical improvement, the parties proceeded to trial pursuant to Petitioner's Section 19(b) and Section 8(a) motion and a finding on the nature and extent of Petitioner's injuries is premature.

Based on the foregoing and the record as a whole, the Arbitrator finds that Petitioner's current cervical spine condition and associated left arm radiculopathy is causally related to her undisputed accident on October 10, 2001 which was aggravated on the date of her second undisputed accident, September 23, 2004.

Bilateral Carpal Tunnel Syndrome

The Arbitrator finds that Petitioner failed to meet her burden of proof to establish a causal connection between her current bilateral carpal tunnel syndrome condition and either accident at work. Specifically, the Arbitrator finds that Petitioner's testimony at trial with regard to this condition is not credible, overall, and that it is materially and repeatedly inconsistent with other record evidence. Moreover, the Arbitrator finds that the opinions of Petitioner's treating physicians, Dr. Stamelos and Dr. Williams, as well as the opinion of Petitioner's independent medical examiner, Dr. Chmell, are unpersuasive given the record as a whole.

First, the Arbitrator addresses Petitioner's testimony about her assigned job duties and actual work activities as compared to record evidence; it is erratic, at best. The record contains varied, vague and contradictory reports made by Petitioner at trial about the job duties she was required to perform and the work activities in which she actually engaged when compared to reports made by her to treating physicians and Section 12 examiners. The record is similarly incongruent as to the amount of time (i.e., hours per day, days per week, etc.) that Petitioner spent performing any particular duty (i.e., using tweezers/pliers, lifting up to 50 lbs., using screwdrivers with 15-20 lbs. force, using vibratory tools, etc.) in any position (i.e., pick and place, laser, inspection/repair, light duty positions, etc.) and for how long she did so (i.e., weeks per month, months per year, etc.). While Petitioner is not a sophisticated claimant and she might not reasonably be expected to recall exact details about her job duties and actual work activities during exact time frames over many years, it is reasonable to expect that Petitioner could consistently recall general details of her job duties and work activities performed during general timeframes that generally correlate to reports made by her to physicians since her first injury in 2001. Given the disparity in the record regarding whether Petitioner injured herself in two traumatic incidents or whether she sustained repetitive trauma injuries as she now claims stemming in whole or in part from her work activities, Petitioner's evidence about her job duties and actual activities is significant. The Arbitrator finds that Petitioner's testimony is wholly inconsistent with record evidence about her job duties and the work activities that she actually performed and, thus, is not credible.

To wit, the record reflects the following varied, vague, inconsistent and/or directly contradictory reports offered by Petitioner: (1) she worked in manual tune for several years approximately 80% of the time 10 hours per day/5 or 6 days per week and she worked in laser much of the remaining time and, limitedly, filled in the pick and place and inspection/repair positions; (2) when she worked in manual tune, she used a small screwdriver-type tool on small circuit boards of differing sizes and she turned her fingers all day long in all directions; (3) when she worked in laser she did so approximately 8-10 hours per day, 4-5 days per week in 2002 and 2003; (4) when she worked in laser she operated four laser machines simultaneously by going from one machine to another and "[j]umping like crazy, around" however she admitted that when she worked in laser she only used a computer mouse; (5) when she worked in laser, she worked four machines, which is contradicted by an October 14, 2004 incident report reflecting that she was working three machines which was crossed out; (6) she worked using an air gun with 15-20 pounds of pressure to close transceivers with screws while in the repairs position, although there is no specification for how often or for how long; (7) in the FQA position she worked in a seated position and used tweezers/brushes/pliers to inspect/clean circuit boards of varying sizes and types that came down a conveyor belt before placing completed ones into a box; (8) in the pick and place position she would snap a part onto a circuit board that came to her on a conveyor belt then placed assembled boards back onto to the conveyor belt; (9) she was lifting 50 lbs. every twenty minutes in her full duty job before her first injury, although there is no specification about what that job was or how long she was in that job; (10) she worked "light duty" after her return to work [in August of 2002] until April of 2004; (11) she only worked "light duty" for one or two weeks after her return to work in August of 2002 before she was performing full duties again, which is contradicted by an October 2, 2002 note and another February 25, 2004 note of Dr. Stamelos that Petitioner was still working light duty; (12) Respondent never accommodated her restrictions with light duty work and she was lifting up to 50 lbs. again before her second injury on September 23, 2004, although there is no specification about what that job was or how long she was in that job; and (13) she worked on an assembly line performing unspecified repetitive motion activities with her hands and wrists for 27 years and she had worked primarily with tweezers and screwdrivers while working on transceivers "doing pretty much the same thing" on a daily/weekly/monthly/ yearly basis since approximately 2001.

As reflected in the findings of fact, the aforementioned list of inconsistencies between Petitioner's reported job duties and actual work activities before and at the time of both accidents at work is not exhaustive. The

variations in Petitioner's reports on this subject at trial are evident when comparing her testimony on direct and cross examination as well as when comparing her testimony overall with reports that she made to treating physicians and independent medical examiners in contemporaneously created records. Petitioner's reports about her job duties and work activities are also inconsistent with and contradicted by written job descriptions. In particular, while the job descriptions offered by Petitioner require repetitive movements, none of them require sufficient force or significant use of vibratory tools as opined by Dr. Fernandez to make the repetitive motions a contributing factor in the development of Petitioner's bilateral carpal tunnel syndrome. In any event, the variations in reported job duties bear unfavorably on Petitioner's credibility.

Moreover, Petitioner's physicians, Dr. Stamelos, Dr. Williams and Dr. Chmell (an independent medical examiner), all relied on Petitioner's reports about her job duties and actual work activities and/or a summary of these created by her attorney in opining that causal connection exists between her condition and both accidents at work. The work activities performed by Petitioner as reported by her vary from one physician to the next and none of the aforementioned physicians reviewed Petitioner's written job descriptions, physical demand requirements, or viewed any video depicting any of the types of work activities in which Petitioner was required to engage at any point during her employment with Respondent.

Second, the Arbitrator notes that the contradictions contained in the record about the mechanisms of Petitioner's injuries. While accident is not in dispute, the Arbitrator notes that Petitioner's applications for adjustment of claim in both cases, the histories given by Petitioner throughout her treatment, and the information made available to physicians opining on causal connection initially allege traumatic injuries and *not* repetitive trauma injuries. Petitioner's reports on this subject are as disparate as her reports about her job duties and work activities (e.g., Petitioner's report to Dr. Chmell on June 14, 2008 approximately 7 years after her first injury that she injured herself on October 10, 2001 when she was repeatedly lifting and pulling 50-pound boxes of steel fixtures resulting in left shoulder and arm pain is singular and contradicted by several other versions of the mechanism of injury on that date throughout the record). In at least one instance, Petitioner also refused to provide historical information to a physical therapist during a functional capacity evaluation about her September 23, 2004 injury. PX6 (On December 5, 2007, Petitioner reported that she had a work related injury to her neck on September 23, 2004, but "**refused to give the therapist any additional history.**" (**emphasis** in original)). The FCE was deemed invalid due to submaximal effort. While the discrepancies regarding the mechanisms of injury alone might not be dispositive even on the issue of accident, it is limitedly relevant here where the dispute centers on whether Petitioner's bilateral carpal tunnel syndrome developed in whole or in part as a result of repetitive trauma and not any traumatic injury. The Arbitrator finds that these discrepancies further erode Petitioner's credibility and they bear on the reliability of the opinions rendered by Dr. Stamelos, Dr. Williams and Dr. Chmell because they relied primarily on Petitioner's reports.

Third, the Arbitrator addresses the causal connection opinions of Dr. Stamelos, Dr. Williams, Dr. Chmell, and Dr. Fernandez. The first three physicians opine that a causal connection exists between Petitioner's bilateral carpal tunnel syndrome and one or both work injuries. Dr. Fernandez opines that no causal connection exists; the Arbitrator agrees.

Dr. Stamelos fervently contends in his deposition, in narrative reports, and throughout his treating records that Petitioner's repetitive work activities contributed to and caused her bilateral carpal tunnel syndrome. The Arbitrator finds that Dr. Stamelos' opinion is not persuasive and gives it no weight.

At trial, Petitioner testified that she was injured on October 10, 2001 when she pulled fixtures from below the assembly line to place them on the table while working the pick and place position. She then experienced a

"hard pain" in her back. Given the record as a whole, it is apparent that Petitioner sustained a traumatic injury resulting in immediate onset of symptoms that she localized to the back of her neck and/or her left shoulder which was ultimately diagnosed and treated as a cervical spine condition. In any event, the fact that Petitioner sustained a traumatic injury is corroborated by the record overall and it is inconsistent with Dr. Stamelos' medical records that Petitioner purportedly reported a repetitive trauma injury from the beginning.

On November 14, 2001, Dr. Stamelos' records show that reported an injury to her left shoulder due to repetitive usage. His records from this date forward are consistently inconsistent regarding whether Petitioner injured herself in a traumatic incident while pushing/pulling/lifting weight, or if she had a traumatic onset of pain secondary to repetitive usage of the left upper extremity (or both extremities, for that matter). Contemporaneous diagnostic records reveal that Petitioner reported a traumatic pushing and pulling injury and not an injury stemming from repetitive usage as Dr. Stamelos contends. Even the MRIs and EMG/NCV that Dr. Stamelos ordered were performed to rule out left shoulder impingement versus a rotator cuff tear as a result of a pushing/pulling injury and not to diagnose any repetitive trauma medical condition based on left-sided or certainly bilateral carpal tunnel syndrome symptomatology.

These important contradictions are highlighted in Dr. Stamelos' deposition. He testified that, while Petitioner told him that she injured herself secondary to pushing a lot of weight, "***[w]ell, that's what she said in Greek, maybe I misinterpreted. What she meant was repetitive motion. There is no Greek word for repetitive motion.*** *Pushing a lot of weight or doing a lot of work, work with her hands of course.*" PX12, p. 51 (***emphasis added***). He added, "***I think*** *there is weight involved,* but ***I think she meant*** *just an awful lot of work went through her hands,* that would be a good way to describe it. [.... And, there] was lifting in her job. ***She said she*** *had to lift some boxes after she filled them, but* ***she said*** *most of her work was doing repetitive motion. And somebody,* ***I think, I don't remember,*** *somebody* ***I think*** *it was this doctor who saw her, said she did like 3,000 maneuvers a day or something*[, which was Petitioner's estimate to that doctor and probably to him as well.]" PX12, pp. 51-52 (***emphasis added***). In addition to the self-evident inconsistencies and liberal interpretations made by Dr. Stamelos about what Petitioner said and what he thinks she meant to say, the Arbitrator notes that a simple internet search for the Greek-English translation of the word "repetitive" renders several immediate results including one for the phrase "done repeatedly."

On cross examination, Dr. Stamelos gave a general differential diagnosis explanation to account for his treatment and focus on Petitioner's central issue (i.e., the neck/left shoulder) instead of her left hand and then both hands for suspected carpal tunnel syndrome. In addition to the context explained above, Dr. Stamelos' otherwise reasonable explanation for his initial treatment and diagnostic focus is not persuasive in this case when his records so blatantly lack in objective clinical findings at most visits such that his diagnoses and ultimate causal connection opinions are reliable. Based on the foregoing, the Arbitrator finds that Petitioner did not report any repetitive usage injury to Dr. Stamelos, but rather that he inferred and concluded as much without relying on objective medical evidence in support thereof.

In addition, Dr. Stamelos admits that he did not review Petitioner's specific job description(s), he is unsure of what exactly Petitioner did "3,000" times per day over 27 years, and Petitioner did not demonstrate to him the repetitive activities that she performed at work. He admits that he had many of Respondent's patients in the past so his "experience with Motorola was repetitive usage of their extremities." He also admits that in at least one instance he essentially gave Petitioner the opinion that she wanted in a narrative report because he "would just rather write it and get her off [his] back than argue with her." PX12, pp. 50-51.

Similarly, the Arbitrator finds that Dr. Stamelos' causal connection opinion regarding Petitioner's bilateral carpal tunnel syndrome and her September 23, 2004 injury is unpersuasive. Dr. Stamelos failed to note

objective clinical findings at most of Petitioner's visits to support his opinion. He relied on Petitioner's unreliable and inconsistent reports about the mechanism of injury. Dr. Stamelos also relied on Petitioner's inconsistently reported job duties and actual work activities, while opining on causal connection without the benefit of any actual job description or other indication of Petitioner's actual work activities. Moreover, as reflected in his deposition testimony, Dr. Stamelos had already opined that Petitioner's work activities caused her carpal tunnel syndrome and he steadfastly maintained his causal connection opinion regarding Petitioner's September 23, 2004 injury while relying primarily on Petitioner's unreliable reports to him.

For example, at trial Petitioner testified that she sustained a traumatic injury while lifting boxes when she hurt herself and felt a sharp pain. Petitioner's testimony on direct and cross examination and her handwritten incident report dated October 14, 2004 conflict regarding the position that she worked when she was injured, manual tune or laser. In further contrast, Dr. Stamelos' records contain two different progress notes dated September 27, 2004 in which Petitioner reportedly sustained "a repetitive motion injury while working in the assembly line" and that she returned after an injury at work four days earlier with "quite significant" pain complaints of neck stiffness, pain, and radiculopathy "that has occurred since the time of the injury while working at Motorola." Dr. Stamelos' most contemporaneous progress notes to Petitioner's September 23, 2004 injury do not specify Petitioner's job at the time of her injury or any objective clinical findings or measurements to support his contention that Petitioner's previously diagnosed bilateral carpal tunnel syndrome was somehow aggravated by the incident at work.

In fact, Dr. Stamelos admitted on cross examination that Petitioner had no hand complaints only four days after her second work accident all the way through November 17, 2004. He further admitted that he did not treat Petitioner for carpal tunnel syndrome from the second half of 2004 through 2007, although he qualified his response by stating that he treated Petitioner for the more important cervical injury. Indeed, Dr. Stamelos could not reasonably treat Petitioner for bilateral carpal tunnel syndrome as his records do not refer to Petitioner's carpal tunnel condition until July 31, 2006 and they are similarly devoid of reference to objective findings through that date and thereafter supporting his ultimate, albeit conclusory, opinion that Petitioner's work activities somehow aggravated Petitioner's already causal connected bilateral carpal tunnel syndrome.

Dr. Stamelos' records are also conspicuously devoid of objective clinical findings or corroborative symptomatology complaints made by Petitioner to support his conclusion about the relatedness of Petitioner's bilateral carpal tunnel syndrome to her work activities after either injury at work. Even assuming that Petitioner's report of numbness, pain and tingling radiating down to the first three digits of the left hand on November 14, 2001 and December 5, 2001stemmed from Petitioner's left sided carpal tunnel syndrome as a result of either a traumatic or a repetitive trauma injury, Dr. Stamelos' records are devoid of any physical examination findings related to the left hand or wrist, much less the right hand or wrist, through the majority of his treatment of Petitioner. In fact, the first time that Dr. Stamelos' records refer to carpal tunnel syndrome is on December 11, 2001 in Petitioner's EMG/NCV results. Prior to and even after this date, Dr. Stamelos' records do not reference any Tinel's, Phalen's or any other objective examination findings to clinically correlate Petitioner's left hand numbness and tingling into the first three digits with her repetitive work activities as opposed to radiculopathy stemming from Petitioner's later-diagnosed cervical condition. Dr. Stamelos even admits in his deposition that Petitioner never showed him exactly what she did at work and he never reviewed any job description for Petitioner such that he could plausibly opine based on objective medical evidence that her left (or right) hand condition resulted even in part from activities at work.

Additionally, Petitioner did not complain of any traumatic injury to the right arm, hand or wrist at any time, nor did she report any right hand/wrist symptomatology until March 20, 2002 when she had been off work for a little over four months and she first reported "numbness and tingling *in the bilateral hands*, left hand worse than

right." PX5 (*emphasis added*). Thereafter, on October 2, 2002, while Petitioner was working light duty Dr. Stamelos diagnosed Petitioner with "[c]ontinued bilateral hand pain, carpal tunnel syndrome and cervical syndrome" even though the work note provided for her only reflects "cervical strain, radiculitis" and different work restrictions than those identified in Dr. Stamelos' progress note. PX5. Petitioner did not seek medical treatment again for nine months until July 2, 2003 and then again for approximately eight months until February 25, 2004 at which time Dr. Stamelos noted that Petitioner would either need surgery at C5-C7 or permanent work restrictions to accommodate the herniated discs in her neck and left radiculopathy, but he did not mention Petitioner's carpal tunnel syndrome, any complaints by Petitioner of bilateral hand pain or right-sided symptoms, much less any objective clinical findings on examination of Petitioner. Approximately one month later, on March 31, 2004, Petitioner returned reporting ongoing neck pain, but she did not report pain in either arm or hand. Three months afterwards, on June 30, 2004, Dr. Stamelos noted that Petitioner had carpal tunnel syndrome and needed surgery, that she had low back pain, and cervical spine syndrome due to herniated discs at C5-C7 "all from an injury on October 10, 2001 at Motorola." PX5. Petitioner's only report of low back pain prior to this time was on July 2, 2003, approximately one year and nine months after her work accident, and now one year after her only complaint of low back pain on July 2, 2003.

Another three months later (and four days after her second accident) on September 27, 2004, Dr. Stamelos noted that Petitioner returned after sustaining "a repetitive motion injury while working in the assembly line and pushing fixtures." PX5. This mechanism of injury is similar to that reported by Petitioner on cross examination and noted in Dr. Stamelos' November 14, 2001, July 2, 2003, and February 25, 2004 progress notes. He diagnosed Petitioner with herniated discs at C5-C7, but makes no mention about carpal tunnel symptomatology or examination findings in either arm or hand other than radiating symptoms to the left upper extremity from the cervical condition. Dr. Stamelos' records contain two different progress notes dated September 27, 2004, the second of which refers to Petitioner's September 23, 2004 accident after which she complained of significant neck stiffness, pain, and radiculopathy that Dr. Stamelos noted "has occurred since the time of the injury while working at Motorola. The radiculopathy and the pain was so severe that she had to get an emergency appointment to see me where I will try to treat her for these new symptoms that she has developed." PX5. Dr. Stamelos' records, however, are unclear about the new symptoms that Petitioner reported on September 27, 2004, whether they involved Petitioner's bilateral hands, and no objective examination findings are noted that distinguish Petitioner's new symptoms from those resulting from the October 10, 2001 injury. Again, Dr. Stamelos does not reference any symptomatology or diagnoses in any other body part whatsoever and no objective evaluation of Petitioner's hands was identified in the records. Dr. Stamelos' records continue to be vague through October 13, 2004 and refer to a continuation of the "current course of management" without any objective clinical examination findings regarding Petitioner's neck, arms, or hands in reference to any of Petitioner's reported symptomatology. As reflected in the findings of fact, the aforementioned list of missing or inconsistent information contained in Dr. Stamelos' records is not exhaustive. Based on all of the foregoing, the Arbitrator finds that Dr. Stamelos' causal connection opinions with regard to either of Petitioner's work accidents are unpersuasive and gives them no weight.

Finally, the Arbitrator gives little weight to the opinions of Dr. Williams and Dr. Chmell. Dr. Williams' causal connection opinion is predicated on a single examination, limited medical records available for review, and incomplete, if not completely inaccurate, information about Petitioner's work activities. Dr. Williams admitted that he did not have Petitioner's actual job description to consider, he did not view any video depicting any of Petitioner's job duties, and he also testified that he based his opinion on his understanding that Petitioner worked in manual tune which required repetitive forceful activities, extensive use of small tools, continuous gripping/grasping/pinching/fine motor activities, and the use of vibratory tools garnered from Petitioner's reports to him and a summary of work duties compiled by Petitioner's counsel. According to her testimony at trial, Petitioner was not working on manual tune or performing related functions at the time of either incident in

2001 or 2004. As explained in detail above, the job duties and work activities reported by Petitioner conflict throughout the record.

Dr. Williams also admitted that there was an increased incidence of carpal tunnel syndrome stemming from genetic factors including age, gender (in postmenopausal women), and increased weight. Regarding the curious increase in Petitioner's symptomatology while she was not at work, Dr. Williams contended that her bilateral carpal tunnel syndrome was "masked" by the cervical spine condition and related symptomatology and that Petitioner initially sustained a "double-pinch" or "double-crush" injury. Dr. Williams' opinion does not, however, adequately explain how Petitioner's left sided cervical spine condition and symptoms masked right sided carpal tunnel for years which is in a very different anatomical distribution than Petitioner's left sided carpal tunnel.

Dr. Chmell's causal connection opinion is similarly predicated on a single examination, limited medical records available for review, and incomplete, if not completely inaccurate, information about Petitioner's work activities and the mechanisms of injury. Based on all of the foregoing, the Arbitrator assigns little weight to the causal connection opinions of Dr. Williams and Dr. Chmell.

The Arbitrator does find Dr. Fernandez's opinion to be persuasive given the totality of this record. He is the only physician to review any job description or specific physical demand description of any of Petitioner's positions with Respondent. He is the only physician that viewed the performance of any of Petitioner's activities at work in a video, even if the activities were done at a slower pace or on fewer machines than Petitioner reports she worked. He is also the only physician to plausibly explain that the potential multifactorial causes of carpal tunnel syndrome do not automatically result in a causal connection opinion linking a patient's work activities and carpal tunnel syndrome; each factor much be considered in the full context of the patient's case including consideration of the specific work activities. For example, Dr. Fernandez plausibly explained that repetitive hand/wrist activities, the use of a vibratory air tool, or the use of any hand tool no matter how repetitively, would not in and of itself cause bilateral carpal tunnel syndrome; it would depend on the type of tool and the force associated with the use of the tool and the repetitive and *heavy* or *forceful* gripping/grasping/ tool use. Dr. Fernandez also admitted that while Petitioner's reported tasks were repetitious and had occurred over decades they were also relatively varied and none of the activities involved gripping or grasping with significant force, the use of heavy tools, or significant hyperextension or hyper flexion for prolonged periods of time.

Furthermore, Dr. Fernandez noted that carpal tunnel syndrome is most commonly seen in females in Petitioner's age group, that Petitioner was at additional risk given her increased body mass index, and that, while there was no doubt that Petitioner's symptoms may increase or worsen with exposure to work activities, her condition could also increase or worsen with exposure to *any* activities which did not warrant a finding of causal relationship or aggravation on that basis alone. Given the totality of the record, the Arbitrator finds that Dr. Fernandez's opinion is persuasive and assigns greater weight to the opinion of Dr. Fernandez in this case because his opinions are based on objective information and a more complete understanding of Petitioner's medical condition and work activities rather than speculation, inference, conjecture or, primarily, Petitioner's incomplete and unreliable reports.

Based on all of the foregoing, the Arbitrator finds that Petitioner failed to meet her burden of proof to establish a causal connection between her current bilateral carpal tunnel syndrome condition and either accident at work.

Lateral Epicondylitis

Petitioner contends that her left elbow condition is causally connected to one or both of her injuries at work. Petitioner did not testify about any mechanism of injury occurring on either date of accident that would plausibly give rise to her claimed current condition of ill being in the left elbow. Indeed, the record is devoid of any elbow complaints made by Petitioner until May 7, 2008, over 6½ years after her first accident and over 3½ years after her second accident. On this basis alone, the Arbitrator finds that no causal connection finding is reasonable given the enormous gap in time between Petitioner's accidents and any onset of left elbow symptomatology. The Arbitrator also notes that Petitioner was not working during much of this time frame.

Notwithstanding, Petitioner's own physician, Dr. Williams, essentially discounts any such causal connection finding. While he opined that Petitioner's lateral epicondylitis is causally related to her injuries at work, he could not identify when Petitioner's elbow symptoms began and he admitted that Petitioner's symptoms developed in middle age which would not be masked by her cervical condition because it was not located in the same anatomical distribution. Based on all of the foregoing, the Arbitrator finds that Petitioner has not established a causal connection between her claimed current left elbow condition of ill being and either work accident.

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

Petitioner alleges entitlement to payment of $8,913.00 in outstanding medical bills from Dr. Stamelos only. AX1;AX2. The bills submitted from Dr. Stamelos reflect dates of service, but not the specific medical treatment underlying each bill. PX16. As causal connection has been resolved in Petitioner's favor with respect to her cervical spine and left arm radiculopathy condition only, the Arbitrator finds that any medical bills related to Petitioner's cervical spine and left arm radiculopathy condition are reasonable and necessary. The Arbitrator awards such bills. The Arbitrator further finds that any medical bills related to Petitioner's bilateral carpal tunnel syndrome or left lateral epicondylitis conditions are not reasonable or necessary and such bills are denied.

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

There is no dispute regarding temporary total disability benefits in Case No. 02 WC 11336. The parties stipulated that Petitioner received full wages while she was off work until she returned to work on August 20, 2002. *See* AX2. Petitioner asserts that she is entitled to temporary total disability from July 24, 2004 through June 12, 2011. *Id.* Respondent disputes Petitioner's entitlement to temporary total disability benefits after May 5, 2009. *Id.* While parties are bound by their stipulations at trial, it appears from the evidence that the "5/5/09" end date listed in the Request for Hearing form is a typographical error. Respondent argues, and Respondent's Exhibit 12 reflects, that payments were made to Petitioner through March 5, 2009. The Arbitrator notes that March 5, 2009 was a Thursday. Mr. Belmonte's final vocational rehabilitation report is dated March 9, 2009, which the Arbitrator notes was a Monday. The Arbitrator finds that Petitioner is not entitled to temporary total disability or maintenance benefits after March 9, 2009.

To the extent that Petitioner's physicians and Respondent's independent medical examiners opine on the matter, they agree that Petitioner can work, but they disagree on the type of work that she can perform and to what degree. Much discussion is contained in the various physicians' depositions about whether Petitioner could work in a position where she types, but this is a red herring. There is no credible evidence in the record that

Petitioner was ever asked to look for a job through Vocamotive or at any time that required her to type repeatedly. In any event, given the findings and conclusions explained above on causal connection, the Arbitrator is persuaded by the opinions of Dr. Fernandez. He opined that Petitioner could work full duty without restriction and that she could keyboard and perform data entry. Moreover, as early as December 5, 2007 Petitioner failed to cooperate during a functional capacity evaluation when she refused to give the physical therapist historical information. On March 24, 2008 Respondent's Section 12 examiner, Dr. Levin, opined that Petitioner could work beyond a sedentary level as noted in the invalid functional capacity evaluation results. Ultimately, the Arbitrator finds Dr. Fernandez's opinion on Petitioner's ability to work persuasive given the totality of the record.

Next, the Arbitrator notes that Petitioner was not cooperative in vocational rehabilitation through a vocational rehabilitation counselor and that she did not engage in an adequate self-directed job search such that she is entitled to maintenance benefits (at the temporary total disability rate) pursuant to the Act. There is ample evidence of Petitioner's non-compliance with the vocational rehabilitation program at Vocamotive. Petitioner's reticence to look for any work is clear not only from Mr. Belmonte's records and deposition testimony, but also from Petitioner's own testimony and other record evidence.

Vocamotive's records and Mr. Belmonte's testimony about vocational rehabilitation efforts made between August 6, 2008 and March 9, 2009 reflect myriad conduct indicating Petitioner's non-compliance including Petitioner leaving before the end of a session, failure to attend sessions, failure to apply for job leads provided, failure to participate in recommended vocational rehabilitation activities, failure to complete some job logs, Petitioner's statements that she could not perform the recommended activities or obtain employment, and her selective cooperation in other recommended vocational rehabilitation activities at Vocamotive or on her own. The Arbitrator places greater weight on the opinions of Mr. Belmonte than those of Ms. Entenberg given the record in this case and finds that Petitioner was not compliant in vocational rehabilitation.

Finally, Petitioner testified that she has continued to look for work after March of 2009 on her own by either submitting applications in person or calling over the phone, that she applied for a part-time position in her neighborhood, and that she called a couple of prospective employers through newspaper ads. Petitioner did not provide any evidence of these or any other job searches performed after March 9, 2009. Thus, the Arbitrator finds that there is no credible evidence of a self-directed job search sufficient to entitle Petitioner to maintenance benefits after March 9, 2009.

Based on all of the foregoing, the Arbitrator finds that Petitioner is not entitled to any temporary total disability or maintenance benefits after March 9, 2009. The Arbitrator also finds that there is no evidence that Petitioner was paid maintenance benefits on Friday, March 6, 2009 or Monday, March 9, 2009. *See* RX12. Thus, the Arbitrator awards Petitioner these additional two days of maintenance benefits.

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

As causal connection has been resolved against Petitioner with respect to her bilateral carpal tunnel syndrome or left lateral epicondylitis conditions, the Arbitrator denies the requested prospective medical care related thereto.

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

VICKY PARAS,

Petitioner,

vs. NO: 02 WC 11336

14IWCC0099

MOTOROLA, INC.,

Respondent,

DECISION AND OPINION ON REVIEW

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

The Commission notes that the Arbitrator's internet search was improper and beyond the evidence contained in the record. However, this error was harmless since this additional information was not necessary for the Arbitrator to reach the appropriate conclusions on the issues in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 17, 2013, 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: FEB 1 1 2014
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CJD/se
049

Michael P. Latz

Ruth W. White

DISSENTING OPINION

I respectfully dissent and find that the testimony of Petitioner was credible as were the causation opinions of Dr. Stamelos, Dr. Williams, and Dr. Chmell. Respondent's Section 12 Dr. Fernandez opined that Petitioner's job duties did not contribute to or aggravate her bilateral carpal tunnel syndrome (CTS) because he reviewed her job description and a video. However, his testimony does not seem to be based on the actual facts of this case. Petitioner's undisputed testimony was that the video was not representative of her work duties because it did not show "manual tune" or "repair." (T.24). "Manual tune" involved using small screwdrivers and required Petitioner to "turn [her] fingers all day long." (T.26). Petitioner testified that she spent 10 hours a day, 6 days a week doing that job and she noticed pain, numbness, and swelling in her hands while doing it. (T.21, 27). Petitioner also did other jobs including "laser trim," "pick and place," and "inspection and repair." (T.22).

Although the video shows the job of "laser trimming," Petitioner testified that she operated four machines at once while the video only showed workers doing one. (T.150). Petitioner testified that nobody else worked on four machines. (T.30). Petitioner testified that she also worked in the "receiver line," which is not shown on the video, and used a pneumatic screwdriver which involved applying 15 to 20 pounds of pressure. (T.67). Petitioner also testified that the video didn't show pliers being used to cut some of the circuit boards. The video only showed work on "the smallest boards." (T.149). When Petitioner was returned to work with light duty restrictions, she was put in "inspection" for only two weeks and then Respondent put her back in "manual tune." (T.39).

Petitioner credibly testified that her hands were hurting her and she had numbness in her fingers in 2001 but she thought it was related to her neck. (T.33). This is supported by the medical records and testimony of her treating physician, Dr. Stamelos, that Petitioner was

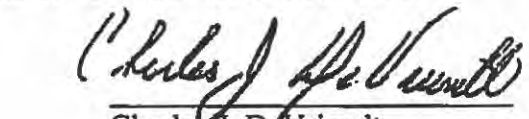
complaining of pain in her left hand and fingers along with numbness at that time. The first mention of right hand numbness and tingling was several months later on March 20, 2002, after Petitioner had been off work, and at a time when Dr. Stamelos noted that her neck and bilateral shoulder pain were getting better. This lends credibility to his testimony that Petitioner's complaints have been similar since the very beginning, including numbness and tingling in both hands (Px12 at 8) and that Petitioner has never stopped complaining about her hands (Id. at 13), but he was more focused on her cervical and shoulder problems because those were more serious (Id. at 42). He testified that Petitioner has double crush syndrome and that she is the "poster girl" for repetitive motion carpal tunnel disease. (Id. at 29). He is "positive" that Petitioner's work activities contributed to or caused her carpal tunnel. (Id. at 36).

Analyzing the testimony of Respondent's Dr. Fernandez in more detail, he testified that Petitioner's pain behavior was not significantly beyond her objective findings and that she does have a bad case of bilateral CTS with the right being much more severe than the left. (Rx7 at 12, 16). He did not believe that Petitioner's work duties, even if done for 27 years, would contribute to CTS and felt that her condition was "idiopathic." However, he did admit that her symptoms "manifested" while she did her job. (Id. at 20). Even though Petitioner's symptoms were worse when she was working, he did not believe that this meant there was a causal connection. On cross examination, he admitted that once someone has CTS, the symptoms can worsen over time even if they aren't working. He also admitted that if the job description and video were not all inclusive and she did, in fact, have to use vibratory tools, pinch/grasp, and press things into place, this would be important in his determination of causation. (Id. at 26). He opined that if Petitioner was exposed to heavy gripping, grasping, using tools on a repetitive basis, and certain vibratory tools, "of course those could be contributory factors considered causal to" CTS. (Id. at 29). He also opined that Petitioner absolutely needs surgery.

In my opinion, Dr. Fernandez's opinion is based on an incomplete understanding of Petitioner's job and should be discounted for that reason. Although the Arbitrator found the opinions of Petitioner's own doctors to be faulty for the same reason, she believed Dr. Fernandez because he viewed the video and reviewed the job description. However, as discussed above, this is immaterial when the video does not show all of Petitioner's job duties and particularly does not show the most strenuous ones.

In addition to Dr. Stamelos, Petitioner was examined by Dr. Williams who felt that there was a significant relationship between her work and her carpal tunnel syndrome. (Px13 at 13). Dr. Chmell also performed an examination and records review and agreed that there was a causal relationship. (Px14 at 17).

Based on the above and a review of the record as a whole, I would reverse the Arbitrator's decision on the issues of accident and causation and would find that Petitioner's bilateral CTS are causally related to the initial accident on October 10, 2001.



Charles J. DeVriendt

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

PARAS, VICKY
Employee/Petitioner

Case# **02WC011336**

04WC059273

14IWCC0099

MOTOROLA
Employer/Respondent

On 1/17/2013, 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 0.10% 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:

0006 LEO ALT
221 N LASALLE ST
SUITE 2014
CHICAGO, IL 60601-1407

1120 BRADY CONNOLLY & MASUDA PC
BEVERLY N MASUDA
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

14IWCC0099

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Vicky Paras
Employee/Petitioner

v.

Motorola
Employer/Respondent

14IWCC0099

Case # 02 WC 11336

Consolidated cases: 04 WC 59273

An *Application for Adjustment 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 G. Lammie**, Arbitrator of the Commission, in the city of **Chicago**, on **June 16, 2011** and the case was later re-assigned and proceedings were concluded by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Chicago**, on **June 12, 2012, July 24, 2012**, and **October 29, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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 **19(b), 8(a)**

ident, **October 10, 2001**, Respondent *was* operating under and subject to the provisions of

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

his 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 $**34,511.36**; the average weekly wage was $**663.68**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

As explained in the Arbitration Decision Addendum, Petitioner established causal connection between her cervical spine and associated left arm radiculopathy condition and both accidents. Petitioner failed to establish causal connection between her bilateral carpal tunnel syndrome condition or left elbow lateral epicondylitis condition and either accident on October 10, 2001 or on September 23, 2004.

Medical benefits

As explained in the Arbitration Decision Addendum, causal connection has been resolved in Petitioner's favor with respect to her cervical spine and left arm radiculopathy condition only. Thus, the Arbitrator finds that any medical bills related to Petitioner's cervical spine and left arm radiculopathy condition are reasonable and necessary and such bills are awarded pursuant to Sections 8(a) and 8.2 of the Act. The Arbitrator further finds that any medical bills related to Petitioner's bilateral carpal tunnel syndrome or left lateral epicondylitis conditions are not reasonable or necessary and such bills are denied.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, Petitioner failed to establish causal connection between her bilateral carpal tunnel syndrome condition and her accident on October 10, 2001 or on September 23, 2004. Thus, Petitioner's claim for prospective bilateral carpal tunnel surgeries and associated recuperative 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

January 16, 2013
Date

ICArbDec19(b) p. 3

JAN 17 2013

141WCC0099

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

Vicky Paras
Employee/Petitioner

v.

Motorola
Employer/Respondent

14IWCC0099

Case # 02 WC 11336

Consolidated cases: 04 WC 59273

FINDINGS OF FACT

The parties participated in a consolidated hearing on June 16, 2011 before Arbitrator Lammie at which time all live testimonial evidence was presented pursuant to Petitioner's Section 19(b) and Section 8(a) motion. Subsequently, these matters were reassigned to the undersigned Arbitrator to conclude the presentation of evidence and render a decision on the issues presented. The Arbitrator finds on the issues presented at trial as stated herein.

Background

Vicky Paras ("Petitioner") testified that she emigrated from Greece in May of 1974 after completing the American equivalent of the first year of high school. June 16, 2011 Arbitration Hearing Transcript ("Tr. pp.") 11-12. Her primary language is Greek and she taught herself English. Tr. pp. 12-13. Petitioner is right-hand dominant. Petitioner's Exhibit ("PX") 5.

Petitioner was employed with Respondent since 1976 through her first date of accident[1]. Tr. pp. 10-12. Petitioner testified that her first job in the United States was with Respondent in Franklin Park[, Illinois] and that she worked with tiny crystals used in watches for a couple of years. Tr. pp. 12-14. Thereafter, Petitioner moved to Schaumburg[, Illinois] in 1978 and worked in parts and then in crystals. Tr. p. 14.

Petitioner testified that she never filed a workers' compensation claim prior to these claims, that she was never sick, and that she worked seven days a week. Tr. p. 15. She also testified that she was never treated for any neck, back, arm or hand condition prior to October of 2001, and that she never had occasion to go to Respondent's clinic or medical department. Tr. p. 15. Petitioner further testified that she did not know what carpal tunnel was prior to 2001 and that it was not until she came under the care of Dr. Stamelos that she understood that she might have carpal tunnel. Tr. p. 27.

On cross examination, Petitioner testified that she could not remember if she only claimed an injury to her left shoulder when she originally filed her workers' compensation claim in 2002, but also acknowledged that her original application for adjustment of claim filed by her prior attorney referred to an injury due to pushing and pulling, which resulted in injury to the left shoulder only. Tr. pp. 73-76; Respondent's Exhibit ("RX") 1. Petitioner's Amended Application for Adjustment of Claim dated March 16, 2004 reflects a pushing and pulling injury to the "left shoulder, neck, arms, hands, etc." RX2.

[1] While Petitioner testified that she worked through October of 1991, the Arbitrator notes that the undisputed date of accident is October 10, 2001. Arbitrator's Exhibit ("AX") 1.

Petitioner further testified on cross examination that her original application for adjustment of claim filed on March 16, 2004 by her prior attorney again referred to an injury sustained on October 10, 2001 due to pushing and pulling, resulting in injury to the left shoulder, neck, arms, and hands. Tr. pp. 115-116; RX2. On re-direct examination, Petitioner testified that her former attorneys filed an amended application on her behalf after she advised them of what her doctors had been telling her. Tr. pp. 140-142. Petitioner also testified that she did not remember exactly what she was doing on the date of injury; she was either in inspection or laser and she believed that she was in laser half of the day and elsewhere for the remainder of the day. Tr. p. 113. She further testified on re-direct examination that her pain was worse after her second injury in 2004 and that it was localized in the upper back, shoulder, and down to her hand. Tr. pp. 148-149.

The Arbitrator notes that no original or amended application for adjustment of claim in the Commission's files in both of Petitioner's cases reflect any injury sustained as a result of repetitive trauma.

Petitioner's Job Duties

Petitioner testified that she was originally assigned to "manual tune" and had been in that position for several years prior to 2001. Tr. pp. 17-21. This position was in the same department as "laser, pick and place, inspection and repair." Tr. p. 20. Petitioner estimated that she worked in manual tune 80% of the time, approximately 10 hours a day, 6 days a week. Tr. pp. 20-22. Petitioner testified that the majority of the remainder of her time was spent working as the "laser" person. Tr. pp. 22-23. Otherwise, Petitioner worked filling in other positions including "pick and place" and "inspection and repair." Tr. p. 23. On cross examination, Petitioner testified that prior to her injury in October of 2001 she also worked in an area called "manual kits." Tr. p. 76.

Petitioner testified that the "laser" position involved using another, more modern [computerized] machine; there she would move around a mouse with little buttons to make cuts into certain places on the board. Tr. pp. 27-28. While in this position, Petitioner testified that she noticed numbness, swelling, and that her hands were hurting. Tr. p. 27.

On cross examination, Petitioner testified that she would stand in front of a computer with a keyboard and tune small, thin circuit boards; to do this, she would take the circuit board out of one box, adjust the circuit board to match the [computer] screen, and then place the completed circuit board in another box. Tr. pp. 97-99. Petitioner testified that the circuit boards in the laser position are bigger than those in manual tune. Tr. pp. 100. She further testified that there are different lasering processes for different boards, but the four machines on which she worked were all the same. Tr. pp. 101-103.

Petitioner testified that she worked in laser approximately 8-10 hours per day, 4-5 days per week in 2002 and 2003. Tr. p. 106. Petitioner testified that Respondent's Exhibit 4 was not representative of what she did when she worked the laser position because it showed the employees operating less than four laser machines simultaneously like she did by going from one machine to another and "[j]umping like crazy, around." Tr. pp. 28-30, 150. Petitioner also testified that she only uses the mouse in this position. Tr. pp. 103-104.

Petitioner further testified that Respondent's Exhibit 4 did not show manual tune or repair or inspection. Tr. pp. 24-25, 137. Petitioner testified that manual tune involved using a small tool that was similar to a screwdriver on small circuit boards of differing sizes and that she would turn her fingers all day long around, forward, and backwards. Tr. pp. 26, 66, 104. Petitioner testified that she also worked with an air gun using 15-20 pounds of pressure to close transreceivers with the screws and later clarified that she did not use this tool while in manual

tune, but rather while she was in repairs. Tr. pp. 67-68, 105. Then she would input information into a computer that could either pass or reject the [circuit] board. Tr. p. 26.

Petitioner also worked in a quality control inspection job (a.k.a. FQA). Tr. pp. 107-108. Petitioner testified that she was seated in this position and that varying sizes and types of thin circuit board sheets would come down to her on a conveyor belt and she would use tools including a tweezers, brush, and pliers to inspect, clean, and place the circuit boards in a box. Tr. pp. 108-110. On re-direct examination Petitioner testified that the pliers she used were not reflected in Respondent's Exhibit 4 and that it only showed the smallest [circuit] boards. Tr. pp. 149-150.

Job Descriptions

Petitioner's line assembly operator job description in Respondent's microcircuits group dated September 22, 2004 reflects that an employee is rotated every two weeks. PX2. Some of the tasks that Petitioner performed required the following: (1) ability to assemble small components into ceramic substrates using tweezers (line assembly); (2) ability to sit and look at small parts under a microscope for eight hours a day (FQA); (3) ability to stand/sit for long periods of time (mostly sitting); and (4) ability to lift up to 15 pounds "(mostly related to fixtures - at the time [Petitioner] was working on Manual tuning and boards weighed about 1 to 2 pounds)[.]" *Id.* The time spent on each task depended on the job and was approximately 5 to 10 min. *Id.* The tools required to perform the job (both manual and power) included tweezers, a hand torque set 15 pounds, and tuning tools for the manual tuning position. *Id.* Petitioner was also required to be able to lift up to 15 pounds. *Id.* The Arbitrator notes that this job description appears to have been created in response to a request about Petitioner's specific job duties.

An internal job description analyzed as of December 28, 2005 and entitled "Physical Demand Documentation" delineates the functions and physical activities required by the FQA, pick and place, and laser trim positions. PX2; RX11. FQA is a quality assurance inspection position. *Id.* The purpose of the pick & place position is to place components on a circuit board. *Id.* The purpose of the laser position is to utilize a machine that automatically trims excess solder or other material from circuit boards. *Id.* All three positions have essential functions that include visual inspection, inspection with use of a powered microscope, utilizing tweezers/picks/fingers to place components onto circuit boards, and picking up trays of circuit boards (weighing approximately 5 to 8 pounds) to trim boards where the employee determines how many boards to place on the tray. *Id.* The physical requirements of the positions are as follows:

	Laser Trim	FQA	Pick & Place
Standing	Occasionally (30% or less of shift)	None	None
Sitting	Constantly (70% of shift)	Constantly (90% of shift)	Constantly (90% of shift)
Walking	Rarely (less than 5% of shift)	"	"
Lifting	Rarely (less than 5% of shift); lifts trays from rack that range in height from 42"-64" on rare basis & lifts trays of boards weighing 5-8 pounds as determined by the employee and how many boards the put on the tray	"	"
Carrying	Rarely (less than 5% of shift)	"	"
Pushing/	Rarely (less than 5% of shift);	"	"

pulling	pushes trays into fixtures with minimal force
Reaching	Infrequently (less than 10% of shift); transferring trays from the rack requires reaching down to 20" and up to 64"; placing boards in fixture requires reaching 15" from body at 42" height; activation button is 20" reach

Id. In addition, repetitive hand motions include bilateral simple grasping, firm grasping, and fine manipulation. *Id.* The use of picks and tweezers also requires fine manipulation as well as simple and firm grasping. *Id.* Holding trays and circuit boards requires grasping, but no repetitive fingering motions are required. *Id.*

October 10, 2001 Accident

Petitioner testified that on October 10, 2001, there were some people missing from the line. Tr. p. 16. Petitioner testified that she was assigned as the pick and place person, but since there was no one to pick up the heavy fixtures she pulled the fixtures from the bottom of the table and put them in a cart to carry them. Tr. p. 16; *see also* Tr. p. 80. Petitioner testified that the second time she pulled the fixtures to place them on the table she felt pain in her back "like I was stung with a hard pain[.]" Tr. pp. 16-17; *see also* Tr. pp. 139-140.

Petitioner further testified that one could either sit or stand depending on the size of the circuit boards and covers, some of which were big. Tr. pp. 81-82. Petitioner was unable to accurately describe the size or weight of these boards, but estimated that they were approximately 1' x 6" and approximately 1-1½" thick. Tr. pp. 82-84.

Petitioner testified that the circuit board would come to her on a conveyor belt and she would snap a part onto the circuit board. Tr. p. 83. She also testified that the circuit boards were copper on the bottom and green on the top, that the metal piece that she attached to the circuit board was the same size as the bottom of the circuit board, and that she would then place the circuit board back onto the conveyor belt to go forward on the line. Tr. pp. 85-86.

Petitioner testified she told her coworker about her injury and that her coworker told Petitioner's supervisor that her back was hurting. Tr. p. 17.

Respondent's Health Services Department & Alexian Brothers

Petitioner testified that she was referred to, and saw, the company nurse. Tr. pp. 17, 30-31. She also went to Respondent's clinic at Alexian Brothers a few times. Tr. pp. 30-31. The medical records reflect that Petitioner went to Alexian Brothers on October 15, 2001. PX4. At that time, Petitioner's restrictions included no lifting/carrying over 2 pounds with the left arm, limited pushing/pulling with the left arm, no limited strong grip/grasp/pinch with the left hand/arm, and no reaching/lifting above the left shoulder. PX4. Petitioner also saw a nurse at Respondent's Health Resources department on October 22, 2001, was sent to the clinic, and then returned to work with restrictions. PX1. Petitioner returned to the nurse on November 2, 2001 and was sent to the clinic at 8:15 a.m. PX1. The work restrictions ordered on October 22, 2001 and November 2, 2001 remained the same with the exception that Petitioner was further restricted from pushing/pulling over 5 pounds. PX4.

Stamelos Clinic

Petitioner testified that she then went to see Dr. Stamelos because he spoke Greek and that all of the treatment that she received from Dr. Stamelos in 2001 and 2002 was for her neck, hands, and arm; he was not treating her for any other purpose. Tr. pp. 31, 62, 88-89. At that time, Petitioner testified that she noticed numbness in her hand and fingers, especially on the left, and pain in her neck and hand. Tr. pp. 33. Petitioner also testified that she was laid off in 2001. Tr. pp. 31-32.

Petitioner testified that she continued to treat with Dr. Stamelos, and occasionally went to Respondent's medical department where they put ice on her shoulder and left hand. Tr. pp. 40-41.

Petitioner first saw Spiros Stamelos, M.D. ("Dr. Stamelos") on November 14, 2001. Tr. p. 88; PX5; PX12, p. 7. At that time, Petitioner reported an injury on October 10, 2001 "of the left shoulder because of repetitive usage. She works in the line resulting in over usage of the left arm." PX5; *see also* PX12, p. 8 (Dr. Stamelos testified that Petitioner attributed her injury primarily to repetitive hand work at Motorola). Petitioner reported that "[s]he was pushing and closing containers when she experienced [numbness, tingling, and pain radiating down to the first, second, and third digits of the left arm/hand] because of repetitive usage." PX5; *see also* PX12, pp. 42, 43-44. A handwritten history, presumably taken by Dr. Stamelos' staff, reflects that Petitioner "sts was pushing & clicking container in assembly line. Pt had repetitive assembly line motion which cause L shoulder pain." PX5.

Dr. Stamelos' records reflect only limited range of motion in the left shoulder and cervical spine, a very painful left shoulder, and paraspinal muscle spasms without any complaint of bilateral hand tingling, primarily on the left. *Id.* The medical records further reflect that Dr. Stamelos' note that Petitioner's x-rays showed a loss of lordosis in the spine. *Id.* Dr. Stamelos administered trigger point injections into the bilateral shoulders and cervical spine. PX5; PX12, p. 34. He ordered different prescription medications from the "inappropriate" ones prescribed at Alexian Brothers that gave Petitioner a rash. PX5. He ordered a left shoulder MRI, a cervical spine MRI, and an EMG/NCV of the left upper extremity "because of the radiation of the pain down the arm." PX5; *see also* Tr. pp. 34-35. Additionally, he ordered physical therapy because of Petitioner's radiating pain down into the left arm. PX5. Dr. Stamelos noted that "I do believe it is soft tissue in the form of impingement versus a rotator cuff injury and possible AC degeneration and possible labrum injuries." *Id.* Petitioner was placed off work by a chiropractor at the Stamelos clinic through November 28, 2001. PX5; *see also* PX12, p. 13.

On November 16, 2001, Petitioner reported diffuse neck pain, moderate pain radiating into the left shoulder, increased pain when lifting the left arm and bending the neck backwards, and headaches. PX5. Petitioner reported being pain free before and an onset of pain while she was working a repetitive job at Motorola on October 10, 2001, which she rated at a level of 7/10. *Id.* Dr. Stamelos noted that muscle relaxant and anti-inflammatories helped minimally as had a course of physical therapy, but that her pain had not improved significantly and that she had difficulty sleeping as well as performing tasks at home. *Id.* After an examination, Dr. Stamelos diagnosed Petitioner with chronic moderate cervical strain with associated mild myofascial pain syndrome and articular dysfunction of the C5-C6 and facet with left arm radiculopathy from suspected arthritic changes or the space occupying disc lesions at C4-C7 and cervicogenic tension headaches. *Id.* He ordered home exercises, a TENS unit for electrical stimulation, and chiropractic care. PX5; *see also* Tr. pp. 36-37. Petitioner returned to a chiropractor at Dr. Stamelos' clinic for continued chiropractic care and/or physical therapy throughout her treatment with Dr. Stamelos. PX5.

Petitioner underwent a cervical spine MRI on November 21, 2001. *Id.* At that time, Petitioner reported "left-sided neck pain radiating down the left arm since lifting and pulling injury at work October 10, 2001." *Id.* The interpreting radiologist noted a large left lateral herniated disc at C6-C7. *Id.* Petitioner underwent a left shoulder MRI on the same date and reported "[p]ain since lifting/pulling injury." *Id.* A different interpreting radiologist noted: (1) mild to moderate increased signal intensity involving the supraspinatus tendon anterodistally consistent with inflammation, degeneration, or contusion if trauma has occurred but no rotator cuff tear; (2) no labral-ligamentous complex tear; and (3) an approximately 1.4 x 1.0 cm circumscribed lesion involving the medial aspect of the humeral head most commonly representing a conjoined lesion/cortical chondroma. *Id.*

On November 28, 2001, Dr. Stamelos placed Petitioner off work through December 5, 2001 pending an orthopedic evaluation. PX5; *see also* Tr. pp. 89, 151-152.

On December 5, 2001, Petitioner returned to Dr. Stamelos complaining of left shoulder pain and neck pain causing headaches as well as numbness in the left hand in the second and third digits. PX5. No objective examination findings were noted at the time of this visit. *Id.*

On December 11, 2001, Petitioner underwent the recommended EMG/NCV to rule out left cervical radiculopathy versus a myofascial referral pattern. PX5. Specifically, Petitioner was being evaluated for her "complaints of neck pain and associated radiation of the pain with paresthesias into her left upper extremity since her work related pulling injury of October 10, 2001. She is referred to rule out a left cervical radiculopathy vs. a myofascial referral pattern." *Id.* The interpreting physician opined that Petitioner's study was abnormal, the EMG findings were consistent with left C7 radiculopathy, there was evidence of a mild-moderate median neuropathy at the left wrist, and evidence of the mild median sensory neuropathy at the right wrist. PX5; *see also* PX12, pp. 9-10.

On December 19, 2001, Dr. Stamelos reviewed Petitioner's MRI films and EMG/NCV test results and noted "[t]he impression" of left carpal tunnel syndrome, right carpal tunnel syndrome mild, and a herniated disc at C6-C7 on the left. PX5. At his deposition, Dr. Stamelos testified that Petitioner's C6-C7 nerve problem affected Petitioner's left upper extremity. PX12, pp. 10-11. Dr. Stamelos referred Petitioner for a neurology consult and ordered continued conservative management (i.e., chiropractic care). PX5. While he notes that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* Petitioner was placed off work through January 16, 2002[2]. *Id.*

On January 28, 2002, Petitioner was placed off work because she was "100% disabled from work until further notice." *Id.*

First Section 12 Examination – Dr. Skaletsky

On February 5, 2002, Petitioner saw Gary Skaletsky, M.D. ("Dr. Skaletsky") at Respondent's request. Tr. pp. 77-78; RX9. Dr. Skaletsky examined Petitioner and took a history from her, reviewed various treating medical records, and rendered opinions regarding Petitioner's cervical spine. RX9.

[2] While the Stamelos clinic note reflects a January 16, 2001 date, the date of Petitioner's visit was December 19, 2001. PX5. The Arbitrator notes that Petitioner's next appointment was scheduled for, and Petitioner's off work status was effective through, January 16, 2002.

Regarding the mechanism of injury, Petitioner reported that on October 10, 2001 she "was performing a function that she says required her to exert significant downward pressure with both upper extremities onto a metal part. This was done repetitively as the parts came past her on a conveyor belt. The purpose of this function was to snap or fit the metal part onto another piece of equipment. In doing so, she felt the immediate onset of pain in her neck radiating to the left upper extremity." *Id.* Petitioner also reported continuing work with increased symptomatology and numbness and weakness of the left upper extremity. *Id.*

Petitioner testified that she did not recall describing a job to Dr. Skaletsky where she worked on a conveyor belt snapping or fitting metal parts into another piece of equipment, but soon thereafter testified that this is what she did on "[t]hat day that I was hurting. That was the job I was hurting." Tr. pp. 78-79. Petitioner testified that this is the pick and place job. Tr. p. 79.

On examination, Dr. Skaletsky noted that Petitioner was uncomfortable, tilted her head toward the right, and held her left upper extremity flexed at the elbow and close to the body. PX9. Petitioner's neck had limited range of motion particularly in extension and turning to the right as well as tenderness and spasm to palpation of the left cervical, trapezius, and scapular muscles. *Id.* Petitioner's deep tendon reflexes were symmetrical and equal with no Babinski's signs or pathologic reflexes. *Id.* Petitioner's gait and station were normal although she kept her left arm relatively close to her body while walking, her strength was decreased rather diffusely in the left upper extremity which Dr. Skaletsky believed to be secondary to pain rather than true weakness, Petitioner's Romberg test was negative, and there was no sign of atrophy or fasciculation. *Id.* Petitioner's sensory examination was decreased on the outer aspect of the left upper extremity down to the level of the second and third fingers of the left hand. *Id.*

Ultimately, Dr. Skaletsky diagnosed Petitioner with a herniated nucleus pulposus on the left at C6-C7 with left cervical radiculopathy. *Id.* He recommended an anterior C6-C7 discectomy with interbody fusion and opined that Petitioner would reach maximum medical improvement 12 weeks postoperatively. *Id.* Dr. Skaletsky also noted his concern about causal connection. *Id.* Specifically, he noted the discrepancy between Petitioner's report of the mechanism of injury on the date of his examination and an October 15, 2001 note indicating that Petitioner was applying gentle pressure with her thumbs at the time of injury. *Id.* He also noted his review of a line assembly operator job description indicating the need to lift up to 15 pounds, use tweezers, and a hand torque set to 15 pounds. *Id.* Dr. Skaletsky further noted that if Petitioner was performing the latter job there was no causal connection between her injury and the diagnosis, whereas his opinion might change if she was performing a different job with different requirements at the time of injury. *Id.*

Continued Medical Treatment

On February 20, 2002, Dr. Stamelos noted Petitioner's "history of neck and *bilateral shoulder injuries*, work related, on 10/10/01." PX5 (*emphasis added*). However, Petitioner only reported neck and left shoulder, arm and/or hand symptoms during chiropractic care prior to February 20, 2002. *Id.* Petitioner did not report any traumatic injury to or symptomatology in the right shoulder, arm, or hand. *Id.* Petitioner complained of "[pain] in the neck and shoulders [that] continues" at a chiropractic visit on February 25, 2002. *Id.* On cross examination, Petitioner denied complaining only about neck pain and not pain in the hands. Tr. p. 120. Dr. Stamelos diagnosed Petitioner with a cervical strain, whiplash and radiculitis of the cervical spine. PX5. While he notes that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* He ordered continued conservative treatment and kept Petitioner off work. *Id.*

Petitioner sought treatment with Wesley Yapor, M.D. ("Dr. Yapor") on March 5, 2002. PX5; *see also* Tr. p. 89. At that time, she reported "that she was perfectly healthy and fine up until November of 2001." PX5. Petitioner

reported that she was working for Respondent where she "was working pain forth at a rather unusual high effort." *Id.* She further reported that "she began experiencing pain in the left upper extremity shortly thereafter.... [and] pain and increasing discomfort, especially in the index and middle finger of the left upper extremity...." *Id.* Dr. Yapor advised Petitioner that surgery was the most definitive way to treat her left upper extremity, but Petitioner reported that she had just started cervical traction which she wanted to continue and he advised that she should do so and return to him after traction was completed. PX5; *see also* Tr. p. 89. Petitioner testified that she refused the recommended surgery because she was afraid. Tr. pp. 89-90.

On March 20, 2002, Petitioner reported improved "neck pain and bilateral shoulder pain" and "numbness and tingling in the bilateral hands, left hand worse than right." PX5. Dr. Stamelos diagnosed Petitioner with cervical degenerative disk disease and a herniated disk at C5-C6. *Id.* While he notes that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* Dr. Stamelos also noted that "[e]ssentially, there is no change in the patient's condition." *Id.* He ordered continued conservative treatment for "cervical disc herniation with radiculopathy on the left at C6-7" and kept Petitioner off work. *Id.*

On May 20, 2002, Petitioner reported "neck pain, left shoulder pain, left wrist pain and right wrist numbness." PX5. While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination results are identified. PX5. Dr. Stamelos changed Petitioner's diagnoses to chronic pain syndrome, carpel tunnel syndrome, left shoulder pain and cervical spine pain, but again noted that "[e]ssentially, there is no change in the patient's condition." PX5. He ordered continued conservative treatment, noted that "wrist surgery for carpal tunnel release will be considered in the future[,]" and kept Petitioner off work. PX5; *see also* Tr. pp. 36-37, 90 and PX12, pp. 13-14.

On June 12, 2002, Petitioner reported "neck pain, left shoulder pain and bilateral wrist numbness and pain." PX5. While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* Dr. Stamelos changed Petitioner's diagnoses to chronic pain and disability, bilateral wrist numbness, and left shoulder pain, but again noted that "[e]ssentially, there is no change in the patient's condition." *Id.* He ordered continued conservative treatment "secondary to chronic pain[,]" and kept Petitioner off work. *Id.*

On August 7, 2002, Petitioner reported "neck pain." *Id.* While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* Dr. Stamelos changed Petitioner's diagnoses to "[c]ontinued cervical syndrome, chronic pain." *Id.* He again noted that "[e]ssentially, there is no change in the patient's condition." *Id.* He also noted that Petitioner was "awaiting for a return to work versus surgical intervention[, and that Petitioner] states that the medications are not helping her." *Id.* Dr. Stamelos kept Petitioner off work and scheduled a return visit in one week. *Id.*

On August 19, 2002, Petitioner reported "neck pain and numbness to the bilateral hands, right side worse then [sic] the left." *Id.* While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination results are identified, however he now noted that Petitioner's "condition" was improving. *Id.* He diagnosed Petitioner with cervical syndrome, ordered continued conservative treatment. *Id.* The work note, however, reflects that Petitioner's diagnoses are "cervical strain, radiculitis[.]" *Id.* Dr. Stamelos returned Petitioner to light duty work with a 5-pound lifting restriction beginning August 20, 2002. PX5; PX12, pp. 15, 45-46; *see also* Tr. pp. 89, 90-93, 151-153 (Petitioner testified that she was off work through this date per Dr. Stamelos' orders, but later testified that she could not recall if she was paid during this period of time or how long she was off work after Dr. Stamelos placed her off work).

At trial, Petitioner testified that she returned to work for Respondent in a light duty position in inspection for approximately two weeks as prescribed by Dr. Stamelos. Tr. pp. 37-38. The inspection position was easy and, while she used her hands, Petitioner testified that she did not lift or turn anything using her wrists. Tr. pp. 38-39. Then Petitioner testified that she was placed back in the laser and manual tune positions. Tr. pp. 39. At this time, Petitioner testified that she noticed that she got tired easily, her back was killing her, her shoulder was killing her, and her hand was killing her. Tr. pp. 39-40. On cross examination, Petitioner denied that Respondent accommodated her restrictions and testified that after one week she was "put on the line again" in her manual tune position. Tr. pp. 93-95.

On October 2, 2002, Petitioner returned to Dr. Stamelos and reported "bilateral hand pain and numbness, right side worse then [sic] the left[, and…] neck pain." PX5; PX12, p. 49. Petitioner also reported that she was working light duty. PX5. While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* Dr. Stamelos changed Petitioner's diagnoses to "[c]ontinued bilateral hand pain, carpal tunnel syndrome and cervical syndrome." *Id.* The work note, however, reflects that Petitioner's diagnoses are "cervical strain, radiculitis[.]" *Id.* He ordered physical therapy with a chiropractor "on an as needed basis[,]" and increased Petitioner's work restrictions to include sedentary work only and no lifting/pushing over 2 pounds. *Id.* The work note reflects that Petitioner was restricted from lifting/carrying over 5 pounds, pushing or lifting at all, and that she was to "continue" light sedentary work. *Id.* The prior work note, however, does not mention sedentary work. *Id.*

Petitioner did not seek medical treatment again for nine months until July 2, 2003. PX5; PX12, p. 16. On this date, Petitioner reported a work related injury on October 10, 2001 "when she was pushing some fixtures into a box resulting in pain in her neck." PX5. Dr. Stamelos noted Petitioner's visit with Dr. Yapor [presumably from March 5, 2001] "where the cervical syndrome was diagnosed not to mention the carpal tunnels and bilateral hand pain." *Id.* He also noted that Petitioner continued to have pain but was avoiding surgery or invasive treatment hoping that it would get better spontaneously, and that she continued to see Dr. Sotos [from his clinic] for noninvasive chiropractic care. *Id.* At his deposition, Dr. Stamelos testified that Petitioner had not yet had surgery and she wanted to continue with therapy and chiropractic treatment. PX12, p. 17.

Regarding her symptoms, Petitioner reported that she "still has neck pain, low-back pain and bilateral wrist pain and numbness." PX5. Dr. Stamelos does not identify any objective examination at the time of this visit. *Id.* Dr. Stamelos noted that Petitioner had been diagnosed with cervical syndrome, herniated discs in the neck, and chronic pain, but she had not responded well to conservative management. *Id.* He further noted that Petitioner would begin treatment at the clinic on a regular basis and that she was "going to probably end up having a carpel tunnel release as a starter since she is not improving all of this time." *Id.* He determined that Petitioner's large C6-C7 herniated disc of the left was causing radicular symptoms and her feeling of ill being. *Id.* He ordered continued restricted duty work and for her to return to the clinic "prn." *Id.* No objective examination findings were noted at the time of this visit. *Id.*

Petitioner did not seek medical treatment again for another eight months until February 25, 2004. PX5; PX12, pp. 17-18. On this date, Dr. Stamelos authored a narrative letter at Petitioner's request noting that she was "presently working in a light duty capacity" and that her restrictions were permanent. PX5; PX12 pp. 50-51. At his deposition, Dr. Stamelos testified that he "would just rather write it and get her off my back than argue with her." PX12, pp. 50-51. In his report, Dr. Stamelos stated that Petitioner was injured at work on October 10, 2001 "secondary to pushing a lot of weight resulting in a strain and injury to her cervical spine and shoulder. This resulted in severe neck pain, left shoulder pain, and left arm pain." PX5; *see also* PX12, pp. 17-18. He opined that Petitioner sustained a permanent injury in the neck and upper girdle that "necessitate either surgical indications at C5-C6 and C6-C7 or for her to modify her workload to accommodate the condition." PX5; *see*

also Tr. pp. 36-37. He noted that Petitioner had "opted for a modification of her work style and to work within her limitations." PX5. He recommended an evaluation and permanent work restrictions along with a permanent position that would accommodate herniated discs in her neck and left radiculopathy. *Id.*

At his deposition, Dr. Stamelos testified that he did not refer to Petitioner's carpal tunnel syndrome because he had to address Petitioner's neck first, which was the "central problem." PX12, pp. 52-53. He further testified that Petitioner injured herself secondary to pushing a lot of weight. PX12, p. 51. Dr. Stamelos qualified his response about the mechanism of Petitioner's injury by stating "[w]ell, that's what she said in Greek, maybe I misinterpreted. What she meant was repetitive motion. There is no Greek word for repetitive motion. Pushing a lot of weight or doing a lot of work, work with her hands of course." PX12, p. 51. He added, "I think there is weight involved, but I think she meant just an awful lot of work went through her hands, that would be a good way to describe it. [.... And, there] was lifting in her job. She said she had to lift some boxes after she filled them, but she said most of her work was doing repetitive motion. And somebody, I think, I don't remember, somebody I think it was this doctor who saw her, said she did like 3,000 maneuvers a day or something[, which was Petitioner's estimate to that doctor and probably to him as well.]" PX12, pp. 51-52.

On March 31, 2004, Petitioner returned reporting ongoing neck pain that was worse over the posterior aspect. PX5. Petitioner did not report pain in either arm or hand. PX5. Dr. Stamelos noted that Petitioner had a repetitive usage injury from Motorola that had been contested and that "[f]or some reason, they do not want her to have the surgery." *Id.* He ordered medications, injections therapy, diagnosed her with cervical syndrome related to her injury on October 10, 2001, and instructed her to return on an as needed basis. *Id.* No objective examination findings were noted at the time of this visit other than Dr. Stamelos' handwritten diagnosis of "cervical syndrome." *Id.*

Approximately three months later, on June 30, 2004, Petitioner returned to Dr. Stamelos. *Id.* He noted that she had carpal tunnel syndrome and needed surgery, low back pain, and cervical spine syndrome due to herniated discs at C5-C7 "all from an injury on October 10, 2001 at Motorola." *Id.* No objective examination findings were noted at the time of this visit other than Dr. Stamelos' handwritten diagnoses of "LBP/C-spine/HND [illegible]." *Id.*

September 23, 2004 Accident & Continued Medical Treatment

Petitioner testified that she was lifting boxes on September 23, 2004 and hurt herself and felt a sharp pain, again. Tr. p. 41. She returned to Dr. Stamelos on September 27, 2004 who placed her off work. Tr. pp. 41-42, 119-120. Petitioner testified that she did not receive workers' compensation benefits or temporary total disability benefits from September 24, 2004 through February 27, 2007. Tr. pp. 42-43.

Dr. Stamelos' records contain two different progress notes dated September 27, 2004. PX5. The first such note reflects Dr. Stamelos' notation that Petitioner returned after sustaining "a repetitive motion injury while working in the assembly line and pushing fixtures." *Id.* He noted that Petitioner developed radiculopathy which turned out to be herniated discs at C5-C6 and C6-C7, and despite conservative treatment, Petitioner's condition had worsened. *Id.* He ordered a physical therapy and surgical evaluation for the cervical spine by Dr. Alburno and further diagnostic testing, prescribed pain medication including Vicodin, ordered physical therapy, and placed Petitioner off work until further notice "[d]ue to excessive pain[.]" *Id.* No objective examination findings were noted at the time of this visit other than Dr. Stamelos' handwritten diagnoses of "cervical syndrome/HND C5 C6 C6 C7[.]" *Id.* Petitioner testified that on cross examination that she did not recall being referred by Dr. Stamelos to Dr. Alburno or being treated by him. Tr. p. 120. Dr. Stamelos' assessment was that Petitioner had

cervical syndrome with herniations from C5-C7 and radiation to the left from the shoulder down to the mid-upper arm. PX5. He noted that conservative management had failed. *Id.*

The second note dated September 27, 2004 reflects Dr. Stamelos' notation that Petitioner returned after an injury at work on September 23, 2004 with "quite significant" pain complaints of neck stiffness, pain, and radiculopathy "that has occurred since the time of the injury while working at Motorola. The radiculopathy and the pain were so severe that she had to get an emergency appointment to see me where I will try to treat her for these new symptoms that she has developed." *Id.* Dr. Stamelos noted that Petitioner had "some kind of history of neck problems in the past[, however], she has had no symptoms for a long time, and it seems to be a new occurrence based on the patient's history and the patient's presentation." *Id.*

On October 13, 2004, Petitioner returned to Dr. Stamelos and reported considering discoplasty with Dr. Alburno. *Id.* While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination[3] results are identified other than Dr. Stamelos' handwritten diagnosis of "cervical syndrome considering discoplasty [with] Dr. Alburno." *Id.* Dr. Stamelos diagnosed Petitioner with cervical syndrome, ordered a continuation of the "current course of management," and instructed Petitioner to return as needed. *Id.*

At his deposition, Dr. Stamelos testified on cross examination that Petitioner had no hand complaints on September 27, 2004 through November 17, 2004. PX12, pp. 54-55. He further testified that he did not treat Petitioner for carpal tunnel syndrome from the second half of 2004 through 2007, but he qualified his response by stating that he treated Petitioner for the more important cervical injury. PX12, pp. 55-56.

October 14, 2004 Incident Report

An Occupational Health Resources Injury and Illness Incident Report ("incident report") completed by Petitioner on October 14, 2004 reflects that when she returned to work after her 2001 injury she worked on the laser machines. Tr. pp. 116-119; PX3; RX3. Petitioner reported that after she returned to work from her 2001 injury she was placed to work on 4 laser machines despite having restrictions. PX3. The Arbitrator notes that the incident report originally reflected three laser machines but that was written over with the number four. *Id.* Petitioner further stated that she complained to Frank as of April 1, 2004 that he needed to move her. *Id.* According to the incident report, Frank asked Petitioner for other paperwork which she provided from her Dr. and he moved her, "but the damage was done and I was visiting the nurses offices for [illegible] often and he was complaining because I was going to the nurse for [illegible] something to relieve my pain so on Sept 23 I visit the office and told them I was going to the doctor after the nurses (Marylyn [illegible]) advised to visit my doctor[.]" *Id.*

On re-direct examination Petitioner testified that she completed the incident report after she was injured the second time noting that Frank, her supervisor, had given her regular work which was contrary to her doctor's restrictions. Tr. pp. 142-143. On re-cross examination, Petitioner testified that Frank put her back to her original position in manual tune. Tr. pp. 156-157.

The incident report reflects that the body parts affected included only the upper back and left arm. Tr. pp. 116-119; PX3; RX3. Petitioner testified that she gave this report to the nurse. Tr. p. 156. Upon questioning as to

[3] The Arbitrator notes that Dr. Stamelos' records contain a note from October reflecting that Petitioner was diagnosed with cervical disc herniation and that an examination was performed, however the day and year of the exam is unidentifiable and the signature appears to be by someone with the first name initial "K," which the Arbitrator infers is not Dr. Stamelos. PX5.

the exclusion of any reference in the incident report of injury of her hands, Petitioner testified that her English was not very good. Tr. pp. 118-119.

Continued Medical Treatment

Petitioner underwent another cervical spine MRI on October 6, 2004 as indicated by a history of "pain." PX5. On October 27, 2004, Petitioner began physical therapy at the Stamelos clinic for her neck pain. *Id.*

On November 17, 2004, Petitioner returned with a "cervical problem" including effacement and the disc herniation at C5-C6 with spurring resulting in cord compression and chronic cervical radiculopathy and cervical syndrome." *Id.* Dr. Stamelos noted that Petitioner was still considering discoplasty and that she was awaiting approval for the surgery. *Id.* Petitioner was to return to him as needed. *Id.*

Approximately four months later, on March 23, 2005, Petitioner returned to Dr. Stamelos and reported that she was not working. *Id.* Dr. Stamelos noted that Petitioner had cervical syndrome and a herniated nucleus pulposus. *Id.* While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* He ordered that Petitioner continue "with the current course of management" and scheduled a follow up in four weeks. *Id.*

On June 15, 2005, Petitioner returned to Dr. Stamelos, who noted that Petitioner suffered from cervical spine syndrome and that she needed physical therapy, which was being denied. *Id.* He also noted that Petitioner had low back pain, and that Petitioner could not work at that time. *Id.*

On September 26, 2005, Dr. Stamelos noted that Petitioner had cervical spine syndrome and that she needed nucleoplasty surgery. *Id.* While Dr. Stamelos noted that he evaluated Petitioner in the office, no objective examination results are identified. *Id.* He referred Petitioner to Dr. Elborno for an evaluation and to schedule surgery at which he wanted to be present. *Id.* No objective examination findings were noted at the time of this visit. *Id.*

Second Section 12 Examination – Dr. Levin

On October 10, 2005, Petitioner underwent a second section 12 evaluation of the neck with Mark Levin, M.D. ("Dr. Levin"). Tr. pp. 120-121; RX10. Dr. Levin examined Petitioner and took a history from her, reviewed various treating medical records, and rendered opinions regarding Petitioner's cervical spine. RX10.

Petitioner gave Dr. Levin a history of her condition. *Id.* She reported working as a full-time cell phone assembler for Respondent for 27 years. *Id.* In 2001, she reported that she was lifting 50 lbs. every twenty minutes and began having neck pain. *Id.* Petitioner treated with Dr. Stamelos, underwent therapy and injections, and that it was recommended that she undergo a cervical fusion, but she was scared and did not undergo the surgery. *Id.* She also reported a temporary improvement while being off work for 6-7 months. *Id.* Petitioner opted to undergo continued therapy and pain management and she worked light duty until April of 2004 when she was returned to full duty work. *Id.* Again, Petitioner reported that in her full duty position she had to lift up to 50 pounds, but she did not specify how often she did so. *Id.* She also reported that after two months of full duty work she started having increased neck pain, saw the company nurse, and underwent some occupational therapy. *Id.* "By September 23, 2004 her neck pain gradually increased and she started getting numbness and tingling down her fingers, more on the left than the right." *Id.* Petitioner was placed off work and underwent some trigger point injections with Dr. Stamelos, who referred her to another doctor for surgery,

which she reported she was then ready to accept. *Id.* Finally, Petitioner reported developing pressure headaches. *Id.*

At the time of her examination, Petitioner complained of neck pain at a level of 7-8/10 with a sharp, constant burning sensation. *Id.* Petitioner reported pain greater on the left then on the right with pain radiating down her arms and "she feels like she drops items." *Id.* Petitioner reported headaches with weather changes, worsening neck pain when turning her neck to the right, minimal driving, and feeling "like she has lost the ability to move her arms behind her back." *Id.*

On examination of the neck, Petitioner complained of tenderness to palpation over the left cervical paraspinal muscles going into the left trapezius, no pain over the right cervical paraspinal muscles or the right trapezius, and pain over the medial border of the left scapula with slight tenderness over the medial border of the right scapula. *Id.* Petitioner had some slight discomfort to palpation over the thoracic spine us processes. *Id.* She was able to forward flex and touch her chin to within 1 inch of her chest and extend back to neutral. *Id.* Her right deviation was 45° and left deviation was 70°. *Id.* On examination of the upper extremities, Petitioner had tenderness over the right and left AC joint and left AC joint and diffuse discomfort over the entire left clavicle and to palpation of the left arm. *Id.* Petitioner's active range of motion in the shoulders was 170° bilaterally on forward flexion, 170° on right abduction, 160° on left abduction, internal rotation on the right to T5 and on the left to T10. *Id.* Petitioner's external rotation was 90° bilaterally and rotator cuff strength was 5/5 bilaterally. *Id.*

Dr. Levin diagnosed Petitioner with cervical spondylosis with secondary neck discomfort and loss of range of motion. *Id.* He noted that Petitioner did not give any one alleged work injury that was causing her discomfort but stated that this gradually became worse on September 23, 2004 causing her to be off work. *Id.* Dr. Levin noted that he did not have Petitioner's actual job description at the time of his report and that he had not reviewed actual films of certain diagnostic studies. *Id.*

Ultimately, Dr. Levin opined that Petitioner had no specific accident occurring on September 23, 2004 and noted that Petitioner described that it was increased work activities beginning in April of 2004 that made her symptoms worse. *Id.* Dr. Levin disagreed with the recommended discoplasty from pain management. *Id.* He noted that the procedure was not the standard of care currently used in orthopedics and that he would not recommend the procedure for Petitioner. *Id.*

Continued Medical Treatment

On November 30, 2005, Petitioner returned to Dr. Stamelos. PX5. At this visit, Dr. Stamelos noted that Petitioner "was inappropriate" at her last visit and that she needed a psychiatric referral to treat her for depression. *Id.* The Arbitrator notes that no such inappropriate behavior was noted in Dr. Stamelos' September 26, 2005 progress note. *Id.* Dr. Stamelos also referred to Petitioner's October 10, 2001 injury and Petitioner's reluctance to have surgery which she now wanted to undergo but had no financial means by which to do so. *Id.* He further noted that Petitioner had recently been evaluated by Dr. Mark Levin of Barrington Orthopedics who felt that she needed her workup and possibly surgery. *Id.* Petitioner reported being in pain and requested injection therapy, which he noted was indicative of a lot of pain because Petitioner was needle phobic. *Id.* The Arbitrator notes that no such phobia was mentioned on November 14, 2001 when Dr. Stamelos first provided injection therapy to Petitioner, or at any time thereafter until this date. *Id.* Dr. Stamelos diagnosed Petitioner with cervical disc syndrome and left radiculopathy with her hand being very weak and painful. *Id.* No objective examination findings were noted at the time of this visit. *Id.*

On July 31, 2006, Petitioner testified that she came under the care of Dr. Bauer as approved by Respondent. Tr. pp. 43-44, 121. Petitioner lists her occupation as laser operator in the new patient information form of the same date. PX6.

Petitioner saw Jerry Bauer, M.D. ("Dr. Bauer") and reported that she was a former machine operator for Respondent with recurrent lifting of 15 pounds. PX6. Dr. Bauer noted Petitioner's history that in 2001 "she was lifting boxes with heavy plates inside and she injured her left arm." *Id.* Petitioner reported problems in her left shoulder, radicular pain and numbness in her left arm, headaches, neck pain, and persistence of symptoms such that she had not worked since 2004. *Id.* Dr. Bauer also noted Petitioner's report of "left sided neck pain with radicular pain radiating down her left arm, hand and fingers with a burning sensation. Driving results in some numbness in her hands and she has to switch hands. Her hands also tend to fall asleep at night." *Id.*

On examination, Dr. Bauer noted that Petitioner had limited range of motion in the neck, tenderness along the left trapezius muscle, and a slightly reduced left triceps reflex and mild weakness of her finger extensors on the left. *Id.* Petitioner had reasonably good strength in both her arms and legs, positive bilateral Tinel's and Phalen's signs, and a positive Hoffman's and Trömner's sign on the right only. *Id.* Dr. Bauer's impression was that Petitioner had a "long history of persistent radicular pain in her left arm. She probably also has carpal tunnel syndrome." *Id.* He recommended repeat MRI of the cervical spine and a repeat EMG study to assess the degree of her radiculopathy and carpal tunnel syndrome. PX6; *see also* Tr. pp. 44-45. He also recommended cervical spine x-rays and a CT scan. PX6.

Petitioner underwent an MRI on August 31, 2006, which showed a small left foraminal disc herniation at the C6-C7 level that would be expected to result in a left C7 radiculopathy and very small midline disc herniations at the C3-C4 and C5-C6 levels. *Id.* A September 18, 2006 MRI showed mild degenerative changes of the lower cervical spine, but was otherwise unremarkable. *Id.*

Petitioner underwent a repeat EMG/NCV on September 8, 2006 that showed very severe right carpal tunnel syndrome on the right and mild left carpal tunnel syndrome. *Id.*

On September 20 and 21, 2006, Petitioner sought treatment with Dr. Bauer. *Id.* Dr. Bauer noted Petitioner's cervical MRI which revealed a small central disc herniation at C5-C6, and a herniated disc on the left at C7[4]. *Id.* Dr. Bauer noted that Petitioner's herniated disc on the left would account for her radiating left arm pain. *Id.* He further noted that Petitioner's EMG revealed bilateral carpal tunnel worse on the right than on the left and that Petitioner was symptomatic from the carpal tunnel syndrome. *Id.* Petitioner wanted to undergo carpal tunnel surgery first and Dr. Bauer referred Petitioner to Dr. Craig Williams. *Id*; *see also* Tr. pp. 121-122.

On October 5, 2006, Dr. Bauer noted that Petitioner called and indicated that she wanted to have her carpal tunnel surgery prior to having neck surgery. PX6. On cross examination, Petitioner denied telling Dr. Williams that she wanted surgery on her hands. Tr. pp. 121-122. She further testified that she did not see Dr. Williams until approximately 2 years later in May of 2008. Tr. p. 122.

[4] The Arbitrator notes that the interpreting radiologist noted that Petitioner also had a small central disc herniation at C3-C4 and that the herniated disc on the left was at C6-C7. PX5.

Third Section 12 Examination & Dr. Fernandez Deposition

On October 17, 2006, Petitioner underwent a third section 12 evaluation by John Fernandez, M.D. ("Dr. Fernandez"). Tr. p. 123; RX8. Dr. Fernandez submitted to a deposition on July 30, 2010. RX7. He is a board-certified surgeon in orthopedics, microsurgery, and hand surgery. *Id*, pp. 5-6.

Dr. Fernandez examined Petitioner and took a history from her. RX8; RX7, pp. 8-12. He did not examine Petitioner's neck or cervical spine. RX7, p. 25. Dr. Fernandez also reviewed certain treating medical records and diagnostic tests, a video depicting the activities of the FQA, pick and place, and laser trim positions, a job analysis entitled physical demand documentation. RX8; RX7, pp. 13-16; *see also* PX2. He rendered opinions regarding Petitioner's carpal tunnel syndrome. *Id.*

On cross examination, Dr. Fernandez testified that Petitioner's description of her job duties correlated with his review of the job video and physical demand analysis and that the accuracy of any job description given to him regardless of the source is important in forming his opinions. RX7, pp. 25-27. He further testified that the simple use of a vibratory air tool would not subject a person to developing carpal tunnel alone; it would depend on the type of tool and the force associated with the use of the tool. RX7, pp. 27-28. Additionally, Dr. Fernandez testified on cross examination that if Petitioner was hypothetically "exposed to heavy gripping, grasping, using tools on a repetitive basis, certain types of vibratory tools as you pointed out, of course those could be contributory factors considered causal to the carpal tunnel syndrome." RX7, pp. 28-29.

At the time of her examination, Petitioner reported that she began to notice discomfort in her hands in 2002. RX8; RX7, p. 8. She also reported neck and shoulder pain, but that her "major" complaints involved numbness and tingling primarily affecting the median nerve distribution right much greater than left. RX8 (quotations in original); RX7, pp. 8-9. The symptoms worsened at night and with activities including driving, and Petitioner reported that her pain and symptoms were at a level of 10/10. RX8; RX7, pp. 8-9. Dr. Fernandez noted that Petitioner was tearful during portions of her examination while speaking about her symptoms and that she did not seem to exhibit symptoms magnification or pain beyond her objective findings. RX8; RX7, p. 12. Petitioner did not report any elbow complaints. RX7, p. 10.

Dr. Fernandez testified that Petitioner related her complaints to her work activities and stated that her 2001 injury occurred at work and she was using her hand tuning tools all day long. *Id.*

Dr. Fernandez diagnosed Petitioner with bilateral wrist carpal tunnel syndrome, right greater than left. RX8. He opined that there was no causal relationship between her work and the development of her carpal tunnel syndrome even though she did the work for 27 years. RX8; RX7, pp. 16-17. He noted that Petitioner's tasks were repetitious, but they were also relatively varied with reference to what she did. RX8. Additionally, he noted that none of the activities involved significant gripping or grasping with significant force, the use of heavy tools, or significant hyperextension or hyper flexion for prolonged periods of time. *Id.* Dr. Fernandez further noted that carpal tunnel syndrome is a multifactorial disorder most commonly seen in females in Petitioner's age group, and that there was an additional risk from Petitioner's increased body mass index/weight. RX8; RX7, pp. 18, 20-21, 35. Finally, Dr. Fernandez noted that there was no doubt that Petitioner's symptoms may increase or worsen with exposure to any activities, including work activities, but that did not warrant a finding of causal relationship or aggravation effect from her work activities. RX8. He opined that Petitioner could work full duty without restriction, that she could keyboard and perform data entry, and that she was at maximum medical improvement unless she decided to proceed with further treatment. *Id.*

At his deposition, Dr. Fernandez testified that carpal tunnel syndrome was caused by excessive pressure on the nerve at the wrist which could be caused by many things including direct trauma although the vast majority of cases were idiopathic "meeting that there is no known single cause. It is multifactorial...." RX7, pp. 17-18. Certain job activities could aggravate or contribute to carpal tunnel syndrome including significantly repetitive activities requiring heavy forceful gripping and hyperflexion or hyperextension. RX7, pp. 18-19. In Petitioner's case, Dr. Fernandez testified that while Petitioner related her symptoms to her job activities because she would get symptoms with job activities the symptoms were a manifestation of her [pre-existing] condition. RX7, pp. 19-20. Dr. Fernandez also testified that there has never really been a proven association between repetitive activities such as keyboarding or data entry without associated force. RX7, pp. 19, 21. On cross examination, Dr. Fernandez testified that a person's genetic predisposition to developing carpal tunnel syndrome coupled with exposure to job activities that everyone agreed could cause carpal tunnel syndrome was insufficient to relate a carpal tunnel diagnosis with the job. RX7, pp. 30-31.

Regarding other factors unrelated to work activities, Dr. Fernandez testified that while carpal tunnel syndrome could progress on its own over time, if Petitioner's job was causing or contributing to her carpal tunnel syndrome then he would expect that Petitioner symptoms would have improved and not worsened while she was off work. RX7, pp. 21-23. On cross examination, Dr. Fernandez acknowledged that carpal tunnel syndrome could progress or deteriorate with or without work activities. RX7, pp. 24-25.

Continued Medical Treatment

On October 29, 2006, Petitioner returned to Dr. Stamelos who noted in a narrative letter that she was a patient "who experienced significant injury to both her wrists and to her cervical spine because of the strenuous work she was involved in working for Motorola." PX5. He noted that it was "well known that her job requires her to be repetitively lifting and grabbing that would be the job description of items in mechanical objects that Motorola builds[,]" that Petitioner was a long time employee of Respondent's and that she had been in good health until recently. *Id.* He also noted that "[d]uring the period of 10/10/01 to 09/23/04, she worked with pain and in September 2004, she was taken off work by me with a letter of medical necessity." *Id.*

Dr. Stamelos opined that Petitioner had known herniations of the cervical spine that were "aggravated by repetitive lifting bending and twisting[,]" that she undoubtedly needed future treatment and surgery, and that while Petitioner was "very appropriate" and her condition was "very subtle" it was also "very serious" because it would ultimately lead to problems in turning her neck and functioning. *Id.* In conclusion, Dr. Stamelos noted that he would "try to become familiar with the case and the terminology and be more than happy to assist [Petitioner's counsel] with deposition because of complexities and difficulties in this type of case, which I believe is a work related repetitive motion injury." *Id.*

On November 9, 2006, Petitioner was cleared for surgery by her insurance company and indicated to Dr. Bauer her wish to proceed with surgery. PX6.

On December 15, 2006, Petitioner returned to Dr. Bauer but was unable to proceed with surgery due to antibiotic treatment for a tooth and gum infection. *Id.* Dr. Bauer noted that Petitioner had persistent burning in pain in the left arm which had been refractory to conservative therapy for a long period of time. *Id.* He also noted that Petitioner had paresthesias in her hand which was related in part to her cervical herniated disc as well as her carpal tunnel syndrome. *Id.*

On February 27, 2007, Petitioner underwent surgery with Dr. Bauer at Advocate Lutheran General Hospital for cervical radiculopathy. PX7; PX6; *see also* Tr. pp. 44-45, 123. Specifically, Petitioner underwent an anterior

cervical discectomy at C5-C6 and C6-C7 with microscope assisted visualization and an anterior cervical interbody fusion at C5-C6 and C6-C7 with placement of hardware including a plate and screws. PX7.

Petitioner testified that she remained under the care of Dr. Bauer after the surgery and began receiving temporary total disability benefits. Tr. p. 46.

The medical records reflect Petitioner saw Dr. Bauer postoperatively. PX6. On February 27 and March 7, 2007, Petitioner underwent x-rays that showed good alignment of the cervical spine and hardware. *Id.* Petitioner also returned to Dr. Bauer postoperatively on April 11, 2007, at which time her x-rays continued to show good alignment. *Id.* He ordered physical therapy for the neck and placed Petitioner off work. *Id.*

On May 9, 2007, Petitioner saw Dr. Stamelos who diagnosed her with depression, referred her to a psychiatrist, and noted that she should return on an as needed basis. PX5.

Petitioner began postoperative physical therapy on May 16, 2007 at Athletico. *Id.*

On May 23, 2007, Petitioner returned to Dr. Bauer, underwent x-rays, and reported residual pain in the left arm which was much improved. PX6. He noted that Petitioner had a normal neurological exam, her wound looked fine, her bone graft, plate, and screws were all in good position, that she had good strength, sensation, and reflexes, and that she reported improved pain as compared to pre-surgical pain. *Id.* He ordered continued physical therapy, prescribed medication, ordered wrist splints, and scheduled a return visit in two months with a repeat x-ray at that time. *Id.*

On July 11, 2007, Dr. Bauer noted that Petitioner's x-rays revealed good positioning of the bone graft, plate, and screws. *Id.* On examination, he noted that Petitioner's wound looked fine, deep tendon reflexes were symmetrical, and that she still had some dysesthesias [pathology] in her left arm. *Id.* Petitioner reported that her neck pain worsened while she was in physical therapy and that she was unhappy with her physical therapy site, therefore she was switched to another one. *Id.* Dr. Bauer kept Petitioner off work in her former position, which he noted was not then available, and scheduled a follow up with x-rays in three months. *Id.*

Petitioner testified that she went to Greece at the end of July of 2007 through August until she returned the first week of September of 2007. Tr. pp. 47, 51. She testified that the purpose of her visit was to see her mother who was sick and to bring her back to the United States. Tr. pp. 47-49; *see also* PX6 (10/31/2007 Dr. Bauer note). Petitioner testified that she did not receive approximately eight weeks of temporary total disability benefits and that her benefits resumed at some point. Tr. pp. 49-53.

On October 31, 2007, Petitioner reported some stiffness down the back of her neck and occasional discomfort in the left arm. PX6. On examination, Dr. Bauer noted that Petitioner's wound looked fine, her deep tendon reflexes and sensation were intact, and she still had some paresthesias in her hands with a positive Tinel's sign which he believed were related to bilateral carpal tunnel syndrome. *Id.* Petitioner testified that Dr. Bauer discharged her from his care and referred her to Dr. Williams. Tr. pp. 54, 124. Indeed, regarding her neck, Dr. Bauer noted that Petitioner reached maximum medical improvement. PX6. He also referred Petitioner to Dr. Williams for carpal tunnel surgery evaluation. PX6; *see also* Tr. p. 54.

In response to correspondence from Petitioner's counsel, Dr. Bauer rendered a report dated November 14, 2007 stating that regardless of whether Petitioner attended her physical therapy she was not able to return to work in August 2007. PX6. In a separate note also dated November 14, 2007, Dr. Bauer noted his placement of Petitioner at maximum medical improvement and stated that if the insurance company wanted specific

restrictions regarding a return to work then Petitioner would need to undergo a functional capacity evaluation. *Id.*

On November 21, 2007, Dr. Bauer referred Petitioner for a functional capacity evaluation. Tr. p. 123.

On December 5, 2007, Petitioner underwent the recommended functional capacity evaluation ("FCE"). Tr. p. 124; PX5; PX6. Petitioner appeared 45 minutes late and reported that she had a work related injury to her neck on September 23, 2004, but "**refused to give the therapist any additional history.**" PX6 (**emphasis in original**). The FCE was invalid due to submaximal effort. *Id.* Petitioner failed 20 of 23 objective validity criteria and the results of the FCE did "not represent a true and accurate representation of [Petitioner's] overall physical capabilities and tolerances at this time." *Id.* The FCE evaluator found that Petitioner was capable of functioning at a higher category of work than the minimal level of sedentary work, which was indicative of 2-hand occasional lift/carry of four pounds from floor-to-waist level, exhibited as a result of the invalid test. *Id.* Petitioner was listed as employable. *Id.*

Psychiatric Treatment

On May 22, 2007[5], Petitioner saw Dale John Giolas, M.D. ("Dr. Giolas"), a psychiatrist, for an initial evaluation based on Dr. Stamelos' referral. PX5. At that time, he noted Petitioner's symptomatology in response to various stressors including "surgical, pain, unemployment" resulting from a work injury and he diagnosed Petitioner with major depressive disorder, single episode, severe without psychotic features. *Id.* Petitioner returned on July 5, 2007[6] and Dr. Giolas maintained his prior diagnosis. *Id.* He recommended a follow up in two months presumably after Petitioner returned from seeing "M" in Greece. *Id.* Petitioner returned to Dr. Giolas on October 4, 2007 and February 6, 2008. *Id.* At the latter visit, Petitioner reported more depression and was "tearful as she is dealing with mother dying of pancreatic Ca at home." *Id.*

Continued Medical Treatment & SSD Benefits

Petitioner testified that she applied for Social Security disability benefits on November 14, 2006 and was eventually approved on September 4, 2008. Tr. pp. 69-70; *see also* PX5 (2/4/08 Stamelos note).

On January 14, 2008, Dr. Bauer noted his review of Petitioner's FCE that was "inconclusive" and stated that he would, thus, be unable to provide reasonable activity level recommendations and possible restrictions for Petitioner. PX6.

On February 4, 2008, Petitioner returned to Dr. Stamelos who noted that she was status post fusion with residual problems, had chronic pain, carpal tunnel syndrome, depression, and residual radiculopathy, and was trying for disability. PX5. No objective examination findings were noted at the time of this visit. *Id.*

She returned three days later on February 7, 2008. *Id.* Dr. Stamelos reiterated that Petitioner was status post cervical fusion and discectomy, that she had been diagnosed with carpal tunnel syndrome and depression, and that she had residual radiculopathy and pain from her cervical spine with chronic pain. *Id.* He opined that Petitioner was "fully disabled for any kind of work since we have the implications of injury, surgery, and some shortcomings." *Id.* He noted Petitioner's age of 53, slight obesity, and difficulty using upper extremities, and

[5] There are two different notes dated May 22, 2007, one of which appears to be incomplete. PX5.
[6] There are two different notes dated July 5, 2007, one of which appears to be incomplete. PX5.

essentially opined that she was fully disabled requiring SSI disability benefits. *Id.* No objective examination findings were noted at the time of this visit. *Id.*

Petitioner was scheduled to see Dr. Bauer again on February 27, 2008, but she did not attend the appointment. PX6. Then, on March 18, 2008, Dr. Bauer responded to correspondence from Petitioner's counsel and advised that he was unable to provide any medical update since he had not seen Petitioner in over four months. *Id.*

Fourth Section 12 Examination

On March 24, 2008, Petitioner saw Dr. Levin a second time at Respondent's request. *See also* Tr. p. 124; RX10. Dr. Levin re-examined Petitioner and took a history from her, reviewed various treating medical records, and rendered opinions regarding Petitioner's cervical spine. RX10. At the time of her examination, Petitioner reported being unemployed since her termination by Respondent in September of 2006, undergoing physical therapy after her surgery through October of 2007, and some continued burning in the left arm and forearm which was constant but varied. *Id.*

On examination, Petitioner was able to forward flex to touch her chin to within 3 inches of her chest and extent back 10°, she had right deviation to 25° and left deviation to 30°, she was tender to palpation over the medial border of the left scapula with minimal tenderness over the right medial border of the scapula, and she had no cervical or thoracic spasm. *Id.* Petitioner's upper extremities revealed no pain to palpation over the AC or SC joints, active shoulder range of motion on forward flexion to 170° on the right and to 90° on the left, passive range of motion to 110° with pain, and abduction on the right to 140° and on the left to 90° with pain. *Id.* Internal rotation on the right was to L1 and to the lumbosacral junction on the left, external rotation was 90° bilaterally, and rotator cuff strength was 5/5 on the right and 5-/5 on the left. *Id.* Petitioner had a negative impingement sign on the right and positive impingement sign on the left which she reported was present for the prior three months. *Id.* She also had a positive Tinel's sign on the left and a negative Tinel sign on the right with normal wrist motion bilaterally. *Id.* Biceps reflexes were normal bilaterally and Petitioner had a negative Phalen's sign. *Id.* Pinprick sensation was decreased over the left arm but otherwise normal. *Id.*

Dr. Levin diagnosed Petitioner as being status post cervical discectomy and fusion at C5/6 and C6/7, and found that she was at maximum medical improvement. *Id.* He also noted that Petitioner had a new onset of some change in her shoulder range of motion which did not appear to be related to her work activities dating back to September of 2004. *Id.* Regarding her ability to work, Dr. Levin noted that Petitioner's functional capacity evaluation was invalid and that Petitioner was capable of doing more than sedentary work, however, based strictly on Petitioner's physical examination, he would restrict Petitioner from work above shoulder level due to the new onset of decreased shoulder range of motion and pain. *Id.*

Continued Medical Treatment

On April 16, 2008, Dr. Stamelos noted that Petitioner was status post cervical fusion, she had disc disease, depression, pain, and carpal tunnel syndrome although [surgery for] that had not yet been approved. PX5. He also stated that she had a "double crush injury," that she worked for Zenith Assembly with repetitive usage of her hand, and that she wanted to have surgery as soon as possible with workers' compensation insurance approval or through alternative insurance. *Id.*

At his deposition, Dr. Stamelos testified on cross examination that Petitioner's carpal tunnel syndrome was related to Petitioner's first accident despite the fact that she had not been treated for it for four years. PX12, p. 57. He testified that the fact that Petitioner had been off work for four years after September of 2004 did not

affect her carpal tunnel syndrome because it never goes away. PX12, pp. 57-58. He also testified that although Petitioner's carpal tunnel syndrome worsened while she was not working, that was due to the normal aging process and Petitioner's hormonal changes. PX12, pp. 57-58. Dr. Stamelos further testified this is why he believed Petitioner wanted "to have it fixed now, but [she didn't] want to pay for it, [she wanted] to get some compensation or something." PX12, p. 58.

Dr. Stamelos referred Petitioner to John Sarantopoulos, D.O. ("Dr. Sarantopoulos") for evaluation of a physical therapy rehabilitation potential status post fusion. PX5; PX8. No objective examination findings were noted at the time of this visit. PX5.

Dr. Williams – Second Opinion and Deposition[7]

On May 7, 2008, Petitioner saw Craig Williams, M.D. ("Dr. Williams") one time per Dr. Bauer's referral for complaints of bilateral hand numbness, worse on the right, tingling and left elbow pain. PX6; PX9; PX13. Petitioner reported being more symptomatic on the right side, experiencing constant numbness bilaterally, worse on the right, and burning dorsal forearm pain on the left. PX9; PX13, pp. 6-10. Among other examination findings, Dr. Williams noted normal bilateral wrist range of motion, tenderness over the left lateral epicondyle and radial tunnel, pain with resisted wrist extension that reproduced forearm burning and pain, and positive Tinel's, Phalen's, and Durkan signs bilaterally. *Id.* At his deposition, Dr. Williams testified that he did not see any evidence of thenar muscle wasting on either side and that if Petitioner told him when her elbow symptoms started, he did not record that in his records. PX13, pp. 9, 44. Dr. Williams' impression was that Petitioner had bilateral carpal tunnel syndrome and evidence of left lateral epicondylitis. PX9; PX13, p. 11. He recommended surgical intervention for the carpal tunnel syndrome and beginning with conservative treatment for the lateral epicondylitis. *Id.*

Dr. Williams submitted to a deposition on May 18, 2009. PX13. He is a board-certified orthopedic surgeon with a subspecialty in hand surgery. *Id*, p. 5.

Dr. Williams testified that he only saw Petitioner on one occasion, May 7, 2008. PX13, p. 5. He authored a report of the same date and a second narrative report, dated September 15, 2008 at Petitioner's counsel's request. PX13, p. 12. He reviewed various records prior to rendering his reports including the following: (1) Petitioner's December 11, 2001 EMG report; (2) Dr. Stamelos' treating record from May of 2002; (3) a letter between Dr. Bauer and Dr. Stamelos from October of 2007; (4) Petitioner's September 8, 2006 EMG; and (5) some of Petitioner's vocational information from Petitioner's counsel. PX13, pp. 26-28.

In response to a lengthy hypothetical question posed by Petitioner's counsel, Dr. Williams testified that Petitioner's carpal tunnel syndrome was related to her work activities based on his "experience with patients with similar activities and similar conditions, as well as [his] knowledge of the anatomy, pathophysiology of the hand." PX13, pp. 14-19. He also testified that a double crush syndrome refers to a neurologic condition in which there may be a compressive neuropathy of a nerve at two levels. PX13, p. 19.

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[7] The Arbitrator notes that Respondent's counsel objected to certain opinions rendered by Dr. Williams at his May 18, 2009 deposition pursuant to *Ghere* because his narrative reports did not encompass all of the issues raised during the deposition and, presumably, those extraneous opinions caught Respondent by surprise at the time of the deposition. PX13, pp. 20; *see also Ghere v. Industrial Comm.*, 278 Ill. App. 3d 840, 663 N.E.2d 1046 (4th Dist. 1996). By the date of hearing, however, and in light of *City of Chicago v. IWCC* and noting the Appellate Court's more recent reiteration of a *Ghere* objection analysis in *Mulligan v. IWCC*, the Arbitrator overrules Respondent's objections. *City of Chicago*, 387 Ill. App. 3d 276, 899 N.E.2d 1247 (1st Dist. 2009); *Mulligan*, 408 Ill. App. 3d 205, 946 N.E.2d 421 (1st Dist. 2011).

Ultimately, Dr. Williams opined that there was a "significant relationship between [Petitioner's] current diagnosis of the carpal tunnel syndrome and the work activities that she had performed at Motorola as described in the letter that [Petitioner's counsel] provided to [him] on July 31st, 2008." PX13, pp. 13-14. On cross examination he clarified that Petitioner's work activities contributed to, but did not cause, Petitioner's carpal tunnel syndrome. PX13, p. 32. Dr. Williams understood Petitioner's job to be in "manual tune" and to require "extensive use of small screwdrivers to screw or tighten components or manipulate components that she estimated was 3,000 times a day; that it required twisting and turning of her wrist, as well as the use of air vibrating tools..." and the use of a "tweezers-type tool" and "some portion of pulling and snapping items together and in place and then filling them in boxes that weighed up to about 50 pounds." PX13, pp. 14, 16.

On cross examination, Dr. Williams testified that carpal tunnel syndrome can have various causes and that the causes are multifactorial. PX13, pp. 31-32. In Petitioner's case, he opined that Petitioner's job duties contributed to her carpal tunnel syndrome and he noted a combination of contributing factors including the repetitious nature of Petitioner's activities as he understood them, the inflammation/thickening of the flexor tendons encroaching upon the carpal tunnel space, the "suggestion and evidence that the use of vibratory tools can also contribute" to carpal tunnel syndrome, and because continuous gripping, grasping, pinching, fine motor activity and forceful activities on a repetitive basis can contribute to carpal tunnel syndrome. PX13, pp. 32, 34-36. However, Dr. Williams acknowledged that he had no specific information about the vibratory air tool used by Petitioner, how she used the tool, or with which hand or both she used the air tool. PX13, pp. 28-29. With regard to the use of vibratory tools, Dr. Williams acknowledged that use alone was insufficient to contribute to carpal tunnel syndrome development and it depended on degree, exposure, and so forth. PX13, p. 35. Similarly, he testified that the use of vibratory tools, gripping, and grasping should be continuous or a significant component of the work activities. *Id.* Dr. Williams also acknowledged that he did not view any video depicting Petitioner's job duties and his assumption that Petitioner's position was full time based on the "report" that Petitioner performed "3,000 repetitions a day." PX13, p. 29.

Regarding factors unrelated to work activities, Dr. Williams acknowledged that there is an increased incidence of carpal tunnel syndrome in older persons, in postmenopausal women, and in heavier persons as a secondary mechanism influencing the carpal tunnel. PX13, pp. 37-38. He also explained that while Petitioner's carpal tunnel symptoms were reportedly worse on the left in 2001, her December of 2001 EMG showed that she was electrophysiologically slightly worse on the right. PX13, pp. 39-40; *but see* PX5 (EMG findings showed evidence of a mild-moderate median neuropathy at the left wrist and evidence of the mild median sensory neuropathy at the right wrist).

Dr. Williams was unable to explain whether that symptomatology stemmed from Petitioner's carpal tunnel syndrome or cervical condition or both, but he suspected that some of the left-sided hand symptoms stemmed from Petitioner's cervical condition that were relieved after her cervical surgery which then "unmasked" the right-sided carpal tunnel syndrome. PX13, p. 40. To explain why Petitioner's right-sided symptoms increased despite the fact that Petitioner had not worked since 2004, Dr. Williams testified that once a person has chronic flexor tendon thickening daily use would continue to irritate the condition and Petitioner's symptoms probably would have been worse had she continued to work. PX13, pp. 40-41.

Dr. Williams also testified that continuous or prolonged keyboarding activities "that are not in, you know, modest and intermittent levels can exacerbate your symptoms much the way that other things that I asked her about here, talking on the phone, sleeping... driving your car, blow drying your hair, all those things can exacerbate your symptoms." PX13, pp. 41-43. He suggested keyboarding should only be done in small bits and in moderation if necessary. PX13, p. 43.

Regarding lateral epicondylitis, Dr. Williams testified that symptoms developed particularly in middle age as was Petitioner at the time of her examination and that this pain would not be masked by a cervical condition because it is not in the same anatomical distribution. PX13, pp. 44-47. Finally, Dr. Williams testified that Petitioner was capable of some work activity in May of 2008. PX13, p. 45.

Continued Medical Treatment

Petitioner underwent the recommended physical therapy evaluation on May 23, 2008. PX6; PX8. Dr. Sarantopoulos recommended that Petitioner undergo updated cervical spine imaging, updated EMG/NCV of the upper extremities for cervical radiculopathy and upper extremity referral entrapment neuropathy, physical therapy to address cervical symptomatology, trigger point injections for treatment of myofascial pain, additional medication for pain control, and, if her symptoms did not improve, cervical epidural injections. *Id.* It was noted that Petitioner was unfit to work as an assembly line worker secondary to her current symptoms and medication necessity that caused drowsiness. *Id.*

Petitioner testified that her temporary total disability benefits stopped in 2008 and her last check was February 6, 2008 until her benefits resumed June 23, 2008 when she went to a vocational rehabilitation assessment at Respondent's request. Tr. pp. 154, 57.

Dr. Chmell – Independent Medical Examination & Deposition[8]

On June 14, 2008, Petitioner underwent an independent medical evaluation at her attorney's request with Samuel Chmell, M.D. ("Dr. Chmell"). PX10; Tr. p. 62. Dr. Chmell submitted to a deposition on July 9, 2009. PX14. He is a board-certified orthopedic surgeon. *Id*, pp. 4-5, 24.

Dr. Chmell reviewed various medical records provided to him prior to rendering his opinions including the following: (1) a November 21, 2001 Arlington Heights MRI report; (2) Dr. Sarantopoulos' December 11, 2001 report; (3) an October 6, 2004 Neuro Open MRI report; (4) an Advanced Radiology Professionals report dated August 31, 2006; (5) a Professional Neurological report dated September 16, 2004; (6) Dr. Bauer's February 27, 2007 surgical report; and (7) Advocate Lutheran General hospital's records regarding Petitioner's surgery. PX14, pp. 7, 25-26. Dr. Chmell did not have any of Petitioner's medical records from 2001 and he reviewed a summary of records from Petitioner's counsel's office for treatment from November 14, 2001 through February 7, 2008. PX10; PX14, pp. 7, 27.

Petitioner reported that her job regularly and repeatedly required her to use her hands manipulating fine tuners and that she performed repeated lifting and pulling of boxes and steel fixtures. PX10. She also reported that she had been "performing repetitive motion activities with her hands and wrists for 27 years, but even more significantly, for the last seven years she has been working on a line assembly for transceivers doing pretty much the same thing on a daily, weekly, monthly and yearly basis. She state[d] that she use[d] the same tweezers and screwdrivers to perform the same assembly functions on a Motorola transceiver." *Id.* Further, Petitioner reported that she was unable to perform her regular job and that while her physicians recommended a job with restrictions and limitations it had not been provided to her by Respondent. *Id.*

Regarding her injury in October of 2001, Petitioner reported that "she was repeatedly lifting and pulling 50-pound boxes of steel fixtures. She developed left shoulder and arm pain. The shoulder and arm pain worsened

[8] Respondent's counsel also made *Ghere* objections to certain opinions rendered by Dr. Chmell at his deposition. PX14, pp. 12-13. The Arbitrator overrules Respondent's objections. *See* Footnote Number 9.

and radiated up into her neck. She then developed pain and swelling in her hands and wrists which became associated with numbness and tingling." *Id.* Regarding her injury in September of 2004, Petitioner reported that she "sustained an injury to her cervical spine with lifting and straining. She developed a severe sharp pain at the base of her neck on the left side and this pain persisted and worsened. The pain radiated all the way down her left arm and became constant, severe, shooting, and burning in nature. She could not move her neck or her arm." *Id.*

On examination of the cervical spine, Petitioner had moderate reduction of the normal cervical lordosis, muscle spasm and tenderness of the cervical paraspinal muscles left side more prominent, a healed but slightly reddened and hypertrophic surgical scar, positive Spurling's test on the left, and diminished range of motion. *Id.* On examination of the hands, Petitioner had slight diffuse swelling of both hands/wrists, full range of motion in both elbows and forearms and the right shoulder, and diminished range of motion in the left shoulder. *Id.* Both wrists demonstrated tenderness at the area of the carpal tunnel. *Id.* Petitioner had a positive median nerve compression test in both wrists and mild thenar atrophy on the right only as well as a positive Tinel's sign along the median nerve in both wrists and a positive Phalen's sign on the right at 15 seconds and 25 seconds on the left. *Id.* At his deposition, Dr. Chmell acknowledged on cross examination that Petitioner did not complain about either of her elbows during his examination and that he made no findings regarding Petitioner's elbows. PX14, p. 27. He also testified that Petitioner had no thenar atrophy on the left. *Id.*

Dr. Chmell diagnosed Petitioner with the following: (1) traumatic aggravation of cervical degenerative disc disease; (2) cervical disc herniations at C5-6 and C6-7 status post surgery; (3) bilateral carpal tunnel syndrome; (4) bilateral double-pinch syndrome secondary to the first three diagnoses; and (5) and rotator cuff tendinosis left shoulder. *Id.*

Regarding her cervical spine, Dr. Chmell opined that Petitioner sustained a cervical spine injury on both dates of accident which required surgery, that her medical and surgical treatment was reasonable and necessary, and that Petitioner had passed the point of maximum medical improvement. PX10; PX14, pp. 8-10. Regarding her bilateral carpal tunnel syndrome and tendinitis of the left shoulder, Dr. Chmell opined that they were causally related to Petitioner's long-term repetitive motion trauma at work to the upper extremities. *Id.* He also opined that both work accidents "likely contributed causally to the bilateral carpal tunnel syndrome and the left shoulder tendinosis[,]" and that Petitioner had double-pinch syndrome where the nerve lesion in her cervical spine likely further aggravated Petitioner's median nerve problem at the carpal tunnel. *Id.* Ultimately, Dr. Chmell testified at his deposition that Petitioner's bilateral carpal tunnel syndrome was caused by both her cervical injury and her repetitive work activity. PX14, p. 29.

At his deposition, Dr. Chmell testified that Petitioner's left-sided symptoms from her double-pinch syndrome in the neck and left arm were so overwhelming that Petitioner's right-sided hand symptoms did not become prominent until after her neck surgery, which alleviated the left-sided symptoms. PX14, pp. 10-13. He further testified that Petitioner's bilateral hand symptoms would not have necessarily improved when she was inactive after her cervical surgery because her bilateral hand condition was permanent and sometimes there is no explanation why such a condition does or does not improve with inactivity. PX14, pp. 17-18. The Arbitrator notes that Dr. Chmell did not provide these explanations about Petitioner's cervical spine condition masking her hand or bilateral hand symptomatology in his report.

In his report, Dr. Chmell also recommended bilateral carpal tunnel release followed by a course of therapy on each side and reassessment thereafter for the degree of permanent partial impairment. PX10. Otherwise without surgery he opined that Petitioner was at maximum medical improvement. *Id.* At his deposition and in response to a lengthy hypothetical question posed by Petitioner's counsel, Dr. Chmell testified that Petitioner's

bilateral carpal tunnel syndrome was related to her work activities because, in general, "...repetitive motion trauma can cause carpal tunnel syndrome, first of all. And I believe that [Petitioner] was subjected to repetitive motion trauma in her job to the extent that, in her, it did cause it. And I have seen other people to where it's caused it in the same fashion." PX14, pp. 13-17.

Dr. Chmell also opined at his deposition about the propriety of Petitioner's vocational re-training to perform computer keyboarding. PX14, pp. 20-21. He testified that such training would not be appropriate because it was usually repetitive in nature and caused the same sorts of problems that Petitioner had experienced with her hands and wrists. *Id.* He further testified that Petitioner was not employable because of her hands and that appropriate jobs are not readily available for undereducated people where at least considerable usage of the hands is involved. *Id.* If Petitioner had the recommended carpal tunnel repair, however, he opined that Petitioner may or may not thereafter be employable. PX14, pp. 22, 30. The Arbitrator notes that Dr. Chmell did not provide these opinions in his report, there is no evidence that he reviewed any vocational rehabilitation documentation before he rendered any of his opinions, and there is no evidence that Dr. Chmell was asked to render opinions regarding Petitioner's prospective employability in his report. PX14, pp. 20-22; PX10.

Continued Medical Treatment

On July 30, 2008, Petitioner returned to Dr. Stamelos complaining of numbness and pain in the hand all this time "and has not been listen [sic] to." PX5. He reiterated that Petitioner needed a carpel tunnel release to reach maximum medical improvement and possibly return to some kind of employment although Petitioner was on disability because she had given up on any return to work due to the cervical fusion and associated pain. *Id.* He also noted that Petitioner still felt that she was disabled for any kind of work. *Id.* No objective examination findings were noted at the time of this visit. *Id.*

A "physical residual functional capacity questionnaire" was also completed on July 30, 2008 by a chiropractor noting Petitioner's then-current symptomatology and history of injury. *Id.* It appears that this questionnaire was provided to Dr. Stamelos and Petitioner's SSD benefits legal counsel. *Id.*

On September 15, 2008, Dr. Williams authored a second narrative report in which he ultimately opined that "there was a significant relationship between [Petitioner's] carpal tunnel syndrome and her work activities at Motorola." PX9; PX13 (Ex. 3). He was unable to definitively opine further on the relationship between Petitioner's left lateral epicondylitis condition and her work, if any. *Id.*

In a narrative letter dated January 12, 2009, Dr. Stamelos authored correspondence at Petitioner's request addressed to "to whom it may concern[9]" in which he reiterated that Petitioner had bilateral carpal tunnel syndrome as a result of repetitive usage that required surgery. PX5; PX12, p. 60. He further noted that Petitioner had been awaiting approval for surgery of this essential procedure which was necessary for her manual dexterity inability to function. PX5. In addition, he stated that Petitioner's condition was being aggravated by "the cold and the chronicity." *Id.* He noted the good suggestion that Petitioner go to school to learn computer work and do keyboarding and data entry, but that people with impaired median nerve function and hand pain would find it almost impossible to function on a computer. *Id.* Dr. Stamelos suggested a delay such schooling and, instead, recommended the bilateral carpal tunnel release surgery so that Petitioner could then be vocationally rehabilitated. *Id.*

[9] This correspondence also appears to have been sent to Petitioner's counsel. PX5.

Petitioner returned to Dr. Stamelos approximately one year and nine months later on October 4, 2010 complaining of bilateral wrist pain. *Id.* Dr. Stamelos diagnosed Petitioner with a cervical strain, whiplash and radiculitis of the cervical spine as well as bilateral carpal tunnel syndrome. *Id.* He prescribed Norco and Darvocet, ordered continued "conservative management," and instructed Petitioner to return on an as needed basis for a reevaluation. *Id.* While Dr. Stamelos notes that he evaluated Petitioner in the office, the only objective examination results identified are Petitioner's blood pressure and pulse levels. *Id.*

Approximately 13½ months later, on November 16, 2011, Petitioner returned to Dr. Stamelos' clinic. *Id.* Petitioner cervical spine fusion was noted, and she reported chronic pain. *Id.* Dr. Stamelos noted that Petitioner probably has carpal tunnel, and later noted that she definitely had bilateral carpal tunnel syndrome as proven by objective testing, and that she could not return to work because she had continued dysfunctions and inability. *Id.* Notably, Dr. Stamelos noted that Petitioner had a right-hand dysfunction and that she suffers from depression despite treatment with a psychiatrist[10]. *Id.* Dr. Stamelos opined that Petitioner continued to be disabled by both psychological and psychiatric problems and the physical impairment of her arms. *Id.* He also noted that Petitioner was obese and unable to function because of hand and upper extremity pain. *Id.* He further noted that there were enough problems to make her disabled but they would not treat all of her issues, they would continue to follow her closely "upon her wishes," and that she had not been in for treatment for a significant amount of time although she felt that she was not well and wanted to be under the treatment of a qualified doctor. *Id.* He referred Petitioner back to her neurosurgeon [Dr. Bauer] for the cervical spine and noted that they could treat her for carpal tunnel, but that Petitioner was reluctant. *Id.*

Vocational Rehabilitation - Vocamotive

Petitioner testified that she underwent a vocational rehabilitation assessment at Vocamotive on June 23, 2008 at Respondent's request with Mr. Belmonte. Tr. pp. 57, 124-125, 153-154, 205. Petitioner testified that they attempted to teach her how to use a computer, keyboard and mouse to look for a job. Tr. pp. 57-58. Vocamotive assisted Petitioner in applying for employment and she applied for employment by phone as well. Tr. pp. 58-59. Petitioner did not obtain any job interviews, but did speak with prospective employers over the phone. Tr. p. 59. Petitioner testified she was instructed by Vocamotive not to tell prospective employers that she had a back operation or that she could not use her hands. Tr. p. 59.

The record reflects assessment, progress and discharge reports from Vocamotive between August 6, 2008 and March 9, 2009. RX6. During that time, Petitioner left before the end of her session, she did not attend sessions, she failed to apply for job leads provided, she did not participate in recommended vocational rehabilitation activities for various reasons including reported effects of her medication on her abilities, she voiced her opinion that she could not perform the recommended activities or obtain employment, she did not complete some job logs, and she was otherwise selective in her cooperation for various reasons in recommended vocational rehabilitation activities. *Id.*

Joseph Belmonte ("Mr. Belmonte") is a certified rehabilitation counselor at Vocamotive. Tr. pp. 194-198; *see also* RX5. Mr. Belmonte testified that when a client, like Petitioner, is referred to him his practice is to contact the client and his attorney and schedule an initial interview at which time he takes a detailed history. Tr. pp. 202-204. Then, he reviews the client's medical information and thereafter issues an initial evaluation report.

[10] The treating psychiatrist is noted as Dr. Saulecky, who is noted as having committed suicide. PX5. The only other reference to Dr. Saulecky (or Dr. Solecki) in this record is contained in the deposition of Petitioner's vocational rehabilitation counselor, Ms. Entenberg, who testified that she reviewed an unidentified number of his treating records for Petitioner. PX15, pp. 14, 26.

Tr. p. 204. In accordance with his practice, Mr. Belmonte conducted an initial interview with Petitioner on June 23, 2008. Tr. p. 205.

Mr. Belmonte testified that he did state or suggest to Petitioner that she should not inform prospective employers of her medical problems. Tr. pp. 249-250. Petitioner testified that Mr. Belmonte advised her that he could only address her back issues. Tr. pp. 59-60. She also testified that she told Mr. Belmonte that she was having problems with her hands. Tr. pp. 60-61.

Mr. Belmonte rendered his initial evaluation report and concluded that Petitioner was prospectively employable and he identified specific job targets for Petitioner reflected more specifically on page 12 of his report including unskilled to low semiskilled occupations such as basic food preparer, laborer within a fast food restaurant, certain cashiering positions, some ticket taker positions, parking lot cashier, some light housekeeping occupations, etc. Tr. pp. 205-214. Mr. Belmonte also considered an invalid functional capacity evaluation report in rendering his opinions. Tr. pp. 215-216. With regard to Petitioner's prospective wages, and given Petitioner's very narrow work experience and the kind of jobs being targeted for her, he projected that Petitioner could earn between minimum wage and nine dollars per hour. Tr. pp. 217-218.

Mr. Belmonte testified that there was some difficulty in initially implementing Petitioner's rehabilitation plan due to communication difficulties, which were resolved, and he met with Petitioner again on September 15, 2008. Tr. pp. 219-220. Mr. Belmonte also testified about some of Petitioner's characteristics including that she was always "very direct" and "does not hesitate to express her opinion or state her position with regard to what she believes she wants or may be entitled to or what she may expect." Tr. pp. 220-221. Mr. Belmonte further testified that at Petitioner's initial interview she asked him why he believed he could get her a job if her employer [Respondent] was not going to take her back. Tr. pp. 221-222. He noted that Petitioner's question was not problematic in and of itself, but he did sense after his discussion with her that Petitioner "was in fact prospectively resistant to the process because of what she stated she felt she wanted from the process which was medical treatment and not vocational rehabilitation." Tr. pp. 222-223. Mr. Belmonte further noted that "[Petitioner] manifested from time to time clear frustration and some resistance to being on time or being present on days when we could [effectively] treat her, but which may not have been her preference. She ultimately did not [effectively] job search on days unless she was actually in the office working under our supervision." Tr. p. 223.

Petitioner submitted to additional educational and aptitude testing by Jim Boyd ("Mr. Boyd") at Vocamotive's request and he generated a report on which Mr. Belmonte relied. Tr. pp. 224-226. On cross examination, Mr. Belmonte testified that Mr. Boyd chose the tests to administer to Petitioner which included Woodcock Johnson, Roman III, and Tests of Achievement. Tr. p. 244. As a result, Mr. Boyd identified Petitioner's aptitudes as follows: letter word identification at 6.7 grade level; reading fluency at 5.8 grade level; story recall at 3.6 grade level; mathematical calculation at 10.8 grade level; math fluency at 13.0 grade level; spelling skills roughly $9^{th}/10^{th}$ grade; writing fluency just below 6^{th} grade; and passage comprehension in reading at 4.5 grade level. Tr. pp. 244-246.

Mr. Belmonte testified that his expectations of Petitioner were conveyed to Petitioner at her initial interview and throughout the vocational rehabilitation process. Tr. pp. 226-228. Petitioner was receptive to Vocamotive's offer for computer assistance to help her find a job, but Mr. Belmonte testified that their job search efforts were not directed at finding Petitioner a job utilizing computers. Tr. pp. 228-229.

Petitioner's vocational rehabilitation through Vocamotive ended on March 9, 2009. Tr. pp. 125-126, 229-231. Mr. Belmonte testified that during the course of his conversations with Petitioner he acknowledged her feelings

about the vocational rehabilitation process and that medical treatment was her priority, but iterated that their services would be to her benefit in either actually finding her a job or ultimately determining whether there was a stable labor market for her. Tr. pp. 230-231. He further testified that he regularly attempted to actively enroll Petitioner in their process, but by March 9, 2009, "it became apparent that she was not going to change the orientation and her attitude, and I felt that at that point that I had made every reasonable effort that was likely to produce any change in the stance, and I felt that I was ethically obligated to advise both her and the people that were paying the bill that I really didn't see that it was cost effective to continue to move forward." Tr. pp. 230-231.

More specifically, Mr. Belmonte testified that Petitioner "consistently stated that her objective was medical treatment, surgery for the arms." Tr. p. 231. He testified that he told Petitioner that despite her complaints, which he acknowledged, he had no objectively, medically identified impairment to work with; "[i]n other words, no doctor had ever said that she was impaired with regard to the carpal tunnel syndrome or whatever might be happening in the upper extremities. So it was never identified by a physician that she couldn't do A, B, or C as an example. And without that, I didn't have [any job targets] that I could determine could be taken off the table...." Tr. pp. 231-233. On cross examination, Mr. Belmonte did acknowledge that Petitioner's reports of difficulty holding objects, dropping objects, clasping her clothes, could prospectively create a problem keyboarding or doing computer work. Tr. p. 247. He further acknowledged the fact that prospective pending surgery could be a significant and potentially complicating factor [in finding employment] for an applicant. Tr. p. 247.

Mr. Belmonte also testified that, while Petitioner was aware of their expectation that she would job search on her own, she did not job search on days that she was assigned to do so other than when she was at the Vocamotive office and he discharged her from their rehabilitation program for this reason. Tr. pp. 235-237. On cross examination, Mr. Belmonte acknowledged Petitioner's report of traveling to prospective employers Hallmark and Red Roof Inn, but her visits were unsuccessful. Tr. pp. 262-263. He testified that on one occasion Petitioner stated to him that "she did not mind coming here because it would make her look good in court[,]" and he explained that this statement is notable in the bigger context of his discussions with Petitioner where her focus was that she wanted surgery, she did not believe that she was employable, she did not want to work in food preparation, be a cashier, or change the date of her schedule from Tuesday to Wednesday even if they required her to do so. Tr. pp. 238-239.

On cross examination, Mr. Belmonte also acknowledged that his December 15th report reflects that he told Petitioner that he could not give her a decision on how she should proceed given the fact that the reported carpal tunnel was not a part of the medical situation that Vocamotive was able to use in analyzing her restrictions. Tr. p. 256. Mr. Belmonte did ultimately receive a report from Dr. Stamelos in which he indicated that working on or using a keyboard was not appropriate for Petitioner given the fact that she needed carpal tunnel surgery. Tr. pp. 258-259. He also acknowledged that Dr. Stamelos' recommendation for carpal tunnel release surgery would make driving in very cold weather troublesome for Petitioner. Tr. p. to 61.

As of December 5, 2008, Petitioner keyboarded eight words per minute, she was not doing very well with it, and Vocamotive subsequently discontinued the training because her level of education and language proficiency would never have led them to the performance of a job by Petitioner requiring anything other than some elemental, utilitarian data entry. Tr. pp. 259-260. Mr. Belmonte clarified on re-direct examination that Vocamotive discourages computer-only job searches and that it is not an indicator in the applicant's success in finding a job. Tr. p. 269.

Mr. Belmonte testified that he did not inquire of Respondent whether they had any positions within Petitioner's restrictions because he operates under the assumption that those issues have already been explored and exhausted once she was referred to him for vocational rehabilitation services. Tr. pp. 266-267; *see also* Tr. pp. 268-269.

Petitioner testified that she was never reimbursed for travel expenses, mileage, or tolls to get to and from Vocamotive, although Petitioner requested it. Tr. p. 61; *see also* Tr. p. 252.

Vocational Rehabilitation – Rehabilitation Service Associates

At Petitioner's counsel's request, she also saw Susan Entenberg ("Ms. Entenberg") at Rehabilitation Service Associates on April 16, 2009. Tr. p. 62; PX11; PX15. Ms. Entenberg completed a report thereafter dated May 22, 2009 and testified at a deposition on March 8, 2011. PX11; PX15.

In her report, Ms. Entenberg noted Petitioner's report that she injured herself on September 23, 2004 while lifting a box and she felt a sharp pain in her neck and left arm. PX11; PX15, pp. 7-8. Regarding Petitioner's earlier injury, Ms. Entenberg notes that Petitioner stated "that she sustained an injury to her left upper extremity, neck on October 10, 2001 while under the employ of Motorola." PX11. Petitioner also reported that she could not turn knobs or perform fine movements with her hands, did not chop/peel/cut, could only write for 10 minutes, and could only be at a computer for 15 minutes. PX11; PX15, p. 9.

Ms. Entenberg testified that prior to reaching her opinions she met with Petitioner and obtained information, she reviewed Petitioner's medical records to determine her work restrictions and recommendations, and she reviewed vocational testing records. PX15, p. 10. Ms. Entenberg concluded that Petitioner was not a candidate for further vocational rehabilitation services in consideration of the factors delineated in *National Tea v. Industrial Comm.* whether or not she had bilateral carpal tunnel surgery, that there was no stable labor market for her, and that if she could perform the jobs listed by Vocamotive Petitioner would only be able to earn $8.80 per hour. PX11; PX15, pp. 11-15.

Ms. Entenberg also testified that she understood that Vocamotive was having Petitioner go "to the office to look for jobs and go on-line and job search" and perform "computer activity on a sustained basis" which was not appropriate given Petitioner's report that she could not be on a computer for any length of time, the symptoms in her hands, and the recommendation for bilateral carpal tunnel surgeries. PX15, pp. 11-13.

On cross examination, Ms. Entenberg admitted she met Petitioner only once and that she primarily works with Petitioners in workers' compensation cases. PX15, p. 16. Ms. Entenberg stated that she understood Petitioner's English, although she had to listen, and that Petitioner was a little excitable, frustrated, and a little upset at times throughout their assessment. PX15, pp. 17-18. Ms. Entenberg also stated that Petitioner "felt that she was not capable of working, that she could not work." PX15, pp. 19-20. Ms. Entenberg further stated that she relied on Dr. Bauer's restriction that Petitioner could perform only sedentary work, but she was unable to locate that medical record at the deposition and she admitted that Dr. Bauer's June 14, 2008 report stated that he could *not* conclude what activities Petitioner could or could not perform based on the invalid December 5, 2007 functional capacity evaluation results. PX15, pp. 23-24, 26-28. Finally, Ms. Entenberg acknowledged that the cashier and food preparation worker positions identified by Vocamotive were appropriate unskilled placement jobs for Petitioner. PX15, pp. 29-30.

Petitioner testified that she has continued to look for work after March of 2009 on her own by either submitting applications in person for calling over the phone. Tr. pp. 126-128. She applied for part-time position with

jewel in her neighborhood in Arlington Heights and she called a couple of prospective employers that she found in the newspaper including a hotel for a desk clerk position. Tr. pp. 128-130. She testified that she does not believe she can work with her hands, but she can answer a phone. Tr. p. 130.

Continued Medical Treatment

Petitioner testified that she saw Dr. Stamelos on October 4, 2010 and she believes she has seen him two or three times thereafter. Tr. p. 126. Petitioner understood that Dr. Stamelos' bill was not paid. Tr. p. 146. The Arbitrator notes that the parties have stipulated that if Dr. Stamelos' bill has been paid Respondent would receive credit for that payment. AX1; AX2; Tr. p. 148.

Dr. Stamelos' Deposition

Dr. Stamelos submitted to a deposition on April 17, 2009. PX12. He is a board-certified orthopedic surgeon. *Id*, p. 5.

Dr. Stamelos testified that Petitioner described doing many things at work that were manual, repetitive, and even lifting. PX12, p. 11. He testified that Petitioner reported using tools, screwdrivers, punches and assembling or snapping things together then putting them in a box or wrapping them up "or whatever it is and then at the end she had to put the box on a belt or something and put it on a skid." *Id.* Dr. Stamelos summarized that Petitioner had a variety of duties working the upper extremities and that she could not "work lifting and bending and twisting without the contributions of the shoulder, the neck and the hand." *Id.* On cross examination, Dr. Stamelos testified that his understanding of Petitioner's work was all based on what Petitioner told him. PX12, pp. 61-62. Dr. Stamelos added that "I have many Motorola patients in the past. So my experience with Motorola was repetitive usage of their extremities. But I never actually had a nurse visit me or somebody giving me a job description of [Petitioner's] work." PX12, p. 62.

Dr. Stamelos testified that Petitioner's initial complaints were cervical spine stiffness and pain, left shoulder pain, and tingling in both hands, primarily on the left. PX12, p. 7. On cross examination, Dr. Stamelos conceded that his November 14, 2001 note makes no mention of carpal tunnel condition or findings with regard to Petitioner's hands. PX12, pp. 38-40. He further conceded that his note of Petitioner's December 5, 2001 visit makes no mention of carpal tunnel although he explained that the C6/C7 innervates the same area of the hand that the carpal tunnel innervates and he did not have any specific objective testing of carpal tunnel at that time. PX12, p. 41.

On cross examination, Dr. Stamelos testified essentially that Petitioner's very large herniation at C6/C7 on the left was masking Petitioner's mild to moderate carpal tunnel syndrome through February 20, 2002. PX12, pp. 42-43. He also testified that Petitioner complained more about left-sided symptoms than right-sided symptoms through March of 2002. PX12, p. 48. Then, Dr. Stamelos further testified on cross examination that Petitioner was complaining more about right-sided symptoms in 2009, but qualified his response by stating that Petitioner's left-sided symptoms masked Petitioner's right-sided symptoms. PX12, p. 48.

Petitioner did not show Dr. Stamelos how she performed her work. PX12, pp. 11-12. Dr. Stamelos merely noted that Petitioner did thousands of maneuvers per day automatically according to her report. *Id.* Dr. Stamelos opined that various maneuvers performed repetitively by Petitioner is the "most consistent and accepted way to create carpal tunnel." PX12, pp. 12-13. Dr. Stamelos also testified that Petitioner never stopped complaining about her hands, but "[w]hen I took her off of work, her symptoms subsided, by [sic] her condition didn't improve." PX12, p. 13. On cross examination, Dr. Stamelos testified that he took Petitioner

off work even when her carpal tunnel syndrome was not improving because Petitioner had multiple orthopedic problems and a psychiatric problem. PX12, p. 59. He testified that he would not have necessarily taken Petitioner off work solely for the carpal tunnel syndrome and might have only restricted her work, but he also testified that "Dr. Bauer also had a lot to do with it." PX12, p. 60.

Dr. Stamelos testified Petitioner's neck and shoulder symptoms improved after her neck surgery, but "there has been a consistency to the symptoms of her hand. When she didn't work or didn't use her hand, the symptoms are not as strong but she still has difficulty with cold, when she sleeps, she has difficulty buttoning her buttons. In other words, the condition is ongoing and stagnant and nonimproving. In other words, the intensity of the symptoms worsened with her doing anything manual, but if she doesn't do anything, she doesn't get an improvement, she just has the carpal tunnel condition, primarily on left and some on the right." PX12, pp. 18-19.

To explain why Petitioner's carpal tunnel syndrome did not improve while she was away from her job, Dr. Stamelos testified about the deterioration of the ligaments, bones, and tendons in the carpal tunnel due to overuse, age, gender, and other factors such that "once you have carpal tunnel you cannot not have carpal tunnel." PX12, pp. 19-22. He further testified that while Petitioner "would have had carpal tunnel" given the type of work that she was doing at 20 years old, her carpal tunnel syndrome has nothing to do with her gender and normal hormonal changes at her age, but rather it was in addition to her predisposing factors. PX12, pp. 22-23. On cross examination, Dr. Stamelos acknowledged that there were many studies showing a peak of carpal tunnel symptomatology in women during menopause between 45 and 55 years of age, however he believed that there had not been any studies regarding Petitioner's particular body habitus (i.e., approximately 190 pounds and 5'3 tall) and the incidence of carpal tunnel. PX12, pp. 47-48. He also testified that the lack of surgical intervention for carpal tunnel syndrome could have had an impact on the severity of Petitioner's condition and that Petitioner continued to refuse such surgery through July of 2003. PX12, pp. 46, 49-50.

Regarding Petitioner's capability of returning to work, Dr. Stamelos testified that "it would have to be one of these special jobs that would be a job that would have to -- we do a functional capacity evaluation and she would just sit and watch a TV screen or an inspector or somebody, in other words where there is no use of the hand. And then there is issue of getting to work and coming home and there is an issue of cold versus warmth. In other words the hands are very sensitive to the cold, so it would have to be a designer job for her to work." PX12, p. 25.

In response to a lengthy hypothetical question posed by Petitioner's counsel, Dr. Stamelos testified that Petitioner was "the poster girl for repetitive motion carpal tunnel disease. There is no question in my mind that her condition, 3000 manual repetitive usage of her extremities a day, doing the work at Motorola, contributed and caused her carpal tunnel primarily in the left, but also on the right." PX12, pp. 25-29. He further testified that the same repetitive conditions that cause carpal tunnel can also cause lateral epicondylitis in some people and that the conditions were irreversible and could only be corrected with surgery. PX12, pp. 29-30. According to Dr. Stamelos, Petitioner did not know what carpal tunnel was until she saw him and that when he "told her about the surgery she was completely against it because she thought I was making it up." PX12, pp. 30-31. Ultimately, Dr. Stamelos testified that he was "positive" that Petitioner's work activities contributed or caused Petitioner's carpal tunnel. PX12, p. 36.

Dr. Stamelos opined that Petitioner could not return to a repetitive nature job at that time. PX12, p. 30. On cross examination, he clarified this opinion and testified that Petitioner would never be able to return to repetitive usage work without an operation. PX12, p. 46.

Dr. Stamelos opined that the vocational training that Petitioner was receiving for computer usage was inappropriate because Petitioner's carpal tunnel syndrome was a deterrent for manual work, data entry, or computer work. PX12, p. 30.

Elli Taylor

Elli Taylor ("Ms. Taylor") testified that Petitioner's counsel had previously represented her in a worker's compensation case against Respondent related to her left hand/thumb while working on a different line from Petitioner. Tr. pp. 159-160, 174. Ms. Taylor testified that her case was settled. Tr. p. 160.

Ms. Taylor testified that she worked in the same department as Petitioner for a long time. Tr. p. 160. She also viewed Respondent's Exhibit 4 and testified that it only partially accurately portrayed what Petitioner did at work. Tr. p. 161. Ms. Taylor testified that Petitioner worked a lot on laser, which was shown in a little bit of the video, but Petitioner also did a lot of work in manual tune and there were only a few people that could do that "[b]ecause it's very, very difficult." Tr. p. 161. Ms. Taylor observed approximately three or four other employees, including Petitioner, performing manual tune duties while Ms. Taylor worked for Respondent, but she did not ever perform manual tune duties after one unsuccessful attempt to do so. Tr. pp. 162-167, 170, 181-182.

Ms. Taylor testified that she observed Petitioner performing work on laser and operating about four machines. Tr. p. 170. She testified that she did not observe others operating four machines. Tr. p. 170. Ms. Taylor also testified that she observed Petitioner working in pick and place once in a while and very little "because it's one of the easier jobs." Tr. p. 172.

In addition, Ms. Taylor testified that everyone did FQA/inspection and that whenever there was a problem, such as an injury, Respondent would place the employee in inspection because it was easy and not hard on the neck or back or hands because the employee is looking at something through a magnifying glass to determine if all the parts are in their proper place. Tr. pp. 172-173.

On cross examination, Ms. Taylor testified that in 2001 she worked in the microcircuits department for approximately 3-4 years and her supervisor with Keith Lulik. Tr. pp. 176-177. Ms. Taylor testified that she was transferred and believed that she still worked in the same area, microcircuits, in 2004 for one year under another supervisor, Maria. Tr. pp. 177-178. Ms. Taylor was never supervised by Petitioner supervisor, Frank Neugebauer. Tr. p. 178.

Ms. Taylor also testified that while she was employed by Respondent she did laser trimming, pick and place, and FQA. Tr. p. 181. Ms. Taylor testified that FQA and pick and place are light jobs, but laser trim is not because the employee was standing—although she also testified that the employee is not really lifting anything. Tr. p. 182.

Additional Information

Petitioner testified that she was terminated from her position with Respondent and she has not worked since September 24, 2004 for any employer. Tr. pp. 55, 119. Petitioner testified that she has not received any other workers' compensation [benefits payments] other than those to which she testified at trial. Tr. p. 55.

Petitioner remains under the care of a primary care physician and occasionally sees Dr. Stamelos. Tr. p. 56. She also testified that she is ready willing and able to undergo the recommended carpal tunnel surgery. Tr. p. 61.

As of the date of her testimony, Petitioner testified that she is in pain and cannot sit or stand for more than a certain amount of time because of her back. Tr. pp. 63-64. She also testified that she lost the ability to move her body more than 40% and that she has to move her whole body to the left or to the right, that she has difficulty bending her head in the front or in the back to wash her hair, that she cannot lift herself from sleep (that she has to reach for something like the bed board in order to get up from the bed), that she suffers while it is raining, and that she is on pills. Tr. pp. 63-64.

With regard to her hands, Petitioner testified that they were numb, that she loses objects from her hands, that she sometimes lacks feeling in her hands when handling money, that her thumb is tingling like it is stuck, and that she cannot move her right thumb at all. Tr. pp. 64-65. She also testified that she experiences this in both hands, but that her right hand is worse. Tr. p. 65.

Petitioner can drive her van, but testified that she cannot sit for a long time and drives only for shopping and similar activities because of pain that "is killing her" in the upper thoracic lower cervical spine area. Tr. pp. 131-134.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above, and the Arbitrator's and parties' exhibits are hereby made a part of the Commission 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 the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

Cervical Spine and Left Arm Radiculopathy

The Arbitrator notes that the parties do not dispute causation regarding Petitioner's cervical spine injury stemming from either date of accident. Notwithstanding, the Arbitrator finds that Petitioner's cervical spine condition and the associated left arm radiculopathy is causally related to her undisputed accident on October 10, 2001 which was aggravated on the date of her second undisputed accident, September 23, 2004.

Petitioner's testimony about the traumatic mechanism of injury occurring on October 10, 2001 and her onset of symptoms is corroborated by record evidence, supported by contemporaneous and objective test results, and supported by objective clinical findings made by various treating physicians and independent medical examiners. Regarding her first accident, Petitioner testified that she felt a hard, stinging pain in her back when she pulled a box of fixtures while working on the pick and place assembly line. Regarding her second accident, Petitioner testified that she was lifting boxes on September 23, 2004 when she hurt herself and felt a sharp pain. Overall, the record corroborates Petitioner's testimony about these traumatic mechanisms of injury at trial as well as her symptoms from each date of injury through the date of her testimony at arbitration.

Furthermore, there is no evidence that Petitioner had any cervical spine injury, left shoulder injury, or left-sided symptoms radiating down to her mid-arm prior to her first accident. The record contains credible evidence that Petitioner's second accident aggravated her cervical spine condition—although Petitioner initially refused recommended surgical intervention for years—given Dr. Bauer's objective findings throughout his treatment of Petitioner particularly when viewed in light of the Section 12 opinions rendered by Drs. Skaletsky and Levin. While the Arbitrator notes that Petitioner's treating physician, Dr. Bauer, placed her at maximum medical improvement regarding her cervical spine condition on October 31, 2007, and that Dr. Levine also opined that Petitioner had reached maximum medical improvement, the parties proceeded to trial pursuant to Petitioner's Section 19(b) and Section 8(a) motion and a finding on the nature and extent of Petitioner's injuries is premature.

Based on the foregoing and the record as a whole, the Arbitrator finds that Petitioner's current cervical spine condition and associated left arm radiculopathy is causally related to her undisputed accident on October 10, 2001 which was aggravated on the date of her second undisputed accident, September 23, 2004.

Bilateral Carpal Tunnel Syndrome

The Arbitrator finds that Petitioner failed to meet her burden of proof to establish a causal connection between her current bilateral carpal tunnel syndrome condition and either accident at work. Specifically, the Arbitrator finds that Petitioner's testimony at trial with regard to this condition is not credible, overall, and that it is materially and repeatedly inconsistent with other record evidence. Moreover, the Arbitrator finds that the opinions of Petitioner's treating physicians, Dr. Stamelos and Dr. Williams, as well as the opinion of Petitioner's independent medical examiner, Dr. Chmell, are unpersuasive given the record as a whole.

First, the Arbitrator addresses Petitioner's testimony about her assigned job duties and actual work activities as compared to record evidence; it is erratic, at best. The record contains varied, vague and contradictory reports made by Petitioner at trial about the job duties she was required to perform and the work activities in which she actually engaged when compared to reports made by her to treating physicians and Section 12 examiners. The record is similarly incongruent as to the amount of time (i.e., hours per day, days per week, etc.) that Petitioner spent performing any particular duty (i.e., using tweezers/pliers, lifting up to 50 lbs., using screwdrivers with 15-20 lbs. force, using vibratory tools, etc.) in any position (i.e., pick and place, laser, inspection/repair, light duty positions, etc.) and for how long she did so (i.e., weeks per month, months per year, etc.). While Petitioner is not a sophisticated claimant and she might not reasonably be expected to recall exact details about her job duties and actual work activities during exact time frames over many years, it is reasonable to expect that Petitioner could consistently recall general details of her job duties and work activities performed during general timeframes that generally correlate to reports made by her to physicians since her first injury in 2001. Given the disparity in the record regarding whether Petitioner injured herself in two traumatic incidents or whether she sustained repetitive trauma injuries as she now claims stemming in whole or in part from her work activities, Petitioner's evidence about her job duties and actual activities is significant. The Arbitrator finds that Petitioner's testimony is wholly inconsistent with record evidence about her job duties and the work activities that she actually performed and, thus, is not credible.

To wit, the record reflects the following varied, vague, inconsistent and/or directly contradictory reports offered by Petitioner: (1) she worked in manual tune for several years approximately 80% of the time 10 hours per day/5 or 6 days per week and she worked in laser much of the remaining time and, limitedly, filled in the pick and place and inspection/repair positions; (2) when she worked in manual tune, she used a small screwdriver-type tool on small circuit boards of differing sizes and she turned her fingers all day long in all directions; (3) when she worked in laser she did so approximately 8-10 hours per day, 4-5 days per week in 2002 and 2003; (4) when she worked in laser she operated four laser machines simultaneously by going from one machine to another and "[j]umping like crazy, around" however she admitted that when she worked in laser she only used a computer mouse; (5) when she worked in laser, she worked four machines, which is contradicted by an October 14, 2004 incident report reflecting that she was working three machines which was crossed out; (6) she worked using an air gun with 15-20 pounds of pressure to close transceivers with screws while in the repairs position, although there is no specification for how often or for how long; (7) in the FQA position she worked in a seated position and used tweezers/brushes/pliers to inspect/clean circuit boards of varying sizes and types that came down a conveyor belt before placing completed ones into a box; (8) in the pick and place position she would snap a part onto a circuit board that came to her on a conveyor belt then placed assembled boards back onto to the conveyor belt; (9) she was lifting 50 lbs. every twenty minutes in her full duty job before her first injury, although there is no specification about what that job was or how long she was in that job; (10) she worked "light duty" after her return to work [in August of 2002] until April of 2004; (11) she only worked "light duty" for one or two weeks after her return to work in August of 2002 before she was performing full duties again, which is contradicted by an October 2, 2002 note and another February 25, 2004 note of Dr. Stamelos that Petitioner was still working light duty; (12) Respondent never accommodated her restrictions with light duty work and she was lifting up to 50 lbs. again before her second injury on September 23, 2004, although there is no specification about what that job was or how long she was in that job; and (13) she worked on an assembly line performing unspecified repetitive motion activities with her hands and wrists for 27 years and she had worked primarily with tweezers and screwdrivers while working on transceivers "doing pretty much the same thing" on a daily/weekly/monthly/ yearly basis since approximately 2001.

As reflected in the findings of fact, the aforementioned list of inconsistencies between Petitioner's reported job duties and actual work activities before and at the time of both accidents at work is not exhaustive. The

variations in Petitioner's reports on this subject at trial are evident when comparing her testimony on direct and cross examination as well as when comparing her testimony overall with reports that she made to treating physicians and independent medical examiners in contemporaneously created records. Petitioner's reports about her job duties and work activities are also inconsistent with and contradicted by written job descriptions. In particular, while the job descriptions offered by Petitioner require repetitive movements, none of them require sufficient force or significant use of vibratory tools as opined by Dr. Fernandez to make the repetitive motions a contributing factor in the development of Petitioner's bilateral carpal tunnel syndrome. In any event, the variations in reported job duties bear unfavorably on Petitioner's credibility.

Moreover, Petitioner's physicians, Dr. Stamelos, Dr. Williams and Dr. Chmell (an independent medical examiner), all relied on Petitioner's reports about her job duties and actual work activities and/or a summary of these created by her attorney in opining that causal connection exists between her condition and both accidents at work. The work activities performed by Petitioner as reported by her vary from one physician to the next and none of the aforementioned physicians reviewed Petitioner's written job descriptions, physical demand requirements, or viewed any video depicting any of the types of work activities in which Petitioner was required to engage at any point during her employment with Respondent.

Second, the Arbitrator notes that the contradictions contained in the record about the mechanisms of Petitioner's injuries. While accident is not in dispute, the Arbitrator notes that Petitioner's applications for adjustment of claim in both cases, the histories given by Petitioner throughout her treatment, and the information made available to physicians opining on causal connection initially allege traumatic injuries and *not* repetitive trauma injuries. Petitioner's reports on this subject are as disparate as her reports about her job duties and work activities (e.g., Petitioner's report to Dr. Chmell on June 14, 2008 approximately 7 years after her first injury that she injured herself on October 10, 2001 when she was repeatedly lifting and pulling 50-pound boxes of steel fixtures resulting in left shoulder and arm pain is singular and contradicted by several other versions of the mechanism of injury on that date throughout the record). In at least one instance, Petitioner also refused to provide historical information to a physical therapist during a functional capacity evaluation about her September 23, 2004 injury. PX6 (On December 5, 2007, Petitioner reported that she had a work related injury to her neck on September 23, 2004, but "**refused to give the therapist any additional history.**" (**emphasis** in original)). The FCE was deemed invalid due to submaximal effort. While the discrepancies regarding the mechanisms of injury alone might not be dispositive even on the issue of accident, it is limitedly relevant here where the dispute centers on whether Petitioner's bilateral carpal tunnel syndrome developed in whole or in part as a result of repetitive trauma and not any traumatic injury. The Arbitrator finds that these discrepancies further erode Petitioner's credibility and they bear on the reliability of the opinions rendered by Dr. Stamelos, Dr. Williams and Dr. Chmell because they relied primarily on Petitioner's reports.

Third, the Arbitrator addresses the causal connection opinions of Dr. Stamelos, Dr. Williams, Dr. Chmell, and Dr. Fernandez. The first three physicians opine that a causal connection exists between Petitioner's bilateral carpal tunnel syndrome and one or both work injuries. Dr. Fernandez opines that no causal connection exists; the Arbitrator agrees.

Dr. Stamelos fervently contends in his deposition, in narrative reports, and throughout his treating records that Petitioner's repetitive work activities contributed to and caused her bilateral carpal tunnel syndrome. The Arbitrator finds that Dr. Stamelos' opinion is not persuasive and gives it no weight.

At trial, Petitioner testified that she was injured on October 10, 2001 when she pulled fixtures from below the assembly line to place them on the table while working the pick and place position. She then experienced a

"hard pain" in her back. Given the record as a whole, it is apparent that Petitioner sustained a traumatic injury resulting in immediate onset of symptoms that she localized to the back of her neck and/or her left shoulder which was ultimately diagnosed and treated as a cervical spine condition. In any event, the fact that Petitioner sustained a traumatic injury is corroborated by the record overall and it is inconsistent with Dr. Stamelos' medical records that Petitioner purportedly reported a repetitive trauma injury from the beginning.

On November 14, 2001, Dr. Stamelos' records show that reported an injury to her left shoulder due to repetitive usage. His records from this date forward are consistently inconsistent regarding whether Petitioner injured herself in a traumatic incident while pushing/pulling/lifting weight, or if she had a traumatic onset of pain secondary to repetitive usage of the left upper extremity (or both extremities, for that matter). Contemporaneous diagnostic records reveal that Petitioner reported a traumatic pushing and pulling injury and not an injury stemming from repetitive usage as Dr. Stamelos contends. Even the MRIs and EMG/NCV that Dr. Stamelos ordered were performed to rule out left shoulder impingement versus a rotator cuff tear as a result of a pushing/pulling injury and not to diagnose any repetitive trauma medical condition based on left-sided or certainly bilateral carpal tunnel syndrome symptomatology.

These important contradictions are highlighted in Dr. Stamelos' deposition. He testified that, while Petitioner told him that she injured herself secondary to pushing a lot of weight, "*[w]ell, that's what she said in Greek, **maybe I misinterpreted. What she meant was repetitive motion. There is no Greek word for repetitive motion.** Pushing a lot of weight or doing a lot of work, work with her hands of course.*" PX12, p. 51 (***emphasis added***). He added, "***I think** there is weight involved,* but ***I think she meant** just an awful lot of work went through her hands*, that would be a good way to describe it. [.... And, there] was lifting in her job. ***She said** she had to lift some boxes after she filled them, but **she said** most of her work was doing repetitive motion. And somebody, **I think, I don't remember**, somebody **I think** it was this doctor who saw her, said she did like 3,000 maneuvers a day or something*[, which was Petitioner's estimate to that doctor and probably to him as well.]" PX12, pp. 51-52 (***emphasis added***). In addition to the self-evident inconsistencies and liberal interpretations made by Dr. Stamelos about what Petitioner said and what he thinks she meant to say, the Arbitrator notes that a simple internet search for the Greek-English translation of the word "repetitive" renders several immediate results including one for the phrase "done repeatedly."

On cross examination, Dr. Stamelos gave a general differential diagnosis explanation to account for his treatment and focus on Petitioner's central issue (i.e., the neck/left shoulder) instead of her left hand and then both hands for suspected carpal tunnel syndrome. In addition to the context explained above, Dr. Stamelos' otherwise reasonable explanation for his initial treatment and diagnostic focus is not persuasive in this case when his records so blatantly lack in objective clinical findings at most visits such that his diagnoses and ultimate causal connection opinions are reliable. Based on the foregoing, the Arbitrator finds that Petitioner did not report any repetitive usage injury to Dr. Stamelos, but rather that he inferred and concluded as much without relying on objective medical evidence in support thereof.

In addition, Dr. Stamelos admits that he did not review Petitioner's specific job description(s), he is unsure of what exactly Petitioner did "3,000" times per day over 27 years, and Petitioner did not demonstrate to him the repetitive activities that she performed at work. He admits that he had many of Respondent's patients in the past so his "experience with Motorola was repetitive usage of their extremities." He also admits that in at least one instance he essentially gave Petitioner the opinion that she wanted in a narrative report because he "would just rather write it and get her off [his] back than argue with her." PX12, pp. 50-51.

Similarly, the Arbitrator finds that Dr. Stamelos' causal connection opinion regarding Petitioner's bilateral carpal tunnel syndrome and her September 23, 2004 injury is unpersuasive. Dr. Stamelos failed to note

objective clinical findings at most of Petitioner's visits to support his opinion. He relied on Petitioner's unreliable and inconsistent reports about the mechanism of injury. Dr. Stamelos also relied on Petitioner's inconsistently reported job duties and actual work activities, while opining on causal connection without the benefit of any actual job description or other indication of Petitioner's actual work activities. Moreover, as reflected in his deposition testimony, Dr. Stamelos had already opined that Petitioner's work activities caused her carpal tunnel syndrome and he steadfastly maintained his causal connection opinion regarding Petitioner's September 23, 2004 injury while relying primarily on Petitioner's unreliable reports to him.

For example, at trial Petitioner testified that she sustained a traumatic injury while lifting boxes when she hurt herself and felt a sharp pain. Petitioner's testimony on direct and cross examination and her handwritten incident report dated October 14, 2004 conflict regarding the position that she worked when she was injured, manual tune or laser. In further contrast, Dr. Stamelos' records contain two different progress notes dated September 27, 2004 in which Petitioner reportedly sustained "a repetitive motion injury while working in the assembly line" and that she returned after an injury at work four days earlier with "quite significant" pain complaints of neck stiffness, pain, and radiculopathy "that has occurred since the time of the injury while working at Motorola." Dr. Stamelos' most contemporaneous progress notes to Petitioner's September 23, 2004 injury do not specify Petitioner's job at the time of her injury or any objective clinical findings or measurements to support his contention that Petitioner's previously diagnosed bilateral carpal tunnel syndrome was somehow aggravated by the incident at work.

In fact, Dr. Stamelos admitted on cross examination that Petitioner had no hand complaints only four days after her second work accident all the way through November 17, 2004. He further admitted that he did not treat Petitioner for carpal tunnel syndrome from the second half of 2004 through 2007, although he qualified his response by stating that he treated Petitioner for the more important cervical injury. Indeed, Dr. Stamelos could not reasonably treat Petitioner for bilateral carpal tunnel syndrome as his records do not refer to Petitioner's carpal tunnel condition until July 31, 2006 and they are similarly devoid of reference to objective findings through that date and thereafter supporting his ultimate, albeit conclusory, opinion that Petitioner's work activities somehow aggravated Petitioner's already causal connected bilateral carpal tunnel syndrome.

Dr. Stamelos' records are also conspicuously devoid of objective clinical findings or corroborative symptomatology complaints made by Petitioner to support his conclusion about the relatedness of Petitioner's bilateral carpal tunnel syndrome to her work activities after either injury at work. Even assuming that Petitioner's report of numbness, pain and tingling radiating down to the first three digits of the left hand on November 14, 2001 and December 5, 2001stemmed from Petitioner's left sided carpal tunnel syndrome as a result of either a traumatic or a repetitive trauma injury, Dr. Stamelos' records are devoid of any physical examination findings related to the left hand or wrist, much less the right hand or wrist, through the majority of his treatment of Petitioner. In fact, the first time that Dr. Stamelos' records refer to carpal tunnel syndrome is on December 11, 2001 in Petitioner's EMG/NCV results. Prior to and even after this date, Dr. Stamelos' records do not reference any Tinel's, Phalen's or any other objective examination findings to clinically correlate Petitioner's left hand numbness and tingling into the first three digits with her repetitive work activities as opposed to radiculopathy stemming from Petitioner's later-diagnosed cervical condition. Dr. Stamelos even admits in his deposition that Petitioner never showed him exactly what she did at work and he never reviewed any job description for Petitioner such that he could plausibly opine based on objective medical evidence that her left (or right) hand condition resulted even in part from activities at work.

Additionally, Petitioner did not complain of any traumatic injury to the right arm, hand or wrist at any time, nor did she report any right hand/wrist symptomatology until March 20, 2002 when she had been off work for a little over four months and she first reported "numbness and tingling *in the bilateral hands*, left hand worse than

right." PX5 (*emphasis added*). Thereafter, on October 2, 2002, while Petitioner was working light duty Dr. Stamelos diagnosed Petitioner with "[c]ontinued bilateral hand pain, carpal tunnel syndrome and cervical syndrome" even though the work note provided for her only reflects "cervical strain, radiculitis" and different work restrictions than those identified in Dr. Stamelos' progress note. PX5. Petitioner did not seek medical treatment again for nine months until July 2, 2003 and then again for approximately eight months until February 25, 2004 at which time Dr. Stamelos noted that Petitioner would either need surgery at C5-C7 or permanent work restrictions to accommodate the herniated discs in her neck and left radiculopathy, but he did not mention Petitioner's carpal tunnel syndrome, any complaints by Petitioner of bilateral hand pain or right-sided symptoms, much less any objective clinical findings on examination of Petitioner. Approximately one month later, on March 31, 2004, Petitioner returned reporting ongoing neck pain, but she did not report pain in either arm or hand. Three months afterwards, on June 30, 2004, Dr. Stamelos noted that Petitioner had carpal tunnel syndrome and needed surgery, that she had low back pain, and cervical spine syndrome due to herniated discs at C5-C7 "all from an injury on October 10, 2001 at Motorola." PX5. Petitioner's only report of low back pain prior to this time was on July 2, 2003, approximately one year and nine months after her work accident, and now one year after her only complaint of low back pain on July 2, 2003.

Another three months later (and four days after her second accident) on September 27, 2004, Dr. Stamelos noted that Petitioner returned after sustaining "a repetitive motion injury while working in the assembly line and pushing fixtures." PX5. This mechanism of injury is similar to that reported by Petitioner on cross examination and noted in Dr. Stamelos' November 14, 2001, July 2, 2003, and February 25, 2004 progress notes. He diagnosed Petitioner with herniated discs at C5-C7, but makes no mention about carpal tunnel symptomatology or examination findings in either arm or hand other than radiating symptoms to the left upper extremity from the cervical condition. Dr. Stamelos' records contain two different progress notes dated September 27, 2004, the second of which refers to Petitioner's September 23, 2004 accident after which she complained of significant neck stiffness, pain, and radiculopathy that Dr. Stamelos noted "has occurred since the time of the injury while working at Motorola. The radiculopathy and the pain was so severe that she had to get an emergency appointment to see me where I will try to treat her for these new symptoms that she has developed." PX5. Dr. Stamelos' records, however, are unclear about the new symptoms that Petitioner reported on September 27, 2004, whether they involved Petitioner's bilateral hands, and no objective examination findings are noted that distinguish Petitioner's new symptoms from those resulting from the October 10, 2001 injury. Again, Dr. Stamelos does not reference any symptomatology or diagnoses in any other body part whatsoever and no objective evaluation of Petitioner's hands was identified in the records. Dr. Stamelos' records continue to be vague through October 13, 2004 and refer to a continuation of the "current course of management" without any objective clinical examination findings regarding Petitioner's neck, arms, or hands in reference to any of Petitioner's reported symptomatology. As reflected in the findings of fact, the aforementioned list of missing or inconsistent information contained in Dr. Stamelos' records is not exhaustive. Based on all of the foregoing, the Arbitrator finds that Dr. Stamelos' causal connection opinions with regard to either of Petitioner's work accidents are unpersuasive and gives them no weight.

Finally, the Arbitrator gives little weight to the opinions of Dr. Williams and Dr. Chmell. Dr. Williams' causal connection opinion is predicated on a single examination, limited medical records available for review, and incomplete, if not completely inaccurate, information about Petitioner's work activities. Dr. Williams admitted that he did not have Petitioner's actual job description to consider, he did not view any video depicting any of Petitioner's job duties, and he also testified that he based his opinion on his understanding that Petitioner worked in manual tune which required repetitive forceful activities, extensive use of small tools, continuous gripping/grasping/pinching/fine motor activities, and the use of vibratory tools garnered from Petitioner's reports to him and a summary of work duties compiled by Petitioner's counsel. According to her testimony at trial, Petitioner was not working on manual tune or performing related functions at the time of either incident in

2001 or 2004. As explained in detail above, the job duties and work activities reported by Petitioner conflict throughout the record.

Dr. Williams also admitted that there was an increased incidence of carpal tunnel syndrome stemming from genetic factors including age, gender (in postmenopausal women), and increased weight. Regarding the curious increase in Petitioner's symptomatology while she was not at work, Dr. Williams contended that her bilateral carpal tunnel syndrome was "masked" by the cervical spine condition and related symptomatology and that Petitioner initially sustained a "double-pinch" or "double-crush" injury. Dr. Williams' opinion does not, however, adequately explain how Petitioner's left sided cervical spine condition and symptoms masked right sided carpal tunnel for years which is in a very different anatomical distribution than Petitioner's left sided carpal tunnel.

Dr. Chmell's causal connection opinion is similarly predicated on a single examination, limited medical records available for review, and incomplete, if not completely inaccurate, information about Petitioner's work activities and the mechanisms of injury. Based on all of the foregoing, the Arbitrator assigns little weight to the causal connection opinions of Dr. Williams and Dr. Chmell.

The Arbitrator does find Dr. Fernandez's opinion to be persuasive given the totality of this record. He is the only physician to review any job description or specific physical demand description of any of Petitioner's positions with Respondent. He is the only physician that viewed the performance of any of Petitioner's activities at work in a video, even if the activities were done at a slower pace or on fewer machines than Petitioner reports she worked. He is also the only physician to plausibly explain that the potential multifactorial causes of carpal tunnel syndrome do not automatically result in a causal connection opinion linking a patient's work activities and carpal tunnel syndrome; each factor much be considered in the full context of the patient's case including consideration of the specific work activities. For example, Dr. Fernandez plausibly explained that repetitive hand/wrist activities, the use of a vibratory air tool, or the use of any hand tool no matter how repetitively, would not in and of itself cause bilateral carpal tunnel syndrome; it would depend on the type of tool and the force associated with the use of the tool and the repetitive and *heavy* or *forceful* gripping/grasping/ tool use. Dr. Fernandez also admitted that while Petitioner's reported tasks were repetitious and had occurred over decades they were also relatively varied and none of the activities involved gripping or grasping with significant force, the use of heavy tools, or significant hyperextension or hyper flexion for prolonged periods of time.

Furthermore, Dr. Fernandez noted that carpal tunnel syndrome is most commonly seen in females in Petitioner's age group, that Petitioner was at additional risk given her increased body mass index, and that, while there was no doubt that Petitioner's symptoms may increase or worsen with exposure to work activities, her condition could also increase or worsen with exposure to *any* activities which did not warrant a finding of causal relationship or aggravation on that basis alone. Given the totality of the record, the Arbitrator finds that Dr. Fernandez's opinion is persuasive and assigns greater weight to the opinion of Dr. Fernandez in this case because his opinions are based on objective information and a more complete understanding of Petitioner's medical condition and work activities rather than speculation, inference, conjecture or, primarily, Petitioner's incomplete and unreliable reports.

Based on all of the foregoing, the Arbitrator finds that Petitioner failed to meet her burden of proof to establish a causal connection between her current bilateral carpal tunnel syndrome condition and either accident at work.

Petitioner contends that her left elbow condition is causally connected to one or both of her injuries at work. Petitioner did not testify about any mechanism of injury occurring on either date of accident that would plausibly give rise to her claimed current condition of ill being in the left elbow. Indeed, the record is devoid of any elbow complaints made by Petitioner until May 7, 2008, over 6½ years after her first accident and over 3½ years after her second accident. On this basis alone, the Arbitrator finds that no causal connection finding is reasonable given the enormous gap in time between Petitioner's accidents and any onset of left elbow symptomatology. The Arbitrator also notes that Petitioner was not working during much of this time frame.

Notwithstanding, Petitioner's own physician, Dr. Williams, essentially discounts any such causal connection finding. While he opined that Petitioner's lateral epicondylitis is causally related to her injuries at work, he could not identify when Petitioner's elbow symptoms began and he admitted that Petitioner's symptoms developed in middle age which would not be masked by her cervical condition because it was not located in the same anatomical distribution. Based on all of the foregoing, the Arbitrator finds that Petitioner has not established a causal connection between her claimed current left elbow condition of ill being and either work accident.

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

Petitioner alleges entitlement to payment of $8,913.00 in outstanding medical bills from Dr. Stamelos only. AX1;AX2. The bills submitted from Dr. Stamelos reflect dates of service, but not the specific medical treatment underlying each bill. PX16. As causal connection has been resolved in Petitioner's favor with respect to her cervical spine and left arm radiculopathy condition only, the Arbitrator finds that any medical bills related to Petitioner's cervical spine and left arm radiculopathy condition are reasonable and necessary. The Arbitrator awards such bills. The Arbitrator further finds that any medical bills related to Petitioner's bilateral carpal tunnel syndrome or left lateral epicondylitis conditions are not reasonable or necessary and such bills are denied.

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

As causal connection has been resolved against Petitioner with respect to her bilateral carpal tunnel syndrome or left lateral epicondylitis conditions, the Arbitrator denies the requested prospective medical care related thereto.

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

JASON HAHS,

Petitioner,

vs.

NO: 10 WC 45193
11 WC 25184

141WCC0100

STATE OF ILLINOIS /
BIG MUDDY RIVER CORRECTIONAL CTR.,

Respondent,

DECISION AND OPINION ON REVIEW

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

The Commission makes a special finding that this case is easily distinguishable from the decision in *Branden Schrader v. State of Illinois / Big Muddy River Correctional Ctr.*, 13 IWCC 0089 (1/28/13), which Petitioner cited in his brief.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 19, 2012, 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: FEB 1 1 2014

Charles J. DeVriendt

Michael J. Brennan

Ruth W. White

SE/
O: 12/18/13
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAHS, JASON
Employee/Petitioner

Case# **10WC045193**

11WC025184

SOI/BIG MUDDY RIVER CORRECTIONAL CENTER
Employer/Respondent

14IWCC0100

On 10/19/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% 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:

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

OCT 19 2012

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)SS.

14IWCC0100

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

Jason Hahs
Employee/Petitioner

v.

State of Illinois/Big Muddy River Correctional Center
Employer/Respondent

Case # 10 WC 45193

Consolidated cases: 11 WC 25184

An *Application for Adjustment 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 **Herrin**, on **8/15/12**. After reviewing all 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 for date of accident 10/15/10?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent for date of accident 10/15/10?
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

14IWCC0100

On 10/15/10 & 5/31/11, 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 accidents that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $61,724.00; the average weekly wage was $1,187.00.

On these dates of accident, Petitioner was 38 years of age, *married* with 2 dependent children.

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

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

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

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

ORDER

Petitioner has not met his burden of proof regarding the issues of accident and causation. Accordingly, Petitioner's claims 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

10/16/12
Date

OCT 19 2012

14IWCC0100

Findings of Fact

Petitioner is employed as a Correctional Officer for Respondent at its Big Muddy River Correctional Center where he has worked as a Correctional Officer for 15 years. Petitioner is alleging he sustained two accidents, both of which will be addressed in this decision. Petitioner's first claim alleges a repetitive trauma accident involving both his hands and elbows for an accident date of October 15, 2010. His second claim is for a traumatic incident on May 31, 2011 involving only his left elbow/arm and left hand. Respondent is disputing the first accident based on the issues of: 1) accident, 2) notice, 3) causation, 4) medical expenses and 5) permanency. Respondent is disputing the second accident based on the issues of: 1) causation, 2) medical expenses and 3) permanency.

Petitioner testified that during the course of performing his job duties up to and including October 15, 2010, he began developing symptoms of tingling, numbness, soreness in his hands and arms, and loss of grip strength. He further testified that he first began developing symptoms when he was a Segregation Officer. He described his job duties as a Segregation Officer involved various activities, including turning keys and opening/closing chuckholes on a regular basis. He would also cuff/uncuff inmates, check property boxes and perform shakedowns in this job.

On October 15, 2010, Petitioner saw Dr. Brent Newell of Southern Illinois Healthcare for an EMG on referral from Petitioner's treating physician, Dr. Anad Salem. Dr. Newell's report from that day indicates a history that the Petitioner **"[h]as numbness in both hands at work and while driving. Has had symptoms for about 1 year."** (PX. 3, emphasis added) The impressions from this exam included moderate bilateral medical neuropathy at his wrists and mild left ulnar neuropathy at the elbow.

On October 29, 2010, Dr. Salem's record indicates that Petitioner saw Dr. Salem for complaints of plantar fasciitis as well as a follow up to the EMG with Dr. Newell. Dr. Newell's records note that the Petitioner **"...is going to file a workman's comp claim, because he is working in the control room, and his wrists hurt from operating the control room without rest. He states that he will use an orthopedics [sic] in St. Louis."** (PX. 4, emphasis added)

Petitioner testified that his attorney referred him to see Dr. Brown of the Orthopedic Center of St. Louis. On November 22, 2010, Dr. Brown saw Petitioner and provided the following history: **"His job entails turning keys, opening and closing doors and operating switches.** He explains to me he has a year plus history of pain, numbness and tingling in both his hands and some elbow pain." (PX. 5, emphasis added) Based on this job description, Dr. Brown believed Petitioner's work activities were "in part an aggravating factor in the need for further evaluation and treatment of carpal tunnel syndrome and/or cubital tunnel syndrome." Dr. Brown sends Petitioner to Dr. Daniel Phillips, who conducts nerve conduction studies that are consistent with bilateral carpal tunnel and cubital tunnel syndrome. Dr. Brown then recommended surgery to address these conditions. Petitioner did not undergo surgery at that time. He continued to work regular duty despite the recommendation for surgery.

On May 31, 2011, Petitioner was involved in an altercation with an inmate. Petitioner claims that in that altercation, he landed on his left side. He testified that his left hand went numb and his symptoms were significantly worse. Following this incident, Petitioner went to Herrin Hospital. The records from Herrin Hospital indicate complaints of pain and abrasion to the left elbow and forearm. The June 25, 2011 diagnostic tests from this provider indicate symptoms of left elbow strain. (PX. 7)

On July 6, 2011, Petitioner saw Dr. George Paletta of the Orthopedic Center of St. Louis. Dr. Paletta notes the previous diagnosis of carpal tunnel syndrome and cubital tunnel syndrome. Petitioner provided Dr. Paletta a history of injuring his left elbow while attempting to restrain an inmate. Petitioner claimed that he felt immediate pain and numbness with tingling into his left hand. Dr. Paletta's impression was a traumatic aggravation of Petitioner's ulnar neuritis of the left elbow. Dr. Paletta ordered an EMG, which revealed moderately severe ulnar neuropathy in the left elbow consistent with cubital tunnel and moderate carpal tunnel syndrome in the right wrist according to his July 7, 2011 record. (PX. 8) Dr. Paletta noted that the EMG test results were similar to the previous EMG and nerve conduction studies from November 2010. Dr. Paletta performed left carpal tunnel release and left elbow ulnar nerve transposition surgery on August 30, 2011.

Petitioner testified that he still experiences soreness in his left elbow, that he cannot straighten his left arm and that he has decreased strength. He cannot work on cars or boat motors and takes over the counter medication for his pain.

On cross-examination, Petitioner testified that he has not been in the Seg Unit or Segregation Unit since 2008. After leaving the Seg Unit, he did not have to handle Folger Adams keys, nor did he have to operate chuckholes. He confirmed that the Seg Unit is the only unit that utilizes the Folger Adams keys. The Petitioner testified that he spent eight years total working in Segregation but for five of those years he only worked in Segregation two days a work week. Petitioner also confirmed that he first began noticing numbness in his hands in 2008. His hobbies and sports include weight lifting and motorcycling.

Respondent retained Dr. Anthony Sudekum as a Section 12 IME. Dr. Sudekum authored reports dated March 19, 2011 and October 2, 2011. He also testified via evidence deposition on May 5, 2011 and May 3, 2012. Dr. Sudekum opined that he did not believe Petitioner's carpal tunnel syndrome and cubital tunnel syndrome were caused by his employment activities – either due to the alleged repetitive activity culminating on October 15, 2010 or by the single incident on May 31, 2011. Dr. Sudekum believed that these conditions were pre-existing and that the Petitioner's obesity as well as his outside activities of weight lifting and motorcycling was all contributing factors to these conditions. Dr. Sudekum testified that during the Petitioner's examination, the Petitioner "scoffed sarcastically" that the State of Illinois and the Department of Corrections were "a joke" in response to Dr. Sudekum's explanation of the purpose behind the evaluation. (RX. 4, pg. 22) Dr. Sudekum also noted elements of symptom magnification by the Petitioner during his examination. (RX. 4, pg. 16-18)

Based on the foregoing, the Arbitrator makes the following conclusions:

Regarding the issue of accident, the Arbitrator finds that the Petitioner's testimony lacks credibility in light of the medical evidence. Essentially, Petitioner is claiming a repetitive trauma accident for work that he had stopped doing 2 years before his alleged accident date. The initial facts surrounding the repetitive trauma claim evolve in the medical records in 3 stages. Initially, his complaints are of numbness in both hands while at work and while driving (per Dr. Newell on October 15, 2010). Then, he explains that his wrists are hurting from operating in control room without rest (per Dr. Salem on October 22, 2010). Later, this evolves into his job involving the turning of keys, opening doors, closing doors, operating switches with a history of pain, numbness and tingling in both hands and elbows (per Dr. Brown on November 22, 2010). Petitioner's testimony then goes into great detail on the job duties he performed in the Segregation Unit – which he later admitted was no longer part of his job duties as of 2008. Even putting aside the Petitioner's lack of credibility, the 2 year passage of time - from the last time Petitioner performed his duties in the Segregation Unit to the alleged

accident/manifestation date of October 15, 1010 – is too great of a factual stretch in this case to prove that Petitioner sustained an accident.

Regarding the Petitioner's claim for an accident stemming from his alleged incident on May 31, 2011, the Arbitrator finds that the Petitioner has failed to meet his burden of proving that his condition of ill-being is causally related to the incident in question. Petitioner testified that this single incident made his symptoms significantly worse. He described how his left hand went numb after the alleged event. However, upon close review of the medical records, the Petitioner's complaints at that time were described as an "elbow sprain." Despite the Petitioner's testimony, the medical records clearly show that the Petitioner's condition both before and after the May 31, 2011 was not significantly different. In fact, Dr. Brown had commented that the Petitioner needed surgery for his condition prior to the May 31, 2011 event. The May 31, 2011 event was a temporary aggravation of the Petitioner's pre-existing condition. As indicated above, the pre-existing condition was not the result of an accident.

In light of these factual issues that cast the Petitioner's credibility into serious doubt, it is not surprising that the Petitioner exhibited symptom magnification at his IME and expressed his belief that both the Respondent and the State of Illinois are a "joke." For all these reasons, the Arbitrator finds that the Petitioner did not meet his burden of proof regarding the issue of accident and causation. Accordingly, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Peggy Stolte,

Petitioner,

vs.

NO: 11 WC 47860

14IWCC0101

St. Anthony's Memorial Hospital,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 21, 2013, 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.

141

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $29,300.00. 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: FEB 11 2014
TJT:yl
o 1 27 14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STOLTE, PEGGY
Employee/Petitioner

Case# **11WC047860**

ST ANTHONY'S MEMOIRAL HOSPITAL
Employer/Respondent

14IWCC0101

On 3/21/2013, 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 0.11% 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:

3067 KIRKPARTICK LAW OFFICES PC
ERIC KIRKPATRICK
#3 EXECUTIVE WOODS CT STE 100
BELLEVILLE, IL 62226

0734 HEYL ROYSTER VOELKER & ALLEN
JOHN FLODSTROM ESQ
PO BOX 129
URBANA, IL 61803-0129

14IWCC0101

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Peggy Stolte
Employee/Petitioner

v.

St. Anthony's Memorial Hospital
Employer/Respondent

Case # 11 WC 47860

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 **Mt. Vernon**, on **January 11, 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. [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. [x] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **September 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 **$20,218.12**; the average weekly wage was **$388.81**.

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

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

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

ORDER

The Respondent shall pay Petitioner permanent partial disability benefits of $233.29 /week for 125 weeks, because the injuries sustained caused the 25% 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.

Deborah L. Simpson
Signature of Arbitrator

March 20, 2013
Date

MAR 21 2013

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Peggy Stolte,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 11 WC 47860**
	)	
St. Anthony's Memorial Hospital,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on September 22, 2010, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. On that date the Petitioner sustained an accidental injury or was last exposed to an occupational disease that arose out of and in the course of the employment. They further agree that the Petitioner gave the Respondent notice of the accident within the time limits stated in the Act.

At issue in this hearing is as follows: (1) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (2) Were the medical services that were provided to the Petitioner reasonable and necessary; (3) Has the Respondent paid all appropriate charges for all reasonable and necessary medical services; (4) What is the nature and extent of the injury; and (5) Is the Respondent due any credit.

STATEMENT OF FACTS

On September 22, 2010, the Petitioner was employed by the Respondent as a laundry technician in the linen department. On that date she was lifting some bedspreads that were clean, folded and packaged together. When she lifted the spreads from where they were stacked overhead the cart she was going to place them on moved, they started to fall backwards, she was able to prevent herself as well as the bedspreads from falling, however the movement caused pain to her lower back that developed into pain down her right leg and into her foot. The Petitioner is claiming an injury to her back from turning to catch the falling bedspreads.

The Petitioner has a history of a prior work related injury to her back. She was working for a previous employer when she injured her back in a lifting incident. She was under the care of Dr. Matthew Gornet and underwent a fusion at L4 to S1 in December 2003. (Pet. Ex. #3).

The Petitioner testified that she had continuing symptoms in her right leg following the surgery in December 2003, and prior to the claimed work accident of September 22, 2010. Specifically, she had ongoing numbness in her right calf and the toes of her right foot. She testified that she had been able to return to her regular job, full duty after the fusion surgery in 2003, and was able to perform all her duties. She acknowledged during her testimony that she was seen by her primary care physician at the Altamont Clinic on December 12, 2008. Her symptoms included right leg pain and back pain.

The Petitioner testified that when she was lifting some bedspreads they fell and she twisted her back while attempting to catch them. She caught herself with her right arm during the incident, but did not fall to the ground. She stated that she immediately felt burning pain in her lower back that eventually developed into pain radiating down her right leg, around her thigh and down into her right foot. She said that this pain was much stronger than the pain she had experienced in the past. She stated that the pain wrapping around her thigh down her leg was something she had never experienced before the accident.

She received her initial care from a chiropractor, Dr. Stanfield, and later transferred her care to Dr. Rudert at the Bonutti Orthopaedic Clinic. She was later referred to Dr. Matthew Gornet, who had treated her for her prior back injury.

Dr. Stanfield's treatment helped a little with the pain in her shoulder and her upper back, but provided no relief from the low back and leg pain.

Dr. Rudert treated the Petitioner with oral steroids and ordered physical therapy. The Petitioner had six physical therapy sessions and was given a TENS unit but that provided no relief from the back and leg pain.

The first visit with Dr. Gornet (related to the present case) took place on December 13, 2010. (Pet. Ex. #3). Dr. Gornet performed an examination and reviewed some test films. He recommended some treatment and stated in his notes that, "I do believe her current symptoms are causally connected to her work related injury of 9/22/10."

The petitioner remained under Dr. Gornet's care following the initial visit on December 13, 2010.

He stated that her current symptoms were causally related to her accident. He prescribed an epidural steroid injection which was done on December 27, 2010. He sent her for two injections. The injections provided a few days relief of her back pain but it was not permanent relief.

On March 3, 2011 Dr. Gornet noted the new MRI revealed pathology at L2-3 with a central disc protrusion. He recommended a discogram at L3-4 and L2-3. The discogram was performed on April 6, 2011. This discogram revealed a mildly provocative disc at L3-4 with a severely provocative disc at L2-3.

When surgical options were discussed on April 25, 2011 Petitioner was adamant about how her pain and symptoms affected all aspects of her life. Petitioner opted for the two-level spinous process distractor rather than another fusion.

Surgery was performed on June 14, 2011 consisting of a laminotomy at L2-3 and L3-4. "X-stop spinous process distractors" were placed at L2-3 and L3-4.

The Petitioner testified that post surgically she was painful but the pain that had wrapped around her right thigh and down her leg was relieved. Her back pain soon also lessened. The same was reported to Dr. Gornet when he saw her on July 7, 2011.

Dr. Gornet ultimately allowed her to return to work with restrictions which her employer accommodated. On June 25, 2012 these restrictions were made permanent; no lifting greater than 20lbs, alternating between sitting and standing and no repetitive bending or lifting.

On June 25, 2012, she was placed at maximum medical improvement.

The Petitioner testified that her employer does accommodate her permanent restrictions. Petitioner stated she cannot stand for more than 30 minutes or sit for more than 30 minutes at a time. She used to walk for exercise and now walks less; one-half of a mile vs. 1.5 miles. She is unable to do heavy housework such as vacuuming. In fact, she removed the carpet in her house because of her limitation.

Her hobbies have also been affected. She cannot sit and sew as she previously had done. She cannot go camping as before. In addition, she is unable to lift her grandchildren. She is also unable to sleep with her husband and many times sleeps in a recliner.

The respondent has stipulated that the petitioner sustained a work related injury to her back during the accident of September 22, 2010. However, the respondent has disputed that all of the medical care for the petitioner's back, including Dr. Gornet's surgery of June 14, 2011, is causally related to the claimed work accident.

CONCLUSIONS OF LAW

Thus, if a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Sisbro supra.* "[*A*] Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd dist. 2000).

Is the Petitioner's current condition of ill-being causally connected to this injury or exposure?

Dr. Gornet, after examining the Petitioner and taking a history from her as well reviewed her medical records. In reviewing the MRI of October 12, 2010 felt it showed a potential lateral disc herniation at L2-L3 which correlated with the symptoms that the Petitioner described. He

also felt she had a lateral disc herniation at L3-L4. He asked for a repeat MRI which Dr. Gornet noted the symptoms correlated with pathology at L2-3 and L3-4 and this was also confirmed by CT/discogram. It was the opinion of Dr. Gornet that her condition was causally related to her accident.

Dr. Matz opinioned that petitioner suffered a lumbar strain from the accident, but that the degenerative conditions in the low back were not related to the injury. He believed that for the work related injury she needed a TENS unit and work hardening. He felt surgery was for the preexisting condition. Dr. Matz's evidence deposition was received into evidence as respondent's Exhibit #1. Dr. Matz testified that he examined the petitioner and reviewed her medical records on January 11, 2012, after the surgery. According to Dr. Matz, and this is confirmed in Dr. Gornet's post-operative diagnosis of "stenosis", the surgery done by Dr. Gornet was done for the purpose of correcting a degenerative condition, lumbar stenosis, and not for any conditions related to the alleged work accident of September 22, 2010. (Resp. Ex. #1 at pg. 11). Dr. Matz concluded the petitioner would have suffered a lumbar strain in the twisting type accident and that that injury would not have created any need for surgical intervention. (Resp. Ex. #1 at pgs. 9-10).

When asked on cross-examination whether the lumbar strain he diagnosed, when superimposed on preexisting conditions could have caused those to become symptomatic he testified he expected that for the stretching to have irritated the nerve he would have expected the foramina to be critically tight. He then agreed that the surgical report of Dr. Gornet noted that the foramen was released as it was compressing the right sided nerve.

Significantly, Petitioner testified to the immediate onset of severe low back and then pain that she had never had before; pain down her right leg that wrapped around her thigh. Her quality of life deteriorated after this accident. Most significant is the fact that Petitioner testified to relief of her symptoms after her surgery.

The Respondent paid TTD and agreed to pay medical bills but disputes causation based upon the opinions expressed by Dr. Matz. This arbitrator finds the testimony of the Petitioner supports the opinion expressed by Dr. Gornet. This arbitrator finds that surgery was related to the accident and was necessary to relieve its effects. The Petitioner has sustained her burden of proving a causal relationship.

Were the medical services that were provided to the Petitioner reasonable and necessary? Is the Respondent entitled to any credit?

Based upon the reasoning above and the testimony of Dr. Gornet that the treatment was reasonable and necessary and the agreement of Dr. Matz that Dr. Gornet's treatment was appropriate for the spinal stenosis the Arbitrator finds that the medical services provided to the Petitioner were reasonable and necessary.

There is no evidence offered to establish that there are any outstanding unpaid medical bills or that there is any outstanding TTD owed. Since the Petitioner's condition of ill being was causally connected to the injury she sustained the Respondent would have been responsible for

the bills and the TTD which the Petitioner agreed were paid. The Respondent is not entitled to any credit against the PPD award.

What is the nature and extent of the injury?

The permanent restrictions placed upon the Petitioner are significant; no lifting greater than 20lbs, alternating between sitting and standing and no repetitive bending or lifting. The Respondent is accommodating these restrictions according to the Petitioner. However the limitations carry over into other aspects of the Petitioner's life. The Petitioner testified that she cannot stand for more than 30 minutes or sit for more than 30 minutes at a time. She used to walk for exercise and now walks less; one-half of a mile vs. 1.5 miles. She is unable to do heavy housework such as vacuuming and has removed the carpet in her house because of her limitation.

Her hobbies have also been affected. She cannot sit and sew or go camping. She cannot lift her grandchildren. She is also unable to sleep with her husband and many times sleeps in a recliner.

The Petitioner has been left with permanent damage that effects all aspects of her life. This arbitrator finds Petitioner is entitled to an award of 25% loss of a person as a whole.

ORDER OF THE ARBITRATOR

Respondent shall pay Petitioner permanent partial disability benefits of $233.29 /week for 125 weeks, because the injuries sustained caused the 25% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Deborah L. Simpson
Signature of Arbitrator

March 20, 2013
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mary J. Deck,

Petitioner,

vs.

NO: 12 WC 9372

14IWCC0102

Freightcar America,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, 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 June 7, 2013, 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.

14IWCC0102

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: FEB 11 2014
TJT:yl
o 1/28/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Daniel R. Donohoo

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

DECK, MARY J
Employee/Petitioner

Case# **12WC009372**

FREIGHTCAR AMERICA
Employer/Respondent

14IWCC0102

On 6/7/2013, 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 0.08% 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:

0874 FREDERICK HAGLE FRANK & WALSH
KEVIN E MARKS
129 W MAIN ST
URBANA, IL 61801-2714

1872 SPIEGEL & CAHILL PC
MARTIN T SPIEGEL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

14IWCC0102

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MARY J. DECK
Employee/Petitioner

v.

FREIGHTCAR AMERICA
Employer/Respondent

Case # 12 WC 9372

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brandon J. Zanotti**, Arbitrator of the Commission, in the city of **Urbana**, on **April 19, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other: 1. Is Dr. Greatting's report admissible?; and 2. Is Petitioner's claim barred by the statute of limitations?

FINDINGS 14IWCC0102

On the date of accident, **August 15, 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 **$42,366.71**; the average weekly wage was **$814.74**.

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

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

Respondent shall be given a credit of **$32,211.15** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$32,211.15**.

Respondent is entitled to all applicable credit under Section 8(j) of the Act. The parties stipulated that Respondent is entitled to credit for any medical bills that had been paid by group medical coverage.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $543.16/week for 5 weeks, commencing 01/07/2013 through 02/11/2013, as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for a functional capacity evaluation.

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

06/04/2013
Date

ICArbDec19(b)

JUN - 7 2013

STATE OF ILLINOIS)
) SS
COUNTY OF CHAMPAIGN)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC0102

MARY J. DECK
Employee/Petitioner

v.

Case # 12 WC 9372

FREIGHTCAR AMERICA
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Mary J. Deck, claims repetitive trauma injuries with an August 15, 2011 date of accident. The injuries involve both arms primarily at the elbows. Petitioner testified at hearing with respect to her job duties for her employer, Respondent, Freightcar America. She also testified regarding her pain symptoms and medical care. The only other witnesses, treating surgeon, Dr. James Sobeski, and Respondent's examining doctor, Mark Cohen, testified by evidence depositions. While Respondent had previously paid benefits, the compensability of the injuries was disputed at hearing.

Petitioner worked for Respondent since 2001, and worked as a decaler since 2003. Her job remained essentially the same until the claimed manifestation date of the accident, August 15, 2011. Petitioner testified that each day she pressed different sized decals onto railroad cars. The largest decals were approximately 2.5 x 3 feet in size and required great effort to apply. Petitioner testified that she would use her full body weight for application of the decals. Fifty-one of these decals were applied each day. 459 smaller decals were personally applied daily by Petitioner.

Petitioner testified regarding the application of the decals. Each involved pulling a portion of the backing material away from the decal in order to permit a starting point to apply the decal. Once a portion of the adhesive was exposed, she placed the decal on the railroad car. The decal was pressed against the surface using a roller squeegee with Petitioner's full weight, and the backing material was gradually pulled to permit the decal to adhere to the car. The process was continued until ultimately the entire decal had been applied to the car, pressed, and the backing material removed. This process was executed 510 times per shift. Petitioner conceded that the smaller decals required less force to apply. She testified that the application of decals was constant and

other than a break in the morning and lunch time, she was applying decals throughout the work day. Throughout her shift she used her arms pushing and pulling in order to apply hundreds of decals.

At hearing, Petitioner described and demonstrated the technique she used when applying decals. She testified that she pressed against the decals with the squeegee with her arms in front of her at approximately chest level. She explained that this technique was utilized because it provided her with the leverage necessary to apply the decals. Petitioner's job duties were unchanged since 2003, but she did testify that a change in the decal adhesive in 2011 hade made the job harder. She found that the change in decal adhesive resulted in greater difficulty when separating the decal from the backing.

Petitioner testified that her arms had been giving her problems for several weeks around August 2011, but that she tried to work through this difficulty. The pain and difficulty completing her job duties prompted her to notify her supervisor, Joel Rocha, that she was having pain in both of her arms on August 15, 2011. She told Mr. Rocha that she believed her pain was related to her job duties and that it had gotten to the point that she believed she may be injured. She testified that in August 2011 the pain was getting to the point where she was crying at night and dropping items at work.

Respondent sent Petitioner for treatment with Nurse Practitioner Mike Wagner. She reported that she believed her pain was caused by her job duties with Respondent. She was sent for physical therapy and ultimately an EMG study was ordered, which revealed moderate cubital tunnel syndrome bilaterally. (Petitioner's Exhibit (PX) 4, p. 8).

Medical records from Professional Physical Therapy dated August 17, 2011 indicate that Petitioner reported that she "has had problems for many years" but that she "felt that if she reported any injury she would be treated unfairly." (RX 1).

Petitioner was referred to Dr. James Sobeski at Carle Physician Group for care and was first seen on December 5, 2011. She provided the doctor with a history of a work injury, and described her job duties. Dr. Sobeski also testified that he had reviewed an October 27, 2011 independent medical examination (IME) report authored by Dr. Mark Greatting, and this report also provided him with details regarding Petitioner's job duties with Respondent. (PX 4, p. 24). The doctor testified that while he discusses job duties with injured workers, he very rarely goes into great detail in his medical chart. (PX 4, p. 25). He testified he knew Petitioner was a decaler with Respondent in Danville, Illinois. (PX 4, p. 25). Petitioner had described having to push on the decals to apply them to the sides of railroad cars. (PX 4, p. 26). Dr. Sobeski testified that based on everything he has seen and read he knows what Petitioner did with Respondent. (PX 4, pp. 26-27).

Dr. Sobeski testified regarding the causal relationship between Petitioner's job duties with Respondent and her bilateral cubital tunnel syndrome. Dr. Sobeski testified that he was able to render opinions to a reasonable degree of medical certainty based upon the history, physical examination, diagnostics, and his own expertise. (PX 4, p. 29). He testified that he believes Petitioner's bilateral cubital tunnel syndrome was causally related to her job duties with Respondent. (PX 4, 30). He testified as follows: "[t]he basis of the opinion is that she needed to keep her elbow in a flexed position which can aggravate cubital tunnel syndrome and applying forceful things also is putting a fair amount of force through her elbow." (PX 4, p. 30).

Dr. Sobeski diagnosed Petitioner with bilateral cubital tunnel syndrome. (PX 4, p. 7). Petitioner received conservative care initially. (PX 4, pp. 9-10). Dr. Sobeski prescribed Heelbo pads, a type of elbow pad/brace, but they had not worked for Petitioner. (PX 4, p. 9). At the time of the December 23, 2011 appointment, Dr. Sobeski discussed surgery due to the lack of improvement in pain symptoms since the August 15, 2011 date of alleged accident. (PX 4, p. 10).

On January 10, 2012, Petitioner proceeded with surgery, a left side cubital tunnel release, performed by Dr. Sobeski. (PX 4, pp. 11-12). Following surgery, Petitioner followed up with Dr. Sobeski's physician's assistant (PA), James Birkes, on January 26, 2012. At that time she was doing well, her wound was healed, and sutures were removed. However, she still had numbness and tingling in the ulnar nerve distribution. (PX 4, pp. 13-14).

Dr. Sobeski testified that Petitioner's symptoms did not really change following surgery. (PX 4, p. 14). He explained that approximately 15% of people never get better after surgery, and Petitioner could be in that group. (PX 4, p. 15). Based upon Petitioner's surgical result on her left side, Dr. Sobeski decided it would not be worth pursuing surgery on the right side as originally planned. (PX 4, pp. 19-20). Petitioner last received care from Dr. Sobeski on December 3, 2012. (PX 4, p. 23). At that time, restrictions were placed upon Petitioner on a permanent basis. (PX 4, pp. 20-24). Petitioner's permanent lift restrictions are one pound on the left and five pounds on the right. (PX 4, p. 32). A functional capacity evaluation (FCE) was recommended (PX 4, p. 31), but not authorized by Respondent as of the date of hearing.

Petitioner testified that she has returned to working for Respondent within her restrictions. She testified that the restrictions are being accomodated. The only portion of temporary total disability (TTD) claimed by Petitioner involves the period of January 7, 2013 to February 11, 2013, when Petitioner testified she was laid off due to a lack of work available within her restrictions.

On June 6, 2012, Petitioner was sent for an examination pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq*. (hereafter the "Act") with Dr. Michael Cohen. Dr. Cohen opined Petitioner's injuries were not causally related to her job duties with Respondent. He was aware that the left elbow cubital tunnel release was approved under workers' compensation, but disagreed that there was a causal relationship. (RX 2, Dep. Exh. 2). He testified that he did not believe Petitioner had any pre-existing condition with respect to cubital tunnel syndrome. (RX 2, p. 52).

Dr. Cohen testified that he was unaware of another IME prior to the time of his deposition. (RX 2, p. 54). At hearing, Petitioner testfied that she brought the prior IME report to her appointment with Dr. Cohen, offering the report to the doctor, but he refused to review it. During his deposition, Dr. Cohen testified that he would potentially be interested in knowing the findings and opinions of another IME doctor. (RX 2, pp. 54-55). However, he never reviewed the report even when presented with the opportunity. He conceded that among a group of doctors differences of opinion are entirely reasonable. (RX 2, p. 55).

Dr. Cohen testfied that he did not know what types of forces were involved with decaling. He did not care what force weights were involved and claimed they would have no bearing on his opinion. (RX 2, p. 57). He testified that he was very knowledgeable with respect to decaling, but conceded he knew of only one or two

people he had ever encountered in the field. (RX 2, p. 53). He relied upon a video showing another individual applying decals while working for Respondent. He watched the video outside the presence of Petitioner and never asked her whether it accurately reflected her job duties and her technique. (RX 2, pp. 53-54). Based upon the technique exhibited by the individual on the video, Dr. Cohen determined that the angle of position of the elbow would not cause cubital tunnel syndrome. (RX 2, p. 58). This opinion was based upon the technique shown in the video. Petitioner testified to the specific technique she utilized at the time of the hearing.

CONCLUSIONS OF LAW

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

Petitioner worked for Respondent in a full duty capacity with no work restrictions for ten years prior to the date of injury, August 15, 2011. The job duties performed by Petitioner as a full time decaler with Respondent, and lack of any significant medical care to her arms, indicate that she was asympomatic and without pain.

Neither Dr. Sobeski, nor Dr. Cohen testified that Petitioner had any pre-existing condition with respect to her arms. On on the issue of causation, Dr. Cohen relied upon a video showing another individual performing decal duties. Petitioner testified specifically how she performed decaling. The treating doctor, Dr. Sobeski, testified that he was familiar with Petitioner's job duties with Respondent and believed that her injuries were causally related, or at least aggravated by those duties. The Arbitrator finds that Petitioner was a very credible witness at trial. She openly testified in a forthcoming manner, including during her cross-examination testimony. She appeared to be endeavoring to tell the full truth during her entire testimony.

Based on the foregoing, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of her employment by Respondent.

Issue (D): What was the date of accident?; and

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

Petitioner testified that she had experienced some pain in her arms a few weeks before the pain increased to the point that she knew she was injured. Once Petitioner became determined to seek medical care, she notified her supervisor, Joel Rocha, on August 15, 2011, that she thought she was injured. She was sent for medical care for the first time on August 15, 2011, and first diagnosed with cubital tunnel syndrome on September 22, 2011.

Petitioner did not delay in giving notice to the employer. She worked through her pain at first, and then reported the injury as soon as she could no longer tolerate it. She did not learn of the specifics of her injuries until after seeking medical care. Based upon Petitioner's testimony and the medical records, the Arbitrator finds the date of accident was August 15, 2011, and further that proper notice was given under the Act.

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

Petitioner sustained work-related repetitive trauma injuries to her arms bilaterally. From the date of accident, August 15, 2011, and throughout the course of her medical treatment, Petitioner's pain complaints remained consistent.

Petitioner was diagnosed with cubital tunnel syndrome to both her left and right side following the EMG study. Her diagnoses remained the same since that time. The treating surgeon, Dr. Sobeski, testified that a causal relationship exists between Petitioner's job duties, her injuries, her need for surgery, and her ongoing pain complaints. He testified that the work restrictions, which have been in place for well over a year, are permanent in nature. The Arbitrator finds the opinions of treating physician Dr. Sobeski more persuasive than the opinions of Respondent's examining physician, Dr. Cohen.

The Arbitrator finds that Petitioner has proven that there is a causal relationship between the repetitive trauma injuries of August 15, 2011, and Petitioner's current condition (bilateral cubital tunnel syndrome) is causally related to the work injuries.

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

Both Dr. Sobeski and Respondent's second examining physician, Dr. Cohen, testified that given the restrictions placed upon Petitioner, a FCE is recommended to formalize the restrictions and determine whether they match Petitioner's job with Respondent. Given the Arbitrator's findings on the issues of accident and causal connection, Respondent is ordered to authorize and pay for the recommended FCE.

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

Petitioner returned to work for Respondent within her restrictions. However, from January 7, 2013 to February 11, 2013, Petitioner was laid off due to a lack of work available within her restrictions. Petitioner was unable to work during this period due to her restrictions.

Given the Arbitrator's findings on the issues of accident and causal connection, Respondent is ordered to pay Petitioner TTD benefits from January 7, 2013 to February 11, 2013, at a rate of $543.16 per week, for five weeks.

Issue (M): Should penalties or fees be imposed upon Respondent?

The Arbitrator finds that Respondent's actions in the defense of the present claim are not unreasonable or vexatious. Accordingly, penalties and fees are not imposed upon Respondent.

Issue (O): 1. Is Dr. Greatting's report admissible?; and 2. Is Petitioner's claim barred by the statute of limitations?

1. ***Is Dr. Greatting's report admissible?***

At trial, Respondent objected to the admission of Dr. Greatting's IME report. Petitioner's Exhibit 6 is hereby stricken. However, Dr. Sobeski testified that he had reviewed and relied upon the IME report in the

ordinary course of rendering medical care. His testimony regarding the IME report and his utilizing the information contained in the report are relevant and admissible. Dr. Sobeski's testimony established that he used the report in the course of rendering medical care to Petitioner.

2. Is Petitioner's claim barred by the statute of limitations?

Medical records offered into evidence by Respondent dated August 17, 2011 indicate that Petitioner reported that she "has had problems for many years" but that she "felt that if she reported any injury she would be treated unfairly." (RX 1). However, Petitioner credibly testified that her pain got progressively worse to the point where she necessitated medical attention in August 2011. She did not receive a formal diagnosis of her condition until September 2011. Based on the principles set forth in *Durand v. Industrial Comm'n*, 224 Ill.2d 53, 862 N.E.2d 918 (2006), Petitioner should not be punished for diligently working through pain to the point where she necessitated medical treatment. Accordingly, the Arbitrator finds that Petitioner's claim is not barred by the statute of limitations.

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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tyson Kilgore,

Petitioner,

vs.

NO: 13 WC 1748

Rick Feeney Homes, Inc.,

14IWCC0103

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, benefit rates, causal connection, medical expenses, temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 24, 2013, 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: FEB 1 1 2014
TJT:yl
o 1/28/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Daniel R. Donohoo

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

KILGORE, TYSON
Employee/Petitioner

Case# **13WC001748**

RICK FEENEY HOMES
Employer/Respondent

14IWCC0103

On 4/24/2013, 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 0.08% 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:

2575 KANOSKI BRESNEY
LARRY APFELBAUM
237 E FRONT ST
BLOOMINGTON, IL 61701

0532 HOLECEK & ASSOCIATES
KENNETH SMITH
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

14IWCC0103

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

- [ ] 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)

TYSON KILGORE ,
Employee/Petitioner

v.

RICK FEENEY HOMES ,
Employer/Respondent

Case # 13 WC 01748

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 **Peoria**, on **February 28, 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. [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. [x] What were Petitioner's earnings?

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

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

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

K. [x] Is Petitioner entitled to any prospective medical care?

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other: _____

14IWCC0103

FINDINGS

On the date of alleged accident, **December 31, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$518.50**; the average weekly wage was **$367.85**.

On the date of the alleged accident, Petitioner was **32** years of age, ***married*** with **three** dependent children.

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

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

Respondent shall be given a credit of **$ 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 for medical benefits.

ORDER

The Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury that arose out of and in the course of his employment by Respondent on **December 31, 2012.**

The Arbitrator further finds that the condition of ill-being complained of is not causally related to the alleged accidental injury of **December 31, 2012.**

All claims for compensation made by Petitioner in this matter are thus hereby denied.

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

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

Signature of Arbitrator JOANN M. FRATIANNI

April 17, 2013
Date

ICArbDec19(b)

APR 24 2013

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

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

Petitioner testified that he worked for Respondent as a carpenter. He was hired to work for Respondent on December 17, 2012. Respondent is in the business of building homes.

Petitioner testified that on December 31, 2012, he was erecting exterior walls on the second floor of a house that was under construction. Working with him that day were Mr. Tyler Cagle and Mr. Joseph Crawford, his supervisor. Petitioner testified the walls were 8 feet high and 11 feet wide. Petitioner testified he was moving the wall with Mr. Cagle and Mr. Crawford by anchoring it with his right shoulder. In order to do this, he placed his neck and right shoulder through a hole in the wall that had been cut out for a window. While they were moving this wall 6-8 feet from the area on the second floor where it was built, the wall slipped, causing Mr. Cagle and Mr. Crawford to stop supporting it. When this occurred the weight of the wall pressed against Petitioner's neck and right shoulder, causing him to scream in pain. Petitioner testified that it then took Mr. Cagle and Mr. Crawford between 20-45 seconds to get the wall off of him.

Following this, Petitioner testified that Mr. Crawford asked him if he was injured. Petitioner testified that he went home soon after the incident, and on cross-examination he testified he went to another job site that day where he and Mr. Crawford installed a window. Petitioner testified that he could not recall how heavy that window was. Petitioner testified that he was in pain immediately after the wall incident, but did not seek treatment until January 2, 2013.

Petitioner testified that he first sought treatment at OSF PromptCare on January 2, 2013. Petitioner at that time complained of right shoulder pain and indicated that the injury was work related. Petitioner following examination was referred the Advocate Medical Group Occupational Health clinic for further care (Px1)

Petitioner then visited the Advocate Medical Group Occupational Health clinic on January 7, 2013, where a history was recorded of drywall falling on his back and striking his neck area and right shoulder. Petitioner testified that this history was inaccurate. (Px2)

Petitioner also sought treatment at Advocate Medical Group on January 9, 2013. A history was recorded at that time of right shoulder pain that he related to tying to move a wall and it slid and fell onto his right shoulder. Petitioner returned to Advocate Medical Group on January 24, 2013 and a history was recorded of right shoulder pain related to a recent accident at work when dropped heavy stuff and slid on his back, right shoulder.

Petitioner testified these histories were inaccurate and he did not give any medical providers a history of a wall falling and hitting him. The Application for Adjustment of Claim filed in this matter also indicates an injury caused by a wall falling on him.

Mr. Joseph Crawford testified that he, Petitioner and Mr. Tyler Cagle built and erected exterior walls at a new home on December 31, 2012. Mr. Crawford testified that in framing walls on the second floor of a house they attempt to build the wall as close to the edge of the framed house where the wall would be erected. This is done because these walls weigh around 600 pounds.

Mr. Crawford testified that they did not have to move the walls they erected on December 31, 2012, and that they were built in such a manner that they just needed to be stood up once built. Mr. Crawford further testified that the walls they erected on that date did not have any windows or holes cut out of them, nor did they move any wall 6-8 feet. Mr. Crawford testified that no wall slipped on that date nor did any wall slip causing Petitioner to only support it. Mr. Crawford testified that at no time on that date did Petitioner yell or scream in pain and that he did not report an injury on that date.

Mr. Crawford further testified that after the walls were erected, Petitioner and he went to another job site to install a window on the second floor of another building. Mr. Crawford testified this window weighed approximately 150 pounds. Mr. Crawford testified that he and Petitioner carried this window to the second floor. He did not observe any signs of injury to Petitioner and they both completed a full work shift of eight hours.

Mr. Crawford further testified that on January 2, 2013, Petitioner advised him he injured himself on December 31, 2012. Mr. Crawford testified that he advised Petitioner to seek medical attention if he was injured.

Mr. Tyler Cagle testified that he was on the job site on December 31, 2012 along with Petitioner and Mr. Crawford. At that time they were building and erecting exterior walls at a new home. Mr. Cagle's testimony corroborated the testimony of Mr. Crawford as to the work performed at the site and how the walls were built and erected. Mr. Cagle testified that no holes were cut in any of those walls so constructed and no wall moved or slipped on ice or fell. Mr. Cagle testified that he never heard Petitioner scream or yell in pain and at no time did Petitioner support a wall by himself. Mr. Cagle testified that he did not learn of any work injury to Petitioner until days later.

Mr. Rick Feeney testified that he is the owner of Respondent. Mr. Feeney testified that he was not present on the job site on December 31, 2012. Mr. Feeney testified that the walls being constructed at that time were 8 feet tall and 16 feet wide. Second floor walls are built on the second floor almost on top of where they are to be erected, so that the walls will match the width of the first floor walls already in place. Mr. Feeney testified there is no procedure where a wall is constructed and moved 6-8 feet to a location where it is to be erected under these circumstances.

Petitioner testified on rebuttal that the wall slid about 10-16 inches. Petitioner testified he believed the wall slid this distance due to ice and because Mr. Crawford and Mr. Cagle had stopped supporting it when it slid. Petitioner testified that the walls could not be constructed next to the edge where they were to be erected because other structures had been erected on the second floor.

Based upon the above, the Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury that arose out of and in the course of his employment with Respondent on December 31, 2012. The testimony of Mr. Crawford and Mr. Cagle are consistent over what occurred on that date, and severely contradict Petitioner's version of events. Even if one were to believe that a wall was moved 6-8 feet or 10-16 inches, the testimony of the lack of a window cut out was not explained or contradicted, nor the testimony that no injury was reported, nor any shouts or screams of pain occurred on that date. Petitioner did continue working a full shift and performed heavy work at another location before the end of his shift.

Based further upon said findings, the Arbitrator further finds that Petitioner failed to prove that the condition of ill-being alleged was caused by an injury at work for Respondent.

G. What were Petitioner's earnings?

Petitioner testified he was hired to work at $13.00 per hour. Respondent's payroll records in evidence (Rx3) reflect total earnings of $786.50. Mr. Feeney testified that this included wages of $208.00 for two days he paid Petitioner after he was unable to work, or payments made for the days of January 2, and January 3, 2013. Petitioner was terminated on January 4, 2013.

Based upon the above, the Arbitrator finds the average weekly wage to be $367.85 based on a total earnings of $578.50 over a period of 11 days prior to this alleged 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?

See findings of this Arbitrator in "C" and "F" above.

Based upon said findings, all claims made by Petitioner for medical expenses in this matter are hereby denied.

K. Is Petitioner entitled to any prospective medical care?

See findings of this Arbitrator in "C" and "F" above.

Based upon said findings, the Arbitrator further finds that all claims made by Petitioner for certain prospective medical care and treatment for this alleged injury are hereby denied.

L. What temporary benefits are in dispute?

See findings of this Arbitrator in "C" and "F" above.

Based upon said findings, the Arbitrator further finds that all claims made by Petitioner for temporary total disability benefits for this alleged injury are hereby denied.

M. Should penalties or fees be imposed upon Respondent?

See findings of this Arbitrator in "C" and "F" above.

Based upon said findings, the Arbitrator further finds that all claims made by Petitioner for penalties and attorneys fees for this alleged injury are hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Syliva Sil,

Petitioner,

vs.

NO: 11 WC 39574

State of Illinois Department of
Commerce & Economic Opportunity,

14IWCC0104

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, 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 14, 2013, 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: FEB 11 2014
TJT:yl
o 1/28/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SIL, SYLVIA
Employee/Petitioner

Case# **11WC039574**

SOI-DEPT OF COMMERCE & ECONOMIC OPPORTUNITY
Employer/Respondent

14IWCC0104

On 3/14/2013, 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 0.11% 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:

1157 DELANO LAW OFFICES LLC
CHARLES H DELANO IV
1 S E OLD STATE CAPITAOL PLZ
SPRINGFIELD, IL 62701

0499 DEPT OF CENTRAL MGMT SERVICES
MGR WORKMENS COMP RISK MGMT
801 S SEVENTH ST
8 MAIN
SPRINGFIELD, IL 62794-9208

4993 ASSISTANT ATTORNEY GENERAL
ANDREW SUTHARD
500 S 2ND ST
SPRINGFIELD, IL 62706

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

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

MAR 14 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0104

STATE OF ILLINOIS)
)
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

Sylvia Sil
Employee/Petitioner

Case # 11 WC 039574

v.

Springfield

State of Illinois – Department of Commerce and Economic Opportunity
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Douglas McCarthy, arbitrator of the Commission, in the city of Springfield, on February 8, 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 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 amount of compensation is due for temporary total disability?

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

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Other _____

FINDINGS

- On **May 5, 2010**, the respondent **State of Illinois** *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 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 $ **91,764.00**; the average weekly wage was $ **1,746.69**.
- At the time of injury, the petitioner was **64** years of age, *single* with **0** children under 18.
- Necessary medical services *have* been provided by the respondent.
- To date, $ **N/A** has been paid by the respondent for TTD and/or maintenance benefits. All payable TTD benefits have been paid by the Respondent.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $ **N/A**/week for **N/A** weeks, from **N/A** through **N/A**, which is the period of temporary total disability for which compensation is payable.
- The respondent shall pay the petitioner the sum of $ **664.72**/week for a further period of **35.875** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **!5% loss of use of the right hand, and 2.5 % loss of use of the left hand.**.
- The respondent shall pay the petitioner compensation that has accrued from **May 5, 2010** through **February 8, 2013**, and shall pay the remainder of the award, if any, in weekly payments.
- The respondent shall pay the further sum of $ **N/A** for necessary medical services, as provided in Section 8(a) of the Act.
- The respondent shall pay $ **N/A** in penalties, as provided in Section 19(k) of the Act.
- The respondent shall pay $ **N/A** in penalties, as provided in Section 19(l) of the Act.
- The respondent shall pay $ **N/A** in attorneys' fees, as provided in Section 16 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

March 12, 2013
Date

MAR 14 2013

In support of the Arbitrator's decision relating to (C) and (F), the Arbitrator finds the following facts:

This is a repetitive trauma claim. The Petitioner, Sylvia Sil, testified that she worked for the State of Illinois for over 20 years. For the last eleven (11) years, Petitioner was employed as an Information Systems Analyst. Petitioner testified that she worked 5 days per week and 7.5 hours per day. Petitioner testified that in order to perform her job she was required to type. Petitioner testified that she typed and did a lot of mouse work for approximately 5 hours of each day she worked.

Petitioner testified that she typed with her forearms resting on the desk and her hands tilted down. She testified that she used the mouse with her hand position in the same manner as when she typed. She further said that the Respondent had provided her with a gel pad to use while typing. She said that she tried the gel pad and it did not work for her so she did not use it.

Petitioner testified that in May of 2010, she was experiencing a problem with her hands. She would wake up in the middle of the night with abnormal sensations and have to shake her hands out. She testified that she also had to do this during the day at work because of the numbness she experienced in her hands. She is right handed, and testified that her right hand were worse than her left. Petitioner testified that she contacted her family physician, Dr. Saunders. Dr. Saunders referred her to Dr. Trudeau. Petitioner saw Dr. Trudeau on May 5, 2010.

Dr. Trudeau's records are included in the record as Petitioner's Exhibit 3. Dr. Trudeau performed an EMG and nerve conduction tests on Petitioner. The results of the EMG documented bilateral carpal tunnel syndrome. The right side was characterized as moderately severe. The left side was characterized as mild and neurapractic. She complained of paresthesias in both hands.

Petitioner then saw Dr. Christopher Maender. Dr. Maender is with the Orthopaedic Center in Springfield. Dr. Maender's records are included in the record as Petitioner's Exhibit 4. Again, she complained of symptoms predominantly in the right hand. Dr. Maender prescribed a splint for Petitioner to wear. When the splint did not relieve the symptoms, Petitioner returned to her family physician, Dr. Saunders. Dr. Saunders referred her to Dr. Mark Greatting at the Springfield Clinic.

Dr. Greatting's records are included in the record as Petitioner's Exhibit 5. Petitioner remained under Dr. Greatting's care from December 9, 2010 through January 30, 2012. Dr. Greatting performed carpal tunnel surgery on Petitioner's right hand on November 15, 2011. Petitioner was off work from November 15, 2011 through December 26, 2011. She received her temporary total disability from the State.

1. THE MEDICAL EVIDENCE

First, with regard to the medical evidence, Dr. Mark Greatting's records are included in the record as Petitioner's Exhibit 5. Dr. Greatting's note of December 9, 2010 states in pertinent part "... patient has chronic right carpal tunnel syndrome. I do think based on her history, her work activities have contributed to or aggravated the symptoms or problems with her carpal tunnel syndrome on the right hand." Dr. James Williams, Respondent's examining physician was deposed on two occasions. His depositions are included in the record as Respondent's Exhibits 4 and 8. Dr. Williams stated as follows:

> "... Richard Gelberman, probably one of the most famous people who have done the study, did a study on that when he was at the Mass General, the chief of hand – now he's the chief of orthopedic surgery at Washington University in St. Louis. Showed that by flexing the wrist even 30 degrees, you'll either triple or even quadruple the pressure within the carpal canal." (Respondent's Exhibit 4, Pages 18 & 19)."

Dr. Williams was asked the following questions:

Q: Assuming Ms. Sil typed with her wrists in a flexed position, could that cause or aggravate the carpal tunnel which you diagnosed her with when you saw her on March 16 of last year?
A: Mattering – obviously I don't have evidence of that, but mattering how much they were flexed or for how long a period of time, yes, that would be an aggravating factor?

Q: Such that it could lead to the need for surgery?
A: Possibly could.
(Respondent's Exhibit 4, Page 19, Lines 2 through 12.)

Dr. Williams supplemental Independent Medical Examination report is included in the record as Respondent's Exhibit 7. In it, Dr. Williams states that it is obvious that the flexed posture of the wrist for a long period of time could be an aggravating factor in the development of carpal tunnel syndrome. Dr. Williams again testified as follows:

Q: It's, also, true with that pressure within the carpal canal of the employee typing is dependent on the position of the wrist when typing, correct?
A: Without a question, Chip. That's what I stated earlier. Correct.

Q: And a person typing with flexed wrists will increase the pressure within the carpal tunnel, correct?
A: That is what the studies have shown, Chip. That's correct.
(Respondent's Exhibit 8, Page 18 & 19).

2. LAY TESTIMONY

This is not a typical case. As indicated, the Petitioner's treating physician and the Respondent's examining physician do not have any real disagreement regarding the cause of carpal tunnel symptoms when typing. The issue in this case is whether or not the Petitioner was credible when describing her job duties. Three witnesses testified regarding Petitioner's job duties. They were Petitioner, a co-worker, Kevin Parks, and Petitioner's former supervisor, Lisa Logan. For the following reasons, the Arbitrator accepts Petitioner's testimony regarding her job duties over that of Mr. Parks and Ms. Logan.

A. KEVIN PARKS' TESTIMONY

Mr. Parks testified that he was a co-worker of Petitioners. He was also shown in a video purporting to demonstrate the job done by Petitioner as shown in Respondent's Exhibit 6. Mr. Parks testified that his job involved very little typing. Mr. Parks testified that Petitioner did not hold her hand in a flexed manner when she typed. He based this upon observations he said he made by walking by Petitioner's cubicle. He further testified that when he observed the Petitioner typing, her wrists were held slightly in an extended position.

Mr. Parks testified that he had a different cubicle from Petitioner. Other than getting up to get coffee or go to the restroom, he sits at his desk throughout the day. He testified that his work day is 7.5 hours. 7 hours of each day is spent sitting at his desk. Mr. Parks testified that he remembered walking around and watching how Petitioner held her hands when she typed.

Mr. Parks was unable to remember the names of any of the contractors who worked in his office. He testified that there were 20 State employees in his office. He could not remember the names of even half of these State workers in his office. Mr. Parks testified that he could remember how several of his co-workers held their hands when they type. He was asked whether he made it a specific habit when walking by people's desks to look at them typing and remember how they held their hands. He testified that he would not say it was a habit because that would be kind of weird. He admitted that walking by someone's desk would take no more than 2 to 3 seconds.

Mr. Parks testified that he had significant interaction with Petitioner on a daily basis. When asked what he considered to be significant interaction, he stated that he would walk by her and say hello. He did not work on the same projects with Petitioner. When asked whether walking by Petitioner's desk and saying hello was a lot of interaction to him, Mr. Parks stated "I guess in your opinion probably not." Mr. Parks also stated that he was not watching Petitioner when she was at her desk. He testified "no, we would not sit together or anything." He admitted that he would have no idea what Petitioner was doing 7 of the 7.5 hours each day she was at work.

Mr. Parks was asked whether he found Petitioner to be an honest person and he said that Petitioner had never lied to him. He testified that if Petitioner said she spent 5 hours of her day typing, he would not have any reason to disagree with that.

As indicated above, Dr. Williams is the physician who the State selected to examine Petitioner. Prior to his second deposition, Dr. Williams was give the DVD of Mr. Parks allegedly performing his job. During that deposition, Dr. Williams was asked the following question and gave the following answer:

> **Q: It seems to me that this person, Mr. Parks, who was the employee on the DVD, was not doing very much of anything. Would you think that that's normal for a person in that position to be doing that little?**
> **A: That's – I'll be honest, Chip. That's what I wondered. And I don't know, Chip. I don't know.**
> (Respondent's Exhibit 8, Pages 21).

Mr. Parks concluded his testimony by saying that if Petitioner testified that she types 5 hours a day in her job he had no reason to disagree with that.

LISA LOGAN'S TESTIMONY

Ms. Logan testified that she was Petitioner supervisor for approximately 3.5 years. She testified that Petitioner essentially did no work in her position. Ms. Logan testified that she arrived at this conclusion based on Petitioner's lack of production.

Ms. Logan testified that she was asked by the State to walk by Ms. Sil's cubicle and observe her. She testified that she was not sure when she observed the Petitioner typing, but estimated that it was from the middle of 2012 to the end of the year. Ms. Logan testified that Petitioner did not type with her hands in a flexed position, but that her wrists were actually bent up in a position of flexion, similar to the testimony of Mr. Parks.

The Arbitrator discounts Ms. Logan's testimony concerning the petitioner's lack of production for several reasons. Ms. Logan testified that she filled out employee evaluations of Petitioner during the years she supervised her. Ms. Logan gave Petitioner good evaluations for each of the years she supervised her. Ms. Logan testified that she knew she was not being truthful in Petitioner's evaluation when she authored it, suggesting that if she truthfully completed the job evaluations it would trigger grievances which she indicated that she did not have time to deal with. However, she completed a job description of Ms. Sil's job on November 21, 2010, when she first learned of the claim. She said on that description that the Petitioner's job involved typing six to eight hours per day. (RX 11) The description was obviously prepared in connection with the Respondent's initial investigation into the claim. If Ms. Sil was doing very little to nothing on the job, then certainly her supervisor, when asked to complete a job description, would have indicated as such.

C. DR. JAMES WILLIAMS CREDIBILITY

In connection with Petitioner's Section 12 evaluation, the Respondent provided documents to Dr. James Williams. He was provided the above referenced job description prepared by Ms. Logan. On page 2 of his report, Dr. Williams notes that he went over the job description with the Petitioner, and that she agreed with it. Dr. Williams also reviewed the ergonomic study performed by Corvel on May 9, 2012, which said that typing, point and click data entry was done on a

frequent basis, characterized as 2.5 to 5.5 hours a day. (RX 6) Despite having that information, he relied on the video, which he acknowledged was not the Petitioner doing her job and appeared to possibly not represent a normal work pace, to say that her typing was intermittent and did not cause or aggravate her condition.

Dr. Williams stated in his first deposition that he was of the school of thought that keyboarding, regardless of the duration, was not a risk factor for carpal tunnel. It really should not have mattered to him whether the Petitioner's keyboarding was intermittent. The crux of his opinion testimony dealt with wrist position. Again, relying on the video which showed her co-worker typing with his hands in a neutral position, the doctor testified to no causation. (RX 8 at 11,12) Not only does that assumption conflict with the Petitioner's testimony that her wrists were flexed with her elbows resting on the edge of her desk, it conflicts with the testimony of both of the Respondent's witnesses who said they observed the Petitioner typing with her wrists in an extended position. As stated above, Dr. Williams agreed that typing with flexed wrists could be causative. He also said at both depositions that holding the wrists in a flexed position would create an even greater risk. (RX 4 at 19; RX 8 at 19)

In other words, Dr. Williams' testimony supports the Petitioner's claim that her work caused or aggravated the condition regardless of whether the Arbitrator believes the Petitioner or Respondent concerning wrist position. The Arbitrator does not believe the Petitioner, without the use of a gel pad, typed with her wrists in a neutral position. The Arbitrator also does not believe the Petitioner did nothing at work. Her testimony that she typed an average of five hours a day is consistent with the job description performed by the Respondent and the Corvel study, both of which were prepared in connection with this claim.

Based upon the foregoing, the Arbitrator finds that Petitioner did sustain an accident which arose out of and in the course of her employment and that her condition of ill-being is causally related to said work related injury.

In support of the Arbitrator's decision relating to (L), the Arbitrator finds the following facts:

In Arbitrator repeats the findings set forth above in support of (C) and (F) as if set forth fully herein:

Petitioner testified that her hands are weak. She is unable to open jars or water bottles. She is unable to turn door knobs. When lifting a gallon of milk, Petitioner must use both hands.

Petitioner still gets numbness in her hands but that condition has improved since her surgery. However, when holding objects and twisting her hand, Petitioner notices a definite lack of strength.

Petitioner has received no treatment for her left hand. Her various treating doctors described the left hand condition as being very mild. Dr. Williams reported that she had no left hand symptoms when he performed his exam.

The Arbitrator finds Petitioner has sustained a loss of use of 15% of her right hand and 2.5% loss of use of her left hand as a result of this injury.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laura Guyon,

Petitioner,

vs. NO: 11WC39290

Heyl Royster Voelker,

14IWCC0105

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the 19(b) herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 6, 2013, 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 $35,000.00. The party commencing the proceedings for review in the Circuit Court shall

file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 11 2014
o-01/29/14
RWW/lj
46

Ruth W. White

Michael J. Brennan

Charles J. DeVriendt

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

GUYON, LAURA
Employee/Petitioner

Case# **11WC019304**
11WC039290

HEYL ROYSTER VOELKER & ALLEN
Employer/Respondent

14IWCC0105

On 3/6/2013, 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 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0225 GOLDFINE & BOWLES PC
ATTN: WORK COMP DEPT
124 S W ADAMS ST SUITE 200
PEORIA, IL 61602

0080 PRUSAK WINNE & McKINLEY LTD
JOSEPH E WINNE
403 N E JEFFERSON ST
PEORIA, IL 61603

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)

LAURA GUYON
Employee/Petitioner

v.

HEYL, ROYSTER, VOELKER & ALLEN,
Employer/Respondent

Case # 11 WC 19304

Consolidated cases: 11 WC 39290

14IWCC0105

An *Application for Adjustment 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 **Bloomington**, on **October 10, 2012.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0105

FINDINGS

On the date of accident, **November 16, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$41,600.00**; the average weekly wage was **$800.00**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **one** dependent child.

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 $ **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 for medical benefits.

ORDER

The Arbitrator finds that Respondent shall pay to Petitioner the reasonable and necessary medical services that total **$5,664.63**, as provided in Section 8(a) and 8.2 of the Act.

The Arbitrator orders Respondent to provide and pay for future medical costs in the form of left elbow surgery as prescribed by Dr. Garst, including all ancillary medical costs concerning same and all periods of temporary total and/or temporary partial disability periods incurred for treatment resulting from these procedures, as this prescription for future care represents reasonable and necessary medical care and treatment that is causally related to this particular accidental injury.

Respondent shall be given full credit for all amounts paid in medical bills incurred as a result of this accidental injury and shall hold Petitioner safe and harmless at all attempts at collection or reimbursement of same.

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 JOANN M. FRATIANNI

February 28, 2013
Date

ICArbDec19(b)

MAR 6 - 2013

14IWCC0105

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

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

Petitioner testified that she works for Respondent as a legal secretary. Since 2005 she has been spending between 80-90% of her time at work typing. She works for a senior partner and an associate attorney. Both of these attorneys perform most of their work through dictation and are involved in federal court practice. Petitioner testified that in federal court practice, all court filings are electronic and she was required to receive each filing and print them out in order to create a hard file. Petitioner testified that she prints out around 50 documents daily on an average.

Petitioner testified that she sits at a corner type workstation and her keyboard is located at desk level in the corner. On her left is a three-drawer printer that is 2-1/2 feet tall and sits on her work station. Petitioner testified that she is 5'3" in height. Petitioner testified that when she prints a document at her workstation, she must reach with her left elbow above her head and pick up the printed document from the tray of the printer. Petitioner testified she quit smoking two years ago and does not currently smoke. She has no evidence or history of diabetes. Petitioner did have a prior Workers' Compensation settlement that was approved on December 17, 2007 by the Commission for repetitive trauma to both hands and arms and was diagnosed with bilateral carpal and capital tunnel syndromes.

Petitioner testified she began experiencing left elbow pain in the fall of 2010. She described the pain as a gradual onset that progressively became worse. She sought treatment for her symptoms with Dr. Jeffrey Garst, an orthopedic surgeon who specialized in hand and upper extremity surgery. Dr. Garst testified by evidence deposition (Px3) that he performs an average of 15-20 surgeries weekly. Petitioner first presented to his office on November 16, 2010 with left elbow pain and pain in her left shoulder. Petitioner testified that Dr. Garst injected her left elbow that turned out to be very painful, but provided her with symptomatic relief for approximately one week until the injection wore off.

Dr. Garst testified that cortisone injections are both diagnostic and therapeutic. If the shot takes the pain away for even a short time, then the correct area was injected and verified the diagnosis. He prescribed a left elbow MRI that was performed on December 27, 2010. This revealed a partial tear at the origin of the common extensor tendon and further revealed a node at the lateral aspect of the left elbow. Petitioner testified the node, which she described as a small mass, had been present on her arm for years and caused her no pain. Dr. Garst testified the node was not the cause of the symptoms. Dr. Garst testified that a tear of the extensor tendon is a common finding with those suffering from lateral upper epicondylitis or tennis elbow, as the tendon would get worn or irritated and it is tearing a bit would cause pain.

Petitioner then saw Dr. Garst on March 15, 2011. On that occasion he diagnosed left shoulder OS acromion and left elbow lateral epicondylitis with extensor origin tear. Dr. Garst testified that left elbow surgery would help as Petitioner had attempted a variety of conservative care to the left elbow with no real improvement. Dr. Garst testified that he would recommend no treatment to the left shoulder at this time but that surgery may also be contemplated there in the future.

Dr. Garst in response to a hypothetical question was of the opinion that the left elbow extensor origin tear and lateral epicondylitis was work related. He also testified that it would be less likely that the left shoulder OS acromion issue would be work related, but was developmental. Dr. Garst testified that normally shoulder injuries are related to heavy lifting or overhead work and he was not sure that she performed such work. Dr. Garst further admitted that it would be a fair statement that Petitioner's left shoulder complaints have noting to do with her work or typing.

Petitioner next saw Dr. Garst on September 27, 2011 with complaints of right elbow pain and a bit of pain in her shoulder. These symptoms are the subject matter of case no. 11 WC 39290, which was consolidated and heard with this matter.

When asked what his plan was for Petitioner's elbow symptoms, Dr. Garst testified the left side has been going on for a couple of years and the right side has been going on for almost a year and a half, and she has gotten conservative care, and he recommended surgery. He thought surgery is indicated. Dr. Garst testified he would like to perform surgery on the left side, then once that was healed, he would perform surgery on the right.

On February 7, 2012, Petitioner saw Dr. Garst with continuing complaints of pain in both shoulders and elbows. She showed Dr. Garst a photograph (Rx1) of her workstation and asked his opinion as to whether her left shoulder symptoms were relate to her work. The photograph depicts the tall printer to her left side. Petitioner testified that she explained to Dr. Garst that she had to frequently reach with her left hand to the top of the printer to retrieve printed documents. Dr. Garst testified that the OS acromial of the left shoulder is a congenital abnormality, but she has pain with impingement on the left side that he felt was significantly contributed to or caused by her workstation setup. Dr. Garst testified that he felt "frequently" meant at least a few times each hour of reaching. Dr. Garst further felt that if Petitioner did not have to perform that type of work then she probably would not have the symptoms she is experiencing. Dr. Garst felt that type of work did significantly contribute to the left shoulder symptoms or caused them.

Dr. Garst further testified that the extensor carpi radialus brevis to the elbow was affected when someone was engaged in typing. Dr. Garst felt the tendon and muscle were affected, stating that she had to use both in typing because it extends the wrist. If you keep doing that all day, you are having your wrist extended all day and that requires th use of the tendon.

Respondent arranged for Petitioner to be examined by Dr. Mark Miller on April 11, 2011. Dr. Miller testified by evidence deposition (Rx3) that he is an orthopedic surgeon who is a shoulder specialist. Dr. Miller agreed that Petitioner has a diagnosis of tendonopathy with changes to the extensor carpi radialus brevis that is a fairly standard tennis elbow. Dr. Miller was of the opinion that the left elbow condition was not work related as he felt the extensor carpi radialis brevis tendon is not involved during the typing process. When pressed on cross-examination as to his opinion, he responded "I don't have a great answer for you."

Concerning the left shoulder, Dr. Miller felt that Petitioner had a OS acromial which was not caused by work. Dr. Miller felt that when you are typing, you are not using your shoulder, so unless you perform a lot of overhead work he could not attribute the condition to work. Dr. Miller during his testimony was under the impression that Petitioner would reach overhead once every 12 minutes or so during a 50 hour workweek. He did not believe this could be defined as "repetitive" which he considered several times a minute lifting the arm overhead. The work place analysis Dr. Miller relied upon (Rx2) does not mention the location or dimensions of her printer.

Based upon the above, the Arbitrator finds the opinions of Dr. Garst to be more credible than those of Dr. Miller and as such, finds that on November 16, 2010, Petitioner sustained accidental injuries that arose out of and in the course of her employment by Respondent and that manifested itself from repetitive trauma on that date.

Based further upon the above, the Arbitrator finds that the condition of ill-being to the left elbow and left shoulder are causally related to the accidental injury of November 16, 2010.

14IWCC0105

J. Were 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 this accident:

Great Plains Orthopedics (Dr. Garst)	$ 604.40
Proctor Hospital	$ 559.72
HCH Administration	$4,213.45
Out of Pocket medical expenses:	$ 287.06

These charges total $5,664.63.

See findings of this Arbitrator in "C" and "F" above.

Based upon said findings the Arbitrator awards the above charges pursuant to the medical fee schedule created by the Act, as those charges represent reasonable and necessary medical care and treatment designed to cure or relieve the condition of ill-being sustained by this accidental injury.

Respondent is entitled to receive a credit as to all amounts paid by them.

K. Is Petitioner entitled to any prospective medical care?

See findings of this Arbitrator in "C" and "F" above.

Based upon said findings, the Arbitrator further finds that the prescribed surgery to the left elbow by Dr. Garst represents reasonable and necessary medical care and treatment designed to cure or relieve the condition of ill-being caused by this accidental injury, and orders Respondent to authorize and pay for same.

No order shall issue as to the left shoulder in accordance with the opinion of Dr. Garst as to the need for surgery to that portion of the body at this time.

All claims for prospective medical care and treatment to the right elbow and right shoulder shall be addressed by this Arbitrator in the decision issued in case no. 11 WC 39290, which was consolidated and heard with this matter.

N. Is Respondent due any credit?

See findings of this Arbitrator in "J" above.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laura Guyon,

Petitioner,

vs.

NO: 11WC19304

14IWCC0106

Heyl Royster Voelker,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the 19(b) herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 6, 2013, 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 $35,000.00. The party commencing the proceedings for review in the Circuit Court shall

file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
o-01/29/14 FEB 11 2014
RWW/lj
46

Ruth W. White

Michael J. Brennan

Charles J. DeVriendt

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

GUYON, LAURA
Employee/Petitioner

Case# **11WC019304**
11WC039290

HEYL ROYSTER VOELKER & ALLEN
Employer/Respondent

14IWCC0106

On 3/6/2013, 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 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0225 GOLDFINE & BOWLES PC
ATTN: WORK COMP DEPT
124 S W ADAMS ST SUITE 200
PEORIA, IL 61602

0080 PRUSAK WINNE & McKINLEY LTD
JOSEPH E WINNE
403 N E JEFFERSON ST
PEORIA, IL 61603

14IWCC0106

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)

LAURA GUYON,
Employee/Petitioner

v.

HEYL, ROYSTER, VOELKER & ALLEN,
Employer/Respondent

Case # 11 WC 19304

Consolidated cases: 11 WC 39290.

An *Application for Adjustment 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 **Bloomington**, on **October 10, 2012.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0106

FINDINGS

On the date of accident, **November 16, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$41,600.00**; the average weekly wage was **$800.00**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **one** dependent child.

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 **$ 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 for medical benefits.

ORDER

The Arbitrator finds that Respondent shall pay to Petitioner the reasonable and necessary medical services that total **$5,664.63**, as provided in Section 8(a) and 8.2 of the Act.

The Arbitrator orders Respondent to provide and pay for future medical costs in the form of left elbow surgery as prescribed by Dr. Garst, including all ancillary medical costs concerning same and all periods of temporary total and/or temporary partial disability periods incurred for treatment resulting from these procedures, as this prescription for future care represents reasonable and necessary medical care and treatment that is causally related to this particular accidental injury.

Respondent shall be given full credit for all amounts paid in medical bills incurred as a result of this accidental injury and shall hold Petitioner safe and harmless at all attempts at collection or reimbursement of same.

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 JOANN M. FRATIANNI

February 28, 2013
Date

ICArbDec19(b)

MAR 6 - 2013

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

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

Petitioner testified that she works for Respondent as a legal secretary. Since 2005 she has been spending between 80-90% of her time at work typing. She works for a senior partner and an associate attorney. Both of these attorneys perform most of their work through dictation and are involved in federal court practice. Petitioner testified that in federal court practice, all court filings are electronic and she was required to receive each filing and print them out in order to create a hard file. Petitioner testified that she prints out around 50 documents daily on an average.

Petitioner testified that she sits at a corner type workstation and her keyboard is located at desk level in the corner. On her left is a three-drawer printer that is 2-1/2 feet tall and sits on her work station. Petitioner testified that she is 5'3" in height. Petitioner testified that when she prints a document at her workstation, she must reach with her left elbow above her head and pick up the printed document from the tray of the printer. Petitioner testified she quit smoking two years ago and does not currently smoke. She has no evidence or history of diabetes. Petitioner did have a prior Workers' Compensation settlement that was approved on December 17, 2007 by the Commission for repetitive trauma to both hands and arms and was diagnosed with bilateral carpal and capital tunnel syndromes.

Petitioner testified she began experiencing left elbow pain in the fall of 2010. She described the pain as a gradual onset that progressively became worse. She sought treatment for her symptoms with Dr. Jeffrey Garst, an orthopedic surgeon who specialized in hand and upper extremity surgery. Dr. Garst testified by evidence deposition (Px3) that he performs an average of 15-20 surgeries weekly. Petitioner first presented to his office on November 16, 2010 with left elbow pain and pain in her left shoulder. Petitioner testified that Dr. Garst injected her left elbow that turned out to be very painful, but provided her with symptomatic relief for approximately one week until the injection wore off.

Dr. Garst testified that cortisone injections are both diagnostic and therapeutic. If the shot takes the pain away for even a short time, then the correct area was injected and verified the diagnosis. He prescribed a left elbow MRI that was performed on December 27, 2010. This revealed a partial tear at the origin of the common extensor tendon and further revealed a node at the lateral aspect of the left elbow. Petitioner testified the node, which she described as a small mass, had been present on her arm for years and caused her no pain. Dr. Garst testified the node was not the cause of the symptoms. Dr. Garst testified that a tear of the extensor tendon is a common finding with those suffering from lateral upper epicondylitis or tennis elbow, as the tendon would get worn or irritated and it is tearing a bit would cause pain.

Petitioner then saw Dr. Garst on March 15, 2011. On that occasion he diagnosed left shoulder OS acromion and left elbow lateral epicondylitis with extensor origin tear. Dr. Garst testified that left elbow surgery would help as Petitioner had attempted a variety of conservative care to the left elbow with no real improvement. Dr. Garst testified that he would recommend no treatment to the left shoulder at this time but that surgery may also be contemplated there in the future.

Dr. Garst in response to a hypothetical question was of the opinion that the left elbow extensor origin tear and lateral epicondylitis was work related. He also testified that it would be less likely that the left shoulder OS acromion issue would be work related, but was developmental. Dr. Garst testified that normally shoulder injuries are related to heavy lifting or overhead work and he was not sure that she performed such work. Dr. Garst further admitted that it would be a fair statement that Petitioner's left shoulder complaints have noting to do with her work or typing.

Petitioner next saw Dr. Garst on September 27, 2011 with complaints of right elbow pain and a bit of pain in her shoulder. These symptoms are the subject matter of case no. 11 WC 39290, which was consolidated and heard with this matter.

When asked what his plan was for Petitioner's elbow symptoms, Dr. Garst testified the left side has been going on for a couple of years and the right side has been going on for almost a year and a half, and she has gotten conservative care, and he recommended surgery. He thought surgery is indicated. Dr. Garst testified he would like to perform surgery on the left side, then once that was healed, he would perform surgery on the right.

On February 7, 2012, Petitioner saw Dr. Garst with continuing complaints of pain in both shoulders and elbows. She showed Dr. Garst a photograph (Rx1) of her workstation and asked his opinion as to whether her left shoulder symptoms were relate to her work. The photograph depicts the tall printer to her left side. Petitioner testified that she explained to Dr. Garst that she had to frequently reach with her left hand to the top of the printer to retrieve printed documents. Dr. Garst testified that the OS acromial of the left shoulder is a congenital abnormality, but she has pain with impingement on the left side that he felt was significantly contributed to or caused by her workstation setup. Dr. Garst testified that he felt "frequently" meant at least a few times each hour of reaching. Dr. Garst further felt that if Petitioner did not have to perform that type of work then she probably would not have the symptoms she is experiencing. Dr. Garst felt that type of work did significantly contribute to the left shoulder symptoms or caused them.

Dr. Garst further testified that the extensor carpi radialus brevis to the elbow was affected when someone was engaged in typing. Dr. Garst felt the tendon and muscle were affected, stating that she had to use both in typing because it extends the wrist. If you keep doing that all day, you are having your wrist extended all day and that requires th use of the tendon.

Respondent arranged for Petitioner to be examined by Dr. Mark Miller on April 11, 2011. Dr. Miller testified by evidence deposition (Rx3) that he is an orthopedic surgeon who is a shoulder specialist. Dr. Miller agreed that Petitioner has a diagnosis of tendonopathy with changes to the extensor carpi radialus brevis that is a fairly standard tennis elbow. Dr. Miller was of the opinion that the left elbow condition was not work related as he felt the extensor carpi radialis brevis tendon is not involved during the typing process. When pressed on cross-examination as to his opinion, he responded "I don't have a great answer for you."

Concerning the left shoulder, Dr. Miller felt that Petitioner had a OS acromial which was not caused by work. Dr. Miller felt that when you are typing, you are not using your shoulder, so unless you perform a lot of overhead work he could not attribute the condition to work. Dr. Miller during his testimony was under the impression that Petitioner would reach overhead once every 12 minutes or so during a 50 hour workweek. He did not believe this could be defined as "repetitive" which he considered several times a minute lifting the arm overhead. The work place analysis Dr. Miller relied upon (Rx2) does not mention the location or dimensions of her printer.

Based upon the above, the Arbitrator finds the opinions of Dr. Garst to be more credible than those of Dr. Miller and as such, finds that on November 16, 2010, Petitioner sustained accidental injuries that arose out of and in the course of her employment by Respondent and that manifested itself from repetitive trauma on that date.

Based further upon the above, the Arbitrator finds that the condition of ill-being to the left elbow and left shoulder are causally related to the accidental injury of November 16, 2010.

J. Were 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 this accident:

Great Plains Orthopedics (Dr. Garst)	$ 604.40
Proctor Hospital	$ 559.72
HCH Administration	$4,213.45
Out of Pocket medical expenses:	$ 287.06

These charges total $5,664.63.

See findings of this Arbitrator in "C" and "F" above.

Based upon said findings the Arbitrator awards the above charges pursuant to the medical fee schedule created by the Act, as those charges represent reasonable and necessary medical care and treatment designed to cure or relieve the condition of ill-being sustained by this accidental injury.

Respondent is entitled to receive a credit as to all amounts paid by them.

K. Is Petitioner entitled to any prospective medical care?

See findings of this Arbitrator in "C" and "F" above.

Based upon said findings, the Arbitrator further finds that the prescribed surgery to the left elbow by Dr. Garst represents reasonable and necessary medical care and treatment designed to cure or relieve the condition of ill-being caused by this accidental injury, and orders Respondent to authorize and pay for same.

No order shall issue as to the left shoulder in accordance with the opinion of Dr. Garst as to the need for surgery to that portion of the body at this time.

All claims for prospective medical care and treatment to the right elbow and right shoulder shall be addressed by this Arbitrator in the decision issued in case no. 11 WC 39290, which was consolidated and heard with this matter.

N. Is Respondent due any credit?

See findings of this Arbitrator in "J" above.

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LAURA STEPHENS,

Petitioner,

14IWCC0107

vs.

NO: 10 WC 29987

STATE OF ILLINOIS – ILLINOIS VETERANS' HOME, QUINCY,

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, and medical expenses both current and prospective, 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 disability compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

This case has been subject to a tortuous procedural history. Previously, the Commission struck Respondent's brief and denied orals. In addition, Respondent filed a motion to reopen proofs apparently in reference to the incomplete records of Dr. Huang submitted as Petitioner's Exhibit 4. A hearing was held on October 24, 2013 before Commissioner Mario Basurto in Springfield. At the hearing Respondent moved to withdraw its motion. Petitioner's lawyer demanded sanctions under Supreme Court Rule 137, penalties under section 19(k) penalties, and attorney fees under section 16. He later filed a motion to that effect. Petitioner's lawyer asserted it took him 11 hours to prepare for the hearing and to drive back and forth to Springfield and seeks $150 an hour for that time. The motion was taken under advisement and deferred until the Decision on Review was filed.

It would appear the Commission does not have authority to imposed sanctions for frivolous pleadings pursuant to Supreme Court Rule 137. The Supreme Court rules are the rules for practice before the courts of Illinois. Supreme Court 137 rule specifies that the "court" may impose sanctions for frivolous pleadings; the Commission is not a "court." The Commission has promulgated its own Rules for practice before the Commission and such practice is subject to those rules and not subject to the rules promulgated by the Supreme Court for practice before the courts of Illinois. The rules of the Commission do not authorize sanctions for frivolous pleadings.

Regarding penalties and fees, Respondent's motion to reopen proofs was apparently based on an allegation that Petitioner did not submit a complete set of medical records. Respondent wanted to supplement the record with the "missing" records. However, it had submitted into evidence a complete set of those records at arbitration. Certainly, the Commission does not favor such superfluous pleadings. Petitioner's position is well taken. However, the travel and costs could have been avoided by appropriate communication in advance of said hearing. In addition, the Commission does not consider section 19(k) penalties appropriate because there is no allegation that there was an unreasonable or vexatious delay in the payment of benefits to Petitioner. Therefore, Petitioner's motion for sanctions pursuant to Supreme Court Rule 137 and for penalties and fees pursuant to sections 19(k) and 16 is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 7, 2013 is hereby affirmed and adopted.

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

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

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

DATED: FEB 13 2014

Ruth W. White

Charles J. DeVriendt

Michael J. Brennan

RWW/dw
Disc. - 1/28/14
46

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

STEPHENS, LAURA
Employee/Petitioner

Case# **10WC029987**

ILLINOIS VETERANS HOME
Employer/Respondent

14IWCC0107

On 5/7/2013, 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:

0293 KATZ FRIEDMAN EAGLE ET AL
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ATTORNEY GENERAL
100 W RANDOLPH ST
13TH FLOOR
CHICAGO, IL 60601-3227

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

MAY 7 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Adams)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Laura Stephens
Employee/Petitioner

v.

Illinois Veterans Home
Employer/Respondent

Case # 10 WC 29987

Consolidated cases: N/A

14IWCC0107

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lindsay**, Arbitrator of the Commission, in the city of **Quincy**, on **March 6, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **July 31, 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 **$32,224.82**; the average weekly wage was **$749.42**.

On the date of accident, Petitioner was **43** 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 **$30,619.97** in TTD, **$0** in TPD, **$0** in maintenance, **$0** in non-occupational indemnity disability benefits, and **$0** for other benefits for which credit may be allowed under Section 8(j) of the Act.

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

ORDER

Respondent shall pay reasonable and necessary medical services directly to the Petitioner, pursuant to the fee schedule, of $3,276.74 for Quincy Medical Group; $481.00 for Springfield Clinic; $66,301.00 for Dr. Michel Malek; $19,413.40 for United Surgical Assistants; $3,097.70 for Professional Imaging; $743.50 for Clinical Radiologists; $47.00 for Joliet Radiological; $10,274.13 for Our Lady of the Resurrection Hospital; and $220.00 for Washington University as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $499.61/week for 73 4/7 weeks, commencing August 1, 2010 through January 7, 2011 and February 10, 2011 through January 30, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $499.61/week for 57 2/7 weeks, commencing January 31, 2012 through March 6, 2013, as provided in Section 8(a) of the Act.

Respondent shall authorize and pay for an initial vocational rehabilitation assessment by a certified counselor as provided in Section 8(a) of the Act and the Rules Governing Practice Before the Illinois Workers' Compensation Commission.

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.

Harry Lindsay
Signature of Arbitrator

May 2, 2013
Date

ICArbDec19(b)

MAY -7 2013

Laura Stephens v. Illinois Veterans Home, 10 WC 29987 (19(b))

Petitioner alleges an injury to her neck and body occurring on July 31, 2010. The issues in dispute are: accident; causal connection; medical expenses; temporary total disability; maintenance, and Petitioner's entitlement to a vocational assessment. Petitioner was the only witness testifying at the time of trial.

The Arbitrator finds:

Petitioner testified that she graduated from high school in 1984 and obtained her CNA through Kankakee Community College in Kankakee, Illinois in approximately 1994. Petitioner testified that she began working for Respondent as a "Veterans Nursing Assistant Certified" ("VNAC") in October of 2001. Petitioner explained that Respondent is a retirement facility for retired veterans.

Petitioner testified that as a VNAC at Respondent, her duties included total care of residents. Petitioner explained that as a VNAC, Petitioner bathed, dressed, fed, put residents in wheelchairs, took them to their appointments, cleaned rooms, made beds, and assisted with their activities of everyday living.

Petitioner's Prior Medical History

Petitioner testified regarding her prior medical history, including a prior neck surgery and shoulder surgery. On February 20, 2005, Petitioner sustained an injury to her neck while working for Respondent. As a result of that accident, Petitioner was diagnosed with a bulging disc at C5-6 and a broad-based disc protrusion at C6-7. (PX 1)

An MRI of Petitioner's cervical spine performed on 5/6/2005 at Quincy Medical Group (QMG), showed reversal of the cervical lordosis. It stated that there was a moderate size disk osteophyte complex at the C6-7 level causing some type of spinal canal stenosis with minimal spinal cord compromise and bilateral foraminal narrowing. There was also a much smaller disk osteophyte complete seen at C5-6 with minimal left neural foraminal narrowing. (PX 1)

Petitioner underwent a cervical fusion surgery performed by Dr. Miles at Columbia Orthopedic Group in September of 2005. (PX 14)

On 1/13/2006, Petitioner saw Dr. Diana Franklin, a chiropractor for severe headaches and stabbing neck pain after a 1/13/2006 work accident where she was assisting a resident who pulled back against her. Petitioner complained of neck pain going into her left arm. Petitioner reported that her pain was worse when she coughed/sneezed, bent forward, lifted, pushed, pulled or turned her head. Petitioner reported that the neck pain work her during the night and was affected by changes in the weather. Petitioner reported that she had neck stiffness and headaches. (RX 5)

Petitioner treated with Dr. Franklin on 1/17/2006, 1/19/2006, 1/20/2006, 1/24/2006, 1/27/2006, 2/3/2006, 2/6/ 2006, 2/17/2006 and 2/21/2006. On 2/26/2006, Petitioner reported that she had pain from the left side of her neck down to her left arm and fingers. Petitioner reported that she had pain on the right side of her neck by her shoulder. A slight headache was noted on January 20, 2006. (RX 5)

At her March 9, 2006 follow-up visit with Dr. Miles, Dr. Miles released Petitioner back to full duty work. (PX14). At her final visit with Dr. Miles on May 23, 2006, Dr. Miles released Petitioner from treatment at maximum medical improvement and continued her full duty work status. Petitioner testified that she continued working full duty for Respondent upon her release from treatment by Dr. Miles. Petitioner was to return in one year but didn't.

On 11/17/2006, Petitioner presented to Dr. Huang, her primary care physician, complaining of neck pain and stiffness. Dr. Huang prescribed Petitioner Naproxen 500 mg and Skelaxin 800 mg. and took Petitioner off work. (RX 2)

On 11/18/2006, Petitioner called Dr. Huang and reported that the Naproxen was not helping. At that time, Dr. Huang prescribed Petitioner Darvocet 40 mg and gave her an off-work slip covering 11/16/2006 and 11/17/2006. (RX 2)

On 10/25/2007, Petitioner again saw Dr. Huang for the pain in her neck. She had been having neck pain for two days with headaches, too. She requested a refill of her medications. Dr. Huang prescribed her Lortab 7.5/500 mg and Ambien 10 mg. (RX 2)

On 12/7/2007, Petitioner again saw Dr. Huang complaining of neck pain and headaches. She requested a refill of her Adderall and Ambien and wanted to discuss her Lortab. Dr. Huang prescribed her a refill of Adderall 20 mg and Ambien 10 mg and, additionally, prescribed Petitioner Ultram 100 mg. (RX 2)

On 2/16/2008, Petitioner saw Dr. Huang complaining of neck pain with range of motion. She stated that her neck hurt and her arms were going numb. Petitioner stated that her left arm gave out at work and that she lifted patients at the Vet Home that caused neck pain. Dr. Huang prescribed Petitioner Lortab 7.5/500 and Flexeril 10 mg and gave her an off-work slip for 2/16/2008. Petitioner was scheduled for an MRI at Blessing Hospital on February 27, 2008. (RX 2)

On 3/28/2008 and 4/7/2008, Petitioner was scheduled to undergo an x-ray of her cervical spine at QMG at the referral of Dr. Huang, but it was cancelled. (PX 1)

On 5/19/2008, Petitioner saw Dr. Huang, stating that she had hurt her lower back at work. She reported that she still had some Lortab or Darvocet at home, but Dr. Huang prescribed her Celebrex 300 mg to use if the Lortab was not working. (RX 2)

On 8/4/2008, Petitioner saw Dr. Huang complaining of a headache the day before and requesting a work excuse. Dr. Huang provided Petitioner a off-work slip for 8/3/2008. (RX 2)

On 8/6/2008, Petitioner saw Dr. Huang for right leg pain with swelling and discoloration. She reported that her foot had been run over by a patient's wheelchair. (RX 2)

On 8/7/2008, Petitioner saw Dr. Huang, complaining of leg pain and requesting a work excuse. Dr. Huang gave Petitioner an off-work slip for 8/8, 8/9 and 9/11/2008. (RX 2)

On 8/7/2008, Petitioner then went to Dr. Arndt at QMG Prompt care for her right leg injury. Dr. Arndt prescribed Petitioner Relafen 500 mg, a drug used to treat pain caused by arthritis or osteoarthritis. (PX 1)

On 8/11/2008, Petitioner saw Dr. Huang for her right leg and requested an extension of her work excuse. Dr. Huang extended Petitioner's off-work slip from 8/11 to 8/17/2008. (RX 2)

On 8/18/2008, Petitioner saw Dr. Huang for her right leg and requested an extension of her work excuse. Dr. Huang extended Petitioner's off-work slip from 8/18 to 8/25/2008. (RX 2)

On 8/25/2008, Petitioner saw Dr. Huang for her right leg. He gave her a work excuse from 8/7 to 8/25/2008 and referred her to QMG for an MRI on 9/2/2008. (RX 2)

On 8/26/2008, Petitioner returned to Dr. Huang and requested another off-work slip. She stated that her leg hurt when she went back to work moving patients. Dr. Huang gave Petitioner a work excuse for 8/26 to 9/2/08. (RX 2)

On 9/2/2008, Petitioner had an MRI of her right calf, which showed a relatively low-grade partial tear at the muscolotendinous junction of the medial head of the gastrocnemius. Petitioner also presented to Dr. Huang, who gave Petitioner a slip taking her off-work indefinitely. (PX 1)

On 9/4/2008, Petitioner saw Dr. Huang, who evaluated her MRI. Dr. Huang diagnosed Petitioner with a muscle tear of the right leg and Petitioner reported her right leg was better. (RX 2)

On 9/11/2008, Petitioner saw Dr. Huang for her right leg. Petitioner reported that her right leg hurt when she was working at the Home. Dr. Huang gave Petitioner a work excuse for 9/12 to 9/18/13. (RX 2)

On 9/18/2008, Petitioner saw Dr. Huang for her right leg. Petitioner reported that she only had mild tenderness when weight bearing. Dr. Huang gave Petitioner a work excuse for 9/19 to 9/24/13. (RX 2)

On 9/24/2008, Petitioner saw Dr. Huang for her right leg. Petitioner reported she was doing well and her muscle tear had improved. (RX 2)

On 10/31/2008, Petitioner underwent an MRI of the cervical spine at the request of Dr. Huang. The MRI's clinical history stated that Petitioner had headaches and neck pain, along with bilateral arm tingling and numbness. The MRI showed loss of the normal cervical lordosis. (PX 1) The report stated:

> There is straightening of the normal cervical lordosis from the levels of C2 to C5. Kyphosis extends from C5-C7. The degree alignment abnormality appears similar to the study dated 5/6/05. Since the prior examination, there has been surgery on the C6-C7 levels. The degree of spinal stenosis previously identified at the C6-C7 level appears to be improved.
> At the level of C2-C3, the central canal and neural foramina are widely patent.
> At the level of C3-C4, the central canal and neural foramina are widely patent.
> At the level of C4-C5, the central canal and neural foramina are widely patent.
> At the level of C5-C6, there is a broadbased posterior disk bulge, which flattens the thecal sac anteriorly. There is loss of CSF signal anterior to the cord. CSF signal is preserved posterior to the cord.
> At the level of C6-C7, there is broadbased posterior disk bulge with flattening of the thecal sac. Mild neural forminal stenosis is identified bilaterally. The degree of stenosis is improved since the presurgical evaluation dated 5/6/2005.
> At the level of C7-T1, the central canal and neural foramina are widely patent.

The MRI's impression was loss of the normal cervical lordosis with kyphotic abnormality identified at the lower cervical spine. Overall, the kyphotic abnormality appears similar to the study dated 5/6/2005. Postoperative changes show improvement in spinal stenosis at the C6-C7 level. (PX 1)

On 12/8/2008, Petitioner saw Dr. Emilio Tayag, an orthopedic surgeon. Cindy Huang, Dr. Huang's CNP had referred Petitioner to Dr. Tayag for Petitioner's neck pain. Dr. Tayag reported that Petitioner had neck surgery in 2005 and was seeing him due to her neck pain with moderate to severe headaches. Petitioner reported constant neck pain that radiated to her shoulder. She reported that this pain started in February 22, 2005 when she moved a patient as a CNA. According to Petitioner, she felt better after her surgery, until a year after that, when she started getting tingling sensations on both of her upper extremities and associated extreme headaches and sensitivity to cold weather.

Petitioner reported that her pain was now radiating to both her shoulders and to her clavicle with a tingling sensation on the shoulders down to the fingers. Petitioner reported that she had been dropping things and that her symptoms were worse with excessive lifting and occasionally sneezing. Petitioner also reported that her symptoms were increased by bending and lying down and that they awakened her during sleep. (PX 1)

Dr. Tayag noted that Petitioner was taking Adderrall 20mg and Ambien 10mg as needed and Motrin 800mg t.i.d. Petitioner reported that work aggravated her symptoms. Petitioner reported that her hobbies included playing with her grandkids, motorcycle riding, bicycle riding, working out, yardwork and walking. (PX 1)

Petitioner stated that her current pain level was "0-25," which she described as mild. Petitioner reported that she was hurting in the neck, arms, hands, back, lower back, clavicle, and shoulders. She stated her goals included increased relief from pain and numbness and weakness and headaches. (PX 1)

For her exam, Dr. Tayag noted Petitioner's musculoskeletal symptoms included neck pain, muscle pain and weakness, arthritis, joint pain and swelling. Petitioner's neurologic symptoms were headaches, change in speech, vision, memory, numbness, tingling, balance problems, and sinus problems. Petitioner had a negative straight leg raise test. (PX 1)

Dr. Tayag diagnosed Petitioner with neck pain and cervicalgia with radiculopathy, possibly from pseudoarthrosis. At that time, Dr. Tayag stated that Petitioner could take Ibuprofen 800 mg. 3 to 4 times per day and should return to clinic in 4 weeks. Dr. Tayag also prescribed physical therapy for Petitioner and scheduled her for an MRI of her cervical spine. Dr. Tayag stated, "If the patient has pseudoarthrosis, we might need to refuse the C6-C7 level." (PX 1)

On 12/8/2008, Petitioner underwent an x-ray of her cervical spine. The x-ray showed a slight anterior translation of C2 on C3 as well as C3 on C4 with flexion positioning, as compared to extension positioning. It also showed an anterior stabilization plate at C6-7. There was no evidence of instability between flexion and extension on C5-C7. (PX 1)

On 12/18/2008, Petitioner underwent the MRI of the cervical spine with flexion and extension. (PX 1) When compared to the 10/31/2008 MRI, the 12/8/2008 findings were:

> There is slight anterior translation of C2 on C3 as well as C3 on C4 with flexion positioning, as compared to extension positioning. Anterior stabilization plate is identified at C6-C7. The C5 through C7 levels show no evidence of instability between flexion and extension positioning. No evidence of acute hardware complication.

On 9/15/2009, Petitioner returned to see Dr. Huang. She requested a refill on her Ambien & Adderall. Dr. Huang prescribed Petitioner Nexium, Ambien 10 mg and Adderall 20 mg. (RX 2).

Petitioner also testified that on October 16, 2009, she sustained another accident while working for Respondent. Petitioner testified that Petitioner injured her right shoulder in that accident.

On 10/16/2009, Petitioner was involved in a work accident and injured her right shoulder. Petitioner saw Dr. Wallace at QMG's prompt care, stating that a patient had yanked her right arm at work, causing pain across her right shoulder, left neck and upper back. Dr. Wallace noted that Petitioner complained of right shoulder and neck pain. Dr. Wallace noted that Petitioner complained of pain across the right upper neck and across the back of the right shoulder and into the AC joint of the shoulder. Dr. Wallace noted that Petitioner complained that she had a little bit of pain across the left neck as well, but most of the problems on the right. Petitioner was placed on light duty. Dr. Wallace noted that Petitioner reported that she was having no problems prior to this incident. (PX 1)

10/28/2009, Petitioner again saw Dr. Wallace. Petitioner reported that she pain in her neck that radiates down to the arm and fingers. She stated that it felt a little like numbness and tingling, but there was pain over the AC joint of her shoulder as well. Petitioner's light duty was continued. Petitioner acknowledged a previous history of cervical spine surgery and reported both neck and shoulder pain at the time of her examination. Dr. Wallace again specifically noted that Petitioner had a cervical spine issue in the past, but that she was having no problems prior to the acute injury on October 16. (PX 1)

On 10/30/2009, Petitioner was seen at QMG Orthopedics for shoulder and neck pain per the referral of Dr. Wallace. Petitioner complained of chest pain, muscle weakness, numbness and tingling, and visual changes. Jean Cross, a CNP at QMG-Orthopedics, noted that she was now having more neurological radicular symptoms, as well. Ms. Cross noted that Petitioner felt weak and had a burning pain and headache. It was noted that Petitioner had neck tenderness and abnormal neck range of motion, as well as shoulder tenderness and abnormal range of motion. Petitioner's light duty was continued and she was referred for physical therapy. (PX 1)

On a QMG Orthopedics Department Medical History – Patient Intake form filled out on 10/30/2009, Petitioner stated she was being treated for shoulder and neck pain. Petitioner stated that she was experiencing chest pain, muscle weakness, numbness and tingling, and visual changes. (PX 1)

Petitioner began shoulder therapy on November 2, 2009. (PX 1)

On 11/9/2009, Petitioner reported to her therapist that there was no change in her pain in the right shoulder. Additionally, she reported increased burning through the neck,

and numbness and tingling throughout the right upper extremity and in the right hand. (PX 1)

On 11/10/2009, Petitioner was seen by Jean Cross, a CNP at QMG- Orthopedics. Petitioner complained of numbness and tingling in her arm, mild neck pain, and shoulder pain, that seemed to be localized in the anterior shoulder, more so than posteriorly. Petitioner's light duty was extended. (PX 1)

On 11/16/2009, Petitioner underwent an MRI of her right shoulder. The MRI showed laterally downsloping configuration to the acromion, which could contribute to the clinical syndrome of impingement. Additionally, the MRI showed supraspinatus and less prominent subscapularis tendinopathy and a posterior labral tear. (PX 1)

On 11/18/2009, Petitioner again saw Jean Cross. According to the Intake Note, Petitioner's neck also ached. Petitioner complained of pain in the shoulder, down the arm, and posteriorly. Ms. Cross recommended an injection in the shoulder and stated that if the injection did not give her any relief, that she would consider looking further, even up into the neck. Petitioner's light duty was extended. (PX 1)

On 11/24/2009, Petitioner saw Steven Dement, a PA, at QMG-Orthopedics. Mr. Dement stated that Petitioner had been struggling with a partial rotator cuff tear and impingement. Mr. Dement noted that Petitioner had undergone an injection through Jean Cross on 11/18/2009. Petitioner stated that she had slightly more free movement and a little better functional activity level. Mr. Dement recommended that Petitioner continue her conservative therapy for another few weeks. (PX 1)

On 12/17/2009, Petitioner saw Dr. Crickard at QMG-Orthopedics. Dr. Crickard stated that the injection one month ago helped, but that Petitioner's pain had returned. Dr. Crickard recommended surgery, and Petitioner stated that she wanted to go to Dr. Greatting in Springfield for the surgery. Petitioner's light duty was extended. (PX 1)

On 1/2/2010, Petitioner again saw Dr. Huang. Dr. Huang refilled Petitioner's Ambien and gave her a work excuse for 1/1 to 1/2/2010. (RX 2)

On 1/7/2010, Petitioner presented to Dr. Wallace at QMG and requested a referral to go to St. Louis for her shoulder surgery. Petitioner was also seeking another shoulder injection but that could not be done at QMC. Instead, Petitioner was given a prednisone taper. Petitioner remained on light duty. (PX 1)

On 2/12/2010, Petitioner saw Dr. Farley, an orthopedic surgeon at Orthopedics & Sports Medicine. Petitioner reported right shoulder pain since 10/16/2009. Dr. Farley specifically noted that Petitioner denied any accident or injury pre-dating or post-dating the October 16th accident. Dr. Farley continued Petitioner's light duty restrictions and referred her to physical therapy. (PX 2)

Petitioner underwent right shoulder surgery performed by Dr. Timothy Farley at Chesterfield Surgery Center on February 25, 2010. (PX2)

Petitioner provided information for a Functional Intake Summary on February 26, 2010. Her current health problems included back pain, headaches, and prior surgery. (PX 1)

On 3/9/2010, Petitioner saw Dr. Farley as she was two weeks post-op of her right shoulder surgery. Dr. Farley noted that Petitioner had no pain within her shoulder. Dr. Farley continued Petitioner's light duty. (PX 2)

On 3/12/2010, Petitioner saw Dr. Huang for lower lumbar pain. Petitioner reported that she was doing squats the day before and heard something pop. Dr. Huang prescribed the Lortab and Flexeril and scheduled her for a x-ray of her lumbar spine. (RX 2)

On 3/15/2010, Petitioner underwent an x-ray of the lumbar spine that showed moderate narrowing of the L4-5 disc space with vacuum phenomena and spurring anterior and posteriorly about this disc space. The x-ray also showed minor spurring about the L3-4 disc space. (PX 1)

On 3/17/2010, Dr. Huang notified Petitioner that the x-ray showed disc disease of the lumbar spine and scheduled her to come back in two weeks. (RX 2)

On 4/6/2010, Petitioner saw Dr. Farley, as she was 6 weeks out from her right shoulder arthroscopy. Dr. Farley noted that Petitioner was doing well, having minimal discomfort in and around her shoulder. Dr. Farley continued to Petitioner's light duty. (PX 2)

On 4/8/2010, Petitioner saw Dr. Huang for lower lumbar pain. Petitioner reported muscle pain and trouble sleeping. Petitioner requested a refill of her Ambien, which Dr. Huang prescribed. (RX 2)

On 5/18/2010, Petitioner saw Dr. Farley, as she was 12 weeks out from right shoulder arthroscopy. Dr. Farley noted that Petitioner had pain at the end of the range of her terminal forward flexion. Dr. Farley extended Petitioner's light duty and prescribed Petitioner work hardening for 3 days a week for 2 weeks. At her May 18, 2010 visit, Dr. Farley advised her to return to work full duty as of July 7, 2010. (Id.). (PX 2)

On 5/19/2010, Petitioner saw Dr. Huang due to neck pain. Petitioner reported that she had neck pain and headaches due to that neck pain. Petitioner reported to Dr. Huang that she was unable to go to work that day due to the neck pain and needed a work excuse. Dr. Huang gave Petitioner a work excuse for 5/19/2010. (RX 2)

Petitioner underwent physical therapy/work hardening for her right shoulder beginning on February 26, 2010 and concluding on June 2, 2010 (a total of 24 visits). The

program was progressive in nature with increasing treatment time (reaching a maximum of three hours) in an effort to improve Petitioner's right shoulder workability. As of the last visit Petitioner exhibited no pain with strengthening activity and had progressed to the three hour work-out with no problem. (PX 1)

On 6/14/2010, Petitioner saw Dr. Huang regarding dizziness. Petitioner stated that she was especially light-headed in the morning. Petitioner stated that she had a headache and had taken Ambien. Dr. Huang gave her an off-work slip for 6/13 to 6/14/2011. (RX 2)

On 6/22/2010, Petitioner saw Dr. Farley. Petitioner reported that she had undergone a fairly disorganized course of work hardening with multiple different people working with her. Petitioner stated that the circumstances of her activities at therapy did not at all reflect her work responsibilities. Dr. Farley noted that Petitioner had only undergone one 3-hour work hardening visit, and that visit had offered her significant improvement by her own admission. Therefore, Dr. Farley recommend three visits of work hardening to be organized, followed by return to full activity without restriction after the third visit. Dr. Farley gave Petitioner a slip returning her to work full duty on 6/29/2011. (PX 2)

On 6/24/2010, Petitioner called and cancelled all of her work hardening visits, stating that she had returned to work full duty. (PX 1)

On July 14, 2010, Petitioner complained of a severe headache to Dr. Huang the day before as well as pain in her shoulder. However, Dr. Huang noted that at the time of that visit, Petitioner was "fine." (PX 1)

On 7/15/2010, Petitioner refilled her Ambien (generic as Zolpidem) at Walgreens. (RX 4)

On 7/27/2010, Petitioner saw Dr. Farley, as she was 5 months out from her right shoulder arthroscopy. Dr. Farley noted that Petitioner had returned to work full duty, but was now complaining of episodic discomfort over the lateral aspect of her right shoulder in the mid-deltoid region near the lateral based portal. Dr. Farley stated, "I think she can continue to work without restriction. I think she will continue to note improvement of comfort over the first year out from the time of surgery." Dr. Farley placed Petitioner at maximum medical improvement (MMI). (PX 2)

Petitioner's Testimony regarding her Accident

Petitioner testified that she was working full-time as a VNAC for Respondent on July 31, 2010. Petitioner further testified that upon arriving to work on the morning of July 31, 2010, she felt fine and went about her regular duties. Petitioner testified that on that day, which was a Saturday, she sustained an accident. Petitioner testified that she was using a "Sara Lift" to move a resident from a toilet to a chair. Petitioner testified that this resident was approximately six feet tall and weighed 240 pounds. Petitioner

explained that the "Sara Lift" is a machine with wheels on the bottom and arms that raise up and down. Petitioner testified that she placed a sling from the machine around the resident to aid her in lifting him onto the chair from the toilet.

Petitioner testified that she had the sling around the resident with her right hand and the lift with her left hand. As Petitioner was maneuvering the resident, he reared back in his seat and caused Petitioner's right arm to pull. Petitioner testified that she felt immediate sharp pain go through her right shoulder and into her neck along with a feeling of dizziness. Petitioner stated the pain went all the way through to the left side of her neck. Petitioner described the pain as stabbing, searing, and burning.

The parties stipulated to notice.

Petitioner's Medical Treatment Immediately Following Her Accident

Petitioner testified that her accident occurred with only approximately forty-five minutes left in her work day. Petitioner was the only one left on her floor at that time so Petitioner continued to work and just sort of rode it out.

Petitioner testified that she was scheduled to work the following day, Sunday, August 1, 2010, however, she did not do so because she was still very dizzy and her neck hurt. Petitioner did not see a doctor that day but stayed home and did nothing. The following day, Monday, August 2, 2010, Petitioner testified that she attempted to return to work for Respondent. However, Petitioner testified that after about one half hour, her pain was too severe and she was still very dizzy. Petitioner decided to leave work and went to see Dr. Huang.

On 8/2/2010, Petitioner saw Dr. Huang, complaining of dizzy spells. Petitioner stated that the dizzy spells were not as bad as a few days earlier, but that she has had intermittent dizziness. Petitioner stated that she was unable to work the day before, so Dr. Huang gave her an off-work slip for 7/31/2010 and 8/1/2010. Dr. Huang scheduled Petitioner for a x-ray of her cervical spine and set her up an appointment with Dr. Raskas for 9/2/2010. (RX 2)

On 8/2/2010, Petitioner underwent an x-ray of her cervical spine because of a clinical history of neck pain. The x-ray found reversal of the normal cervical lordosis which was most likely related to patient positioning. Mild osseous neural foraminal stenosis at the left C5-6 level was also noted. (RX 7)

Petitioner testified that she told Dr. Huang about her accident of July 31, 2010 at her visit on August 2. At her initial visit, Dr. Huang noted Petitioner's complaints of neck pain and dizziness. (PX4; RX2) Dr. Huang referred Petitioner to Dr. Raskas and noted an appointment date of September 2, 2010. (Id.)

The following day, August 3, 2010, Petitioner treated with Dr. David Arndt of the Quincy Medical Group pursuant to the referral of Respondent. Dr. Arndt noted Petitioner

injured her neck while moving a patient with a lift at the Illinois Veterans Home. He also noted that Petitioner's shoulder got "tugged" and she had developed pain across the trapezius which extended to the left trapezius. Dr. Arndt noted Petitioner's complaints of, "...vertigo and unsteadiness every second of the day since it happened that Petitioner is awake." Petitioner reported tingling in both arms, but no weakness. Petitioner reported tightness in the posterior cervical musculature and a headache. He noted that Petitioner reported her shoulder surgery of February that same year. (Id.) Dr. Arndt believed Petitioner's neck injury to be mostly soft tissue and suspected her headache and unsteadiness were related to her symptoms. He advised Petitioner to remain off work for the next week. His diagnosis was a cervical sprain with stiffness and, secondarily, headache and unsteadiness. (PX 1)

Petitioner signed her Application for Adjustment of Claim on August 4, 2010. (AX 2)

On 8/10/2010, Petitioner again saw Dr. Arndt. Dr. Arndt noted that Petitioner had significantly less dizziness, but that she continued to have neck discomfort which started in area midline and soft tissues at C7 and radiates into the left trapezius. Petitioner reported that she felt some extension of that pain into the arms, left much more than right. Petitioner reported that her headaches had calmed down, but had not fully resolved. (PX 1)

Dr. Arndt scheduled Petitioner for an MRI and recommended physical therapy to try to get Petitioner back to her light duties at her job site. (PX 1)

On 8/11/2010, Petitioner underwent an MRI of her cervical spine. When compared to 10/31/2008 MRI, the 8/11/2010 MRI did not show any specific change in degree when compared to the earlier study of 10/31/2008. (PX 1) The 8/11/2010 MRI showed:

> C2-3: Normal.
> C3-4: Some desiccation with minimal diffuse disc bulge. No significant compromise of
> the canal or exiting roots however.
> C4-5: Desiccation and loss of disc height. Minimal diffuse disc bulge. Very slight ventral cord effacement there is shows no change when compared to earlier study.
> C5-6: Similar findings with desiccation and loss of disc height. Uncinate hypertrophy bilaterally with minimal encroachment upon each foramen. Due to the diffuse disc bulge there is slight ventral effacement of the cord without abnormal cord change. Again this shows a similar findings to the prior study No abnormal cord signal change. No significant change when compared to the earlier study.
> C6-7: Fusion. Some component of bony ridging with disc as well. No significant compromise of the canal or existing roots. Stable appearance when compared to the earlier study.

C7-T1: Relatively well-preserved level as well without change in appearance.

The 8/11/2010 MRI's Impression was: Postoperative changes with fusion at believe spanning the C6 and C7 levels. Reversal of the normal lordotic curvature through these levels as before. Most affected level appears at C5-C6 as might be anticipated. Minimal diffuse disc bulge with ventral effacement of the cord was noted; however, no abnormal cord signal change was seen. The study did not show any specific change in degree when compared to the earlier study of 10/31/2008. (PX 1)

On 8/12/2010, Petitioner returned to see Dr. Arndt. Dr. Arndt reviewed the MRI and found that the results really looked very good. Dr. Arndt noted that there were no areas of nerve impingement in the spinal column. Dr. Arndt noted that Petitioner continued to have some discomfort in her lower cervical and left trapezius areas which were palpably tender. Dr. Arndt returned Petitioner to light duty work on 8/13/2010. (PX 1)

Petitioner underwent physical therapy at QMG on 8/13/201, 8/17/2010 and 8/19/2010. (PX 1)

On 8/25/2010, Petitioner again saw Dr. Arndt. Dr. Arndt stated that Petitioner had not changed much. Dr. Arndt stated the he believed that Petitioner might have worsened, as she was still having dizziness, burning sensation in the posterior cervical area mostly on the left, headache late in the day, and tingling in her fingers at times. Petitioner also described knots in the back of her neck. Petitioner told Dr. Arndt that she was going to see another physician in St. Louis for a second opinion and Dr. Arndt noted that that seemed an excellent idea as nothing that had been done, to date, had really helped her. Dr. Arndt gave Petitioner an off-work slip. (PX 1)

On September 2, 2010, Petitioner had her initial visit with Dr. David Raskas, a physician located in the same office as her shoulder surgeon, Dr. Farley. Dr. Raskas, an orthopedic surgeon, took a history from Petitioner, which included a chief complaint of neck pain with a secondary complaint of radiation into her arms with numbness and tingling in her hands. Petitioner stated she was dropping things and having difficulty lifting things with her left hand. (PX2). He noted her prior history of a neck injury in 2005, which resulted in a fusion done by Dr. Miles as well as her 2010 shoulder surgery. Petitioner advised the doctor that she would have some occasional neck pain and an aching sensation intermittently since her original neck surgery but prior to her accident of July 31, 2010.Petitioner also reported that it would just go away naturally. He also noted Petitioner sustained a jolting injury to her neck when Petitioner was trying to lift a patient with a Sara Lift. He further noted that Petitioner felt nauseous and experienced a lot of neck pain followed by persistent trouble with her upper extremities, including numbness and tingling. (PX 2)

Dr. Raskas reviewed the MRI scan "that she had done"[1] and stated it revealed a central cervical disc herniation at C5-6 along with central canal stenosis at C5-6 and C6-7. Dr. Raskas also stated that x-rays taken that day indicated Petitioner had an incomplete healing of her prior fusion. His impression was cervical pseudoarthrosis with new cervical disc herniation and myelopathy. (Id.). He explained that, "...the injury at work aggravated the pseudoarthrosis and also caused the herniated disc..." (PX 2)

Dr. Raskas recommended a myelogram/CT scan and stated Petitioner would most likely need some type of repair of the pseudoarthrosis and reconstruction at the disc herniation level. He further advised her to remain off of work and concluded that the need for the above testing and her work status was directly related to her work injury. (PX 2)

On 9/7/2010, Petitioner underwent a CT scan due to neck pain with pain and tingling extending down both arms, prior cervical fusion, and possible non-union. (PX 2) The CT showed no distinct bony fusion across this disc space at any point, except for possibly immediately dorsal to the plate, although there is streak artifact through this region. There is loss of usual cervical lordosis. There is retrolisthesis of C5 on C6 as well. The degenerative changes will be described by level below:

> C2-3: There is minimal disc bulging but no significant neuroforaminal compromise. The cervical canal appears small on a congenital basis with the midline AP canal diameter at this level measuring 10 mm (lower limits of normal 12 mm)
> C3-4: There is mild disc bulging and some uncovertebral and facet arthropathy. There is borderline midline AP canal narrowing but no significant neuroforminal narrowing.
> C4-5: There is mild disc bulging, uncovertebral and facet arthropathy. There is mild flattening of the ventral thecal sac but no neuroforminal narrowing and borderline AP canal narrowing.
> C5-6: There is broad based disc protrusion flattening the ventral thecal sac and the ventral cord. There is end plate degeneration and bilateral uncovertebral and facet arthropathy. There is mild AP canal narrowing, and moderate bilateral neuroforaminal narrowing.
> C6-7: This level has instrumentation, with mild to moderate canal narrowing and moderate to severe bilateral neuroforminal narrowing due to uncovertebral degeneration, and mild facet arthropathy.
> C7-T1: Unremarkable.

The CT scan conclusion was C5-6 degenerative changes, concern for non-union of C6-7 fusion, and a small canal on a congenital basis. (PX 2)

On 9/7/2010, Petitioner also underwent a Myelography. The Myelogram showed no suggestion of canal stenosis, but the nerve root sleeves were difficult to visualize on oblique views. Additionally, on lateral views, there is still lucency suggested through the C6-7 disc space with Grade 1 retrolisthesis of C6 on C7. There is no lucency suggested

[1] Presumably 8/1/10 as that is what is found in PX 3

around the hardware. There are end plate osteophytes and ventral impressions on the thecal sac at all levels from C2-3 through C5-6. (PX 2)

The myelogram conclusion was multilevel degenerative changes. (PX 2)

Petitioner had a follow-up visit with Dr. Raskas on September 9. (PX2). Dr. Raskas reviewed the CT scan and recommended an anterior revision of the fusion plus resection of the herniated disc. In a letter to Respondent, Dr. Raskas again confirmed his belief that the work injury caused the herniated disc and aggravated the pseudoarthrosis. Petitioner testified that Respondent authorized this surgery and it was performed by Dr. Raskas on September 29, 2010. (PX 2; PX3) According to Petitioner's Admission Note of September 27, 2010 Petitioner was injured in a work-related injury causing her C5-6 herniated disc and C6-7 pseudoarthrosis to become symptomatic; for which she might have had symptoms from C6-7 non-fusion in the past. Certainly, the persistence of her symptoms has been caused by the work injury that resulted in a herniated disc at the C5-6 level. (PX 3)

Following this surgery, Petitioner testified she felt relief from the tingling and numbness in her hands and that the "stabbing, sharp pains were pretty much gone." Petitioner continued to follow-up with Dr. Raskas after her surgery.

Petitioner's 10/14/2010 visit was rescheduled for 10/21/2010. (PX 2)

On 10/21/2010, Petitioner saw Dr. Raskas as she was 3 weeks post-op. Dr. Raskas noted that Petitioner was doing well clinically. Dr. Raskas stated that Petitioner was to remain off work until he saw her again, after the first of the year, at which point he believed that she should be able to return to work full duty. (PX 2)

On 12/17/2010, Petitioner again saw Dr. Huang. Petitioner requested a refill of her Ambien and stated that she had had neck surgery in St. Louis, but she still had neck pain. Dr. Huang refilled Petitioner's Ambien 10 mg. (RX 2)

On 1/6/2011, Petitioner again saw Dr. Raskas. Dr. Raskas noted that Petitioner continued to have some left-sided axial neck pain. He noted Petitioner's arms symptoms are gone in terms of numbness and tingling and radiation, but that she continued to have some instability at C4-5 on her flexion/extension x-rays. Petitioner had undergone an x-ray which showed anterior cervical plate and fusion at C5 to C7. The x-rays showed that Petitioner's grafts appeared to be incorporating nicely. The x-ray stated that there was no motion on flexion/extension x-rays. The x-ray impression was healing cervical spine fusion. (PX 2)

Dr. Raskas gave Petitioner work restrictions that he felt might very well become permanent as Petitioner had some mechanical instability at C4-5. Dr. Raskas stated that he did not want to really get into fusing that many levels in Petitioner's neck and that he thought it probably would not lead to an improved level of function. Dr. Raskas stated that Petitioner certainly had no neurological reason for a surgical intervention at that

time. Dr. Raskas stated that Petitioner's fusion looked like it was developing into a solid fusion. (PX 2)

Petitioner returned to work in a light duty capacity for Respondent from January 8, 2011 through February 9, 2011. Petitioner testified that her duties included taking vitals, passing water and linens out, feeding residents, putting away laundry, helping other nurses, and engaging in some paperwork. Petitioner furthere testified that as she went about these duties her neck and shoulder areas were becoming more uncomfortable. Petitioner described her neck as "irritated" and her headaches as "worsening."

On 2/10/2011, Petitioner again saw Dr. Raskas. Dr. Raskas noted that Petitioner was having a lot of headaches and mechanical neck pain. Petitioner reported that just twisting, turning her neck, or doing light things bothered her. Petitioner reported that her symptoms were worse at the end of the day. Dr. Raskas noted that Petitioner was developing spondylolisthesis at the C4-5 level above her fusion and that she has significant angulation at that level in the neutral posture. Dr. Raskas stated that Petitioner's flexion/extension x-rays did not show any motion at the fused levels at C5-6 and C6-7, but that Petitioner had significant instability at the C4-5 level. Dr. Raskas stated that Petitioner needed a CAT scan and a 4-5 facet block to see if her symptoms were alleviated. Dr. Raskas stated that Petitioner was likely going to need to have her fusion extended up to C4-5 because of the mechanical instability and objective findings on the x-ray. Dr. Raskas stated that Petitioner's x-rays that day did not look like she was necessarily solidly fused. (PX 2)

He recommended facet joint injections and advised her to remain completely off work until after a likely second surgery. (Id.). That same day, Petitioner underwent a CT scan and facet joint injections performed by Dr. Barry Feinberg. (PX7; PX 3)

On 2/10/2011, Petitioner then underwent a CT scan due to a prior fusion in September 2010 with neck pain extending down both arms with numbness and tingling. It was compared to the post-myelogram CT done on 09/07/2010. The 2/10/2011 CT scan showed unusual soft tissue air locules, with clinical correlation recommended. It showed extension of instrumentation to C5-6 with increased kyphotic angulation. (PX 7)

On February 17, 2011, Petitioner had a telephone conversation with Dr. Raskas in which he confirmed his recommendation of another cervical surgery. On 2/17/2011, Petitioner again saw Dr. Raskas, who stated that the CT showed that Petitioner's fusion was not incorporated, as there was some loosening about the hardware and some halos around the screws in C7. Dr. Raskas stated that the graft itself did not appear to be incorporating on the sides at C7. Dr. Raskas also stated that Petitioner had a spondylolisthesis at C4-5. (PX 2)

Dr. Raskas stated that all in all, he thought Petitioner's residual symptoms were related to her spondylosisthesis. Dr. Raskas stated that Petitioner did not appear to have healing of her fusion and that she had some hardware loosening. Dr. Raskas stated that he was recommending a revision anterior decompression and fusion. (PX 2)

According to the Commission website and public records contained therein, Petitioner settled her workers' compensation claim for her shoulder injury (d/a: 10/16/09, 09 WC 49771) and the contracts were approved on April 11, 2011. Petitioner settled her claim for 32.5% loss of use of the right arm.

Petitioner testified that following her phone conversation with Dr. Raskas, Petitioner treated with Dr. Huang on April 19, 2011 to get a referral for a second opinion regarding surgery. (PX4)

On 4/19/2011, Petitioner again saw Dr. Huang. Petitioner requested a refill of her Ambien and stated that she would like to try Celebrex again and Skelaxin. Petitioner requested a referral to Dr. Daniel Adair in Springfield, as she was still having neck pain. Dr. Huang refilled Petitioner's Ambien 10 mg, Celebrex 200 mg and Flexeril 10 mg. Dr. Huang referred Petitioner to Dr. Payne in Springfield. (RX 2)

Petitioner was initially examined by Dr. Payne on May 5, 2011. Petitioner gave a history of undergoing an ACF for a herniated disc in 2005 and that she had done "fairly well" with that until 2010. Petitioner ended up having persistent neck pain and adjacent level disease, was diagnosed with pseudoarthrosis at C6-7 and underwent revision ACF at C5-6-7 from which she did "okay." Dr. Payne's history further states that Petitioner began experiencing neck pain again in February of 2011 and was found to have adjacent level disease at C4-5. Petitioner's complaints included axial spine pain with persistent pain over the triceps albeit mild by description. Petitioner explained she had tried to return to work in January of 2011 light duty and it aggravated her neck too much. Dr. Payne stated in his office notes,

> "When I saw Laura today, I did not realize that this was related to a workman's compensation claim. I did not ask her about how this injury started or why it is a compensation claim. I simply was trying to get a good physical exam and history to try to figure out why her neck is giving her persistent pain after two-level ACF."
>
> (PX 5)

Dr. Payne concluded that in order to make an accurate recommendation regarding her neck, he needed to review the February, 2011 CT scan. (PX 5)

At Petitioner's follow-up visit with Dr. Payne on May 13, 2011, he reviewed the CT scan and noted a nonunion at C5-6 and C6-7. He discussed another surgery with her as well but recommended Petitioner see Dr. Dan Riew in St. Louis due to his experience. (PX 5)

Prior to treating with Dr. Riew, Petitioner testified Petitioner returned to Dr. Huang on May 16, 2011[2]. At that visit, Petitioner requested a referral to Dr. Michael

[2] The office visit may have been May 10, 2011. The date is not entirely legible.

Malek for her continued neck pain. Dr. Huang referred her to Dr. Michel Malek noting the appointment had been made by Petitioner's attorney. (PX4)

Petitioner's initial visit with Dr. Malek, an orthopedic surgeon from Chicago, occurred on June 6, 2011. (PX8). Dr. Malek took a detailed history from Petitioner regarding her July 31, 2010 work accident noting Petitioner stated she twisted to the right side with her right arm elevated and a resident jerked her. He also noted her history of injury in 2005 and 2009. Petitioner reported to the doctor that her symptoms progressed to include pain in her neck with radiation in to her head and tingling in both upper extremities all the way to her fingers. Petitioner denied a history of previous similar episodes. Following his physical examination and review of radiographs, including the CT scans of September 7, 2010 and February 10, 2011, Dr. Malek diagnosed Petitioner with pseudoarthrosis at C5-6 and C6-7, amongst other cervical findings. He recommended a cervical fusion revision surgery. (PX 8)

Dr. Malek reviewed Petitioner's 2/10/2011 CT of cervical spine w/o contrast that was compared to CT myelogram of 9/7/10. Dr. Malek stated that the post-myelogram CT done on 9/7/10 showed broad-based disc protusion flattening of the ventral thecal sac and the ventral cord at C5-C6, with plate degeneration and bilateral uncovertebral and facet arthropathy and to matter at bilateral neuroforaminal narrowing. Dr. Malek stated at C6-C7 there was instrumentation with mild to moderate canal narrowing and moderate to severe bilateral neuroforaminal narrowing. (PX 8)

Dr. Malek stated that the view of the actual films confirm focal kyphosis at the C4-C5 level on the CT scan. Dr. Malek stated that he did not that the fusion at C5-C6 especially has not taken, but also at C6-C7. Dr. Malek stated that there were areas of lucency with compression of the C6 veterbral body to a bare minimum anteriorly. (PX 8)

Dr. Malek told Petitioner that prior to an additional surgery, he wanted an updated MRI scan to make sure that no pathology is present at C3-C4.(PX 8)

Dr. Malek then stated that it was his opinion that he patient's current condition of ill being is directly related to her injury of 7/31/10. Dr. Malek stated that it was "his opinion that of time of her injury of 7/31/10 patient's condition was compensated and not likely to result in the short term in any intervention at the C4-C5 level, or at the C5-C6 or C6-C7 levels. But as a result of the injury of 7/31/10 that condition became aggravated, precipitated or accelerated beyond the natural progression of disease, absent the above injury, resulting in the need for treatment recommended and treatment delivered." (PX 8)

Dr. Malek noted in his office notes, "It is my opinion to a reasonable degree of medical or neurosurgical certainty that the patient's current condition of ill being is directly related to her injury of July 31, 2010." (PX8)

Following her first appointment with Dr. Malek, Petitioner kept her original appointment with Dr. Riew on July 5, 2011, as recommended by Dr. Payne. (PX6)

On 7/5/2011, Petitioner saw Dr. Daniel Riew at Washington University Orthopedics at the request of Dr. Payne. Petitioner reported to Dr. Riew that she had neck pain since 7/31/2010, but her condition had worsened since February of 2011 becoming more consistent and sometimes unbearable. Petitioner stated that the pain started with a neck injury at work. Petitioner reported pain in the right upper back, shoulder, and upper arm and in the left upper back and shoulder. Petitioner reported weakness in the left shoulder and numbness and tingling in the right ring and small fingers that have been present for the last four month. Petitioner reported occasional but severe headaches from neck pain, for which she takes Ibuprofen and Ambien. Petitioner described her occupation as requiring her to lift more than 45 lbs. Her average pain level was described as 5-6/10. Petitioner's physical examination revealed a positive Hoffmann's sign bilaterally. Petitioner's neck pain was noted to be located on the left of the mid-cervical spine. (PX 5, 6)

Dr. Riew told Petitioner that she was not suffering from a dangerous condition, as she was not at a risk for nerve damage. He then stated that if the pain was intolerable, she could pursue surgery. (PX 5, 6)

On 7/26/2011, Petitioner underwent an MRI that was compared to the noncontrast MRI of 2/27/08 and the plain film of 8/2/10. (RX 7) The MRI showed:

> At the C2-C3 level, minimal spondylosis is present without significant central canal or neural foraminal narrowing.
> At the C3-C4 level, minimal disk and/or osteophyte effaces the anterior thecal sac and approaches the anterior aspect of the cord. No significant central canal stenosis believed to be present. No significant neural foraminal narrowing.
> At the C4-C5 level, disk and/or osteophyte effaces the anterior thecal sac and approaches the anterior aspect of the cord. It is difficult to assess the degree of potential narrowing due to metallic artifact. This may also create the appearance of greatest narrowing of the right neural foramina than what is truly present. On the T1 images, no significant foraminal narrowing at this level.
> At the C5-C6 level, metallic artificat present. It is doubtful that there is significant central canal stenosis. Artifact extends up to the anterior aspect of the cord. No significant neural foraminal narrowing believed to be present either.
> At the C6-C7 level, again metallic artifact present. It is doubtful that there is significant central canal stenosis or neural foraminal narrowing. Evaluation of the neural foramina appears to be best performed on the axial T1 weighted images.
> At the C7-T1 level, minimal spondylosis without significant central canal or neural foraminal narrowing.

The MRI found no abnormal signal, expansion or enhancement of the cervical cord. It also found some focal reversal of the normal cervical curvature of the C4

through the C6 levels. The Impression was spondylosis of the cervical spine without obvious significant central canal or neural foraminal narrowing. (RX 7)

On 8/1/2011, Petitioner saw Dr. Huang for her pre-op for exploration C5-7. Petitioner reported a dull pain in her neck. Dr. Huang noted that Petitioner was not to smoke or drink. (RX 2)

Dr. Riew noted the accident of July 31, 2010 as well as Petitioner's worsening of symptoms through February of 2011. He diagnosed Petitioner with pseudoarthrosis at C5-6 and C6-7. He advised Petitioner that they would contact "Workmen's Compensation" for approval of a cervical MRI, an ENT evaluation, and the recommended cervical surgery. (PX 6)

After Petitioner obtained the opinions of Drs. Raskas, Payne, Malek, and Riew, all of whom recommended another cervical surgery due to pseudoarthrosis at C5-6 and C6-7, Petitioner elected to undergo surgery with Dr. Malek. This second surgery was completed by Dr. Malek on August 4, 2011 at Our Lady of the Resurrection Hospital in Chicago. Petitioner underwent an anterior cervical discectomy and fusion at the C4-5, C5-6 and C6-7 levels. Dr. Malek's operative record found evidence of pseudoarthrosis at C6-C7 with moderate foraminal narrowing bilaterally; evidence of pseudoarthrosis at C5-C6 with moderate-to-severe foraminal narrowing bilaterally, worse on the left side; evidence of moderate foraminal narrowing at C4-C5 bilaterally; sponylolisthesis at C4 on C5; and retrolistesis of C6 on C7. (PX 8, 9)

Petitioner testified that she continued to receive temporary total disability benefits from Respondent while she remained off work.

On 8/15/2011, Petitioner again saw Dr. Malek, as she was 9 days post C4-C7 ACDF. Dr. Malek found good clinical results. Dr. Malek ordered an x-ray and prescribed physical therapy to begin in a month for 8 weeks. Dr. Malek believed Petitioner would be at MMI after that. (PX 8)

On 9/21/2011, Petitioner saw Dr. Dietrich, for her well women exam. Dr. Dietrich noted that the Petition had undergone a breast augmentation sometime between her last visit on 7/21/2010 and her 9/21/2011 visit. (RX 6)

On 10/2/2011, Petitioner again saw Dr. Malek. Dr. Malek noted that Petitioner reported improved in her symptoms after the cervical fusion with her activities of daily living, but that she still had a decreased tolerance to activity. Dr. Malek prescribed Petitioner physical therapy for six weeks. (PX 8)

On 10/25/2011, Petitioner again saw Dr. Huang. Petitioner requested a refill of her Ambien and Lexapro, as she was having pain after her surgery. Petitioner also requested a prescription for Norco. Dr. Huang diagnosed mild neck pain and prescribed Petitioner Lexapro 10 mg, Norco 10/325 mg, and Ambien 10 mg. (RX 2)

At the request of Respondent, Petitioner underwent a Section 12 examination performed by Dr. Joseph Williams on November 7, 2011. (RX1). Petitioner testified that she recalled this examination and provided Dr. Williams with a history of her accident of July 31, 2010. Petitioner testified she was in his office for ten to fifteen minutes and that Dr. Williams was present in his office with her for seven to ten minutes. Petitioner testified he performed a short physical examination, which included turning her head from side to side, squeezing his fingers, checked her reflexes, and touch her toes.

In his report, Dr. Williams concluded Petitioner had chronic axial neck pain and cervical degenerative disc disease and that her current condition was not causally related to her accident of July 31, 2010. (RX 1, p. 54) He stated that the radiographic findings did not appear to be consistent with the accident as described to him by Ms. Stephens. (Id.). He felt the findings were degenerative and related to age and genetic factors. (RX 1)

Dr. Williams stated the findings can be related to smoking but confirmed Petitioner is not a smoker. (RX 1, p. 54) His "assumption" was that the degenerative changes in her cervical spine were related to her previous surgeries as well as her age and genetic changes. (RX 1) He did not specify within his report which surgeries were related to the changes. (See RX1) He stated Petitioner was capable of performing her full duties as a certified nursing assistant. RX 1, p. 55)

On 11/2/2011, Petitioner underwent an x-ray of her cervical spine. Dr. Malek noted that the xray looked excellent, and that he was very pleased, but that he wanted to make sure that there was some bony growth there. Dr. Malek stated that he wanted Petitioner to complete her physical therapy and provided her an off-work slip for 3-4 weeks. Dr. Malek stated that he wanted light duty to start in 3 to 4 weeks with a weight limit of 10 pounds, no repetitive motion or motion of the neck. (PX 8)

At her December 5, 2011 visit, he advised her to remain completely off work. (PX8) By letter dated December 5, 2011 Petitioner was advised her temporary total disability benefits were being terminated as of December 12, 2011, based upon Dr. Williams' examination and report. (PX 8)

On 1/30/2012, Petitioner saw Dr. Malek. Dr. Malek noted that Petitioner had only attended 2 weeks of physical therapy, after which she moved on to her home therapy program, which he stated "is not unreasonable." Dr. Malek noted that Petitioner complained of pain with changes in weather on left side, which he thought was going to be permanent. Dr. Malek stated that Petitioner was at maximum medical improvement (MMI) and gave her permanent work restrictions of lifting only 10 pounds 3-4 days/week, no repetitive motion of the neck & no repetitive motion of the upper extremities, no driving or operating heavy equipment and no work in vibratory environment. (PX 8)

Dr. Malek recommended that Petitioner undergo another x-ray of the cervical spine in 6 months, continue her home therapy program, continue her spinal fusion stimulator for 3-4 more months, and take medication as needed. (PX 8)

On 3/9/2012, Petitioner again saw Dr. Huang. Petitioner complained of neck pain with range of motion and requested a refill on her Norco. Dr. Huang gave Petitioner a prescription for Norco 10/325 mg. (RX 2)

On 7/30/2012, Petitioner again saw Dr. Malek. Petitioner stated that the surgery helped her significantly with her symptoms, although she still had a significant restriction with range of motion of her cervical spine. Dr. Malek noted that Petitioner had continued excellent clinical results. (PX 8)

Deposition Testimony of Dr. Williams and Dr. Malek

Dr. Williams testified by way of evidence deposition on May 22, 2012. (RX1). He testified that he has been board certified in orthopedic surgery since 2008. He completed a spine fellowship in Indianapolis. Dr. Williams currently practices at the Orthopedic Center of Illinois in Springfield, Illinois. He testified that he only performs independent medical examinations once every two to three weeks. (RX 1, pp. 4, 5, 1, 44)

Dr. Williams testified that he had an actual, independent recollection of Petitioner from his November 7, 2011 exam. (RX 1, p. 25) Petitioner told Dr. Williams that she had suffered three injuries: a February of 2005 neck injury, an October of 2009 shoulder injury, and a July of 2010 neck injury. (RX 1, pp. 6-7) Dr. Williams testified that Petitioner did not report any other injuries to him, including injuries she reported to Respondent had occurred at work: a July 7, 1989 injury to her back, December 20, 1989 injury to her lower back, August 11, 1992 injury to her lower back and legs, January 13, 2006 injury to her neck, August 6, 2008 injury to her legs. (RX 9 and RX 1, pp. 7-9)

Dr. Williams testified that on her intake form, under the question: Did you have prior neck pain?, Petitioner checked "No." (RX 1, p. 48)

Dr. Williams also testified that Petitioner was asked to provide a complete surgical history. Dr. Williams testified that Petitioner did not report her breast augmentation surgery to him. (RX 1, pp. 9-10)

Dr. Williams testified that on November 7, 2011, Petitioner complained of neck pain and numbness and tingling in her fingers, worse on the right than left. (RX 1, p. 9) On his exam, Dr. Williams found good strength in Petitioner's upper extremetities, no focal deficits, a soft and supple neck, a normal gait and no focal deficits with regards to neurologic function. (RX 1, p. 11)

Dr. Williams testified that he had reviewed Petitioner's physical therapy forms, operative reports, physician visits, radiology reports, and the actual radiographic studies. (RX 1, p. 12) After his examination of Petitioner and review of her records, Dr. Williams diagnosed Petitioner with chronic axial neck pain, C6-7 anterior cervical discectomy and fusion in 2005, C5-6 anterior cervical discectomy and fusion on September 29, 2010, C4-

5, C5-6, C6-7 anterior cervical discectomy and fusion on August 4, 2011, and cervical degenerative disc disease. (RX 1, p. 12)

Dr. Williams opined that Petitioner's diagnoses were related to her 2005 neck injury and surgery, not the 7/31/2010 "accident." (RX 1, p. 12) Dr. Williams opined that Petitioner was suffering from a phenomenon known as Adjacent Level Degenerative Changes, which typically occurs several years after the initial procedure was performed. (RX 1, p. 12) Dr. Williams stated that Petitioner's degenerative disc disease was also related to her genetic background, which Dr. Williams stated that Petitioner's prior, chronic lower back problems were further proof of Petitioner's genetic role in her neck condition. (RX 1, p. 13) Dr. Williams stated that if a person is having low back symptoms, it is expected that they will also have problems with the neck as well. (RX 1, p. 13)

Dr. Williams then specifically stated that Petitioner's C5-6 cervical fusion and subsequent C4-5, C5-6 and C6-7 cervical fusion revision were not necessitated by the 7/31/2010 "accident." (RX 1, 14). Additionally, Dr. Williams specifically opined that Petitioner's chronic neck pain and cervical degenerative disc disease was not caused by her 7/31/2010 work accident. (RX 1, p. 15) When asked on cross-exam if Petitioner's 7/31/2010 "accident" accelerated or aggravated her symptoms, Dr. Willams stated that it had not. (RX 1, p. 35) When asked on cross-exam if Petitioner's fusion at C5-6 and revision fusion at C4-5, C5-6 and C6-7 would not have been necessary but for the 7/31/2010 "accident" aggravating Petitioner's neck condition, Dr. Williams stated that they would have have been necessary regardless of the 7/31/2010 "accident." (RX 1, p. 36) Dr. Williams stated that the 7/31/2010 "accident" did not accelerate Petitioner's cervical condition beyond the natural progression of her degenerative disc disease, but rather that Petitioner would have needed additional cervical fusion surgery regardless of what occurred on 7/31/2010. (RX 1, p. 36) Dr. Williams stated Petitioner's genetic degenerative changes and her prior surgeries were the cause of her current cervical condition. (RX 1, pp. 38-39)

Dr. Williams opined that if Petitioner was suffering from the symptoms of neck pain, headaches, numbness and tingling, and trouble sleeping prior to the 7/31/2010 "accident," that any herniation was therefore present prior to the "accident." (RX 1, p. 15)

Dr. Williams further testified that Petitioner did not need any further medical treatment. (RX 1, 16) Dr. Williams stated that Petitioner appeared to have fully recovered from her most surgery. (RX 1, p.16)

Dr. Williams testified that he was familiar with Petitioner's job duties as a certified nursing assistant, including the activity of lifting patients. (RX 1, 42) Dr. Williams stated that based on Petitioner's physical exam and her radiographic studies there were no objective findings that would necessitate any work restrictions. (RX 1, p. 16) Dr. Williams testified that a person with prior surgeries to the cervical spine would be a greater risk for new cervical injuries. (RX 1, p. 41) Dr. Williams also testified that Petitioner, like any person who had undergone a three level anterior discectomy and

fusion, had changes to the biomechanical function of her spine that would place her at a higher risk of having advanced degenerative changes occurring at adjacent levels. (RX 1, p. 18) Therefore, Dr. Williams stated that Petitioner may require further surgery because of her prior surgeries, but that Petitioner's physical findings and radiographs did not show any evidence that her activities needed to be limited. (RX 1, p. 18)

Dr. Williams testified that he needed additional information to determine whether the cervical surgeries performed on September 29, 2010 and August 4, 2011 were reasonable and necessary. (RX 1, p. 26) He testified that he would need additional information regarding Petitioner's symptoms prior to those surgeries and some of the radiographic studies completed prior to the studies. (RX 1, p. 27)

Dr. Williams continued that he was provided with medical records prior to his examination of Petitioner but did not know whether he was provided with all of the radiographic studies. He reiterated his opinion that he had no opinion whether the two surgeries of September 29, 2010 and August 4, 2011 were reasonable and necessary. He continued that Petitioner did not appear to be exaggerating her symptoms nor be a malingerer. Respondent's counsel questioned Dr. Williams whether Petitioner's weight could have contributed to her need for cervical surgeries. Upon cross-examination, Dr. Williams clarified that Petitioner's weigh, estimated to be 125 pounds at five-feet-three inches tall, in no way contributed to her injuries. (RX 1, pp. 29-30, 46, 49-50)

Dr. Michel Malek testified by way of evidence deposition on August 29, 2012. (PX 21) He testified that he is a board certified neurosurgeon who has been licensed to practice medicine since 1985. (Id. at 5) He testified he was board certified by the American Board of Neurological Surgeons in 1997 and that this is a permanent certification. (Id.)

Dr. Malek testified he first treated Petitioner on June 6, 2011 and had an independent recollection of her. (PX 21, p. 9) He explained the history of the July 31, 2010 accident as provided to him by Petitioner. (Id. at 10-12) He testified that this accident aggravated or accelerated her underlying cervical condition. (Id. at 24) He explained that the accident compensated her condition aggravating and accelerating her underlying condition beyond the natural progression of her disease. (Id. at 23-24)

On cross-examination, Dr. Malek was asked by Respondent's counsel, "And you said it was unquestionable her symptoms were related to this incident (of July 31, 2010). And that's because Petitioner didn't have any of those symptoms prior?"

Dr. Malek responded, "No. It is not that finding – Petitioner was compensated before. Petitioner had had problems. Petitioner had the surgery, but Petitioner was able to work in a compensated position. And the injury basically precipitated that. And the fact that Petitioner had prior surgery at the one level does predispose her to having problems at the next level.

"So the injury of 7-31-10 is a cause of the condition, but on the background of somebody who already had surgery. So it is definitely a contributing factor, but it is not all of the injury or all of the problems related to that injury." (PX 21, pp. 44-45) He explained that a June 14, 2010 office note of Dr. Huang, which indicated dizzy spells and a positive Romberg test, were not significant in this case because the positive Romberg test was a test for cerebellar function, which is not related to her cervical spinal injuries. (PX 21, p. 57)

Dr. Malek stated that his opinion providing causation for the 7/31/2010 "accident," is based on Petitioner's prior history of being able to work without any problems, her mechanism of injury, the contemporaneous nature of the complaint, the finding of the physical exam, the finding on diagnostic testing, Petitioner's prior history of cervical spine problems with subsequent return to work, the intraoperative findings, and his education/training/experience as a neurosurgeon. (PX 21, 39-40)

Dr. Malek also stated that Petitioner's new onset of pain after the 7/31/2010 accident was shown by a subsequent diagnosis of disc herniation. (PX 21, 41) Dr. Malek described this new pain as radicular pain in her extremities, including pain in Petitioner's neck radiating into both upper extremities with tingling. (PX 21, 42) Dr. Malek stated that Petitioner was able to work without this pain prior to 7/31/2010. (PX 21, 42) Dr. Malek stated that at the time of Petitioner's 7/31/2010 injury, she was not under any active care. (PX 21, p. 47)

Dr. Malek stated that he had reviewed Petitioner's medical records from Springfield Clinic and Blessing Hospital. When presented with Dr. Huang's 5/19/2010 record where Petitioner complained of severe neck pain that made her unable to work, Dr. Malek was not able to explain the situation. (PX 21, 67-70) Dr. Malek also stated that it is possible that Petitioner did not have an acute injury on 7/31/2010, although he did not find it likely. (PX 21, 70-72)

Dr. Malek also reviewed medical notes of Dr. Tayag dated December of 2008, which indicated possible pseudoarthrosis. (PX 21, pp. 63-64) He explained with the symptoms discussed within those office notes were in line with his opinion that the accident of July 31, 2010, while not the cause in totality of Petitioner's condition, was a contributing factor. (PX 21, p. 66) He agreed that the records provided to him during his deposition confirmed Petitioner had a prior cervical condition. (PX 21, p. 67) However, he testified that the July 31, 2010 accident, "...tipped the precarious patient who was predisposed and was unquestionably a contributing factor in her subsequent care." (PX 21, p. 67)

Respondent's counsel also asked Dr. Malek whether it was possible that Petitioner did not actually sustain an acute accident on July 31, 2010. (RX 21, p. 70) Dr. Malek answered this was possible as, "Everything is possible. But likely, it's not likely at all." (Id.) He explained that all of her work at Respondent as a CNA was something that predisposed her but culminated in the specific event of July 31, 2010 that "tipped her over the edge and contributed unquestionably to her subsequent care and need for

subsequent care…" (PX 21, p. 71) He continued, "If Mrs. Laura Stephens was normal person eighteen years old with healthy spine, the injury of 7-31-10 would not have caused her problems. But because of her compromised background, then that injury was a competent cause of her requiring surgery and the treatment that Petitioner need." (PX 21, p. 72-73)

Petitioner's Arbitration Testimony

Following her release with permanent restrictions by Dr. Malek, Petitioner testified she contacted Respondent to determine whether it would accommodate her. In a letter dated April 5, 2012, the State of Illinois Department of Veterans' Affairs notified Petitioner that it was in receipt of her permanent restrictions as provided to her by her physician. (PX19) It further notified Petitioner that her application for the Alternative Employment Program was denied and that Petitioner was left with only two alternatives: resign or retire, if eligible. (PX 19)

Petitioner began looking for work, which she documented in a job search log. (PX17) Her first entry in her job search log was dated March 19, 2012. The last entry in her log was August 15, 2012.During that time period, Petitioner documented applications to over 120 potential employers. Petitioner further documented six job interviews from those applications. (PX 17)

Petitioner testified she received two job offers but was not able to accept one because it was outside of her restrictions. Petitioner was offered another job at a travel agency but the offer was canceled due to another applicant being more qualified. Although her written job search logs ended in August of 2012, Petitioner testified she continued to look for work but got tired of writing it down all the time. Petitioner testified she continues to look for work on Job Finder, Career Builder, and other such internet sites. At the time of trial, Petitioner remained unemployed and looking for work. Petitioner testified that she has not received any assistance or offers to assist in her job search from Respondent but would accept it if provided.

The Arbitrator concludes:

1. Petitioner sustained an accident on July 31, 2010 that arose out of and in the course of her employment with Respondent.

Although Respondent disputed accident at trial, it provided no testimony or other evidence to suggest that the accident did not occur exactly as described by Petitioner and as described throughout her related medical records. Petitioner's testimony regarding accident was credible as it was corroborated by the medical records and unrebutted. Petitioner was employed by Respondent in essentially a certified nurse's assistant position. She was injured while assisting a resident from a toilet to a chair using a Sara Lift. As Petitioner was holding a sling around the resident with her right hand, he reared back in his seat and caused her right arm to pull. Petitioner felt an immediate sharp pain go through her right shoulder and into her neck.

2. Petitioner's current condition of ill-being as it relates to her cervical spine is causally related to her work accident of July 31, 2010.

There is no dispute that Petitioner had pre-existing neck pain and problems as well as headaches. However, Petitioner's testimony about her prior medical condition was upfront and open. Petitioner's description of her symptoms, and their occasional nature, was corroborated by the medical records. As such, Petitioner's testimony was credible. While Petitioner had some periodic visits for neck pain and headaches between late May of 2006 and December of 2008, the medical records indicate she had no further significant treatment for such complaints until after the July 31, 2010 accident. The Arbitrator notes that Petitioner underwent physical therapy and work hardening as part of her recovery from her right shoulder injury in 2009. The therapist noted Petitioner was able to complete a three hour simulation of work activities without any problem. Petitioner returned to full duty work after that injury and continued in that capacity until this accident. She had no visits for her neck between that time and the work accident. While she may have taken medications to help alleviate symptoms, Petitioner was working full duty at a job which was quite physical and, again, she credibly acknowledged that she did experience occasional soreness and aches with her work. Even Dr. Tayag noted in December of 2008 that Petitioner's work aggravated her symptoms. (PX 1) Her explanation as to the difference in her symptoms before and after the accident on July 31, 2010 was very believable.

While Petitioner's visit with Dr. Tayag in December of 2008 might give some "cause for pause" regarding just what state Petitioner's neck was in at that time, the fact that Petitioner's MRI did not show pseudoarthrosis is noteworthy. Furthermore, Petitioner did not follow-up and seek any further treatment. She continued working full duty until injuring her right shoulder on October 16, 2009.

Respondent relies on Dr. Williams' opinions to refute causal connection. Dr. Williams, however, appears to be the only doctor believing that the accident of July 31, 2010 was not a contributing factor in Petitioner's current condition and he related everything to Petitioner's age and genetic factors, although he did not specify any particular genetic factors that would cause Petitioner's problems. While Dr. Williams did not believe Petitioner's condition was caused by her work accident, he never really discussed or explained with any real specificity why he disagreed with Dr. Raskas' opinion regarding an aggravation. He simply stated he disagreed. Similarly, on redirect examination he was asked to explain why an acute injury can result in an aggravation but it is only temporary. Dr. Williams testified that it is temporary because "typically" such patients go back to their baseline pain prior to their injury within a few months. (RX 1, pp. 45-46) Petitioner in this instance is not a "typical" patient. Dr. Williams did not adequately or persuasively address the question of aggravation.

However, every other medical doctor who commented on causation all related Petitioner's condition to her acute accident of July 31, 2010. Respondent initially sent Petitioner to Dr. Arndt who noted an assessment of "continued neck pain after acute injury at Illinois Veterans Home." At Petitioner's initial visit with Dr. Raskas on September 2, 2010, he summarized her July 31 accident and explained, "At this point, my impression is cervical pseudoarthrosis with new cervical disc herniation and myelopathy...directly related to her work injury." Similarly, at Petitioner's visit on July 5, 2011 with Dr. Riew, Dr. Riew indicated Petitioner's chief complaint was neck pain that started on July 31, 2010. He diagnosed her with pseudoarthrosis at the C5-6 and C6-7 levels and elected to contact the workers' compensation carrier to obtain authority for additional treatment, including surgery.

Dr. Michel Malek also testified extensively to show Petitioner's current condition of ill-being of her cervical spine was causally connected to her accident of July 31, 2010. While some of his testimony was somewhat confusing and exactly what he meant by the repeated use of the word "compensated" was not entirely clear, he nonetheless displayed an understanding of Petitioner's prior medical history in reaching this conclusion and his explanation as to an aggravation theory made sense. Dr. Malek was very clear that, although Petitioner had an underlying condition for which Petitioner had been treated for, the accident of July 31, 2010 aggravated and accelerated that condition. The Arbitrator accords greater weight to the opinions of Drs. Raskas, Riew, and Malek than to the opinion of Respondent's examiner, Dr. Williams.

Based upon the foregoing, the Arbitrator concludes that Petitioner's cervical spine injury is causally related to her work-related accident of July 31, 2010.

3. The medical services provided to Petitioner have been reasonable and necessary. Respondent has not paid all appropriate charges.

The overwhelming testimony and medical evidence in this claim supports the finding that Petitioner's cervical treatment following her accident through her visit with Dr. Malek on July 20, 2012 was reasonable, necessary, and causally connected to her accident.

At her initial visit on September 2, 2010 with Dr. Raskas, his impression was cervical pseudoarthrosis with new cervical disc herniation and myelopathy. He opined that the July 31, 2010 accident aggravated the pseudoarthrosis and also caused the herniated disc. Based on his recommendations, Respondent authorized this surgery. Dr. Malek confirmed this diagnosis throughout his testimony as well as the need for surgery to correct the condition. Respondent's expert, Dr. Williams, testified he was unable to provide an opinion whether this surgery was reasonable or necessary without additional information.

Petitioner's own testimony and related medical records confirmed that Petitioner felt relief from the tingling and numbness in her hands and arms and also that the

stabbing, sharp pains were diminished following her first cervical surgery with Dr. Raskas on September 29, 2010. However, her symptoms increased upon her return to light duty work in January and February, 2011.

Although Dr. Williams testified he was unable to provide an opinion whether the second cervical surgery following her accident was necessary, four other surgeons evaluated Ms. Stephens personally and reviewed her medical records and recommended it.

Drs. Raskas, Payne, Riew, and Malek all agreed that a second surgery was necessary due to the ongoing psuedoarthrosis following the initial surgery performed by Dr. Raskas. Dr. Malek confirmed during his testimony that the need for surgery was not related to anything done incorrectly by Dr. Raskas but was simply a surgery that did not work out as well as anticipated.

The second surgery was performed by Dr. Malek and his surgical assistant, which he confirmed was necessary for this surgery. The only opinions provided in this claim from the treating physicians or experts were that the treatment provided to Petitioner was reasonable and necessary. Therefore, the Arbitrator finds that medical services provided to Petitioner have been reasonable, necessary, and related to her accident of July 31, 2010.

For these reasons, Respondent shall pay reasonable and necessary medical services directly to Petitioner, pursuant to the fee schedule, of:

$3,276.74 for Quincy Medical Group;
$481.00 for Springfield Clinic;
$66,301.00 for Dr. Michel Malek;
$19,413.40 for United Surgical Assistants;
$3,097.70 for Professional Imaging;
$743.50 for Clinical Radiologists;
$47.00 for Joliet Radiological;
$10,274.13 for Our Lady of the Resurrection Hospital; and
$220.00 for Washington University as provided in Sections 8(a) and 8.2 of the Act.

4. Petitioner was temporarily totally disabled from August 1, 3010 through January 7, 2011 and February 10, 2011 through January 30, 2012, a period of 73 4/7 weeks. Petitioner is also awarded maintenance benefits from January 31, 2012 through March 6, 2013, a period of 57 2/7 weeks.

The treating records entered into evidence by Petitioner at trial outline her ability to work following her accident of July 31, 2010 through her release from treatment with permanent work restrictions by Dr. Malek on January 30, 2012. Respondent did not present any medical evidence or testimony to negate the contemporaneous

medical opinions regarding Petitioner's work status throughout her course of treatment.

The Arbitrator has already concluded that Petitioner's need for treatment was causally connected to her work accident of July 31, 2010. The Arbitrator shall also rely on the opinions of Petitioner's treating physicians to award the TTD period requested.

Further, Petitioner credibly testified that she attempted to return to work for Respondent pursuant to the permanent restrictions provided to her by Dr. Malek. Her testimony that no position was provided to her was corroborated by Petitioner's Exhibits 18 and 19. Petitioner immediately began an extensive independent job search as documented by Petitioner's Exhibit 17. Because of her ongoing job search and permanent restrictions, Petitioner is entitled to maintenance benefits. The law is clear that an injured worker need not participate in a "prescribed rehabilitation program" in order to be entitled to maintenance benefits. *Greaney v. Industrial Comm'n,* 358 Ill.App.3d 1002, 1020, 832 N.E.2d 331, 348 (1st Dist. 2005). While Petitioner did not have job logs for her more recent searches, her testimony regarding her efforts was credible as she sounded and appeared sincere in her efforts to find same.

Per the stipulation of the parties, Respondent is given a credit of $30,619.97 for TTD benefits paid.

5. Respondent shall authorize and provide an initial vocational rehabilitation assessment by a properly certified and qualified vocational rehabilitation counselor pursuant to Section 8(a) of the Act and Section 7110.10(a) of the Commission Rules.

The test for determining the appropriateness of vocational rehabilitation was laid out in the landmark case of *National Tea Co. v. Industrial Comm'n*, 97 Ill.2d 424, 454 N.E.2d 672 (1983). In *National Tea*, the Illinois Supreme Court held that a claimant is generally entitled to vocational rehabilitation when he or Petitioner sustains a work-related injury that causes a reduction in his or her earning capacity and there is evidence that rehabilitation will increase that capacity. 97 Ill.2d at 432, 454 N.E.2d at 676. Pursuant to Section 8(a) of the Act and Section 7110.10(a) of the Commission Rules, it is incumbent upon a respondent to provide a vocational assessment, vocational rehabilitation, and maintenance to a petitioner/claimant when it is apparent that the claimant will not be able to return to his or her former employment.

In recognizing the guidelines provided in *National Tea*, the Arbitrator notes, among other factors, that Petitioner is a viable candidate for, at minimum, an initial assessment. Petitioner has already demonstrated through her own testimony, medical records, the deposition of Dr. Malek, and Respondent's refusal to accommodate her permanent restrictions, that Petitioner is unable to return to her former work as a CNA. It further appears that Petitioner may benefit if provided assistance in regaining her loss of earning power and job security due to her accident. Petitioner was only forty-three years old at the time of her injury in 2010 and has a significant work-life expectancy remaining. Petitioner also demonstrated a willingness and eagerness to be

provided assistance in her job search efforts. Nothing in the record suggests that Petitioner is not employable. Indeed, she presented herself at arbitration as articulate, professional, well-groomed, and pleasant. She has a nursing background and while she may not be able to engage in certain physical aspects of her former position that does not necessarily mean there is not another possibility out there – albeit some training and education may be necessary.

Respondent has not offered to assist Petitioner to find suitable employment or otherwise assess the need for and/or provide any vocational rehabilitation. On her own, Petitioner has diligently pursued alternate employment following her release from medical treatment. Petitioner remains unemployed and in need of vocational rehabilitation assistance. Respondent shall provide a vocational rehabilitation assessment by a properly certified and qualified vocational rehabilitation counselor pursuant to Section 8(a) of the Act and Section 7110.10(a) of the Commission Rules.

****

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

Bronislawa Stekala,

Petitioner,

vs.

NO: 04 WC 60828

14IWCC0108

ABM,

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, notice, temporary total disability, permanent partial disability, medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 19, 2012, 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.

14IWCC0108

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: FEB 13 2014
TJT:yl
o 2/10/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STEKALA, BRONISLAWA Case# **04WC060828**
Employee/Petitioner

ABM
Employer/Respondent

14IWCC0108

On 12/19/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% 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:

0233 KENNETH B GORE LTD
DONNA ZADEIKIS
39 S LASALLE ST SUITE 1205
CHICAGO, IL 60603

1120 BRADY CONNOLLY & MASUDA PC
MARK F VIZZA
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

14IWCC0108

☐ 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

BRONISLAWA STEKALA
Employee/Petitioner

v.

ABM
Employer/Respondent

Case # 04 WC 60828

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 **Chicago**, on **11/07/2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0108

FINDINGS

On 12/02/2004, 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* 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 $20,280.00; the average weekly wage was $390.00.

On the date of accident, Petitioner was 47 years of age, *married* with no dependent children.

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

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

Respondent shall be given a credit of $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 $115,296.93 under Section 8(j) of the Act.

ORDER

Petitioner failed to meet her burden of proof regarding the issue of causation. Claim 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

12/18/12
Date

DEC 19 2012

Findings of Fact

The Petitioner testified that the last date she worked for the Respondent was December 4, 2004. She was employed by Respondent as a janitor. Her duties included cleaning office buildings. She would vacuum, mop and take out garbage. She had worked for 11 years prior to this for Respondent. On the date of accident, she was emptying garbage cans and pulling out a large, heavy trash bag when she fell backwards. She believes she had a loss of consciousness. She was taken to the emergency room. She was treated at Northwestern Emergency Room and she gave a history of hitting her head and back and having neck and low back pain. She also had pain that went down her left and right arms and down her right leg. They told her to follow up with her doctor. She was seen at Union Health, which was where her doctor was. She testified that before the accident, she had no low back pain and was able to do her job. She also testified that she had no history of depression before the accident. She was seen at Union Health on December 7, 2004. They gave her a brief exam and she treated with Mercy Works. She treated there on December 8, 2004, and December 27, 2004. On December 27, 2004, she told them she had blunt head trauma, and they told her she suffered a cervical strain with left radiculopathy and a lumbar strain with right radiculopathy. They kept her off work until January 5, 2005. She wanted to have physical therapy, but it was not authorized.

She returned to Union Health on January 10, 2005, and on January 19, 2005, they referred her to Dr. Nam, an orthopedic specialist. They then decided to refer her to a neurosurgeon. She was seen by Dr. Kayvanara, a neurosurgeon. A repeat CT and MRI were recommended. Then she began treating with Dr. Englehart at University of Illinois Chicago. He performed two surgeries on her spine: on December 7, 2005, a cervical discectomy, and on February 16, 2006, a lumbar fusion. He also performed a carpal tunnel release, which was not related. She had a follow-up with Dr. Englehart on March 15, 2007, and was having difficulty with her legs. Her spine is still bad. Pain radiates to her legs and she stopped feeling her left leg. She was seen by Dr. Slavin for a spinal cord stimulator. She had follow-up treatment from 2008 through 2012. She had pain in her upper back and lower back. She takes four to five Hydrocodone tablets a day. She has developed a new symptom where her feet get cold. She has pain in her back that travels through her head and both arms. Her low back pain goes down both legs. She wears a brace on her left leg, as she will fall without her brace. She has trouble walking more than half a block and does not use stairs. She cannot stand more than five minutes.

On cross-examination, Petitioner testified that she never had any prior problems to her neck or back. She has always had the cervical and lumbar pain.

The medical records show that the petitioner had neck pain as early as March 2004. At that time, her family doctor had noted that she was complaining of neck pain for three weeks. She was diagnosed with chronic neck pain in May 2004. In November 2004, she was treated for back pain. She noted at that time that her back pain was unbearable. She was also treated for depression and referred to a psychiatrist on November 24, 2004.

Based on the foregoing, the Arbitrator makes the following conclusions:

Regarding the issue of causation, the Arbitrator finds that the Petitioner failed to meet her burden of proof. This finding is based primarily on the Petitioner's lack of credibility. Her testimony was clearly contradicted by her medical records. She testified that she never had any back pain or neck pain before this incident and had not treated for depression. The medical records from her family doctor indicate that her neck pain seven months before this was diagnosed as chronic, and less than a month before the accident, she was describing her back pain as unbearable. Further, it should be noted that the treating records indicate that there was a referral to a psychiatrist approximately one week before the incident.

14IWCC0108

The Arbitrator finds the opinions of Dr. Bauer both credible and persuasive. Dr. Bauer was the only doctor to review all the medical records. (RX 12) He noted her treatment in March and May 2004 for neck pain, which the Petitioner denied. The records of Accelerated Rehab show that on May 25, 2004, the Petitioner had a complaint of insidious onset of cervical pain, left worse than right, for about six months. On July 14, 2004, she was complaining of pain in her right lower leg. Dr. Bauer noted that a CT of the cervical spine was performed in December 2004 and showed a 2mm anterior listhesis at C3-4 secondary to moderate left facet hypertrophy. The CT scan also showed degenerative disc disease in the remainder of the lumbar spine. As Dr. Bauer noted, the Petitioner had a history of spinal stenosis as early as February 9, 2004. There is also reference to a 2003 MRI scan by Dr. Lesniak in his note of April 6, 2005. (RX 12) The petitioner complains of referred symptoms to both legs consistent with spinal stenosis. There are no acute abnormalities identified in either of the lumbar MRI scans or at the time of the spinal fusion. (RX 12) Dr. Bauer also noted that the findings on the MRI of December 20, 2004, would not cause left arm symptoms. (RX 12) The MRI of March 15, 2005, (RX 7) again revealed a slightly eccentric disc on the right at C5-6 and was interpreted as not causing nerve root compression on either right or left side. No acute disc herniation was identified by Dr. Englehart, and the osteophytes he found are of a chronic, degenerative nature. (RX 12) Dr. Bauer found that after review of the records and the operative reports, that the neck pain and osteophytes clearly preceded the incident of December 2, 2004. (RX 12) He notes that the herniated disc on the right at C5-6 which was found on the MRI would not have caused left upper extremity symptoms. (RX 12)

It is apparent from the reports that the surgeons did not have the benefit of the Petitioner's previous medical records, and therefore were unable to have the complete facts regarding the petitioner's histories in front of them. Therefore, any opinions they may have had regarding causal connection are flawed, due to the petitioner's less than candid history regarding her prior neck and low back problems. The medical records also note a worsening depression over the months of October and November 2004. (RX 1-3) Those reports also note that the Petitioner felt she was being discriminated against at work and that she was moved to a different building and did not like it. (RX 2)

Based upon the inconsistency between the Petitioner's testimony and her own medical records, the Arbitrator finds that Petitioner failed to meet her burden of proof on the issue of causation. Based on this finding, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Geyman,
Petitioner,

14IWCC0109

vs.

NO: 12WC 32505

SOI/Shawnee Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 15, 2013 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: FEB 14 2014
KWL/vf
O-1/14/14
42

Kevin W. Lamborn

Daniel R. Donohoo

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0109

GEYMAN, JOSEPH Case# **12WC032505**

Employee/Petitioner

SOI/SHAWNEE CORRECTIONAL CENTER

Employer/Respondent

On 7/15/2013, 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:

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0558 ASSISTANT ATTORNEY GENERAL
FARRAH L HAGAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUL 15 2013

KIMBERLY B. JANAS 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

14IWCC0109

Joseph Geyman
Employee/Petitioner

v.

State of Illinois/Shawnee Correctional Center
Employer/Respondent

Case # 12 WC 32505

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 Herrin, on June 13, 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 _____

14IWCC0109

FINDINGS

On August 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 $58,680.00; the average weekly wage was $1,128.46.

On the date of accident, Petitioner was 42 years of age, married with 4 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 $amounts paid for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $amounts paid.

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 1, 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 $752.31 per week for three and six-sevenths (3 6/7) weeks commencing November 22, 2012, through December 19, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability of $677.08 per week for 48.375 weeks because the injuries sustained caused the 22 1/2% loss of use of the left leg as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from January 28, 2013, through June 13, 2013, 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.

William R. Gallagher, Arbitrator

July 8, 2013
Date

ICArbDec p. 2

JUL 15 2013

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on August 14, 2012. According to the Application, Petitioner injured his left leg/knee while restraining an inmate. This case was previously tried in a 19(b) proceeding on October 24, 2012, and an award was written in favor of the Petitioner ordering the Respondent to pay medical and temporary total disability benefits. Respondent did not file a review of that decision so the primary dispute in this case is in regard to the nature and extent of permanent partial disability.

Dr. George Paletta performed surgery on November 29, 2012, the procedure consisting of a partial medial and lateral menisectomy of the left knee. Petitioner recovered from the surgery and Dr. Paletta opined that Petitioner could do home exercises and that a formal physical therapy program was not required. Petitioner was released return to work without restrictions effective December 20, 2012. Dr. Paletta saw Petitioner again on January 28, 2013, and noted that Petitioner had returned to work full duty and that all activities of daily living were normal. He opined that Petitioner had an excellent outcome, discharged him from care and stated that Petitioner was at MMI. Dr. Paletta did not provide an AMA impairment rating report nor was such a report obtained on behalf of the Respondent.

At trial, Petitioner testified that while he was able to return to work without restrictions, that when he stands for long hours, in particular, while at work on concrete surfaces, his knee hurts. Petitioner further testified that his knee pain has limited his ability to stay in shape and that he has limited his physical activities such as running and basketball. Petitioner continues to take over-the-counter medication on an "as needed" basis.

Conclusions of Law

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

The Arbitrator concludes that all the medical treatment provided to Petitioner was reasonable and necessary and that Respondent is liable for payment of the medical bills associated therewith.

Respondent is to make payment of the medical bills identified in Petitioner's Exhibit 1 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for 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 that Petitioner is entitled to temporary total disability benefits for three and six-sevenths (3 6/7) weeks, commencing November 22, 2012, through December 19, 2012.

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

The Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 22 1/2% loss of use of the left leg.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner nor Respondent tendered into evidence an AMA impairment rating report.

At the time of the accident, Petitioner was a Correctional Officer, and his job duties required him to stand on his feet on a concrete surface for considerable periods of time, although not the entire working day.

Petitioner was 42 years of age at the time of the accident meaning that he will have to live with the effects of this injury for a considerable period of time.

Petitioner was able to return to work in his normal capacity so there is no evidence that this injury will have any effect on his future earning capacity.

The medical treatment indicates that Petitioner sustained tears to both the lateral and medial meniscus which required surgery. Petitioner credibly testified that he still has some symptoms and he has modified his level of activities as a result thereof.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bernard Butler,
Petitioner,

vs. NO: 04 WC 18116

McDaniel Fire System,
Respondent.

14IWCC0110

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability, Section 8(j) credit, and nature and extent of the disability, and being advised of the facts and law, vacates the Arbitrator's award of credit to Respondent for $8,910.40 for temporary total disability payments, modifies the award of Section 8(j) credit to include the $8,910.40, and reverses the Arbitrator's finding of causal connection for the period after May 7, 2004. The Commission reduces the temporary total disability and nature and extent awards and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

On January 7, 2004, Petitioner, working as a union sprinkler fitter, descended a scissor lift, struck his right knee, and fell backwards, twisting that knee as he fell. Petitioner was diagnosed with a right medial meniscal tear and underwent arthroscopic surgery to repair the tear. On May 7, 2004, Petitioner reported to his surgeon, Dr. Luke, that he had no pain, he had full range of motion, and he could perform all of his activities. Dr. Luke released him to return to work without restrictions on that date.

Petitioner testified at hearing that when he attempted to return to work following his first surgery, Respondent advised him that he was laid off. He continued to work full duty as a union sprinkler fitter for different employers until October 16, 2005, when he retired and moved to Florida. On October 19, 2005, Petitioner sought treatment for his right knee with Dr. Schiappa, who performed a partial meniscectomy to repair a radial tear of the posterior horn of the medial meniscus on December 22, 2005. Dr. Schiappa causally related Petitioner's condition to his work accident in 2004, found his condition was permanent, and suggested a total knee replacement might eventually become necessary. Petitioner testified at hearing that his right knee is painful and he uses a cane.

14IWCC0110

Prior to hearing, the parties stipulated that Respondent was entitled to Section 8(j) credit for medical expenses paid by Respondent's group health insurer and disability payments made by its group non-occupational disability insurer. At hearing, the parties stipulated that Respondent was entitled to Section 8(j) credit for disability payments made in the amount of $8,910.40, that the related medical expenses totaled $42,411.59, and that Respondent's group health insurer had paid $40,807.26 toward the medical expenses.

Arbitrator Thompson-Smith entered her Decision on February 6, 2013, and Petitioner filed a "Motion to Recall Arbitrator's Decision" on February 28, 2013, seeking correction of the PPD rate and Section 8(j) credit award. The Arbitrator granted Petitioner's Section 19(f) Motion and filed her Corrected Decision on April 9, 2013, modifying the PPD rate as requested and revising the paragraphs of the Decision pertaining to credit for Respondent's or its insurer's payments. Respondent appealed on the issues of accident, causal connection, medical expenses, temporary total disability, Section 8(j) credit, and nature and extent of the disability.

Temporary Total Disability Credit. At hearing, the parties stipulated that Respondent was entitled to Section 8(j) credit of $8,910.40 with respect to TTD payments. However, on the Request for Hearing form presented prior to trial, the parties stipulated that Respondent had paid no TTD or maintenance. In both her original and corrected Decisions, the Arbitrator notes that "Respondent shall be given a credit of $0.00 for TTD, $8,910.40 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $8,910.40," and in her Order finds that "Respondent shall receive a credit of $8,910.40 for payment of temporary total disability pursuant to Section 8(b) of the Act." Pursuant to *Walker v. Illinois Workers' Compensation Commission*, 345 Ill. App. 3d 1084, 804 N.E.2d 135, 138, 281 Ill. Dec. 509 (4th Dist. WC 2004), the Request for Hearing is binding on the parties as to claims made therein, and Respondent is bound by its stipulation that it had paid no TTD or maintenance benefits. Moreover, there is no evidence in the record to support the Arbitrator's finding that Respondent paid $8,910.40 in disability benefits, and the parties stipulated on the record at hearing that Respondent was entitled to a Section 8(j) credit of $8,910.40 for disability payments. Tr. 10. Therefore, the Commission strikes the following paragraph of the Arbitrator's Order of her Corrected Decision: "Respondent shall receive a credit of $8.910.40 for payment of temporary total disability pursuant to Section 8(b) of the Act."

Section 8(j) Credit. Arbitrator Thompson-Smith found that Respondent was entitled to Section 8(j) credit of $46,717.66. The amount appears to be the sum of the medical expenses paid by Respondent's group health insurer ($40,807.26) and the net amount paid to Petitioner by Respondent's group disability insurer ($5,910.40), according to Respondent's Exhibit 4. However, pursuant to the parties' stipulation on the record (Tr. 10), Respondent was entitled to a Section 8(j) credit of $8,910.40 for payments made by its disability insurer. That amount, when added to the group health payments, totals $49,717.66 in Section 8(j) credit. The Commission vacates the Arbitrator's award of $46,717.66 in Section 8(j) credit to Respondent and increases the credit to $49,717.66.

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Causal Connection. Arbitrator Thompson-Smith found that Petitioner's second right knee surgery was causally related to his January 7, 2004 work injury and found Respondent liable for all temporary total disability and related medical expenses through February 20, 2007. Respondent argued on appeal that Petitioner's condition of ill-being at the time of hearing was not causally related to his work accident. It noted that Petitioner's surgeon found him at maximum medical improvement and returned him to full duty work on May 7, 2004. Petitioner worked full duty for different employers for 19 months before seeking additional treatment for his right knee. Respondent argues that all treatment and lost time after May 7, 2004 is not causally related to Petitioner's January 7, 2004 work injury.

Petitioner offered the causation opinion of his second surgeon, Dr. Schiappa, who causally related his condition and need for his second surgery to the January 7, 2004 accident. Respondent argues that Petitioner never returned to the first surgeon after his release and continued to work full duty for 19 months before seeking treatment. The Commission notes that Dr. Schiappa admitted that he had not reviewed Petitioner's medical records, did not know whether Petitioner had taken pain medications during the period between his release by Dr. Luke and his initial appointment with Dr. Schiappa, and did not inquire whether Petitioner had sustained a second injury following his first surgery. Given these omissions, the Commission finds that Dr. Schiappa's causation opinion is entitled to no weight. Moreover, an MRI performed on February 11, 2004, shortly after the first accident, revealed Petitioner's medial tear that was repaired by Dr. Luke, but not the radial tear surgically addressed by Dr. Schiappa. Based upon the gap in treatment from May 7, 2004 to October 19, 2005, on Petitioner's ability to work full duty for 19 months following his release by Dr. Luke, and upon Petitioner's failure to provide a credible causation opinion, the Commission finds that Petitioner reached maximum medical improvement on May 7, 2004. All subsequent treatment and temporary total disability are not causally related to his January 7, 2004 work accident, and the Commission finds that Respondent is not liable therefor.

The Commission further reduces the Arbitrator's permanency award from 35% to 20% loss of use of the right leg.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's finding that Respondent paid Petitioner $8,910.40 in temporary partial disability benefits is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to credit in the amount of $49,717.66 under Section 8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims by providers of the benefits for which Respondent is receiving credit under this order.

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IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $888.00 per week for 11-6/7 weeks, commencing January 8, 2004 through January 9, 2004 and February 14, 2004 through May 6, 2004, as provided in §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner all reasonable and necessary medical expenses incurred prior to and including May 7, 2004. All subsequent medical treatment is found not causally related to Petitioner's January 7, 2004 injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $550.47 per week for a period of 43 weeks, as provided in §8(e) of the Act, for the reason that the injury sustained caused the loss of use of 20% of the Petitioner's right leg.

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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at $12,000.00. 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: FEB 14 2014

Daniel R. Donohoo

Kevin W. Lamborn

Thomas J. Tyrrell

o-12/17/13
drd/dak
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

BUTLER, BERNARD
Employee/Petitioner

Case# **04WC018116**

McDANIEL FIRE SYSTEMS
Employer/Respondent

14IWCC0110

On 4/10/2013, 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 0.09% 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:

0226 GOLDSTEIN BENDER & ROMANOFF
DAVID Z FEUER
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

0532 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 CORRECTED DECISION

Bernard Butler
Employee/Petitioner

v.

McDaniel Fire Systems
Employer/Respondent

Case # **04** WC **18116**

Consolidated cases:

14IWCC0110

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Peterson and Thompson-Smith, Arbitrators of the Commission, in the city of **Chicago**, on **February 24, 2010 and December 7, 2012.** After reviewing all of the evidence presented, the Arbitrator. Lynette Thompson-Smith 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 7, 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 sustain an accident that arose out of and in the course of employment.
Timely notice of this accident was given to Respondent.
Petitioner's current condition of ill-being *is* causally related to the accident.
In the year preceding the injury, Petitioner earned **$69,264.00**; the average weekly wage was **$1,332.00**.
On the date of accident, Petitioner was **49** years of age, ***married*** with **1** dependent child.
Petitioner has received all reasonable and necessary medical services.
Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.
Respondent shall be given a credit of $0.00 for TTD, $8,910.40 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $8,910.40.
Respondent is entitled to a credit of $40,807.26 under Section 8(j) of the Act.

ORDER

Respondent shall be given a credit of $46,717.66 for benefits that have been paid pursuant to Section 8(j) of the Act and Respondent shall hold petitioner harmless from any claims by providers of the services for which Respondent is receiving this credit.

Respondent shall receive a credit of $8,910.40 for payment of temporary total disability pursuant to Section 8(b) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $888.00 per week for 76 3/7 weeks, commencing 1/8/2004 through 1/9/2004; 2/14/2004 through 5/6/2004; and 12/10/2005 through 2/20/2007, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from January 8, 2004 through February 20, 2007, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services of $42,411.59, awarded to the petitioner, less Respondent's Section 8(j) credit, pursuant to Sections 8(a) and 8.2 of the Act, where applicable.

Respondent shall pay Petitioner permanent partial disability benefits of $550.47/week for 70 weeks, because the injuries sustained caused the 35% loss of the right leg, as provided in Section 8(e) of the Act.

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

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

L. Thompson Smith
Signature of Arbitrator

April 9, 2013

APR 10 2013

14IWCC0110

FINDINGS OF FACT

The disputed issues in this matter are: 1) accident; 2) causal connection; 3) notice; 4) temporary total disability; 5) nature and extent; and 6) medical services and bills.

Mr. Butler testified he is now retired, living in Florida. He formerly resided in Chicago.

On January 7, 2004, he was employed as a union sprinkler fitter working at McDaniel Fire Systems. Near break time, as he was coming off of a scissor lift, he missed one of the receded steps and struck his right knee on the flat end of the scissor lift. He fell backwards, twisting his right knee.

Mr. Butler denied having any prior injuries to the right knee and continued his full-time work on January 7, 2004. He testified that he spoke to a co-worker, Anderson Evans, about his knee the day that he injured it and that unrebutted testimony was corroborated by Mr. Anderson Evans when he testified. Mr. Evans testified that he witnessed the accident and approached the petitioner to inquiry whether or not he was injured. *See*, Tr. Pgs. 12-13; 57-58.

The next day, he called and spoke with Mr. Anderson Evans, asking him to call the project manager, Dave Stevens, to inform him he that his knee was sore and would not be in work that day. Mr. Butler testified he did not call Mr. Stevens because he did not have his phone number. *See,* Tr. Pgs. 14-15 & 57-58.

Mr. Butler returned to full-time work on January 9, 2004. He returned to full-time employment, with no restrictions, working as a union sprinkler fitter at the University of Illinois parking garage project. He subsequently worked full-time at the Northeastern University project. While working at both of these projects, he was not wearing any braces on his right knee.

Mr. Butler testified his right knee became progressively more painful. He sought out medical care for the first time on January 27, 2004. He presented to Dr. DeSilva and Petitioner acknowledged that he did not tell Dr. DeSilva of a work-related accident regarding his right knee. At a subsequent visit, Petitioner was directed to undergo an MRI of the right knee. It was only after the MRI on February 16, 2004, which showed a bone bruise, or a micro-trabecular fracture and a meniscus tear, did the petitioner acknowledge that, for the first time, he spoke with one of the superintendents from McDaniel Fire Systems, informing him of the January 7, 2004 occurrence. Mr. Butler acknowledged up until that time, he had not filled out an accident report regarding a work-related accident

and his explanation was that he did not think that he had hurt his knee that badly.

Dr. DeSilva referred the petitioner to Dr. Kevin Luke, who diagnosed him as having suffered a tear of the medial meniscus in his right knee. On March 2, 2004, Dr. Luke performed an arthroscopic surgery, repairing a tear of the medial meniscus and subsequent to surgery; and Petitioner remained under his care. At his last visit with Dr. Luke, on May 7, 2004, Petitioner informed Dr. Luke that he had no complaints of pain or any problems with his right leg. On physical examination, Dr. Luke noted Mr. Butler had full range of motion of his right leg and commented that Petitioner was up and ambulating without any external aids. Dr. Luke asked Mr. Butler to heel-walk, toe-walk, and squat. Petitioner was able to perform all of these activities. Dr. Luke directed Mr. Butler to return to full-time work and no restrictions were imposed.

At his attorney's request, Mr. Butler was examined on June 26, 2004, by Dr. Barry Lake Fischer. Dr. Fischer reviewed medical records and took a history from the petitioner. He performed a physical examination and it was his opinion that Petitioner had sustained a sprain injury to his right knee resulting in internal derangement, requiring surgical intervention.

Dr. Fischer opined there was a relationship between Petitioner's condition of ill being on June 26, 2004 and the work-related accident of January 7, 2004 and that Petitioner's condition of ill being had reached a state of maximum medical improvement.

After receiving the full-duty release from his treating surgeon in May 2004, the petitioner continued to work for the next nineteen (19) months as a union sprinkler fitter. He worked full-time, for various contractors at various jobs. All of his job assignments were obtained through his union hall and he continued working, in a full duty capacity, with no restrictions, as a union sprinkler fitter, until October 19, 2005.

The petitioner testified that he developed pain and swelling in his right knee and in December of 2005 he presented to Dr. Schiappa, who related this present right knee condition to the accident of January 7, 2004. On December 22, 2005, Dr. Schiappa performed a partial meniscectomy to the right leg, after an MRI which showed a radial tear of the posterior horn of the medial meniscus. The doctor further opined that because of the two (2) surgeries, the petitioner developed an arthritic condition that inhibited a full recovery. Dr. Schiappa testified that the petitioner's condition was permanent and that if the pain became intolerable, he should consider a total knee replacement. The last visit to Dr. Schiappa was February 20, 2007, when the petitioner was advised "not to return to his original job."

Petitioner testified that when he was released to return to work on May 7, 2004, the respondent informed him that he was laid off. He sought employment elsewhere and worked for approximately one year; ending his career as a union sprinkler fitter on October 19, 2005. He testified that he has not gone to work for any employer since retiring and moving to Florida. He is presently receiving a retirement pension from the union. He further testified that his knee is painful and that he needs to use a cane to ambulate.

Mr. Anderson Evans testified that he is a union sprinkler fitter who was working with Mr. Butler on January 7, 2004; and that he and Petitioner are friends. He observed Petitioner coming down from the lift and twisting his leg as he was getting off. Mr. Evans testified he observed the petitioner limping at break time on January 7, 2004. Mr. Evans further testified that Mr. Butler called him on January 8, 2004, telling him he was unable to come to work because of his knee and requested that he notify Mr. Stevens, their supervisor. Mr. Evans testified he spoke with Mr. Stevens on January 8, 2004, informing him that Mr. Butler had hurt his knee, on the job and would not be coming to work on that date.

CONCLUSIONS OF LAW

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

The Arbitrator concludes Mr. Butler suffered a compensable accident on January 7, 2004. Respondent argues Mr. Butler did not suffer an accident, as the first notification of a work-related accident did not occur until more than a month after the incident. Respondent further argues that the petitioner continued full-time work without verbalizing any complaints of a work-related accident, problems to his knee or seeking medical attention. Thus Respondent argues Mr. Butler's testimony of an accident should not be believed. Based on the corroborating testimony of Mr. Evans, the Arbitrator concludes that the petitioner suffered an accident, at work, on January 7, 2004, when he missed one of the steps while exiting the scissor lift.

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

The Arbitrator finds that both witnesses, i.e. the petitioner and Mr. Evans testified that Petitioner requested that Mr. Evans notified the respondent's agent that he injured his knee, at work, and would not be coming in, the day after the accident. This testimony is unrebutted therefore; the Arbitrator finds that the Respondent was given timely notice of the accident, pursuant to the Act. It was Petitioner's unrebutted testimony that on February 16, 2004, he personally notified one of the superintendents from McDaniel Fire Systems, informing him of his January 7, 2004 accident; which was within the forty-five (45) day statutory requirement.

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

The Arbitrator concludes Mr. Butler suffered a tear of the medial meniscus in his right knee, which caused internal derangement to the right knee. The Arbitrator further concludes that the necessity for the March 2, 2004 surgery was related to the January 7, 2004 accident. The Arbitrator bases her decision on the opinions of Drs. Fischer and Luke and Petitioner's treating doctors. At his last visit with Dr. Luke, on May 7, 2004, the petitioner informed Dr. Luke he was having no complaints of pain, nor any problems with his right leg. On physical examination, Dr. Luke noted that Petitioner had full range of motion of his right leg and commented that Petitioner was up and ambulating without any external aids. Dr. Luke asked him to heel-walk, toe-walk, and squat and he was able to perform all of these functions. Dr. Luke directed Mr. Butler to return to full-time work and no restrictions were imposed. Also, on June 26, 2004, Dr. Fischer opined that Petitioner's condition of ill being had reached a state of maximum medical improvement.

However, Petitioner testified that he again developed pain and swelling in his right knee and in December of 2005 and presented to Dr. Schiappa; who related this present right knee condition to the accident of January 7, 2004. On December 22, 2005, Dr. Schiappa performed a partial meniscectomy to the right leg, after an MRI which showed a radial tear of the posterior horn of the medial meniscus. The doctor further opined that because of the two (2) surgeries, the petitioner developed an arthritic condition that inhibited that knee from full recovery. Dr. Schiappa testified that the petitioner's condition was permanent and that if the pain became intolerable, he should consider a total knee replacement. The last visit to Dr. Schiappa was February 20, 2007, when the petitioner was advised "not to return to his original job." The Arbitrator concludes that Petitioner's current condition of ill-being is related to the work injury.

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?

On May 7, 2004, the physical examination of the treating surgeon, Dr. Luke, determined that Petitioner was able to ambulate without external aids and able to heel-toe walk and squat. The doctor stated that Mr. Butler's condition had reached maximum medical improvement on May 7, 2004. At such time, Mr. Butler had no complaints of pain or problems. He was released to return to work in a full duty capacity. He had a full range of motion of the knee. He was discharged from medical care by his treating orthopedic surgeon. Also, Petitioner's expert Dr. Barry Lake Fischer, who examined Mr. Butler one month later, concluded similarly, that the condition of Mr. Butler's knee had apparently, reached a state of permanency. However, Dr. Schiappa, upon re-examination and additional diagnostic tests revealed a second meniscus tear and opined that this second right knee condition was related to the accident of January 7, 2004.

On December 22, 2005, Dr. Schiappa performed a partial meniscectomy to the right leg, after an MRI which showed a radial tear of the posterior horn of the medial meniscus. The doctor further opined that because of the two (2) surgeries, the petitioner developed an arthritic condition that inhibited a full recovery. The Arbitrator having examined the treating medical records and the testimony of Petitioner concludes that both surgeries were necessary and reasonable and related to the work accident.

The parties have agreed to the information contained in Petitioner's Exhibit Number 4 with respect to the medical providers, the dates of service, co-payments by Mr. Butler and payments by the group health carrier. The Arbitrator awards Petitioner all necessary and related medical services incurred for the right knee from January 27, 2004 through February 20, 2007; with Respondent given an 8j credit for amounts paid.

K. What temporary benefits are in dispute?

Respondent shall be given a credit of $40,807.26 for benefits that have been paid pursuant to Section 8(j) of the Act and Respondent shall hold petitioner harmless from any claims by providers of the services for which Respondent is receiving this credit.

Respondent shall receive a credit of $8,910.40 for payment of temporary total disability pursuant to Section 8(b) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $888.00 per week for 76 3/7 weeks, commencing January 8, 2004 through January 9, 2004; February 14, 2004 through May 6, 2004; and December 10, 2005 through February 20, 2007, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services directly to the petitioner, of $42,411.59, less payments made by Respondent, as provided in Sections 8(a) and 8.2 of the Act, where applicable.

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

The Arbitrator concludes Mr. Butler suffered a 35% loss of use of his right leg. Petitioner has failed to prove, by a preponderance of the evidence, that he is permanently, totally disabled.

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

Timothy Sykes,

Petitioner,

vs. No. 10WC007919

A-Z Welding & Machine, Inc., 14IWCC0111

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, notice, the necessity of medical treatment and temporary disability, and being advised of the facts and law, reverses the decision of the Arbitrator for the reasons stated below.

FACTS

Pre-manifestation date records show that on August 5, 2002, Petitioner sought treatment with Dr. John Wuellner and complained of pain and discomfort in his wrists that usually occurred on weekends. Petitioner reported that he worked with signs that were fairly heavy. On examination, Petitioner had point tenderness and negative Tinel's signs in the wrists. Dr. Wuellner opined that Petitioner likely had a strain or an "inflammatory process of the wrist" from the work he did on weekends and recommended that Petitioner wear wrist splints. On December 9, 2002, Petitioner returned to Dr. Wuellner and reported that his wrists were doing much better and the splints had helped. Dr. Wuellner noted that Petitioner had high blood pressure and Petitioner was in the process of losing weight to lower his blood pressure.

On November 13, 2009, Petitioner sought treatment with Dr. Wuellner and complained of intermittent numbness in his fingers bilaterally that had worsened in the past four to six weeks. Dr. Wuellner noted that Petitioner was obese and diagnosed Petitioner with symptomatic

carpal tunnel syndrome, benign hypertension and controlled mixed hyperlipidemia. On November 16, 2009, Petitioner underwent electromyogram and nerve conduction studies of the upper extremities at Dr. Wuellner's recommendation which revealed severe, bilateral median entrapment neuropathy and left ulnar sensory neuropathy. At the arbitration hearing, Petitioner testified that Dr. Wuellner referred him to Dr. William Hoffman.

On December 18, 2009, Dr. Hoffman conducted a pre-operative history and physical examination of Petitioner. Dr. Hoffman noted that Petitioner was right-handed and had some numbness in both hands that bothered him at night and when driving or using a telephone. Dr. Hoffman also noted: "[f]or 19 years he did mix paint for Sherwin-Williams and now works as a machinist, using his hands fairly vigorously." That day, Dr. Hoffman performed a right medial nerve decompression surgery. On January 15, 2010, Petitioner underwent a left median nerve decompression surgery also performed by Dr. Hoffman.

At his January 24, 2010, deposition, Dr. Michael Beatty, a board certified orthopedic hand surgeon, testified that in September of 2011, he performed a section 12 examination at Petitioner's attorney's request. Dr. Beatty opined that Petitioner was at maximum medical improvement as of his examination. Dr. Beatty described his understanding of Petitioner's job duties with Respondent:

> "His job description was that of a machinist-laborer. And initially he related to the deburring and sanding activity which was the most problematic for him. And that work, and involvement in that work is what led to hand complaints that subsequently led him to seek treatment; the associated numbness and tingling involved in the use or the performance of those kinds of duties. And he did the deburring and the sanding, throughout the day that he described to me as just hours at a time."

Petitioner also used a grinder to de-burr about 600 to 900 metal pieces each day. Dr. Beatty opined that based on the history that Petitioner provided and the medical records, Petitioner's work activities were causally related to the development or worsening of his bilateral carpal tunnel syndrome. Further, Petitioner's weight, diabetes and high blood pressure were not causative factors in his development of carpal tunnel syndrome.

On January 28, 2010, Dr. Hoffman examined Petitioner and noted that Petitioner was symptom free. Dr. Hoffman recommended that Petitioner return as needed.

On February 24, 2010, Mr. Terry Strauch, Respondent's agent, completed an Employer's First Report of Injury or Illness form and indicated that Petitioner sustained an injury to his hands and wrists on November 16, 2009, as a result of repetitive work. Mr. Strauch also noted that "[c]laimant stated injury started at prior employment."

On March 2, 2010, Petitioner filed an Application for Adjustment of Claim, alleging that on November 16, 2009, he sustained repetitive trauma injuries to his hands as a result of his repetitive work duties.

14IWCC0111

On April 13, 2010, Dr. Hoffman prepared a narrative report of Petitioner's treatment and opined:

> "As far as causation, Mr. Sykes has bilateral carpal tunnel. It has been my experience that people who do tremendous repetitious wrist flexing and extending over prolonged periods of time seemed to have a tendency to start to feel and express symptoms of carpal tunnel which may reach a point where surgical intervention can be a consideration. Generally speaking, these patients must identify the fact that the work activity either aggravated the preexisting symptoms or initiated those symptoms."

A work analysis report dated June 3, 2010, evaluating the job of a "shop helper," states that shop helpers are responsible for assisting machinists and other employees in "completing orders for metal cutting, welding and fabrication." The report summarized that the job of a shop helper as observed on June 3, 2010, "carries no risk for repetitive motion disorders, in particular CTS due to the more than adequate rest periods and the variability of tasks."

On August 2, 2010, Dr. Mitchell Rotman, a board certified orthopedic surgeon, performed a section 12 examination at Respondent's request. Dr. Rotman noted that Petitioner worked for Respondent as a machinist and laborer for some time, and prior to working for Respondent, detailed parts, ran machines and mixed paints for other employers. Dr. Rotman also noted that Petitioner did not recall having wrist symptoms before 2009 and Petitioner's job duties included:

> "detailing metal parts, using grinders, sanders and files and deburring tools. He would do those type of activities for about 50% of the time. He loaded at times 3 inch bars 5 feet long into a lathe. Sometimes they were just 3/8 inch thick and they would frequently have to change out tools, that the jobs changed day to day. Other times, he would run and set up machines. He would do some cutting and sawing and sometimes cut and split and stock wood. Weights varied from ounces to numerous pounds. . . . He would use a sanding disc, file or grinder to de-bur which he felt was about 50% of his day. He worked on the metal burning machine just a few times."

Dr. Rotman opined that based on the work analysis report and video, Petitioner's work for Respondent was not repetitive and varied from day to day. Dr. Rotman opined further that Petitioner's EMG/NCV studies showed that "his carpal tunnel condition had been coming on for years, [and] that it was already [at] an advanced state when he presented." Petitioner had other risk factors, including diabetes and obesity, which led to the development of his bilateral carpal tunnel syndrome.

A handwritten job description dated January 5, 2011, and signed by Petitioner states that he worked as a machinist and laborer and his symptoms began on November 16, 2009. Petitioner described his symptoms:

> "Set up and ran various machines. Loading and unloading machines in vices and clamps. Cleaning up parts with a sanding disces [sic] – holding very small parts in finger tips to a sanding disc to deber [sic] or using a hand sanding disc to deber [sic] a large part. Detailing parts using a hand scraper. Maintenance on machines and cleaning sweeping. Loading and unloading trucks and driving. Splitting wood for wood burning stoves."

Petitioner also indicated that he used hand grinders and air drills "some times all day," and worked from 7 a.m. to 5 p.m. on a normal workday.

On February 2, 2011, Dr. Beatty wrote a letter to Petitioner's attorney and noted that he examined Petitioner on January 27, 2011. At the examination, Petitioner reported that his hands were "okay now" and "the deburring and sanding parts of his job [were] the most problematic with numbness and tingling occurring throughout the day and increasing toward the end of the work day when completing those tasks." Petitioner also reported that he performed the tasks of sanding and de-burring for "hours at a time" and he had no problems with his hands prior to working for Respondent. Dr. Beatty opined that "it appears that the job description as he related to me would be the causative basis for the development of his bilateral carpal tunnel syndrome."

An Application for Adjustment of Claim signed by Petitioner on June 9, 2011, alleges that on May 15, 2009, Petitioner sustained repetitive trauma injuries to both hands and wrists while working for Versatile Machining, which caused bilateral carpal tunnel syndrome.

At his January 26, 2012, deposition, Dr. Rotman, a board certified orthopedic surgeon, reiterated his opinion that Petitioner's obesity and diabetes caused him to develop carpal tunnel syndrome. On cross-examination, Dr. Rotman acknowledged that although Petitioner had carpal tunnel complaints in 2002, Petitioner had no diagnostic evidence of carpal tunnel syndrome until 2009. In addition, Dr. Rotman opined that if Petitioner performed a heavy activity for over 50 percent of the day, it could have aggravated his predisposition to carpal tunnel syndrome.

At the July 23, 2012 arbitration hearing, Petitioner testified that about 19 years before he began working for Respondent, he worked in the paint industry for Sherwin-Williams; and about 18 months before he began working for Respondent, he started working for Versatile Machining full-time. Petitioner's job duties at Versatile Machining included setting up and operating machines, as well as detailing and cutting parts. In the fall of 2008, Petitioner began working part-time for Respondent, "a couple hours a couple of times a week during the nights," while he continued to work full-time for Versatile Machining. In May of 2009, Petitioner began working 40 hours per week for Respondent and stopped working for Versatile Machining. Petitioner did not work overtime often and earned $12.00 per hour while employed with Respondent.

Petitioner's job duties for Respondent included "deburring," cutting, and the use of grinding wheels. De-burring consisted of using a small disk sander, hand grinder or file to remove burrs from the edges of various-size metal parts. Each workday, Petitioner de-burred a couple to hundreds of parts and used a saw to cut 10 to 100 sheets of metal, which weighed about 15 to 20 pounds. Additionally, Petitioner sanded metal parts with a power or hand sander, set up and loaded machines, and occasionally split wood and drove a Bobcat. Petitioner testified that

the job site analysis video only showed some of the work duties that he performed and it did not show the speed or frequency at which Petitioner performed his job duties. Petitioner did not have symptoms in his hands when he worked for Sherwin-Williams and did not have symptoms between the fall of 2008 and May of 2009. Petitioner has been overweight his entire life and has never used insulin to manage his diabetes.

In September of 2009, Petitioner began to experience numbness and tingling in his hands. That month, he spoke with Brian Zirkelbach about his symptoms "in passing a couple times." Additionally, Petitioner spoke to Mike Zirkelbach and believed the conversation also took place sometime in September of 2009. In October of 2009, Petitioner spoke to Brian Zirkelbach again and told him that his symptoms had worsened. In November of 2009, Petitioner had another conversation with Brian Zirkelbach about his symptoms and Brian told him to "get it taken care of." Between May 2009 and September 2009, operating the sanders and de-burring parts caused Petitioner to experience increased pain, numbness and tingling in his hands. Respondent terminated Petitioner's employment at the end of January 2010.

On cross-examination, Petitioner testified that when he worked for Sherwin-Williams, he carried and opened paint cans until he became a manager. Petitioner did not recall whether he sought medical treatment for bilateral wrist pain in August of 2002. Petitioner acknowledged that while working for Versatile Machining, he sometimes de-burred parts with sanders and hand-filing tools; however, he worked on machines more than he de-burred parts. While working for Respondent, Petitioner de-burred parts all day as much as five days a week while he also operated the machines. Petitioner did not remember signing an Application for Benefits on June 9, 2011, and could not recall what symptoms he may have experienced in May of 2009.

Mike Zirkelbach testified at the arbitration hearing on Respondent's behalf. At the time of the hearing, Mr. Zirkelbach had been Respondent's coordinator for 11 years and worked alongside Petitioner when Petitioner worked for him. Petitioner did not have a specific job title and his job duties included operating machinery, loading and unloading parts into a machine, driving an automatic vehicle, sweeping floors, answering phones, splitting firewood, polishing and de-burring parts, operating a saw, and other small jobs. Mr. Zirkelbach performed the same job duties that Petitioner performed as Respondent's business is not large and everyone is required to perform various job duties. On average, Petitioner de-burred about 100 parts per day and at the most, de-burred 200 parts per day. There were some days when Petitioner only de-burred 50 parts and it was rare for a worker to perform de-burring for five days straight. At the most, a worker would de-bur parts for four non-consecutive hours in one day. There is a significant amount of down time between de-burring parts as workers must wait for each part to go through a machining process and cool before de-burring. Petitioner would sit on a chair, organize or clean while waiting for parts to come out of his machine. Mr. Zirkelbach described the job as "very laid back." Petitioner first notified Mr. Zirkelbach of pain in his hands "probably a few months before he got operated on or a month before he got operated on, a couple months."

DISCUSSION

The Arbitrator found Petitioner failed to prove that he sustained compensable repetitive trauma injuries to his hands. The Commission disagrees.

On November 13, 2009, Dr. Wuellner diagnosed Petitioner with symptomatic carpal tunnel syndrome. On November 16, 2009, Petitioner underwent diagnostic testing which showed he had severe, bilateral median entrapment neuropathy and left ulnar sensory neuropathy. Dr. Hoffman performed a pre-operative history and physical examination on December 18, 2009, and noted that Petitioner worked as a machinist and used his hands "fairly vigorously." The Commission notes that Mike Zirkelbach agreed with Petitioner's stated job duties and only disagreed with the frequency at which Petitioner performed those duties. The Commission also notes Petitioner testified that the work activities of de-burring and sanding caused him to experience the most symptoms in his hands, which is consistent with the job description that Petitioner provided to Dr. Beatty. The Commission finds persuasive Dr. Beatty's opinion that Petitioner's work activities were causally related to the development or worsening of his bilateral carpal tunnel syndrome. With respect to Petitioner's 2002 wrist symptoms, the Commission agrees with Dr. Rotman's observation that although Petitioner had some bilateral wrist complaints at that time, he had no diagnostic evidence of carpal tunnel syndrome until 2009. The Commission finds Petitioner proved by a preponderance of the evidence that he sustained compensable repetitive trauma injuries to his right and left hands as a result of his repetitive job duties.

With respect to notice, Petitioner testified that in September of 2009, he began to notice symptoms in his hands and spoke with Brian Zirkelbach about his symptoms "in passing a couple times." Petitioner also spoke to Mike Zirkelbach and believed the conversation took place sometime in September of 2009. In October of 2009, Petitioner spoke to Brian Zirkelbach again and told him that his symptoms had worsened. In November of 2009, Petitioner had another conversation with Brian Zirkelbach about his symptoms and Brian told him to "get it taken care of." Mike Zirkelbach testified that Petitioner told him he had pain in his hands "probably a few months before he got operated on or a month before he got operated on, a couple months." The Commission finds that beginning in September of 2009, Petitioner had an ongoing dialogue with Brian and Mike Zirkelbach about his bilateral hand symptoms, which continued after November 16, 2009, the date when Petitioner's work-related bilateral hand symptoms manifested. Mike Zirkelbach's testimony that Petitioner told him he had pain in his hands about one or two months before the December 18, 2009, surgery shows that Respondent had timely notice or timely defective notice of Petitioner's work-related repetitive trauma injuries. Respondent has shown no undue prejudice.

The Commission finds that Petitioner is entitled to medical expenses in the sum of $15,038.81 for treatment related to Petitioner's bilateral carpal tunnel syndrome. With respect to temporary total disability, the Commission notes that Petitioner claims he did not miss work as a result of his work-related injuries. As to the nature and extent of Petitioner's disability, the Commission finds that Petitioner's injuries caused the loss of the use of the right and left hands to the extent of 10 percent of each hand.

The Commission notes that at the arbitration hearing, the parties disputed the issues of benefit rates and wage calculations and the Arbitrator made no findings with respect to these issues. Petitioner testified that he began working part-time for Respondent in 2008 and became a full-time employee in May of 2009, working 40 hours per week and earning $12.00 per hour. When asked if he worked overtime, Petitioner stated that he did not work overtime very often.

Respondent's Exhibit Eight shows that Petitioner earned $585.00 in November and December of 2008, and earned $16,128.50 between January and November of 2009. It appears that Petitioner also worked some scattered overtime hours in 2008 and 2009. The Commission declines to include Petitioner's overtime hours in the calculation of his yearly earnings as Petitioner provided no specifics about how much overtime he may have worked in the year preceding November 16, 2009, and whether it was mandatory. The Commission finds that Respondent's wage documents are more reliable and detailed than Petitioner's testimony regarding his earnings. Lastly, the Commission finds that Petitioner earned $16,713.50 ($16,128.50 + $585.00) during the year preceding the manifestation date of his injuries and had an average weekly wage of $321.41 ($16,713.50/52).

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed on August 29, 2012, is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $15,038.81 for all reasonable and necessary medical bills related to his bilateral carpal tunnel syndrome under §8(a) and §8.2 of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $245.33 per week for a period of 41 weeks, as provided in §8(e) of the Act and subject to the minimum rate, for the reason that the injuries sustained caused permanent partial disability equivalent to the 10 percent loss of use of each hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay 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 $25,200.00. 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: FEB 14 2014
MB/db
o-12/18/13
44

Michael J. Brennan

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SYKES, TIMOTHY
Employee/Petitioner

Case# **10WC007919**

A-Z WELDING & MACHINE INC
Employer/Respondent

14IWCC0111

On 8/29/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4888 SHORT & SMITH PC
KEITH SHORT
515 MADISON AVE
WOOD RIVER, IL 62095

2593 GANAN & SHAPIRO PC
IAN M WHITE
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

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

14IWCC0111

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Timothy Sykes
Employee/Petitioner

v.

A-Z Welding and Machine, Inc.
Employer/Respondent

Case # 10 WC 7919

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on July 23, 2012. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On November 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 $n/a; the average weekly wage was $n/a.

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 $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00.

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

ORDER

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

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

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

William R. Gallagher, Arbitrator

August 27, 2012
Date

AUG 29 2012

Findings of Fact

Petitioner filed an Application for Adjustment of Claim in which he alleged a repetitive trauma injury arising out of and in the course of his employment for Respondent. The Application alleged a date of accident (manifestation) of November 16, 2009, and alleged repetitive work to both hands and wrists causing bilateral carpal tunnel. Respondent disputed its liability primarily on the basis of accident, notice and causal relationship.

Petitioner worked for Respondent as a machinist and became employed by Respondent on a part-time basis in November, 2008. From November, 2008, through May, 2009, Petitioner worked as a machinist for another employer, Versatile Machinery. In May, 2009, Petitioner was laid off by Versatile Machinery, but he was able to become a full-time employee of Respondent at that same time.

Petitioner testified that most of the time he spent working for Respondent consisted of running various machines or deburring or sanding various metal parts. Deburring consists of taking a small disc sander or hand grinder and knocking the burrs off of the edges of the parts. Petitioner testified that on some days or weeks, he would deburr hundreds of parts. The precise amount of deburring required to be performed by Petitioner would vary from one week to the next. Petitioner testified that he also operated lathes, a manual hydraulic press, and a "CNS" machine which cuts parts from larger pieces of metal. Petitioner would also cut wood with a chainsaw, stack the wood and stoke the stoves that heated of the shop. Petitioner would, on occasion, drive a pickup truck to make deliveries or operate a bobcat.

Petitioner first began experiencing symptoms of numbness in both of his hands in September, 2009. Even though Petitioner was performing similar work for Versatile from November, 2008, to May, 2009, Petitioner did not experience any hand symptoms during this period of time. Petitioner testified he informed his employer, Brian Zirkelbach, in September, 2009, that he was developing numbness and tingling in his hands and the symptoms were when he did deburring and other hand intensive work.

Mike Zirkelbach, a supervisor/coordinator for Respondent, testified on behalf of the Respondent and his testimony focused on the nature of Petitioner's job duties. Initially, Mike Zirkelbach stated that Respondent operated a small machine shop and that it did not produce enough parts for Petitioner to spend all or even a significant amount of time deburring or polishing parts. Because of the size of the shop, all of the employees had to do a little bit of everything to keep the shop running. Zirkelbach testified that no employee of the shop would be deburring parts for an entire week of work; however, he did testify that perhaps a day or so someone might have to deburr parts and, even then, it was usually not more than four or five hours for an entire work week.

A work analysis report was performed by Occupational Consulting and Rehabilitation on June 3, 2010, and a DVD videotape was obtained at that same time. The work activities addressed by the work analysis included truck driving, burn table watch, CNC lathe, drop band saw, maintenance, shop cleanup, fork truck and bobcat, and shop sander. The work analysis found that the repetitive nature of a shop helper job fell short in the number of repetitions associated with increased risk

for development of cumulative trauma disorders. The work analysis report found the work of the shop helper did not require the employee to generate forces of a small or large degree of a constant nature, and found that all of the tasks that were observed that were required of the shop helper to generate forces common to this job are consistent but not constant. Further, the report found there was more than adequate periods for muscle rest and regeneration. Both the report and DVD were tendered into evidence at the time of trial.

Petitioner initially sought medical treatment from Dr. John Wuellner, his family physician, on November 3, 2009. Dr. Wuellner opined that Petitioner had bilateral carpal tunnel syndrome and ordered nerve conduction studies to be performed. The nerve conduction studies were performed on November 16, 2009, and were positive for bilateral carpal tunnel syndrome. Petitioner was subsequently treated by Dr. William Hoffman, a neurosurgeon. Dr. Hoffman's record contains the statement that there was no history of hand or wrist trauma, but that Petitioner worked as a machinist and used his hands fairly vigorously. Dr. Hoffman confirmed the diagnosis of bilateral carpal tunnel syndrome and performed carpal tunnel surgical releases on the right and left wrist on December 18, 2009, and January 15, 2010, respectively. Dr. Hoffman did not opine as to whether or not there was a causal relationship between Petitioner's work activities and the bilateral carpal tunnel syndrome condition. Petitioner did not lose any time from work while he was undergoing this treatment because the Respondent made limited duty available to him.

At the request of his attorney, Petitioner was examined by Dr. Michael Beatty on January 27, 2011, and Dr. Beatty was deposed on January 24, 2012. Dr. Beatty opined that Petitioner's work for Respondent was a causative basis for the development of bilateral carpal tunnel syndrome or a worsening of the underlying condition to where it required surgery. The job history as related to Dr. Beatty was that Petitioner's work required to do detailing, deburring, and sanding of metal parts throughout the day for about 50% of the time and that Petitioner would have to handle 600 to 900 pieces of metal per day. Petitioner would then have to grind or deburr them to take off the sharp edges. Dr. Beatty also took into consideration Petitioner's medical history including the history of diabetes and obesity but he remained of the opinion that Petitioner's employment caused or aggravated the carpal tunnel syndrome condition.

At the request of Respondent, Petitioner was examined by Dr. Mitchell Rotman on August 2, 2010, and Dr. Rotman was deposed on January 26, 2012. In respect to his work duties, Petitioner communicated essentially the same information regarding this to Dr. Rotman that he also communicated to Dr. Beatty. Dr. Rotman also reviewed the job analysis and DVD and concluded that the work requirements were not nearly as hand intensive as Petitioner had represented them to be.

Dr. Rotman testified the cause of Petitioner's bilateral carpal tunnel syndrome was his obesity and diabetes. At the time of Dr. Rotman's examination, Petitioner was 5'8" and weighed 305 pounds and also had a long history of being diabetic. Dr. Rotman testified the work that Petitioner did for Respondent was not an aggravating factor for the development of the carpal tunnel syndrome because Petitioner had only worked for Respondent for a short period of time, the work was not repetitive or heavy enough, and, Petitioner was obese and a diabetic. Dr. Rotman agreed that the job activities different depicted on the DVD were not consistent with the Petitioner's description of his job duties.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusions of law:

The Arbitrator finds that Petitioner failed to prove that he sustained a repetitive trauma injury to his hands arising out of and in the course of his employment for Respondent.

The Arbitrator finds the job activities of Petitioner while employed by Respondent were not sufficiently repetitive to constitute a repetitive trauma injury. Petitioner's job duties varied substantially on a day-to-day basis and the activity of deburring alleged to be the primary repetitive trauma was not sufficient enough to constitute repetitive trauma injury. In this respect, the Arbitrator is persuaded by the testimony of Michael Zirkelbach and his review of the DVD video.

The Arbitrator finds the opinion of Dr. Rotman be more credible than Dr. Beatty. This finding is based, in part, on the fact that the history of work activity communicated by Petitioner to Dr. Beatty was not accurate.

In regard to disputed issues (E), (G), (J), and (L) the Arbitrator makes the following conclusions of law:

The Arbitrator makes no conclusions of law in regard to these issues as they are rendered moot by his conclusion in regard to issues (C) and (F).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANGELO MILANO,

Petitioner,

vs.

NO: 09 WC 28339

14IWCC0112

CITY OF ELMHURST,

Respondent.

DECISION AND OPINION ON REVIEW
UNDER SECTION 8(A)

This cause comes before the Commission on Petitioner's Section 8(a) Petition, filed on February 28, 2013. A hearing on Petitioner's petition was held by Commissioner Tyrrell on May 23, 2013. The issues under Petitioner's petition were whether Petitioner is entitled to prospective medical care and whether Petitioner is entitled to the medical expenses he has incurred for treatment since the arbitration hearing. The Commission, after having considered the record, hereby finds that Petitioner is entitled to prospective medical care and to the medical expenses he has already incurred. Petitioner's Section 8(a) petition is granted.

FINDINGS OF FACT

The Arbitrator heard Petitioner's case on September 13, 2011, and awarded Petitioner permanent partial disability benefits on November 15, 2011. Petitioner previously had a valid functional capacity examination that found Petitioner capable of performing at a modified heavy physical demand level. Petitioner was released to return to work with those restrictions. Petitioner returned to his position full duty on February 11, 2011, as a mechanic for Respondent.

He maintains all of Respondent's vehicles, and fire and public works equipment. Petitioner testified his job requires him to lift heavy weights and exert strong force. Petitioner testified that two people will carry 100 pound snow plow blades from the back room out to the floor. On average, the parts Petitioner works with weigh about 20 to 30 pounds. However, he does have to apply strong force during his job duties. He is not allowed to use an impact gun to torque wheels and they have to be torqued at 110 to 140 pounds. Instead, Petitioner has to go on his hands and knees and push until the ratchet clicks. Petitioner explained on cross exam that he works with tires a lot and Respondent has a new wheel lift system so Petitioner does not have to lift the heavy tires anymore. Overall, Petitioner testified on direct exam that he does a lot of bending, twisting, torquing, pushing, pulling, working overhead, getting inside a trunk, working inside and under a trunk and generally performing a lot of repetitive movement.

After the arbitration hearing, Petitioner returned to his primary care physician, Dr. Baubly, on November 1, 2011, complaining of low back and leg pain. Dr. Baubly prescribed Tramadol. Petitioner then saw Dr. Ghanayem, who performed his second surgery, in February 2012. Petitioner was still having low back pain and was totally dependent on narcotics to function. In March 2012, Dr. Baubly referred Petitioner to a pain management physician for additional treatment.

Petitioner then treated with Dr. Fikaris, a pain management physician, in August 2012. Petitioner told Dr. Fikaris that his lumbar spine pain radiated to his right SI joint and rated his pain at 5/10 but stated it can increase to 9/10. Dr. Fikaris prescribed Petitioner Norco and recommended Petitioner receive a right SI joint injection and a caudal injection into his lumbar spine. Petitioner had those injections on August 8, 2012, and they provided Petitioner with 20 to 30 percent pain relief for one to two weeks. Petitioner saw Dr. Fikaris again on November 1, 2012, and he recommended another injection. However, that injection was not approved and Petitioner has not received it.

Petitioner then went to Dr. Levin for a Section 12 exam on December 3, 2012. He noted that Petitioner's low back pain had increased over the past summer and radiated into both his legs. Petitioner told Dr. Levin that when sitting he has to lean forward to relieve the pressure he feels in his back and lifting elicits a sharp, stabbing pain in his low back. Dr. Levin offered two opinions as to the cause of Petitioner's continued pain. Dr. Levin opined that Petitioner either had cancer in his lumbar spine or the pain was the normal result of intermittent back discomfort following a lumbar fusion. Petitioner had a bone scan on December 26, 2012, which was negative and there were no further concerns of spinal cancer. Yet, ultimately, Dr. Levin opined that any treatment for Petitioner's lumbar spine was not related to the May 2009 work accident.

Petitioner returned to Dr. Ghanayem on January 21, 2013. Petitioner told Dr. Ghanayem that he was exceeding his restrictions at work, and he was unsure of how much weight he was lifting and if he was properly bending and twisting. Dr. Ghanayem recommended that a therapist visit Petitioner's work site to ensure that Petitioner's assignments were compatible with his restrictions and stressed that his restrictions were to be strictly enforced. However, that never occurred. He told Petitioner to return to work with his previous restrictions and prescribed

Petitioner a stronger arthritis medication. Dr. Ghanaymen opined that Petitioner's symptoms are related to his prior back injury and subsequent fusion that was necessary to treat it.

Petitioner testified on direct exam at the hearing that he currently takes Ultram and Norco, but he is almost out of Norco and tries to save them to fall asleep at night. Petitioner testified that when he wakes up in the morning, his lower back is always stiff and it takes him five to ten minutes to loosen up to put on his socks and shoes. Petitioner explained that his personal life is extremely limited and he no longer participates in activities with his children. Petitioner testified his children play softball and he used to coach but cannot do that anymore. He also cannot play catch with them. Petitioner testified that he comes home from work, eats dinner and then lies down – that is his life. He stated that he has problems falling asleep and takes Norco so he can sleep. Petitioner stated that he is miserable and always in pain. Petitioner testified his stabbing pain is in his lower back and he experiences a lot of stiffness to the point he can hardly move. Petitioner explained that he has to take medications three times a day and just does not feel right.

Petitioner testified that he feels like his low back has gotten worse and the two surgeries did not help him. Petitioner explained that his legs ache all the time, like he just ran a marathon. Petitioner testified he wants to have a second injection and is willing to try anything that will lessen his pain.

CONCLUSIONS OF LAW

The Commission concludes that Petitioner's current condition in his lumbar spine and his need for additional treatment as recommended by Dr. Ghanayem and Dr. Fikaris are causally related to the work accident he sustained on May 20, 2009. We find that Petitioner sustained his burden of proof under Section 8(a) that his lumbar spine symptoms worsened.

Even though Petitioner was not actively seeking treatment at the time of the hearing, he clearly had unresolved back complaints. Petitioner had two lumbar spine surgeries, but Dr. Baubly diagnosed Petitioner with failed back surgery. Petitioner sought additional treatment for his worsening condition within two months of the hearing. There is no indication of any new trauma, and his symptomology is the same type he experienced during his initial treatment. Petitioner treated with the same physicians before and after the arbitration hearing. Dr. Ghanayem described Petitioner's pain as "persistent" and opined that Petitioner's ongoing back complaints were residual from his lumbar spine surgery. Petitioner also began treating with Dr. Fikaris, a pain management physician, after the arbitration hearing in an attempt to better control his worsening complaints of pain.

Respondent's Section 12 examiner offered two reasons for Petitioner's continuing pain complaints. Ultimately, however, Dr. Levin's opinions support Petitioner's contention that his symptoms continue to relate to the work accident. One of the reasons Dr. Levin suggested was spinal cancer, which was ultimately not found via a bone scan. Dr. Levin's other potential reason

14IWCC0112

was that Petitioner's pain is the normal sequalae from the lumbar fusion. Petitioner only underwent the lumbar surgeries because of the work injury. The surgeries were not successful as Petitioner experiences extreme lumbar pain. Petitioner testified that his pain is still rather severe and has become worse. Petitioner has returned to work full duty but essentially all he is able to do is work and rest in bed after dinner. Petitioner testified that his social life is now very restricted because of his pain. Dr. Levin fails to offer a suggestion as to how Petitioner's symptoms are no longer related to his work injury.

Petitioner's complaints of pain have increased since the arbitration hearing. Petitioner testified he heavily relies on prescription medication to slightly ease his pain. He stated that he feels like he is 80 years old and takes at least five minutes to loosen up in the morning after waking up. Petitioner testified his sleep is interrupted from the pain. He also explained he is no longer as active in his children's lives. Petitioner testified that his pain is becoming worse and his legs now ache.

Petitioner has experienced increasing pain and has continuing medical issues that are related to his work accident. The treatment Petitioner underwent following the hearing has been a continuation of his previous treatment and appears to have given some pain relief. Therefore, Petitioner's Section 8(a) motion for medical treatment is granted. We also award Petitioner the bills he has incurred for treatment for his lumbar spine following the arbitration hearing.

Further, we clarify the Arbitrator's Decision. The Arbitrator awarded Petitioner permanent partial disability benefits. His order does not specify the body part for which the benefits are awarded. We clarify that Petitioner is entitled to permanent partial disability benefits of $664.72 per week for 175 weeks because the injuries sustained the caused the loss of 35% of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Section 8(a) petition for prospective medical treatment in the form of a right SI joint injection, lumbar epidural steroid injection and pain medication, and for medical bills for treatment he already underwent subsequent to the arbitration hearing is granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 175 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 35% loss of use of the person as a whole.

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

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

14IWCC0112

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: FEB 18 2014
TJT: kg
R: 5/23/13
51

Thomas J. Tyrrell

Daniel R. Donohoo

Kevin W. Lamborn

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FRANK BORT,

Petitioner,

vs. NO: 13 WC 10583

ABF FREIGHT SYSTEM, INC.,

14IWCC0113

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b-1) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical treatment, temporary total disability, whether a non-attorney representative from Respondent can sit in the hearing room and whisper questions to counsel, whether the Arbitrator was correct in overruling the objection to Respondent's question regarding Petitioner's referral to Dr. Verma, and whether the Arbitrator was correct in striking a sentence from Dr. Verma's note relating to causation, 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 remands this case to the Arbitrator for additional proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission modifies the decision of the Arbitrator and finds that Petitioner proved that his right knee and left hip conditions of ill being are causally connected to his work related accident. We further award Petitioner reasonable and necessary prospective medical treatment for his right knee and left hip.

Petitioner suffered a work related injury on March 8, 2013. Petitioner credibly testified that while pushing an extremely heavy pallet, he fell on both knees and rolled. Petitioner stated that it felt like he "bounced" on his left hip. We find the record replete with sufficient evidence to find that Petitioner proved his right knee and left hip injuries are causally connected. Petitioner worked for Respondent for 23 years yet never voiced any complaints or sought treatment for his right knee and left hip until March 8, 2013. Additionally, in the accident report Petitioner filled out, he wrote that he injured his left knee, left hip and right knee.

Once Petitioner sought medical treatment, his medical records continually reference complaints of right knee and left hip pain, even though the treatment focused on Petitioner's left knee. Petitioner treated at Concentra in Hammond the same day as his accident. Petitioner had x-rays on March 11, 2013, for his right knee and left hip and Dr. Taiwo's note the same day reflect that Petitioner had pain with palpation and decreased range of motion in Petitioner's right knee and left hip. Dr. Verma noted on April 1, 2013, that Petitioner continues to have right knee symptoms. Additionally, Dr. Sporer wrote in his June 12, 2013, note that further treatment for Petitioner's left hip was indicated but advised Petitioner to complete treatment for his left knee first. Dr. Sporer recommended Petitioner have an MRI of his left hip. Moreover, Respondent's own Section 12 examiner, Dr. Lieber, agreed that Petitioner did not suffer from symptoms to his left knee, left hip or right knee before the work injury. Dr. Lieber also admitted that he examined Petitioner's left knee, left hip and right knee and noted they all became significantly worse after the accident, and that Petitioner's complaints have not abated. Based on Petitioner's credible testimony, the accident report, the medical records and the chain of events, we hold that Petitioner's left hip and right knee conditions of ill being are causally connected. Petitioner is also entitled to prospective medical treatment for his right knee and left hip as deemed reasonable and necessary by his treating physicians.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $778.07 per week for a period of 32-4/7 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 Respondent pay to Petitioner the sum of $2,019.25 per the fee schedule for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize left total knee replacement surgery as recommended by Dr. Sporer and appropriate postoperative care, and reasonable and necessary prospective medical treatment for Petitioner's right knee and left hip under §8(a) of the Act.

14IWCC0113

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 $6,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 18 2014
TJT: kg
O: 2/10/14
51

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the majority's decision. I disagree with the majority's stretch in reasoning finding a causal connection regarding Petitioners right knee and left hip. Arbitrator Kelmanson after conducting a hearing and making a thorough review of the record found it to be "...insufficiently developed to make well reasoned findings, which would become the law of the case, with respect to these conditions" (Arbitrators Decision at P. 8). The Arbitrator then declined to make requested findings regarding the right knee and left hip. I agree with the Arbitrator's interpretation of the record. I take issue with the Arbitrator's failure to deliver a complete decision. When evidence is found to be insufficient as it was here, the burden of proof has not been met. I would complete the Arbitrator's decision and find no causal connection regarding the right knee and left hip. I would affirm and adopt the remainder.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b-1) DECISION OF ARBITRATOR

BORT, FRANK
Employee/Petitioner

Case# **13WC010583**

ABF FREIGHT
Employer/Respondent

14IWCC0113

On 11/4/2013, 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 $ 993.25 for the final cost of the arbitration transcript and attaches a copy of the check to the Petition; and

3) Perfects a review in accordance with the Act and Rules.

If the Commission reviews this award, interest of 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:

0926 LEONARD LAW GROUP LLC
JOSEPH LEONARD ESQ
300 S ASHLAND AVE SUITE 101
CHICAGO, IL 60607

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
CHRISTOPHER H St PETER
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

14IWCC0113

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-1)

Frank Bort
Employee/Petitioner
v.
ABF Freight
Employer/Respondent

Case # 13 WC 10583

Consolidated cases: _____

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 **August 19, 2013**. Respondent filed a *Response* on **September 6, 2013**. The Honorable **Svetlana Kelmanson**, Arbitrator of the Commission, held a pretrial conference on **October 3, 2013**, and a trial on **October 22, 2013**, 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

14IWCC0113

FINDINGS

On the date of accident, **3/8/2013**, 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 left knee condition ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$58,355.55**; the average weekly wage was **$1,167.11**.

On the date of accident, Petitioner was **58** 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 **$20,785.59** for TTD, benefits, for a total credit of **$20,785.59**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$778.07**/week for **32 4/7** weeks, commencing **March 9, 2013**, through **October 22, 2013**, as provided in Section 8(b) of the Act. Respondent shall be given a credit for the temporary total disability benefits that have been paid.

Respondent shall pay the medical bills in Petitioner's Exhibit 12 pursuant to sections 8(a) and 8.2 of the Act. Respondent shall be given a credit to the extent it had made payments toward these medical bills.

Respondent shall provide the left total knee replacement surgery recommended by Dr. Sporer and appropriate postoperative care, pursuant to sections 8(a) and 8.2 of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of 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 the ***final*** cost of the arbitration transcript and attaches a copy of the check to the *Petition*; and 3) perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

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

Signature of Arbitrator

11/1/2013
Date

NOV - 4 2013

14IWCC0113

FINDINGS OF FACT AND CONCLUSIONS OF LAW

On April 2, 2013, Petitioner filed an application for adjustment of claim, alleging that on March 8, 2013, he sustained accidental injuries to his knees and left hip that arose out of and in the course of his employment with Respondent.

Petitioner testified that he worked as a truck driver for Respondent since 1988, most recently as a pickup and delivery driver. He made 10 to 15 delivery stops a day, and his job duties included unloading product at delivery stops. He used a hydraulic, "man powered" pallet jack to unload pallets of product. The jack was not electrically powered. Petitioner denied prior treatment for either knee or left hip. On cross-examination, Petitioner admitted having knee pain every so often, along with body aches and pains, attributing them to the physical nature of his job. The medical records in evidence from Petitioner's primary care physician show no prior treatment related to either knee or left hip.

Petitioner further testified that on March 8, 2013, he was performing his usual pickup and delivery duties. One of his stops was at Valtech to pick up a skid weighing in excess of 1,400 pounds. Petitioner backed into the loading area, and a Valtech employee used a forklift to load the skid into the back of the trailer. Petitioner then had to use a pallet jack to move the skid to the front of the trailer. Petitioner described the accident as follows:

> "I went and got my pallet jack secured, untied it, brought it back, jacked up the pallet and pulled it back about 15, maybe 20 feet inside the trailer. And I had a 45 foot trailer.
>
> Q. It the pallet in front of you at this time or behind you?
>
> A. The pallet's in front of me and I'm walking backwards pulling it.
>
> ***
>
> I got about *** 15, 20 feet, about halfway within the trailer somewhere. And I stopped it. And going to start pushing it to turn it around and push it the rest of the way.
>
> ***
>
> As I stopped it, you try to do it all in one motion, especially with a heavy pallet. *** You get an anchor, stop it and pushing—you don't stop and wait. You try to keep it rolling somehow.
>
> And I started pushing it, and I don't know if I took one or two steps. I know I had—just going to start to turn it to spin it around, and I heard a pop in my knee.
>
> Q. Which knee?

A. I believe it was my left knee.

Q. What happened?

A. It was like somebody pulled a rug out from under me.

Q. And did you fall?

A. I fell. I went down.

Q. What position did you fall on—or into?

A. I fell on my knees and went over onto—rolled almost I felt like I bounced onto my hip is what it felt like to me."

Petitioner testified that he felt pain in the knees, especially the left knee. One leg was underneath him. He "felt like somebody whacked [him] with a baseball bat or a hammer in [his] knee and [his] hip." It took Petitioner approximately 5 minutes to get up. He secured the pallet and the jack right where they were, climbed out of the trailer with difficulty and called his dispatcher, Darrin Marsh. Ultimately, Petitioner was able to drive to the terminal. At the terminal, Petitioner and Mr. Marsh completed an accident report. Mr. Marsh also took Petitioner's videotaped statement of the accident. After that, Mr. Marsh sent Petitioner for treatment to Concentra. Subsequently, on March 12, 2013, Phil Scoggins, a risk manager for Respondent, called Petitioner and took his recorded statement.

The accident report in evidence states that Petitioner reported falling in the back of the trailer while making a pickup, injuring both knees and left hip. Petitioner described the accident as follows: "I was moving pallet (1440 lbs) when I felt and heard my left knee crack and went out from under me."

The medical records in evidence show that on March 8, 2013, Petitioner saw Dr. Taiwo at Concentra, who recorded the following history: "Using pallet jack to move heavy skid left knee popped and gave out fell." Petitioner reported falling on his left side, and complained of severe pain in the left hip and knee. Gross examination of the left knee revealed no swelling, deformity, effusion, mass, wound or ecchymosis. The range of motion of the knee and hip was difficult to assess because of complaints of pain. Dr. Taiwo ordered X-rays, provided Petitioner with crutches and released him to return to work on sedentary duty. On March 11, 2013, Petitioner followed up at Concentra, reporting no improvement. X-rays showed osteoarthritis of both knees and mild osteoarthritis of the left hip. On March 14, 2013, Petitioner began physical therapy at Concentra. Petitioner consistently described to the physical therapist significant pain in the left knee and left hip, and mild pain in the right knee. On March 20, 2013, Petitioner followed up with Dr. Ross at Concentra, reporting persistent pain in the left knee and hip and stating that the right knee pain was "resolving." Dr. Ross instructed Petitioner to continue physical therapy and kept him on sedentary duty. On March 27, 2013, Petitioner followed up with Dr. Ross, reporting no improvement in the left knee or hip and stating that the right knee

was "better." Dr. Ross referred Petitioner to an orthopedic surgeon and kept him on sedentary duty.

On April 1, 2013, Petitioner consulted Dr. Verma, an orthopedic surgeon. In his testimony, Petitioner explained that his wife had a good experience with another surgeon at Midwest Orthopaedics at Rush. Petitioner called Midwest Orthopaedics at Rush and asked which doctor could see him as soon as possible. The staff scheduled him to see Dr. Verma. Dr. Verma's clinical note from April 1, 2013, states the following history: "[The patient] presents today for evaluation of his bilateral knees. He reports a history of an injury, which occurred on 03/08/2013. At that time, he was performing his normal occupation as a driver for [Respondent]. *** He states that he was pushing a pallet when he slipped and fell, landing directly onto the anterior aspect of both knees." Petitioner complained of significant symptoms in the left knee and milder symptoms in the right knee. Dr. Verma noted that Petitioner walked with an antalgic gait, using a crutch. Dr. Verma reviewed the X-rays, noting significant degenerative changes in the knees. He opined that Petitioner "has had an aggravation of preexisting degenerative disease with knee contusion, left greater than right," performed a steroid injection into each knee, and took Petitioner off work. On April 22, 2013, Petitioner followed up with Dr. Verma, complaining of left significantly greater than right knee pain as well as left hip pain. Dr. Verma referred Petitioner to Dr. Sporer, also at Midwest Orthopaedics at Rush, stating that Petitioner "has essentially bone-on-bone articulation on the medial side." Dr. Verma also wanted Dr. Sporer to evaluate the left hip.

On May 15, 2013, Dr. Lieber, an orthopedic surgeon, examined Petitioner at Respondent's request. Dr. Lieber recorded the following history: "The petitioner states that while using a pallet jack pushing about 1800 pounds of material with the pallet jack and spinning, twisted felt a popping in his right knee and fell down on the ground, sustaining injury to his left knee and hip. He states that he struck his right knee on the pallet jack." Petitioner complained of pain in the knees and left hip. Dr. Lieber noted that Petitioner walked with an antalgic gait, using crutches. X-rays showed degenerative osteoarthritis of the knees with varus deformity and "medial joint line bone on bone," the left knee worse than the right, and minor degenerative changes in the left hip. Dr. Lieber felt Petitioner's subjective complaints of pain in the knees and left hip were out of proportion of the objective findings, noting "significant magnification behavior." Dr. Lieber diagnosed osteoarthritis of the knees and minor degenerative osteoarthritis of the left hip, opining that "Petitioner's current abnormalities are related to pre-existing abnormalities that are not related to the work event of March 8, 2013," and Petitioner's "[c]omplaints are degenerative in nature, non-traumatic. There is no evidence of any acceleration, aggravation of the underlying degenerative osteoarthritis that can be related to March 8, 2013 traumatic event." Dr. Lieber thought Petitioner might require a total left knee replacement. However, any medical treatment for the knees or left hip or any restrictions would not be related to the work accident because Petitioner had reached maximum medical improvement with respect to the work accident.

On June 12, 2013, Petitioner consulted Dr. Sporer. Dr. Sporer recorded the following history: "The patient *** states that he had injury to his knees on 03/08/2013. At that time, he was working as a driver for [Respondent]. He states, he was pushing a pallet when it slipped and landed directly on to the anterior aspect of his knees." Petitioner admitted "very infrequent

intermittent knee pain" and stated that his symptoms became significantly worse after the accident. Dr. Sporer reviewed the X-rays, noting that they showed severe degenerative arthritis of the medial compartment with moderate patellofemoral degenerative changes in both knees. The left hip appeared to show well preserved articular surface. Dr. Sporer opined that "the majority of [the] symptoms are related to severe underlying left knee degenerative arthritis," and recommended left knee replacement surgery. Regarding the left hip, Dr. Sporer recommended completing treatment for the left knee before further evaluating the hip. In an addendum dated July 5, 2013, Dr. Sporer opined that Petitioner's "current knee pain is an aggravation of a pre-existing medical condition due to the alleged injury on 03/08/2013."

Dr. Lieber testified via evidence deposition on September 12, 2013, that X-rays of the left knee, taken March 11, 2013, showed significant preexisting degenerative findings, without evidence of significant recent trauma. Dr. Lieber explained that he based his opinion of symptom magnification "[j]ust [on] the antalgic gait and the use of *** crutches." Regarding causal connection, Dr. Lieber stated:

> "From the standpoint that in relation to the March 8th, 2013 event, there was no relationship to the underlying degenerative abnormalities in that event, that there was no relationship to the present symptomatic complaints in that event, and there was no objective evidence of any acceleration or aggravation of his degenerative joint disease in that of the March 8th, 2013 event."

Dr. Lieber continued that the mechanism of injury was "minor in nature and was not significant enough to cause any significant further damage to the joint that would either require joint replacement surgery just because of that isolated event and/or evidence from an objective standpoint of any changes in the soft tissues, the bone or the cartilaginous surfaces." Dr. Lieber opined that the conditions of Petitioner's knees and left hip would have been the same, regardless of the March 8, 2013, accident. Dr. Lieber agreed that Petitioner's knee condition required further treatment and work restrictions, maintaining that neither the treatment nor the restrictions would be related to the work accident.

On cross-examination, Dr. Lieber agreed that the symptoms Petitioner voiced to the Concentra staff on March 8, 2013, stemmed from the work accident, and the follow-up visits to Concentra on March 11, 2013, March 20, 2013, and March 27, 2013, also resulted from the work accident. Further, Dr. Lieber agreed that Petitioner's visits to Dr. Verma on April 1, 2013, and April 22, 2013, were causally related to the work accident. However, Dr. Lieber opined that as of April 22, 2013, Petitioner was at maximum medical improvement and required no further treatment as a result of the work accident, explaining: "I feel that his symptoms aren't related to the injury anymore." The following colloquy then occurred:

> "Q. Would you admit that the medical records you reviewed prior to your independent medical evaluation support or suggest that his condition relative to his left knee, right knee and left hip became significantly worse after the accident?
>
> A. No. His subjective complaints became worse, but there's no objective evidence that his condition became worse, so I guess that's the definition of what

your condition is. I'm saying that his subjective complaints became worse; objective findings in my opinion, no.

***

Q. What I asked you was would you admit that per [Petitioner] his condition became significantly worse after the accident?

A. His subjective—again, I don't know what you mean by 'condition.' Condition could mean objective and subjective findings, could mean diagnostic findings. I don't know. I don't like the word condition. So I'm saying no to that.

Q. Okay. Let me rephrase it then so you can admit or deny. Would you admit that his subjective complaints relative to his right knee, left knee and left hip became significantly worse after this accident?

A. Yes.

Q. Would you admit that the accident is a contributing cause to the need for the additional treatment that you recommended?

A. No.

***

The need for further treatment is not related to the injury."

The colloquy continued:

"Q. Would you agree with me that [Petitioner] had the ability to perform his full-duty work activities prior to this accident?

A. Yes.

Q. Would you agree with me that subsequent to this accident he has an inability to perform the same full-duty activities regardless of your opinion on causation?

A. Yes.

Q. Would you agree with me that petitioner, Mr. Bort, would probably have gone on to require the treatment you are recommending, Doctor Sporer is recommending or Doctor Verma is recommending at some point in time in the future given his age and his condition?

A. Yes.

Q. Would you agree with me that this injury was responsible in part for hastening the need for his treatment, a/k/a moving up the time frame of this eventual treatment?

A. No."

Upon further questioning, Dr. Lieber agreed that Petitioner's symptoms had not abated between the time of the accident and the examination on May 15, 2013, and as of May 15, 2013, and as of the date of the consultation with Dr. Sporer on June 12, 2013, Petitioner had not returned to his baseline level of functioning. Further, Dr. Lieber agreed that Petitioner's preexisting degenerative condition made him more vulnerable to injury.

Dr. Sporer testified via evidence deposition on August 23, 2013, that Petitioner's primary complaints related to his left knee. Regarding the mechanism of injury, Dr. Sporer understood that Petitioner was pushing a pallet when it slipped and Petitioner landed directly on the anterior aspect of his knees. Dr. Sporer diagnosed degenerative arthritis of the knees and possible intraarticular pathology of the left hip, and reiterated his recommendation for left total knee replacement and completing treatment for the left knee before further evaluating the left hip. Based on the chain of events, Dr. Sporer opined the work accident aggravated the underlying degenerative arthritis and accelerated the need for left knee replacement surgery. Dr. Sporer admitted the recorded mechanism of injury in his note could contain a typographical error. When given a hypothetical consistent with Petitioner's testimony, Dr. Sporer testified the hypothetical did not change his causation opinion or treatment recommendation, explaining that he based his causation opinion mainly on the chain of events, rather than a precise mechanism of injury.

Petitioner testified that he had not seen Dr. Sporer since June 12, 2013. Petitioner further testified that Respondent has not authorized the left knee replacement surgery or any other treatment for his injuries, and he received no treatment for his injuries since June 12, 2013. No doctor released him to return to work full duty, and Respondent has not offered him any light duty work. Respondent stopped paying temporary total disability benefits as of September 12, 2013, stating it was not responsible for a preexisting condition. Petitioner did not know whether any of the medical bills from Dr. Verma or Dr. Sporer remained unpaid.

On cross-examination, Petitioner described the accident as follows:

"I was pushing a pallet—and I believe it was my left knee. I heard a pop and I—both my legs went out from under me. When I heard the pop I believe it was my left knee. And that—cause that's what I went down on first.

It happened so fast. It was less than a second from one—I started by pushing, and I was—the next thing I was on the ground. And the main thing I was worried about was where that pallet was going. I didn't want it to come back and roll over."

In support of the Arbitrator's decision regarding (C), did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

Respondent highlights the inconsistencies in the descriptions of the injury between Petitioner's testimony, the accident report and the various histories recorded by the medical providers. In its opening statement, Respondent characterized the histories as "slightly inconsistent." In its closing statement, Respondent conceded the history recorded by Dr. Sporer likely contained a typographical error. However, in its proposed decision, Respondent contends that "Petitioner's stories and testimony are inconsistent and unreliable," and "Petitioner cannot be assumed to be credible in a case in which he has given no less than five different mechanisms of injury." Respondent asserts that the early descriptions of the injury did not show "direct trauma" to either knee or left hip. Further, Respondent relies on Dr. Taiwo's examination of the left knee on March 8, 2013, which revealed no swelling, deformity, effusion, mass, wound or ecchymosis, and Dr. Lieber's reading of the X-rays performed March 11, 2013, as showing no evidence of significant recent trauma.

Petitioner points out that Respondent did not introduce into evidence his videotaped statement or his recorded statement, and asks the Arbitrator to draw an inference that Respondent withheld the evidence under its control because it is adverse to Respondent's position.

Having carefully reviewed the record and observed Petitioner's demeanor, the Arbitrator finds Petitioner credible. In particular, the Arbitrator finds credible Petitioner's testimony that the accident happened very quickly. During his testimony, Petitioner tried his best to describe the accident. The gist of Petitioner's testimony is his left knee popped and gave out while he was maneuvering a 1,400 pound pallet toward the front of the trailer. He fell to his knees and then his side. The Arbitrator infers from Respondent's withholding of the evidence under its control that the videotaped statement and the recorded statement corroborate Petitioner's testimony. See Szkoda v. Human Rights Comm'n, 302 Ill. App. 3d 532, 544 (1998); Reo Movers, Inc. v. Industrial Comm'n, 226 Ill. App. 3d 216, 223 (1992) ("Where a party fails to produce evidence in his control, the presumption arises that the evidence would be adverse to that party").

For the foregoing reasons, the Arbitrator finds Petitioner proved a compensable accident.

In support of the Arbitrator's decision regarding (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner relies on the chain of events and the opinions of Dr. Sporer and Dr. Verma. Petitioner contends the work accident caused a mostly asymptomatic preexisting condition to become highly symptomatic, preventing him from performing his regular job duties. Respondent, on the other hand, relies on the opinion of Dr. Lieber that Petitioner's current condition is in no way related to the work accident.

It is undisputed that Petitioner had significant preexisting degenerative osteoarthritis of the knees when he sustained work injuries on March 8, 2013. However, it is well established that "[a]ccidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being." Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193, 205 (2003). The Arbitrator finds the opinion of Dr. Sporer to be far more credible than the opinions of Dr. Lieber. The Arbitrator finds the opinions of Dr. Lieber to be conclusory, bordering on intellectual dishonesty, and his deposition testimony to be evasive. Amongst other things, the Arbitrator finds troubling Dr. Lieber's pronouncement that Petitioner was magnifying his symptoms because he walked with an antalgic gait and used crutches to ambulate (presumably the crutches given to him by Dr. Taiwo), even though Dr. Lieber contemporaneously diagnosed significant degenerative arthritis of the knees, which was bone on bone in the area of medial joint line, and agreed that Petitioner might require a left total knee replacement. Furthermore, the Arbitrator finds Dr. Lieber's opinion that Petitioner had reached maximum medical improvement by April 22, 2013, to be arbitrary and illogical. Based on the chain of events and the opinion of Dr. Sporer, the Arbitrator finds Petitioner's current left knee condition is causally connected to the work accident, and Petitioner has not yet reached maximum medical improvement. See International Harvester v. Industrial Comm'n, 93 Ill. 2d 59, 63-64 (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"); Twice Over Clean, Inc. v. Industrial Comm'n, 214 Ill. 2d 403 (2005) (The work activity must be a causative factor in hastening the onset of the disabling condition). As to Respondent's argument that Petitioner did not sustain "direct trauma" to the knees, the Arbitrator notes that even Dr. Lieber agreed Petitioner's preexisting degenerative condition made him more vulnerable to injury. It bears repeating that Petitioner was injured while maneuvering a 1,400 pallet with a non-electrical pallet jack.

The Arbitrator declines to make findings regarding the right knee condition or the left hip condition. The Arbitrator finds the record to be insufficiently developed to make well reasoned findings, which would become law of the case, with respect to these conditions.

In support of the Arbitrator's decision regarding (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 awards the medical bills in Petitioner's Exhibit 12 pursuant to sections 8(a) and 8.2 of the Act.

The parties stipulated that Respondent should be given a credit to the extent it made payments toward these medical bills.

In support of the Arbitrator's decision regarding (K), is Petitioner entitled to any prospective medical care, the Arbitrator finds as follows:

The Arbitrator finds that the work accident aggravated the preexisting left knee condition and accelerated the need for knee replacement surgery. Accordingly, the Arbitrator awards the left total knee replacement surgery recommended by Dr. Sporer and appropriate postoperative care.

In support of the Arbitrator's decision regarding (L), what temporary benefits are in dispute, the Arbitrator finds as follows:

The Arbitrator awards temporary total disability benefits in the sum of $778.07 per week for a period of 32 4/7 weeks, from March 9, 2013, through the date of the arbitration hearing on October 22, 2013.

In support of the Arbitrator's decision regarding (M), should penalties or fees be imposed upon Respondent, the Arbitrator finds as follows:

Petitioner seeks penalties and attorney fees for nonpayment of temporary total disability benefits after September 12, 2013, asserting that Respondent's reliance on Dr. Lieber's opinions was unreasonable.

As discussed, the Arbitrator has found Dr. Lieber's opinions to be conclusory and not credible. Nevertheless, Respondent could reasonably dispute causal connection between the accident and the recommendation for left knee replacement, given that Dr. Taiwo's examination of the left knee on March 8, 2013, revealed no swelling, deformity, effusion, mass, wound or ecchymosis.

The Arbitrator finds that penalties and attorney fees are not warranted under the circumstances.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Frank Ojeda,

Petitioner,

14IWCC0114

vs.

NO: 09 WC 09141

City of Chicago,

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, prospective medical expenses, causal connection, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 22, 2013 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.

14IWCC0114

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: FEB 19 2014

David L. Gore

DLG/gal
O: 2/6/14
45

Stephen Mathis

Mario Basurto

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

OJEDA, FRANK
Employee/Petitioner

Case# **09WC009141**

14IWCC0114

CITY OF CHICAGO
Employer/Respondent

On 3/22/2013, 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 0.11% 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:

0009 ANESI OZMON RODIN NOVAK KOHEN
JEFFREY ALTER
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
BRANDON DEBERRY ESQ
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)

14IWCC0114

Frank Ojeda
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **09** WC **09141**

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 **Svetlana Kelmanson**, Arbitrator of the Commission, in the city of **Chicago**, on **February 8, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0114

FINDINGS

On the date of accident, **1/6/2009**, 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 $**60,153.60**; the average weekly wage was $**1,156.80**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **1** dependent child.

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

Petitioner was temporarily totally disabled from **January 7, 2009**, through **July 6, 2012**.

Petitioner is entitled to maintenance benefits from **July 7, 2012**, through **February 8, 2013**.

Respondent shall be given a credit of $**139,895.74** for TTD and $**24,678.40** for maintenance benefits, for a total credit of $**164,574.14**.

ORDER

Respondent shall pay the medical bills in Petitioner's Exhibit 12 pursuant to sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for the sums it paid toward these bills.

Respondent shall provide the knee replacement surgery recommended by Dr. Luu and further necessary and related care for the left knee condition

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

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

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

Signature of Arbitrator

3/22/2013
Date

ICArbDec19(b)

MAR 22 2013

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The issues in the instant 19(b) proceeding are limited to causal connection, medical expenses and prospective medical care related to Petitioner's left knee condition. All other issues are reserved for further proceedings.

Petitioner testified that he worked for Respondent as a union laborer since 1982. Petitioner had undergone arthroscopic surgery on his left knee in 1993. He denied any treatment or problems with his left knee after recovering from the surgery, and testified that he returned to work for Respondent full duty.

Petitioner further testified that on January 6, 2009, he was assigned to the garbage collection detail. His job duties were to walk behind the garbage truck, collecting garbage and discarded bulky items and depositing them into the garbage truck. At one point, while crossing into the next alley, Petitioner slipped on a patch of ice. He tried to grab hold of a fence with his right arm, but ended up falling backward, pinning his left leg under him and striking his head on the cement. After the fall, Petitioner had some difficulty getting up. He developed a headache, swelling in the left knee and pain in the right shoulder. He reported the accident and sought treatment for his injuries. The accident report in evidence describes the accident as follows: "While laborer was walking to next alley, laborer slid on a patch of ice that was covered by snow – left knee buckled – while falling laborer landed on back hurting his back, neck and right shoulder." Petitioner explained on cross-examination that the left knee popped when it got pinned behind him, and gave out after the fall. He attempted to work for approximately half an hour after the accident, but could not continue because of the pain.

Petitioner further testified that he sought treatment with Dr. Pye at one of Respondent's company clinics. The medical records from Dr. Pye show that Petitioner reported slipping and falling on ice while performing his job duties, explaining that his left knee buckled and popped, and he landed with the knee flexed and the ankle plantar flexed against the ground. Petitioner complained of sharp prepatellar anterior knee pain, and pain in the neck and right shoulder. Dr. Pye prescribed physical therapy and took Petitioner off work. An MRI of the left knee performed January 7, 2009, showed: diffuse erosion of the medial compartment articular cartilage to the bone, with prominent reactive edema and sclrerosis; prominent osteophytes arising from the articular margins of all three compartments; chronic tearing of the posterior horn of the medial meniscus; a tear at the root of the posterior horn of the lateral meniscus; and an absent anterior cruciate ligament. On January 9, 2009, Petitioner followed up with Dr. Pye, complaining of posterior headaches and pain in his back, right shoulder and left knee. Dr. Pye recommended continuing physical therapy and referred Petitioner to Dr. Morgenstern for evaluation and treatment of the left knee condition. On January 20, 2009, Petitioner followed up with Dr. Pye and complained of persistent headaches and pain in his neck, right shoulder and left knee. An MRI of the cervical spine, performed January 22, 2009, showed a disc protrusion at C6-C7. An MRI of the right shoulder, also performed January 22, 2009, showed degenerative changes and evidence of impingement. Petitioner continued to follow up with Dr. Pye through February of 2009, complaining of pain in the neck, back and left knee.

Petitioner testified that he limped badly in January and February of 2009. On March 4, 2009, Petitioner went to MercyWorks at Respondent's request. The medical records from MercyWorks show Petitioner complained of headaches and pain in his neck, back, right shoulder and left knee, rating the left knee pain an 8/10. Dr. Diadula noted that Petitioner planned to see specialists of his choosing, and kept Petitioner off work. During subsequent follow-up visits, Dr. Diadula noted that Petitioner had difficulty getting an appointment with Dr. Ho for his left knee condition.

On May 1, 2009, Petitioner consulted Dr. Goldberg regarding his cervical and lumbar spine complaints. Dr. Goldberg diagnosed mechanical neck and low back pain, recommended continuing physical therapy, and instructed Petitioner to follow up with Dr. Diadula.

On June 19, 2009, Petitioner consulted Dr. Ho regarding his left knee and right shoulder conditions. Dr. Ho examined Petitioner, reviewed the diagnostic studies, and diagnosed an "end-stage arthritic knee on the left with ACL deficient knee and a mensical tear with may or may not be significant." Dr. Ho advised Petitioner that "given the arthritic nature of his knee that any work done for his mechanical symptoms and his meniscal tear would likely not be very beneficial to him and that he ultimately needs a total knee replacement." With regard to the right shoulder, Dr. Ho diagnosed a partial rotator cuff tear. Dr. Ho prescribed physical therapy for both conditions and performed a Kenalog injection into the left knee. On August 4, 2009, Petitioner followed up with Dr. Ho and reported no significant relief with the injection. He also complained of persistent right shoulder symptoms. Dr. Ho referred Petitioner to Dr. Luu to evaluate the appropriateness of left knee replacement. On September 18, 2009, Petitioner followed up with Dr. Ho, who recommended a right rotator cuff repair and performed a Synvisc injection into the left knee. On September 25, 2009, Dr. Ho performed a second Synvisc injection into the left knee, and on October 2, 2009, Dr. Ho performed an Orthovisc injection into the left knee. On November 24, 2009, Petitioner followed up with Dr. Ho, complaining of persistent symptoms in the right shoulder and left knee. Dr. Ho prescribed an unloader knee brace and reiterated his recommendation to consult Dr. Luu about left knee replacement.

On December 14, 2009, Dr. Raab examined Petitioner at Respondent's request with respect to his left knee condition. Dr. Raab also diagnosed end stage osteoarthritis of the left knee, opining that the MRI findings were preexisting, but conceding it is possible the accident aggravated the preexisting condition. Dr. Raab recommended a total knee replacement surgery, opining that Petitioner "would have required total knee arthroplasty with or without his reported work related injury of January 6, 2009."

On January 12, 2010, Petitioner followed up with Dr. Ho, complaining of pain in the neck, right shoulder and left knee. Dr. Ho opined the left knee arthritis "was preexisting but that it was aggravated by [the patient's] fall and that the aggravation continues to affect his ability to return to work." Regarding the neck condition, Dr. Ho referred Petitioner to Dr. Gupta. Petitioner began treating with Dr. Gupta on February 3, 2010. On February 23, 2010, Petitioner followed up with Dr. Ho and continued to complain of pain in his neck, right shoulder and left knee, reporting that the shoulder was his main problem. Dr. Ho put the knee treatment "on hold" and focused on the right shoulder condition. On March 25, 2010, Dr. Ho operated on the right shoulder. During postoperative follow-up visits, Dr. Ho noted that Petitioner's left knee

condition remained essentially unchanged. On January 27, 2011, Dr. Ho issued a narrative report, stating:

> "The patient's x-rays and MRI findings *** are consistent with a likely chronic ACL-deficient left knee, medial compartment arthritis, and a medial meniscus tear. It is likely that the ACL tear and arthritis pre-date his injury by many years and were therefore asymptomatic prior to his fall and injury. It is not uncommon for patients to develop arthritis slowly over many years without noticing any pain in the knee, until a fall or new injury becomes the 'straw that breaks the camel's back,' the new injury in this case being the meniscus tear, or possibly the further bruising or breakdown of the arthritic compartments of his knee. In medical terminology this would be considered an 'acute-on-chronic' injury.
>
> The medial meniscus tear was likely caused by, or further torn by the fall and is likely contributing to his post-injury pain. It is not clear what percentage of his current knee pain is being caused by the meniscus tear, and what percentage is being caused by the arthritis."

Dr. Ho recommended arthroscopic surgery to address the acute injuries to the knee, followed by a partial knee replacement several years later, followed by a total knee replacement after the age of 60. Dr. Ho opined: "Given the findings of a complex medial meniscus tear, and the lack of any knee symptoms prior to his fall, it is my opinion that the fall caused or extended the meniscus tear and permanently aggravated his underlying, previously asymptomatic knee arthritis. The treatment recommendations outlined above are therefore related to his fall, the arthroscopy directly so and the unicompartmental and total knee replacements secondarily so."

Beginning in August of 2010, Petitioner mainly focused on his neck condition. On January 31, 2011, Dr. Gupta performed fusion surgery at C6-C7. Petitioner's postoperative recovery was slow, and he complained of persistent symptoms. On January 21, 2012, and February 27, 2012, Dr. Gupta noted that Petitioner's left knee condition precluded work hardening. A functional capacity evaluation performed February 28, 2012, put Petitioner's capabilities at the medium physical demand level, noting complaints of pain in the neck, right shoulder and left knee. The physical therapist opined Petitioner could not return to his regular job duties as a garbage collector.

On June 29, 2012, Petitioner consulted Dr. Luu regarding his left knee condition. Dr. Luu diagnosed end stage osteoarthritis with a varus deformity and recommended a total knee replacement surgery.

Petitioner testified that he delayed consulting Dr. Luu regarding his left knee condition because Respondent did not authorize the consultation. Petitioner's group insurance carrier paid for the visit on July 3, 2012. Respondent did not authorize the knee replacement surgery.

Petitioner introduced into evidence a letter from Respondent, dated October 12, 2012, stating that his restrictions precluded him from returning to his job as a laborer and asking him to

look for work. Petitioner testified that he has been looking for work. However, he suffers from constant pain in his left knee, which causes him to walk "off balance" and affects his ability to perform activities of daily living. Petitioner takes prescription medication once or twice a day to help alleviate the pain. He would like to proceed with the knee replacement surgery recommended by Dr. Luu.

In support of the Arbitrator's decision regarding (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

The Arbitrator finds Petitioner's left knee condition is causally connected to the work accident. The Arbitrator relies on the chain of events and Dr. Ho's narrative report. The Arbitrator notes Dr. Raab conceded it is possible the work accident aggravated preexisting pathology in the left knee.

In support of the Arbitrator's decision regarding (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 parties stipulate Respondent is liable for the medical bills in Petitioner's Exhibit 12, with the exception of the medical bills for treatment of Petitioner's left knee condition after December 14, 2009. Having found that Petitioner's left knee condition is causally connected to the work accident, the Arbitrator awards the medical bills in Petitioner's Exhibit 12 pursuant to sections 8(a) and 8.2 of the Act, giving Respondent credit for the sums it paid toward these bills.

In support of the Arbitrator's decision regarding (K), is Petitioner entitled to any prospective medical care, the Arbitrator finds as follows:

The Arbitrator finds the work accident accelerated the need for knee replacement surgery. The Arbitrator awards the knee replacement surgery recommended by Dr. Luu and further necessary and related care for the left knee condition.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jorge Reyes,

Petitioner,

14IWCC0115

vs.

NO: 12 WC 15700

Greco and Sons, 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, prospective medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission hereby adopts the Arbitrator's findings of fact and conclusions of law. 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 2, 2013 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.

14IWCC0115

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 $15,000.00. 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: FEB 19 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gal
O: 2/6/14
45

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

REYES, JORGE
Employee/Petitioner

Case# **12WC015700**

14IWCC0115

GRECO AND SONS INC
Employer/Respondent

On 7/2/2013, 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 0.08% 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:

2932 KUGIA & FORTE PC
MARTIN V KUGIA
711 W MAIN ST
WEST DUNDEE, IL 60118

0560 WIEDNER & MCAULIFFE LTD
DAN SIMONES
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC0115

Case # 12 WC 15700

Jorge Reyes
Employee/Petitioner

v.

Greco and Sons, 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 **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rockford**, on **May 14, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0115

FINDINGS

On the date of accident, **February 24, 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 **$46,800.00**; the average weekly wage was **$900.00**.

On the date of accident, Petitioner was **35** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$0.00** for TTD, **$4,059.42** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$4,059.42**.

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

ORDER

Respondent shall authorize and pay the reasonable, necessary, and causally related expenses associated with the arthroscopic right elbow surgery and the right carpal tunnel release prescribed for the Petitioner by his treating physician, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Arbitrator Anthony C. Erbacci

June 26, 2013
Date

12 WC 15700
ICArbDec19(b)

JUL - 2 2013

FACTS:

14IWCC0115

The Petitioner is a 35 year old delivery driver for the Respondent, where he has worked for more than 6 years. He speaks Spanish and testified through an interpreter. He was injured at work on February 24, 2012 when he slipped on fell off the back of his truck. He testified that as he fell, his back hit the top of the ramp connected to the back of his truck, and then he fell to the asphalt ground. His right hand hit the ground first. His right hand slid on the snow and then his elbow hit the asphalt hard. He reported the accident immediately and finished his shift.

The Petitioner was seen the same day as the accident after work at a CDH Convenient Care Center where he gave a history of falling off a ramp on the truck that morning. He complained of buttock pain from hitting his buttock on the ramp, slight tingling to his right hand, and inability to move his right elbow due to pain. The exam revealed slightly diminished grip strength on the left hand (the Petitioner testified that he is right hand dominant) and the doctor was unable to examine the right arm due to his elbow pain. The clinic took x-rays of the right arm, placed him on light duty, and gave him a sling to wear on his right arm.

The Petitioner testified that he began wearing the sling, began consuming the prescribed Vicodin for his pain, and began working light duty. The Respondent provided the Petitioner with a helper to assist with his duties. The Petitioner followed up several times with Central DuPage Business Health. On his visit of March 8, 2012 the records reflect: "Right elbow feels worse. Now it clicks and locks." The records of that date also note that there is "visual and audible clicking" of the right elbow. The doctor ordered an MRI, continued his light duty status, and prescribed 800 mg of ibuprofen twice a day. On his March 15, 2012 visit the records document similar findings and the doctor referred him to an orthopedic physician.

The Petitioner testified that he was referred to Orthopedic Associates of DuPage. Those records indicate he was seen by Dr. Ling on March 20, 2012. The history noted indicate the Petitioner fell off the back of his truck and "his right hand slid on the snow and he hit his right elbow as well." The record indicates his body also fell onto his right upper extremity. The Petitioner complained of increasing pain and locking in his right elbow and decreased range of motion. Dr. Ling reviewed the MRI results and observed that the Petitioner has a congenital bone fusion of the proximal radial ulnar joint in his elbow, causing him to have no forearm rotation. This is a congenital condition in both his right and left elbows. The MRI also showed "mild common extensor tendinopathy" in the right elbow. The Petitioner stated that his range of motion in his right arm "has not returned to baseline which was essentially full elbow arc of motion. He has had some numbness and tingling which was not present before the injury." Dr. Ling's exam noted his right elbow range of motion was from 30 to 100 degrees, compared to the uninvolved left elbow which was from 0 to 145 degrees. She also noted positive Tinel's and positive median nerve compression test in the right wrist. Her Assessments were that the Petitioner had: "(1)Internal derangement in the right elbow (may be from loose body or capsular flap), (2) Numbness and tingling in the right upper extremity (new onset since the injury), and (3) Mr. Reyes may have sustained contusion to the

median nerve at the time of the fall." Dr. Ling ordered an EMG/NCS and stated that he will most likely need surgical intervention for the right elbow. She referred him to her partner, Dr. Makowiec.

Dr. Makowiec evaluated the Petitioner on April 5, 2012. The Petitioner gave a history of slipping off the back of his truck and landing on his outstretched right upper extremity. The Petitioner complained of painful locking and clicking to his right elbow and numbness and tingling in his right hand. Dr. Makowiec noted that the Petitioner has a history of restricted motion in his elbow due to a congenital synostosis; however, the Petitioner stated that the synostosis only limited his pronation and supination and that he has always been able to brush his hair and shave using his right upper extremity. The doctor observed that he was wearing a splint on his right elbow.

Dr. Makowiec's exam noted an audible click in the right elbow consistent with the Petitioner's complaints of a painful clicking. The Petitioner also had positive Tinel's and Phalen's signs. Dr. Makowiec noted that the Petitioner's history and exam were consistent with internal derangement such as a loose body or cartilaginous flap, although he could not see one on the x-rays or MRI. Dr. Makowiec noted that the images could be clouded somewhat by the fact that the Petitioner has atypical anatomy at the elbow. Dr. Makowiec recommended arthroscopic surgery of the Petitioner's right elbow and a right carpal tunnel release.

The Respondent had the Petitioner examined by Dr. Heller on May 22, 2012. With respect to the right hand, Dr. Heller opined that it was unlikely that the Petitioner's fall of February 24, 2012 was primarily responsible for the right carpal tunnel syndrome. He opined that the accident may have caused a temporary exacerbation of underlying carpal tunnel syndrome that likely resolved within six weeks. With respect to the right elbow, Dr. Heller opined that it was unlikely that the fall was "primarily responsible" for the Petitioner's current elbow symptoms. He opined that it was more likely that the elbow symptoms were from the Petitoner's pre-existing congenital condition. With regard to treatment, Dr. Heller agreed all treatment to date was reasonable, and he stated that he did not disagree with Dr. Makowiec's proposed arthroscopic elbow surgery and carpal tunnel release.

At the Request of his attorney, the Petitioner was examined by Dr. Dana Tarandy on October 18, 2012. Dr. Tarandy agreed with Dr. Makowiec's proposed arthroscopic elbow surgery and carpal tunnel release, and he opined that those conditions and surgeries are causally related to the Petitioner's work accident.

The Petitioner testified that prior to the work accident, he had never experienced any pain or clicking in his right elbow and did not have any trouble performing his job duties and did not have any trouble performing activities of daily living, including shaving and combing his hair which are painful now. He also did not have any right hand pain or tingling before the work accident. He also testified that he has the identical congenital condition in both elbows and does not have any pain or tingling or clicking or problems using the left hand or elbow which were not involved in this accident.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

It is not disputed that the Petitioner had a work related accident when he fell and landed on his right hand and right elbow, and that he needs surgery to address his symptoms in both. The Petitioner has provided consistent histories to all of the doctors and those histories indicate that he subjectively relates all his current symptoms to his accident. The Petitioner told Dr. Ling that his right upper extremity numbness and tingling is a new onset since the injury. Dr. Ling also recorded Petitioner's report that his range of motion has not returned to its baseline from before the accident. Furthermore, Dr. Ling compared his right elbow range of motion to the range of motion of his uninvolved left elbow and the right side was much worse.

Dr. Makowiec also recorded the Petitioner's history that although his congenital condition has always limited his pronation and supination, he had no trouble with activities of daily living such as shaving and brushing his hair before the accident. He also noted that the painful click in his elbow has only been present since the accident. The recommended elbow arthroscopy is not designed to address his pronation and supination, but to investigate and repair the cause of his audible elbow click, and his pain which is interfering with his ability to function at work and at home only since the accident.

Dr. Tarandy, the Petitioner's examining physician, testified that the Petitioner's symptoms of a painful, audible and palpable click in the elbow are consistent with a ligament tear or a loose piece of cartilage within the joint. Dr. Makowiec concluded the same thing, that the symptoms are consistent with a loose body or cartilaginous flap. Although no specific loose body is seen on the MRI, Dr. Tarandy testified that it is not uncommon to find a loose body in surgery that was not identified on an MRI. Dr. Tarandy testified that the MRI did show moderate effusion and he saw something unclear that may have been a loose piece of cartilage. Furthermore, Dr. Makowiec commented that the congenital condition could be clouding the MRI study. Dr. Tarandy testified that the work accident wherein the Petitioner fell on his outstretched right hand and right elbow is a causative factor in his current condition and in the need for the right elbow arthroscopy and right carpal tunnel release.

Dr. Heller, the Respondent's IME physician, testified that the work accident did not cause the current condition in the Petitioner's right elbow and right hand. The Arbitrator notes that in his report and direct exam, Dr. Heller stated that the work accident was not the "primary cause" of his current conditions, which is not the medical standard for causation under the Illinois Workers' Compensation Act. Furthermore, Dr. Heller agreed that the audible elbow click may be from loose pieces of cartilage and agreed that the loose cartilage could come from a direct single trauma, although he did not think it did in this case. He also agreed that carpal tunnel syndrome can be caused by a direct single trauma. Although Dr. Heller

opined that the Petitioner's underlying congenital condition caused his current symptoms, when he was asked at his deposition to explain why the Petitioner would only have symptoms in the right side and not the uninvolved left side, he had no explanation. Moreover, Dr. Heller could not explain why the Petitioner's symptoms, which did not exist before the accident, would suddenly come on after the fall. Additionally, the Arbitrator notes that while Dr. Heller opined that the accident may have caused a temporary aggravation of the Petitioner's underlying carpal tunnel syndrome, it is clear that the Petitioner's subjective and objective symptoms were not present before the accident and have not improved since the accident.

The Arbitrator also notes the credible testimony of the Petitioner that prior to the work accident; he had never experienced any pain or clicking in his right elbow and did not have any trouble performing his job duties. He also testified that he did not have any right hand pain or tingling before the work accident.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's current condition of ill being in his right elbow and right hand are causally related to the work accident of February 14, 2013.

In Support of the Arbitrator's Decision relating to (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

The Arbitrator notes that all of the doctors who have examined the Petitioner agree that the Petitioner should have arthroscopic right elbow surgery to identify and repair the cause of his right elbow symptoms, and that the Petitioner should also have a right carpal tunnel release. Having found that the Petitioner's current condition of ill being in his right elbow and right hand are causally related to the work accident of February 14, 2013, the Arbitrator finds that the arthroscopic right elbow surgery and the right carpal tunnel release prescribed for the Petitioner by his treating physician are reasonable, necessary, and causally related medical treatment which the Respondent is obligated to provide.

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

Joel Pena,

Petitioner,

14IWCC0116

vs.

NO: 10 WC 39631
10 WC 17814
12 WC 20638

FedEx,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical expenses, wage rate, 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 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 15, 2013 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

14IWCC0116

without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $35,600.00. 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: FEB 19 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gal
2/13/14
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PENA, JOEL
Employee/Petitioner

Case# **10WC039631**

10WC017814

12WC020638

FEDEX
Employer/Respondent

14IWCC0116

On 7/15/2013, 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:

2234 CHEPOV & SCOTT LLC
MARSHA A CHEPOV
5440 N CUMBERLAND SUITE 150
CHICAGO, IL 60656

1401 SCOPELITIS GARVIN LIGHT ET AL
GERALD F COOPER JR
30 W MONROE ST SUITE 600
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 14IWCC0116

Joel Pena
Employee/Petitioner

v.

Case # **10** WC **039631**

Consolidated cases: **10 WC 17814; 12 WC 020638**

FedEx
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 **Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **April 25, 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 **Prospective medical treatment.**

14IWCC0118

FINDINGS

On **April 6, 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 $**46,910.24**; the average weekly wage was $**902.12**.

On the date of accident, Petitioner was **34** 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 $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $23,764.99 for other benefits, for a total credit of $23,764.99. 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, for only those services for the lumbar spine and radicular symptoms, pursuant to Sections 8(a) and 8.2 of the Act.

Respondent shall pay to Petitioner temporary total disability benefits of $601.41 week for 98 & 4 7 weeks, commencing 4 27 2010 through 9 19 2010 and commencing 12 4 2010 through 6 1 2012, as provided in Section 8(b) of the Act.

Respondent shall be given credit for $23,764.99 for non-occupational indemnity disability benefits paid pursuant to the Act

Respondent shall pay reasonable and necessary medical services pursuant to the medical fee schedule for prospective medical care treatment recommended by Dr. Sokolowski as well as any preoperative testing, post-operative physical therapy and other medical treatment necessitated by the recommended surgery, as provided in Sections 8(a) and 8.2 of the Act.

No benefits are awarded for case numbers 10 WC 39631 & 10 WC 17814, pursuant to the Act.

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

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

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

D. Thompson-Smith

Signature of Arbitrator

July 15, 2013

IC ArbDec p. 2

JUL 15 2013

JOEL PENA
10 WC 39631
10 WC 17814
12 WC 20638

FINDINGS OF FACT

The disputed issues in these matters are: 1) did an accident occur that arose out of and in the course of Petitioner's employment by the Respondent; 2) whether Petitioner's current condition of ill-being is causally related to the injury; 3) whether the medical services provided to Petitioner were reasonable and necessary; 4) what amount of compensation is due for temporary total disability; 5) whether Respondent is entitled to any credits; and 6) whether Petitioner is entitled to prospective medical care.

12 WC 20638, filed July 2012; date of accident, April 6, 2010

Joel Pena, (the "petitioner"), testified that on April 6, 2010, the date of accident, he was a 34 year-old truck driver for Federal Express (the "respondent"); and that prior to the alleged work accident, he was in good health. He had never had any injuries to or suffered pain in his lower back, hips, thighs or legs; nor had he experienced any symptoms of radiculopathy in the lower extremities. Petitioner testified he was able to perform his daily activities and work requirements without any difficulty or pain, prior to the alleged accident.

Petitioner further testified that he began working for Respondent in 2003, as a local truck driver. Petitioner testified that until approximately one month before the accident date, his job duties included driving a 16-wheel semi-tractor-trailer and delivering oversized items weighing between seventy-five (75) to three thousand (3,000) pounds. Petitioner stated that he would perform between three (3) to eight (8) deliveries and one (1) to eight (8) pickups per day and that his service route was only in and around the Glenview area; which providing considerable downtime for him throughout the day. He explained that the loading and unloading in this route was done primarily by the accounts he serviced. He rarely had to manually load or unload, and if he did, it was

once per week at most and the truck was equipped with a lift gate and ramp. The materials were on a pallet and he would use a pallet jack to move them. Petitioner further testified that the semi-truck he drove was designed to provide a comfortable ride, in that it was equipped with an air ride seat and large cushioned leather seat with lumbar adjustments.

Petitioner then testified that about one month prior to the accident date, he was taken off his regular route and assigned a new truck with a much larger geographic area. The new route consisted of approximately two (2) to six (6) areas within the city and north suburbs. This route required more driving, considerably more time sitting in traffic and little downtime between deliveries. Of significance, this route serviced residential customers, requiring Petitioner to load and unload every single piece of freight, making 6 to 12 deliveries and 2 to 6 pickups daily. The new route required a straight truck in order to maneuver around residential areas and Petitioner testified that the straight truck did not have an air-ride cab or seat. Instead, this truck's seat was a hard wooden bench with a worn down cushion held down with an x-frame; which Petitioner testified protruded out of the cushion and dug into the back of his thighs throughout the day. Petitioner testified that the ride was so bumpy that his head would regularly hit the ceiling of the cab and occasionally, after hitting a bump in the road, he would end up on the passenger's side of the bench.

On April 6, 2010, just before lunch, Petitioner testified that he was driving his straight truck, en route to a delivery. It was spring weather and as he was driving, he hit a large pothole. This caused him to jump up in the seat and forcefully land with all his body weight onto the wooden bench of the driver's seat. The Petitioner testified he felt an immediate sharp pain in the back of his right leg, similar to what he described as a cramping sensation. Petitioner testified that as he continued working that day, his pain was further aggravated by constant bouncing on the hard wooden driver's seat, as the edge of the metal X-frame continued to push into his thigh. He testified that by the end of the day, he felt a burning sensation from his buttock, down the outside and back of

his right leg, ending at his knee. Petitioner testified that when he returned the truck to the lot that day, he reported to his supervisor, Troy Kruess, that he had pain in his leg from what he thought was caused by bouncing around in the truck all day after hitting a large pothole. Upon returning home that evening, Petitioner testified that he rested and took over-the-counter medication for his pain. The Arbitrator notes that the petitioner testified that he told all of his doctors that he hit a pothole however; none of his doctors' notes indicate that mechanism of injury and upon cross-examination, the petitioner stated that he did not remember what he told his doctors.

Petitioner testified that despite his pain, he continued to work over the next few weeks and that his pain increased further as he drove the straight truck, continuously bouncing on the hard wooden seat and doing manual loading and unloading. He testified that he began to feel the sensation of pins and needles in his buttock area along with cramping and burning starting from the buttock, going into the outside of the thigh and traveling into the foot and little toes. Petitioner testified that the pain increased to the point that he was unable to sleep, stand or sit without significant pain. Petitioner testified that he again discussed his injury with his supervisor, Mr. Kruess on April 27, 2010, and explained that the pain was becoming unbearable and that he needed to seek medical treatment. Petitioner then completed an accident report and was sent to Alexian Brothers' Occupational Health Clinic ("Alexian Brothers").

Petitioner presented to Alexian Brothers on April 27, 2010 and was examined by Dr. Salvador Cabanit. Medical records from this visit document pain and tenderness in the posterior aspect of the distal third of the right thigh, extending to the popliteal area; with radiation into the buttocks and medial aspect of the thigh; and to the distal third of the right foot. The history states the pain started about April 6, 2010, while driving a truck at work. Dr. Cabanit's diagnosis was a right hamstring strain and Petitioner was given pain medication and referred for a Doppler ultrasound of the right lower extremity to rule out DVT. Petitioner was also placed on light duty with no driving, kneeling or squatting and alternating standing/sitting as needed. Petitioner followed up with Dr.

Cabanit on April 29, 2010, to review the results of the ultrasound, which came back negative. Petitioner was again complaining of pain radiating down the back and side of his thigh, traveling down to his toes and up to his buttock. Dr. Cabanit's additional diagnosis was radicular syndrome and he referred Petitioner for an EMG/NCV of the right lower extremity to rule out nerve impingement. Petitioner was instructed to remain on light duty and return to the clinic after the EMG. The EMG/NCV, performed on May 21, 2010, was interpreted as normal but stated that the study could not entirely exclude radiculopathy, pure sensory radiculitis, intermittent nerve compression or small fiber neuropathy. Petitioner testified he returned to see Dr. Cabanit on May 28, 2010, but was not examined because of lack of approval from Respondent. Petitioner testified that Dr. Cabanit referred him for an MRI of the lumbar spine, to attempt to determine the source of his pain. *See,* PX 1, 1-5; 17; 25-32.

Petitioner testified that after each appointment with Dr. Cabanit, he brought his light duty work slip to his supervisor. Petitioner testified that he was initially told that his employer would try to accommodate his restrictions however; Petitioner was then informed that no accommodations could be made and that he should apply for short-term disability and family leave ("FMLA"). Petitioner applied for both and received benefits from April 27, 2010 to September 19, 2010.

10 WC 17814; date of accident, April 17, 2010

Petitioner signed and or filed a claim on May 7, 2010, alleging injury to his right leg and upper buttocks. *See,* RX3. The Arbitrator notes that RX4 has no case number and therefore is not indicative of any claim.

Petitioner next sought treatment with his primary care physician, i.e. Dr. Forys, at Central Medical Clinic of Chicago ("Central Medical"). On June 1, 2010, Dr. Oksana Barilyak, another physician at Central Medical, examined Petitioner, as Dr. Forys was

unavailable. Petitioner complained of pain in the posterior aspect of the right thigh radiating to the right buttock, right foot and toes; which he stated started on April 6, 2010, while driving his truck at work. Dr. Barilyak also referred Petitioner for an MRI of the lumbar spine and continued his light duty restrictions. *See,* PX2 at 58.

On June 16, 2010, Petitioner was examined by Dr. Victor Forys and said examination revealed positive right straight leg raise at 45 degree, diminished power, sensation and tenderness over the facets at L3-L5. Dr. Forys administered a facet block injection at L4-L5 and diagnosed Petitioner with sciatica and facet arthropathy/lumbago; placed him off work and referred him for physical therapy. Petitioner began physical therapy to his lumbar spine on June 18, 2010 and underwent twenty-nine (29) visits, through September 14, 2010. Therapy consisted of hot packs, ultrasound, massage, e-stimulation and exercises, as well as at home exercises. Petitioner testified physical therapy treatments provided him with some pain relief and increased his range of motion however, the pain and numbness in his right leg persisted. *See,* PX2 at 54-55.

On July 13, 2010, Petitioner underwent an MRI of the lumbar spine at Edgebrook Radiology, which revealed disc herniations at L4-L5 and L5-S1 measuring 2-3mm and 3-4mm respectively. After reviewing the MRI results with Dr. Forys on July 21, 2010, Petitioner was referred for a pain management consultation. On July 29, 2010, Petitioner presented for an initial consultation to Premier Pain Specialists and was examined by Dr. Arpan Patel. Petitioner's complaints included lower back pain with radiation down the buttock into the calf, foot and toes. The pain was described as sharp and burning in nature. Petitioner reported the pain would turn to numbness without a change in position. Dr. Patel preformed three lumbar epidural injections under fluoroscopy at L4-L5 and L5-S1. During this time, Petitioner remained off work, was taking prescription pain medication and undergoing physical therapy. As documented by Dr. Patel and Dr. Forys' records and testified by Petitioner at hearing, Petitioner's pain and symptoms decreased with each injection. Following the series of three injections, Petitioner was examined by Dr. Forys on September 17, 2010 who noted

marked decrease in pain and Petitioner testified he wanted to return to work. Dr. Forys released Petitioner to return to work in a full duty capacity and instructed him to return if his symptoms worsened. Petitioner was further provided with a lumbar support belt and lumbar support cushion whenever driving and/or working. Petitioner testified he uses this cushion not only at work but also throughout his daily activities. *See,* PX3 &PX4 at 10.

Petitioner returned to work on September 20, 2010. Petitioner testified that although he requested his Glenview route, he was assigned the same route and truck, which he alleged, caused his initial injury. Petitioner testified that once back to work, the driving and lifting caused his pain to return and by the end of the first week, his pain was back at 50% of its original intensity; and that by the end of the second week the pain was back at 100%.

On October 7, 2010, Petitioner returned to Dr. Forys and complained of returning pain in the low back radiating to the right lower extremities, since returning to work. Dr. Forys performed a physical examination, which revealed a positive straight leg raise and low back tenderness. Dr. Forys prescribed pain medication and physical therapy. Petitioner was to return to work and follow up with Dr. Forys in two weeks. Petitioner testified that he began therapy but unfortunately could not attend regularly because he had to schedule appointments around his work schedule. Petitioner underwent five therapy visits between October 16, 2010 and November 20, 2010. *See,* PX2 at 38.

12 WC 20638; date of accident, December 2, 2010

Petitioner alleges an accident while moving a king-sized mattress on December 2, 2010, which temporarily exacerbated his condition. Petitioner testified that on December 2, 2010, he suffered a temporary exacerbation of his back pain while at work making his last delivery for the day. He testified that he was unloading a king-sized mattress from the back of his straight truck; and unstrapped the mattress from the wall in an effort to load it onto the truck's ramp. While unstrapping the mattress, he felt a sharp pain in his

lower back. When Petitioner's pain persisted, he called Dr. Forys the next morning, to make an appointment. Petitioner testified that he did not file an accident report with Respondent. Dr. Forys examined Petitioner on December 4, 2010 and the examination again revealed a positive right straight leg raise and tenderness at L3-S1. Petitioner was prescribed Vicodin, taken off work, told to continue physical therapy and referred for an orthopedic consultation. Petitioner testified that he again applied for short-term disability and FMLA and stayed off work until June 2012. Petitioner testified that the pain he felt following this incident temporarily increased his lower back pain but did not change or cause any new symptoms. *See*, PX2 at 34.

On December 7, 2010, Petitioner saw orthopedic spine specialist, Dr. Mark Sokolowski. Dr. Sokolowski testified that when he first examined petitioner, the petitioner did not give him a description of the mechanics of the injury of the accident in April 2010, which caused the onset of his pain. Dr. Sokolowski's history notes stated that the pain has persisted since April and increased after Petitioner returned to work in September 2010. Significant findings included reciprocal gait pattern, positive sagittal profile, concordant pain with restoration to neutral, positive right straight leg raise, tenderness to palpation at the right sciatic notch and paraspinal muscles. Dr. Sokolowski's personal review of the lumbar MRI from July 2010 was disc herniation at L5-S1. Dr Sokolowski diagnosed Petitioner with lumbar radiculopathy and L5-S1 disc herniation. Petitioner was referred for a repeat EMG because Dr. Sokolowski believed the initial EMG was performed too early in the course of the radicular symptoms, and likely a false negative study. Petitioner was also prescribed additional pain medication and instructed to remain off work. The Arbitrator notes that this doctor also testified that the petitioner work related injury in April of 2010, "when his vehicle hit a large bump is causally related to his need for ongoing treatment. *See*, PX5 at 17 & PX11 at 16-21 & 370.

The repeat EMG was performed on December 29, 2010 revealing right-sided radiculopathy at L4-L5 and L5-S1. Petitioner next saw Dr. Sokolowski on January 4, 2011. On this visit, Petitioner rated his back pain at 7-8/10 and his right buttock and leg

pain at 8-9/10. Dr. Sokolowski recommended continued physical therapy and increased pain medication to optimize control of Petitioner's symptoms and provide an opportunity for non-operative improvement of his pain. Between December 13, 2010 and April 28, 2011, Petitioner underwent thirty-one (31) sessions of physical therapy and varying regiments of medication. It was Dr. Sokolowski's opinion that after completing this treatment Petitioner would be at non-operative maximum medical improvement. At the February 14, 2011 visit, Petitioner complained of bilateral radicular symptoms and physical examination revealed decreased sensation in the right L5 and S1 dermatomes. Petitioner was prescribed an MRI of the lumbar spine and a functional capacity evaluation ("FCE") to complete at the end of his physical therapy sessions. Following the results of the MRI and FCE, a decision regarding surgical management versus permanent restrictions would be made. *See,* PX5 at 11-14 & PX6.

Intervening Accident

Petitioner testified that on May 24, 2011, a vehicle, attempting to turn in front of him, a vehicle struck his truck. Petitioner testified that his truck was "T-boned" and because of this accident, he suffered injury to his left shin, neck, upper back, and right knee. Petitioner also testified that at the time of the accident, per the instructions of Dr. Forys, he was wearing his lumbar support belt and had his lumbar support cushion on his car seat. He further testified that the cushion helped his lumbar spine from moving much in the accident and that although he did initially feel a slight increase in lumbar pain, he returned to his prior pain levels within a few days. Petitioner testified the pain in his low back and legs did not change following this motor vehicle accident but it took him four to five months to recover and he was prescribed a back brace. Respondent's Exhibit 1 consists of subpoenaed records from State Farm Insurance regarding the May 24, 2011 accident, including medical treatment from Central Medical Clinic, Dr. Paskov and various diagnostic tests.

Following the May 24, 2011 accident, Petitioner testified that Dr. Forys examined him on May 25, 2011. The physical examination noted decreased range of motion in the

neck, moderate muscle spasm in the trapezius, mild right knee effusion, decreased left shin flexion, and left shin tenderness. The initial examination by Dr. Forys mentioned subjective complaints of on-going back pain. Petitioner underwent a total six (6) visits with Dr. Forys and nine (9) physical therapy sessions for treatment of injuries to his neck, right shoulder and right knee. Petitioner also underwent a series of cervical epidural injections with Dr. Paskov. Petitioner testified his symptoms in the neck; right shoulder and right knee completely subsided by the end of treatment. The Arbitrator notes that after an exhaustive search of PX2, there are no notes from May 25, 2011. However, in RX1, on the date of May 25, 2011 Dr. Forys' notes state that the petitioner's Expedition SUV "struck a car that made a turn in front of his SUV" and that Petitioner had slid forward striking his right knee on the dashboard/parking brake. And that the motor vehicle accident caused pain in the left shin, neck, upper back, occipital (bilateral) right knee, back and new pain radiating to upper back and occipital and exacerbated the sciatica. And that the petitioner had previously been in treatment for back pain sciatica/lumbago, obesity and lumbar facet syndrome.

On June 3, 2011, Petitioner underwent an Independent Medical Examination ("IME") with Dr. Zelby, admitted into evidence as Respondent Exhibit 2. Petitioner testified that the history of injury, treatment history and description of current symptoms was elicited by an assistant and he never discussed them with Dr. Zelby. Petitioner further testified that the examination conducted by Dr. Zelby was brief; lasting no more than five minutes and that Dr. Zelby never touched his skin. The physical examination was significant for positive right straight leg raise, diminished sensation to touch in the right lower extremity and diminished but symmetric bilateral deep tendon reflexes. The report goes on to opine that Petitioner's symptoms in his right leg did not follow a radicular distribution and that the lumbar MRI revealed no herniated discs or neural impingement, which could have resulted in radiculopathy. Dr. Zelby's conclusion following examination and review of unlisted medical records was in agreement with the doctor's at Alexian Brothers i.e., that Petitioner suffered a hamstring strain that should

have resolved within eight to twelve (8-12) weeks and any on-going symptoms in the spine were attributed to super morbid obesity.

On June 10, 2011, Petitioner underwent a Functional Capacity Evaluation ("FCE") at ATI Physical Therapy. The valid FCE demonstrated that Petitioner's lifting capabilities fell below those required for his employment with Respondent. Petitioner testified he brought the results of the FCE to his employer and was told that his job requirements could not be modified, at that time. On July 5, 2011, Petitioner saw Dr. Sokolowski and the physical examination once again demonstrated positive straight leg raises and evidence of radiculopathy including, decreased sensation in the L5 and S1 dermatomal distributions, decreased dorsiflexion and plantar flexion strength bilaterally. Petitioner again reported that his pain limited his functional abilities, adversely affected his quality of life and limited his ability to perform routine activities of daily life. Dr. Sokolowski opined that Petitioner had exhausted non-operative treatment and recommended surgical intervention. In order to best plan for surgery, Dr. Sokolowski referred Petitioner for an updated MRI of the lumbar spine and at the August 4, 2011, office visit, Dr. Sokolowski reviewed the MRI taken at Golf Diagnostics dated July 12, 2011. His interpretation of the MRI was disc pathology from L4 to S1 with resultant neural impingement on the right greater than the left, specifically at L5-S1. Dr. Sokolowski opined that the MRI images correlated with his findings on multiple physical examinations as well as the EMG results. Dr. Sokolowski opined that the petitioner was suffering from a L4-S1 lumbar decompression. *See*, PX5 at 2 & 7.

Petitioner testified at hearing that he is eager to proceed with surgery and return to work and his daily life without pain. He testified and it is documented in the records of both Dr. Sokolowski and Dr. Forys that authorization for the surgery was submitted to Respondent but was denied. Petitioner testified he also attempted to have the surgery performed through his personal health insurance carrier however; his insurance lapsed after six months of long-term disability, which Petitioner testified he was not expecting. Petitioner further testified that for over one year he has appealed this issue with his

insurance carrier but with no success. During this time, Petitioner continued treating with Dr. Forys and taking prescription medication, to alleviate his pain symptoms.

By June 2012, Petitioner had exhausted his disability benefits as well as his FMLA leave. Petitioner testified that he had to return to work without restrictions in order to keep his job because of financial hardship. On May 17, 2012, his primary care physician, Dr. Forys, again examined Petitioner. Records from Dr. Forys on this visit state that Petitioner had followed recommendations for weight loss and a self-directed home exercise program. His physical examination was again positive for straight leg raises and the assessment was chronic sciatica; and per the request of Petitioner, he was returned to work with no restrictions. *See,* PX2 at 2.

Petitioner testified that he returned to work on June 2, 2012, despite his pain and radicular symptoms. He testified that upon returning to work, new management was more understanding, and although they could not give him a light duty position, he was returned to his old Glenview route with the semi-tractor trailer with air-cushioned seats. Petitioner testified that he works in his lumbar support belt and that he no longer loads or unloads; and that his route requires minimal driving. Petitioner testified that his route again allows significant down time between deliveries, which allows him to rest and is helpful for dealing with his pain. Additionally, the truck he currently drives has air ride seats and lumbar support, which Petitioner stated helps alleviate some of his pain. Despite the advantages of his route, Petitioner testified that he continues to experience pain throughout the workday and that his sitting and standing tolerances are minimal. Petitioner further testified that the pain, radicular symptoms and weakness in his legs greatly interfere with his ability to perform routine work tasks and those of daily life; and impair his quality of life.

On July 13, 2011 an MRI of the cervical spine, taken at Golf Diagnostic Imaging was read to indicate degenerative disc disease at multiple levels and at C-5-C6 a 3MM disc herniation/protrusion that abuts the anterior aspect of the spinal cord. An MRI of the lumbar spine, taken the same date was read as the petitioner having minimal

degenerative disc disease with posterior disc bulging from level L-2 through S-1 with minimal spinal stenosis at L3-4 and L4-5; with minimal degenerative changes of the posterior elements at the lower spine. *See,* RX1

On January 21, 2013, Petitioner returned to see Dr. Sokolowski, seeking incremental pain relief for his ongoing pain and symptoms. The physical examination revealed bilateral, positive straight leg raises, decreased bilateral dorsiflexion and plantar flexion strength, a positive sagittal profile, reproduction of concordant pain with extension, decreased sensation in L5 and S1 dermatomal distributions and tenderness over the lumbosacral joint. Dr. Sokolowski's records state that Petitioner had exhausted conservative management and that after being symptomatic for several years, the only option was surgical intervention. *See,* PX5 at 1.

Petitioner testified at hearing that his pain has remained persistently severe. Petitioner stated that he takes pain medication two to three (2-3) times per day to help alleviate his pain and does his home exercises daily. He testified that he experiences pain in the lower back and radiation to the bilateral buttocks and lower extremities to the toes, right greater than left, throughout the day. Petitioner testified he wants to undergo surgery in order to return to his normal life without pain.

10 WC178148; date of accident, unknown

Although these cases are consolidated, the Arbitrator has no information or testimony regarding this accident as the petitioner did not testify that he had a third work-related accident nor did Petitioner's proposed findings delineate a third accident and as such, no benefits will be awarded. *See,* AX1.

14IWCC0116

CONCLUSIONS OF LAW

10 WC 3963; date of accident, April 6, 2010

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

Under the provisions of the Illinois Workers' Compensation Act, the Petitioner has the burden of proving by a preponderance of credible evidence that the accidental injury both arose out of and occurred in the course of employment. *See, Horath v. Industrial Commission*, 96 Ill. 2d 349, 449 N.E. 2d 1345 (1983). An injury "arises out of" the Petitioner's employment if its origin is in the risk connected with or incidental to employment so that there is a causal connection between the employment and the accidental injury. *See, Warren v. Industrial Commission*, 61 Ill. 2d 373, 335 N.E. 2d 488 (1975). *See, Hannibal, Inc. v. Industrial Commission*, 38 Ill. 2d 473, 231 N.E. 2d 409, 410 (1967). 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). In addition, 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).

Petitioner's testimony was unrebutted and credible concerning his pain increase as he continued driving his truck, and as his body continued bouncing on the hard seat with metal frame protruding into his lower legs, causing further injury to Petitioner. His testimony regarding the mechanism of accident is not corroborated by the histories of the accident documented by Petitioner's medical providers, Drs. Cabanit, Forys and Sokolowski. While each of these doctors noted Petitioner stating that he had a sudden onset of pain while driving on April 6, 2010; that the pain was radicular in nature; and that the symptoms worsened with time, as Petitioner continued driving and lifting at

work; not one doctor mentions Petitioner hitting a pothole. Petitioner testified that his pain increased quickly after he returned to work and that he sought treatment with Dr. Forys in the form of additional pain medications and physical therapy. He further testified that the lifting incident of December 2, 2010, further intensified his pain.

Respondent offered no witnesses or evidence to rebut Petitioner's testimony regarding the April 6, 2010 accident. This Arbitrator notes Respondent's argument that Petitioner provided inconsistent dates of accident, i.e. as Respondent's Exhibits 3 and 4 purport to be Applications for Adjustment of Claims previously filed. However, Petitioner argues that these Applications were amended since the date of filing, to reflect the date of accident stated herein. Additionally, Respondent's IME physician, Dr. Zelby, states in Respondent's Exhibit 2 that some type of injury, which he opines is a muscle strain, that arose out of and in the course of Petitioner's employment. Accordingly, the Arbitrator finds that Petitioner has proven by, a preponderance of the evidence, that he sustained an accident arising out of and in the course of his employment.

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

The petitioner bears the burden of establishing, by a preponderance of credible evidence, all elements of his claim. Specifically, the Petitioner must establish that his current condition of ill-being is causally related to the work injury and not the result of the normal degenerative aging process. *See, Peoria County Bellwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524 (1987). The requirement that the petitioner prove by a preponderance of evidence, all elements of his claim, means that he must present evidence which is more credible and convincing to the mind and when viewed as a whole, establishes the facts sought to be proved as more probable than not. *See, In Re: K.O.*, 336 Ill.App.3d 98 (2002). In the present matter, for the reasons outlined below, the Arbitrator finds that the petitioner has established, by a preponderance of the

evidence, that his some of his current condition of ill being is causally related to the work injury of April 6, 2010.

Intervening Accident

Petitioner testified that on May 24, 2011, a vehicle, attempting to turn in front of him, a vehicle struck his truck. Petitioner testified that his truck was "T-boned" which is contrary to his doctor's records. According to Petitioner's treating doctor's notes of May 25, 2011, petitioner told him that he was the one who struck the other vehicle, while it was turning in front of him. This is the second time that the petitioner's medical records contradict his testimony. And the Arbitrator finds that, pursuant to the medical records, the petitioner back condition was exacerbated by this accident.

Because of this accident, Petitioner suffered injuries to his left shin, neck, upper back, and right knee, and his lower back condition was aggravated. Following this accident, Petitioner received chiropractic treatment for two months after which time he testified that he suffered no residual pain.

Because there is evidence in the record, that the petitioner's initial complaints were hamstring pain with radicular syndrome in the right lower extremity, the Arbitrator finds that Petitioner's present condition of ill-being in the lumbar spine and radicular symptoms are casually related to the work accident of April 6, 2010, however this condition was exacerbated by the intervening accident.

J. Were the medical services provided to Petitioner reasonable and necessary?

Having determined that Petitioner's current condition of ill-being is partially, casually related to the work accident, the Arbitrator finds all of the treatment provided was not reasonable or necessary for the treatment of Petitioner's work-related injuries. The bill for Gold diagnostic contains Charges for two MRIs; one for the cervical spine and one

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for the lumbar spine. The Arbitrator finds that all treatment for the cervical spine, right knee, left shin, neck, and upper back was caused by the May 24, 2011 motor vehicle accident and is not work related therefore; only those charges for treatment to the lumbar spine and radicular symptoms will be awarded, pursuant to the medical fee schedule.

K. What amount of compensation is due for temporary total disability?

Petitioner claims he was temporarily totally disabled from April 27, 2010 to September 19, 2010 and from December 4, 2010 to June 1, 2012, a total of 98 4/7 weeks. There are off-work slips from the treating doctors for these periods therefore, the Arbitrator finds that the petitioner was temporarily, totally disabled for these periods.

N. Is Respondent entitled to any credits?

Arbitrator notes that Respondent paid a total of $23,764.99 in non-occupational indemnity disability benefits for the periods of May 4, 2010 through August 26, 2010 and December 11, 2010 through June 1, 2012.

O. Is Petitioner is entitled to prospective medical care?

Based on Petitioner's on-going subjective complaints, objective findings on exam, EMG and MRI results, Dr. Sokolowski has recommended Petitioner undergo a L4 to S1 lumbar decompression. Petitioner testified at arbitration that he wishes to undergo this surgery to alleviate his pain and symptoms and to be able to return to his daily routines of life.

The Arbitrator, having found the petitioner's condition of ill-being regarding the lumbar condition and radicular pain; is casually related to his accidental injuries of April 6, 2010, hereby orders Respondent to authorize treatment recommended by Dr.

Sokolowski as well as any preoperative testing, post-operative physical therapy and other medical treatment necessitated by the recommended surgery.

12 WC 20638; date of accident, December 2, 2010

Petitioner alleges an accident while moving a king-sized mattress on December 2, 2010, which temporarily exacerbated his condition. While unstrapping the mattress, he felt a sharp pain in his lower back. When Petitioner's pain persisted, he called Dr. Forys the next morning, to make an appointment. Petitioner testified that he did not file an accident report with Respondent. Dr. Forys examined Petitioner on December 4, 2010 and the examination again revealed a positive right straight leg raise and tenderness at L3-S1. Petitioner was prescribed Vicodin, taken off work, told to continue physical therapy and referred for an orthopedic consultation. Petitioner testified that he again applied for short-term disability and FMLA and stayed off work until June 2012. Petitioner testified that the pain he felt following this incident temporarily increased his lower back pain but did not change or cause any new symptoms. The Arbitrator finds that the petitioner has not proven, by a preponderance of the evidence, that he suffered an accident that arose out of and in the course of his employment and therefore, benefits will not be awarded, pursuant to the Act.

10 WC178148; date of accident, unknown

Although these cases are consolidated, the Arbitrator has no information or testimony regarding this accident as the petitioner did not testify that he had a third work-related accident nor did Petitioner's proposed findings delineate a third accident and as such, no benefits will be awarded. *See,* AX1.

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

Miguel Gonzalez,

Petitioner,

14IWCC0117

vs.

NO: 10 WC 05767

Elite Staffing,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) and §8(a) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, prospective medical expenses, causal connection, 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 June 17, 2013 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.

14IWCC0117

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 $34,500.00. 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: FEB 19 2014

DLG/gal
O: 2/13/14
45

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR
& 8(A)

GONZALEZ-JUAN, MIGUEL
Employee/Petitioner

Case# **10WC005767**

14IWCC0117

ELITE STAFFING
Employer/Respondent

On 6/17/2013, 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 0.08% 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:

1315 DWORKIN AND MACIARIELLO
DAVID VANOVERLOOP
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

4866 KNELL & O'CONNOR PC
KAROLINA M ZIELINSKA
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CHICAGO, IL 60607

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B) & 8(A)

14IWCC0117

Miguel Gonzalez-Juan
Employee/Petitioner

v.

Elite Staffing
Employer/Respondent

Case # 10 WC 005767

An *Application for Adjustment 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 **February 19, 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: Whether prospective medical should be awarded?

FINDINGS

On **January 15, 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 as it relates to his **lumbar spine** *is* causally related to the accident.

Petitioner's current condition of ill-being as it relates to his **right shoulder** *is* causally related to the accident.

Petitioner's current condition of ill-being as it relates to his **cervical spine** *is* causally related to the accident.

Petitioner's average weekly wage was **$258.07**.

On the date of accident, Petitioner was **31** years of age, ***married*** with **1** dependent children.

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

Respondent shall be given a credit of **$6,820.44** for TTD, **$0** for TPD, **$0** for maintenance, and **$3,584.63** for medical benefits under Section 8(j) of the Act, for a total credit of **$10,405.07**.

ORDER

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $258.07 per week for 161.143 weeks commencing on January 17, 2010 through February 19, 2013 pursuant to Section 8(b) of the Act.

Medical Benefits
Respondent shall pay medical bills for Petitioner's right shoulder, including Dr. Blair Rhode for $3,266.71.

Respondent shall pay medical bills of relating to lumbar spine treatment pursuant to Utilization Review and the fee schedule. The fusion at level L4-5 is not compensable under the Act.

No cervical spine or right shoulder treatment is awarded after July 19, 2010. Likewise, no bills are awarded after this date.

Prospective Medical
Respondent shall approve and pay for prospective medical treatment for Petitioner's lumbar spine injury.

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

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

6·16·13

JUN 17 2013

Miguel Gonzalez-Juan v. Elite Staffing
Case # 10 WC 5767

FINDINGS OF FACT

Petitioner, Miguel Gonzalez-Juan, was involved in an undisputed work accident while working for Respondent, Elite Staffing, on January 15, 2010. On the date of the accident, Petitioner was squatting to lift and stack pallets when he felt a pop in his right shoulder and upper back. Petitioner testified the pain in his upper back was a kind of "heat", and the pain in his lower back was as if someone was poking him. Petitioner immediately gave notice of the injury. Petitioner testified that he completed work that day, but the pain continued after leaving work. He reported for work the next day but was unable to complete his shift and was directed to Premier Occupational Health. (TX)

At Premier Occupational Health, Petitioner reported right shoulder and upper back pain. During physical examination it was noted that movement of Petitioner's low back caused pain, that Petitioner had abnormal range of motion of the lumbar spine and tenderness to palpation as well as spasm in the paraspinous muscles of the lumbar spine. Petitioner was diagnosed with a thoracic strain/sprain as well as a lumbar sprain and was given a back brace and medications and ordered off work for three days. Petitioner followed up at Premier Occupational Health on January 18, 2010 at which time he was ordered to continue use of the back brace and was released to work with restrictions. (PX 1, 3)

On January 19, 2010 Petitioner presented to the Silver Cross Hospital emergency department with complaints of pain, spasm, stiffness, tightness and tenderness in the right side of his upper back. He was examined and released. (PX 2)

On January 22, 2010 Petitioner returned to Premier Occupational Health and again was diagnosed with a thoracic strain/sprain as well as a lumbar sprain. A diagnosis of right shoulder strain/pain was added, and Petitioner was taken back off work and referred to an orthopedic surgeon, Dr. Mukund Komanduri of MK Orthopaedics Surgery & Rehabilitation. (PX 1, 3)

Petitioner presented to Dr. Komanduri that same day. Following an examination Dr. Komanduri diagnosed Petitioner with a possible SLAP tear in his right shoulder, as well as a

possible pectoralis rupture. He recommended an MR arthrogram of the right shoulder to rule out rotator cuff tear and prescribed medications. Petitioner did not return to Dr. Komanduri. (PX 3)

On January 25, 2010 Petitioner presented to Clinica Su Red. Petitioner testified he found the clinic on his own by way of a radio advertisement. An intake sheet completed on January 25, 2010 indicates Petitioner's complaints of cervical, thoracic and lumbar pain. Specifically, Petitioner indicated that his low back felt like pins and needles and that the pain radiated to his right buttock. Petitioner also complained of right shoulder pain. Petitioner was diagnosed with a suspected SLAP lesion, a lumbar strain/sprain with radiculitis and intercostal muscle strain. The notes of Clinica Su Red indicate that a referral would be made to an orthopedic surgeon on January 27, 2010, and on that date the notes indicate Petitioner would be seeing Dr. Rhode on January 29, 2010 for consultation regarding his right shoulder. (PX 4)

Petitioner did present to Dr. Blair Rhode of Orland Park Orthopedics on this referral on January 29, 2010. Following an examination Dr. Rhode diagnosed Petitioner with a rotator cuff strain and cervical strain due to lifting and planned an injection in Petitioner's right shoulder for diagnostic and therapeutic purposes. The injection was performed that day. (PX 5)

Petitioner returned to Dr. Rhode on February 12, 2010 with complaints of continued rib cage pain as well as low back pain with radiation to his right leg. Dr. Rhode ordered MRIs to rule out radiculopathy. On February 17, 2010 Petitioner underwent an MRI of the thoracic spine at Orland Park Orthopedics which proved to be a normal study. In follow-up with Dr. Rhode on February 24, 2010 Dr. Rhode noted Petitioner's right shoulder complaints had improved for 8 hours following the injection performed on January 29, 2010, but had since returned. Dr. Rhode recommended continuing the conservative course of treatment with Clinica Su Red. (PX 5)

On February 27, 2010 Petitioner again presented to the Silver Cross Hospital emergency department. Petitioner complained of pain in his right scapular and right subscapular area, as well as radiating pain to his right leg. (PX 2)

Throughout this time Petitioner continued his treatment at Clinica Su Red. On March 8, 2010 the records of Clinica Su Red indicate that Petitioner was being referred to a pain specialist in attempts to make him more comfortable. On March 10, 2010 it was noted that Petitioner had filled out the paperwork at Clinica Su Red for the pain specialist he would be seeing the following day. (PX 2)

Petitioner presented to Dr. Xavier Pareja at Belmar Physicians on March 11, 2010 on this referral. At this visit Petitioner complained of aching, throbbing, sharp, stabbing back pain and right shoulder pain from the January 15, 2010 work accident. Dr. Pareja opined the pain may have been coming from Petitioner's ribs and obtained a chest x-ray to evaluate for back and rib pain. (PX 6)

On March 18, 2010 Petitioner underwent an EMG study of his upper and lower extremities at Professional Neurological Services. The study revealed C6-7 cervical radiculopathy, more aggressive on the right side, as well as bilateral L4 lumbar radiculopathy with right S1 peripheral neuropathy. (PX 6)

Petitioner returned to Dr. Pareja on March 25, 2010 with complaints of neck and low back pain radiating down both arms and legs. After reviewing the findings of the EMG Dr. Pareja recommended MRIs of the cervical and lumbar spine. These were performed on March 27, 2010 at Archer Open MRI. The cervical MRI revealed spondylotic changes with 2 mm broad based protrusions at C3-4 and C4-5 without spinal stenosis. The lumbar MRI revealed 8 mm anterolisthesis of L5 on S1 and a 3 mm central protrusion associated with an annular tear at L4-5. The radiologist opined that the uncovered disc at L5-S1 combined with malalignment to result in moderate bilateral foraminal stenosis. (PX 6)

Petitioner followed up with Dr. Pareja on April 1, 2010 to review the MRIs. At that time, Dr. Pareja diagnosed Petitioner with lumbar radiculopathy, paresthesia and lumbar/lumbosacral degenerative disc disease. Dr. Pareja recommended beginning a series of bilateral L4-5 and L5-S1 injections. Petitioner testified that these injections were to be performed by Dr. Axel Vargas, a physician with an office adjacent to Dr. Pareja's. (PX 6, TX)

On April 6, 2010 Petitioner presented to Dr. Axel Vargas of Physician Surgery Care Center with complaints of progressively worsening cervical pain rated from 6 to 9 out of a possible 10 with right radicular symptoms as well as intermittent lower back pain rated 7 to 9 out of a possible 10 with radiation into the right buttock and lower extremity. Dr. Vargas reviewed the MRIs and diagnosed Petitioner with L5-S1 bilateral neuroforaminal stenosis, C3-4 and C4-5 degenerative disk disease, discogenic cervical radiculopathy and discogenic lumbo-sacral radiculopathy. He confirmed Dr. Pareja's recommendation for injections and performed bilateral L5-S1 nerve root blocks and a transforaminal epidural steroid injection at that time. (PX 7)

Petitioner saw Dr. Vargas in follow up on April 27, 2010 and reported significant improvement of his overall lower back pain and radicular symptoms of 20-30%. The records indicate Petitioner continued to suffer from persistent low back pain and neck pain rated 6 out of a possible 10. Petitioner continued on a series of cervical and lumbar injections with Dr. Vargas through June 15, 2010. Petitioner testified that after the injections he would experience temporary relief of his symptoms, but that the pain and radiation would return. (PX 7)

On June 16, 2010 Petitioner again presented to the Silver Cross Hospital emergency department. He complained of an increase in pain since the most recent injection the day prior, and related that throughout the period following the January 15, 2010 injury he had been suffering with the pain and numbness radiating from his lower back to his right leg, but it was particularly worse following the injection. (PX 2)

On June 22, 2010 Petitioner presented to Dr. Anthony Rinella of Illinois Spine and Scoliosis Center. Petitioner testified that he was referred to Dr. Rinella by Clinica Su Red and they arranged his first appointment as they had with Drs. Rhode, Pareja and Vargas. On physical examination Dr. Rinella noted diminished sensation in right C6, 7 and 8 distribution relating to the cervical spine, as well as diminished sensation on the right side between L5 and S1. He reviewed the cervical and lumbar MRIs from March 27, 2010 and diagnosed Petitioner with cervical and lumbar strains with possible cervical and lumbar radiculopathy. Dr. Rinella ordered an x-ray of Petitioner's lumbar spine as well as an updated MRI of the thoracic spine to focus on the cause of Petitioner's leg symptoms. These tests were performed on July 3, 2010. (PX 8)

Petitioner returned to Dr. Rinella on July 19, 2010 for review of the studies. Dr. Rinella opined that the lumbar x-ray showed isthmic spondylolisthesis at L5-S1 with approximately 25% anterior translation of L5 on S1. Dr. Rinella further opined that the condition was most likely present at the time of the injury, but was definitely aggravated by the injury. Due to continued complaints of radiculopathy and the failure of aggressive conservative treatment over the previous months, Dr. Rinella recommended an L5-S1 transforaminal interbody fusion. (PX 8)

That same day Petitioner presented to Dr. Avi Bernstein, Respondent's Section 12 Examiner at Respondent's request. Dr. Bernstein opined that the MRIs of March 27, 2010 showed no significant pathology, and that all findings were chronic and pre-existing. Further,

Dr. Bernstein believed Petitioner to be at maximum medical improvement and capable of full-duty work. (RX 19)

Petitioner presented to Dr. Rinella for follow-up on September 1, 2010. Dr. Rinella reviewed the report of Respondent's Section 12 Examiner and agreed that the MRIs showed degenerative changes. However, Dr. Rinella further asserted that Petitioner clearly suffered from L5 radiculopathy secondary to isthmic spondylolisthesis which without question was an aggravation of the pre-existing phenomenon. He renewed his recommendation of the fusion at L5-S1 and ordered Petitioner off work. (PX 8)

Throughout this time Petitioner continued to treat with Clinica Su Red in efforts to improve conservatively. On September 24, 2010 the records indicate Petitioner was to consult with a spine surgeon on September 27, 2010. (PX 4)

Petitioner was seen by Dr. Richard Kube of Prairie Spine and Pain Institute of Orland Park on September 27, 2010. The records of Dr. Kube indicate that Petitioner was there as a referral from Dr. Dorough, the primary treater at Clinica Su Red. At this visit Petitioner reported significant amounts of pain toward the right side in the base of his neck and shoulder, as well as pain in the buttock and posterior thigh on the right and at the lumbosacral junction. Dr. Kube reviewed the MRIs of March 27, 2010 and diagnosed Petitioner with right sacroiliac joint pain and pain in mid-low lumbar spine in the region of the spondylolisthesis, opining that Petitioner at the least had strained his back and could have also aggravated the spondylolisthesis and degenerative changes he had in that region. Dr. Kube confirmed Dr. Rinella's recommendation for a fusion at L5-S1, as well as recommending a discography for the L4-5 disc tear. (PX 9)

Petitioner returned to Dr. Rinella on October 1, 2010 and the diagnosis remained the same: cervical spondylosis, cervical spondylotic radiculopathy, L5-S1 isthmic spondylolisthesis with related right L5 radiculopathy. Dr. Rinella recommended a new cervical MRI and reiterated his prescription for a lumbar fusion. (PX 8)

Petitioner saw Dr. Vargas for pain management on October 12, 2010 complaining of persistent lower back pain and stiffness with radicular symptoms and exquisite pain around the right trapezoid with paresthesia throughout the right C3-4 and C4-5. Dr. Vargas diagnosed Petitioner with L5-S1 bilateral neuroforaminal stenosis, discogenic lumbo-sacral radiculopathy, intractable lower back pain syndrome, C3-4 and C4-5 cervical disk disease, and discogenic

cervical radiculopathy. Dr. Vargas confirmed Dr. Kube's recommendation for a discography with CT scan of Petitioner's lumbar spine. (PX 7)

On November 2, 2010 the discogram was performed. The test revealed concordant pain at the L4-5 and L5-S1 levels. The CT following the procedure showed grade 4 annular tears at L4-5 and L5-S1 with a grade 5 tear at L3-4, as well as grade 1 anterolisthesis of 8 mm of L5 on S1 secondary to bilateral pars defects. (PX 7)

On November 8, 2010 Petitioner began treating with Dr. Mark Cohen of Physician's Plus, LTD. The records indicate that Petitioner's care was transferred to Dr. Cohen on a referral from Dr. Dorough, the primary treater at Clinica Su Red. (PX 10)

Petitioner returned to Dr. Vargas on November 16, 2010. Following review of the findings from the discogram, Dr. Vargas recommended Petitioner heed the recommendations of the spine surgeon. (PX 7)

Petitioner followed up with Dr. Rinella on December 3, 2010 and December 10, 2010, undergoing an updated MRI of his cervical spine in between visits. The diagnoses and recommendations continued to indicate cervical pain as well as the need for an L5-S1 fusion due to the aggravation of Petitioner's isthmic spondylolisthesis occurring during the work injury of January 15, 2010. (PX 8)

On January 1, 2011 Petitioner again presented to the Silver Cross Hospital emergency department. Petitioner reported chronic pain in his lower back radiating down his right leg related to the work injury from the January 15, 2010 which had become worse over the last few days. (PX 2)

On February 17, 2011 Dr. Cohen of Physician's Plus, LTD referred Petitioner to Dr. Sweeney for neurosurgical consult and treatment. (PX 10)

Petitioner was first examined by Raymond Hines, Physician's Assistant for Dr. Patrick Sweeny of Minimally Invasive Spine Specialists on February 17, 2011. At that time Petitioner complained of constant right upper back pain with tingling, numbness and weakness in his right upper extremity and associated weakness in his left upper extremity. Petitioner further reported intermittent hard pain in his low back radiating into his groin and down both legs, greater on the right, with associated weakness. Dr. Sweeney's Physician's Assistant noted that Petitioner had

attended physical therapy without relief. With Dr. Sweeney's review, it was agreed that Petitioner needed a lumbar fusion. (PX 11)

Petitioner followed up with Dr. Sweeney on April 7, 2011 and May 5, 2011. On both visits Dr. Sweeney diagnosed Petitioner with discogenic pain with herniated nucleus pulposus and related radiculitis unresponsive to conservative care. Dr. Sweeney recommended surgery. (PX 11)

On May 9, 2011 Dr. Sweeney performed a right L4-5, L5-S1 transforaminal laminotomy, facetectomy and discectomy; L4-5, L5-S1 transforaminal lumbar interbody fusion with life-spine cages and local autograft augmented by EquivaBone; L4-5, L5-S1 posterior spinal fusion with avatar screw system, local autograft augmented by EVO3c DBM; and image guided screw placement. The surgery required Petitioner to remain in Franciscan Hospital until May 11, 2011. PX 11, 12, 14)

Following the surgery Petitioner continued to follow up with Dr. Sweeney to monitor the progress of the surgery. Throughout this time Petitioner continued to complain of neck pain, and increasing return of the lower back pain. He returned to Dr. Vargas on July 12, 2011 and was recommended a spinal cord stimulator for his cervical spine. (PX 7, 11)

Petitioner continued to see Drs. Sweeney and Vargas and an updated MRI of Petitioner's cervical spine was ordered and subsequently performed on October 1, 2011. The test revealed 2 mm broad based protrusions at C3-4 and C4-5 without central canal or neural foraminal stenosis. Following this study Dr. Sweeney recommended a diagnostic discogram of Petitioner's cervical spine which was performed on October 25, 2011. (PX 7, 11)

In follow up on November 10, 2011 Dr. Sweeney reviewed the findings of the discogram and recommended against cervical surgery, instead confirming Dr. Vargas's recommendation for a cervical spine stimulator. Dr. Sweeney also noted that during the recovery from the fusion Petitioner's lower back complaints continued and worsened, and Dr. Sweeney opined Petitioner may need to have the hardware associated with the fusion removed. (PX 11)

Petitioner continued to see Dr. Sweeney on a monthly basis to monitor the progress of the healing lumbar fusion. Dr. Sweeney consistently noted Petitioner's continued complaints and repeatedly recommended hardware injections and/or hardware removal. Regarding Petitioner's cervical spine, Dr. Sweeney recommended a trial of a cervical spinal cord stimulator. (PX 11)

The deposition testimony of both Drs. Sweeney and Bernstein were taken prior to trial. Dr. Sweeney testified to detailed physical examinations of Petitioner as well as reviewing the actual films from the MRIs and CT scans. Upon reviewing the lumbar films Dr. Sweeney found preexisting spondylolysis at L5 with spondylolisthesis and central herniation and discogenic injuries at L4-5 and L5-S1, and determined these to be related to Petitioner's work injury. Further, the discogram and CT were reproductive of pain at these levels. Based on these findings Dr. Sweeney had agreed with the recommendation of spinal fusion opining, however, that it would be necessary to address both L4-5 and L5-S1. Dr. Sweeney testified in detail about the necessity for the specific procedure that was performed May 9, 2011. (PX 13)

Further, Dr. Sweeney testified as to the difficulties Petitioner continues to experience, and the justification for further treatment in the form of spinal hardware injections/removal and cervical spine stimulator. Moreover, Dr. Sweeney testified that the prior conservative treatment including therapy, modalities and epidural treatments was reasonable and necessary, and that throughout this treatment Petitioner was to remain off of work. (PX 13)

Dr. Bernstein testified that he examined Petitioner on July 19, 2010 at the request of Respondent. He further testified that of the 100 to 200 independent medical examinations he performs each year, about 85% are performed on behalf of Respondents. Dr. Bernstein testified that on that day Petitioner described an accident at work on January 15, 2010 causing pain in the back of his right shoulder and low back, with symptoms worsening the next day. Dr. Bernstein testified that he performed a physical examination of Petitioner on both the cervical and lumbar spines. Dr. Bernstein also testified to reviewing only the reports of the MRIs of Petitioner's cervical and lumbar spines, noting the radiologist had found degenerative changes at C3-4 and C4-5, as well as L5-S1 spondylolisthesis and a central disk protrusion at L4-5. Dr. Bernstein testified that it was his opinion that Petitioner had not suffered any spinal injury as the findings on the MRIs were all degenerative in nature, and that Petitioner could work full duty. On cross-examination Dr. Bernstein admitted that degenerative changes could be aggravated and become symptomatic through a trauma such as a lifting injury. Further, Dr. Bernstein admitted that if an individual with back pain had a discogram performed that supported that pain, such pain would be related to the spine. (RX 19)

Respondent introduced into evidence 18 separate Utilization Reviews of the treatment rendered to Petitioner. While the majority of the treatment provided Petitioner is deemed not certified, of note is Respondent's Exhibit #13, in which Petitioner is considered to be a surgical candidate at L5-S1, although not the requested adjoining level of L4-5. (RX 1-18)

Petitioner testified at trial that prior to January 15, 2010 he had no complaints of lower back pain, neck pain or right shoulder pain. Petitioner further testified that although he continues to have issues with his lower back pain, prior to the surgery of May 9, 2011 the pain and symptoms were such that he could not even walk, but following the surgery the symptoms in his right leg had been resolving and he was primarily suffering from the lower back pain, as well as the neck pain. Petitioner further testified that he has not worked since the date of the injury. Moreover, Petitioner testified that he would undergo the hardware injections/removal and spinal cord stimulator if such procedures were available. (TX)

CONCLUSIONS OF LAW

(F) In support of the Arbitrator's decision regarding whether the Petitioner's current condition of ill-being is causally related to the January 15, 2010 work injury, the Arbitrator concludes the following:

The Arbitrator finds the Petitioner's lower back and right shoulder condition to be causally related to the January 15, 2010 work accident. In doing so, the Arbitrator puts greater weight on the opinions of Petitioner's treating physicians, specifically Drs. Pareja, Vargas, Rinella and Sweeney, as well as Dr. Kube than the opinion of Respondent's Section 12 Examiner Dr. Bernstein.

Petitioner's description of the accident and immediate treatment would lead one to believe it was a thoracic and right shoulder claim. As a matter of fact, his application of adjustment claim stated that his only injury was to his right shoulder. After attempting work the following day, Petitioner was sent to Premier Occupational Health Partners where he complained of upper back and right shoulder symptoms, an incidental finding was to his lower back, from which he suffered a chronic condition. As a result, he was diagnosed with thoracic and lumbar injuries.

Throughout his treatment Petitioner's complaints were often bizarre and migrating, but his lower back complaints seems fairly consistent, especially after seeing the chiropractors.

Diagnostic testing of Petitioner's cervical spine revealed protrusions at C3-4 and C4-5 and led Drs. Vargas, Rinella and Sweeney to all diagnose Petitioner with symptomatic degenerative disc disease and cervical radiculopathy related to the work injury. Other reports state Petitioner denied neck pain. Dr. Bernstein even admitted that a traumatic injury such as one that could be caused by lifting could aggravate a degenerative condition.

Diagnostic testing of Petitioner's lumbar spine revealed isthmic spondylolisthesis at L5-S1 and a 3 mm protrusion with annular tear at L4-5. Dr. Rinella reviewed the films and opined that while the spondylolisthesis was a preexisting condition, Petitioner's radiculopathy was without question caused by an aggravation of this condition. Dr. Rinella identified the undisputed work injury of January 15, 2010 as the cause of that aggravation and recommended a fusion, noting the radiculopathy could be treated but it was unlikely to cure the lower back pain. Dr. Kube also reviewed the lumbar MRI films and confirmed that a January 15, 2010 lumbar strain could have aggravated the spondylolisthesis, and recommended a fusion to address the symptoms brought on by this aggravation.

Likewise, Dr. Sweeney reviewed the lumbar MRI films and identified discogenic injuries at L4-5 and L5-S1 related to the undisputed work injury of January 15, 2010. Moreover, Utilization Review confirmed the reasonableness of a lumbar fusion at L5-S1 based on Petitioner's complaints and records; recommendation for fusion at L4-5 was only withheld due to a lack of documentation of instability. However, Dr. Sweeney testified to the instability of L4-5 based on his personal encounters with Petitioner and believed the two level fusion to be the most prudent course of treatment.

Following the surgery of May 9, 2011 Petitioner's radiculopathy has improved, yet his lower back pain continues. Dr. Sweeney testified credibly that this is not uncommon with patients with hardware implants, and that the hardware is likely the cause of Petitioner's ongoing lower back pain.

Based on the balance of totality of evidence, much of conflicting and incredible, the Arbitrator finds Petitioner's lumbar complaints to be causally related to the January 15, 2010 injury. As a result, Petitioner's lumbar fusion at L5-S1 was causally related to the accident of

January 15, 2010, The fusion level at L4-5 was not reasonable or necessary per Peer Review and Dr. Rinella. Petitioner is entitled to follow up care for this condition. No future care for any other condition is awarded.

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

Petitioner introduced $451,246.21 in unpaid medical charges at hearing. Respondent denies liability for these expenses based on causal connection, reasonableness and necessity and Petitioner exceeding his choice of doctors. (PX 15)

The Arbitrator has previously found Petitioner's current condition of ill-being to be causally related to the undisputed work injury of January 15, 2010. In doing so, the Arbitrator has found the opinions of the treating physicians to be mostly credible. But not entirely, little weight is given to their opinions regarding the proper course of treatment for Petitioner's work injury. Dr. Sweeney testimony about the extensive conservative care including therapy, modalities, and epidurals was not compelling.

Petitioner did not exceed his choice of doctors. Petitioner testified that after selecting Clinica Su Red and initiating treatment with Dr. Ryan Dorough, that facility set up the appointments on a referral basis with Drs. Rhode, Pareja, Vargas, Rinella, Kube and Cohen.

Moreover, the records of Clinica Su Red indicate that on January 27, 2010 a referral would be made to see an "ortho"; Petitioner first saw Dr. Rhode on January 29, 2010. The Clinica Su Red records further indicate that on March 8, 2010 Petitioner would be referred to a pain specialist; Petitioner first saw Dr. Pareja on March 11, 2010. Petitioner testified that following his visits with Dr. Pareja, once injections were prescribed his care was transferred to Dr. Vargas, who did, in fact, perform the injections.

The records of Dr. Kube indicate Petitioner to be there "as a referral from Dr. Dorough". Similarly, the records of Dr. Cohen indicate Petitioner "presents ... with a referral from Dr. Dorough for continued care."

Petitioner further testified that it was through this chain that he arrived with Dr. Sweeney. The records of Dr. Dorough contain what is indicated to be a Professional Referral Slip to "Dr. Sweeney, MD for neurosurgical consult and treatment."

The only physician to whom there is no clear referral after Petitioner initiated treatment with Clinica Su Red is Dr. Rinella. However, Petitioner testified that his initial consultation with Dr. Rinella was facilitated by Clinica Su Red. As such, Dr. Rinella would at most be considered Petitioner's second choice of doctor. Therefore, the Arbitrator finds Petitioner has not exceeded his choice of physicians, and Respondent must pay all medical expenses approved by their Utilization Review, with the understanding that the fusion at level L5-S1 is awarded.

No specific dollar amount can be awarded for the lumbar treatment provided at this time. The Arbitrator defers until more specific evidence is presented. However, the Arbitrator does award $ 3,266.71 to Dr. Blair Rhode for treatment rendered.

(K) In support of the Arbitrator's decision regarding whether the Petitioner is entitled to any prospective medical care, the Arbitrator concludes the following:

Based on the finding of causal connection for Petitioner's current condition of ill-being, the Arbitrator further finds Petitioner to be entitled to the prospective lumbar treatment as prescribed by Drs. Sweeney and Vargas. Petitioner testified that prior to the May 9, 2011 surgery he was nearly unable to walk due to the symptoms radiating down his right leg. Dr. Sweeney testified that the remaining pain in the lower back is likely due to the hardware, and that such a phenomenon is not unusual following a fusion with instrumentation. Dr. Sweeney recommended injections into the hardware and/or removal of the hardware in order to alleviate Petitioner's remaining symptoms. As one level of the fusion surgery was found to be causally related, Petitioner is entitled to this necessary follow up treatment resulting from it. The Arbitrator orders Respondent to pay all the reasonable, necessary and related charges for the treatment prescribed by Dr. Sweeney pursuant to Section 8(a).

Drs. Sweeney and Vargas both have recommended a dorsal spinal cord stimulator to address Petitioner's ongoing cervical complaints, but no award is given. The Arbitrator notes that Dr. Sweeney specifically determined that Petitioner is not a candidate for cervical spine

surgery based on the diagnostic testing and exams. The Arbitrator does not find Dr. Sweeney to be credible about the cervical condition being causally related to the work accident. Petitioner did not immediately complain of neck pain after the accident and often denied neck pain in subsequent treatment notes that Dr. Sweeney failed to review. As a result, Petitioner is not entitled to the dorsal spinal cord stimulator prescribed by Drs. Sweeney and Vargas.

(L) In support of the Arbitrator's decision regarding whether Petitioner is entitled to Temporary Total Disability Benefits, the Arbitrator concludes the following:

Based on the finding of causal connection for Petitioner's current condition of ill-being, the consistent work statuses in the records, and Dr. Sweeney's credible testimony that Petitioner was to remain off work through the duration of his treatment, the Arbitrator further finds that Petitioner was temporarily totally disabled for a period of 161-1/7 weeks commencing January 17, 2010 through February 19, 2013 pursuant to Section 8(b) of the Act. Further, Petitioner is entitled to ongoing TTD benefits until he is at MMI for his lumbar condition.

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

Evelyn C. Farrar,

Petitioner,

vs.

14IWCC0118

NO: 12 WC 13163

United Airlines,

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 statute of limitations 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 1, 2013 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.

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

DATED: FEB 19 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gal
O: 2/13/14
45

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

FARRAR, EVELYN C
Employee/Petitioner

Case# **12WC013163**

14IWCC0118

UNITED AIRLINES INC
Employer/Respondent

On 7/1/2013, 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 0.10% 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:

1544 NILSON STOOKAL GLEASON CAPUTO
MARC B STOOKAL
205 W RANDOLPH ST SUITE 440
CHICAGO, IL 60606

0560 WIEDNER & MCAULIFFE LTD
TIMOTHY S McNALLY
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC0118

Evelyn C. Farrar
Employee/Petitioner

v.

United Airlines
Employer/Respondent

Case # 12 WC 13163

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 **Svetlana Kelmanson**, Arbitrator of the Commission, in the city of **Chicago**, on **June 13, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0118

FINDINGS

On the date of accident, **4/19/2003**, 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 the date of accident, Petitioner was **42** years of age, ***married*** with **0** dependent children.

ORDER

This claim is barred by the statute of limitations and the doctrine of *res judicata*.

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

6/28/2013
Date

ICArbDec19(b)

JUL - 1 2013

14IWCC0118

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The sole issue in the instant 19(b) proceeding is whether Petitioner's application for adjustment of claim was untimely filed or, alternatively, is barred by the doctrine of *res judicata*.

The facts are not in dispute. The parties stipulate that on April 19, 2003, Petitioner, a pilot, sustained an accidental injury arising out of and in the course of her employment with Respondent. After the accident, Respondent began paying temporary total disability and medical benefits. As a result of the work injury, Petitioner underwent cervical fusion surgery in January of 2007. On February 19, 2008, Petitioner's former attorney, James Tutaj, filed an application for adjustment of claim on her behalf, which was assigned claim No. 08WC06935. Respondent paid no workers' compensation benefits to Petitioner since June 30, 2008. On April 28, 2011, Arbitrator Lammie dismissed claim No. 08WC06935 for want of prosecution. Petitioner never filed a petition to reinstate.

On April 13, 2012, Petitioner, *pro se*, filed an application for adjustment of claim arising out of the same work accident on April 19, 2003.[1] The case was assigned claim No. 12WC13163. The parties stipulate that "[n]o payments have been made pursuant to Section 8(j) of the Act that would extend the time for filing an Application for Adjustment of Claim." On July 16, 2012, the firm of Nilson, Stookal, Gleason & Caputo entered its appearance of Petitioner's behalf.

Respondent's defense in case No. 12WC13163 is two-fold. Respondent argues that the dismissal of claim No. 08WC06935 became final upon the expiration of the period to file a petition to reinstate pursuant to the Commission rules. As such, the dismissal of claim No. 08WC06935 operates as *res judicata* in case No. 12WC13163. Alternatively, Respondent argues that claim No. 12WC13163 was filed after the running of the statute of limitations applicable to workers' compensation claims. Petitioner responds that she filed claim No. 12WC13163 within a year after the dismissal of claim No. 08WC06935, which is allowed by the Code of Civil Procedure.

It is well established that procedural aspects of matters before the Commission are governed by the Workers' Compensation Act (the Act) and the Rules Governing Practice Before the Illinois Workers' Compensation Commission (the Rules), rather than the Code of Civil Procedure. Preston v. Industrial Comm'n, 332 Ill. App. 3d 708, 712 (2002). Rule 7020.90 provides, in pertinent part: "Where a cause has been dismissed from the arbitration call for want of prosecution, the parties shall have 60 days from receipt of the dismissal order to file a petition for reinstatement of the cause onto the arbitration call." The 60-day limit for filing a petition to reinstate is jurisdictional in nature. TTC Illinois v. Workers' Compensation Comm'n, 396 Ill. App. 3d 344, 354 (2009).

The record is silent as to when Petitioner learned of the dismissal of claim No. 08WC06935. The Arbitrator infers from the filing of a duplicate application for adjustment of claim on April 13, 2012, that Petitioner or her former attorney learned of the dismissal more than 60 days before April 13, 2012, and filed a duplicate claim rather than an untimely petition to reinstate.

The defense of *res judicata* may be invoked in proceedings before the Commission. See Scott v. Industrial Comm'n, 184 Ill. 2d 202, 219 (1998); J & R Carrozza Plumbing Co. v. Industrial Comm'n,

[1] The Arbitrator notes that although Attorney Tutaj did not complete the appearance section of the application for adjustment of claim, he signed the proof of service on Respondent.

307 Ill. App. 3d 220 (1999). Under the doctrine of *res judicata*, a final judgment by an adjudicative tribunal on the merits is conclusive as to the rights of the parties and their privies, and operates as an absolute bar to a subsequent action involving the same claim, demand or cause of action. J & R Carrozza Plumbing, 307 Ill. App. 3d at 223. The claim need not be tried and decided by the arbitrator or the Commission. For instance, a settlement approved by the Commission operates as a final adjudication of all matters in dispute up to the time of the settlement that arose out of the same work accident. J & R Carrozza Plumbing, 307 Ill. App. 3d at 224-25. In a civil case, the supreme court has held that when a suit is dismissed for want of prosecution and the refiling period expires, the dismissal constitutes a final judgment on the merits because the order effectively ascertains and fixes absolutely and finally the rights of the parties in the lawsuit. See S.C. Vaughan Oil Co. v. Caldwell, Troutt & Alexander, 181 Ill. 2d 489, 502 (1998).

Here, the dismissal of claim No. 08WC06935 is a final judgment with respect to Petitioner's rights to recover workers' compensation benefits from Respondent arising out of the work accident on April 19, 2003. As such, it operates as *res judicata* in case No. 12WC13163, which arises out of the same work accident.

Furthermore, claim No. 12WC13163 was filed after the running of the statute of limitations. Section 6(d) of the Act provides that "unless the application for compensation is filed with the Commission within 3 years after the date of accident, where no compensation has been paid, or within 2 years after the date of the last payment of compensation, where any has been paid, whichever shall be later, the right to file such application shall be barred." 820 ILCS 305/6(d) (West 2011). Section 8(j) of the Act further provides that the statute of limitations is tolled during the time period the employee receives non-occupational disability benefits from a group plan contributed to by the employer. 820 ILCS 305/8(j) (West 2011). As noted, the parties stipulated that Respondent paid no workers' compensation benefits to Petitioner after June 30, 2008, and "[n]o payments have been made pursuant to Section 8(j) of the Act that would extend the time for filing an Application for Adjustment of Claim."

Accordingly, the Arbitrator finds that Petitioner's claim No. 12WC13163 is barred.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Manriquez,

Petitioner,

14IWCC0119

vs.

NO: 11 WC 26401

Unique Thrift Store,

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 expenses, 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 July 15, 2013 is hereby affirmed and adopted.

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

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

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

DATED: FEB 19 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gal
O: 2/6/14
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MANRIQUEZ, MARIE
Employee/Petitioner

Case# **11WC026401**

14IWCC0119

UNIQUE THRIFT STORE
Employer/Respondent

On 7/15/2013, 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:

2221 VRDOLYAK LAW GROUP LLC
MICHAEL P CASEY
741 N DEARBORN 3RD FL
CHICAGO, IL 60654

RUSIN MACIOROWSKI & FRIEDMAN LTD
JEFF RUSIN
10 S RIVERSIDE PLZ SUITE 1530
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 14IWCC0119

Maria Manriquez
Employee/Petitioner

v.

Unique Thrift Store
Employer/Respondent

Case # 11 WC 26401

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 **April 4, 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 _____

14IWCC0119

FINDINGS

On **April 27, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$14,924.00**; the average weekly wage was **$287.00**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$1,540.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,540.00**.

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

ORDER

Causation: The Petitioner proved that she sustained accidental injuries that arose out of and in the course of her employment, those injuries were treated and resolved by June 14, 2011. The Petitioner failed to prove that her current condition of ill-being is causally related to the accident.

Medical Treatment: The Respondent shall pay for the reasonable and necessary medical treatment pursuant to the Medical Fee Schedule through June 14, 2011. Respondent is not liable for any treatment received after June 14, 2011 as Petitioner failed to prove that the treatment was reasonable or necessary. Respondent shall be given a credit of $13,981.44 for medical bills paid pursuant to the parties stipulation.

TTD: The Petitioner failed to prove that her current condition of ill-being is causally related to the injuries sustained on April 27, 2011. TTD benefits for the time period of August 4, 2011 through September 22, 2011, are denied.

Permanent Partial Disability: Petitioner is found to have suffered a permanent injury pursuant to Section 8(d)2 of the Act. Respondent shall pay Petitioner permanent partial disability benefits of **$253.00/week** for **25** weeks, because the injuries sustained caused the **5%** loss of use of man 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.

Deborah L. Simpson
Signature of Arbitrator

July 14, 2013
Date

ICArbDec p. 2

JUL 15 2013

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Manriquez,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 11 WC 26401**
	)	
Unique Thrift Store,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on April 27, 2011, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They further agree that the Petitioner gave the Respondent notice of the accident which is the subject matter of this hearing within the time limits stated in the Act.

At issue in this hearing is as follows: (1) Did Petitioner sustain an accidental injury that arose out of and in the course of her employment with Respondent; (2)Is the Petitioner's current condition of ill-being causally connected to this injury; (3) Has Respondent paid all the reasonable and necessary medical bills; (4) Is the Petitioner entitled to TTD payments from August 4, 2011 through September 22, 2011; (5) What is the nature and extent of the injury; and (6) Is Petitioner entitled to penalties and attorneys fees.

STATEMENT OF FACTS

Petitioner testified that she was born and raised in Mexico; she has an elementary school level education from Mexico. She moved here about ten years ago. She speaks very little English. She is currently employed by the Respondent and has been for more than three years.

Petitioner alleged that on April 27, 2011 she was employed by Respondent and was responsible for sorting and hanging clothes that were offered for sale on hangers and then putting them on racks. Petitioner stated that she was injured while moving a rack full of clothing. Petitioner testified that she had worked for Respondent for approximately three years prior to the accident in April of 2011 (T. 15).

Petitioner testified that her job consisted of putting clothes onto a hanger and then hanging those clothes, one piece of clothing at a time onto a metal rack (T. 40). Petitioner testified that the racks were on wheels. Once she was finished hanging the clothes, she would pull the racks onto the store floor and the clothes would be sorted by size and gender (T. 15-16). Petitioner testified that the floors that the racks were pulled on were cement floors (T. 41).

On April 27, 2011, Petitioner testified that as she was pulling one of the clothing racks to sort the clothing, one of the wheels on her rack got caught on the wheel of another rack/cart (T. 17). She had not pulled the cart very far before it got tangled with a tire on another cart (T. 43). Petitioner testified that she felt a strain or pull in her mid back at that time (T. 18). She continued working and did not inform her supervisor of the incident at that time.

Petitioner testified that even though she had some pain in her back she did not notify her supervisor about her alleged injury at the end of the day, she just went home (T. 19). At home she took a pill and sat down so she could rest. It did not make the pain go away (T. 20). She had difficulty sleeping that night (T. 20). She returned to work the following day with a little less pain (T. 20). She did not work the full day, she would work a little and then rest (T. 20). She testified that she did not work the whole day, she left early because a friend at work said she would take her for a massage to help with the pain (T. 21). She did not notify her supervisor of her injury on that day either (T. 20).

Petitioner did not go for the massage, when she got home that night the pain was getting worse, travelling up her back. The pills were not helping and she had trouble sleeping that night as well (T. 21-21). When she got up the next morning she noticed that her back was hurting a lot (T. 22).

Petitioner testified that on the third day after her back injury she went to work and notified her supervisor as to her pain in her mid back (T. 22). Petitioner testified that her supervisor then sent her to the doctor (T. 23).

Petitioner was first seen at Physicians Immediate Care on April 29, 2011. (P. Ex. 1) Petitioner testified that she complained of back pain and leg pain. She had x-rays and was authorized to return to work with light duty restrictions of lifting no greater than fifteen (15) pounds (T. 24-25, 45). (P. Ex. 1)

She returned to Physicians Immediate Care on May 16, 2011, and was authorized to return to work with restrictions of no lifting greater than thirty (30) pounds (T. 46). (P. Ex. 1) Petitioner was prescribed physical therapy at Flexeon Rehabilitation. Petitioner first attended therapy on May 23, 2011. (P. Ex.2) Petitioner testified that her last day of physical therapy was on June 13, 2011 (T. 26). (P. Ex. 2)

On June 1, 2011, Petitioner went to Physicians Immediate Care for follow-up. At that time she reported that she thought physical therapy was helping, she only had leg pain when she has been standing on her feet working for a long time. (P. Ex. 1) She reported that she did not have pain when she was relaxing. Her pain on that day was 0 on a scale of 1 to 10. (P. Ex. 1)

Petitioner testified that on her June 7, 2011 follow up at Physicians Immediate Care, she first complained of upper arm and leg pain (T. 46). The medical notes from that day indicate that she complained of pain from the top of her shoulder to her fingertips, her entire left arm. It had been happening for the past three days. Her low back pain was not any better, the pain goes down to her foot now rather than just in her thigh. (P. Ex. 1) Her sister, who was interpreting for her indicated that they needed to tell the people at physical therapy to go very slowly because the physical therapy hurts. (P. Ex. 1) Petitioner complained of pain at a seven out of ten (7/10) on the pain scale. On examination, the doctor notes that Petitioner ambulated easily, and continued to have tenderness to superficial palpation of the entire left arm, left leg, fingers and toes, and left side of the upper/mid/lower back. There was no swelling or deformities and Petitioner was able to easily heel and toe walk. Petitioner had full range of motion in the back. It was noted that petitioner had positive Waddell's sign to superficial hyper tenderness and simulated rotation. The physician noted that all of Petitioner's pain was very superficial palpation of the skin (P. Ex. 1). Petitioner was diagnosed with a new onset of arm, upper back, and lower leg pain, which was not related to the original injury of a lumbar strain.

Petitioner testified that on June 10, 2011, she presented at Physicians Immediate Care with zero pain. Petitioner did not remember the exact date of her last treatment, but stated that she was discharged from care and authorized to return to full duty work (T. 47). Petitioner testified that she did return to full duty work at that time.

The medical records from June 10, 2011, indicate that the Petitioner was there for a blood draw for rheumatoid factor, sed rate and ANA. At the time the Petitioner reported that she currently was pain free. She stated that when she wakes up in the morning she does not have any pain at all anywhere on her body. The pain starts after she has been at work for three or four hours. She also stated that she does get a little bit of pain at home but nothing like what she gets at work. (P. Ex. 1) Her pain at that time was 0 on a 1 out of 10 scale. (P. Ex. 1)

Petitioner testified that she began treating with Dr. Barnabas, an internist, on June 24, 2011 (T. 26-27). Petitioner testified that she sought treatment with Dr. Barnabas after seeing him on television (T. 27). Petitioner testified that she complained of low back pain with some radiation. Petitioner testified that she underwent an MRI on June 24, 2011 (T. 27). Petitioner testified that Dr. Barnabas provided her with light duty restrictions (T. 28).

The medical records from Dr. Barnabas indicate that Petitioner was examined on June 24, 2011 by Dr. Ravi Barnabas, M.D. She gave history of the work accident as described at hearing. She complained of pain at level 5 going down the left leg with tingling numbness, standing makes it worse, sitting and walking makes it better difficulty sleeping at night. Dr. Barnabas found positive straight leg on the right for pain but no radiculopathy and positive on the left for pain and radiculopathy. (P. Ex. 3)

Petitioner testified that she attended physical therapy with Dr. Bermudez, a chiropractor. Petitioner testified that after multiple physical therapy visits, her pain was not improving so Dr. Barnabas referred her for a pain consultation. Petitioner was referred to treat with Dr. Chami (T. 28). She continued to work during her treatment with Dr. Barnabas and Dr. Bermudez (T. 48).

Petitioner testified that she was discharged from care from Dr. Bermudez and Dr. Barnabas on November 7, 2011 (T. 51).

Petitioner first saw Dr. Chami on July 28, 2011. Petitioner testified that Dr. Chami recommended injections into her back (T. 28-29). Petitioner testified that she underwent her first injection on August 4, 2011. Dr. Chami ordered her off of work from August 4, 2011 through September 22, 2011 (T. 30). He released her to return to work with restrictions after September 22, 2011 (T. 30-31). (P. Ex. 5) Petitioner testified that she had some pain relief after the first injection, but still had pain (T. 49).

Petitioner testified that she underwent an independent medical examination with Dr. Levin on September 19, 2011 (T. 49). Petitioner testified that she was honest and truthful in her representations of her condition and symptoms to Dr. Levin (T. 50). Petitioner testified that she became aware that Dr. Levin authorized her to return to full duty work after the examination (T. 50).

Petitioner testified that she underwent injections into her back on August 18, 2011, September 8, 2011 and October 18, 2011. Petitioner testified that she continued to have pain in her back, despite the injections (T. 49). Petitioner testified that she underwent a medial branch nerve block injection on December 1, 2011 (T. 33-34). Petitioner reported that she underwent her last injection on December 8, 2011 (T. 34). (P. Ex. 5) Petitioner testified that she had less pain, but still had pain in her low back (T. 51).

Petitioner testified that she continued to treat with Dr. Chami after the injections. Petitioner testified that Dr. Chami recommended physical therapy and/or work conditioning with Dr. Santiago, another chiropractor (T. 34). Petitioner testified that she attended therapy with Dr. Santiago and was released on February 24, 2012 (T. 35). Petitioner testified that she was also discharged from care from Dr. Chami and authorized to return to full duty work on February 24, 2012 (T. 35-36).

Petitioner testified that she has worked her full duty job for the employer since February 24, 2012. Petitioner testified that she continues to work for the employer, performing the same functions. Petitioner testified that she performs her regular duty work, without any restrictions, but performs her job functions "a little bit slower" (T. 36). Petitioner testified that she works about the same amount of hours as she did prior to April 27, 2011 (T. 37).

Petitioner testified that she gets tired faster and has pain after she stands or sits for three to four hours. Petitioner stated that she has to change positions every three to four hours if she is sitting or standing (T. 37). Petitioner testified that her employer accommodates her need to change positions. Petitioner denied any other aggravating factors that caused her pain in her low back (T. 54). Petitioner testified that she was able to complete all of her normal activities of daily living (T. 54).

Petitioner testified that she has not treated with any physician for her low back since February 24, 2012, and does not have any scheduled appointments or intention to seek any further treatment (T. 53-54)

At the request of the Respondent the Petitioner saw Dr. Levin for an examination pursuant to Section 12 of the Act. In his Section 12 examination report on September 19, 2011, and his addendum report drafted on February 12, 2013, Dr. Levin determined that the Petitioner did suffer a mild lumbar myofascial strain. (Rx. 1, 2). Dr. Levin noted in addition to the symptom magnification found in the treating records from Physicians Immediate Care, his physical examination of the Petitioner also revealed significant symptom magnification and nonorganic findings. These abnormal findings included focal weaknesses that were inconsistent with the MRI findings, markedly positive Hoover sign and the inability to feel proprioception in the lower extremities in spite of Petitioner being able to walk in a normal reciprocal heel/toe gait pattern (Rx. 1). Dr. Levin opined that Petitioner did not require any additional medical care after her discharge from Physicians Immediate Care on June 14, 2011 (R. Ex. 1). Dr. Levin determined that it was reasonable for Petitioner to undergo a course of treatment post-injury for approximately four weeks (R. Ex. 1). Petitioner had reached MMI and was capable of returning to full duty work on June 14, 2011 (R. Ex. 1).

The addendum narrative report drafted by Dr. Levin on February 12, 2013, in response to his review of Petitioner's medical records from July 2011, through February 2012 (R. Ex. 2). Dr. Levin opined that based on his review of Petitioner's MRI on June 24, 2011, as well as his examination of the Petitioner and the totality of information in his possession, he did not concur with Dr. Chami's treatment and injection therapy. Further, Dr. Levin noted that even Dr. Santiago diagnosed Petitioner with a lumbar sprain/strain. Dr. Levin opines that there was no medical evidence to support performing epidural injections or radiofrequency rhizotomies for such a diagnosis (R. Ex. 2). Based on his physical/objective examination and review of all of the medical evidence, Dr. Levin opined that Petitioner sustained a lumbar strain wherein she could have worked in a full duty capacity without restrictions within four weeks following her injury on April 27, 2011. Further, Dr. Levin opined that Petitioner would have reached MMI within 4-6 weeks post injury. Dr. Levin opined that invasive procedures such as injections are not indicated for Petitioner's occurrence on April 27, 2011, and based on the 14th AAOS' Occupational Orthopedics and Workers' Compensation course, such treatments are contraindicated (R. Ex. 2).

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). This includes the nature and extent of the petitioner's injury.

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission*, 58 Ill. 2d 226, 317 N.E.2d 515 (1974) "Arising out of" is primarily concerned with the causal connection to the employment. The majority of cases look for facts that establish or demonstrate an increased risk

to which the employee is subjected to by the situation as compared to the risk that the general public is exposed to.

To be compensable under the Act, the injury complained of must be one "arising out of and in the course of the employment". *820 ILCS 305/2*(West 1998). An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment, involving a causal connection between the employment and the accidental injury. *Parro v. Industrial Comm'n*, (1995) 167 Ill. 2d 385,393, 212 Ill. Dec. 537, 657 N.E. 2d 882.

Did Petitioner Sustain an Accidental Injury that Arose out of and in the Course of her Employment with Respondent? And Is Petitioner's Current Condition of Ill-being Causally Related to the Injury?

Petitioner suffered a sprain/strain injury on April 27, 2011.

After considering all of the evidence, and in reliance on the medical evidence and the independent medical examination findings of Dr. Levin, the Arbitrator finds that Petitioner suffered a mild lumbar strain. The Arbitrator noted that Petitioner did not have significant physical examination findings, and showed significant symptom magnification and nonorganic findings inconsistent with her diagnostic tests and objective pathology. Dr. Levin, found that four weeks of treatment and therapy post-injury was reasonable relating to Petitioner's lumbar sprain/strain. Based upon the medical records and the statements of the Petitioner to her treating physicians on June 1, 2011 and again on June 10, 2011, that her pain was zero on scale of one out of ten, that she was feeling no pain, the Petitioner's injury was resolved.

Any treatment after June 14, 2011, her date of discharge from Physicians Immediate Care, was unreasonable, unnecessary and not indicated. Specifically, therefore Petitioner's treatment with Dr. Chami and the five injections she received were unreasonable and unnecessary for the injury she sustained on April 27, 2011.

The Arbitrator notes that on Petitioner's initial examination at Physicians Immediate Care on April 29, 2011, Petitioner exhibited positive Waddell's signs with superficial hyper tenderness and simulated rotation (P. Ex. 1). Petitioner ambulated normally and was able to get up and down from sitting and lying position according to the medical records. There was tenderness to superficial palpation to the low back, left buttock and left hip/thigh. X-rays of the lumbar spine showed mild anterior osteophytic spurring at L3-5, with no other abnormalities. Petitioner was diagnosed with a lumbar strain and given light duty work restrictions (P. Ex. 1).

Petitioner continued to treat at Physicians Immediate Care on May 2, 2011 and May 16, 2011, complaining of tenderness to superficial palpation and also had positive Waddell's sign with simulated rotation and superficial hyper tenderness. Petitioner continued to be diagnosed with a lumbar strain. As of May 16, 2011, Petitioner's work restrictions were to lift no greater than thirty (30) pounds. The Petitioner's job is not a strenuous or heavy job (P. Ex. 1). Further, Petitioner informed Dr. Chami that her job involved lifting a maximum of thirty pounds. (P. Ex. 4).

The medical records note that Petitioner was prescribed and initiated physical therapy on May 23, 2011, on May 25, 2011 Petitioner continued to have tenderness to very superficial palpation and a positive Waddell's sign to superficial hypersensation. (P. Ex. 1). It was noted that Straight Leg Raise testing could not be performed because petitioner would not relax her leg, sitting or lying. (P. Ex. 1)

On June 1, 2011, and again on June 10, 2011, Petitioner rated her pain at a zero out of ten on the pain scale (0/10). As of June 14, 2011, Petitioner was found to have complaints of pain and hypersensitivity to her skin which were unrelated to her work injury and of unknown etiology. At that time, Petitioner was discharged from care at MMI and was authorized to return to full duty work without restrictions. Petitioner was found to have no residual disability or impairment and no further medical treatment recommended or necessary (P. Ex. 1).

The Arbitrator notes that Petitioner did return to full duty work after her discharge from care on June 14, 2011. Petitioner did not attend any additional physical therapy after June 13, 2011 (P. Ex. 2). The Arbitrator finds that the treatment received at Flexeon therapy and at Physicians Immediate Care was reasonable and necessary. The Arbitrator agrees with the recommendations that as of June 14, 2011 Petitioner had reached MMI and was capable of returning to full duty work without restrictions and did not require any additional treatment (P. Ex. 1, 2).

The Arbitrator notes that in addition to the symptom magnification found in the treating records from Physicians Immediate Care, Dr. Levin's physical examination also revealed significant symptom magnification and nonorganic findings. These abnormal findings included focal weaknesses that were inconsistent with the MRI findings, markedly positive Hoover sign and the inability to feel proprioception in the lower extremities in spite of petitioner being able to walk in a normal reciprocal heel/toe gait pattern (R. Ex. 1).

The Arbitrator finds that the Petitioner did sustain an accidental injury on April 27, 2011, that arose out of and in the course of her employment with the Respondent. The Petitioner's current condition of ill being is not causally connected to those accidental injuries. Based upon the physical examination findings and opinions of Dr. Levin and the medical records contained in Petitioner's exhibits 1 and 2 the Petitioner, at most, sustained a mild lumbar myofascial strain.

Has Respondent Paid all the Reasonable and Necessary Medical Bills?

The Respondent is responsible for the medical bills for treatment from April 29, 2011, through June 14, 2011, when the Petitioner was discharged from treatment. At the start of the hearing the parties agreed that the Respondent had paid some of the medical bills that were contained in Exhibit A and Exhibit B. They agreed that the Respondent has paid $13,981.44 for expenses that were listed on Exhibit A, and that the Respondent should be given credit for those expenses already paid. They also agreed that all of the medical bills that were submitted for treatment that the Petitioner received were subject to the fee schedule pursuant to the Act.

Petitioner's treatment with Dr. Barnabas and Dr. Bermudez, and their referral for Petitioner to treat with Dr. Chami was unreasonable and unnecessary and not causally related to Petitioner's lumbar sprain/strain on April 27, 2011. The Arbitrator finds that the medical evidence and testimonial evidence establish that Petitioner's continued complaints of subjective and nonorganic pain complaints after June 14, 2011, were not causally related to the alleged April 27, 2011. The Arbitrator's findings are supported by Petitioner's MRI of the lumbar spine which did not show any acute abnormalities and instead only degenerative findings.

To the extent that any medical bills remain outstanding for the medical treatment form Physicians Immediate Care and at Flexeon Rehabilitation, they were reasonable and necessary and the Respondent is responsible for those bills.

Is the Petitioner Entitled to TTD Payments from August 4, 2011 through September 22, 2011?

The Petitioner reported on June 1, 2011, and again on June 10, 2011, that she was pain free, she rated her pain as 0 on a scale of one to 10. Petitioner was authorized to return to full duty work as of June 14, 2011 and did not require any additional medical treatment as she had reached MMI. In reliance on the medical evidence and the expert opinion of Dr. Levin, the Arbitrator finds that Petitioner was capable of returning to full duty work at MMI as of June 14, 2011. In addition, the Arbitrator having found that Petitioner's treatment with Dr. Chami, who authorized Petitioner off of work from August 4, 2011 through September 22, 2011, was not reasonable or necessary, Petitioner's claim for TTD benefits is denied.

What is the Nature and Extent of the Injury?

Based on the medical evidence and the expert opinions of Dr. Levin, the Arbitrator finds that Petitioner sustained a mild lumbar myofascial strain/sprain to the lumbar spine as a result of the April 27, 2011 injury. Petitioner received reasonable and necessary medical treatment at Physicians Immediate Care and Flexeon Rehabilitation from April 29, 2011, through June 14, 2011. The Arbitrator agrees with the medical evidence authorizing Petitioner to return to full duty work without restrictions as of June 14, 2011. The Arbitrator also concurs with the medical opinions that as of June 14, 2011, Petitioner had reached MMI and did not require any additional medical treatment as causally related to her April 27, 2011 work injury.

The Arbitrator notes that Petitioner was authorized to return to light duty work from April 29, 2011, through June 14, 2011. Petitioner then returned to full duty work from June 15, 2011, through August 4, 2011, when Dr. Chami authorized her off of work. Regardless, Petitioner returned to light duty work as of September 23, 2011, and eventually returned to full duty work on February 25, 2012. Petitioner testified that she has continued to work her full duty job, working approximately the same number of hours ever since February 24, 2012. Petitioner testified that she is able to perform all of her job activities and all of her regular activities of daily living, albeit slightly slower. Petitioner testified that she has not received any medical treatment since February 24, 2012, and has no intention to seek medical treatment for her low back.

Based on the record as a whole, the Arbitrator finds that Petitioner sustained a loss of use of the person as a whole of 3% pursuant to Section 8(d)(2) of the Act.

Petitioner is found to have suffered a permanent injury of 3% loss the use of man as a whole pursuant to Section 8(d)2 of the Act. Respondent shall pay Petitioner permanent partial disability benefits of $253.00/week for 25 weeks, because the injuries sustained caused the 5% loss of use of man as a whole, as provided in Section 8(d)2 of the Act.

Is Petitioner entitled to penalties and attorneys fees?

The Arbitrator denies Petitioner's claim for penalties pursuant to Section 19(k) or 19(l) of the Act, and accordingly, does not award attorneys' fees pursuant to Section 16 of the Act. The Arbitrator finds that Petitioner sustained a mild lumbar strain and was discharged from care at MMI and authorized to return to full duty work on June 14, 2011 without any additional medical treatment pursuant to her alleged accidental injuries on April 27, 2011.

The Arbitrator relies on the opinions of Dr. Levin and the medical records from Physicians Immediate Care and Flexeon Physical Therapy in making this determination. The Arbitrator finds Dr. Levin's medical opinions credible and supported by the medical records and the statements of Petitioner to her treating medical personnel in April, May and June of 2011. Thus, the Arbitrator finds Respondent's termination of temporary total disability benefits and denial of further orthopedic and surgical intervention valid based on the expert opinions of Dr. Levin.

It is undisputed that Respondent paid temporary total disability benefits. Payment of temporary total disability benefits is not an admission of liability. TTD benefits were terminated after Respondent relied upon its credible Section 12 examination. Therefore, the Arbitrator does not award penalties and fees against the Respondent.

ORDER OF THE ARBITRATOR

Petitioner is found to have suffered a permanent injury pursuant to Section 8(d)2 of the Act. For the foregoing reasons, Respondent shall pay Petitioner permanent partial disability benefits of **$253.00/week** for **25** weeks, because the injuries sustained caused the **5%** loss of use of man as a whole, as provided in Section 8(d)2 of the Act.

Deborah L. Simpson — Signature of Arbitrator

July 14, 2013 — Date

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ALLAN D. WHEELER,

Petitioner,

vs. NO: 11 WC 34788

BALDWIN MANUFACTURING CO.,

Respondent.

14IWCC0120

DECISION AND OPINION ON REVIEW

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

Findings of Fact and Conclusions of Law

1. Petitioner testified that on February 21, 2011 he was employed by Respondent which manufactures pallets, crates, and boxes, and had been so employed since about the end of January of 2009. He got "sometimes 20 hours or more" of overtime. He saw Respondent's video of activities at its plant; it did not depict all of his job duties. It only depicted about 15% to 20% of his activities.

2. In his job he cut wood to sizes needed for assembling the final product. He would use various types of power saws in his work. When using the saws he felt vibration in his arms. He used the saws about 50% of the time he worked; the remaining 50% was spent assembling the product.

3. In assembling the product, Petitioner would use pneumatic nail guns ranging between 10-15 pounds to 25-30 pounds, depending on the size of the nails being driven. "On the big ones you had to punch pretty hard," and there was "some" kickback "on the smaller ones." The videos only show use of the small nail guns. Petitioner used both hands when using the nail guns; "probably 60% to 70% with his right, the rest left." Petitioner also has to hand stamp the finished product. Petitioner estimated that sawing, assembling, and stamping consist of 95% to 100% of his work.

4. Petitioner further testified his arms starting bothering him with numbness, tingling, and a little bit of pain; he began waking up in the middle of the night. The condition worsened and he saw Dr. Ahn on February 21, 2011. He diagnosed bilateral carpal tunnel syndrome and cubital tunnel syndrome. When Petitioner told Dr. Ahn what he did for a living, Dr. Ahn stated the condition was work related. Dr. Ahn ordered an NCV which confirmed the diagnosis of bilateral carpal tunnel and cubital tunnel surgeries.

5. Petitioner had an unrelated workers' compensation claim against Respondent concerning his thumb. He treated for that condition with Dr. Froehling. Dr. Froehling was also familiar with the condition of his arms and about complications that occurred after surgery in the left arm. He ordered a functional capacity examination ("FCE") and put permanent work restrictions on Petitioner of lifting 15 pounds frequently and 50 pounds occasionally.

6. Respondent paid for the surgeries and for the time he was off work. However, after the surgeries Respondent sent him for an IME with Dr. Strecker. Dr. Strecker recommended a repeat NCV and FCE, which Respondent approved five months later. Petitioner would return to work with Respondent if it could accommodate his restrictions; he has demanded vocational rehabilitation, but it has not been provided.

7. Petitioner also testified that currently he still had "quite a bit of pain" and weakness "mainly in the elbows." He still has numbness through the palm of his hand. Petitioner has tried to find work on his own and documented his job search. Dr. Strecker told him he could have additional surgery for his elbows if he desired. He informed Respondent he was going to see Dr. Ahn for his arms; he had to take the day off.

8. On cross examination, Petitioner testified the first year he worked for Respondent he worked a 32-hour week. Then "things picked up" and he was able to work a 40-hour week and had opportunities for overtime. Petitioner denied telling Dr. Ahn that he had the symptoms for two years. However, he saw his general practitioner prior to seeing Dr. Ahn and told her he had symptoms for two years. There are about eight employees at Respondent that perform work activities similar to his.

9. Petitioner agreed that the number and type of product he builds differ depending on the particular order. Some of the saws had automatic feeders through which one only had to load the wood in and did not have to manually feed the wood, "when it's working right." From time to time Petitioner would have to band stacks of pallets before they are shipped. He also operated a forklift and cleaned the work area.

10. Petitioner also testified the devise depicted in the video is a nail gun and not a staple gun; Petitioner did not recall using a staple gun. One has to pull the trigger to release the nail from the nail gun. The nail guns take care of 80% to 90% of the nailing, but occasionally he had to manually hammer in nails that were missed or not completely flush. Petitioner told Dr. Ahn he used pneumatic hammers. Dr. Froehlich did tell him the more he used his limbs the stronger they would get. He was lifting weights in physical therapy.

11. Prior to his employment with Respondent, Petitioner worked as a laborer on a farm. He "kind of ran parts to them and farmed, drove a tractor, greased stuff, serviced equipment." He took classes in auto repair at a Community College. He did not have a commercial driver's license, but he does own a motorcycle. He generally uses the motorcycle for short trips; he only takes a long ride once or twice a month. The motorcycle did "not really" produce vibration. He has played a guitar for amusement for a few years. He probably has not played the guitar for a month or two. He does some gardening of flowers around the house.

12. Petitioner sought work from companies even though he did not know they were hiring. He just contacted everybody he knew to contact. He would follow up after his initial contact. He applied for jobs at a pizza place and at least three other restaurants. He has not worked since he left Respondent to have his surgeries. The two EMGs were over a month apart; he did not work in the interim. The later EMG showed his elbows "were actually getting worse."

13. On redirect examination, Petitioner testified when he banded he would wrap the steel banding around a stack of crates, "jack it and then slap it up to cut it." He did not believe it was accurate that he told his general practitioner he had symptoms for two years; he thought "it was probably a year." By February of 2011 his arms got much worse. He would have appreciated help in finding a job.

14. On re-cross examination, Petitioner testified he did not recall telling Dr. Ahn he had symptoms for two years; he "thought it was a year."

15. Matt Deen testified he runs Respondent's "operation from payroll to being on the floor with the guys and building pallets and cutting wood and pretty much do it." He has performed all the job activities that Petitioner performed. Respondent was not able to bring him back because they did not have any light duty for a general laborer. The 15 pound restriction was a problem.

16. After the Respondent's business increased in 2010, Petitioner probably worked 48 hours or more per week. The day before Petitioner went to the doctor was the first time he heard about any problems he had. At that time Petitioner told him he was going to see a doctor to have his hand looked at. He did not complain about any other part of his body. After he saw the doctor was the first time Petitioner indicated his condition may be work-related.

17. Each worker's duties change from day to day and from week to week. Mr. Deen testified that Petitioner's description of his job duties "pretty much sums it up for the most part." Some pallets are built with pine, some with hardwood, and some with both. They use staple guns and guns that use nails between 1½ inches and 3¼ inches. Some of the saws do create vibration.

18. The witness further testified the videos "could accurately depict a guy's day." "It just so happened that the guy showed up that day and [they] were running the single-head resaw," and then when they were actually building the pallets. The witness did not recall seeing Petitioner use a nail gun with his left hand; Petitioner is right-hand dominant. Forklifts do not produce vibration. Petitioner asked a co-worker to arm-wrestle after he told the witness of his problem but before his surgery. Petitioner did not actually arm-wrestle the other employee.

19. On cross examination, the witness testified they have to cut down wood to make their product. They had both a "cut shop" and a "build shop." He estimated that an employee work 50% of their time in the cut shop and 50% in the build shop. "Somewhere in the neighborhood" of 90% of employees' work is either in the cut chop or the build shop. The witness does a lot of the "set up" tasks himself. When one uses the small nail guns, the process is pretty fast.

20. The medical record indicates that on February 21, 2011, Petitioner presented to Dr. Ahn. On the intake form Petitioner noted he had 10/10 pain. There was no injury but was of gradual onset for 2 years and was related to his repetitive work activities. He was 6' 230 pounds, and smoked a pack of cigarettes a day for 35 years.

21. At the initial appointment with Dr. Ahn, Petitioner complained of bilateral hand numbness and tingling for about two years. He has been wearing splints and taking Tramadol but still wakes seven to eight times a night. He sought "further intervention." Dr. Ahn diagnosed bilateral carpal tunnel syndrome and cubital tunnel syndrome. Petitioner had already tried anti-inflammatories and the next step would be cortisone injection. In an "addendum" Dr. Ahn noted that Petitioner reported working as a "manual laborer and constant hammering and pounding on the palm aspect and constant repetitive motion for the past three years or so." He wanted to know if his condition could be work related. Dr. Ahn posited it was "at least a contributing factor." Petitioner wanted to start a workers' compensation claim prior to getting an EMG. Dr. Ahn would put it off and seek approval.

22. An EMG taken on April 4, 2011 showed moderate to severe bilateral carpal tunnel syndrome and cubital tunnel syndrome, left worse than right. Dr. Ahn recommended surgery as soon as possible. Dr. Ahn performed right carpal tunnel and cubital tunnel release on April 21, 2011.

23. Petitioner returned to Dr. Ahn on May 2, 2011, at which time he removed the sutures and noted Petitioner was doing well without complaints. His sensation was back to normal and night symptoms had resolved. Dr. Ahn released Petitioner to light duty.

24. On May 26, 2011, Dr. Ahn performed left carpal tunnel and cubital tunnel release.

25. Petitioner returned to Dr. Ahn on June 10, 2011, who noted Petitioner developed a hematoma and possible infection in the left elbow area, which Dr. Ahn wanted to treat conservatively. He kept Petitioner off work for another week. On June 15, 2011, Dr. Ahn noted that the hematoma was "quite substantial" with "quite a bit of swelling." They would continue conservative treatment, but surgery may be necessary. On June 29, 2011, Dr. Ahn noted that the arm looked much better. He put Petitioner on light duty through July 20, 2011.

26. On October 25, 2011, Petitioner had an FCE on referral from Dr. Froehling. It was noted that initially Petitioner had a "comminuted fracture of distal phalanx right thumb on March 19, 2010; bilateral cubital tunnel release and bilateral carpal tunnel release approximately May/June 2011." Petitioner was cooperative and exhibited consistent and maximum effort. The primary limiting factor was "weakness in the bilateral wrist/elbow musculature, and impaired grip strength."

27. Petitioner also reported a history of back pain as a limiting factor in his performance. The therapist assessed Petitioner to be able to work and a medium physical demand level. The therapist could not determine whether he could work at his current job because of inconsistencies in the job demand level provided by the employer and Petitioner as well as inconsistency within the job demand description provided by the employer.

28. Dr. Ahn testified by deposition on July 9, 2012. He testified when he first saw Petitioner, he reported progressively worsening numbness and tingling for two years. He reported being a manual laborer and did a lot of hammering, pounding, and using power tools. An EMG showed moderate to severe bilateral carpal tunnel syndrome and cubital tunnel syndrome, left worse than right, with mild denervation. He performed bilateral surgery on Petitioner wrists and elbows. He decompressed but did not transpose the ulnar nerves.

29. Petitioner developed hematoma after the left surgery and Dr. Ahn kept him off work longer than he did after the right surgery because he wanted to limit his activity. He released Petitioner to light duty after his visit on June 29, 2011. After that "he sort of disappeared."

30. When asked what he understood to be Petitioner's work activities, Dr. Ahn testified all he remembered was that Petitioner told him he used a power nail gun that impacted into the palmar aspect and he had to lift quite a bit. He read Dr. Strecker's report but he did not see the videos to which Dr. Strecker referred. Dr. Ahn was asked to assume that Petitioner frequently used saws and various tools to cut lumbar that transfer vibration, he frequently manipulated stick lumber and plywood, and frequently used a nail gun and performed forceful stamping, for 2/3 or more of his work day. He was then asked whether such work activities caused or contributed to Petitioner's condition. Dr. Ahn answered it was "pretty safe to say it is a definitely a contributing factor."

31. On cross examination, Dr. Ahn testified the only information he had about Petitioner's job activities came from Petitioner. He added the addendum because Petitioner asked him whether his condition could be work-related. With non workers' compensation patients, he does not really go into great detail about the patient's work. If was going to be a workers' compensation case, he had to ascertain the patient's job activities and whether those activities could be related to the condition.

32. Petitioner informed him he used tools "constantly;" usually in FCE terms that would mean more than 2/3 of a work day. He assumed Petitioner worked at least 40 hours a week. Petitioner is right-handed and typically a right-handed person with use that hand more than the left.

33. Dr. Ahn disagreed with counsel's statement that it was difficult to ascribe the condition to work activities because the EMG showed the condition of the left hand/arm, or non-dominant side, was worse. One still uses the non-dominant hand to perform functions. Petitioner is a pack a day smoker and had been for 35 years. Dr. Ahn testified there is "some suggestion" of a link between compressive neuropathies, but he would not "go so as to say" it is "the absolute risk factor."

34. Dr. Ahn agreed that if he were provided information about Petitioner's work activities and weekly hours of work that differed from what Petitioner told him, his opinion on causation may be different. Dr. Ahn agreed that on his intake form Petitioner noted he was in 10/10 pain, however, Dr. Ahn indicated in his treatment note that Petitioner was not in acute distress.

35. Dr. Ahn further testified that crooking the hand increases symptomology of carpal tunnel syndrome. Dr. Ahn does not ride a motorcycle so he did not know whether that would cause such a position of the hands. However he does ride a bicycle and typically the wrists are relatively straight. He thought unlikely vibration from a motorcycle would be a contributing factor for carpal tunnel syndrome, but playing a guitar could possibly exacerbate the symptomology.

36. Finally, Dr. Ahn testified the hematoma Petitioner developed could have delayed his healing process but it should not result in any long term deficit. He has not seen Petitioner since June 29, 2011 so he does not know his condition after that date. He was satisfied with the results of the surgeries because Petitioner's symptoms improved. It is possible that he might not achieve total return of sensation because the nerve was damaged prior to the surgery.

37. Dr. Strecker testified by deposition on July 11, 2012. The witness testified he is a board-certified orthopedic surgeon specializing in upper extremity and hand surgery. At the request of Respondent, he examined Petitioner, reviewed medical records, and issued a report. Petitioner indicated he was a materials handler and would load and unload wood, use a chop saw and nail guns, drive a forklift, occasionally use a bander, and push and drag push crates weighing up to 210 pounds.

38. Petitioner told the witness he did gardening but had not ridden "his motorcycle for some time." In his examination, Dr. Strecker noted some non-anatomic responses in the pattern of sensation loss; he showed significant numbness without any motor dysfunction.

39. Dr. Strecker recommended a repeat EMG. The new EMG showed some improvement from the pre-surgery EMG. However, he still showed neuropathy particularly in the left elbow. That neuropathy could not have been cause by work activities because he had not worked since the surgery. Dr. Strecker also recommended a repeat FCE. The new FCE indicated Petitioner should be restricted to lifting 30 pounds and 25 pounds frequently, and carrying 35 pounds.

40. Dr. Strecker opined that the carpal tunnel syndrome in Petitioner's left wrist was not work-related. He did not have to use power tools with his left hand. Petitioner was a heavy smoker, "at least overweight" at 6' 250 lbs, and was being treated for hypertension. These are all risk factors for developing carpal tunnel syndrome. However, Dr. Strecker believed Petitioner's work activities were a contributing factor in his developing carpal tunnel syndrome in his right wrist. Dr. Strecker also opined that Petitioner's bilateral cubital tunnel syndrome was not causally related to his work activities.

41. Dr. Strecker explained that work-related cubital tunnel syndrome is generally caused by repeated trauma to the elbows, resting on one's elbows for a prolonged period of time, and forced flexion of the elbows greater than 100 degrees for prolonged periods of time. Petitioner indicated his job duties varied and he did not experience the factors Dr. Strecker described. There is "nothing in the medical literature at all that shows flexing your elbows causes cubital tunnel."

42. On cross examination, Dr. Strecker testified there was no doubt that Petitioner had bilateral cubital tunnel syndrome and cubital tunnel syndrome. When he examined Petitioner he noted sensory loss which indicated he may have some other neuropathies. He also thought "it would be reasonable to do a more extensive exploration of his ulnar nerve" and possibly transposition.

43. Dr. Strecker agreed that use of vibratory tools on a regular basis does correlate with higher instances of cubital tunnel syndrome. If Petitioner experienced vibration in his left hand on a regular basis that may have contributed to his left-sided cubital tunnel syndrome. Dr. Strecker agreed that lifting very heavy objects can result in cubital tunnel syndrome because it can cause trauma to the elbows.

44. After the second FCE, which was not submitted into evidence, Dr. Strecker agreed that Petitioner's work should be restricted. He also agreed that the restrictions would not be in accordance with the physical demands of the job he had with Respondent. While the second FCE was not in evidence, in his report, Dr. Strecker noted the new FCE indicated Petitioner should be restricted to lifting 30 pounds and 25 pounds frequently, and carrying 35 pounds.

45. On redirect examination, Dr. Strecker testified that while vibration can contribute to the development of cubital tunnel syndrome, the crucial issue is the extent the person is exposed to such vibration. He agreed that "there has to be the exposure to it and there has to be some duration associated with it."

46. Respondent submitted into evidence a labor market survey which concluded Petitioner was employable. It specified eight positions within the sedentary to medium physical demand level. The survey ranged from automobile detailer earning $9.92 an hour to motorcycle sales associate earning $24.47 an hour. Hiring frequency for these positions was either "seldom" or "occasional."

47. Petitioner submitted into evidence a "job search log." The log appears to span a period between November 22, 2011 through October 16, 2012 (the years are not designated). It appears to include 79 contacts of which there is a "not hiring" or "no positions" notation on about 61 of them. Those were pretty much the first entries. Thereafter, Petitioner indicated he applied on line for about 11 jobs. On the remaining entries Petitioner noted he was not qualified. In addition, the log has 39 entries between November 22, and January 31. Thereafter, there is a hiatus up to June 4 after which the log continues.

In finding Petitioner proved causation of his bilateral carpal tunnel syndrome and cubital tunnel syndrome, the Arbitrator noted that the testimony of Mr. Deen actually corroborated Petitioner's testimony about his work activities. In addition, he found the opinion testimony of Dr. Ahn more persuasive than that of Dr. Strecker. After reviewing the entire record as outlined above, the Commission concurs with the analysis of the Arbitrator and affirms and adopts the decision regarding causation. The Commission also agrees with the analysis of the Arbitrator on the issues of notice and temporary disability benefits and affirms and adopts those portions of the Decision of the Arbitrator.

It is clear that in many ways Petitioner's job search efforts were inadequate. He often contacted companies that were not hiring about positions for which he was not qualified. Initially, Petitioner may have been at least somewhat motivated from the beginning of his search to January 31, 2011. Thereafter, his job search was moribund for more than four months before the search logs include additional entries. There was no explanation for that lengthy hiatus. It appears that at that point Petitioner may not have been sincerely looking for employment, but rather simply attempting to enhance his eventual workers' compensation award. Therefore, the Commission terminates maintenance after January 31, 2011.

In awarding Petitioner permanent partial disability of 40% of the person as a whole, the Arbitrator noted that the injuries Petitioner suffered made it impossible for him to pursue his normal employment. First, it is not entirely clear that Petitioner indeed sustained his burden of proving he is incapable of "performing his normal and customary duties of his job." The Commission acknowledges that Dr. Strecker did opine that Petitioner was not capable of returning to his previous job with Respondent based on the second FCE. However, that FCE was never submitted into evidence. In addition, while Mr. Deen testified that the 15 pound limitation was a "problem" in performing the job, that restriction was imposed by Dr. Froehlich who did not treat Petitioner's current conditions of ill-being and it appears to be at odds with the FCEs.

The Commission also notes that in the first FCE the physical therapist assessed Petitioner to be able to work at a medium physical demand level. He also specifically stated that he was unable to assess Petitioner's ability to return to his previous employment because he did not have adequate information of the physical demands of Petitioner's previous job. The Commission is also in that position because no assessment of the physical demands of the job was submitted into evidence. In addition, the physical therapist in the first FCE specifically noted that the deficit in Petitioner's performance in the FCE was affected by his back condition. The Commission concludes that it is unclear from the record what percentage of Petitioner's disability identified in the FCEs is related to his current conditions of ill-being of his hands and arms and that which is related to his thumb and back conditions, which are not at issue here.

Second, it appears from the Decision of the Arbitrator that based on a 40-hour work week Petitioner was earning $9.50 an hour in his employment with Respondent. The labor market survey, though in itself far from a model of a comprehensive such survey, identified jobs that all paid $9.92 an hour or more.

Therefore, the Commission concludes that because Petitioner's injuries were sustained to discreet parts of his body, awards for the permanent partial disability of those specific parts of the body is more appropriate than an award for loss of the person as a whole. Assessing the record in its entirety, the Commission finds that an award of 10% loss of the use each hand and 15% of the use of each arm is appropriate in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $286.00 per week for a period of 33 2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $286.00 per week for a period of 116.9 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 10% loss of the use of each hand and the loss of the use of 15% of each arm.

IT IS FURTHER ORDERED BY THE COMMISSION that maintenance benefits of $286.00 for 7 4/7 weeks as provided by §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the medical bills as identified in Petitioner's Exhibit 6 as provided in §8(a) of the Act, pursuant to the applicable 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.

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Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $70.000.00. The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: FEB 19 2014

Ruth W. White

Charles J. DeVriendt

Michael J. Brennan

RWW/dw
O-1/28/14
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WHEELER, ALAN
Employee/Petitioner

Case# **11WC034788**

14IWCC0120

BALDWIN MANUFACTURING COMPANY
Employer/Respondent

On 12/7/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0246 HANAGAN & McGOVERN PC
BRIAN McGOVERN
123 S 10TH ST SUITE 601
MOUNT VERNON, IL 62864

0332 LIVINGSTONE MUELLER ET AL
MARTIN HAXEL
620 E EDWARD ST PO BOX 335
SPRINGFIELD, IL 62705

14IWCC0120

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

Alan Wheeler
Employee/Petitioner

v.

Baldwin Manufacturing Company
Employer/Respondent

Case # 11 WC 34788

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **William R. Gallagher**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 19, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On February 21, 2011, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $19,760.00; the average weekly wage was $380.00.

On the date of accident, Petitioner was 50 years of age, ***married*** with 1 dependent children.

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

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

Respondent shall be given a credit of $17,518.46 for TTD/maintenance, $0.00 for TPD, and $0.00 for other benefits, for a total credit of $17,518.46.

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

ORDER

The Respondent is to make payment of the medical bills as identified in Petitioner's Exhibit 6 as provided in Section 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall receive a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers for any 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 $286.00 per week for 33 2/7 weeks commencing April 21, 2011, through December 9, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $286.00 for 45 weeks commencing December 10, 2011, through October 19, 2012, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner the sum of $286.00 per week for 200 weeks as provided in Section 8(d)2 of the Act because the injury sustained caused the 40% loss of use of the body as a whole.

Respondent shall pay Petitioner compensation that has accrued from April 21, 2011, through October 19, 2012, 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.

William R. Gallagher, Arbitrator
ICArbDec p. 2

December 3, 2012
Date

DEC - 7 2012

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent. The Application alleged a date of accident (manifestation) of February 21, 2011, and stated Petitioner sustained repetitive trauma to the bilateral upper extremities. Respondent denied liability in this case on the basis of accident, notice and causal relationship.

Petitioner testified he became employed by Respondent in January, 2009. For the first year Petitioner worked approximately 32 hours a week and then, due to an increase in business, Petitioner worked a substantial amount of overtime, sometimes as much as an additional 20 hours per week. Respondent's business consists of cutting various types and sizes of lumber which is then used for assembly into pallets, boxes and crates.

Petitioner testified that he spent approximately 50% of his time working in the "cut shop," which is where the lumber is cut into appropriate sizes; and 50% of his time doing the assembly work. When the lumber is cut, there are a wide variety of electrical saws used. Petitioner testified he did feel vibration in his hands when he was using these saws, although some saws did have more vibration than others, in particular, the gang rip saw and notcher saw. In performing his assembly duties, Petitioner used three different types of pneumatic air nailers and stated that a significant amount of force was required when using the large nailer. Petitioner estimated that the saw and assembly work took up approximately 95% of his time with the remainder being spent cleaning, driving a forklift, retooling, etc.

Matt Deen, Respondent's Vice President, testified on behalf of the Respondent at trial. Deen stated that he works on the floor with the other employees and performs manual labor and has himself operated all of the tools in the shop. Deen agreed with Petitioner that some of the saws result in vibration to the hands and arms and that the larger nailer did require significant force to be used especially when it was used on the harder woods. Deen did not have any significant disagreement with Petitioner's description of his job duties.

Petitioner began to experience symptoms in both of his hands and initially sought medical treatment from Dr. Joon Ahn on February 21, 2011. Petitioner testified he informed Deen that he was going to see Dr. Ahn on that date and, afterwards, informed Deen that Dr. Ahn had told him that he had a work-related condition. Deen prepared a First Report of Injury on March 10, 2011, which did not contain any specific information about the injury and described the incident as being "unknown."

Dr. Ahn initially diagnosed Petitioner with bilateral carpal tunnel and cubital tunnel syndromes. Dr. Ahn had nerve conduction studies performed which confirmed this diagnosis. On April 21, 2011, Dr. Ahn performed surgery on the right hand and elbow consisting of an open carpal tunnel release and endoscopic cubital tunnel release, respectively. Dr. Ahn performed the same surgical procedures on the left hand and arm on May 26, 2011. Post surgically, Petitioner received occupational therapy and was under the care of Dr. Alan Froehling. At Dr. Froehling's request, a functional capacity evaluation (FCE) was performed on October 25, 2011. Dr. Froehling reviewed the FCE and in his record of December 9, 2011, opined that Petitioner was at

MMI but that he had a light duty restriction of frequent lifting not to exceed 15 pounds, and occasional lifting not to exceed 50 pounds.

At the direction of Respondent, Petitioner was examined by Dr. William Strecker on February 22, 2012. Dr. Strecker opined Petitioner did have bilateral carpal tunnel and cubital tunnel syndromes and that the medical treatment he had received for those conditions was appropriate. In respect to causality, Dr. Strecker opined that the right carpal tunnel syndrome was related to Petitioner's work activities; however, Dr. Strecker opined that the left carpal tunnel syndrome and bilateral cubital tunnel syndrome were not related to Petitioner's work activities. Dr. Strecker's opinion was based primarily on the fact that Petitioner used his right hand in his operation of the vibratory tools. At Dr. Strecker's direction, another FCE was performed and based on this, Dr. Strecker opined Petitioner could lift 30 pounds occasionally, 25 pounds frequently but had a restriction no carrying greater than 35 pounds.

Dr. Ahn was deposed on July 9, 2012, and his deposition was received into evidence. In regard to causality, Dr. Ahn testified that frequently using saws and tools to cut lumber, which transmit vibration through the lumber, frequent manipulation of lumber, and frequent use of a nail gun which requires force, would definitely be contributing factors to the development of bilateral carpal tunnel and cubital tunnel syndromes.

Dr. Strecker was deposed on July 11, 2012, and his deposition was received into evidence at trial. He testified that Petitioner's work was a contributing factor to the development of the right carpal tunnel syndrome due to the power tool usage by Petitioner. He opined there was no history of the Petitioner using vibratory tools with his left hand. In respect to the cubital tunnel syndrome, Dr. Strecker opined that Petitioner's work duties varied and did not cause any trauma to his elbows.

Respondent tendered into evidence 3 DVD's which are videos of other individuals performing some of the job duties of Petitioner. These videos are extremely brief and only show a small portion of Petitioner's job duties. The videos are not nearly as complete or descriptive as the testimony of both the Petitioner and Deen.

The Petitioner remains unable to return to work at this time and Respondent does not have any work to offer him of that conforms to the restrictions that have been imposed upon him. This was confirmed by the testimony of Respondent's witness, Matt Deen. Petitioner testified that he has been looking for a job but has been unsuccessful in doing so. At the time of trial, a job search log prepared by the Petitioner was tendered into evidence. Petitioner's counsel also tendered into evidence various letters from him to Respondent's counsel wherein he demanded vocational assistance. The Respondent has not offered any vocational assistance to Petitioner.

Respondent did obtain a labor market survey prepared by Michael McKee, CRC, on August 1, 2012. This was received into evidence and it did indicate that Petitioner was capable of performing work tasks in the light to light–medium work task level. McKee opined Petitioner was employable and the labor market survey report listed eight employers; however, in respect to the hiring potentials of these eight employers six of them indicated that they were hiring "occasionally" and two of them indicated they were hiring "seldom."

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator finds Petitioner sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent to both of his hands and arms as alleged in the Application for Adjustment of Claim.

In support of this conclusion the Arbitrator notes the following:

The Arbitrator finds there was no dispute that Petitioner did use various tools that cause vibration and pressure to Petitioner's hands and arms. Both the Petitioner and Respondent's witness testified regarding the various tool usage and there was no substantial difference in their testimony.

The Arbitrator further finds the testimony of Petitioner's treating doctor, Dr. Ahn, to be more credible than Respondent's Section 12 examining doctor, Dr. Strecker.

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

The Arbitrator finds Petitioner gave notice to Respondent within the time limit prescribed by the Act.

In support of this conclusion the Arbitrator notes the following:

Petitioner informed Respondent's agent, Matt Deen, that he had a work-related injury following his return from Dr. Ahn's examination of February 21, 2011. A First Report of Injury was prepared by Deen on March 10, 2011. While this report contains no specific information about the exact nature of the injury being claimed, there is no controversy that Petitioner was claiming to have sustained a work-related injury at that time. Further, even if this notice is found to be defective, Respondent has not shown any undue prejudice to its interest because of any alleged defect in said notice.

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

The Arbitrator finds all the medical treatment provided was reasonable and necessary and Respondent is liable for payment of the medical bills associated therewith.

The Respondent is to make payment of the medical bills as identified in Petitioner's Exhibit 6 as provided in Section 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall receive a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers for any 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 conclusions of law:

Respondent is liable for payment of temporary total disability benefits to Petitioner for 33 2/7 weeks commencing April 21, 2011, through December 9, 2011.

Respondent is liable for payment of maintenance benefits to Petitioner for 45 weeks commencing December 10, 2011, through October 19, 2012.

In support of these conclusions the Arbitrator notes the following:

As is stated herein, the Arbitrator has found Petitioner's bilateral carpal tunnel and cubital tunnel syndromes to be compensable. Respondent is thereby liable for payment of temporary total disability benefits from the time Petitioner became disabled until he was found to be at maximum medical improvement.

It is undisputed that Respondent does not have work to offer to Petitioner that conforms to his permanent restrictions. Petitioner made repeated demands to Respondent for vocational assistance all of which received no response. Petitioner attempted to do a self-directed job search but unsuccessfully. Respondent did have a labor market survey conducted and it is noteworthy that of the eight potential employers, six of them indicated that jobs were available occasionally and two of them indicated that jobs were available seldom.

In respect to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator finds Petitioner's repetitive trauma injury has caused permanent partial disability to the extent of 40% loss of use of the body as a whole.

In support of this conclusion the Arbitrator notes the following:

The cumulative effect of Petitioner's injuries and the permanent work restrictions that have been imposed have incapacitated him from performing his normal and customary duties of the job which he had prior to the injury.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANNIE WADE,

Petitioner,

vs.

NO: 10 WC 30912

GENERAL DYNAMICS,

14IWCC0121

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Williamson County. The Commission had affirmed the Decision of the Arbitrator denying compensation. However, the Commission found the Arbitrator's determination that Petitioner was not credible was not supported by the record. The Commission noted that the case had been heard by another Arbitrator and the decision was issued by an Arbitrator who had not heard the case after the Arbitrator that heard the case was not reappointed as arbitrator. The Commission then wrote a full decision explaining that Petitioner's accident, caused by tripping over a shoelace, was not within the scope of her employment.

The Circuit Court of Williamson County reversed the Commission on the issue of accident and found that Petitioner proved that the requirement that she work at an accelerated pace put her at greater risk than the general public to trip over her shoelace. The Circuit Court of Williamson County remanded the case to the Commission to determine all other issues. Therefore, the issues now before the Commission are causation, temporary total disability, permanent partial disability, and medical expenses.

Findings of Fact and Conclusions of Law

1. Petitioner testified on June 10, 2010 she worked for Respondent as an "NAIC" and performing the task of "reverse torque." In that role you "pick up two parts. You examine them for gaps. You take them in. You put them in. You come back out. You work the levers. You pick up two more parts inspect them as you go in. You go in, I pick one out, drop one in, pick one out, drop one in. You inspect for gaps again. You

come around, put them in, do your thing." The parts to which she was referring are projectiles or bullets. Her job was ensuring that the top of the projectile is properly screwed into the body. If they're good she puts them in the good box, if there is a gap she puts them in the reject box.

2. She indicated she inspected two projectiles at a time; one in each hand. Respondent would like them to process 400 projectiles an hour. After every 500, "parts had to be mastered" "to make sure it was still working." She observed the video submitted as Respondent's exhibit 4. It was accurate but did not show the speed of the job. "You can't work at that speed and do what you've got to get done."

3. Petitioner also testified that during the process of doing that job, she "turned to leave the bay looking for [her] parts" and stepped on her shoestring. When she pivoted it jerked her and threw her off balance. She "twisted back to grab the table to keep from falling and hitting the floor." She felt pain in her lower back and "butt cheek." The incident occurred at about 1:30. She completed her shift which ended at 3:00. Petitioner sought treatment on June 15, 2010. She waited to seek treatment because she thought she simply pulled a muscle. But her symptoms got worse. Pain started moving down into her knee; "from [her] butt, into [her] knee, burning real bad." Monday it hurt so much she could not sleep; she went to Logan Primary Care on Tuesday and was prescribed Flexeril.

4. Petitioner further testified she did not immediately report her accident to Respondent because she "hadn't been back two months from [her] hand surgery" and "didn't want to get in trouble." However, her condition progressively got worse; the more she sat it got worse. She couldn't stand, she couldn't sit, so she had to "turn it in." She was directed by Respondent to see Dr. Austin, whom she saw on July 19, 2010. She reported the accident date as June 17, 2010. She really could not remember the date but knew it was a Thursday because she "remembers pay day." Dr. Austin prescribed medication and put her on light duty.

5. On August 9, 2010, Respondent concluded the claim was not meritorious and would not let her work light duty. Petitioner's condition continued to get worse. Physical therapy and injections were recommended but she did not have the injections. Physical therapy was discontinued because it was not doing her any good. Finally, surgery was performed on February 7, 2011. The surgery was successful and her radiating pain is mostly gone. Dr. Jones indicated that residual pain would persist for about six months before the nerve irritation subsided. She has occasional flare-ups but her back is good. She is able to perform her job without restrictions.

6. On cross Petitioner testified she had a previous workers' compensation claim and was knowledgeable about the process (on February 28, 2011, she settled 09WC44943 for $12,000 representing 13% loss of the left hand). She acknowledged she claimed the accident occurred on June 10, 2010, but did not report it to Respondent until July 16, 2010; she also conceded that she initially reported the accident was on June 17, 2010.

7. She reported that stepping on her shoelace actually precipitated the accident. She

continued working until August 9, 2010, when Respondent refused to accommodate her light duty. From the date of the accident to the time she was put on light duty, Petitioner was working "20 Manyard." In that position, the workers are rotated. They catch projectiles with their hands coming out of a chute, put them in a can and send them down, "put the lid on them, scoot them down, weigh them, skid them," and load the cases. In the job the only thing she lifted were cans onto the skids. The cans weigh "168 pounds. And then up front you turn, lift a box of projectiles, you load it onto the table, flip it up, then you walk over, you get a box of cases, and you load them on the table."

8. Petitioner also testified that she did report to the physician's assistant at Logan Primary Care that her condition was work-related but that she had not reported it yet. She had the bills paid by her group insurance. She received some short-term disability benefits from Respondent, which she applied for immediately after she was "out of work on August 9, 2010." She has worked for Respondent 10 years. She has always worn the same type of boots. It was just "understood" that she was to produce 800 projectiles in two hours.

9. Her previous workers' compensation claim was for carpal tunnel syndrome and Respondent had not yet decided whether to accept that claim at the time of the instant accident. She was not reprimanded for filing the first claim, but while on light duty she was forced "to go outside in the smoke shack, pick up cigarette butts in front of [her] co-workers. That was humiliating." She did not want to be put back on that crew.

10. On redirect examination, Petitioner testified "reverse torque" was not her regular job and she worked it only one day. When she backtracked to try to remember the date of the accident, she missed it by a week. She tripped over her shoelace while inspecting parts and moving quickly to get the task done.

11. Cecil Glover testified on June 10, 2010, he was working reverse torque in the bay next to that in which Petitioner was working. He noticed Petitioner limping and asked her whether she hurt her knee. She replied that it was not her knee but she thought she "pulled her butt muscle." He did not see her trip. He viewed the video. The rate of speed it showed was "about a third" of the speed of actual work. If you performed at that speed "you would have been pulled out because you wouldn't have gotten enough done."

12. On cross examination, the witness answered that Respondent would have liked employees to process at least 2,000 projectiles in a work day.

13. The medical records indicate that on June 15, 2010, Petitioner presented to Dr. Workman at Logan Primary Care with lower back and right hip pain for four days after twisting her leg. Dr. Workman noted tenderness on palpitation, muscle tightness, and decreased range of motion was noted but with no neurological deficits. He diagnosed Muscle spasm and prescribed Flexeril.

14. On July 19, 2010, Petitioner presented to Dr. Austin complaining of pain in her lower back radiating into her "butt cheek down right leg into knee where it feels on fire." She reported on June 17, 2010 twisting while stepping on her shoelace at work. Dr. Austin

diagnosed strain/sprain/pain in the right lumbosacral spine with some spasms, in the right hip joint, and in the right knee. He ordered x-rays, recommended exercises, and put her on light duty. On July 26, 2010, Petitioner returned to Dr. Austin and reported no improvement. Dr. Austin continued her work restrictions.

15. On August 11, 2010, Petitioner returned to Logan Primary Care reporting of low back pain after twisting her back at work in June. She also had pain in her right knee and her foot and ankle turned cold. She indicated she got the accident date wrong and it was deemed not compensable under workers' compensation. Currently, she was taking Flexeril and Norco.

16. On August 17, 2010, Petitioner returned to Logan Primary Care. Her prescriptions were refilled, an MRI was ordered, and she was "instructed off work."

17. An MRI showed central and left-sided disc bulge/herniation at L4-5 with narrowing of the left neural foramen, a mild posterior disc bulge at L5-S1 with some narrowing of the left neural foramen, and a disc bulge at T11-12 which was not well visualized in the lumbar scan. The radiologist indicated the MRI reported the findings were of unknown significance because her symptoms were right sided.

18. On August 25, 2010, Dr. Workman continued Petitioner's off work status and referred her to Dr. Kennedy, an orthopedic surgeon, for a herniated disc. On October 25, 2010, Petitioner reported her symptoms persisted and she was scared to walk because of fear of falling. Dr. Workman referred her to a neurological spine specialist, Dr. Jones.

19. On September 21, 2010, Petitioner presented to Dr. Kennedy complaining of low back pain since a work accident. She reported twisting her back and had radiating pain down her right leg. She was on light duty for about two months but her condition worsened. She was unable to work since August 9th. Dr. Kennedy noted that the MRI showed a disc prolapsed at L4-5 with some mild foraminal encroachment and some mild degenerative changes at L5-S1. He did not see too much in the MRI that was worrisome with respect to nerve root compression. He thought she would benefit from physical therapy and trigger point injections but she is not then a surgical candidate.

20. On December 14, 2010, at Respondent's request Petitioner presented to Dr. Lange for an examination pursuant to Section 12 of the Workers' Compensation Act. Petitioner related twisting her back while at work when she turned and stepped on her shoelace. She felt pain in the right hip and knee. However, toward the end of August or early September she developed symptoms in the left lateral thigh area. She did not report it to Respondent until July 16, 2010, because she thought her condition would resolve. Her attorney sent her to Dr. Kennedy who recommended injections, which apparently were not administered. She was unable to get another appointment with Dr. Kennedy and was referred to Dr. Jones. She was currently not working because Respondent would not accommodate light duty.

21. Dr. Lange noted "Waddell testing was moderately positive," and objective neurological

functions were normal. He looked at the MRI film and noted degenerative disc changes at T11-12 and degenerative desiccation at L4-5 and L5-S1, which were consistent with her age (45), gender, and nicotine exposure (the record indicates that Petitioner reported smoking up to two packs of cigarettes daily for about 20 years). "She does have disc prominences interestingly on the left not only L4-5, but also L5-S1 with small high intensity zones at each adjacent to the applicable lower vertebral body."

22. Dr. Lange did not relate Petitioner's current condition to her work incident because her initial symptoms were on the right side which apparently had resolved. The MRI showed no significant pathology on the right. Because symptoms on the left did not arise until about three months after the incident "it would seem impossible to correlate her left sided symptoms, therefore, with her activities in June."

23. On December 28, 2010, Petitioner presented to Dr. Jones' physician's assistant ("PA") upon referral from Dr. Workman. She reported severe pain which began six months ago after tripping and twisting her back at work. Heat, ice, and physical therapy did not relieve pain. Dr. Jones' PA related that the MRI showed degenerative disc disease at L4-5 and L5-S1 with moderate left foraminal narrowing at L4-5 and bilateral foraminal narrowing at L5-S1. Dr. Jones' PA diagnosed degenerative disc disease of the lumbar spine, lumbar disc displacement, lumbar radiculitis, and lumbar spondylosis, ordered an EMG, and referred Petitioner for epidural steroid injections.

24. On February 2, 2011 Petitioner reported that the pain was now mostly going down the left leg rather than the right. Dr. Jones noted that Petitioner had a herniated disc at L4-5 which was most likely compressing the transversing L5 nerve root. He noted that Petitioner failed conservative treatment and because the condition lasted more than six months it was unlikely to resolve itself. He informed her that he did not believe the surgery would relieve all of her leg pain but it would help. They would schedule surgery.

25. On February 7, 2011, Dr. Jones performed L4-5, L5-S1 hemilaminotomy/laminectomy with foraminotomy for L4-5, L5-S1 lateral recess and foraminal stenosis with radiculopathy.

26. On February 22, 2011, Petitioner presented for follow up after surgery. The pain had markedly improved and she did not need pain medication. She was able to increase activity without incident.

27. On March 16, 2011, Petitioner reported doing well. She had intermittent pain, but Dr. Jones indicated that the "severity of the problem" was "mild." He released her to work, but is unclear from his note whether it was with restrictions.

28. On March 26, 2011, Petitioner was doing very well. Her leg pain had revolved but she did have some intermittent but tolerable paresthesis in her legs. Petitioner wanted to return to work; Dr. Jones thought that was reasonable and released her without restrictions. He warned her that her back had significant degeneration and she should be

cautious lifting heavy objects, and released her from care.

29. Dr. Jones testified by deposition on July 20, 2011. He reviewed Petitioner's MRI which showed disc herniations at L4-5 and L5-S1 with and a "newer annular tear at L5-S1." He indicated it was recent because the signal at T2 was still hot. "She had done it in the last three months."

30. Dr. Jones explained the change in the radiating pain from the right leg to the left leg to the fact that the herniations were "pretty central." "If you initially have like a large left central disc herniation at its irritating the left leg, well it can retract enough that the left leg gets better but there is still enough of a central portion that it's bulging out and starts hitting the right nerve root which is now getting irritated because your facet is more arthritic on that side." He "sees this all the time." Her history correlated to the objective findings in the MRI. The surgery he performed was minimally intrusive. He released her to work on March 16, 2011. She had a good recovery and was able to return to work in five weeks.

31. When asked whether the reported accident was a cause of the condition, Dr. Jones responded: "probably was." "Most of these people herniated a disc bending and twisting and it's actually the twisting motion is worse than the actual bending and it's usually we are doing something silly. It doesn't even have to be a lot of weight."

32. On cross examination, Dr. Jones acknowledged that the in the initial visit, his PA did not note a date of accident, and there was little in the way of detailed description of the mechanism of injury. He did not review any other medical records. He did not note any weakness or sensory disturbances, which would indicate neurologic abnormalities. He did not remember Petitioner saying anything about carrying anything at the time of the accident.

33. Dr. Jones did not have any imaging reports prior to the date of the accident. He agreed that the MRI report did not mention an annular tear at L5-S1, but "it's pretty evident." He has not heard from Petitioner after he released her from care. He did not believe she suffered functional loss due to the surgery.

34. On redirect examination, Dr. Jones testified that Petitioner consistently related the onset of pain to the twisting injury. The history of the accident would be consistent with the pathology. Petitioner appeared to be a "straight shooter" to the witness.

35. Dr. Lange testified by deposition on August 30, 2011. He examined Petitioner on December 14, 2010 at the request of Respondent. She reported that in the process of working she started to turn and was standing on a loose shoestring. She suggested that she twisted her torso and began to fall but broke the fall with her left arm on adjacent machinery. She developed pain in her right hip and knee. In August or September her symptoms changed and developed pain in her left thigh. At the time of his examination her left leg symptoms were the most bothersome. His neurologic examination was objectively normal. The MRI showed some abnormalities including a degenerative disc

at T11-12, prominences at both L4-5 and L5-S1, abnormal desiccation at those levels, and a little abnormality in the annulus.

36. Dr. Lange noted that the initial medical records did not indicate any relation of the injury to Petitioner's work activities. He thought she did have radicular symptoms on the left, but they were not really radicular on the right because the pain did not extend below the knee. Her symptoms were not in any nerve root distribution that would correlate with the MRI findings or clinical examination. He opined that Petitioner had reached maximum medical improvement with regard to the right leg symptoms and the left leg symptoms would not have been related to the alleged accident. For her left leg he would have recommended conservative treatment.

37. On cross examination, the witness testified a twisting injury as described by Petitioner could cause or aggravate herniations at L4-5 and L5-S1, and/or an annular tear at L5-S1. "Everybody has annular tears given enough time on MRI," but they can be traumatic. He did not believe Dr. Jones had any scientific basis to opine that the annular tear was less than three months old. He agreed that the MRI showed a herniation at L4-5 and disc bulge with some narrowing at L5-S1. A person with a central herniation can have radicular symptoms on either or both sides. However, her primary pathology was at L4-5 which "was purely right sided." He was not provided the records of Dr. Jones, his operative report, or his deposition. He had no problem with Petitioner's report of right leg pain associated with her history of accident.

As noted above the Circuit Court of Williamson County reversed the Commission's affirmation of the Decision of the Arbitrator and found that Petitioner did sustain her burden of proving accident. The Circuit Court then remanded the case back to the Commission to determine all other issues including causation, temporary total disability, permanent partial disability, and medical expenses.

In determining the issue of causation, the Commission finds the opinion of Dr. Jones more persuasive that that of Dr. Lange. Dr. Lange stressed that the pathology was on the right but her current symptoms were on the left. The MRI report indicates there was pathology in the left spine. In addition, Dr. Jones explained the change in the radiating pain from the right leg to the left leg to the fact that the herniations were "pretty central." "If you initially have like a large left central disc herniation at its irritating the left leg, well it can retract enough that the left leg gets better but there is still enough of a central portion that it's bulging out and starts hitting the right nerve root which is now getting irritated because your facet is more arthritic on that side." Dr. Jones testified he "sees this all the time." Dr. Jones also noted that Petitioner's symptoms and history of mechanism of injury correlated to the objective findings in the MRI.

The Commission finds that the medical expenses incurred by Petitioner were all necessary and reasonable to alleviate her condition of ill-being caused by her work accident. Therefore, the Commission awards all medical expenses submitted by Petitioner subject to the applicable medical fee schedule.

The Commission concludes that Petitioner was not able to work between August 8, 2010,

14IWCC0121

the date Respondent refused to accommodate her light duty restrictions and March 16, 2011, the date Dr. Jones released her to work. Therefore, the Commission awards Petitioner 31 2/7 weeks of benefits for the period of her temporary total disability.

Petitioner seeks an award of 25% loss of the person as a whole. The Commission notes that Dr. Jones testified that his surgical procedure was minimally intrusive, Petitioner had an excellent recovery, she was able to return to work within five weeks of the surgery, and Dr. Jones did not believe she suffered any functional loss after the surgery. Considering the entire record before us, the Commission awards Petitioner 75 weeks permanent partial disability benefits, representing loss of 15% of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $434.47 per week for a period of 31 2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $391.02 per week for a period of 75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of the use of 15% of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses submitted into evidence by Petitioner under §8(a) of the Act, subject to the applicable 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 $60,000.00. The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: FEB 19 2014

Ruth W. White

Ruth W. White

Michael P. Latz

Michael P. Latz

Charles J. DeVriendt

Charles J. DeVriendt

RWW/dw
O-1/22/14
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WADE, ANNIE
Employee/Petitioner

Case# **10WC030912**

GENERAL DYNAMICS
Employer/Respondent

14IWCC0121

On 12/14/2011, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1580 BECKER SCHROADER & CHAPMAN
MATT CHAPMAN
PO BOX 488
GRANITE CITY, IL 62040

0299 KEEFE & DEPAULI PC
JAMES K KEEFE SR
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

STATE OF ILLINOIS)

COUNTY OF WILLIAMSON)

14IWCC0121

☐ 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

ANNIE WADE
Employee/Petitioner

Case: 10WC 30912

v.

Consolidated cases: N/A

GENERAL DYNAMICS
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 Andrew Nalefski, arbitrator of the Commission, in the city of Herrin, on October 13, 2011. As Arbitrator Nalefski is no longer an arbitrator of the Commission, the matter was administratively assigned to the Honorable Peter Akemann, arbitrator of the Commission, who renders the decision which follows.

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 ARBITRATOR

14IWCC0121

On 06/10/2010, Respondent was operating under and subject to the provisions of the Act.

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

The arbitrator finds that the petitioner failed to prove that she sustained an accident that arose out of and in the course of employment on June 10, 2010.

The issue of notice is moot.

The issue of causal connection is moot.

In the year preceding the injury, Petitioner earned $33,876.44; the average weekly wage was $ 651.70.

On the date of accident, Petitioner was 45 years of age, married with no dependent children.

The issue of medical services is moot.

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 $ 1,665.00 for non occupational benefits paid.

Orders of the arbitrator

Compensation is denied

All other issues are moot.

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

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

Arbitrator Peter Akemann

December 8, 2011

DEC 14 2011

In support of the Arbitrator's finding under (C) ACCIDENT; the Arbitrator finds the following facts:

On June 10, 2010, Petitioner was employed as an MCA Operator with Respondent. On that date she was working in the job classification of Reverse Torque. Respondent's Exhibit #4 is a DVD which depicts the work activities and the work area involved. Petitioner testified that her job was to inspect projectiles and put them in a machine to tighten the projectiles. Petitioner would then inspect the projectiles before repeating the task. The task is performed in two rooms, or bays, separated by a wall. One room contains the projectiles on a pallet and the other room contains the reverse torque machine. The projectiles weigh only ounces.

Petitioner testified that while there were no specific quotas, it was generally expected that employees run approximately 800 projectiles through the reverse torque every two hours. She testified on June 10, 2010, after taking two projectiles out of the reverse torque machine and inspecting them for gaps, she tripped over her shoelace and twisted her lower back. Cecil Clover, a co-worker, testified that Petitioner complained on that date that she pulled her "butt muscle." Testimony by both Petitioner and Mr. Clover reflects that Respondent's Exhibit #4 does accurately reflect the job activities and the size of the area where the job is performed; however, when performing the job duties, they work at a faster pace.

Petitioner did not report the alleged injury to Respondent until July 16, 2010, or approximately 40 days later. (Res. Ex. 2) The First Aid/Injury Report completed by Petitioner on July 16, 2010, specifically states: "Doing reverse torque. Went to pivot back around and stepped on shoestring. Top half moved, lower did not." Petitioner reported pain in her right hip and right thigh. She reported that the cause of the injury was an untied shoe. (Id)

The medical records offered reflect Petitioner was seen at Logan Primary Care, her primary care physician, June 15, 2010. (Pet. Ex. 2) The records reflect she reportedly injured herself four days earlier. She complained of right hip pain for four days. She reported she may have twisted her leg four days ago. There was no mention that the injury occurred at work. Petitioner testified she did submit medical expenses through her group health insurance. She continued to work without lost time or any further medical care and treatment until July 16, 2010, when she first reported the alleged injury.

Petitioner was seen by the plant nurse on July 16, 2010. She reported the injury occurred on June 17, 2010 and not June 10, 2010. She reportedly went to Logan Primary Care on June 22, 2010; however, the records from Logan Primary Care reflect the visit was on June 15, 2010.

Petitioner was next seen by Dr. Mark Austin and reported the mechanism of injury was that she stepped on an untied shoelace. (Pet. Ex. 1) She followed up with Dr. Austin and was subsequently referred to Dr. David Kennedy. Following the visit with Dr. Kennedy, she came under the care of Dr. Jones who performed surgery February 7, 2011 consisting of an L4-5, L5-S1 hemilaminotomy/laminectomy with foraminotomy. Dr. Jones released her to return to work without restriction on March 16, 2011 and Petitioner returned to work without restriction at that time. (Pet. Ex. 3)

ANALYSIS

The Arbitrator notes that the Petitioner did not report her alleged accident for 40 days. While this does not defeat her claim based on Notice, the Arbitrator finds such a detail strains the Petitioner's credibility based on her testimony and the early medical records. When asked why she took so long to report the injury, she testified that she was " hoping that it was just a pulled muscle, and I had just got back—I hadn't been back two months from my hand surgery, and I didn't want to get in trouble." (Transcript, page 21) The Arbitrator notes that there is nothing in the medical records that would support Petitioner's testimony in that regard and clearly Petitioner was aware of what is required to pursue benefits under the Workers' Compensation Act as a result of a work injury.

The Arbitrator concludes that the first medical visit after the alleged date of injury makes no mention of any work related event. The record indicates that the Petitioner presented for "right hip paid for 4 days." (Pet. Ex. 2, page 2) Nothing is said about a work related injury. Bills were submitted through the respondent's group carrier.

The Arbitrator concludes that for someone who had so recently had a accepted claim from the same employer, the reporting of a different accident date (June 17, 2010) and the length of time the Petitioner had taken to report said claim (40 days) strains the Petitioner's credibility.

The Arbitrator further notes that the surgery performed by Dr. Jones was a result of degenerative disc disease with no clear evidence of a traumatic injury. Dr. Lange testified the surgery performed was reasonable and necessary, but could not correlate Petitioner's complaints to the injury. Dr. Lange pointed out that Petitioner's complaints in the early medical records as of July 16, 2010 revealed right lower extremity complaints, but when treatment was provided by Dr. Jones, the complaints involved the left lower extremity and therefore there would fail to exist causal relationship between anything that may have occurred on June 10, 2010 and the left lower extremity complaints which were not reported to any physician until the end of August or early September, 2010.

Finally, the Petitioner's testimony and her hand written description of the events, support that she tripped over her untied shoe lace. . The Arbitrator further notes that there was no evidence offered to suggest that Petitioner's work requirements prevented her from the inability to take the time to tie her shoe.

The Arbitrator concludes as a matter of law that our Supreme Court has held that Illinois is not a positional risk state. There must be a showing of an increased risk to which the employee is subjected as compared to the general public. In this case, the alleged injury was, by the Petitioner's own testimony, a result of a risk personal to the employee rather than incidental to her employment. Clearly, keeping one's shoes tied is personal and is one that the entire population shares and is not connected to Petitioner's employment.

The arbitrator finds that the petitioner failed to prove that she sustained an accident that arose out of and in the course of employment on June 10, 2010.

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

Nancy Hernandez,
Petitioner,

vs.
White Chocolate Grill,
Respondent,

NO: 10 WC 46243

14IWCC0122

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, permanent partial 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 15, 2013 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 19 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
O:2/6/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HERNANDEZ, NANCY
Employee/Petitioner

Case# **10WC046243**

14IWCC0122

WHITE CHOCOLATE GRILL
Employer/Respondent

On 4/15/2013, 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 0.09% 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:

0140 CORTI ALEKSY & CASTANEDA PC
JOHN J CASTANEDA
180 N LASALLLE ST SUITE 2910
CHICAGO, IL 60601

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
JEFFREY T RUSIN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

14IWCC0122

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

Nancy Hernandez,
Employee/Petitioner

v.

White Chocolate Grill,
Employer/Respondent

Case # **10** WC **46243**

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 **Wheaton**, on **2/15/13**. After reviewing all 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 _____

14IWCC0122

FINDINGS

On **10/16/10**, 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 **$34,836.36**; the average weekly wage was **$669.93**.

On the date of accident, Petitioner was **23** years of age, ***single*** with **1** dependent child.

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

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

Respondent shall be given a credit of **$959.54** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$3,654.98** for other benefits (disputed medical after 1/23/12), for a total credit of **$4,614.52**. (Arb.Ex.#1).

Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act. (Arb.Ex.#1).

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $446.62 per week for 4-5/7 weeks, commencing 10/20/10 through 11/21/10, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 10/17/10 through 2/15/13, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $959.54 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $53,040.83 to Accredited Ambulatory Care, $3,121.73 to Chicago Pain & Orthopedic Institute, $265.29 to Injured Workers Pharmacy, $3,438.82 to Dr. Mark A. Lorenz, and $4,842.59 to Pinnacle Pain Management, as provided in Sections 8(a) and 8.2 of the Act. (Arb.Ex.#2).

Respondent shall be given a credit of $3,654.98 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 $401.96 per 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.

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.

Peter M. Finley

Signature of Arbitrator

4/12/13

Date

ICArbDec p 2

APR 15 2013

STATEMENT OF FACTS: 14IWCC0122

Petitioner testified through a Spanish interpreter. The parties stipulated that Petitioner suffered an accidental injury on October 16, 2010. (Arb.Ex.#1). Petitioner testified that she worked in the pantry area for Respondent making salads which required her to remove boxes of lettuce from the cooler and carry containers of other produce from the storeroom to her work station.

Petitioner testified that on the date of injury, October 16, 2010, she was carrying a container of avocados from the storage room when she slipped on oil and fell to the ground. She finished her work day but noticed pain in her hip and back area near the middle of the back. Petitioner's shift normally started at 4:00 p.m. and she worked until closing - usually 11:00 p.m. She indicated that she fell between approximately 9:40 pm and 10:00 p.m. Petitioner noted that the injury occurred on Saturday and that the next day, Sunday was her normal scheduled day off work. She indicated that she did not engage in any activities over the weekend.

Petitioner testified that when she returned to work on Monday October 18, 2010 she advised her manager Jessica that the bottom part of her back was hurting. She noted that Jessica had seen her fall on the date of the accident.

Petitioner subsequently visited chiropractor Dr. John Roza on October 19, 2010. Petitioner indicated that a friend had recommended Dr. Roza. (PX1). Dr. Roza recorded a history of slipping and falling, that the patient complained of severe pain and that bending aggravated the pain. (PX1). Dr. Roza also noted that Petitioner denied any previous injury or back complaints. (PX1). Dr. Roza ordered x-rays that were reported as normal, started chiropractic therapy for two visits and eventually prescribed an MRI. (PXX1). Petitioner noted that instructed her to remain off work at the time of her visit on October 20, 2010.

At the suggestion of her cousin, Petitioner went on her own to see Dr. Mark Lorenz on October 28, 2010. (PX2). Dr. Lorenz. At the time of this initial visit Dr. Lorenz recorded the aforementioned history of the accident, that she had seen Dr. Roza for two visits and that she had been taken off work as of October 20, 2010. (PX2). Dr. Lorenz diagnosed an acute back strain, prescribed physical therapy and advised Petitioner to remain off work. (PX2).

Petitioner thereupon attended physical therapy at ATI from November 3, 2010 through January 28, 2011. (PX3). Petitioner stated that physical therapy treatments had helped a "little bit."

On March 14, 2011, Petitioner returned to Dr. Lorenz who prescribed an MRI and maintained a light duty restriction of no lifting over 20 lbs., which Dr. Lorenz had imposed as of November 18, 2010. (PX2). On March 24, 2011, Petitioner underwent an MRI at Hinsdale Ortho Imaging which was interpreted as evidencing a L5-S1 broad-based central disk protrusion without significant central spinal stenosis or encroachment of descending S1 nerve roots. (PX2).

On April 11, 2011, Petitioner returned to Dr. Lorenz who reviewed the MRI and diagnosed L5-S1 spondylosis with a central disc herniation. (PX2). Dr. Lorenz discussed surgical and non-surgical options, including an FCE. (PX2). After discussing the options with Petitioner, Dr. Lorenz ordered a discogram and maintained the 20 lb. lifting restriction. (PX2). On May 24, 2011, Petitioner underwent a discogram at Accredited Ambulatory Care which revealed discogenic pain at the L5-S1 level. (PX4).

On June 6, 2011, Petitioner visited Dr. Avi Bernstein at the request of the Respondent for purposes of a §12 examination. (RX1). Dr. Bernstein reviewed medical records but did not have the MRI report or the discogram

report at the time of the examination. (RX1, p.2). Dr. Bernstein opined that Petitioner's options were to live with the diagnosed condition or consider a fusion surgery. (RX1, p.2). Dr. Bernstein also noted although he felt from a non-surgical standpoint Petitioner was at MMI, he indicated that it would not be unreasonable to obtain an FCE. (RX1,p.2).

Petitioner visited Dr. Lorenz the same date of her §12 examination with Dr. Bernstein, on June 6, 2011. Dr. Lorenz reviewed the discogram and diagnosed L5-S1 disc herniation with annular tears and axial back pain. (PX2). As a result, Dr. Lorenz recommended a L5-S1 fusion and maintained Petitioner's light duty restrictions. (PX2).

Petitioner worked light duty from November 2010 through the present. She indicated light duty meant she did not have to do any lifting at work, like lifting garbage, boxes of lettuce or the crepe machine.

On August 16, 2011, Dr. Lorenz noted that Petitioner had failed conservative care and recommended a surgical fusion. (PX2). Petitioner testified that she decided that she did not want to undergo surgery because of her baby and the fact that she was scared that something might happen to her.

In an addendum report dated September 26, 2011, Dr. Bernstein opined that at the time of his last examination on June 6, 2011 Petitioner "... was functioning reasonably well and did not demonstrate pain behavior to the extent that I would consider surgery to be reasonable or appropriate." (RX2).

On November 28, 2011, Dr. Lorenz referred Petitioner for pain management, maintained her work restrictions of 20 lbs. and requested that she return after an FCE. (PX2).

Petitioner subsequently underwent an FCE on December 14, 2011. (PX3). The FCE indicated that Petitioner was capable of working at the light level. (PX3).

On January 23, 2012, Dr. Bernstein authored another addendum report wherein he opined that Petitioner "is capable of returning to her prior work without restriction. She is at maximum medical improvement. No further treatment is indicated or necessary. She is not a surgical candidate." (RX3).

On June 14, 2012, Petitioner returned to Dr. Lorenz at which time the latter imposed restrictions of occasionally lifting 32 lbs. and discharged Ms. Hernandez with a recommendation to follow up with pain management. (PX2).

On July 3, 2012, Petitioner visited Dr. Morgan at Chicago Pain and Orthopedic Institute per the referral of Dr. Lorenz. (PX5). Dr. Morgan examined Petitioner, reviewed the MRI and x-rays, and recommend bilateral facet joint injections. (PX5). Dr. Morgan also continued the work restrictions imposed by Dr. Lorenz. (PX5). Petitioner thereupon underwent injections on July 17, 2012. (PX4). Petitioner returned to Dr. Morgan on July 31, 2012 at which time it was noted that Petitioner had "zero improvement" from the injections. (PX5).

On August 21, 2012, Petitioner underwent a second set of injections noted as "bilateral sacroiliac joint injections." (PX5). Petitioner stated that she had no improvement from these injections either.

Petitioner returned to the Chicago Pain and Orthopedic Institute on September 4, 2012 where she saw Dr. Louis Demetrios. (PX5). Dr. Demetrios recommended repeat bilateral SI joint injections and advised that Petitioner remain off work. (PX5).

On October 17, 2012, Petitioner underwent her third set of injections. (PX4). Petitioner once again noted that the injections did not provide any relief. She indicated that this was the last time she received injections.

On February 11, 2013, Dr. Bernstein authored a third addendum report and opined that Petitioner's additional treatment was not the result of her work related injury on October 16, 2010. (RX4). Dr. Bernstein also opined that Petitioner was not a surgical candidate and that she can continue to work full duty without restrictions. (RX4).

Petitioner has not received any further medical care or treatment since October 17, 2012. Petitioner continues to have pain in the bottom part of her back and her legs go numb. At times her pain is "strong" and she uses hot patches on her back two-three times per week. Petitioner does not take prescriptive medication but does use Advil once a day. She indicated that she works six to seven hours a day, Monday through Saturday, or the same number of hours as before the accident. She also testified that she wears a support or brace for her back that keeps her body straight. On cross-examination, Petitioner noted that in order to perform her complete job activities she would be required to lift about 40 lbs. Petitioner also agreed that her job as a salad prep cook is of a light physical demand level. In addition, Petitioner indicated that she has continued to work for her concurrent employer, Flat Top Grill, doing the same type of food preparation while working light duty for the Respondent.

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 suffered a back injury as a result of her slipping on oil on October 16, 2010. On the date of her fall she had pain in her back and her hips and two days later notified her supervisor Jessica that she had pain in the bottom part of her back and requested authorization to see a physician. The initial medical provider, Dr. Roza, indicated in the history that Petitioner fell on her back on October 16, 2010 and that she denied any previous injury or back complaints. Dr. Roza also noted that Petitioner had severe pain, that bending aggravated the pain and that she had severe tenderness and spasm in the thoracic area and severe tenderness in the lumbar area. (PX1). Dr. Roza opined that Petitioner's medical care was causally related to her accidental injury. (PX1, p.19).

A subsequent MRI of Petitioner's low back on March 24, 2011 indicated that she had a L5-S1 broad-based central disk protrusion without significant central spinal stenosis or encroachment of descending S1 nerve roots. (PX2, p.7). On May 24, 2011, Petitioner underwent a discogram that demonstrated discogenic pain at L5-S1. (PX4, pp.1-3).

Dr. Bernstein, Respondent's §12 examining physician, opined that Petitioner had "chronic persistent subjective complaints of low back pain following a fall on October 16, 2010" and that "pending seeing the results of her lumbar discogram, (the disc degeneration at the L5-S1 level) is likely responsible for her persistent symptoms." (RX1, p.2). In a later addendum, after reviewing the results of the lumbar discogram performed on May 24, 2011, Dr. Bernstein opined that "[b]ased on the results of this lumbar discogram, this patient likely has pain emanating from the L5-S1 disc level." (RX2).

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner suffered a herniated disk at L5-S1 as a result of the undisputed work accident on October 16, 2010 and that Ms. Hernandez's current condition of ill-being 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:

The parties submitted into evidence an agreed stipulation outlining the medical expenses that would be due and owing pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act in the event this matter was found to be compensable, with Respondent maintaining any and all objections to said bills on the basis of liability, reasonableness and necessity. (Arb.Ex #2).

In the present case, the record shows that following the accident Petitioner came under the care of chiropractor Dr. Roza followed by her second choice of medical provider, Dr. Lorenz of Hinsdale Orthopedic Associates. (PX2). Dr. Lorenz initially recommended conservative care. When that failed he recommended surgery in the form of a fusion at L5-S1. (PX2, pp.8-9). Respondent's §12 examining physician, Dr. Bernstein, initially agreed that fusion surgery was on option (RX1) only to change his mind and opine that surgery was not medically necessary. (RX3). Regardless, Petitioner opted not to undergo surgery. As a result, Dr. Lorenz recommended an FCE and eventually discharged Petitioner from his care after restricting her from work activities as demonstrated in the FCE. (PX2, p.14). Dr. Bernstein likewise relied on the results of the FCE to opine that Petitioner could return to work in her prior position without restriction. (RX3). No utilization review report was submitted with regard to Dr. Lorenz's treatment. Certainly, this treatment provided by Dr. Lorenz was reasonable and necessary in an attempt to alleviate Petitioner's symptoms and complaints.

Therefore, 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 services as provided in §8(a) and fee schedule provisions of §8.2 of the Act in the amount of $53,040.83 for services provided by Accredited Ambulatory Care, $3,121.73 for services provided by Chicago Pain & Orthopedic Institute, $265.29 for services provided by Injured Workers Pharmacy, $3,438.82 for services provided by Dr. Mark A. Lorenz, and $4,842.59 for services provided by Pinnacle Pain Management. (Arb.Ex.#2).

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

The record shows that Petitioner was initially restricted from work by Dr. Roza as of October 20, 2010 and that she remained off work until November 21, 2010 when she was released to light duty work by Dr. Lorenz.

Based on the above, and the record taken as a whole, as well as the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner was temporarily totally disabled from October 20, 2010 through November 21, 2010, for a period of 4-5/7 weeks.

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

The record shows that as a result of the accident in question Petitioner suffered an L5-S1 disc herniation. The record further shows that following conservative treatment treating orthopedic surgeon Dr. Lorenz recommended that Petitioner undergo fusion surgery at L5-S1, an option that was initially endorsed by Respondent's §12 examining physician, Dr. Bernstein, only to be later retracted. Petitioner, given her fear of the procedure, opted not to proceed with surgery, as is her right. Instead, she was referred to pain management specialist Dr. Morgan where she received a series of three injections, without noticeable relief in her pain symptoms.

Dr. Lorenz last saw Petitioner on June 14, 2012 at which time he noted that Petitioner could return to work within the parameters of the FCE which had shown that she was capable of lifting 32 pounds on an occasional basis. (PX2).

Petitioner continues to work in her former position of food preparer, working six to seven hours a day, Monday through Saturday, or the same number of hours as before the accident. She noted that she currently notices pain throughout the day in the bottom part of her back, which she stated is sometimes strong. She indicated that she uses hot patches on her back two or three times a week for her pain and takes over the counter medicine once a day for same.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner suffered the permanent partial loss of use of 15% person-as-a-whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott Dopkus,
Petitioner,

vs.

NO: 09 WC 13364

IDOT,
Respondent,

14IWCC0123

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 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 23, 2013 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 for State of Illinois cases.

DATED: FEB 19 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
O: 2/6/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DOPKUS, SCOTT
Employee/Petitioner

Case# **09WC013364**

14IWCC0123

IDOT
Employer/Respondent

On 7/23/2013, 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:

0190 LAW OFFICES OF PETER F FERRACUTI
THOMAS STROW
110 E MAIN ST PO BOX 859
OTTAWA, IL 61350

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE C COPELAND
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1430 CMS BUREAU OF RISK MGMT
WORKERS COMPENSATION MANAGER
PO BOX 19208
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0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PKWY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

JUL 23 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

14IWCC0123

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

SCOTT DOPKUS
Employee/Petitioner

v.

IDOT
Employer/Respondent

Case # **09** WC **13364**

Consolidated cases: **N/A**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Geneva**, on **May 14, 2013**. By stipulation, the parties agree:

On the date of accident, **January 14, 2009**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$42,744.00**, and the average weekly wage was **$822.00**.

At the time of injury, Petitioner was **32** years of age, ***single*** with **0** children under 18.

Respondent remains liable for $1,102.63 in necessary medical services and reimbursement to Petitioner of $25.49 in out-of-pocket expenses awarded in the prior 19(b) decision.

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

14IWCC0123

ORDER

Respondent shall pay Petitioner the sum of **$493.20**/week for a further period of **7.5** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **3% loss-of-use of Petitioner's left arm.**

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

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

Signature of Arbitrator

7/22/13
Date

ICArbDecN&E p.2

JUL 23 2013

FINDINGS OF FACT

On September 2, 2011, the Illinois Workers' Compensation Commission affirmed the decision of Arbitrator Giordano in a 19(b) proceeding under the Act. (PX1). At the time of the original trial, Respondent had stipulated that Petitioner's left forearm contusion was casually related to an undisputed accident on January 14, 2009. (PX2). The Commission found that Petitioner was at Maximum Medical Improvement as of May 20, 2010, for his causally related left forearm contusion and that all other claimed conditions were unrelated. The matter was thereafter returned to the arbitration level for further findings. Petitioner offered no further evidence at the time of hearing on the Nature and Extent of his injury, but rather relied on the original 19(b) Decision and Record as a basis for permanency. The Arbitrator hereby adopts and incorporates the Findings of Fact and Conclusions of Law from the original 19(b) proceeding into his current decision. (PX1).

Petitioner was found to be at Maximum Medical Improvement after unsuccessfully completing a Functional Capacity Evaluation on several occasions. However, Petitioner was consistently diagnosed with a left arm contusion, and again, his condition as of the date of trial was stipulated to be causally related. Petitioner further testified to his complaints on the day of hearing.

The Arbitrator has carefully considered the prior Commission Decision and reviewed the Record. Based upon the foregoing, the Arbitrator awards Petitioner 3% loss-of-use of his left arm for his undisputed left forearm contusion suffered as a result of an undisputed workplace injury in January 2009. All other aspects of the Commission's prior decision are hereby adopted and remain in effect for this decision.

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

Shelia Leach,
Petitioner,
vs.

NO: 11 WC 21644

KOBYCO Inc.,
Respondent,

14IWCC0124

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, prospective medical expenses, 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 July 2, 2013 is hereby affirmed and adopted.

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

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

DATED: FEB 19 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
O:2/6/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LEACH, SHEILA
Employee/Petitioner

Case# **11WC021644**

14IWCC0124

KOBYCO INC
Employer/Respondent

On 7/2/2013, 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 0.08% 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:

2489 LAW OFFICE OF JIM BLACK & ASSOC
TRACY L JONES
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
GARY J WALLACE
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

14IWCC0124

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

Sheila Leach
Employee/Petitioner

v.

Kobyco, Inc.
Employer/Respondent

Case # 11 WC 21644

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 **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rockford**, on **May 14, 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 _____

14IWCC0124

FINDINGS

On **November 12, 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 **$24,875.76**; the average weekly wage was **$478.38**.

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.

ORDER

As the Arbitrator has found that the Petitioner failed to meet her burden of proof with regard to the issues of accident and causation, the Petitioner's claim for compensation is 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

June 27, 2013
Date

JUL - 2 2013

FACTS:

The Petitioner testified that in November of 2010 she was employed with the Respondent, a window and garage door company, as a secretary. She testified that she had been employed by the Respondent since 1986 and that since 1990 she has held the job title of secretary. She testified that her job involved data entry, reception work, book keeping, and processing of orders. She described her work station and she described her job activities which included keyboarding, writing in ledgers, answering telephones, and using a fax machine frequently throughout the day. The Petitioner testified that her work day involved several different activities throughout the day, but that she was constantly using both of her hands. She testified that she spent about 40% of her day typing on the keyboard and 60% of her day handwriting information in various forms. She testified that she would also have to lift small boxes of hardware that would be brought in from various part suppliers..

The Petitioner testified that in November of 2010, she began to have problems with her hands falling asleep and having decreased grip strength. On November 12, 2010 the Petitioner sought treatment for her hands with her primary care physician, Dr. Paul Schroeder. The history noted by Dr. Schroeder was of a 50 year old patient who complains of possible carpal tunnel symptoms in both hands. It was reported that the symptoms had been present for 6 months or longer, that the left wrist was painful and that there was tenderness in the right forearm going up to the right shoulder. Numbness and tingling in the thumb and fingers was also reported. It was noted that the Petitioner reported that "she does work in a secretarial capacity and does a lot of keyboard entry." Dr. Schroeder diagnosed the Petitioner as having bilateral carpal tunnel syndrome and he ordered an EMG of both hands. He advised her to use wrist splints and to take over the counter medication for pain relief.

The EMG was done on January 2, 2011 and was reported to demonstrate bilateral median neuropathy of the wrist, predominately sensory, demyelinating, and right minimally worse than the left. There was no evidence of cervical radiculopathy or brachial plexopathy. Based on the results of the EMG, Dr. Schroeder referred the Petitioner to an orthopedic physician.

On February 21, 2011, in response to the Petitioner's request to do so, Dr. Schroeder authored a letter wherein he sated "I believe her condition is related to her work as a secretary so please consider this a work related injury". The Petitioner testified that she asked Dr. Schroeder to write a letter after being advised by her employer that they did not consider her condition to be work related. The Petitioner testified that she had discussed her job duties with Dr. Schroeder when she had seen him on November 12, 2010 and that he indicated at that time that her condition was work related. She testified that she sent him the letter asking him to place his opinion regarding causal relationship in writing so that she could tender it to her employer. The February 21, 2011 letter from Dr. Schroeder was his response to her written request.

At the request of the Respondent, the Petitioner was examined by Dr. John Fernandez on April 28, 2011. The transcript of Dr. Fernandez' deposition testimony was admitted into the record as Respondent's Exhibit 1. Dr. Fernandez testified that the Petitioner described her job activities to him and also demonstrated the "positional factors" of her wrists and elbows when she worked. Dr. Fernandez testified that the Petitioner reported that she keyboarded 40% of her workday and spent 60% doing other tasks. Dr. Fernandez opined that the Petitioner's bilateral carpal tunnel syndrome was not causally related to her work as a secretary for Respondent. Dr. Fernandez further opined that the Petitioner did not have any work factors which would be causative or aggravating to carpal tunnel syndrome. Dr. Fernandez noted that other factors contributed to the Petitioner's carpal tunnel syndrome. Specifically, Dr. Fernandez noted that the Petitioner's increased weight, diabetes, and thyroid disease were all risk factors in the development of carpal tunnel syndrome. Dr. Fernandez also noted that the Petitioner did not use any exaggerated flexion or any exaggerated force in the performance of her secretarial duties. Dr. Fernandez did agree that surgery was appropriate for the Petitioner's bilateral carpal tunnel condition.

On July 25, 2011, the Petitioner came under the care of Dr. Scott Nyquist, an orthopedic surgeon. Dr. Nyquist noted a history of a 51 year old, right handed female who had pain, numbness, and tingling in both of her hands for approximately a year. He recorded a history that she was a secretary and does a lot of repetitive type tasks and has been with the company for several years. He noted that she was still performing her job at the time he saw her. Dr. Nyquist diagnosed bilateral carpal tunnel syndrome, diabetes, and hypothyroidism and he recommended that the Petitioner undergo surgery for both hands. He further stated in the record "I feel it is related to the repetitive type tasks she does at work."

The Petitioner underwent the right carpal tunnel release on August 31, 2011 followed by the left carpal tunnel release on October 18, 2011. The parties stipulated that the Petitioner was off of work from August 30, 2011 to September 6, 2011 following the first surgery and from October 18, 2011 to October 23, 2011 for the second surgery. No temporary total disability benefits were paid during that time.

The Petitioner testified that she last saw Dr. Nyquist on October 25, 2011, at which time he released her at maximum medical improvement. She has not been back to Dr. Nyquist, Dr. Schroeder, or any other physician for her hands since being released. She testified that her hands are much improved following the surgeries. However she still has tenderness over the incision and decreased pinch grip strength. This causes her to drop small items such as make-up brushes and pens frequently. On cross-examination, the Petitioner admitted to other health issues including diabetes, thyroid disease and weight issues.

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 her claim by a preponderance of the credible evidence. The Petitioner here relies upon the opinion generated by Dr. Schroeder and the opinion of Dr. Nyquist contained in his treatment records. Neither doctor testified at trial. The opinion generated by Dr. Schroeder is in a letter dated February 21, 2011 directed to "To Whom It May Concern". This letter was written in response to the Petitioner's request that Dr. Schroeder resubmit his diagnosis stating that the condition was work related. The opinion of Dr. Nyquist is contained in his initial treatment record of July 25, 2011. Dr. Schroeder's opinion letter indicates that the Petitioner "works in a secretarial capacity" and Dr. Nyquist's note indicates that "She is a secretary and does a lot of repetitive type tasks." Neither Dr. Schroeder's records nor Dr. Nyquists records contain any notation or description of the Petitioner's actual specific job duties or activities. Neither Dr. Schroeder's records nor Dr. Nyquists records contain any notation or description of the "positional factors" of the Petitioner's wrists and elbows when she worked.

While the Arbitrator notes the Petitioner's testimony that she "discussed" her job duties with Dr. Schroeder and "described" her job duties to Dr. Nyquist, there is nothing in the records of either of those physicians which indicates that they did, in fact, have an accurate understanding of the Petitioner's actual job activities. Dr. Fernandez, however, testified that in addition to describing her job duties and activities to him the Petitioner also demonstrated the "positional factors" of her wrists and elbows.

Dr. Fernandez testified that the Petitioner's bilateral carpal tunnel syndrome was not causally related to her work as a secretary for Respondent. Dr. Fernandez further testified that the Petitioner did not have any work factors which would be causative or aggravating to carpal tunnel syndrome. Dr. Fernandez testified that the Petitioner's increased weight, diabetes, and thyroid disease were all risk factors in the development of carpal tunnel syndrome and he opined that these other factors contributed to the Petitioner's carpal tunnel syndrome. Additionally, Dr. Fernandez noted that the Petitioner did not use any exaggerating flexion or used any exaggerating force in the performance of her secretarial duties.

As it is not clear from the record that either Dr. Schroeder or Dr. Nyquist had an accurate understanding of the Petitioner's actual job duties and activities, the Arbitrator questions the reliability of those opinions. While the Arbitrator notes that Dr. Fernandez examined the Petitioner at the request of the Respondent, his testimony demonstrates that he did have an understanding of the Petitioner's actual job duties and activities as well as the "positional factors" of her wrists and elbows when she performed those activities. In light of

the opinions of Dr. Fernandez and the questionable reliability of the opinions of Dr. Schroeder and Dr. Nyquist, the Arbitrator finds that the opinions of Dr. Schroeder and Dr. Nyquist are not sufficiently reliable and persuasive so as to satisfy the Petitioner's burden of proof.

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 that arose out of and in the course of her employment with the Respondent. The Arbitrator further finds that the Petitioner failed to prove that her current condition of ill-being is causally related to her job activities with the Respondent.

As the Arbitrator has found that the Petitioner failed to meet her burden of proof with regard to the issues of accident and causation, determination of the remaining disputes issues is 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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Timothy Harris,

Petitioner,

14IWCC0125

vs.

NO: 11 WC 25456

Flying Food Fare, Inc. ,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care, evidentiary rullings, did Petitioner exceed his choice of medical providers, and penalties and attorney's 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. 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 14, 2014 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.

14IWCC0125

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 $1,900.00. 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: FEB 20 2014

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

MJB:bjg
0-2/10/2014
52

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

14IWCC0125

HARRIS, TIMOTHY
Employee/Petitioner

Case# 11WC025456

FLYING FOOD FARE INC
Employer/Respondent

On 5/14/2013, 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 0.08% 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:

2194 STROM & ASSOCIATES
LINDSEY STROM
180 N LASALLE ST SUITE 2510
CHICAGO, IL 60601

0532 HOLECEK & ASSOCIATES
STAURT PELLISH
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

14IWCC0125

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

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

Timothy Harris
Employee Petitioner

v.

Flying Food Fare, Inc.
Employer/Respondent

Case # **11** WC **25456**

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 March 11. 2913. After reviewing all 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. [ ] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other Necessity of prospective medical care; P. Did Petitioner exceed his choice of physicans?

FINDINGS

On **5/12/2011**, 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 $**17,992.00**; the average weekly wage was $**344.00**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **1** dependent child.

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

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

Respondent shall be given a credit of $**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 for Petitioner reasonable and necessary medical services, in the amount of $1,845.00 and shall pay all reasonable and necessary future medical expenses, as provided in Section 8(a) and 8.2 of the Act.

Penalties and attorney's fees are not awarded.

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 13, 2013

MAY 14 2013

TIMOTHY HARRIS
11 WC 25456

FINDINGS OF FACT

The disputed issues in this matter are: 1) causal; connection; 2) medical bills; 3) has the petitioner exceeded his choice of physicians; 4) prospective medical services; 5) penalties; and 6) attorney's fees. *See*, AX1.

Petitioner testified that on May 11, 2011, he was working as a porter for Respondent, Flying Foods Fare, Inc. and that his job duties included cleaning, mopping, scrubbing, and lifting boxes that weigh approximately ten to fifteen (10-15) pounds. Petitioner testified that he worked for the Respondent for approximately 2 & 1/2 to 3 years exclusively as a porter. *See*, TX pgs. 10-12.

Petitioner further testified that on the date of the accident, he reported to work at his usual time of 5:00 a.m. He was bending over to clean and drain the sewers when he slipped on grease in the kitchen and hit his right knee on the edge of the sewer. Petitioner testified that he felt a lot of pain subsequent to the accident and stated that he tried to "walk off" the pain because he did not think it would last long.

Petitioner testified that he did not report the accident to anyone on May 11, 2011, because he "did not think it was a big deal". Petitioner continued to work the rest of his shift on that day, even though he continued to have pain in his right knee. Petitioner testified that he did not seek immediate medical attention because he did not think that he had injured himself badly. Petitioner testified that after he had returned home from work, he began to feel more pain and his right knee became stiff. *See*, TX pgs. 13-14.

Petitioner testified that he reported the injury to his supervisor, Tim Gaddis, who did not direct Petitioner to any hospital or occupational health clinic for treatment. Petitioner testified that he went to St. Anthony's Hospital and sought treatment on his own, on May 18, 2011. At the hospital, Petitioner provided the

same history of accident as described at trial and in the initial reports completed for his employer. The records state that Petitioner followed up with the work nurse and she told him to go to the emergency room. Upon physical examination, it was noted that Petitioner had right knee swelling and pain with walking. Per the medical notes, Petitioner described sharp pain and tenderness to the right knee, both medially and laterally. He was treated and released. *See*, PX4 & TX p. 18.

Petitioner testified that he was referred to Advanced Occupational Medicine Specialists ("AOMS") and examined by Dr. Khanna, on June 15, 2011. Dr. Khanna noted the same history of the accident that Petitioner provided at trial. Upon physical examination, Dr. Khanna reported that the lateral joint line was tender to palpation on the right side of the knee and that there was a positive squat test on the right. Dr. Khanna further noted that there was a 3.5 x 3.0 cm cystic mass noted on the right lateral knee, with tenderness to palpation. *See,* PXs 4, 5 & TX p. 20.

Dr. Khanna ordered an MRI of the right knee, which was performed on June 16, 2011, at Athletic Imaging. Per the radiologist's report, this MRI was interpreted to reveal trace effusion and a mild increased signal in the interior and posterior horns of the lateral meniscus. The medial meniscus demonstrated a mild increased signal, anteriorly and posteriorly, but it was noted that there was no evidence of a lateral meniscal tear. There was grade II-III chondromalacia within the medial and lateral tibiofemoral compartments and mild joint space narrowing with mild osteophyte formation. A multiobulated cystic structure was identified along the inferior margin of the lateral patellar retinaculum and seen along the posterior margin of the patellar tendon, posterior to the tendon. The radiologist noted that it might represent a soft-tissue ganglion cyst and opined that due to the atypical location of the lesion; post-contrast imaging was necessary for further evaluation. *See,* PX 5.

Petitioner testified that Dr. Khanna referred to him Dr. Christos Giannoulias of G&T Orthopaedics and Sports Medicine. Petitioner began treatment with Dr. Giannoulias on July 5, 2011 and the doctor's report, from that office visit, relates the same mechanism of injury that Petitioner previously reported and recounted at trial. Dr. Giannoulias' report states that Petitioner has a cystic mass over the anterolateral aspect of the right knee and that he did not report any problems with his knee prior to the injury. Petitioner was diagnosed with a right knee ganglion cyst and during this office visit; Dr. Giannoulias aspirated 2 cc's of fluid from Petitioner's right knee. Petitioner received two more injections during the course of his treatment with Dr. Giannoulias and Petitioner testified that the injections helped his knee initially, but then his pain returned. *See*, TX p.20-21 & PX6.

On July 14, 2011, Petitioner returned to Dr. Giannoulias and reported that the asipiration did not fully relieve the right knee symptoms and that the ganglion cyst recurred. Dr. Giannoulias re-examined Petitioner and opined that there was tenderness over the anterolateral joint line. He noted that there was pain with McMurray's maneuver and that Petitioner had trouble with full extension and full flexion. At this time, Dr. Giannoulias added an additional diagnosis of meniscus tear and ganglion cyst of the right knee and recommended arthroscopic excision of the cyst. Petitioner indicated that he wished to proceed. Petitioner testified that Dr. Giannoulias continued to recommend surgery but that this procedure was never performed because the insurance company did not provide authorization. Petitioner testified that he does not have group health insurance and therefore, could not proceed with surgery on his own. Petitioner testified that he continued to work on light duty while treating with Dr. Giannoulias because Respondent was accommodating the doctor's light duty restrictions. *See*, PX6 & TX pp. 20-22.

On September 27, 2011, Dr. Giannoulias reported that Petitioner's symptoms were not improving and he explained that the only other treatment for the

petitioner was the excision of the cyst with arthroscopic evaluation of the cartilage surface. Dr. Giannoulias opined that the cyst had developed after the trauma and there is no evidence to believe otherwise.

In Dr. Giannoulias' March 8, 2012 note, he once again recommended arthroscopy to address the lateral meniscus tear and cyst since Petitioner had failed conservative treatment. He opined that Petitioner was not doing well and was having difficulty with most of his daily activities. He also stated that Petitioner's condition was not degenerative and was directly related to his work injury.

Petitioner testified that he continues to have pain and stiffness in his right knee. He testified that he continues to feel a burning sensation inside his knee. Petitioner testified that he did not have right knee pain or symptoms prior to the date of the accident. He also testified that he had not sought any medical treatment for right knee pain prior to the date of the accident. Furthermore, Petitioner testified that he did not notice any bulges in his right knee prior to the date of the accident. *See*, TX p. 23.

CONCLUSIONS OF LAW

F. Is Petitioner's present condition of ill-being is causally related to the injury:

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 undisputed that Petitioner was performing his regular duties of employment for Respondent on May 11, 2011; and that he experienced pain in his right knee subsequent to a fall on a sewer drain, while performing that work. As Petitioner's symptoms worsened, he sought medical treatment at St. Anthony's Hospital and provided a consistent history of accident and complaints. When Petitioner's symptoms failed to improve, Respondent referred him for treatment at Advanced Occupational Medicine Specialists. Dr. Khanna referred Petitioner to an orthopaedic specialist, Dr. Giannoulias; and he underwent a course of conservative treatment. Petitioner continued to work for the Respondent within light duty restrictions while undergoing treatment. Dr. Giannoulias diagnosed Petitioner with a right knee meniscal tear and ganglion cyst noting that Petitioner had no right knee complaints prior to the date of the accident.

The Arbitrator relies on the medical reports and the credible deposition testimony of Petitioner's treating physician, Dr. Giannoulias. He testified that on July 5, 2011, the first date that he evaluated Petitioner, there was pain and swelling over the anterior lateral aspect of the right knee; the exact place

Petitioner struck his knee on the sewer. Dr. Giannoulias added that Petitioner complained of tenderness any time that he touched it. Dr. Giannoulias further testified that Petitioner had a cystic structure over the anterior lateral joint line that was tender to compression and he also had tenderness over the anterior lateral joint line, the lateral meniscus; as well as over the medial joint line. Dr. Giannoulias testified that the subjective complaints were supported by the objective findings and that most of Petitioner's pain was focused directly on the cystic structure over the anterior lateral aspect. He further noted that Petitioner had pain with circumduction and this correlated with the subjective complaints. Dr. Giannoulias' opinion was that the ganglion cyst was caused as a direct result of the work accident. This is because Petitioner had denied any prior problems with his knee and that he noticed swelling and pain two days after the injury.

Dr. Giannoulias re-evaluated Petitioner on July 14, 2011. Dr. Giannoulias testified that Petitioner continued to have tenderness over the anterior lateral joint line and that the cyst had recurred. Dr. Giannoulias believed that Petitioner still had the ganglion cyst, but also believed that clinically, the meniscus was a problem because there was tenderness and pain with McMurray's maneuver. He opined that based upon the MRI findings and the physical examination that the ganglion cyst and meniscus tear were correlating; and surgery was recommended. *See,* PX8, pgs. 12-13; PX6.

The petitioner was examined, by request of Respondent, by Dr Miller, who opined that the cyst was not related to the accident. Dr. Giannoulias testified that he disagreed with Dr. Miller's diagnosis of Petitioner's injury as well as Dr. Miller's opinion that there is no causal connection. Dr. Giannoulias noted, "there is no evidence in the medical records or by Mr. Harris' history that he had any difficulty with his knee prior to the injury". Dr. Giannoulias believed that the swelling in Petitioner's right knee was consistent with a cyst that developed a couple days after the injury per Petitioner's history. Dr. Giannoulias testified that the meniscal or retinacular cysts seen on Petitioner's MRI are very common with

trauma, and that Dr. Miller's belief that all of these types of cysts are degenerative was "absolutely not true". *See,* PX 8, pgs. 14, 15.

As recommended by Dr. Miller's IME report, Dr. Giannoulias provided another cortisone injection to Petitioner's knee, on September 12, 2011. Petitioner followed-up with Dr. Giannoulias on September 27, 2011 and he continued to complain of pain over the anterior lateral aspect of the knee and over the cyst. Dr. Giannoulias testified that the physical examination findings were essentially unchanged and that he again recommended surgery, as he believed it to be medically necessary. *See,* PX 8, p. 17-19.

The Arbitrator finds that Dr. Giannoulias' opinion is more credible and holds more weight than the Respondent's expert, Dr. Miller. Dr. Miller did not dispute that there were objective findings on Petitioner's examination, at the time of the Independent Medical Examination ("IME"). He noted during the deposition that Petitioner's examination did show pain, hypersensitivity and that Petitioner was limping. Dr. Miller opined that the cyst was "totally unrelated" to the work accident. Dr. Miller stated in his report as well as during his deposition, that the relationship between the cyst and the fall at work was "mere coincidence". Dr. Miller admitted that he had no medical evidence to show that Petitioner had the cyst prior to the date of accident. Additionally, Dr. Miller acknowledged that Petitioner told him that he was asymptomatic prior to the date of the accident. *See,* RX 1, pgs. 8, 14-17; 32 & RX 1-A. *Also see,* TX pgs. 32, 34; RX 1-A pg. 15.

On cross-examination of Dr. Miller, he admitted that he did not have the medical records from St. Anthony's Hospital, where Petitioner first sought medical treatment subsequent to the work injury. Dr. Miller testified that according to the medical records, Petitioner waited "at least a week or perhaps longer" to seek medical treatment.

The Arbitrator notes that Petitioner's medical records admitted into evidence from St. Anthony Hospital show that he was admitted on May 18, 2011. Dr. Miller admitted that just because someone injures him or herself and does not seek treatment on that particular date, does not necessarily mean that they do not have any pain on the accident date. *See,* PX 6; & RX 1, pgs. 6-24.

Dr. Miller stated several times throughout the deposition, as well as in his report, that he has never heard of a ganglion cyst being caused by a traumatic event. The doctor attempted to show that he had literature on this subject to prove that a ganglion could not be caused by trauma; however, the literature that the doctor read aloud did not corroborate his opinion. Dr. Miller read from a pamphlet on ganglion cysts authored by the American Society for Surgery of the Hand and "Operative Hand Surgery", by David Green. While reading directly from the "Operative Hand Surgery" literature, he stated, "the etiology and pathogenesis of ganglion remains obscure and review of the literature indicates the confusion exists". He added that, "although the pathogenesis of ganglions has never been satisfactorily explained, surgical treatment can be undertaken with confidence". When asked if he wanted to retract his earlier statement whether trauma could "never" be the cause of a ganglion cyst, Dr. Miller proclaimed that he was going to stand by his original statement. *See,* RX1, pgs. 34-43; RX1, p. 14; & RX1-A.

Dr. Miller stated during his deposition that if the cyst was symptomatic, it would have responded to the aspiration, at least temporarily. The Arbitrator noted that Petitioner testified and Dr. Giannoulias' records corroborate, that the injections did temporarily alleviate Petitioner's pain complaints. Dr. Miller opined in his report and again during the deposition that based upon Petitioner's symptoms that surgery is reasonable and appropriate. However, Dr. Miller believed that there is no causal relationship between the cyst and the work incident and that the ganglion cyst was present all along. It was Dr. Miller's professional opinion that "this is a simple coincidence. This ganglion was there and he simply never noticed it before the incident in question". *See,* RX 1, p. 15; 57-63; RX 1-A.

It is well settled in medical literature that the cause of ganglion cysts is not known. One theory suggests that trauma causes the tissue of the joint to break down, forming small cysts, which then join into a larger, more obvious mass. The most likely theory involves a flaw in the joint capsule or tendon sheath that allows the joint tissue to bulge out. In addition, most ganglion cysts cause some degree of pain, usually following acute or repetitive trauma therefore, suggesting an aggravation of a pre-existing condition. For Dr. Miller, to unequivocally state, that such cysts cannot be caused by trauma when his own literature states that the causes of such cysts are vague; results in the Arbitrator finding that Dr. Miller's testimony, with regard to causality, is less than credible.

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to his May 11, 2011, work injury. In support of this finding, the Arbitrator relies on the unrebutted, credible testimony of Petitioner; medical records from St. Anthony's Hospital, Advanced Occupational Medicine Specialists, G&T Orthopedics & Sports Medicine, Cook County Stroger Hospital; and Dr. Giannoulias' testimony. Therefore, the Arbitrator finds that because the cystic mass was a result of the work-related accident, Respondent is hereby ordered to approve the surgery requested by Dr. Giannoulias.

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

Because the Arbitrator found that Petitioner's accident was causally connected to his current condition of ill-being, the Arbitrator finds that Respondent is liable for all necessary medical bills that are related to Petitioner's work injury; namely, bills from G&T Orthopaedics totaling $1,845.00.

M. Should penalties or fees be imposed upon Respondent?

The Arbitrator does not find that Respondent's failure to authorize and pay for said surgical procedure ordered by Dr. Giannoulias rises to the level of unreasonable, vexatious and without good cause, therefore no penalties of attorney's fees are awarded.

O. Is there a necessity for prospective medical care?

Having found causal connection of the accident and Petitioner condition of ill-being; the Arbitrator orders Respondent to authorize surgery as recommended by Dr. Giannoulias as well as any reasonably related prospective medical care subsequent to that procedure.

P Did Petitioner exceed his choice of physicians?

The Arbitrator finds that Petitioner did not exceed his choice of physicians. Petitioner initially went to St. Anthony's Hospital subsequent to the work-related injury. Petitioner testified that he was referred to AOMS by the Respondent. Petitioner was referred to G&T Orthopaedics from AOMS and treated with Dr. Giannoulias. Because Dr. Khanna referred Petitioner to Dr. Giannoulias, this is within the chain of referral and Petitioner may continue to treat with Dr. Giannoulias.

Respondent is responsible for Dr. Giannoulias' medical bills that have been incurred to date, as well as the prospective medical bills as they relate to Petitioner's right knee injury. Petitioner sought treatment at Stroger Hospital because he continued to have pain in his right knee and Respondent refused to authorize further treatment with Dr. Giannoulias. Petitioner's first choice of

doctor would be AOMS, who then referred him to Dr. Giannoulias. Stroger would be Petitioner's second choice.

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

Patricia Vargas,

Petitioner,

14IWCC0126

vs.

NO: 12 WC 38709

Lifetouch Portrait Studio,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, and prospective medical care,0 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 18, 2013 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.

14IWCC0126

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

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

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

DATED: FEB 2 0 2014

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

MJB:bjg
0-2/10/2014
52

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

14IWCC0126

VARGAS, PATRICIA
Employee/Petitioner

Case# 12WC038709

LIFETOUCH PORTRAIT STUDIOS INC
Employer/Respondent

On 7/18/2013, 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:

0290 KARCHMAR & STONE
GARY P STONE ESQ
111 W WASHINGTON ST SUITE 1030
CHICAGO, IL 60602

2337 INMAN & FITZGIBBONS
KEVIN DEUSCHLE
33 N DEARBORN SUITE 1825
CHICAGO, IL 60602

14IWCC0126

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)

Patricia Vargas
Employee/Petitioner

v.

Lifetouch Portrait Studios, Inc.
Employer/Respondent

Case # **12** WC **38709**

An *Application for Adjustment 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 **6/26/13**. After reviewing all 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, **Lifetouch Portrait Studios, Inc.**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$41,860**; the average weekly wage was **$805.00**.

On the date of accident, Petitioner was **32** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of **$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 **$5,711.41** under Section 8(j) of the Act.

ORDER

Respondent shall be given a credit of $5,711.41 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay reasonable and necessary medical services of $(see attached), as provided in Section 8(a) of the Act.

Respondent shall pay all reasonable and necessary prospective medical services as provided in Section 8(a) of the Act see attached).

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

July 18, 2013
Date

ICArbDec19(b)

JUL 18 2013

STATEMENT OF FACTS

The Arbitrator observed the demeanor of the Petitioner and manner in which she testified and responded to questions, both during direct and cross examination and finds her credible.

As testified, the Petitioner sustained injuries to her left hip on January 26, 2012 while working for the Respondent performing her duties as a studio manager and photographer at the Respondent's photography studio located at 2656 N. Elston Avenue, Chicago, Illinois. Petitioner has been working for the Respondent for approximately 13½ years. Her usual work week consists of 40 hours, but fluctuates between 40 and 60 hours during busy season. Petitioner's duties consist of hiring, firing, creating the work schedule, photography, training and other administrative duties, including inventory. When she is performing her duties as a photographer, she is required to be very active including taking photographs from her knees.

Petitioner testified that at approximately noon on January 26, 2012 she was at Respondent's studio and was performing inventory work in the storage area where the floor was slippery. This required her to get on a ladder to count frames and other items at the studio. She was on the 2nd step of the ladder and while descending, she missed the 1st step causing her left leg to over extend. She immediately noticed pain in her left hip.

She reported this incident and completed the required Employee Incident/Injury Report that day. (Petitioner's Exhibit 1). She did not see a physician that day as she thought she may have just strained or pulled a muscle. She continued to work over the next several weeks but the left hip pain remained steady. She decided to call Dr. Brian Cole who treated her for a left knee injury several years earlier. Dr. Cole referred the Petitioner to Dr. Nho since he was better able to treat a hip injury.

On February 27, 2012 the Petitioner first saw Dr. Nho and provided him with a history of the occurrence, specifically that she felt she had over extended her left leg while stepping down from a ladder. Further, she stated she was experiencing sharp pain in her left hip. She thought it would go away, but the pain persisted. Dr. Nho's record of February 27, 2012 reflects the prior left knee history and indicates that she had no issues related to the left hip other than some occasional achiness around the hip following the left knee injury. (Petitioner's Exhibit 2). Dr. Nho notes that the pain is worse with pivoting, twisting, turning and crossing her legs and that she feels like her hip is coming out. (Petitioner's Exhibit 2). He further noted that Petitioner tried oral anti-inflammatories, activity modification and ice. (Petitioner's Exhibit 2). Dr. Nho recommended that Petitioner undergo an MR arthrogram to determine if a labral tear exists. (Petitioner's Exhibit

2). Of note, the Petitioner completed a General Intake Form at the initial visit with Dr. Nho on February 27, 2012 in which she indicated that this is a work related injury. (Petitioner's Exhibit 2). Additionally, a Hip Survey was completed on that date in which Petitioner provided the history of the injury from January 26, 2012 and indicated that there was no prior history. Moreover, the Petitioner rated the function of her hip prior to the injury as a 10 (normal). (Petitioner's Exhibit 2). The MR arthrogram was performed on March 28, 2012 and Petitioner returned to Dr. Nho on April 16, 2012. (Petitioner's Exhibit 2). Dr. Nho recommended an injection which was performed on June 4, 2012. (Petitioner's Exhibit 2). Thereafter, Dr. Nho recommended physical therapy which Petitioner underwent at Athletico, the same facility where she was treated for her left knee injury several years earlier. (Petitioner's Exhibits 2 and 4). Dr. Nho further stated that Petitioner has a symptomatic hip labral tear with an underlying diagnosis of femoroacetabular impingement, which was exacerbated by her work injury on January 26, 2012. (Petitioner's Exhibit 2).

At the outset of physical therapy, Petitioner completed an Outpatient Screening Form in which she indicated that the problem area was her left hip and that the symptoms started on January 26, 2012. (Petitioner's Exhibit 4). But, an initial therapy evaluation note dated July 17, 2012 states

that Petitioner feels that her current left hip injury is due to lingering problems stemming from her left knee surgery and that her left hip was thrown out during therapy. (Petitioner's Exhibit 4). However, immediately following that comment, the therapist notes that on January 26, 2012 Petitioner was stepping off a step ladder at work and slipped. She felt a stretching type pain in her left hip and that the pain has not gotten better. (Petitioner's Exhibit 4). Petitioner testified that she did not injure her left hip prior to January 26, 2012 and that she only experienced occasional stiffness in her left leg, including her left hip, after the left knee injury, but that was just muscular. She further testified that she did not experience any hip pain, symptoms or problems after being discharged from care for her left knee in 2010. Petitioner testified that the note associating her left hip pain to her prior left knee injury is incorrect. A review of the medical records from Dr. Brian Cole and Athletico from 2009 and 2010 following her left knee injury in November 2009 are void of any left hip complaints whatsoever and corroborate the Petitioner's testimony. (Petitioner's Exhibit 3 and 4).

As a result of physical therapy and the injection, it appears that some temporary relief was experienced but then the persistent pain returned. On July 30, 2012, Dr. Nho evaluated the Petitioner and indicated that all

nonsurgical treatment was exhausted. His recommendation was that Petitioner undergo a left hip arthroscopy, labral repair, possible acetabular rim trimming, femoral osteochondroplasty and capsular plication. (Petitioner's Exhibit 2). Respondent then scheduled an IME with Dr. Kevin Walsh on September 27, 2012.

It appears that Dr. Walsh is of the opinion that any complaints the Petitioner has with regard to her left hip are related to her pre-existing femoral acetabular impingement and not the incident of January 26, 2012. (Respondent's Exhibit 1). However, he did not express any opinion as to whether the incident of January 26, 2012 exacerbated the underlying condition. (Respondent's Exhibit 1). Dr. Walsh did note that the Petitioner can consider surgical intervention as recommended by Dr. Nho as she underwent a long course of conservative care. (Respondent's Exhibit 1). He further stated that treatment to date has been reasonable. (Respondent's Exhibit 1). In his report, Dr. Walsh did not specify which medical records he reviewed, although it is clear he did not review the medical records of Dr. Cole and Athletico which contain the treatment details stemming from the Petitioner's prior left knee injury. (Respondent's Exhibit 1). Moreover, given the date of the IME report (October 4, 2012), Dr. Walsh did not review any of the medical records subsequent thereto,

including the medical records of Dr. Nelson, Dr. Domb and the second MR arthrogram performed on April 1, 2013. (Respondent's Exhibit 1).

Petitioner testified that after her IME with Dr. Walsh, Dr. Nho would no longer see her as workers' compensation would not approve any treatment. She further testified that Dr. Nho would not accept her health insurance and even declined to see her when she offered to pay for the visit herself. In need of medical treatment, Petitioner sought the help of Dr. Dirk Nelson who was referred to her by Dr. Perns, a physician who was treating a family member. On March 12, 2013 Dr. Nelson evaluated the Petitioner and noted the history of her injury that began on January 26, 2012. (Petitioner's Exhibit 5). Dr. Nelson opined that it was somewhat likely that the Petitioner does have some type of labral pathology causing persistent symptoms and agreed with Dr. Nho that a diagnostic arthroscopy and possible labral repair was indicated. (Petitioner's Exhibit 5). Since Dr. Nelson does not specialize in the hip, he referred the Petitioner to "Dr. Benjamin Domb who does a lot of hip arthroscopy for his opinion". (Petitioner's Exhibit 5).

On March 18, 2013, Dr. Domb evaluated the Petitioner and noted the history of the injury to the left hip beginning after an incident when she was doing inventory at work in January 2012. (Petitioner's Exhibit 6). After

examining the Petitioner, it appears that Dr. Domb reviewed the MR arthrogram film from March 28, 2012 and noted that it shows an anterosuperior labral tear that was not read by the radiologist. (Petitioner's Exhibit 6). Dr. Domb concurred with Dr. Nho that arthroscopy was appropriate, but requested a new MR arthrogram of better quality. (Petitioner's Exhibit 6). On April 1, 2013 an MR arthrogram of the left hip was performed which revealed an anterior labral tear. (Petitioner's Exhibit 6). On April 2, 2013, Dr. Domb confirmed the tear and stated that the tear was caused by the injury. (Petitioner's Exhibit 6). He further noted the slight acetabular retroversion and stated that it was not caused by the injury nor was it in and of itself the cause of her hip problem. (Petitioner's Exhibit 6). On April 25, 2013, Dr. Domb met with the Petitioner and recommended arthroscopic repair. (Petitioner's Exhibit 6). The surgery is pending approval.

Petitioner testified that she continues to work full duty, with pain, but desires to have the recommended treatment to alleviate her left hip symptoms.

CONCLUSIONS OF LAW

The Arbitrator finds that an accident occurred that arose out of and in the course of the Petitioner's employment by the Respondent and in support thereof adopts Petitioner's Exhibits 1 through 6 and further finds as follows:

The Petitioner testified credibly and the evidence presented by Petitioner demonstrates that an accident occurred on January 26, 2012 that arose out of and in the course of the Petitioner's employment by the Respondent. Petitioner testified that she was employed by the Respondent as a studio manager and photographer on and prior to January 26, 2012. Her duties consist of hiring, firing, creating the work schedule, photography, training and other administrative duties, including inventory. Petitioner testified that at approximately noon on January 26, 2012 she was at Respondent's studio and was performing inventory work in the storage area where the floor was slippery. This required her to get on a ladder to count frames and other items at the studio. She was on the 2nd step of the ladder and while descending, she missed the 1st step causing her left leg to over extend. She immediately noticed pain in her left hip. She reported this incident and completed the required Employee Incident/Injury Report that day. (Petitioner's Exhibit 1). This history of injury was noted by the

medical providers who treated the Petitioner subsequent to January 26, 2012. (Petitioner's Exhibits 2, 4, 5 and 6). Even the Respondent's IME physician, Dr. Kevin Walsh, notes the incident in his report of October 4, 2012. (Respondent's Exhibit 1).

Accordingly, based upon the Petitioner's testimony and the documentary evidence contained in the Petitioner's exhibits 1, 2, 4, 5, and 6, all of which are unrefuted, the Arbitrator finds that an accident occurred that arose out of and in the course of the Petitioner's employment by the Respondent.

As to the issue of whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds that the Petitioner's current condition of ill-being as to her left hip is causally related to the injury and in support thereof adopts Petitioner's Exhibits 1 through 6.

The Petitioner testified credibly and the evidence presented by Petitioner demonstrates that the Petitioner's current condition of ill-being is causally related to the injury.

Petitioner testified that she had never injured her left hip prior to January 26, 2012. As previously noted, the Petitioner was injured when she was on the 2nd step of a ladder taking inventory for the Respondent

and while descending, she missed the 1st step causing her left leg to over extend. She immediately noticed pain in her left hip. She reported this incident and completed the required Employee Incident/Injury Report that day. (Petitioner's Exhibit 1). The incident report clearly states the manner in which the accident occurred, identifies the body part affected (left hip) and describes the nature of the injury as "over extended so I think just strain". (Petitioner's Exhibit 1). The Petitioner then notes that she is not seeking medical treatment as of now. (Petitioner's Exhibit 1). Petitioner testified that the left hip pain steadily persisted in the weeks following the accident so she called Dr. Cole, a physician who treated her left knee injury several years prior. Dr. Cole referred her to Dr. Nho who was better able to treat a hip injury.

On February 27, 2012 the Petitioner first saw Dr. Nho and provided him with a history of the occurrence, specifically that she felt she had over extended her left leg while stepping down from a ladder. Further, she stated she was experiencing sharp pain in her left hip. She thought it would go away, but the pain persisted. Dr. Nho's record of February 27, 2012 reflects the prior left knee history and indicates that she had no prior issues related to the left hip other than some occasional achiness around the hip following the left knee injury. (Petitioner's Exhibit 2). Dr. Nho notes

that the pain is worse with pivoting, twisting, turning and crossing her legs and that she feels like her hip is coming out. (Petitioner's Exhibit 2). He further noted that Petitioner tried oral anti-inflammatories, activity modification and ice. (Petitioner's Exhibit 2). Dr. Nho recommended that Petitioner undergo an MR arthrogram to determine if a labral tear exists. (Petitioner's Exhibit 2).

Of note, the Petitioner completed a General Intake Form at the initial visit with Dr. Nho on February 27, 2012 in which she indicated that this is a work related injury. (Petitioner's Exhibit 2). Additionally, a Hip Survey was completed on that date in which Petitioner provided the history of the injury from January 26, 2012 and indicated that there was no prior history. Moreover, the Petitioner rated the function of her hip prior to the injury as a 10 (normal). (Petitioner's Exhibit 2). The MR arthrogram was performed on March 28, 2012 and Petitioner returned to Dr. Nho on April 16, 2012. (Petitioner's Exhibit 2). Dr. Nho recommended an injection which was performed on June 4, 2012. (Petitioner's Exhibit 2). Thereafter, Dr. Nho recommended physical therapy which Petitioner underwent at Athletico, the same facility where she was treated for her left knee injury several years earlier. (Petitioner's Exhibits 2 and 4). Dr. Nho further stated that Petitioner has a symptomatic hip labral tear with an underlying diagnosis of

femoroacetabular impingement, which was exacerbated by her work injury on January 26, 2012. (Petitioner's Exhibit 2).

After the IME performed by Dr. Walsh, the Petitioner was forced to seek medical treatment with Dr. Dirk Nelson who concurred with Dr. Nho but referred the Petitioner to Dr. Domb, who was a hip specialist. (Petitioner's Exhibit 5). On March 18, 2013, Dr. Domb evaluated the Petitioner and noted the history of the injury to the left hip beginning after an incident when she was doing inventory at work in January 2012. (Petitioner's Exhibit 6). Dr. Domb was aware of the prior left knee injury that occurred in 2009 as noted in his records. (Petitioner's Exhibit 6). After examining the Petitioner, it appears that Dr. Domb reviewed the MR arthrogram film from March 28, 2012 and noted that it shows an anterosuperior labral tear that was not read by the radiologist. (Petitioner's Exhibit 6). Dr. Domb concurred with Dr. Nho that arthroscopy was appropriate, but requested a new MR arthrogram of better quality. (Petitioner's Exhibit 6). On April 1, 2013 an MR arthrogram of the left hip was performed which revealed an anterior labral tear. (Petitioner's Exhibit 6). On April 2, 2013, Dr. Domb confirmed the tear and stated that the tear was caused by the injury. (Petitioner's Exhibit 6). He further noted the slight acetabular retroversion and stated that it was not caused by the injury

nor was it in and of itself the cause of her hip problem. (Petitioner's Exhibit 6). On April 25, 2013, Dr. Domb met with the Petitioner and recommended arthroscopic repair. (Petitioner's Exhibit 6).

In contrast, the Respondent's well-known IME physician, Dr. Kevin Walsh, opined that any complaints the Petitioner has with regard to her left hip are related to her pre-existing femoral acetabular impingement and not the incident of January 26, 2012. (Respondent's Exhibit 1). It appears that this opinion is based mostly on the mistaken belief that the Petitioner had left hip symptoms that waxed and waned from the time of her left knee surgery. (Respondent's Exhibit 1). However, it is clear that Dr. Walsh did not review the medical records from Dr. Brian Cole or Athletico from 2009 and 2010 relating to her left knee injury or he would have noted the complete absence of any left hip complaints throughout that period. Further, Dr. Walsh did not ask the Petitioner about her complaints of left hip pain prior to January 26, 2012. Instead, Dr. Walsh merely relied on the July 17, 2012 physical therapy note from Athletico in which the therapist noted that the Petitioner feels that her current left hip injury is due to lingering problems stemming from her left knee surgery and that her left hip was thrown out during therapy. Although the therapist's statements immediately thereafter clearly detail the incident of January 26, 2012 and

the injury to the left hip following therefrom, Dr. Walsh ignores these facts. Had Dr. Walsh asked the Petitioner about the statement that appeared in the physical therapy note relating to her left knee injury, he would have known that this was not accurate. Moreover, given the date of the IME report (October 4, 2012), Dr. Walsh did not review any of the medical records subsequent thereto, including the medical records of Dr. Nelson, Dr. Domb and the second MR arthrogram performed on April 1, 2013. (Respondent's Exhibit 1).

Additionally, it appears Dr. Walsh did not even consider whether the incident of January 26, 2012 exacerbated the underlying condition. Rather he simply opines that the underlying condition is responsible for all of Petitioner's left hip problems, despite the contemporaneous complaints of pain immediately following the January 26, 2012 work accident. (Respondent's Exhibit 1).

Thus, it appears that the only basis for Dr. Walsh's opinion about the causal relationship of the left hip condition and the accident is the erroneous belief that Petitioner had left hip symptoms that waxed and waned since her left knee injury several years prior. Since a review of the medical records of Dr. Cole and Athletico reveals no such history, Dr. Walsh's opinion is of little value and is neither persuasive nor credible.

The Arbitrator thus places greater weight upon the findings and opinions of the Petitioner's treating physicians, Dr. Nho and Dr. Domb, whose opinions are credible and persuasive.

Dr. Nho has been the Petitioner's treating orthopedic surgeon since the outset of her injury beginning in February 2012 and has continuously examined and treated the Petitioner since that time. Thus, he is in the best position to formulate an opinion as to the injury and causation. In addition, Dr. Domb, a hip specialist, considered all the issues and after a repeat MR arthrogram confirmed the diagnosis of a labral tear and an underlying impingement, he provided a well reasoned opinion as to the diagnosis and causation.

It is well settled that where an injury is a contributing factor, compensation will be allowed even if it is possible that the Petitioner's condition of ill-being resulted from other contributing factors or degenerative processes. (See International Vermiculite Company v. Illinois Industrial Commission, 76 Ill2d 1, 31 Ill. Dec. 789, 394 N.E.2d 1166 (1979)). Furthermore, in deciding between varying medical opinions, it is for the Commission to decide which medical view is to be accepted and it may attach greater weight to the opinion of the treating physician. International Vermiculite Company, 76 Ill2d at 3.

Accordingly, based upon the Petitioner's testimony and the opinions of Dr. Nho and Dr. Domb, the Arbitrator finds that the Petitioner's current condition of ill-being as to her left hip is causally related to the injury sustained on January 26, 2012.

As to the issue of whether the medical services that were provided to Petitioner were reasonable and necessary and the issue of whether Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds that the medical services provided to Petitioner were reasonable and necessary and the Respondent has not paid all appropriate charges for all reasonable and necessary medical services and in support thereof the Arbitrator adopts Petitioner's Exhibits 1 and 2 and 4 through 12 and further finds as follows:

It should be noted that the Respondent's IME physician, Dr. Walsh, after reviewing the medical records and examining the Petitioner, agreed that treatment to date has been reasonable. (Respondent's Exhibit 1). Furthermore, Dr. Nho, Petitioner's initial treating physician, focused on conservative treatment for the left hip injury. (Petitioner's Exhibit 2). After the IME was performed, the Petitioner was treated conservatively by Dr. Nelson and then Dr. Domb. (Petitioner's Exhibits 5 and 6). Dr. Nho, Dr.

Nelson and Dr. Domb all recommend arthroscopic surgery at this point and Dr. Walsh even agrees that given the long course of conservative treatment, the Petitioner can consider surgical intervention. (Petitioner's Exhibits 2, 5 and 6 and Respondent's Exhibit 1).

Therefore, the Arbitrator finds that the treatment rendered to the Petitioner was reasonable and necessary. The Respondent makes no claim of payment for the bills offered into evidence by Petitioner, except for those for which they are entitled to an 8(j) credit. Thus, the Respondent shall pay the medical bills from Midwest Orthopaedic Associates (Petitioner's Exhibit 7), Streeterville Open MRI, LLC (Petitioner's Exhibit 8), Athletico (Petitioner's Exhibit 9), Midland Orthopedic Associates (Petitioner's Exhibit 10), Dr. Benjamin Domb (Petitioner's Exhibit 11) and Radiology and Nuclear Consultants (Petitioner's Exhibit 12).

As to the issue of whether the Petitioner is entitled to any prospective medical care, the Arbitrator finds that the Petitioner is entitled to prospective medical care for her left hip as recommended by Dr. Nho, Dr. Nelson and Dr. Domb and supported by Respondent's IME physician, Dr. Walsh, and in support thereof the Arbitrator adopts Petitioner's Exhibit 2

and Exhibits 4 through 6 and Respondent's Exhibit 1, and further finds as follows:

The Petitioner testified that she has continued complaints of pain and discomfort in her left hip. Petitioner has been under the care of Dr. Nho consistently since February 2012 and then began seeing Dr. Nelson and Dr. Domb thereafter. She has undergone extensive conservative care that has not alleviated her symptoms and all of her physicians as well as the Respondent's IME physician agree that surgical intervention is appropriate. Since the Arbitrator found that the left hip injury is causally related to the accident, the Arbitrator finds that the opinions and recommendations as to future medical treatment proffered by Petitioner's treating orthopedic surgeons are credible and persuasive as they are based upon consistent treatment and examinations of the Petitioner. Accordingly, the Arbitrator finds that Petitioner is entitled to prospective medical care as outlined by her treating physicians.

As to the issue of whether penalties or fees should be imposed upon the Respondent, the Arbitrator finds that Petitioner failed to prove she is entitled to such penalties and fees. The Arbitrator finds that there was a reasonable dispute as to causal relationship in this matter and therefore

denies penalties and fees under sections 19(k), 19(l) and section 16 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose Cuevas,

Petitioner,

14IWCC0127

vs.

NO: 11 WC 37441

Imperial Marble Company,

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 conneaction, temporary total disability, medical expenses and prospective medical care, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 23, 2013 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.

14IWCC0127

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,700.00. 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: FEB 2 0 2014

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

MJB:bjg
0-2/10/2014
52

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

14IWCC0127

CUEVAS, JOSE
Employee/Petitioner

Case# **11WC037441**

IMPERIAL MARBLE CORPORATION
Employer/Respondent

On 4/23/2013, 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 0.08% 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:

2044 ALVARO COOK LTD
149 S LINCOLNWAY
SUITE 200
NORTH AURORA, IL 60542

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
JEFFREY T RUSIN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

14IWCC0127

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JOSE CUEVAS
Employee/Petitioner

v.

IMPERIAL MARBLE CORPORATION
Employer/Respondent

Case # **11** WC **037441**

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 **Falcioni**, Arbitrator of the Commission, in the city of **Geneva**, on **April 10, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **08/29/11**, 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 **$29,388.17**; the average weekly wage was **$565.16**.

On the date of accident, Petitioner was **38** years of age, *married* with **2** dependent children.

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

Respondent shall be given a credit of **$19,531.33** for TTD, **$2,027.16** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$21,558.49**.

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

ORDER

Temporary Partial Disability

Respondent shall pay Petitioner temporary partial disability benefits of $81.58/week for 21-5/7 weeks, commencing May 4, 2012 through August 11, 2012, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of $2,027.16 for temporary partial disability benefits that have been paid.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $376.77/week for 59 2/7 weeks, commencing August 30, 2011 through May 3, 2012 and August 12, 2012 through December 19, 2012 and December 21, 2012 through January 27, 2013, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $19,531.33 for temporary total disability benefits that have been paid.

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, that remain unpaid toValley West Community Hospital, Aurora Radiology Consultants – DeKalb, Nandra Family Practice, DuPage Medical Group and Rush-Copley Medical Center, as listed on the addendum to request for hearing pursuant to Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $0 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.

Prospective Medical

The respondent shall authorize and pay for medical services associated with arthroscopic surgery of the right shoulder recommended by Dr. Asselmeier .

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.

Albert E Thomas — Signature of Arbitrator

April 19, 2013 — Date

ICArbDec19(b)

APR 23 2013

MEMORANDUM OF DECISION OF ARBITRATOR

Petitioner testified at hearing that he was injured on August 29, 2011, in the course of his employment while lifting a large double bowl sink onto his right shoulder. He was in the process of lifting the sink when he lost balance and was jerked backward by the weight of the sink causing him to twist his upper back, neck and right shoulder. Mr. Cuevas testified that he heard a crack in his cervical spine and shoulder and felt immediate pain which he reported to his supervisor. He received treatment on August 30, 2011, at Valley West Community Hospital where he underwent x-rays of his cervical and thoracic spine, was prescribed medication and taken off of work. He was provided with an off work note from Valley West Community Hospital which he tendered to his supervisor (PEX #2).

The petitioner testified that the pain in his upper back, neck and right shoulder continued and he sought treatment from Dr. Nandra of Nandra Family Practice on September 1, 2011. Dr. Nandra attended the petitioner on several occasions for neck and back pain. He recommended physical therapy, medication and MRIs of the cervical and thoracic spine which were performed at Valley West Community Hospital on September 7, 2011. The petitioner was referred to physical therapy at Advanced Physical Medicine of Yorkville with Dr. Berkey. Dr. Nandra continued Mr. Cuevas' off work status and provided him with notes which the petitioner tendered to his supervisor.

The petitioner continued physical therapy and sought treatment from Dr. Matthew Ross of Midwest Neurosurgery and Spine Specialists beginning on October 28, 2011. Dr. Ross recommended additional physical therapy, medication and continued Mr. Cuevas' disability status. The petitioner provided his employer with off work slips and was paid temporary total disability benefits by the respondent. On November 18, 2011, Dr. Ross recommended an EMG/NCV of the right arm and referred the petitioner to Dr. Asselmeier an orthopedic surgeon for evaluation of his right shoulder (PEX #5).

On November 23, 2011, at the request of the respondent's insurance carrier, the petitioner underwent an IME performed by Dr. Shaun T. O'Leary. Dr. O'Leary also recommended an EMG of the right upper extremity, a CT of the cervical spine, an epidural steroid injection for his arm pain and continued physical therapy (PEX #9).

On December 15, 2011, Dr. Ross reiterated his recommendation for an EMG/NCV as well as an orthopedic evaluation for shoulder complaints. Dr. Ross continued to place the petitioner in an off work status (PEX #5).

Petitioner underwent an EMG/NCV on December 16, 2011. He was examined by Dr. Asselmeier of DuPage Medical Group on January 4, 2012. Dr. Asselmeier recommended an MRI of the right shoulder and continued the petitioner's off work status. The petitioner underwent an MRI of the right shoulder on January 24, 2012, and continued to treat with Dr. Asselmeier who recommended physical therapy and performed a subrocomial injection on March 7, 2012. He also continued the petitioner's off work status. On April 4, 2012, Dr. Asselmeier diagnosed rotator cuff syndrome, acromioclavicular arthropathy, and myofascial pain syndrome. Dr. Asselmeier's note discussed the petitioner's options as: return to work on light duty or proceed with arthroscopic surgery of the right shoulder (PEX #6).

The petitioner returned to light duty work on May 4, 2012. He testified that T.T.D. had been paid up to that point. He continued to work on light duty status through August 11, 2012, when no further light duty was available (PEX #16). He testified that he was paid T.P.D. during the time he was working light duty. The petitioner was examined by Dr. Asselmeier in May and June of 2012, at which time Dr. Asselmeier reiterated his recommendation for arthroscopic surgery of the right shoulder (PEX #6).

On August 14, 2012, at the respondent's request, the petitioner submitted to an examination with Dr. Mark N. Levin. Dr. Levin recommended an arthrogram MRI of the right shoulder. Dr. Asselmeier, the treating physician, stated in his treatment note of September 12, 2012, that the arthrogram was unnecessary because he did not believe the petitioner's condition involved a labral tear. Dr. Asselmeier continued to recommend the 10 pound lifting restriction and surgical intervention. Despite Dr. Asselmeier's recommendation against the arthrogram, the petitioner followed the IME doctor's recommendation and underwent the arthrogram on October 1, 2012. Dr. Asselmeier examined the petitioner after the arthrogram on October 10, 2012, and noted that there was no superior labral abnormality. He renewed his recommendation for acromioplasty and distal clavicle resection and recommended that the petitioner remain off work until surgery was approved (PEX #6). On November 1, 2012, the arthrogram was reviewed by Dr. Levin who indicated that he found no evidence that required additional orthopedic intervention and recommended that the petitioner return to work full duty (PEX #3).

The petitioner testified that he became aware of Dr. Levin's recommendation mid December of 2012, and presented for regular duty work on December 20, 2012. He testified that he was required to work with a pressurized spray gun attached to a hose. The petitioner testified that he is right hand dominant and that the he was offered required that he have his right arm extended and move his arm back and forth repeatedly while holding the spray gun throughout an eight hour day. He testified that his right shoulder

and neck symptoms increased and that he reported it to his supervisor, who instructed him to go home.

The petitioner then applied for vacation time pay for several weeks until he was again able to return to work without restriction on January 28, 2013. The petitioner testified that his vacation pay as well as his current rate of pay since returning to work was $8.25 per hour which is less than the $13.24 per hour that he was earning at the time of his injury. The petitioner further testified that he was not lifting heavy sinks or using the heavy spray gun since his return to work in January of 2013. He testified that at the time of hearing he continued to experience pain in his shoulder and neck which affected him on a daily basis and required that he take Tylenol three times a day. He testified that his pain had improved very slightly since the date of accident and it affected him in his work activities as well as in his normal daily activities. He testified that he had never injured his neck, upper back or right shoulder prior to or since the accident.

ISSUES PRESENTED

CAUSAL CONNECTION:

The history of the mechanism of injury and the injury itself alleged by the petitioner was consistently documented in the medical records. A minor exception is found in the records of Valley West Community Hospital in the treatment note of August 30, 2011, which states "the patient is a 38 year old male who was at work yesterday lifting furniture" (PEX #2). That treatment note stated that he lifted above his head turned toward the right and felt pain between his shoulder blades mainly in the thoracic and cervical area.

Dr. Nandra's note of September 1, 2011, states the symptoms began following a specific injury involving the upper back and mid back. Dr. Nandra's note of October 10, 2011, states the visit is for follow-up of right scapular area and that the patient complained of back pain (scapular area). His note of October 19, 2011, indicates neck pain injury happened two months ago activity involved lifting and the activity was performed at work (PEX#3). The September 15, 2011, note of Dr. Berkey at Advanced Physical Medicine of Yorkville states that the petitioner presented for neck pain and bilateral upper extremity pain with the right being worse than the left. The treatment note outlines an injury which occurred while lifting a sink on August 29, 2011 (PEX #4).

The treatment note of Dr. Ross of October 28, 2011, states that on August 29, 2011, the petitioner was lifting a sink onto his shoulder when it hit something causing him to twist at which point he experienced a crack in the back of his neck and pain which tracked into his arms (PEX #5).

The November 23, 2011, IME report of Dr. O'Leary documented an injury at work while lifting a sink in August of 2011, which caused neck and pain radiating into the right arm (PEX #9). The IME report of Dr. Levin dated August 14, 2012, documented an injury that occurred at work on August 29, 2011, when the petitioner picked up a double bowl marble sink that weighed about 140 pounds to his right shoulder. Dr. Levin documented that the sink hit the angled ceiling and jarred his right shoulder where he heard a pop (REX #2).

The petitioner's symptoms have also been consistent since the date of injury. Valley West Community Hospital documented pain between the shoulder blades mainly to the thoracic and cervical area (PEX #2). Dr. Nandra documented neck, upper back, mid back and right scapular pain (PEX #3). Dr. Berkey documented neck pain, weakness and pain in the arms and diagnosed cervical/brachial syndrome and noted tenderness of the cervical spine, thoracic spine, suboccipital muscle and trapezius muscle (PEX #4).

On October 28, 2011, Dr. Ross documented tenderness over the paravertebral muscles and right trapezius give-way weakness in the right arm. On November 18, 2011, Dr. Ross documented that the petitioner's right shoulder had limited mobility with flexion, abduction and internal rotation along with tenderness to palpation over the right trapezius muscle as well as over the posterior shoulder capsule. His note states "it is becoming increasing apparent that a component of Mr. Cuevas' pain is originating from the right shoulder itself" (PEX #5).

The MRI report of Salt Creek Medical Imaging of Hinsdale documented A.C. joint degenerative change and rotator cuff tendinosis with bursal surface fraying of the supraspinatus tendon (PEX #6).

Dr. Asselmeier in the first visit of January 4, 2012, documented some scapular maltracking, mild discomfort with neck movement and limited recreation of anterior shoulder symptomatology with movement. His impression/diagnosis was rotator cuff syndrome, possible rotator cuff tear. On February 8, 2012, Dr. Asselmeier documented a bit of crepitus, a mild abduction arc and some pain with flexion and internal rotation. His diagnosis was trapezial myofascial strain, possible radiculitis, probable rotator cuff syndrome, right shoulder. His March 7, 2012, note documented subacromial crepitus, positive abduction arc, some trouble with internal rotation. His diagnosis remained probable rotator cuff syndrome. By April 4, 2012, the diagnosis was rotator cuff syndrome, acromioclavicular arthropathy, myofascial

pain syndrome. Having failed conservative care Dr. Asselmeier recommended arthroscopic acromioplasty and distal clavicle resection of the right shoulder on April 4, 2012 (PEX #6).

The only evidence offered by the respondent concerning causal connection and the necessity of surgery were two reports prepared by Dr. Levin of Barrington Orthopedics. The report of August 14, 2012, documents a physical examination which proved to be painful for the right arm with abduction up to 170 degrees and limitation of external rotation to 60 degrees on the right versus 90 degrees on the left as well as shoulder pain on the right with abduction and external rotation. Dr. Levin discussed the MRI findings of the cervical spine noting the bulging discs at C2, C3, C4 and C5-C6 with no disc herniation and nerve impingement. He reviewed the MRI of the thoracic spine which he found unremarkable. Dr. Levin did not specifically mention the MRI of the right shoulder performed on January 24, 2012, however he appears to allude to it in stating that the rotator cuff is intact but that there was slight AC joint hypertrophy. He did not mention the findings of the MRI concerning rotator cuff tendinosis with bursal surface fraying of the supraspinatus tendon. Dr. Levin's conclusion was that there was insufficient objective evidence of pathology of the right shoulder to warrant surgical intervention and recommended an arthrogram MRI. Petitioner testified that Dr. Levin's examination lasted three to four minutes.

Dr. Asselmeier's treatment note of September 12, 2012, documents his opinion that an MRI arthrogram was excessive and unnecessary due to the fact that the patient had already undergone a noncontrast MRI. Dr. Asselmeier indicated that the arthrogram was not likely to reveal a labral tear as a source of the petitioner's pathology (PEX #6, 09/12/12). Nevertheless, the petitioner underwent the MRI arthrogram going so far as to have the prescription for that test made out by Dr. Ross (PEX #5, 09/.18/12).

Dr. Levin's IME report of November 28, 2012, involved the review of the arthrogram MRI. Dr. Levin stated that the study was relatively normal and did not recommend any additional orthopedic interventions and recommended that the petitioner return to work full duty. It is clear from the report as well as the petitioner's testimony that Dr. Levin did not reexamine the petitioner and that his sole examination was conducted on August 14, 2012.

Dr. Asselmeier did examine the petitioner after the arthrogram on October 10, 2012. He reviewed the arthrogram which confirmed that there was no labral abnormality. At that time Dr. Asselmeier stated in the treatment plan section of his note as follows; "I have again related to Jose the complexity of his case. Unfortunately, he has had no improvement in functionality. He continues to aspire to get back and work. I think his only chance of doing this would be to proceed with arthroscopy of his right shoulder. I have offered arthroscopic

acromioplasty and distal clavicle resection in the future. He is working on workers' compensation approval. He will remain off work in the interm" (PEX #6).

Dr. Asselmeier also examined the petitioner on January 9, 2013, his treatment plan stated as follows; "Jose has certainly failed fairly exhaustive attempts at conservative care. His clinical presentation is complex and his exam is to a degree confusing and inconsistent, but he certainly has a fairly profound disability in his shoulder at this point and I think the only chance that we have of getting him back to a reasonable functional level or at least a reasonable pain level would be to consider arthroscopic surgery of his shoulder. I have offered arthroscopic acromioplasty and distal clavicle resection". (PEX #6)

Dr. Asselmeier's narrative report dated January 18, 2013, stated that the petitioner has an element of chronic impingement with acromioclavicular arthropathy of the right shoulder which is complicated by chronic trapezial myofascial syndrome with possible cervical radiculitis. He stated that Mr. Cuevas' current condition was caused and/or aggravated by the accident of August 29, 2011.

The arbitrator finds that the petitioner's mechanism of injury has been consistently documented as have his persistent symptoms. At the time of trial his symptoms had not improved and he experienced continual difficulty with the use of his right arm and pain in his cervical spine and upper back. The petitioner cooperated with treatment and exhausted all conservative measures in seeking a cure of his condition including undergoing an MR arthrogram not recommended by his treating doctor. The respondent offered no evidence of alternate causation or intervening accident. Dr. Levin's report seems to focus on the petitioner's subjective complaints and negative finding of rotator cuff tear and seems to imply that subjective complaints are not valid physical findings. Furthermore, Dr. Asselmeier's diagnosis is not that of a rotator cuff tear but impingement with acromoclavicular arthropathy. Based on the record as a whole, the Arbitrator finds Dr. Asselmeier to be more credible and finds that the petitioner's current condition of ill being is causally connected to the accident of August 29, 2011.

TEMPORARY TOTAL DISABILITY AND TEMPORARY PARTIAL DISABILITY:

The petitioner was treated at Valley West Community Hospital where he was instructed to remain off of work until cleared by his physician (PEX #2). The petitioner testified that he was provided with an off work slip which he tendered to his supervisor. The petitioner was then treated by Dr. Nandra who placed the petitioner in an off work status from the first visit of September 1,

2011 through the last visit of October 19, 2011, until he was cleared by a neurosurgeon (PEX #3). The petitioner was then treated by Dr. Ross of Midwest Neurosurgery who continued his disability status as of October 28, 2011 through January 12, 2012, when he referred the petitioner to Dr. Asselmeier for orthopedic evaluation of his right shoulder (PEX #5).

The petitioner was treated by Dr. Asselmeier on January 4, 2012, at which time his disability status was continued until Dr. Asselmeier recommended a return to work on light duty basis as of April 4 and 11th of 2012 (PEX #6). The respondent provided the petitioner with light duty work May 4, 2012, which continued through August 11, 2012. The petitioner testified that during the time he was working light duty he received temporary partial disability benefits from the workers' compensation insurance carrier. The petitioner testified that there was no light duty work available for him after August 11, 2012. His testimony is corroborated by a letter from the respondent dated August 15, 2012 (PEX #16).

The petitioner was examined by Dr. Levin on August 14, 2012. Dr. Levin's IME report of that date states that if the petitioner did not elect to undergo the arthrogram MRI he would be at MMI and could return to work full duty. Dr. Levin did not state what the petitioner's work status would be if he were to undergo the arthrogram. The petitioner underwent the arthrogram on October 1, 2012. Dr. Levin prepared a second report on November 28, 2012, releasing the petitioner to regular duty work which was sent to petitioner's attorney by respondent's attorney. However the petitioner's attorney did not receive said letter until December 17, 2012, consequently the petitioner was not informed of Dr. Levin's recommendation until mid December, 2012 (PEX #10).

The petitioner testified that he attempted to return to work on December 20, 2012, despite the fact that his treating doctor had recommended surgery and placed him in an off work status (PEX #6, 10/10/12). He testified that he was required to use a heavy pressure spray gun attached to a hose with his arm extended moving the gun back and forth from side to side throughout the work day. The petitioner testified that he experienced an increase of pain in his right shoulder, upper back and neck in performing those duties and was unable to complete the work day. The petitioner informed his employer of his condition and was sent home. The petitioner then applied for vacation benefits which were paid at $8.25 an hour instead of his hourly rate of $13.24 per hour (PEX #11).

After he had exhausted his vacation pay the petitioner returned to regular work on January 28, 2013, and continued to work for the respondent as of the date of hearing. Petitioner testified that he was currently being paid $8.25 an hour instead of his hourly rate of $13.24 an hour. His testimony was corroborated by check stubs dated February 8 through April 5, 2013 (PEX #12).

The majority of the petitioner's temporary total disability and temporary partial disability were paid. The arbitrator finds that the remainder of T.T.D. claimed by Petitioner should be paid given the fact that the petitioner attempted to return to regular work but was unable to perform the duties assigned to him due to his symptoms. The petitioner acted in good faith in doing so despite the recommendations of his treating physician that he remain off of work. He should not have had to rely on vacation benefits when his treating doctor had placed him in an off work status and no light duty work was available.

The arbitrator finds that T.T.D. periods should be paid from August 30, 2011 through May 3, 2012, August 12, 2012 through December 19, 2012 and December 21, 2012 through January 27, 2013 for a total of $22,337.25 in T.T.D. benefits. Respondent paid a total of $19,531.33 which should be subtracted from the total T.T.D. award.

Additionally the respondent offered no reason for underpayment of the petitioner's current wages. However the Petiitoner testified that he was back working full duty for Respondent, albeit with substantial pain. What the respondent chooses to pay workers who are working full duty is not a matter that the Commission can concern itself with, therefore Petitioner's request for TPD during the period January 27, 2013 through the date of hearing is denied.

MEDICAL EXPENSES:

The petitioner claims unpaid medical bills as stated on the addendum to the request for hearing from Valley West Community Hospital, Aurora Radiology Consultants, Nandra Family Practice, DuPage Medical Group and Rush-Copley Medical Center. The treatment at Valley West Community Hospital August 30, 2011, per petitioner's exhibit number 2 clearly relates to a lifting incident at work on August 29, 2011. The dates of treatment listed on the addendum with Nandra Family Practice all relate to injury of the neck, upper back and right shoulder per PEX #3.

The bill with a balance due of $152.00 from DuPage Medical Group relates to treatment with Dr. Marc Asselmeier the petitioner's orthopedic surgeon. All of said treatment clearly relates to an injury sustained in the course of employment on August 29, 2011 per PEX #6. Dr. Asselmeier's narrative report states that treatment he had rendered as well as testing conducted is related to the accident of August 29, 2011 (PEX #8).

The treatment at Rush-Copley Medical Center on October 1, 2012, for an arthrogram MRI of the right shoulder is clearly related to the petitioner's injury and was in fact recommended by Dr. Levin, the respondent's IME physician.

The arbitrator finds that the treatment was reasonable and necessary and related to the petitioner's accident of August 29, 2011, and orders the respondent to pay the outstanding bills pursuant to the fee schedule. Respondent to receive credit for al sums previously paid hereunder.

PENALTIES AND ATTORNEY'S FEES:

The Arbitrator declines to award penalties and attorney fees as requested by Petitioner herein and finds that Respondent did not act vexatiously or unreasonably.

PROSPECTIVE MEDICAL:

The petitioner has not recovered from injuries sustained on August 29, 2011, in the course of his employment. His symptoms have been consistent since the date of injury.

Per his narrative report, Dr. Asselmeier recommended diagnostic arthroscopy of the right shoulder with treatment of featured pathology, and quite possibly distal clavicle resection. He stated that the basis for his recommendation would be related to the petitioner's ongoing symptom complex, localizing symptoms over his acromioclavicular joint, pain with shoulder level movement, abnormal MRI of the right shoulder and his response to subacromial injection. In relating the course of treatment rendered to Mr. Cuevas, Dr. Asselmeier stated in his narrative report, "an MR arthrogram would not relieve Jose's symptoms. If in deed it was normal or equivocal, the transition would still be towards surgery. It is my feeling that unless further treatment would be rendered, Jose was now a year since his injury and he would quite probably have close to zero possibility of getting him back to his prior level of employment or managing his pain." Dr. Asselmeier concluded that the treatment recommended is related to the accident of August 29, 2011.

Dr. Asselmeier's recommendation for surgery is reasonable given the petitioner's continued symptoms, the findings of the MRI and the fact that Dr. Asselmeier examined the petitioner as recently as January of 2013. Therefore the arbitrator directs the respondent to authorize and pay for the arthroscopic surgery recommended by Dr. Asselmeier as well as any postoperative care if that is indicated.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert T. Stanley II,

Petitioner,

14IWCC0128

vs.

NO: 99 WC 48947

II-in-One Contractors, Inc,
Illinois State Treasurer as Ex-Officio
Custodian of the Group Self-Insurers
Insolvency Fund, &
Illinois State Treasurer as Ex-Officio
Custodian of the Group Workers'
Compensation Pool Insolvency Fund,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent (Illinois State Treasurer) herein and notice given to all parties, the Commission, after considering the issues of entry of award against the self-insurance insolvency fund, and other insolvency funds 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 FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 21 year old employee of Respondent, II-In-One, in October 1997. Petitioner who, began his employment with Respondent in 1993, described his job as a construction laborer. Respondent was involved in erecting, removing, remodeling, altering and demolishing buildings and other structures; engaged in the construction business. Petitioner, a member of Laborers' Local 149, agreed that Respondent had the

right to control the manner in which he performed his work. Petitioner was a construction worker and Respondent was a contractor. Petitioner testified that Respondent supplied tools, materials, and equipment. Petitioner testified that he earned $22.35 per hour and normally worked a 40-hour work week ($894.00 per week). Petitioner's pay scale was set per a collective bargaining agreement and Respondent withheld taxes from his pay. Respondent, per the bargaining agreement, had the right to fire Petitioner if he was not doing an adequate job. Petitioner testified his job duties included pouring concrete, working with carpenters, and cleaning up. Petitioner testified in his job he did a lot of bending, stooping and heavy lifting among other things.

- Petitioner testified that in October 1997 Respondent sent Petitioner to a Metropolitan Water Reclamation District facility around Skokie, Illinois; he had been working at that facility for about two months. Petitioner was 21 years old and unmarried at the time of the assignment (Petitioner married and had first child in 1998). Petitioner testified that they were redesigning the facility's human waste tanks. He stated the tanks were square and the waste was being caught in the corners of the tanks so they were rounding the tanks; pouring more concrete to circularize the tanks (instead of square). Petitioner testified that he was working inside the tanks which were drained but not cleaned so there was still human waste on the walls in the tanks. Petitioner testified that he had worked in that environment for about two months and got sick around October 18, 1997. Petitioner testified that when he became ill his body had turned yellow from head to toe. Petitioner first sought medical treatment at Ottawa Community Hospital on October 18, 1997. Petitioner testified that he notified his supervisor, Dave Lester of the events.

- Petitioner testified he was first hospitalized at Ottawa Community Hospital; however, he was transferred to the University of Illinois (UIC) Medical Center on October 19, 1997. Petitioner was ultimately diagnosed with acute hepatitis/hepatic failure (Hepatitis A - infectious hepatitis) and was treated by Dr. Thomas Layden, the chief of the section of digestive and liver disease at UIC Medical Center. Petitioner was discharged from UIC on October 21, 1997 but remained under the care of Dr. Layden through October 30, 1997. Petitioner was released to return to work as of November 3, 1997. Petitioner viewed PX12 and indicated those were the bills regarding his hospitalization and treatment for his illness; Petitioner testified that he had paid all of the bills out of pocket. Petitioner testified that he had received two payments from a liquidator appointed by the Illinois Department of Insurance. Petitioner stated that aside from those payments he had not been reimbursed for his medical bills from Respondent or any other source. Petitioner testified that he did not have any residual symptoms or complaints from his illness and that he was not claiming any permanent disability in this case.

The Commission finds the evidence is undisputed that Petitioner suffered a work related exposure resulting in his contracting hepatitis A from the human waste which was in the tank in which he worked. There is an undisputed causal connection opinion by Petitioner's treating doctor and there is the history of the exposure in the record. The evidence and testimony clearly

establishes accident, causal connection and consequently, Petitioner's entitlement to benefits which is not in dispute.

The Commission notes that Respondent asserts that the Arbitrator incorrectly determined that the Petitioner had a vested right to obtain payment from a non-existent fund. Respondent argues that the Arbitrator erred when he ordered an Illinois State official to transfer money from an existing state fund to a non-existent one. Respondent stated the Arbitrator ordered the Illinois State Treasurer to transfer funds from the Group Worker's Compensation Pool Insolvency Fund to the non-existent Group Self-Insurers' Insolvency Fund. Respondent argues that the Arbitrator further erred in directing that payment be made from the non-existent Group Self-Insurers' Insolvency Fund. Respondent asserts that the Arbitrator's order exceeded his statutory authority and is directly contrary to controlling law. Respondent argues that the Arbitrator's order directing the State Treasurer to transfer money out of the Group Workers' Compensation Pool Insolvency Fund directly violates §107a.13(c) of the Illinois Insurance Code. Respondent argues that the Arbitrator's reliance on the Appellate Court's decision in Elsbury is misplaced because the Appellate Court's decision was vacated by the Illinois Supreme Court. Furthermore, neither the issue nor the resulting analysis bears any relationship to the instant case. Respondent asserts that if the Commission rules that either the non-existent Insolvency Fund or the Pool Insolvency Fund (or they are one in the same) is responsible for making payment it should simply state so and leave it to the responsible State officials to determine how to make payment consistent with the Commission decision and applicable State law. Accordingly, Respondent argues that the Commission should vacate that portion of the Arbitrator's order requiring the State Treasurer to transfer funds to and make payment from the non-existent Group Insurers' Insolvency Fund.

The Commission finds that the Arbitrator does not have the authority to order the transfer of moneys between the funds and as such the Commission, herein, vacates the Arbitrator's order to transfer funds from the existing fund to the old fund. The Commission finds that the Respondent (now non-existent) Group Self-Insurance Insolvency Fund/Pool Insolvency Fund is clearly responsible to satisfy the award as otherwise found in the Arbitrator's decision and affirms all else. The Commission herein, orders the responsible State of Illinois officials to determine how to make payment of this award consistent with decision and applicable State law.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrators order to transfer funds is hereby vacated, with the remainder of the award, herein, affirmed

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $596.00 per week for a period of 2-1/7 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 $13,062.40 for medical expenses under §8(a) of the Act.

14IWCC0128

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: FEB 2 0 2014
O: 12/12/13
DLG/jsf
45

David L. Gore

Michael P. Latz

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STANLEY, ROBERT
Employee/Petitioner

Case# **99WC048947**

14IWCC0128

II-IN-ONE CONTRACTORS INC ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE GROUP SELF-INSURERS INSOLVENCY FUND & ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE GROUP WORKERS' COMPENSATION POOL INSOLVENCY FUND
Employer/Respondent

On 5/15/2013, 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 0.08% 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:

0274 HORWITZ HORWITZ & ASSOC
MARC A PERPER
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

0522 THOMAS MAMER & HAUGHEY
JOHN M STURMANIS
30 E MAIN ST SUITE 500
CHAMPAIGN, IL 61820

5048 ASSISTANT ATTORNEY GENERAL
MEGAN JANICKI
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert Stanley
Employee/Petitioner

v.

Il-in-One Contractors, Inc., Illinois State Treasurer, as Ex-Officio Custodian of the Group Self-Insurers Insolvency Fund, and Illinois State Treasurer, as Ex-Officio Custodian of the Group Workers' Compensation Pool Insolvency Fund,
Employer/Respondent

Case # **99** WC **48947**

14IWCC0128

An *Application for Adjustment 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 **April 19, 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? Should penalties or fees be imposed upon Respondent?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☒ Other **Occupational Disease**

FINDINGS:

On **October 18, 1997**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner was exposed to an occupational disease that arose out of and in the course of employment.

Timely notice of this exposure was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$46,488.00**; the average weekly wage was **$894.00**.

On the date of accident, Petitioner was **21** 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 **$6,582.94** for other benefits, for a total credit of **$6,582.94**.

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

ORDER:

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $596.00/week for 2-1/7 weeks, commencing October 19, 1997 through November 2, 1997, as provided in §8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued.

Medical benefits

Respondent shall pay Petitioner the further sum of $13,062.40 for reimbursement of reasonable and necessary medical expenses, as provided in §8(a) of the Act.

Credit

Respondent shall be given credit for $6,582.94 for benefits paid to Petitioner by the Special Deputy Receiver for Illinois Earthcare Workers' Compensation Trust in Liquidation.

Group Self-Insurers Insolvency Fund and Group Workers' Compensation Pool Insolvency Fund

The Illinois State Treasurer was named as a co-Respondent in this matter, as ex-officio custodian of both the Group Self-Insurers Insolvency Fund established under the former §4a of the Act, 820 ILCS 305/4a (1996) (repealed January 1, 2001 by PA-91-757 §10, effective January 11, 2001), and the Group Workers' Compensation Pool Insolvency Fund established under the Workers' Compensation Pool Law, 215 ILCS 5/107a.01 et seq. The State Treasurer, as ex-officio custodian of both Funds, was represented by the Illinois Attorney General, and this award is hereby entered against the Group Self-Insurers Insolvency Fund and the Group Workers' Compensation Pool Insolvency Fund for the balance of the benefits due and owing the

Petitioner after accounting for Respondent's credit. Payment shall be made to Petitioner by the Group Self-Insurers Insolvency Fund. The Group Workers' Compensation Pool Insolvency Fund, as successor to the Group Self-Insurers Insolvency Fund, shall, if necessary, transfer sufficient funds to the Group Self-Insurers Insolvency Fund to enable it to pay the benefits due and owing the Petitioner.

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

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

Signature of Arbitrator

May 15, 2013
Date

MAY 15 2013

STATE OF ILLINOIS)
)
COUNTY OF COOK)

BEFORE THE WORKERS' COMPENSATION COMMISSION OF ILLINOIS

ROBERT STANLEY,)
)
Petitioner,)
)
-v.-)
)
II-IN-ONE CONTRACTORS, INC., ILLINOIS STATE TREASURER, as Ex-Officio Custodian of the GROUP SELF-INSURERS INSOLVENCY FUND, and ILLINOIS STATE TREASURER, as Ex-Officio Custodian of the GROUP WORKERS' COMPENSATION POOL INSOLVENCY FUND,)
)
Respondents.)

ATTACHMENT TO DECISION OF ARBITRATOR:
FINDINGS OF FACT AND CONCLUSIONS OF LAW

FINDINGS OF FACT:

Petitioner ROBERT STANLEY II was a 21-year old construction laborer and member of Local 149 of the Laborers Union, employed by Respondent II-IN-ONE CONTRACTORS, INC. on and before October 18, 1997. At that time, he was single with no dependent children.

Petitioner testified without rebuttal that II-in-One was in the business of erecting, maintaining, removing, remodeling, altering and demolishing structures, and was engaged in the business of construction. II-in-One supplied Petitioner's tools, materials and equipment and had the right to control the manner in which he performed his work. II-in-One hired Petitioner pursuant to its collective bargaining agreement with Laborers Local 149, pursuant to which he was paid $22.35 per hour over a forty-hour workweek, for an average weekly wage of $894.00. Taxes were withheld from his pay. Respondent had the right to discharge him, subject to the terms of the union contract.

In late September or early October, 1997, Respondent assigned Mr. Stanley to work at the Metropolitan Water Reclamation District Skokie water filtration plant. His job duties involved rebuilding existing waste tanks at the facility. The tanks had been drained; however, a residue of raw sewage -- including untreated human waste -- remained in the tanks. Petitioner was exposed to this contaminated waste on a daily basis for a period of one to two months.

By October 18, 1997, Petitioner felt ill and noticed that his skin appeared yellow. He was hospitalized at Community Hospital of Ottawa on October 18, 1997 with symptoms of nausea and vomiting. Examination of the abdomen revealed right upper quadrant tenderness. Lab work demonstrated markedly elevated liver enzymes anywhere from 400 to 500 times normal. He was diagnosed with acute hepatitis and was transferred to University of Illinois Medical Center in Chicago (PX 2). Petitioner notified his supervisor, Dave Lester, of his illness.

Petitioner was admitted to UIC Medical Center from October 19 through 21, 1997 under the care of Dr. Thomas J. Layden, Chief of the Section of Digestive and Liver Diseases at UIC. Petitioner gave a history of being "involved in sewer work" for three weeks prior to admission. While hospitalized, his condition gradually improved. Mr. Stanley was discharged home on October 21, 1997 with a diagnosis of acute hepatitis A virus. He was instructed to follow up with the gastrointestinal clinic on October 30, 1997 and to remain off work in the interim (PX 3).

On October 22, 1997, Dr. Layden wrote Oliver Pfiefer at II-in-One Contractors, stating that Petitioner's acute hepatitis A virus was a "work-related illness especially from his working in the sewer weeks prior to the onset of jaundice" (PX 3; PX 4).

Petitioner remained under Dr. Layden's care. By October 30, 1997, only mild tenderness about the liver was present. Dr. Layden diagnosed "recovered HAV" and released Petitioner to return to work effective Monday, November 3, 1997 (PX 4).

At the present time, Petitioner experiences no residual symptoms of his acute hepatitis A virus and alleges no permanent disability as a result of the illness.

The following medical bills were admitted in evidence:

Provider	Amount
Dr. Arturo Tomas	$165.50
Superior Air-Ground Ambulance	1,789.37

Ottawa Medical Center	233.17
Community Hospital of Ottawa	4,023.38
Associated Gastroenterology	173.00
UIC Medical Center	4,940.98
Dr. Harney	450.00
Dr. Swamy	146.00
I.M.A. Dept of Medicine	1,110.00
Univ of IL Radiology	31.00
Totals	$13,062.40

(PX Group 12). Petitioner testified that he paid the above bills out of pocket, in their entirety.

At the time of the occurrence, II-in-One was a member of a risk pool styled, "Illinois Earth Care Workers' Compensation Trust" (hereinafter, "Earth Care") for the purpose of pooling its liabilities under the Act with other employers (see PX 9; PX 10; PX 11). On October 26, 2000, by order of the Circuit Court of Cook County, Illinois, Hon. Julia M. Nowicki, Judge Presiding, Earth Care was declared insolvent, with all its assets transferred to the Director of the Department of Insurance as Liquidator (PX 5). The order provided that "all ... persons and entities having knowledge of this order" are "restrained from bringing or further prosecuting any claim ... against EARTH CARE, or its property or assets, or the Director or Liquidator" (PX 5).

The Director of the Department of Insurance, as Liquidator, appointed a Special Deputy Receiver who made two distributions to Petitioner totaling $6,582.94 out of the confiscated Earth Care assets (PX 10; PX 11). Petitioner testified that neither his employer nor its representatives has made any payments towards his lost time or reimbursement of his medical expenses, aside from the $6,582.94 he received from the Special Deputy Receiver.

Petitioner's Second Amended Application for Adjustment of Claim names as Respondents II-in-One Contractors, Inc., along with the State Treasurer as Ex-Officio Custodian of two special funds; i.e., the Group Self-Insurers Insolvency Fund, and the Group Workers' Compensation Pool Insolvency Fund.

CONCLUSIONS OF LAW:

With reference to (A) and (O) (Was Respondent operating under and subject to the Illinois Workers' Occupational Diseases Act), the Arbitrator finds as follows:

Three parties Respondent have been named. With reference to II-in-One Contractors, Inc., the Arbitrator finds that II-in-One was an extra-hazardous business or enterprise covered automatically and without election by the provisions of the Workers' Compensation Act, in that II-in-One was engaged in the erection, maintaining, removing, remodeling, altering or demolishing structures, as defined by §3.1 of said Act, 820 ILCS 305/3.1, and was engaged in construction work, as defined by §3.2 of said Act, 820 ILCS 305/3.2. This determination is based upon the unrebutted testimony of the Petitioner.

The Arbitrator further notes that under §2(a) of the Workers' Occupational Disease Act, an employer who is covered automatically and without election by the Workers' Compensation Act pursuant to §3 is, by operation of law, also covered automatically and without election by the provisions of the Workers' Occupational Disease Act, provided the date of last exposure to the hazards of the disease occurred on or after July 1, 1957. See 820 ILCS 310/2(a).

Accordingly, the Arbitrator finds that Respondent II-in-One Contractors, Inc. was operating under and subject to the Workers' Occupational Diseases Act at all times relevant to this claim.

With reference to the obligations of the State Treasurer as Ex-Officio Custodian of the Group Self-Insurers Insolvency Fund and/or the Group Workers' Compensation Pool Insolvency Fund, the Arbitrator notes that a worker's rights under the Workers' Compensation and Occupational Diseases Acts are governed by the law in effect at the time of the injury or disease. See e.g., Wilson-Raymond Constructors Co. v. Industrial Comm'n, 79 Ill.2d 45, 51, 402 N.E.2d 584 (1980). In the instant case, Petitioner's disablement and last exposure to the hazards of the occupational disease occurred on October 18, 1997; therefore his rights are governed by the version of the Act in effect on that date. Id.

On and before October 18, 1997, §4a(5) of the Workers' Occupational Diseases Act provided, in pertinent part, as follows:

> Except as hereinafter provided, on January 1, 1984, and July 1, 1984, and on January 1 and July 1 of each year thereafter, all group self-insurers shall pay a sum equal to .5% of all compensation payments made under either the Workers' Compensation Act or the Workers' Occupational Diseases Act during the 6 months immediately preceding the date of payment, into a Fund to be known as the "Group Self-Insurers' Insolvency Fund."
>
> The State Treasurer is ex-officio custodian of the Group Self-Insurers' Insolvency Fund. Monies in the Fund shall be deposited the same as are State funds and any interest accruing on moneys in the Fund shall be added to the Fund every 6 months It shall be subject to audit the same as State funds and accounts and shall be protected by the general bond given by the State Treasurer. It is considered always appropriated for the purposes of compensating employees who are eligible to receive benefits from their employers pursuant to the provisions of the Workers' Compensation Act or Workers' Occupational Diseases Act, when their employer is the member of a group self-insurer and the group self-insurer has been unable to pay compensation due to financial insolvency either prior to or following the date of the award. Monies in the Fund may be used to compensate any type of injury or occupational disease which is compensable under either Act.
>
> The State Treasurer shall be joined with the group self-insurer as party respondent in any claim, or application for adjustment of claim filed against a group self-insurer whenever the compensation and medical services provided by this Act may be unpaid by reason of default of an insolvent group self-insurer.
>
> Payment shall be made out of the Group Self-Insurers' Insolvency Fund only upon order of the Commission and only after the penal sum of the surety bond and/or securities and the assessment against the individual members of the group self-insurer in default have been exhausted.

820 ILCS 310/4a(5) (1996).

On January 1, 2001, the General Assembly repealed §4a of the Act and, through Public Act 91-757, enacted the "Workers' Compensation Pool Law" (hereinafter, the "Pool Law"), 215 ILCS 5/107a.01 et seq. Pub. Act 91-757, §10 (eff. January 11, 2001). The Pool Law provides, in pertinent part, as follows:

Sec. 107a.13. Group Workers' Compensation Pool Insolvency Fund.

(a) All qualified group workers' compensation pools shall pay a sum equal to 0.5% of all compensation and medical service payments made under either the Workers' Compensation Act or the Workers' Occupational Diseases Act during the 6 months immediately preceding the date of payment, into the Group Workers' Compensation Pool Insolvency Fund, the successor fund to the Group Self-Insurers' Insolvency Fund. On the effective date of this amendatory Act of the 91st General Assembly, all moneys in the Group Self-Insurers' Insolvency Fund shall be transferred into the Group Workers' Compensation Pool Insolvency Fund.

(b) The State Treasurer is ex-officio custodian of the Group Workers' Compensation Pool Insolvency Fund. Moneys in the Fund shall be deposited the same as are State funds and any interest accruing on moneys in the Fund shall be added to the Fund every 6 months. The Fund shall be subject to audit the same as State funds and accounts and shall be protected by the general bond given by the State Treasurer. The Fund shall be considered always appropriated for the purposes of compensating employees who are eligible to receive benefits from their employers pursuant to the provisions of the Workers' Compensation Act or Workers' Occupational Diseases Act when their employer is a member of a qualified group workers' compensation pool and the qualified group workers' compensation pool has become unable to pay compensation and medical service payments due to financial insolvency either prior to or following the date of award. Moneys in the Fund may be used to compensate any type of injury or occupational disease that is compensable under either the Workers' Compensation Act or the Workers' Occupational Diseases Act. The State Treasurer shall be joined with the qualified group workers' compensation pool as party respondent in any claim or application for adjustment of claim filed against a qualified group workers' compensation pool whenever the compensation and medical services provided pursuant to this Article may be unpaid by reason of default of an insolvent qualified group workers' compensation pool.

(c) Payment shall be made out of the Group Workers' Compensation Pool Insolvency Fund only upon order of the Director and only after the penal sum of the fidelity bond and securities, if any, has been exhausted. It shall be the obligation of a qualified group workers' compensation pool or its successor to make arrangements to repay the Group Workers' Compensation Pool Insolvency Fund for all moneys paid out in its behalf. The Director is authorized to make arrangements with the qualified group workers' compensation pool as to terms of repayment. The obligations of qualified group workers' compensation pools to make contributions to the Group Workers' Compensation Pool Insolvency Fund shall be waived on any January 1 or July 1, if the Fund has a positive balance of at least $2,000,000 on the date one month prior to the date of payment.

Sec. 107a.14. Group workers' compensation pools assessment provisions.

(a) When the Director determines by means of audit, annual certified statement, actuarial opinion, or otherwise that the assets possessed by a pool are less than the reserves required together with any other unpaid liabilities, he or she shall order the pool trustees to assess the individual pool participants in an amount not less than necessary to correct the deficiency. This Section is not intended to restrict or preclude the trustees from time to time levying

assessments or increasing premium deposits in accordance with the pooling agreement.

(b) When the Director determines that the compensation and medical services provided pursuant to this Article may be unpaid by reason of the default of an insolvent qualified group workers' compensation pool and the penal sum of the fidelity bond and the securities provided by the qualified group workers' compensation pool are about to become exhausted, the Director shall declare the qualified group workers' compensation pool to be in default and first levy upon and collect from the individual employer members of the qualified group workers' compensation pool in default an assessment to assure prompt payment of compensation and medical services. No assessment of any individual employer member of the qualified group workers' compensation pool made pursuant to this subsection shall exceed 25% of the average annual contribution paid by that employer over the previous 3-year period; however, if the Group Workers' Compensation Pool Insolvency Fund is then for any reason financially unable to assure prompt payment of compensation and medical services, the employer member may be assessed without limitation. If and only if (i) the Group Workers' Compensation Pool Insolvency Fund has a positive balance of less than $1,000,000, (ii) the Director has declared a qualified group workers' compensation pool to be in default, and (iii) the Group Workers' Compensation Pool Insolvency Fund is financially unable to pay all employees whose compensation and medical services have been approved, the Director shall levy upon and collect from all qualified group workers' compensation pools an assessment to provide the balance necessary to assure prompt payment of approved compensation and medical services. If an insurance carrier becomes liable for workers' compensation and occupational diseases payments under the terms of the policy covering the qualified group workers' compensation pool, the carrier shall make appropriate payments and payments from the Fund shall cease. Payments from the Fund shall resume only when the insurance carrier's liability is exhausted.

Sec. 107a.15. Authority of Director.

(a) If the Director determines that a group workers' compensation pool is not in compliance with this Article, the Director shall require the pool to eliminate the condition causing the noncompliance within a specified time from the date the notice of the Director's requirement is mailed or delivered to the pool.

(b) If a pool fails to comply with the Director's requirement, the pool shall be deemed to be in a hazardous financial condition, and the Director may take one or more of the actions authorized by law as to pools in hazardous financial condition.

215 ILCS 5/107a.13, 107a.14, 107a.15.

In examining the two statutes, one finds that the relevant portions of the current "Pool Law" are substantially identical to the old §4a, except that the Pool Law provides that the new Group Workers' Compensation Pool Insolvency Fund (hereinafter, the "Pool Fund") is to be administered by the Department of Insurance, whereas the old "Group Self-Insurers' Insolvency Fund" (hereinafter, the "Group Fund") had been administered by the Commission. See 215 ILCS 5/107a.13(c).

In Elsbury v. Stann, 371 Ill.App.3d 181, 861 N.E.2d 1031 (2006), a group of claimants received workers' compensation awards against employers covered by the Earth Care risk pool. The Commission found that because of the Earth Care insolvency, liability for payment of the awards rested upon the State, whether under

the old §4a of the Workers' Compensation Act or §107a.13(b) of the new Pool Law. The State Treasurer represented to the Commission that neither the old Group Fund nor the new Pool Fund could pay the awards, because both funds were themselves insolvent. Because the old §4a(5) provided that the Group Fund was to be "protected by the general bond given by the State Treasurer," the Elsbury claimants filed a writ of mandamus to compel the Treasurer to fulfill her statutory duty to financially protect the Group Fund by tendering the general bond of the State of Illinois. The Circuit Court granted the writ of mandamus, finding, *inter alia,* that petitioners had a right to receive payment from either the Group Fund or the Pool Fund. Elsbury, 371 Ill.App.3d at 182-185.

The Treasurer appealed. By then, all but one of the Elsbury petitioners had settled their claims. As to the last remaining petitioner, James Dobry, the Appellate Court affirmed the judgment of the Circuit Court in all respects. Noting that an injured worker's rights under the Act are governed by the law in effect on the date of the injury, the Appellate Court found that the Group Fund under§4a was the responsible payer, rather than the Pool Fund, which was created only after the date of petitioner's work injury. Accordingly, the Court ordered the Department of Insurance to transfer sufficient funds into the Group Fund from the Pool Fund, which is defined by the Pool Law as the successor to the Group Fund. The Court further concluded that the intent of the legislature was to ensure payment of benefits from the Group Fund without interruption, by having the Treasurer protect the Fund with the general bond of the State. Accordingly, the Court ordered the Treasurer to post the general bond of the State of Illinois to ensure the solvency of the Group Fund. 371 Ill.App.3d at 185-192.

The Illinois Supreme Court granted the Treasurer's petition for leave to appeal. By that time, the last remaining Elsbury claimant, Mr. Dobry, had settled his case at the Commission (see Dobry v. CMS, d/b/a Marko Constr., Docket No. 97 WC 43484). Accordingly, the Supreme Court dismissed the lawsuit as moot and directed the Appellate Court to vacate its judgment. See Elsbury v. Stann, No. 104388 (Ill. S. Ct.) (unpublished order entered April 28, 2008).

Notwithstanding the fact that the Appellate Court's judgment in Elsbury was vacated on grounds of mootness, the Arbitrator finds that the reasoning in the decision is sound and provides persuasive authority for the proposition that the Group Fund bears responsibility for payment of the instant claim; that sufficient funds should be transferred to the Group Fund from the Pool Fund, as successor to the Group Fund; and that the State Treasurer is required by statute to post the general bond of the State of Illinois, if necessary, to ensure the solvency of the Group Fund pursuant to the old §4a.

With reference to (B) (employer-employee relationship), the Arbitrator finds as follows:

Petitioner testified without rebuttal that II-in-One supplied his tools, materials and equipment and had the right to control the manner in which he performed his work. II-in-One hired Petitioner pursuant to its collective bargaining agreement with his union, Laborers Local 149, pursuant to which he was paid by the hour for a forty-hour workweek, with taxes withheld from his pay. Respondent had the right to discharge him, subject to the terms of the union contract. II-in-One was in the construction business, and Petitioner was a construction worker.

On these facts, the Arbitrator finds that the relationship of employer-employee existed between II-in-One and Mr. Stanley under both the common law "control" factors and the more modern "relative nature of the work" test. See Ragler Motor Sales v. Industrial Comm'n, 93 Ill.2d 66, 442 N.E.2d 903 (1982); Peesel v.

Industrial Comm'n, 224 Ill.App.3d 711, 586 N.E.2d 710 (1992).

With reference to (C) (D) and (O) (whether Petitioner was exposed to the hazards of an occupational disease that arose out of and in the course of his employment and dates of last exposure and disablement), the Arbitrator finds as follows:

Petitioner testified without rebuttal that while rebuilding waste tanks at the Metropolitan Water Reclamation District Skokie filtration plant, he was exposed to contaminated waste in the form of untreated, raw sewage for a period of one to two months. Ultimately he was diagnosed with hepatitis A, which Dr. Layden found to be causally related to the exposure to sewage.

Based upon the testimony of Petitioner and the uncontroverted opinion of Dr. Layden, the Arbitrator finds that Petitioner was exposed to the hazards of an occupational disease on and before October 18, 1997 that arose out of and in the course of his employment for II-in-One. Dates of last exposure and disablement both occurred on October 18, 1997.

With reference to (E) (notice), the Arbitrator finds as follows:

Section 6(c) of the Workers' Occupational Diseases Act provides, in pertinent part, that notice of disablement due to occupational disease shall be given to the employer "as soon as practicable after the date of the disablement," and that failure to give notice will not bar the employee from proceeding under the Act unless the Commission finds that such failure "substantially prejudices the rights of the employer." 820 ILCS 310/6(c).

In the instant case, Petitioner testified without rebuttal that he notified his supervisor, Dave Lester, of his illness when he began losing time from work after October 18, 1997. In addition, Dr. Layden wrote Respondent on October 22, 1997 advising of Petitioner's exposure to the hazards of an occupational disease resulting in hepatitis A. The Arbitrator therefore finds that Respondent received timely notice under §6(c) of the Act.

With reference to (G) (earnings), the Arbitrator finds as follows:

Petitioner testified without rebuttal that he was paid $22.35 per hour over a forty-hour workweek, for an average weekly wage of $894.00. Accordingly, the Arbitrator finds that the average weekly wage was $894.00.

With reference to (H) (age) and (I) (marital status), the Arbitrator finds as follows:

Petitioner testified without rebuttal that on October 18, 1997, he was 21 years of age and single with no dependent children. The Arbitrator adopts the unrebutted testimony of the Petitioner.

With reference to (F) (causal connection), the Arbitrator finds as follows:

On October 22, 1997, Dr. Layden opined that Petitioner's acute hepatitis A was a "work-related illness especially from his working in the sewer weeks prior to the onset of jaundice." Based upon the uncontroverted

opinion of Dr. Layden, the Arbitrator finds that Petitioner's condition of ill-being was causally related to the exposure.

With reference to (J) (medical), the Arbitrator finds as follows:

Medical bills totaling $13,062.40 are in evidence. Petitioner testified without rebuttal that he paid these bills out-of-pocket in their entirety. The Arbitrator notes that a paid bill is presumptively reasonable. Flynn v. Cusentino, 59 Ill.App.3d 262, 266, 375 N.E.2d 433 (1978).

Petitioner testified that his condition improved during his inpatient hospitalization and on outpatient follow-up with Dr. Layden. Petitioner's testimony was corroborated by the records of Dr. Layden and UIC Medical Center.

Based upon the above, the Arbitrator finds that the medical bills and treatment herein were in all respects reasonable, necessary and causally related to the injury. Accordingly, Respondent shall pay the sum of $13,062.40 for reasonable and necessary medical expenses.

With reference to (K) (TTD), the Arbitrator finds as follows:

Petitioner was off work from October 19, 1997 through November 2, 1997 while under the care of Ottawa Community Hospital, UIC Medical Center and Dr. Layden. He was released to return to work effective November 3, 1997. Accordingly, the Arbitrator finds that Petitioner was temporarily totally disabled for 2-1/7 weeks, from October 19, 1997 through November 2, 1997.

With reference to (L) (nature and extent of the injury), the Arbitrator finds as follows:

Petitioner testified that he has experienced no residual symptoms or complaints with reference to his acute hepatitis A. No permanent disability is claimed or awarded.

With reference to (N) (credit), the Arbitrator finds as follows:

Petitioner received payments from the Special Deputy Receiver for Illinois Earthcare Workers' Compensation Trust in Liquidation totaling $6,582.94. The Arbitrator finds that Respondent is entitled to receive credit in that amount.

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)
☒ Remand	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin Rafferty,

Petitioner,

14IWCC0129

vs.

NO: 06 WC 05568

City of Chicago,

Respondent.

DECISION AND ORDER ON REMAND FROM THE APPELLATE COURT

This matter had previously been heard and the Decision of the Arbitrator had been filed May 21, 2009. The Arbitrator found that Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent; that Petitioner established a causal connection between these accidental work related injuries and his condition of ill-being; that Petitioner is entitled to an award of 42-3/7 weeks of temporary total disability benefits (2/20/07-12/13/07) at a rate of $681.24 per week under §8(b) of the Act ($28,904.04 total TTD); that Petitioner is entitled to an award of $-0- for reasonable and necessary medical expenses under §8(a) of the Act as Respondent had paid all reasonable and necessary medical care; that Petitioner is entitled to an award of 40% loss of use of Petitioner's right arm under §8(e)(10) of the Act (94 weeks at $571.96 per week =$53,764.24 total PPD) and denied penalties. Petitioner claimed permanent and total disability.

- Mr. Belmonte testified for Petitioner at the initial hearing. He is a certified vocational rehabilitation counselor. He met with Petitioner on March 14, 2008. He learned of

Petitioner's permanent restrictions and that he was a high school graduate with no additional education or training. Mr. Belmonte understood that Petitioner did not own a computer or have any typing skills, and that he was a garbage collector for Respondent for about 26 years. Petitioner had a felony conviction for battery and intimidation of a witness. Petitioner was inarticulate and did not have transferable skills that could translate from heavy manual labor. Mr. Belmonte had recommended that Petitioner undergo vocational testing and that an upper extremity specific functional capacity evaluation (FCE) be considered. To Mr. Belmonte's knowledge no such testing was ever provided to Petitioner and without such testing he had no scientific basis to determine whether Petitioner could benefit from training. Therefore, Mr. Belmonte could not opine on Petitioner's prospective employability. However, Mr. Belmonte opined that there was "a very meaningful probability that [Petitioner was] facing the prospect of total disability." On cross examination, Mr. Belmonte testified he was aware that Petitioner did return to work with Respondent for some time after his accident. Petitioner did not avail himself of the rehabilitation training his company provides. On redirect, Mr. Belmonte testified Respondent did not authorize training.

- Petitioner testified at the hearing that on April 5, 2006 he had right shoulder surgery. Another surgery was recommended on his right shoulder and was performed on May 4, 2007, after the initial arbitration. Between the surgeries he could barely move his right, dominant arm, so began using his left. Then his left shoulder started to hurt. He returned to treat with his second surgeon, Dr. Nuber, for his left arm, as well as his right. Petitioner stated that after the second surgery, he had three injections into the right shoulder. He never had problems with his left shoulder prior to his fourth right shoulder surgery. On 12/13/07, Dr. Nuber restricted Petitioner permanently to sedentary activity with his right shoulder. Currently Petitioner was not taking prescription medication because it was no longer authorized. He has trouble sleeping, waking up 3 or 4 times a night. He has to sleep on his back to reduce shoulder pain. Weather impacts his right shoulder pain. He cannot throw a baseball or Frisbee with his kids. Petitioner testified that he graduated High School but had no additional training. Petitioner stated that he has to go to his sister's where she or his kids access the internet for him. Petitioner's driver's license was currently suspended. Petitioner further testified that after he was released to work in December 2007, "the city doctor – the specialist said [he] was never supposed to show up back to work." Petitioner had worked for Respondent as a garbage collector for 26 years. He never interviewed for a job and did not know how to write a resume or cover letter. His family has had to pay his mortgage and child support, on which he had fallen behind "big time." He would have followed up with Mr. Belmonte if it had been authorized. He was declared to be at maximum medical improvement (MMI) and had not had additional medical treatment after December 13, 2007. On cross examination, Petitioner testified he had not applied for any employment in the past 6 months. He returned to work for Respondent with restrictions, but he was discharged "as soon as [he] went back." There was some discussion about falsifying time sheets, which was funny

because as a laborer, he had no access to time sheets. On redirect, Petitioner testified after he was declared at MMI, Respondent did not offer him any employment.

- Petitioner filed a timely Petition for Review and on review the Commission vacated the permanent partial disability (PPD) award and ordered vocational rehabilitation testing and for Respondent to provide a rehabilitation plan and the Commission remanded the matter back to the Arbitrator for such order. The Arbitrator on remand, thereafter, found there was no new evidence and reinstated his initial award. Petitioner motioned under §19(f) requesting the decision be recalled, corrected and reissued. A hearing was held before Commissioner Gore on April 30, 2010 with Petitioner claiming a clerical error in remanding for vocational rehabilitation testing without ordering maintenance from maximum medical improvement (MMI) to present. The Commission found no clerical error and denied the motion. Petitioner brought the matter before the Circuit Court who initially found no jurisdiction and remanded the matter back to the Commission on August 3, 2010. A hearing on remand was heard on August 19, 2011 before the Arbitrator. The matter came before the Commission again August 2, 2012 wherein the Commission again affirmed their prior decision. The matter again went before the Circuit Court of Cook County June 3, 2013 which retained jurisdiction and remanded the matter back to the Commission for clarification of specific evidence as why the Commission removed the order to Respondent to provide appropriate vocational rehabilitation testing and for Respondent to submit a rehabilitation plan.

The Commission notes that, at the initial hearing before the Arbitrator, the Commission, on Review, found that Petitioner had failed to prove entitlement to permanent and total disability. On review, the Commission, in finding that Petitioner failed to establish permanent and total disability further indicated that Mr. Belmonte did not find Petitioner to be permanently and totally disabled, but had recommended vocational rehabilitation testing to assess Petitioner's vocational rehabilitation potential. The Commission ordered vocational testing, vacated the permanency award and remanded the matter to the Arbitrator for such action and additional hearing on that issue. The Arbitrator subsequently found no new evidence for such action and reinstated his prior award. The Petitioner, at the August 19, 2011 Commission hearing, did not contest and thus acquiesced to Respondent's position that no new evidence was permitted to be presented to the Arbitrator and, essentially, refused the Commission order for the vocational rehabilitation testing and vocational rehabilitation plan. At that hearing, Petitioner essentially indicated he did not believe the Commission's remand order required the taking of additional evidence (i.e., vocational rehabilitation testing and Respondent's rehabilitation plan) and Petitioner did not seek to enforce that Commission order. Petitioner in their Statement of Exceptions filed December 19, 2011 then did request the vocational testing, contrary to their prior assertions at hearing. Petitioner agreed at hearing with Respondent's position that no additional evidence was required/permitted and therefore rejected the vocational rehabilitation

testing and rehabilitation plan order. The Commission, therefore, has no other alternative but to reinstate the Decision of the Arbitrator to affirm the prior TTD, and PPD award of 40% loss of use of Petitioner's right arm based on the evidence on the record and Petitioner's acquiescence that no additional evidence was required or permitted.

The Commission therefore vacates its prior decision (which had ordered vocational assessment). Given the parties apparent agreement that no new evidence could be taken, the Commission, has no choice but to reinstate the May 21, 2009 decision of the Arbitrator, wherein it was found; that Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent January 24, 2006; that Petitioner established a causal connection between these accidental work related injuries and his condition of ill-being; that Petitioner is entitled to an award of 42-3/7 weeks of temporary total disability benefits (2/20/07-12/13/07) at a rate of $681.24 per week under §8(b) of the Act ($28,904.04 total TTD); that Petitioner is entitled to an award of $-0- for reasonable and necessary medical expenses under §8(a) of the Act as Respondent had paid all reasonable and necessary medical care; and that Petitioner is entitled to an award of 40% loss of use of Petitioner's right arm under §8(e)(10) of the Act (94 weeks at $571.96 per week =$53,764.24 total PPD) and the denial of penalties.

IT IS THEREFORE ORDERED BY THE COMMISSION that their prior decision on Review is, herein, vacated and the May 21, 2009 decision of the Arbitrator is, herein, reinstated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $681.24 per week for a period of 42-3/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any. (As in the Arbitrators May 21, 2009 decision).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $571.96 per week for a period of 94 total weeks, as provided in §8(e)(10) of the Act, for the reason that the injuries sustained caused the loss of use of 40% of Petitioner's right arm. (As in the Arbitrators May 21, 2009 decision).

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

14IWCC0129

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: FEB 20 2014
o-12/12/13
DLG/jsf
045

David L. Gore

Michael P. Latz

Mario Basurto

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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Andrew E. Kroll,
Petitioner,

vs. No. 12 WC 01877

A. N. Webber Inc.,
Respondent.

14IWCC0130

DECISION AND OPINION ON REVIEW

Petition for Review having been timely filed by Respondent and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, prospective medical treatment, notice, causal connection, and temporary total disability, and being advised of the facts and law, modifies the April 1, 2013 §19(b) Decision of Arbitrator Andros 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).

After considering the entire record, the Commission affirms and adopts the Arbitrator's findings with respect to all issues. However, the Commission modifies the Arbitrator's Decision by striking the following language, found on page 3 of the Arbitrator's Findings of Fact:

> This Commission has on a previous occasion found his opinions to be suspect. In Ferguson v. Harrah's Casino, this Commission affirmed and adopted the Arbitrator's decision in favor of petitioner. We did not find section 12 examiner, Dr. Lieber's opinions credible as they were diametrically opposed to every other treating or examining doctor who opined on a causal connection, including Respondent's other Section 12 examiner, who on two prior occasions and having reviewed surveillance produced by respondent, gave opinions in favor of Petitioner . 12 IWCC 0876. (attached) The same is true in the case at bar.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 1, 2013 is hereby modified.

IT IS FURTHER ORDERED BY THE COMMISSION that the language contained in the Arbitrator's Findings of Fact and cited above be stricken from the Arbitrator's Decision.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable, necessary, and related medical bills for the treatment of Petitioner's bilateral shoulders, pursuant to the medical fee schedule, in accordance with and subject to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary prospective medical expenses, as provided in Sections 8(a) and 8.2 of the Act, for the bilateral shoulder treatment recommended by Dr. Komanduri.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $628.03 per week for 44-1/7 weeks commencing January 10, 2012 through June 5, 2012, and August 2, 2012 through January 11, 2013, as provided in Section 8(b) 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 injuries.

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

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

Bond for 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: FEB 25 2014

Daniel R. Donohoo

o- 11/15/13
drd/dak
68

Thomas J. Tyrrell

Kevin W. Lamborn

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

KROLL, ANDREW E
Employee/Petitioner

Case# **12WC001877**

A N WEBBER INC
Employer/Respondent

14IWCC0130

On 4/1/2013, 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 0.10% 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:

0412 JAMES M RIDGE & ASSOC PC
MATTHEW J COLEMAN
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

1408 HEYL ROYSTER VOELKER & ALLEN
TOM CROWLEY
120 W STATE ST
ROCKFORD, IL 61105-1288

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)

Andrew E. Kroll
Employee/Petitioner

v.

A. N. Webber Inc.
Employer/Respondent

Case # 12WC 001877
~~14IWCC0130~~

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 **New Lenox**, on **January 11, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0130

FINDINGS

On the date of accident, 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 **$$48,986.60**; the average weekly wage was **$$942.05**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **1** children under 18.

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

Respondent shall be given a credit of **$15,694.75** for TTD, **$0** for TPD, **$0** for maintenance, and **$5,601.90** for other benefits, for a total credit of **$21,296.65**.

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 $628.03/week for 44 1/7 weeks, commencing January 10, 2012 through June 5, 2012, and August 2, 2012 through January 11, 2013 as provided in Section 8(b) of the Act.

Respondent shall pay reasonable necessary medical services recommended by Dr. Komanduri regarding treatment of the Petitioner's left and right shoulders.

Respondent shall authorize all prospective medical treatment as recommended by Dr. Komunduri regarding Petitioner's left and right shoulders.

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.

George J. Andros

Signature of Arbitrator

March 30, 2013
Date

ICArbDec19(b)

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In regards to (c), the Arbitrator finds that the Petitioner has proven by preponderance of the evidence that he sustained an accident which arose out of and in the course of his employment. The Petitioner works as an over the road truck driver. On January 9, 2012, he made a delivery in Arkansas. When he opened the trailer doors an eight hundred pound pallet of computers fell on top of him. The pallet fell striking Mr. Kroll's right shoulder, forcing him to fall to the ground and strike his left shoulder. Mr. Kroll credibly testified to this incident. His testimony is corroborated by the following medical notes:

1.) **January 9, 2012, Lake County Medical Center.**
The triage note states "patient complains of neck, pain, and pain to both shoulders, after a pallet full of computers fell onto patient after opening the door to his trailer, patient states that the pallet struck him in the right side of the head and neck causing him to fall landing onto his left shoulder, denies LOC, C Collar applied triage SMC intact." (PX1)

2.) **January 9, 2012, Lake County Medical Center.**
Mechanism of injury: patient works at Wal-Mart, was unloading a semi when a pallet of laptop computers fell on patient striking right side of neck and right shoulder, knocking patient to the ground. (PX1)

3.) **January 9, 2012, MK Orthopedics, Phone Note.**
Summary of call: Patient is in Arkansas, states that a pallet fell on his head, neck, and right shoulder. Because of this, he fell onto his left shoulder. Patient states that he went to the ER, X-Rays were done. The ER told him that, per X-Rays, he has a "category 2 right shoulder separation," and, that he potentially tore something in his left shoulder. Patient was advised to make an appointment with MK or see another orthopedic in Arkansas. (PX3)

4.) **January 16, 2012, MK Orthopedics.**
History of Present Illness: "Andrew was involved in an accident on January 9, 2012, when a pallet fell off the back of a truck and struck him on the right shoulder and right side of his neck driving him into the ground onto his left shoulder. The pallet weighed 800 lbs. It appears that he was grazed rather than collapsed underneath the pallet. (PX3)

5.) **January 16, 2012, MK Orthopedics, Patient Intake Form.**
The Patient Intake Form from MK Orthopedics dated January 16, 2012. Mr. Kroll described an incident which occurred on "1/9/12" and described that his problem occurred when "a pallet of freight fell on me." He described his pain being located in both his right and left shoulder. (PX3)

Based upon the totality of the evidence, the Arbitrator finds as a matter of law and fact Petitioner sustained an accident, which arose out of and in the course of his employment as a truck driver.

In regards to (e), the Arbitrator finds that the Petitioner has proven by a preponderance of the evidence that he did give timely notice of the accident to his supervisor under Section 6(c).

Petitioner credibly testified that he gave notice to his supervisor. Respondent offered no evidence to rebut this. Nor did Respondent offer any evidence to show that it was unduly prejudiced by Mr. Kroll's form of notice. In fact, Respondent paid all medical and temporary total disability benefits until its section 12 physician issued a

report stating Mr. Kroll had reached maximum medical improvement. Therefore, the Arbitrator finds that the Petitioner gave timely notice of the accident to Respondent.

In regards to (f), (j), (k), and (l), the Arbitrator finds the following:

LEFT SHOULDER

The Arbitrator finds that the Petitioner has proven by preponderance of the evidence that his work injury caused his current condition of ill-being to the left shoulder requiring Mr. Kroll to be totally incapacitated and require further medical care.

Mr. Kroll credibly testified that he was struck by an eight hundred pound pallet of computers which forced him to fall to the ground and strike his left shoulder. This is corroborated by the above medical notes. (PX1, PX3)

Mr. Kroll testified that prior to this January 9, 2012 he had never before received any treatment to his left shoulder.

The Arbitrator notes that Mr. Kroll has had significant treatment to his right shoulder since 2007. However, in a review of all the medical evidence, the Arbitrator could only find two notes prior to January 9, 2012 regarding Mr. Kroll's left shoulder. Dr. Komunduri's medical records reflect that on 12/08/2008 a shoulder arthrogram of the left shoulder found severe acromioclavicular osteoarthritis and a high grade partial thickness tear involving the entire supraspinal tendon with a delaminating component. The infraspinatus tendon demonstrates a moderate grade partial thickness tear with associated severe tendinosis. On 01/23/2009, Dr. Komanduri provided pre-surgical orders to Mr. Kroll for a left shoulder arthroscopy and subacromial decompression with mini open rotator cuff repair to take place on 03/05/2009. However, the medical records are absent of any objective tests and surgical reports regarding the petitioner's left shoulder. On cross examination, Mr. Kroll credibly denied any treatment to his left shoulder on these dates, specifically that no surgery ever took place.

The Arbitrator reconciles this difference in three ways. First by reviewing the radiology reports performed on the day of the accident. (PX1) A view of the right shoulder showed findings of "postsurgical changes and grade 3 AC separation of indeterminate age." (PX1) The views of the left shoulder had no findings of prior surgery. (PX1) The Arbitrator also reviewed the medical records following January 9, 2012 accident. In the medical note dated January 16, 2012 Dr. Komunduri stated "Mr. Kroll is a patient well known to me who has had a previous right shoulder injury and surgery for a complex AC joint dislocation." (PX3) No medical note mentions prior treatment to the left shoulder. Last, there appears to be a pre-surgical order for left shoulder arthroscopy with a hand written slash through it and a hand written note stating, "patient canceled surgery wasn't sure when he could reschedule." Therefore, the Arbitrator finds Mr. Kroll's testimony credible in that he never before received treatment to his left shoulder prior to the date of the accident.

Following the accident Dr. Komunduri ordered MRI's of both shoulders. (PX3) He also took Mr. Kroll off work. On February 10, 2012, Dr. Komunduri reviewed the MRI arthrograms and diagnosed Mr. Kroll with full thickness rotator cuff tears in both shoulders. (PX3) Dr. Komunduri further opined "this is a fresh injury . . .and it

is directly causally connected to his work injury." (PX3) Respondent offered no evidence to rebut that Mr. Kroll's left shoulder injury was related to his work accident. Even Respondent's examing physician failed to comment on causation. Therefore, the Arbitrator finds as a matter of fact and as a conclusion of law Petitioner's left shoulder condition to be causally connected to his accident of January 9, 2012.

Dr. Komunduri recommended physical therapy and left shoulder arthroscopy, subacromial decompression, and mini-open rotator cuff repair. (PX3) Dr. Komunduri stated "we plan on taking care of his left shoulder first. . .[Petitioner] understands that the right shoulder will be addressed somewhere at around the three month mark if he does well with his left." (PX3) Dr. Komunduri performed surgery on March 15, 2012. (PX3) Following prescribed outpatient physical therapy. (PX3, PX5)

On May 31, 2012 Dr. Lawrence Lieber for Respondent's section 12 exam. Dr. Lieber noted that Mr. Kroll's flexion, abduction, and external rotation were "decreased with extremes secondary to pain." Dr. Lieber reviewed a surveillance video produced by Respondent's workers' compensation insurance carrier and noted:

> "Surveillance video from May of 2012 confirms petitioner driving a motor vehicle, frequent use of his upper extremities, overhead activity, as well as lifting up a trunk. Also confirms individual lifting packs of bottled water with no apparent distress, as well as pushing a cart and lifting multiple objects."

Just two and a half months since Dr. Komunduri performed open surgery on Mr. Kroll, Respondent's examining physician opined that "the petitioner requires no further treatment at this time or in the future in association with the work accident of January 2012."

Dr. Lieber further opined that Mr. Kroll's left shoulder had reached maximum medical improvement, he required no further narcotics, and he could return to work June 1, 2012 full duty. (RX1, RX2)

The Arbitrator does not find the opinion of Dr. Lieber persuasive compared to Dr.koumounduri.This Commission has on a previous occasion found his opinions to be suspect. In Ferguson v. Harrah's Casino, this Commission affirmed and adopted the Arbitrator's decision in favor of petitioner. We did not find section 12 examiner, Dr. Lieber's opinions credible as they were diametrically opposed to every other treating or examining doctor who opined on a causal connection, including Respondent's other Section 12 examiner, who on two prior occasions and having reviewed surveillance produced by respondent, gave opinions in favor of petitioner. 12 IWCC 0876. (attached) The same is true in the case at bar. The Arbitrator has reviewed Respondent's surveillance and did not see Petitioner perform any activities in contrast to his work restrictions. (RX7)

As of January 2, 2013, Dr. Komunduri continues to recommend physical therapy for the left shoulder. (PX4) He also continues to keep Mr. Kroll off work until his left shoulder be treated. (PX4)

Therefore, the Arbitrator as a matter of law under section 8 of the Act, orders Respondent to authorize all treatment as prescribed by Dr. Komunduri.

The Arbitrator further finds as a matter of law and fact that Petitioner is entitled to temporary total disability benefits from January 10, 2012 through June 5, 2012 and August 2, 2012 through January 11, 2013 (AX1) and orders Respondent to pay accordingly.

RIGHT SHOULDER

The Arbitrator finds that the Petitioner has proven by preponderance of the evidence that his work injury caused his current condition of ill-being to the right shoulder requiring Mr. Kroll to be totally incapacitated and require further medical care.

Mr. Kroll credibly testified that he was struck by an eight hundred pound pallet of computers which forced him to fall to the ground and strike his left shoulder. This is corroborated by the above medical notes. (PX1, PX3) Mr. Kroll testified that he has had a prior injury to his right shoulder which required extensive treatment. The Arbitrator takes note of the following medical records:

> 01/11/2007: Petitioner underwent a right shoulder arthroscopy with Dr. Komanduri.
>
> 01/15/2007: Petitioner returned for a post-op follow-up with Dr. Komanduri. X-ray indicated a coracoclavicular screw did not hold in the coracoid and has backed out which may require hardware removal at a later date.
>
> 08/03/2007: Following a 07/31/2007 FCE, Dr. Komanduri believed Petitioner may need a permanent 20lbs weight restriction at light duty level with his affected right shoulder only. However, use of the left shoulder could allow him to carry more weight. Dr. Komanduri found Petitioner to be at maximum medical improvement at this time.
>
> The Arbitrator takes judicial notice that on October 19, 2007, Petitioner settled his workers compensation case regarding his right shoulder.
>
> 11/27/2007: Petitioner visited Dr. Komanduri. Dr. Komanduri found that Petitioner regained full strength and full range and has no strength deficits as to his right shoulder. Dr. Komanduri noted Petitioner's shoulder seems much better than when he had previously seen him and provided permanent deficits. Petitioner was released on full duty.
>
> 10/19/2012 and 11/10/11: Petitioner presented to Dr. Komunduri with pain in right shoulder. Dr. Komunduri removes screw in his shoulder.
>
> 1/6/2012: Petitioner returns to Komunduri for follow up. (RX6)

Despite this pre-accident medical treatment, Mr. Kroll testified that he was able to work full duty with his condition. Following the accident, Dr. Komunduri ordered bilateral MRI arthrograms. He reviewed the MRI's and diagnosed Mr. Kroll with bilateral full thickness tears describing the injury as "fresh." (PX3) Therefore, the Arbitrator finds Petitioner's right shoulder condition to be causally connected to his work accident. Presently, Mr. Kroll's treatment to the right shoulder is on hold until he gains more strength in his left shoulder.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Staci L. Spillare,
Petitioner,

vs. No. 09 WC 07873

14IWCC0131

Emery Air, 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, temporary total disability, medical expenses, and prospective medical treatment, and being advised of the facts and law, modifies the April 16, 2013 Decision of Arbitrator Erbacci as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Comm'n, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

After considering the entire record, the Commission affirms and adopts the Arbitrator's findings with respect to all issues. However, the Commission modifies the Arbitrator's Decision by striking the following language, found on page 9 of the Decision in the Conclusions section:

> The Arbitrator notes that the Petitioner testified that she began receiving unemployment benefits from the State of Illinois shortly after her termination by the Respondent and that those benefits continued until February 2010. As the Arbitrator has awarded the Petitioner temporary total disability benefits for that period of time, the Arbitrator finds that the Petitioner is obligated to repay to the State of Illinois all of the unemployment insurance benefits she received.
>
> All else is otherwise affirmed and adopted

14IWCC0131

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 16, 2013 is hereby modified.

IT IS FURTHER ORDERED BY THE COMMISSION that the language contained in the Arbitrator's Conclusions and cited above be stricken from the Arbitrator's Decision

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical expenses of $33,428.61, as provided in §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay all reasonable and necessary prospective medical expenses associated with the spinal cord stimulator trial prescribed by Dr. Lubenow, as provided in §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION Respondent shall pay Petitioner temporary total disability benefits of $344.50 week for 160 1 7 weeks, commencing October 7, 2008 through October 8, 2008, and from February 5, 2010 through March 6, 2013, as provided in Section 8(b) 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 Section 19(n) of the Act, if any.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: FEB 2 5 2014

Daniel R. Donohoo

Kevin W. Lamborn

Thomas J. Tyrrell

o-11/25/13
drd/dak
68

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

SPILLARE, STACI
Employee/Petitioner

Case# **09WC007873**

EMERY AIR INC
Employer/Respondent

14IWCC0131

On 4/16/2013, 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 0.09% 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:

4788 HETHERINGTON KARPEL BOBBER ET AL
MATTHEW MILLER
161 N CLARK ST SUITE 2080
CHICAGO, IL 60601

KOPKA PINKUS DOLIN & EADS
BRIAN KAPLAN
100 LEXINGTON SUITE 100
BUFFALO GROVE, IL 60089

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
19(b)

Staci Spillare
Employee/Petitioner

Case # 09 WC 7873

v.

Emery Air, Inc.
Employer/Respondent

14IWCC0131

An *Application for Adjustment 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 **Woodstock**, on **March 6, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **October 6, 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 the Petitioner's average weekly wage was **$516.75**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of **$5,020.12** for TTD.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $344.50 /week for 160 1/7 weeks, commencing October 7, 2008 through October 8, 2008, and from February 5, 2010 through March 6, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from October 7, 2008 through March 6, 2013,, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of **$5,020.12** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of **$33,428.61**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay the reasonable and necessary medical expenses associated with the spinal cord stimulator trial prescribed by Dr. Lubenow, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Arbitrator Anthony C. Erbacci

April 12, 2013
Date

09 WC 7873
ICArbDec19(b)

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FACTS:

On October 6, 2008, the Petitioner was working for the Respondent as an airplane detailer having been so employed for one month. The Petitioner testified that her job duties included maintaining and cleaning airplanes and that she was paid $10.00 per hour and typically worked 40 hours per week. The Petitioner testified that she had previously obtained an airplane pilot's license in 1993 but that her pilot's license had expired about one year prior to her employment with the Respondent.

The Petitioner testified that on October 6, 2008, she was also working at Upper Crust, her family's bakery business, where her job duties included baking and decorating cakes and pies. She testified that she was paid $16.00 per hour for that work and that she typically worked 13 hours per week as of October 2008. The Petitioner testified that she had informed the Respondent of her employment at Upper Crust during the interview process and that her supervisor at the Respondent, Chris, was aware of her employment at the bakery. The Petitioner testified that other employees of the Respondent were also aware of her employment at the bakery as she would occasionally bring baked goods to work for consumption by her co-workers.

During her shift on October 6, 2008, the Petitioner was assigned to clean an airplane. She testified that as she was in the process of cleaning the airplane doorway from the air stairs she fell backwards off the stairs and landed on the ground approximately 5-6 feet below. She testified that she lost consciousness for a time and that, after she regained consciousness, she was taken to Physicians Immediate Care in Rockford. The Respondent did not dispute that an accident occurred which arose out of and in the course of the Petitioner's employment.

The records of Physicians Immediate Care reflect that the Petitioner gave a history of falling and twisting her left ankle. It was noted that the Petitioner was complaining of pain mainly on the lateral aspect of her left ankle and in her leg. It was noted that there was swelling in the ankle and the assessment was a left ankle sprain. The Petitioner was prescribed medication, provided with an ankle brace and told to remain off work for two days.

The Petitioner testified that she remained off work for two days following the accident and then returned to work for the Respondent performing secretarial duties. The Petitioner testified that she continued to perform secretarial work for the Respondent for several weeks and that she continued to follow up at Physicians Immediate Care. The Petitioner testified that she continued to have pain in her left leg and ankle as well as pain in her right rib cage and her low back.

The records of Physicians Immediate Care reflect that the Petitioner continued to follow up for her left ankle sprain/strain and rib contusion and continued to complain of occasional ankle pain. On October 29, 2008, the assessment was "left ankle sprain, improving" and the Petitioner was released to return to full duty work.

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The Petitioner testified that she returned to her regular full duty work for the Respondent but that while performing that work, which included climbing stairs and ladders, she began to experience severe pain in her left leg and ankle again.

On November 19, 2008, the Petitioner followed up at Physicians Immediate Care and complained of a relapse of her left ankle pain. She was prescribed more physical therapy and instructed to avoid climbing ladders. On November 24, 2008 the Petitioner followed up again and complained of increasing ankle pain. She was given restrictions of sit down work only and an MRI of the ankle was prescribed. That MRI was performed on December 2, 2008 and was reported to demonstrate a mild talar bone contusion and a talonavicular ligament sprain. On December 4, 2008 the MRI findings were noted and the assessment continued to be a left ankle sprain/strain. On December 18, 2008 it was recommended that the Petitioner follow up with Dr. William Bush at Rockford Orthopedics. The restrictions of only sit down work were continued.

The Petitioner also sought treatment with her primary care provider, Dr. Gayle Crays, on December 5, 2008. At that time the Petitioner complained of ankle pain and Dr. Crays assessment was an ankle strain/sprain.

On January 15, 2009 the Petitioner was seen by Dr. Bush who noted that the Petitioner had complaints of a burning sensation in her left calf, pain in her left ankle and tingling in the bottom on her left foot. Dr. Bush recommended an EMG which was performed on February 19, 2009 and which was reported to be normal. Dr. Bush diagnosed the Petitioner with common peroneal neuropraxia, and he prescribed an articulating AFO brace, pain medication, and continued physical therapy.

On February 10, 2009, the Petitioner was notified that her employment with the Respondent was terminated effective February 5, 2009. The Petitioner testified that she began receiving unemployment benefits from the State of Illinois shortly thereafter and that those benefits continued until February 2010.

The Petitioner returned to Dr. Crays on March 10, 2009 "for referral to neurology at the suggestion of her lawyer." It was noted that the Petitioner was "improving with her left ankle" but "still has foot drop". It was also noted that the Petitioner reported that she had headaches and vision changes from time to time that might be from her fall. Dr. Crays' assessment was unspecified head injury and muscle weakness, and she referred the Petitioner for a neurology consult. On March 16, 2009, the Petitioner underwent a brain MRI which was reported to be normal. On April 28, 2009 the Petitioner underwent a lumbar MRI which was reported to demonstrate a very small central disc protrusion at L5-S1 with no other abnormalities noted and no compromise of the canal or foramen seen at any level.

On May 7, 2009, the Petitioner saw Dr. Shaun O'Leary of Rush University Neurosurgery. Dr. O'Leary noted that the Petitioner complained of pain in her left thigh and left lower leg and he also noted that "there is also some associated back pain". He noted the EMG and MRI findings and he prescribed medication and physical therapy for the low back.

The Petitioner returned to Dr. O'Leary on July 22, 2009 and continued to complain of pain in her left lower extremity and lower back. A repeat EMG was performed and was reported to be normal. A repeat MRI of the lumbar spine was performed on August 3, 2009 and was noted by Dr. O'Leary to show a mild disc bulge at L4-5 and a smaller bulge at L5-S1 which he noted did not fit with her symptoms. A cervical MRI was performed on September 2, 2009 and was reported to be normal. Shortly thereafter, the Petitioner was placed on work restrictions of sedentary work only with no lifting over 10 pounds, no prolonged sitting and no prolonged standing. On October 8, 2009, Dr. O'Leary recommended that the Petitioner undergo a trial of epidural steroid injections.

On November 17, 2009, the Petitioner consulted with Dr. John Jaworowicz of Medical Pain Management Services for the epidural steroid injections Dr. O'Leary recommended. The Petitioner declined to undergo the recommended injections at that time but, after she discussed the injections with Dr. O'Leary in December 2009, she ultimately underwent the first injection with Dr. Jaworowicz on January 12, 2010. The Petitioner testified that the injection only provided her with minimal relief for a few days following the injection and her pain eventually returned to the pre-injection level.

On February 24, 2010, the Petitioner followed up with Dr. O'Leary and complained of back pain and a burning sensation in her left leg. Dr. O'Leary noted that an epidural steroid injection had provided the Petitioner with little relief and he recommended that she follow up with the Rush Pain Center for a trial of a spinal cord stimulator. Dr. O'Leary diagnosed the Petitioner with chronic regional pain syndrome and lumbar spondylosis.

On March 30, 2010, the Petitioner underwent a myelogram CT examination of her cervical, thoracic and lumbar spine. The cervical examination was reported to be normal, the thoracic examination was reported to show a small disc protrusion at T10-11, and the lumbar examination was reported to show minimal disc bulges at L3-4 and L4-5 and a small disc protrusion at L5-S1. On April 9, 2010, the Petitioner followed up with Dr. Asokumar Buvanendran at the Rush Pain Center and he recommended that she continue taking her medication to help manage her ongoing pain. Thereafter, the Petitioner continued to follow up with Dr. Buvanendran and his partner, Dr. Timothy Lubenow for pain management. On June 8, 2011, Dr. Lubenow prescribed a spinal cord stimulator trial for the Petitioner and on January 26, 2012 Dr. Lubenow prescribed the psychological evaluation which is the pre-requisite to the spinal cord stimulator trial.

At the request of the Respondent, the Petitioner was examined by Dr. John Ruge on November 3, 2011. Dr. Ruge testified that he also reviewed the records of the Petitioner's medical treatment and the video recordings of the surveillance conducted on the Petitioner. Dr. Ruge testified that his examination of the Petitioner revealed marked inconsistencies and symptom magnification and that those examination findings were supported by the Petitioner's activities as shown in the surveillance video. Dr. Ruge opined that as a result of the work injury of October 6, 2008, the Petitioner suffered a left ankle strain, a possible concussion, and mild soft tissue trauma. Dr. Ruge further opined that the Petitioner did not have a peroneal nerve injury but that it was possible that she has complex regional pain

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syndrome. Dr. Ruge indicated he would defer to Dr. Lubenow as to whether the Petitioner should undergo a trial of a spinal cord stimulator.

In his deposition testimony of September 20, 2012, Dr. Lubenow opined that the Petitioner's condition of complex regional pain syndrome was causally related to the work injury of October 6, 2008. In his deposition testimony of December 14, 2012, Dr O'Leary opined that the Petitioner's condition of complex regional pain syndrome was more likely than not causally related to the work injury of October 6, 2008.

At trial, The Petitioner testified that she continues to experience pain, numbness and tingling in her left leg, ankle, and foot, as well as low back pain. She testified that her pain is increased with activity and that she continues to take medication for her pain. She further testified that she has occasional headaches once or twice a month. The Petitioner testified that she never suffered an injury to her head, back or left lower extremity before the October 6, 2008 work accident and that, when she reported to work on October 6, 2008, she was not experiencing any difficulties with her head, back or left lower extremity. The Petitioner testified that she would like to undergo the spinal cord stimulator trial prescribed by Dr. Lubenow.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Petitioner sustained undisputed accidental injuries which arose out of and in the course of her employment with the Respondent when she fell off the air stairs of a plane she was cleaning and landed on the ground approximately 5-6 feet below. Immediately following the injury she sought medical treatment at Physicians Immediate Care where a history of falling and twisting her left ankle was recorded and complaints of pain in her left ankle and left leg were noted. It was noted that there was swelling in the ankle and the assessment was a left ankle sprain. The records of Physicians Immediate Care reflect that the Petitioner continued to follow up for her left ankle sprain/strain and a rib contusion and continued to complain of occasional ankle pain. On October 29, 2008, the assessment was "left ankle sprain, improving" and the Petitioner was released to return to full duty work. On November 19, 2008, the Petitioner followed up at Physicians Immediate Care and complained of a relapse of her left ankle pain. The Arbitrator notes that there is no mention of any head or back injury or complaints noted in the records of Physicians Immediate Care.

The Petitioner next sought treatment with her primary care provider, Dr. Gayle Crays, on December 5, 2008. At that time the Petitioner complained of ankle pain and Dr. Crays assessment was an ankle strain/sprain. There is no mention of any head or back injury or complaints noted in the records of that visit.

On January 15, 2009 the Petitioner was seen by Dr. Bush who noted that the Petitioner had complaints of a burning sensation in her left calf, pain in her left ankle and tingling in the bottom on her left foot. Dr. Bush diagnosed the Petitioner with common peroneal neuropraxia, and he prescribed an articulating AFO brace, pain medication, and continued physical therapy. There is no mention of any head or back injury or complaints noted in the records of that visit.

On February 10, 2009, the Petitioner was notified that her employment with the Respondent was terminated effective February 5, 2009.

On March 10, 2009 the Petitioner returned to Dr. Crays "for referral to neurology at the suggestion of her lawyer." It was noted that the Petitioner's left ankle was improving but she "still has foot drop". The Petitioner reported that she had headaches and vision changes from time to time that might be from her fall. Dr. Crays' assessment was unspecified head injury and muscle weakness, and she referred the Petitioner for a neurology consult. The Arbitrator notes that this is the first occurrence in the medical records of any head injury or complaints and there is no mention of any back injury or complaints in the record of that visit. A brain MRI was normal and a lumbar MRI was reported to demonstrate a very small central disc protrusion at L5-S1 with no other abnormalities.

On May 7, 2009, the Petitioner saw Dr. O'Leary who noted that the Petitioner complained of pain in her left thigh and left lower leg and "some associated back pain". The Arbitrator notes that this is the first time that complaints of back pain are specifically noted in the medical records.

Thereafter, the Petitioner continued to complain of pain in her left lower extremity and lower back and she continued to seek treatment for those complaints. The Petitioner was ultimately diagnosed with complex regional pain syndrome and was prescribed a spinal cord stimulator trial.

Dr. Lubenow and Dr. O'Leary both opined that the Petitioner's condition of complex regional pain syndrome was causally related to the work injury of October 6, 2008 and that the trial spinal cord stimulator was reasonable and necessary medical treatment for the Petitioner. Dr. Ruge, the Respondent's examining physician, testified that his examination of the Petitioner revealed marked inconsistencies and symptom magnification. Dr. Ruge opined that as a result of the work injury of October 6, 2008, the Petitioner suffered a left ankle strain, a possible concussion, and mild soft tissue trauma. Dr. Ruge further opined that it was possible that the Petitioner has complex regional pain syndrome and he indicated he would defer to Dr. Lubenow as to whether the Petitioner should undergo a trial of a spinal cord stimulator.

While the Arbitrator notes that Petitioner did undergo various diagnostic studies which were reported to demonstrate small disc protrusions at L4-5, L5-S1, and T10-11, Dr. O'Leary noted that those findings did not fit with the Petitioner's symptoms. Additionally, the medical records do not demonstrate that the Petitioner had any complaints of back or head problems

until March of 2009, five months after her accident, and one month after her employment with the Respondent was terminated. Further, no physician specifically opined that those findings were causally related to the Petitioner's work injury. Additionally, the Arbitrator notes that EMG studies of the Petitioner's brain and left lower extremity were reported to be normal.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's current condition of complex regional pain syndrome is causally related to the injury of October 6, 2008. In so finding, the Arbitrator notes the records of the Petitioner's treating physicians which demonstrate that the Petitioner suffered an injury to her left ankle which eventually led to a diagnosis of complex regional pain syndrome – type 1, the deposition testimony of Dr. Lubenow and Dr. O'Leary, and the deposition testimony of Dr. Ruge, the Respondent's examining physician. The Arbitrator further finds, however, that the Petitioner failed to prove any specific current condition of ill-being in her head or lumbar spine which is causally related to that injury.

In Support of the Arbitrator's Decision relating to (G.), What were Petitioner's earnings, the Arbitrator finds and concludes as follows:

The Petitioner earned $1,235.00 during the 4 weeks ($308.75 per week) she was employed by the Respondent prior to the October 6, 2008 accident. The Petitioner testified that after she obtained employment with the Respondent she worked 13 hours per week at her family's bakery and was paid $16.00 per hour for that work. As such, the Petitioner earned $208.00 per week from her concurrent employment during the relevant time period. The Petitioner testified that the Respondent was aware of her concurrent employment, having been so advised during the interview process and thereafter through her conversations with her supervisor, Chris. The Petitioner's testimony in that regard was not contradicted or rebutted.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's average weekly wage was $516.75.

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 Petitioner introduced evidence of medical expenses totaling $33,428.61which were incurred by the Petitioner as a result of her injury of October 6, 2008. The Respondent disputed liability for the Petitioner's medical expenses but did not dispute their reasonableness or necessity. The Respondent specifically disputed its liability for the expenses resulting from the Petitioner's medical treatment which occurred after March 23,

14IWCC0131

2009, Dr. Bush's last date of treatment. Accordingly, having found that the Petitioner's current condition of complex regional pain syndrome is causally related to the accident, the Arbitrator awards the following medical expenses that were offered into evidence by Petitioner, subject to the medical fee schedule, and directs the Respondent to hold the Petitioner harmless from any claims made by the Illinois Department of Health and Family Services (formerly the Illinois Department of Public Aid) for payments that were made on said bills:

Medical Providers	**Charged Amount**
Physicians Immediate Care	$5,132.90
Swedish American Medical Group/Dr. Gayle Crays	408.00
Rockford Orthopedic Associates/Dr. William Bush	3,103.00
Saint Anthony Medical Center	126.00 318.00
Rush University Neurosurgery/Dr. Shaun O'Leary	6,260.00
Rush University Medical Center	2,242.25 11,420.46
Medical Pain Management Services, Ltd./Dr. John Jaworowicz	1,350.00
University Anesthesiologists, S.C./Dr. Asokumar Buvanendran/Dr. Timothy Lubenow	3,068.00
Total:	$33,428.61

The Respondent is entitled to a credit for payments it has made for medical expenses incurred by the Petitioner as a result of her injuries.

In Support of the Arbitrator's Decision relating to (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions relating to the issue of causation are adopted and incorporated herein.

The Arbitrator has found that the Petitioner's current condition of complex regional pain syndrome is causally related to the injury of October 6, 2008. Dr. Lubenow and Dr. O'Leary have prescribed a spinal cord stimulator trial for the Petitioner and opined that such treatment was reasonable, necessary, and causally related medical treatment for the Petitioner. Dr. Ruge opined that it was possible that the Petitioner has complex regional pain syndrome and he indicated he would defer to Dr. Lubenow as to whether the Petitioner should undergo a trial of a spinal cord stimulator. Therefore, the Arbitrator finds that the spinal cord stimulator trial prescribed for the Petitioner by Dr. Lubenow is reasonable, necessary, and causally related medical treatment to which the Petitioner is entitled. The Respondent is therefore ordered to authorize, and pay all of the reasonable and necessary medical expenses associated with, the spinal cord stimulator trial prescribed for the Petitioner by Dr. Lubenow.

In Support of the Arbitrator's Decision relating to (L.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions relating to the issue of causation are adopted and incorporated herein.

The Petitioner claimed to be entitled to temporary total disability benefits for October 7 and 8, 2008 and from February 5, 2010 through the date of hearing, March 6, 2013, a period of 160-1/7 weeks. The Respondent claimed that the Petitioner was disabled form December 19, 2008 through February 27, 2009 and from May 29, 2009 through June 25, 2009, a period of period of 14 1/7 weeks.

The evidence demonstrates that the Petitioner was taken off work for two days when she was seen at Physicians Immediate Care on October 6, 2008. The Petitioner then returned to work for the Respondent doing secretarial work until she was released to return to full duty work on October 29, 2008. The Petitioner testified that she did return to regular work at that time but she began to experience severe pain in her left leg and ankle again. On November 24, 2008 the Petitioner was given restrictions of sit down work only and on December 18, 2008 those restrictions were continued. On February 10, 2009, the Petitioner was notified that her employment with the Respondent was terminated effective February 5, 2009. Following her termination, the Petitioner continued to seek medical treatment from Dr. Crays, Dr. Bush and Dr. O'Leary. In September of 2009, Dr. O'Leary placed the Petitioner on work restrictions of sedentary work only with no lifting over 10 pounds, no prolonged sitting and no prolonged standing. In February of 2009 Dr. O'Leary recommended a spinal cord stimulator trial. The Petitioner thereafter treated with Dr. Lubenow who prescribed a spinal cord stimulator trial for

the Petitioner. The Petitioner has been unable to obtain that treatment through the present time.

While there are no specific off work slips contained in the records of the Petitioner's treating physicians subsequent to her release to return to regular work on October 29, 2008, she was given work restrictions on November 24, 2008 and she remained under those work restrictions at the time of her termination by the Respondent as of February 5, 2009. The Petitioner had not reached maximum medical improvement from her injuries as of that date and she continued to receive medical treatment thereafter. The Petitioner's physicians testified that the Petitioner continues to be subject to work restrictions and continues to be in need of medical treatment, specifically a spinal cord stimulator trial. Thus, the Petitioner has not yet reached maximum medical improvement from her injury and is entitled to temporary total disability benefits.

Therefore, having previously found that the Petitioner's present complex regional pain syndrome condition is causally related to her October 6, 2008 work accident, the Arbitrator finds that the Petitioner is entitled to temporary total disability benefits of $344.50 per week from October 7, 2008 through October 8, 2008 and from February 5, 2010 through March 6, 2013, a period of 160 1/7 weeks.

The Arbitrator notes that the Petitioner testified that she began receiving unemployment benefits from the State of Illinois shortly after her termination by the Respondent and that those benefits continued until February 2010. As the Arbitrator has awarded the Petitioner temporary total disability benefits for that period of time, the Arbitrator finds that the Petitioner is obligated to repay to the State of Illinois all of the unemployment insurance benefits she received.

In Support of the Arbitrator's Decision relating to (M.), Should penalties or fees be imposed upon Respondent, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions relating to the issue of causation are adopted and incorporated herein.

The Arbitrator notes the Petitioner was initially diagnosed as having suffered an ankle strain/sprain injury. The Petitioner was taken off work for only two days and, after a short period of light duty work, the Petitioner was released to return to regular unrestricted work. The Petitioner returned to regular work and performed her regular duties for about three weeks before resuming medical treatment for what was diagnosed as an ankle strain/sprain. The Petitioner was again placed on work restrictions and her employment was subsequently terminated. Following her termination, the Petitioner applied for and received unemployment insurance benefits. The Arbitrator notes that in order to have received unemployment insurance benefits, the Petitioner would have been required to certify to the State of Illinois, that she was able and available to work. The Petitioner thereafter continued a protracted course of treatment for her ankle and underwent numerous objective tests which were normal

or did not demonstrate an objective basis for her complaints. The Petitioner's protracted course of treatment eventually led to a diagnosis of complex regional pain syndrome.

Dr. Ruge, the Respondent's examining physician, reviewed the records of the Petitioner's medical treatment and the video recordings of the surveillance conducted on the Petitioner. Dr. Ruge testified that his examination of the Petitioner revealed marked inconsistencies and symptom magnification and that those examination findings were supported by the Petitioner's activities as shown in the video of surveillance conducted on the Petitioner. Dr. Ruge was of the opinion that as a result of the 2008 incident, Petitioner suffered a left ankle strain, with evidence of a history of concussion, and a mild soft tissue trauma, but nothing else. Dr. Ruge further opined that Petitioner did not suffer any permanent disability as a result of the October 6, 2008 accident and that, by the time of his deposition of March 20, 2012, she had been at MMI for a significant amount of time.

Based upon the totality of the evidence in the record, the Arbitrator finds that the Respondent's denial of benefits to the Petitioner was not objectively unreasonable under the circumstances. The Arbitrator, therefore, declines to award penalties in the instant matter.

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

Todd Hall,
Petitioner,

vs. NO. 11 WC 025567

Advance Packaging Technology Laboratories,
Respondent.

14IWCC0132

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Illinois, Cook County. The Circuit Court reversed the Commission Decision related to the calculation of temporary partial disability benefits and remanded the matter "for a recalculation of TPD benefits due to Todd Hall using the gross earnings rather than the net from 6/28/11 forward."

Based on the Circuit Court's findings, the Commission hereby sets aside its Decision and Opinion on Review issued on December 17, 2012 (modifying the Decision of the Arbitrator filed on April 18, 2012) and issues a Decision and Order on Circuit Court Remand in accordance with the Circuit Court's September 11, 2013 Order.

This case was initially heard by Arbitrator Flores who filed her Decision on April 18, 2012. Arbitrator Flores found that Petitioner's temporary permanent disability award should be calculated pursuant to the version of the Act in effect at the time of the injury, January 26, 2011. Arbitrator Flores calculated the temporary partial disability, subtracting the ***net*** amount Petitioner was earning in his modified position from the average amount that he would have been able to earn at the time he was working light duty had he been able to fully perform his regular duties. Penalties and fees were denied. The Commission modified the Arbitrator's award of temporary partial disability to clarify her Decision and include credit that had been omitted. The remainder of the Arbitrator's Decision was affirmed and adopted.

Respondent appealed the Commission Decision to the Circuit Court of Cook County, which by order of September 11, 2013, reversed and remanded the temporary partial disability portion of the Commission Decision with directions to recalculate the temporary partial disability benefits using Petitioner's ***gross*** earnings, rather than his ***net*** earnings, at his modified position. No other issues were addressed by the Court.

At the time of Petitioner's injury, on January 26, 2011, §8(a) of the Act provided that the temporary partial disability rate should be equal to two-thirds of the difference between the average amount that the employee would have been able to earn in the full performance of the job in which he was engaged at the time of accident and the ***net*** amount he earned in the modified job. On 6/28/11, §8(a) was amended to provide temporary partial disability at two-thirds the difference between the full performance earnings and the ***gross*** amount earned in the modified job. This amendment resulted in a reduction in the amount of temporary partial disability for which Respondent is liable, so the application of the amended version, as ordered by the Circuit Court, will reduce Petitioner's temporary partial disability award significantly.

According to the rules of statutory construction, the version of §8(a) that is to be applied is determined by whether the amendment is considered ***substantive*** or ***procedural***. Substantive amendments are generally not applied retroactively, but procedural amendments may be so applied. In the Arbitrator's Decision and the Commission's Decision on Review affirming and adopting that decision, the Commission found the amendment to be ***substantive***, as it affected Petitioner's ***substantive*** right to temporary partial disability benefits under the Act. Respondent argued before the Commission, and the Circuit Court found, that Petitioner's ***substantive*** right to temporary partial disability was not affected by the amendment. The Court implicitly found that the method of calculating temporary partial disability was not a ***substantive*** provision, but merely ***procedural***, and therefore should have been applied retroactively to calculate Petitioner's temporary partial disability.

Pursuant to the Circuit Court's directions, the Commission calculates Petitioner's temporary partial disability as follows:

	Income			
	Full Duty	Light Duty		
Dates worked	Potential	Gross	Difference	TPD owed
6/30-7/6/11	$800.00 -	$298.00 =	$502.00 x 2/3 =	$334.67
7/7-7/13/11	$800.00 -	$338.00 =	$462.00 x 2/3 =	$308.00
7/14-7/20/11	$800.00 -	$326.00 =	$474.00 x 2/3 =	$316.00
7/21-7/27/11	$800.00 -	$389.00 =	$411.00 x 2/3 =	$274.00
7/28-8/3/11	$800.00 -	$374.00 =	$426.00 x 2/3 =	$284.00
8/4-8/10/11	$800.00 -	$338.00 =	$462.00 x 2/3 =	$308.00
8/11-8/17/11	$800.00 -	$350.00 =	$450.00 x 2/3 =	$300.00
8/18-8/24/11	$800.00 -	$368.00 =	$432.00 x 2/3 =	$288.00
8/25-8/31/11	$800.00 -	$336.00 =	$464.00 x 2/3 =	$309.33
9/1-9/7/11	$800.00 -	$426.00 =	$374.00 x 2/3 =	$249.33
9/8-9/14/11	$800.00 -	$353.00 =	$447.00 x 2/3 =	$298.00
9/15-9/21/11	$800.00 -	$353.00 =	$447.00 x 2/3 =	$298.00
9/22-9/28/11	$800.00 -	$338.00 =	$462.00 x 2/3 =	$308.00
9/29-10/5/11	$800.00 -	$374.00 =	$426.00 x 2/3 =	$284.00
10/6-10/12/11	$800.00 -	$380.00 =	$420.00 x 2/3 =	$280.00
10/13-10/19/11	$800.00 -	$374.00 =	$426.00 x 2/3 =	$284.00
10/20-10/26/11	$800.00 -	$386.00 =	$414.00 x 2/3 =	$276.00
10/27-11/2/11	$800.00 -	$639.38 =	$160.62 x 2/3 =	$107.08
11/3-11/9/11	$800.00 -	$808.13 =	NO LOSS	---
11/10-11/16/11	$800.00 -	$667.50 =	$132.50 x 2/3 =	$ 88.33
11/17-11/23/11	$800.00 -	$810.00 =	NO LOSS	---

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11/24-11/30/11	$800.00 - $717.50 =	$ 82.50 x 2/3 =	$ 55.00
12/1-12/7/11	$800.00 - $735.00 =	$ 65.00 x 2/3 =	$ 65.00
12/8-12/14/11	$800.00 - $822.08 =	NO LOSS	---
12/15-12/21/11	$800.00 - $847.50 =	NO LOSS	---
12/22-12/28/11	$800.00 - $652.50 =	$147.50 x 2/3 =	$ 98.33
12/29/11-1/4/12	$800.00 - $785.20 =	$ 14.80 x 2/3 =	$ 9.87
1/5-1/11/12	$800.00 - $686.50 =	$113.50 x 2/3 =	$ 75.67
1/12-1/18/12	$800.00 - $660.05 =	$139.95 x 2/3 =	$ 93.30
1/19-1/25/12	$800.00 - $667.50 =	$132.50 x 2/3 =	$ 88.33
1/26-2/1/12	$800.00 - $696.30 =	$103.70 x 2/3 =	$ 69.13
2/2-2/8/12	$800.00 - $712.50 =	$ 87.50 x 2/3 =	$ 58.33
2/9-2/15/12	$820.00*-$694.50 =	$125.50 x 2/3 =	$ 83.67

TOTAL TPD OWED BY RESPONDENT **$5,891.37**

The modification ordered by the Circuit Court results in a reduction in temporary partial disability from the amount ordered by the Arbitrator in the amount of $2,548.25.

The parties stipulated prior to hearing that Respondent paid and should receive credit for payment of $4,203.26 in temporary partial disability and $165.67 in overpayment of temporary total disability. The Commission finds that these amounts should be credited against Respondent's liability for $5,891.37 for temporary partial disability, leaving $1,522.44 net liability.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner $1,522.44 in underpaid temporary partial disability benefits. The Commission finds that Petitioner is entitled to a total of $5,891.37 in temporary partial disability benefits for the 33-3/7 week period from June 27, 2011 through February 15, 2012. The parties agreed that Respondent is entitled to a credit of $4,203.26 for temporary partial disability payments and $165.67 in overpayment of temporary total disability payments, leaving $1,522.44 for the net underpayment of temporary total and partial disability payments.

IT IS FURTHER ORDERED BY THE COMMISSION that penalties and fees under Sections 19(k), 19(l) and 16 of the Act are denied.

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

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

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

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Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,600.00. 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: FEB 25,2014

Daniel R. Donohoo

Kevin W. Lamborn

Thomas J. Tyrrell

drd/dak
o-01/28/14
68

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RAYMOND JONES,

Petitioner,

vs.

14IWCC0133

NO: 12 WC 44243

KELLY SERVICES, 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 accident, causal connection, medical, prospective medical, and temporary total disability (TTD) 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).

The Commission modifies the Decision of the Arbitrator and finds that Mr. Jones failed to prove that he was temporary and totally disabled from December 21, 2012 through January 8, 2013. Dr. Bruce Summerville examined Mr. Jones on December 20, 2012. Dr. Summerville provided Petitioner with left arm restrictions consisting of no lifting, carrying, pushing or pulling greater than 10 pounds, and no overhead work. PX.2. The Petitioner testified that his supervisor, Eloy Vela, offered him light duty work. T.35. The Petitioner, however, did not return to work as it was his belief that Mr. Vela terminated him. *Id.*

The Commission finds that the Petitioner's testimony as to his alleged termination is not supported by the evidence. The Petitioner's testimony is contradicted by both Mr. Vela and Paul McConnell. Mr. Jones testified that he informed Mr. Vela of his work restrictions and light duty work was provided to him. However, he then testified that he was terminated by Mr. Vela. Mr. Vela testified that he never spoke to the Petitioner after December 5, 2012. Further, Mr. McConnell testified that, as the Branch Manager for Kelly Services, he would have been made

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aware of the Petitioner's termination. However, he never received such notice. T.74.- T.75. There is no credible evidence supporting Petitioner's testimony regarding the alleged termination. Further, there is no evidence indicating that the Petitioner was unable to work light duty from December 21, 2012 through January 8, 2013.

Therefore, the Commission modifies the Decision of the Arbitrator and finds that Petitioner is not entitled to TTD benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 6, 2013, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,724.00 for medical expenses under §8(a) of the Act pursuant to the fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for the MR arthrogram as recommended by Dr. Summerville and Dr. Tonino.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,700.00. 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: FEB 2 6 2014

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
2/10/2014
052

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

14IWCC0133

JONES, RAYMOND D
Employee/Petitioner

Case# **12WC044243**

KELLY SERVICES INC
Employer/Respondent

On 5/6/2013, 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 0.08% 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:

0512 NOONAN PERILLO POLENZANI & MARKS
JASON S MARKS
25 N COUNTY ST
WAUKEGAN, IL 60085

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
KAREN A HAARSGAARD
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602-4195

14IWCC0133

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)

Raymond D. Jones
Employee/Petitioner

v.

Kelly Services, Inc.
Employer/Respondent

Case # 12 WC 44243

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 **Waukegan**, on **March 25, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **12/3/12**, 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 **$1,669.20**; the average weekly wage was **$333.84**.

On the date of accident, Petitioner was **42** 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 **$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

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $286.00/week for 2 5/7 weeks, commencing 12/21/12 through 1/8/13, as provided in Section 8(b) of the Act.

Medical benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,057 to Advocate Condell Medical Center, $36.00 to Lake County Radiology, and $631 to Illinois Bone and Joint-Lake Shore Orthopedics, as provided in Sections 8(a) and 8.2 of the Act.

Other

Respondent shall authorize and pay for MR arthrogram recommended by Dr. Summerville and Dr. Tonino.

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.

Edwin Lee
Signature of Arbitrator

5/6/13
Date

ICArbDec19(b)

MAY - 6 2013

Illinois Workers' Compensation Commission

Raymond Jones Employee/Petitioner	)		
v.	)	Case No.:	12 WC 44243
Kelly Services, Inc. Employer/Respondent	)	Setting:	Woodstock

FINDINGS OF FACT AND CONCLUSIONS OF LAW IN SUPPORT OF ARBITRATOR'S 19(b) DECISION

FINDINGS OF FACT

Testimony of Raymond Jones

Petitioner began employment with Respondent, a temporary agency, in approximately September of 2012. His first job assignment was with Baxter. In November of 2012 he was reassigned by Respondent and placed at Medela in McHenry.

Medela assembles and distributes breast pumps. Petitioner was placed on an assembly line at Medela where he was charged with packing product into boxes, pushing the boxes through a taping machine and then loading the boxes onto a pallet.

On December 3, 2012, Petitioner was loading four to five boxes at a time from the assembly line to the pallet. Petitioner did not stack the boxes on top of each other in order to move them. Rather, he pushed four to five boxes together, side by side, placed his hands around the outermost box on each side, squeezed the boxes together and transported them to the pallet. Petitioner stacked the pallet to about eye level after which he was forced to reach overhead. As Petitioner was stacking boxes overhead he felt and heard a pop in his left shoulder.

Petitioner reported the incident to Eloy Vela, an onsite supervisor from Respondent. Eloy instructed Petitioner to speak with a nurse from Medcor about the injury. Petitioner was instructed to go home, apply ice to his shoulder and use over the counter medication. While at home that day Petitioner noticed a deformity in his left shoulder and his girlfriend helped him maneuver the shoulder back in place.

In light of ongoing problems with his shoulder, Petitioner called in sick to work the following day. He returned to work on December 5, 2012, but was instructed to perform light duty. Petitioner was eventually seen in the emergency room at Condell Medical Center on December 7, 2012, with complaints of left shoulder pain. He was referred to an orthopedic surgeon for further care and treatment.

Petitioner saw Dr. Summerville of Illinois Bone and Joint Institute on December 20, 2012. He was provided with an injection and given light duty work restrictions. The injection helped, but wore off after a short period of time. Petitioner returned to see Dr. Summerville on January 10, 2013, at which time he recommended an MR arthrogram of the left shoulder. He also provided Petitioner with additional light duty work restrictions at that time.

Petitioner has not worked since December 6, 2012. He has not been paid any temporary total disability benefits. Petitioner was advised of Respondent's light duty offer of employment shortly after Ben McConnell's letter of January 7, 2013. Petitioner testified that he left a message for Ben McConnell in response to the job offer, but received no response.

Notwithstanding the documentation submitted by Respondent, Petitioner did not actually receive payment from Respondent for the period of time beyond which he last worked on December 6, 2012.

Testimony of Eloy Vela

Eloy Vela is a senior staffing supervisor for Kelly Services. He works at Medela in McHenry. Petitioner advised him of an injury to his left shoulder on December 3, 2012. He instructed petitioner to contact Medcor regarding the incident.

Petitioner called in sick to work on December 4, 2012. When he returned to work on December 5, 2012, he was placed in the "rework" area so he could perform light duty. Petitioner's regular job did involve overhead work.

Eloy Vela did not receive any messages or contact from Petitioner after his last day worked.

Testimony of Paul Ben McConnell

Ben McConnell is the branch manager for Kelly Services. He offered Petitioner light duty to begin on January 9, 2013, pursuant to his letter of January 7, 2013. He denies receiving any contact from Petitioner in response to this job offer.

He testified regarding Respondent's payroll system and payroll records. Employees are paid by direct deposit or on a company issued debit card. The records do not reflect whether Petitioner was paid by direct deposit or debit card. Ben McConnell indicated that the records reflect that Petitioner was paid for days beyond December 6, 2012. However, the records do not reflect, and he has no way to determine, whether Petitioner actually received those funds.

Eloy Vela is the onsite supervisor for Respondent at Medela. Espe Hart would have been Petitioner's supervisor at Medela. It was the responsibility of Respondent's supervisor, Eloy Vela, to approve any payroll requests.

Medical Records

Petitioner was seen in the emergency room at Condell Medical Center on December 7, 2012. At that time he reported having sustained an injury to his left shoulder four days ago at work while lifting boxes. PX 1, p. 21. He was noted to have symptoms of pain with range of motion and that he "could not move the shoulder/elevate the shoulder" after the injury. PX 1, p. 21. Physical examination indicated tenderness to the left lateral shoulder. PX 1, p. 22. Petitioner's left shoulder was x-rayed, he was diagnosed with a left shoulder strain and referred to an orthopedic surgeon. PX 1, p. 23 – 25.

Petitioner was next seen at Illinois Bone and Joint by Dr. Bruce Summerville on December 20, 2012. PX 2, p. 10. At that time he reported that he was injured at work on December 3, 2012, while lifting boxes. PX 2, p. 10, 12. He was noted to have ongoing pain in the anterior superior shoulder region and with overhead motion. PX2, p.12. He denied any prior problems with regard to his shoulder. PX 2, p. 12. Physical examination noted tenderness of the left shoulder and "positive impingement" sign. PX 2, p. 12. Dr. Summerville diagnosed Petitioner with a left shoulder sprain and impingement syndrome, provided him with a cortisone injection and light duty work restrictions of no lifting, pushing, carrying or pulling greater than 10 pounds with the left arm as well as no overhead work. PX 2, p. 12, 13, 17.

Petitioner returned to see Dr. Summerville on January 10, 2013. PX 2, p. 8. Dr. Summerville noted that the injection provided relief for about a week, but that the symptoms returned. PX 2, p. 8. He noted pain over the lateral deltoid region and, particularly, with overhead motion. PX 2, p. 8. Physical examination demonstrated a positive impingement and positive SLAP sign. PX 2, p. 8. Dr. Summerville's assessment was "left shoulder sprain" and he provided Petitioner with a prescription to obtain an MR arthrogram. PX 2, p. 9-9, 14. He also provided Petitioner with ongoing work restrictions of no lifting, carrying, pushing or pulling with the left hand greater than 10 pounds as well as no overhead work. PX 2, p. 9, 16.

IME – Dr. Tonino

Petitioner was seen by Dr. Tonino for a Section 12 examination on February 21, 2013. He provided a history of an injury to his left shoulder that he sustained on December 3, 2012, while "lifting four to five boxes to stack them on top of other boxes which were on a pallet." At that time he felt a painful pop in his left shoulder. At the time of the IME, Petitioner continued to complain of pain in his left shoulder and, particularly, with overhead activities. See RX 6.

Dr. Tonino examined Petitioner and noted that his elevation was significantly decreased on the left as compared to the right (100 degrees versus 160 degrees). Likewise, his external rotation was noted to be limited on the left as compared to the right (30 degrees versus 60 degrees). Dr. Tonino noted "pain with rotator cuff testing of the left shoulder." See RX 6.

Dr. Tonino reviewed Petitioner's records from Condell Medical Center and Dr. Summerville. After his review of the records and examination of Petitioner, his impression was "possible labrel tear and subacromial impingement" of the left shoulder. His opinion is that " an MRI arthrogram is indicated." Dr. Tonino specifically stated that it was his opinion that "the patient's left shoulder condition is related to the injury that occurred on the 3rd of December,

2012." The basis for his opinion is Petitioner's lack of any prior shoulder problems, the fact that it was reported on the day of the injury and that the mechanism of injury is consistent with examination findings. Dr. Tonino indicated that Petitioner has not reached maximum medical improvement since further diagnostic testing is indicated. He is capable of working with a five pound lifting restriction with no overhead or repetitive use of the left arm. Petitioner's subjective symptoms are consistent with his objective findings and there is no evidence of symptom magnification. See RX 6.

IN SUPPORT OF THE ARBITRATOR'S DECSION REGARDING C (ACCIDENT), THE ARBITRATOR FINDS AS FOLLOWS

Petitioner testified regarding the work accident that occurred on December 3, 2012, and offered specific testimony regarding the mechanics of his injury. Petitioner was moving four to five boxes at a time to stack them on a pallet. Petitioner aligned the boxes side by side. In order to move them he extended his arms outward and pressed the end of each side of the row of boxes and then lifted them onto the pallet. When Petitioner reached a certain level he was forced to reach overhead at which time he heard a pop and felt pain in his left shoulder.

Petitioner testified that he reported the injury immediately to Eloy Vela, Respondent's onsite supervisor at Medela. Eloy Vela confirmed that Petitioner reported the injury on December 3, 2012.

Finally, an incident report was filled out by Espe Hart, Petitioner's supervisor at Medela, regarding the incident. PX 4. The incident report is consistent with Petitioner's testimony as to the mechanism of injury.

In light of the foregoing, the Arbitrator does hereby find that Petitioner sustained an accident on December 3, 2012, that arose out of and in the course of his employment with Respondent.

IN SUPPORT OF THE ARBITRATOR'S DECSION REGARDING F (CAUSAL CONNECTION) AND K (PROSPECTIVE MEDICAL), THE ARBITRATOR FINDS AS FOLLOWS

Petitioner spoke with a nurse at Medcor on the date of the accident and was diagnosed with a sprain/strain of the left shoulder. RX1. He was seen in the emergency room at Condell Medical Center four days later on December 7, 2012, where he was also diagnosed with a shoulder strain and given instructions to follow-up with an orthopedic surgeon. PX 1, p. 24. Petitioner sought treatment with Dr. Bruce Summerville of Illinois Bone and Joint Institute and was first seen on December 20, 2012. PX 2, p. 12 -13. Dr. Summerville diagnosed Petitioner with a left shoulder sprain and impingement syndrome and provided him with an injection. PX 2, p. 12 – 13. Petitioner returned to see Dr. Summerville on January 10, 2013. PX 2, p. 8. It was noted that the injection provided minimal relief and he had continued symptoms of left shoulder pain especially with overhead motion. PX 2, p. 8 – 9. Dr. Summerville recommended an MR arthrogram. PX 2, p. 9, 14.

Dr. Tonino, Respondent's examining physician, examined Petitioner as well as reviewed his medical records. His impression is that Petitioner has a possible labrel tear and subacromial impingement of the left shoulder and that this condition is related to the work accident that occurred on December 3, 2012. RX 6. Dr. Tonino cited a lack of any prior injury to Petitioner's left shoulder, the fact that it was reported on the date of incident and noted the mechanism of injury to be consistent with his examinations findings as the basis for his opinion. RX 6. Dr. Tonino noted that Petitioner's subjective complaints are consistent with his objective findings and that there is no evidence of symptom magnification. RX6. He concurs with the recommendation for an MR arthrogram. RX 6.

In light of the above, the Arbitrator does hereby find that the Petitioner's condition of ill-being is causally related to the work accident that occurred on December 3, 2012. The arbitrator further orders Respondent to authorize and pay for the MR arthrogram recommended by Dr. Summerville and Dr. Tonino.

IN SUPPORT OF THE ARBITRATOR'S DECSION REGARDING J (RESONABLE AND NECESSARY MEDICAL SERVICES), THE ARBITRATOR FINDS AS FOLLOWS

Based on the Arbitrator's decision regarding C (accident) and F (causal connection) the Arbitrator hereby orders Respondent to pay Petitioner's reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,057.00 to Advocate Condell Medical Center, $36.00 to Lake County Radiology and $631.00 to Illinois Bone and Joint – Lake Shore Orthopedics.

IN SUPPORT OF THE ARBITRATOR'S DECSION REGARDING L (TEMPORARY TOTAL DISABILITY), THE ARBITRATOR FINDS AS FOLLOWS

While Petitioner did not work after December 6, 2012, he did not have work restrictions until being seen by Dr. Summerville on December 20, 2013. PX 2, p. 12, 17. Respondent did not offer light duty employment to Petitioner until January 9, 2013, as indicated in Ben McConnell's letter of January 7, 2013. PX 5. Petitioner declined Respondent's offer of light duty employment pursuant to his email that was sent on January 10, 2013. RX 7.

In light of the above, the Arbitrator finds that the Petitioner is entitled to temporary total disability benefits for the period December 21, 2012, through January 8, 2013, or a period of 2 and 5/7ths weeks. As Petitioner's average weekly wage is $333.84 and he has two dependents, Petitioner is entitled to the statutory minimum temporary total disability rate of $286.00 per week. AX 1, paragraph 5 and 6.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TERRY BONE,

Petitioner,

14IWCC0134

vs.

NO: 11 WC 43241

ARAMARK MANAGEMENT SERVICES,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of nature and extent 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 modifies the Decision of the Arbitrator and finds that the Petitioner sustained fifteen percent loss of use of the right foot as the result of his September 23, 2011 work-related accident.

According to Section 8.1(b) of the Act, 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.

Mr. Bone was 39 years old when he sustained a right Achilles laceration on September 23, 2011. He underwent open repair of the Achilles tendon on September 26, 2011. PX.4. The Petitioner returned to work full-duty and without restriction on August 10, 2012. PX.3. He currently performs the same duties as he did prior to the accident and earns fifty cents more per hour than he did prior to the accident. T.13, T.19. Subjectively, the Petitioner experiences some pain while pushing a cart uphill. T.17. He also experiences some tightness in the morning or if it is cold outside. *Id.* He will also develop a shooting pain up to the kneecap, while walking on uneven ground. The shooting pain causes his knee to buckle. *Id.* The Petitioner testified that he has not sought medical treatment since August 2012 and does not take pain medication. T.20.

Dr. John Krause performed an AMA rating. He found Petitioner has a six percent combined lower extremity impairment which converts to a two percent person-as-the-whole impairment. RX.3. pg.5. Dr. Krause testified that the Petitioner has atrophy of the calf, thickening of the Achilles tendon and diminished range of motion, all of which are permanent. RX.3. pg.30. Dr. Krause found that the Petitioner has satisfactory alignment, full hind foot motion, satisfactory plantar flexion and normal sensibility. *Id.*

Applying Section 8.1(b) to the above facts, the Commission finds that the Petitioner sustained 15% loss of use of the right foot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 30, 2013, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $489.92 per week for a period of 25.05 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the Petitioner 15% loss of use of the right foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

14IWCC0134

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 $12,300.00. 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: FEB 2 6 2014

MJB/tdm
O: 2-10-14
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0134

BONE, TERRY
Employee/Petitioner

Case# **11WC043241**

ARAMARK
Employer/Respondent

On 8/30/2013, 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 0.06% 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:

1580 BECKER SCHROADER & CHAPMAN PC
NATHAN BECKER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

0560 WIEDNER & MCAULIFFE LTD
MARY SABATINO
1 N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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
NATURE AND EXTENT ONLY

Terry Bone
Employee/Petitioner

v.

ARAMARK
Employer/Respondent

Case # 11 WC 43241

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on July 22, 2013. By stipulation, the parties agree:

On the date of accident, September 23, 2011, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $42,459.56, and the average weekly wage was $816.53.

At the time of injury, Petitioner was 39 years of age, married with 3 dependent child(ren).

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

Respondent shall be given a credit of $7,543.06 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $7,543.06. The parties stipulated that all TTD had been paid in full by Respondent.

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

ORDER

Respondent shall pay Petitioner the sum of $489.92 per week for a period of 50.1 weeks because the injury sustained caused the 30% loss of use of the right foot, as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

August 26, 2013
Date

AUG 30 2013

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on September 23, 2011. At trial, counsel for the parties stipulated that Petitioner did sustain a work-related accident, temporary total disability benefits were paid in full and all related medical bills had either been paid or would be paid pursuant to the Act and fee schedule. Accordingly, the only disputed issue at trial was the nature and extent of disability.

Petitioner worked for Respondent as a shuttle driver and, on September 23, 2011, a cart full of mats broke loose and rolled striking the Petitioner in the back of the right foot and ankle. Following the accident Petitioner went to the ER of Gateway Regional Hospital and was diagnosed with a contusion and laceration of the right heel as well as a laceration of the right Achilles tendon.

Petitioner was subsequently treated by Dr. Craig Beyer, an orthopedic surgeon, who initially saw Petitioner on September 26, 2011. Dr. Beyer diagnosed Petitioner as having a complete traumatic laceration of the Achilles tendon. Dr. Beyer recommended that Petitioner have corrective surgery and he performed an open repair surgical procedure that same day. Following the surgery, Petitioner remained under Dr. Beyer's care and received physical therapy.

At the direction of the Respondent, Petitioner was examined by Dr. John Krause, an orthopedic surgeon, on December 12, 2011. Dr. Krause reviewed medical reports provided to him by the Respondent and examined the Petitioner. Dr. Krause opined that Petitioner had sustained a near complete laceration of the Achilles tendon which had been treated appropriately by Dr. Beyer. He also opined that Petitioner was not at MMI and that he could work but with restrictions of sitting with intermittent standing and no lifting more than 20 pounds.

Petitioner remained under Dr. Beyer's care who discharged him from treatment and released him to return to work without restrictions on January 31, 2012. When Petitioner returned to work at that time, he experienced considerable difficulties in performing his duties, in particular, pushing the heavy carts. Petitioner testified that when he was required to push these carts uphill that his ankle would roll.

Because of his continued symptoms, Petitioner was seen by Dr. Jeffrey Johnson, an orthopedic surgeon, on March 30, 2012. Petitioner informed Dr. Johnson of the history of the work-related accident and the corrective surgery performed by Dr. Beyer. He also informed Dr. Johnson that he experienced a burning pain when he attempted to push heavy carts as well as intermittent popping and pain in the ankle joint. On examination, Dr. Johnson noted that the Achilles tendon was thickened, there was ankle tenderness, atrophy of the calf musculature, a positive Tinel's sign over the sural nerve and no swelling. Dr. Johnson opined that Petitioner had sural nerve neuritis because of nerve entrapment/injury at the site of the surgical incision.

Dr. Johnson recommended Petitioner continue with rehabilitation and that he have an MRI scan performed. An MRI was performed on May 11, 2012, which revealed significant thickening of the Achilles tendon but no other pathology. Dr. Johnson saw Petitioner that same day and his

condition was improved. Dr. Johnson's examination revealed tenderness of the area of the surgical incision and a full range of motion but there was still right calf atrophy. Dr. Johnson opined that no surgery was indicated and that the sural nerve sensitivity would improve with therapy. Dr. Johnson authorized Petitioner to return to work with an 800 pound pushing restriction. Dr. Johnson saw Petitioner again on August 10, 2012, and Petitioner's complaints and findings on examination, including the calf atrophy, were consistent with the prior examination of May 11, 2012. Dr. Johnson released Petitioner to return to work without restrictions and discharged him from care.

On December 10, 2012, Petitioner was examined for the second time by Dr. Krause. On examination Dr. Krause noted a slightly diminished range of motion and also observed the atrophy of the right calf. He opined that there was an AMA impairment rating of six percent (6%) of the lower extremity which computed to a rating of two percent (2%) of the whole person.

Dr. Krause was deposed on June 26, 2013, and his deposition testimony was received into evidence at trial. Dr. Krause's deposition testimony was consistent with his medical reports and he reaffirmed his opinion that there was an impairment of six percent (6%) of the right lower extremity under the AMA guidelines. On cross-examination, Dr. Krause agreed that impairment and disability are two different concepts and that in arriving at Petitioner's impairment rating he did not consider Petitioner's complaints of pain. He also agreed that the diminished range of motion and calf atrophy that he observed on examination were permanent conditions.

At trial Petitioner testified that he still has pain in his ankle which goes up to his knee and that he still experiences tightness in the ankle especially during cold weather. The Petitioner also stated that he continues to experience pain whenever he has to walk on uneven ground. He did agree that he was able to return to work and perform all of his job duties. Petitioner is also presently making $.50 more per hour than he was at the time of the accident.

Conclusions of Law

The Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 30% loss of use of the right foot.

In support of this conclusion the Arbitrator notes the following:

Dr. Krause opined that there was an AMA impairment rating of six percent (6%) of the right lower extremity. When deposed, Dr. Krause agreed that impairment and disability are separate concepts and that Petitioner's diminished range of motion and atrophy of the calf musculature were permanent conditions.

Petitioner is employed as a shuttle driver and his job duties require him to push heavy carts and this will likely cause him to experience ongoing symptoms in his right ankle.

At the time of the accident, Petitioner was 39 years of age meaning that he will have to live with the effects of this injury for a significant period of time.

There was no evidence of the effects of this injury will have any effect on Petitioner's future earning capacity.

The medical treatment records revealed that Petitioner sustained a tear of the Achilles tendon which required surgical repair.

Dr. Johnson noted that Petitioner has thickening of the Achilles tendon, atrophy of the calf musculature and sural nerve neuritis.

Petitioner's ongoing complaints are consistent with the type of injury he sustained.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

☐ 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

14IWCC0135

Steve Oleksy,
Petitioner,

vs.

NO: 11 WC 23122

Illinois Department of Transportation,
Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission notes that in finding that Petitioner failed to prove that his condition of ill-being was causally related to the March 28, 2011 accident, the Arbitrator relied on Petitioner's medical records and found that they were "inconclusive as to whether or not Petitioner suffered a stroke the morning of March 28, 2011 prior to going to work." (Arb.Dec.5) The Arbitrator noted that Petitioner reported having suffered a visual abnormality that morning before going to work. (Arb.Dec.5, PX3) The Arbitrator also indicated that Petitioner failed to provide an expert opinion linking Petitioner's symptoms to the March 28, 2011 accident. (Arb.Dec.5)

After a complete review of the record, the Commission agrees with the Arbitrator that Petitioner complained of visual impairment when he woke up on March 28, 2011. However, the Commission notes that the record shows that despite this, Petitioner went to work and was able to do his job without problem until the undisputed work accident occurred. Furthermore, Petitioner testified that the visual impairment was only for "[a] couple of seconds." (T.36) The symptoms in question in this case are Petitioner's headaches and left side paresthesias. The medical records and Petitioner's uncontested testimony establish that these symptoms started after the work accident. The Commission further notes that as Petitioner received treatment for the injuries sustained from the work accident, Petitioner complained not of visual impairment but of ongoing headaches and left side paresthesias, symptoms which, again, according to the medical records, appeared shortly after the work accident. (PX1, PX3, PX6, PX7)

The Commission also finds that Petitioner did, in fact, provide expert opinion linking his headaches and left side paresthesias to the March 28, 2011 accident. On July 16, 2012, Petitioner called Dr. Robert R. Rivers, his treating physician, and asked if his transient ischemic attack (hereinafter "TIA") was caused by the March 28, 2011 work accident. (PX7) Dr. Rivers

reviewed the medical records and diagnostic exams and explained that Petitioner "[h]aving a vascular TIA would seem an unlikely coincidence. Seeing him after his discharge from the hospital with his dysesthesia and H/A [headache] made a post concussive injury a ***more likely consideration*** although I could not rule out a TIA." (PX7, emphasis added) Petitioner then saw Dr. Nicholas Schlageter, his neurologist, on July 17, 2012. (PX6) Dr. Schlageter specifically stated that Petitioner's "[s]ymptoms from head trauma in March resolved by November" and indicated that Petitioner's post-concussion syndrome, caused by the work accident, had resolved. (PX6) That same day, Dr. Schlageter wrote to Dr. Rivers and explained that Petitioner's diagnosis was resolved post-concussion syndrome and that the post-concussion syndrome had been "caused by overhead garage door falling and hitting [Petitioner] in head." (PX6, PX7) On July 25, 2012, Dr. Rivers read Dr. Schlageter's letter and noted that Dr. Schlageter concurred with his original finding that Petitioner's work-related head injury "was the cause of his symptoms requiring treatment." (PX7)

The Commission also notes that of all the doctors Petitioner saw while admitted at Delnor hospital, only Dr. Schlageter seemed to note and consider the work accident in his diagnosis and treatment. (PX1, PX6) Furthermore, when Petitioner followed up with Dr. Schlageter on July 21, 2011, Dr. Schlageter diagnosed Petitioner as having chronic ***post-traumatic*** headache and left side paresthesias. (PX6) Again, the Commission notes that these are symptoms that appeared after Petitioner's undisputed head injury and not before. Also, the Commission finds that Dr. Schlageter's diagnosis of chronic ***post-traumatic*** headache and left side paresthesias indicates that Petitioner's condition of ill-being is a result of the head injury and not a pre-existing condition.

Therefore, for the reasons set out above, the Commission reverses the Arbitrator's Decision regarding causation and finds that Petitioner's condition of ill-being and need for treatment was causally related to the March 28, 2011 accident. The Commission further finds that Petitioner is entitled to all medical expenses incurred in the treatment of his conditions as a result of the accident, which, as noted in the Request for Hearing form (AX1) and the Arbitrator's Decision, have already been paid by Respondent, as well as out-of-pocket payments made by Petitioner towards his medical treatment, totaling $135.00 ($75 to Delnor (PX8), $15 to Geneva Family Practice (PX9), and $20 & $25 to Tri City Neurology (PX10 & PX11)).

Regarding temporary total disability benefits, the Arbitrator found that Petitioner "was paid full wages for five days, March 29, 2011, March 30, 2011, March 31, 2011, April 1, 2011 and April 4, 2011 as part of the Collective Bargaining Agreement....Petitioner was paid TTD from March 5, 2011 through April 17, 2011." (Arb.Dec.5-6) However, the Commission notes that the Request for Hearing form indicates that Respondent did not pay any temporary total disability benefits to Petitioner. (AX1) The Commission also notes that Petitioner was kept off work from March 29, 2011 through April 16, 2011 by Dr. Rivers. (PX3) Therefore, the Commission finds that Petitioner is entitled to temporary total disability benefits from March 29, 2011 through April 16, 2011.

In his decision, the Arbitrator found Petitioner's average weekly wage to be $956.19. The Arbitrator relied on the Computation Sheet entered into evidence by both Petitioner and Respondent which shows Petitioner's salary in the year preceding the accident to be $49,722.00.

(PX5, RX2) After reviewing the Computation Sheet, the Commission notes that Petitioner's salary was divided by 52 weeks, a full year of work. However, the Petitioner's employment records indicate that Petitioner was hired by Respondent on May 16, 2010. (PX5-pg.4, RX2) Petitioner and Dan Scandiff, Respondent's tech of the yard, testified that Petitioner's first day of work for Respondent was on May 17, 2010. (T.8-9, 79) Based on the employment records and the testimony provided, Petitioner worked 316 days for Respondent (45-1/7 weeks) prior to the accident. Therefore, the Commission finds that Petitioner's average weekly wage is $1,101.44 ($49,722.00 ÷ 45-1/7).

Finally, regarding the issue of permanency, the Commission notes that Petitioner testified that his symptoms continued until they resolved in November of 2011. (T.22, 33) And as previously noted, On July 17, 2012, Dr. Schlageter also found that Petitioner's post-concussion syndrome and symptoms had resolved by November 2011. (PX6) Therefore, based on the evidence provided, the Commission finds that Petitioner has suffered a 2% loss of use of the person as a whole as result of the March 28, 2011 accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 9, 2013, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $734.29 per week for a period of 2-5/7 weeks, from March 29, 2011 through April 16, 2011, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $660.87 per week for a period of 10 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 2% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $135.00 for out-of-pocket payments made by Petitioner for medical expenses under §8(a) and §8.2 of the Act.

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

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

DATED: FEB 26 2014
MJB/ell
o-02/11/14
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0135

OLEKSY, STEVE
Employee/Petitioner

Case# **11WC023122**

IL DEPT OF TRANSPORTATION
Employer/Respondent

On 5/9/2013, 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:

0512 NOONAN PERILLO POLENZANI & MAR
JASON S MARKS
25 N COUNTY ST
WAUKEGAN, IL 60085

5031 ASSISTANT ATTORNEY GENERAL
JILL OTTE
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1430 CMS BUREAU OF RISK MGMT
WORKERS COMPENSATION MANAGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PKWY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

MAY 9 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0135

STATE OF ILLINOIS)
)SS.
COUNTY OF Wheaton)

- [ ] 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

Steve Oleksy
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # 11 WC 23122

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 **Wheaton**, on **March 8, 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On **March 28, 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 not* causally related to the accident.

In the 10 months preceding the injury, Petitioner earned **$49,722.00**; the average weekly wage was **$956.19**.

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

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

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

Respondent shall be given a credit for TTD paid **March 29, 2011 through April 16, 2011**, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

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

ORDER

Based on the evidence presented at trial, including witnesses' testimony, as well as both parties' exhibits, the undersigned Arbitrator hereby denies Petitioner's Application for Benefits and makes no award in his favor.

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

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

Signature of Arbitrator

05-08-13
Date

MAY - 9 2013

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

STEVE OLEKSY, Employee/Petitioner,	)	
v.	)	11 WC 23122 Chicago
ILLINOIS DEPARTMENT OF TRANSPORTATION, Employer/Respondent.	)	

ARBITRATOR'S FINDINGS OF FACT AND CONCLUSIONS OF LAW

This action was pursued by the Petitioner under the Workers' Compensation Act seeking relief from his employer the Illinois Department of Transportation ("IDOT"). On March 8, 2013 a hearing was held before Arbitrator Kurt Carlson at the Illinois Workers' Compensation Commission in Wheaton, Illinois. Petitioner Steve Oleksy was represented by counsel. IDOT was represented by the Illinois Attorney General's Office. After hearing the proofs and reviewing all of the evidence presented, this Arbitrator hereby makes findings on the disputed issues below and includes those findings in this document.

I. Findings of Fact

Petitioner was a seasonal Highway Maintainer ("snowbird") for IDOT on March 28, 2011 when he was hit on the stop of his head by a garage door at the Oak Brook Yard. Petitioner was working with fellow Highway Maintainer Jose Negron that day loading tractors on a trailer. While loading the tractors, Petitioner walked in and out of the garage several times. The garage door is 12' high and 20'2" wide. As Petitioner was leaving the garage for the final time, the garage door fell and hit the top of his head, causing him to fall to the ground. His head hurt and he had an immediate headache. He also started feeling numbness on his entire left side.

Petitioner continued to work until the end of his shift at 3 p.m. After talking to his wife when he got home, she decided he needed to go to Delnor Hospital's Emergency Room ("Delnor"). Julie Oleksy, Petitioner's wife, testified that when Petitioner arrived home, he looked "not quite right", his face was red, he looked tired and his "speech was off." Petitioner testified that at Delnor he complained of headache, his head hurting and numbness on his left side. Petitioner's counsel asked whether he reported to Delnor that he had double vision or blurry vision. Petitioner's response was the "only thing I could think of" was when he "woke up too fast" that morning he had difficulty with his "eyes trying to focus on two different things." Petitioner testified that he made these comments about his vision because he was repeatedly questioned about his medical condition by several doctors. On cross examination, Petitioner admitted to giving truthful information to the Delnor staff regarding his condition. Petitioner was in Delnor three days and two nights. There was no evidence of a cut, contusion, bruise or abrasion to the head in the medical records. Upon discharge, Petitioner was referred to a neurologist. Petitioner saw Dr. Schlageter and was told that his injury would resolve over time.

Petitioner testified inconsistently as to how is currently feeling. He testified that he still gets headaches and feels numbness on his left side. He also testified, however, that his symptoms resolved in November 2011, adding that his symptoms are constant, that he is unstable as far as balance, and that nothing seemed to bring on his symptoms any more than anything else.

Petitioner's medical records reveal that he presented to Delnor's emergency department on March 28, 2011 complaining that "when he woke up this morning he said his vision seemed a bit off. He says it was not blurry and it was not exactly double. He just felt like his vision was not seeing as good as it should, especially that he would see like 2 pictures on the wall in

different spots than he knew that they were." Pet. Ex. 3 at 205. Petitioner further told staff that "he was able to go to work, but he was noticing a numbness and tingling sensation, especially in his left arm going from his shoulder down to his hand as well as a much more minor feeling but in his left leg on the left side of his torso." Id. Petitioner denied any "vision loss, focal weakness, fevers, or any loss of balance." Id. Petitioner's wife told Delnor staff that "when he got home from work that he seemed to slur his words for a moment, but nobody at work noticed anything wrong with him, and she had not noticed a recurrence of that." Id. Petitioner also told staff he had a headache earlier. Petitioner did not tell staff that he was hit by a garage door earlier that day. It bears repeating that these records show no evidence of a cut, contusion, abrasion or bruise to the head.

Petitioner was admitted to Delnor for observation and given aspirin. Pet. Ex. 3 at 206. The nurse noticed a slight facial asymmetry, but the examining doctor did not observe it. Id. Petitioner was diagnosed with left-sided parasthesias and possible acute cerebrovascular accident. Id. at 207. A CT scan on March 28, 2011 of Petitioner's head showed "no acute intracranial abnormality." Id. at 208. Dr. Mrunal Shah noted that "**the initial CT scan did not reveal a stroke, but unable to do an MRI because patient has a spinal stimulator.**" Id. and 215 (emphasis added). A Carotid Duplex Ultrasound on March 28, 2011 revealed "no hemodynamically significant stenosis seen in either carotid artery. The right vertebral artery was never clearly visualized and may be hypoplastic or stretic in this case." Id. 210-211.

On March 29, 2011, the day after his injury, Petitioner tells Dr. Nicholas Schlageter that "yesterday morning he got up and had some type of visual abnormality. It was not blurred vision, it was not double vision. He went to work and states that at about 10 o'clock in the morning, the garage door fell 13 feet and struck him on the head. He was knocked to the ground.

He does not know if he lost consciousness, but he rapidly got up off the ground and felt okay." Id. at 212. Petitioner also told Dr. Schlageter that "at about 1:30 in the afternoon, he developed left arm numbness. He continued to work, went home at about 4 o'clock and his wife thought that his speech was slurred. He also started to have left leg numbness." Id.

At the time of Petitioner's injury, Jose Negron was on a tractor outside the garage facing away from Petitioner. He did not actually witness or see Petitioner get hit by the garage door, but he did hear it slam on the ground. When he saw Petitioner walk out of the garage, Petitioner was "full of dirt" and had dirt in his hair. Negron also remembered Petitioner was complaining of a headache. Negron told Petitioner to report it, but Petitioner said he wanted to see how he felt. Petitioner "took it easy" most of the day and Negron did all of the work. Negron did not see any evidence of a head injury, nor did he notice Petitioner slurring his speech throughout the day. Negron worked with Petitioner for three years.

Oak Brook Yard Technician Dan Scandiff also testified. His responsibilities include managing the team section needs, including indirectly supervising the Highway Maintainers. Scandiff saw Petitioner early in the morning, around 6:30 or 7:30 a.m. on March 28, 2011. Petitioner did not tell Scandiff of his injury that day. Scandiff was present at the Yard until 3 p.m. that day, except for when he left to go to lunch at 11:20 a.m. Scandiff was notified of Petitioner's injury at 7 p.m. on March 28, 2011 via a phone call from Lead Worker Charles Miller. Scandiff was unaware of any issues with the garage door prior to Petitioner's accident. On March 29, 2011, Scandiff had repair work done on the garage door.

Since the accident, Petitioner has been promoted to Temporary Vacated Acting Lead Worker, a supervisory position of authority over that of a Highway Maintainer. At the time of his injury, he had worked for IDOT for only 10 months.

II. Conclusions of Law

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

Petitioner failed to prove that his current condition of ill being is related to his injury on March 28, 2011. Petitioner's medical records are inconclusive as to whether or not Petitioner suffered a stroke the morning of March 28, 2011 prior to going to work. Pet. Ex. 3 at 215. Petitioner described to Delnor staff in detail the visual abnormalities he was having prior to going to work that day, which were idiopathic.

At the hearing, Petitioner tried to paint a picture that he was coerced by the numerous doctors asking about his medical condition and that in order to satisfy them, he exaggerated his visual symptoms earlier that morning, which makes no logical sense. As a result, this testimony was not credible. If Petitioner had been attempting to satisfy doctors and make up a story, he simply would have fabricated a better story. Instead it is clear to this Arbitrator that Petitioner was having visual problems in the morning before he reported for work.

Further, Petitioner did not provide an expert opinion relating to causation. For this reason, as well as those stated, above, this Arbitrator finds that Petitioner has failed to meet his burden of proving that his current condition of ill-being is causally related to his injury.

G. What were Petitioner's earnings?

IDOT's Computation Sheet reveals that Petitioner's total salary for the one year preceding the accident was $49,722.00. The same document also shows that Petitioner's AWW was $956.19. Resp. Ex. 2.

K. What amount of compensation is due for TTD?

Petitioner was paid full wages for five days, March 29, 2011, March 30, 2011, March 31, 2011, April 1, 2011 and April 4, 2011 as part of the Collective Bargaining Agreement between

his union and IDOT. Petitioner was paid TTD from March 5, 2011 through April 17, 2011. TTD was properly terminated at this point because Petitioner returned to work on April 18, 2011. Therefore, this Arbitrator makes no further award of TTD to Petitioner.

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

At trial, Petitioner's testimony was inconsistent. He stated he still gets headaches and has numbness on his left side, but he also testified that his symptoms resolved beginning in November 2011. Petitioner did not prove any ongoing symptoms as a result of his accident. Nor was there any objective medical evidence to suggest an injury to the body's physical structure, such as cut, contusion, abrasion or bruise. Therefore, this Arbitrator makes no award to Petitioner for the nature and extent of his injury.

M. Should penalties or fees be imposed upon Respondent?

Based on the evidence presented, the Arbitrator finds that penalties and fees against Respondent are unwarranted. Respondent has a legitimate and reasonable defense in this matter. IDOT was never presented with any documentation that Petitioner sustained a compensable injury as a result of the accident. Therefore, IDOT acted reasonably in denying benefits. Based on how Petitioner presented to Delnor, the staff attempted to determine whether or not Petitioner had a stroke. Further, Petitioner's symptoms as he described to Delnor are consistent with a person who suffered a stroke; the staff gave him aspirin the day he was presented. Petitioner's CT scan the day of the accident was negative for trauma. Finally, there is no medical evidence to suggest that Petitioner suffered a traumatic blow to his head. For these reasons, this Arbitrator does not impose penalties or fees upon Respondent.

III. Conclusion

Therefore, based on the evidence present at trial, including Petitioner's testimony as well as both parties' exhibits, the undersigned Arbitrator hereby finds that Petitioner's medical records are inconclusive as to whether or not Petitioner suffered a stroke on the day of his accident, though it is clear that he suffered some visual problems prior to going to work. This arbitrator finds that Petitioner did suffer a compensable accident, but has not proven that he has a compensable injury. Accordingly, Respondent is not liable for any further TTD. Additionally, penalties and fees should not be imposed upon Respondent.

ARBITRATOR KURT CARLSON

05-08-13

DATE

STATE OF ILLINOIS)
) SS.
COUNTY OF DuPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stacy McKenna,
Petitioner,
vs.

14IWCC0136

NO: 08 WC 03412

Domino's Pizza Distribution,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, permanent partial disability, and 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 March 1, 2013 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: FEB 2 6 2014

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

MJB:bjg
0-2/11/2014
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0136

McKENNA, STACY
Employee/Petitioner

Case# 08WC003412

08WC003411

DOMINO'S PIZZA DISTRIBUTION
Employer/Respondent

On 3/1/2013, 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 0.13% 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:

1471 KARNO, MARK L & ASSOC
GINA KOSCAL
33 N LASALLE ST SUITE 2600
CHICAGO, IL 60608

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
DOUGLAS S STEFFENSON
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

14IWCC0136

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

Stacy McKenna,
Employee/Petitioner

v.

Domino's Pizza Distribution,
Employer/Respondent

Case # **08** WC **3412**

Consolidated cases: **08 WC 3411**

An *Application for Adjustment 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 **Wheaton**, on **11/14/12**. After reviewing all 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 _____

Stacy McKenna v. Domino's Pizza Distribution, 08 WC 3412

FINDINGS

On **9/12/06**, 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*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$24,950.64**; the average weekly wage was **$479.82**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$0.00** 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 that she sustained accidental injuries arising out of and in the course of her employment on September 12, 2006 and failed to prove that her current condition of ill-being with respect to her cervical spine is causally related to said alleged accident. Accordingly, Petitioner claim is hereby denied.

No benefits are awarded.

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

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

Signature of Arbitrator

2/28/13
Date

ICArbDec p. 2

MAR 1 - 2013

STATEMENT OF FACTS:

Petitioner, a 31 year old production team worker, testified that her job involved removing balls of dough from an assembly line and placing them onto trays. A video job analysis for the position in question was submitted into evidence as part of Dr. Tulipan's evidence deposition. (RX1, "Petitioner's Ex.#1"). The Arbitrator has viewed this video (actually a DVD), which depicts several workers picking up and weighing balls of dough at about chest and/or shoulder level and placing the dough on trays at waist level. The Arbitrator notes that the conveyor belts on which the dough is first removed and then placed are moving at a fairly rapid pace. Petitioner testified that she had seen the video in question and that it was filmed at a facility in Missouri, given that the site Petitioner worked at had been shut down. Petitioner claimed that the line she worked on ran twice as fast as the one shown in the video and that the workers in the video were not pressing down on the dough as hard as she had to in order to make sure the dough stuck to the tray. Petitioner testified that she worked 4 days a week, 10 hours a day and she was supposed to be rotated every 2 hours and allowed 15 minute breaks between shifts. However, she noted that she could work up to 17 hours if there was a breakdown. She testified that there were other jobs in the rotation, but she was mainly kept on the production line because she was good at it. Other duties included moving and stacking dirty trays, and replacing the dirty trays with clean trays.

Petitioner noted that she began working for Respondent on August 22, 2005, and that prior to working for Respondent she managed a Quick Lube store for five years. Petitioner testified that she started noticing pain, numbness and tingling in her hands, as well as neck pain, during the year leading up to the date of the alleged injury.

Petitioner testified that by September 6, 2006 (the alleged date of accident in claim 08 WC 3411) she was experiencing major burning, numbness and tingling in her hands. Petitioner visited Dr. Kalpesh Patel on September 12, 2006 (the alleged date of accident in claim 08 WC 3412) at which time he noted that Ms. McKenna presented on that date with complaints of neck discomfort. (PX3). Dr. Patel noted that "[t]he character of the pain is aching, moderate and sharp. The pain began 8 years ago. The pain is better with rest. The pain is located in the subscapular area and to the sides of the neck. Neck pain started after a MVA. Patient indicates ambulation worsens condition. Patient had mva 8 years ago which is when pain started. However, for past one year she has been working in a production job where she places dough balls with both hands. Denies one hand working more than other at work … Associated signs and symptoms include aching and altered sleep pattern. Factors that aggravate neck pain: turning neck to the left and right." (PX3). Dr. Patel's impression was neck sprain, spasm, noting no neurological abnormalities, and recommending conservative care, including physical therapy, as well as Naprosyn, Norco and Flexeril for two weeks. (PX3).

Petitioner testified that when she first saw Dr. Patel her neck was the focus but then her hands became a priority thereafter. In an office note dated September 26, 2006, Dr. Patel recorded that in addition to her neck complaints Petitioner now presented with increased right hand and right arm numbness. (PX3). Dr. Patel recommended continued physical therapy for the neck, which was reportedly improving, as well as an additional three weeks of Naprosyn, Norco and Flexeril. (PX3). Dr. Patel also instructed Petitioner to use wrist splints at night. (PX3).

Petitioner testified that she subsequently went to HealthWorks on October 5, 2006 where she was seen by Dr. James T. John. (PX2). She indicated that she described her symptoms at that time, noting that her problems were more severe in her right hand. Dr. John's office note on that date related complaints of increasing numbness in the right hand over the past week, primarily in the third and fourth fingers, and that the symptoms were worse at night, often keeping her from sleeping. (PX2). Dr. John's assessment was right wrist strain and paraesthesia of the right hand. (PX2). He prescribed a cock-up type wrist splint to be worn at work and while

sleeping as well as Naproxen tablets. (PX2). Dr. John also indicated that Petitioner could return to work using the splint but that she was to avoid repetitive activities of the right wrist as well as heavy gripping with the right hand. (PX2).

Petitioner was next seen at HealthWorks on October 11, 2006 at which time it was noted that "... she feels about 75% better. She is quite happy with her rate of progress and now states that she is able to sleep without difficulty." (PX2). Petitioner returned for a final visit at HealthWorks on October 18, 2006 at which time it was noted that "... she feels 100% better. No longer any paraesthesia or numbness. She is happy with the improvement and now states that she is able to sleep without any difficulty. She does feel that she would now be able to do her regular work." (PX2). Petitioner denied that she related that she was 100% better at that time, but did acknowledge that the splint helped. Petitioner was released to return to work without restrictions at that time, discharged from the clinic and instructed to continue to wear the splint while sleeping. (PX2).

Petitioner was discharged from ATI Physical Therapy on October 23, 2006 at which time it was noted that "Stacy called and notified office staff week of 10/10 that she was cancelling all remaining visits due to worsening of wrist condition which she is addressing with occupational health MD at her work." (PX3).

Petitioner eventually visited Dr. Rodrigo M. Ubilluz on November 18, 2006 at which time he related that "[t]he patient is a 31 y/o, left handed, known to me more than 10 years ago. She is now having severe numbness in the right hand and also the left hand, or more intensity on the right. She has been using a splint in the right hand. She does have neck pain, but she does not know, if this is related with her hands numbness. Weeks ago for a month she has been having pain in her neck and upper thoracic spine. This has been relieved, but she is still with some soreness. She does a lot of repetitive movements with her hands and arms, in a constant fashion. No history of injuries in her neck. I saw her in the past because of a MVA. She had at that point an injury to her lip." (PX4). Dr. Ubilluz's differential diagnosis at that time was cervical radiculopathy versus spinal stenosis and CTS bilaterally. (PX4).

Petitioner subsequently underwent an EMG on November 28, 2006 which revealed evidence of bilateral carpal tunnel syndrome. (PX5). An earlier MRI of the cervical spine, performed on November 21, 2006, was interpreted as revealing a herniated disc at C6-C7 on the left as well as mild foraminal stenosis at C5-C6 on the right. (PX4). Petitioner was thereupon referred to Dr. Suresh Velacapudi at Castle Orthopaedics.

Petitioner visited Dr. Velacapudi on January 17, 2007 complaining of pain and tingling in both hands. (PX5). Dr. Velacapudi noted evidence of a C6-7 disc herniation as well as cervical radiculopathy. Dr. Velacapudi performed an injection to Petitioner's right wrist on January 19, 2007, in addition to a nerve block on March 27, 2007, with no relief. (PX5).

In an office note dated March 27, 2007, Dr. Ubilluz indicated that the Fetanyl patches he gave Petitioner, which were supposed to last a month, only lasted two days, and that "[t]his patient clearly shows a drug seeking behavior." (PX4). Dr. Ubilluz noted that Petitioner had been referred to a pain management specialist, Dr. Durrani, to deal with her medication issue. (PX4). When questioned about these Fentanyl patches, Petitioner indicated that she was working in a cooler at the time and was all bundled up, and that the patches were not sticking and were depleting too fast. She also claimed that the reference in the doctor's notes to using a month's worth of patches in two days must have been a "typo" and that the doctor did not want to listen to her.

Petitioner subsequently sought and received treatment at Multispecialty Medical Center (MSMC) from March 29, 2007 through July 17, 2008, including trigger point injections, physical therapy, neck extensions and hand exercises. A report by Dr. Zia Durrani on March 29, 2007 noted that Petitioner "... claims that about 10 years

ago she had some motor vehicle accident [and] because of that she started having some problem in the hand and pain in the back off and on. However, in the last six months the pain in her hand has gotten worse..." (PX7).

In a note dated February 8, 2008, Dr. Jordan Trafimow at MSMC recorded that "[t]he patient has had difficulty for approximately 16 months. She was apparently involved in an auto accident. Later on she was working at a job, which required a good deal of motion of her right arm and she thinks that overuse of the arm contributed to her difficulties. Apparently, she has had two diagnosis [sic] made in the past, one is herniated disc. The only documentation I have seen on this is the MRI report. However, she says that the pain is very largely gone, she has only an occasional difficulty on the left side of her neck." (PX7). Dr. Trafimow went on to state that "[t]he real problem is on the right side where she has been diagnosed with carpal tunnel syndrome... The patient has still enough pain that she want[s] surgery and I agree that that surgery is a good idea. The patient wanted to be referred to Dr. Bartucci to have the surgery done and I gave her prescription to this effect." (PX7).

Petitioner eventually sought treatment with Dr. Eugene J. Bartucci at Elmhurst Orthopaedics on February 19, 2008. At that time, she noted that she was experiencing burning, tingling and numbness in her arms. Dr. Bartucci recorded that Petitioner "... has had trouble with her hand since 2006. Right hand worse than her left hand. The left hand is getting better. She has worked in the same job since then and has had restrictions for the last year which have helped her cope with the problem. The bracing for 7 months has also helped. She is on medication." (PX8). Dr. Bartucci noted that the previous EMG in November of 2006 revealed bilateral carpel tunnel syndrome as well as left cervical radiculopathy, and that a cervical MRI performed in November 2006 showed a left sided C5-7 disc herniation. (PX8). Dr. Bartucci recommended a right carpal tunnel release, noting that "[t]he left hand is ok for now. It is likely that her symptoms are due to overuse syndrome from her work." (PX8).

Dr. Bartucci performed a right carpal tunnel release at Elmhurst Memorial Hospital on February 28, 2008. Petitioner indicated that the surgery went well, although she did suffer a superficial infection and was prescribed antibiotics as a result.

Petitioner followed up with Dr. Bartucci on March 24, 2008. On that date Dr. Bartucci noted that Petitioner had been involved in a motor vehicle accident on March 20, 2008 and that she as a result she suffered "... a hyperextension injury to her neck and both hands, wrists impacted into the steering column." (PX8). Dr. Bartucci provided Petitioner with a splint and noted that Ms. McKenna was to check with Dr. Koutsky for her neck problems. (PX8).

With respect to this car accident, Petitioner testified that she was rear-ended while she was driving, injuring her hands as a result, and that the incident "really set off [her] left hand." She indicated that she visited Dr. Bartucci right after the accident due to the fact that she was experiencing a lot of pain, presumably in both hands. She also agreed that she had been involved in a previous MVA in 1997 as well as one on July 23, 2007. In addition, Petitioner agreed that she had been involved in a few more car accidents since the one in March of 2008.

In a note dated April 2, 2008 Dr. Bartucci indicated that Petitioner's right wrist was getting better, that her strength was good but that she was still very sore and tender in the region of the scar and the hypothenar eminence, for which he prescribed physical therapy. (PX8). Dr. Bartucci also noted that "[h]er left hand is bothering her. That was injured in a car accident on March 20, 2008." (PX8).

In a note dated April 8, 2008 Dr. Bartucci indicated that Petitioner had undergone an EMG which revealed severe carpal tunnel on the left side. (PX8). Dr. Bartucci went on to state that "[s]he was having some mild symptoms before, but they has [sic] gotten much worse since her motor vehicle accident on March 20 and now

she has a severe carpal tunnel on EMG." (PX8). Dr. Bartucci recommended surgery on the left wrist, but noted that Petitioner was still recovering from the right CTS release. (PX8).

Dr. Bartucci eventually performed a left carpal tunnel release on May 22, 2008. (PX8). Once again Petitioner experienced a superficial infection of the wound following surgery. Petitioner testified that she underwent physical therapy on the left hand thereafter, including massage, light weights and exercise. She also noted that she was taking pain medication for her neck during this time and received three epidural steroid injections in August of 2008.

Petitioner testified that she was off work following the initial surgery on February 28, 2008 and that she received short term disability benefits until her release to return to work by Dr. Bartucci on September 5, 2008. She indicated that she did not return to work for Respondent at that time, having been told that her position had been filled. Petitioner is presently not working.

Dr. Bartucci testified by way of evidence deposition on December 7, 2011. (PX12). Dr. Bartucci was asked to review the previously mentioned video job analysis. (PX12, p.18). Following his review of the video job analysis, Dr. Bartucci opined that if the activity shown was done over a period of time -- namely, a few hours a day for at least several months -- it could result in carpal tunnel syndrome. (PX12, pp.18-19). On cross examination, Dr. Bartucci agreed that as part of his analysis along these lines he did not attempt to ascertain the amount of wrist flexion required to move a dough ball from an upper conveyor to a lower dough tray or the weight of the dough balls involved in the process. (PX12, pp.24-25). In addition, Dr. Bartucci conceded that he had no idea as to the frequency of the repetitive activity in question, the amount of flexion that was required or the amount of force that was needed to perform this activity. (PX12, pp.25-26). Dr. Bartucci was also of the opinion that Petitioner would have needed a carpal tunnel release on the left side even if she had not been involved in a motor vehicle accident in March of 2008 given the positive EMG prior to that date. (PX12, p.21). However, on cross examination, Dr. Bartucci conceded that one of the reasons for the new EMG following the MVA was the involvement of Petitioner's wrist in said car mishap. (PX12, p.29). Finally, Dr. Bartucci noted that he did not place any restrictions on Petitioner at the time of his release in September of 2008, and that he did not restrict Petitioner from returning to her previous position at that time. (PX12, p.29).

At the request of Respondent, board certified orthopedic hand surgeon Dr. David J. Tulipan conducted a record review in this case. Dr. Tulipan testified by way of evidence deposition on June 27, 2012. (RX1). Dr. Tulipan was also able to view the aforementioned video/DVD. (RX1, p.20). Based on this information, Dr. Tulipan noted that "[i]t would seem that this would be a very low force-type job since they're light dough balls (weighing .67 pounds for a small one to 1.19 pounds for a large one) and they don't require any axial pressure on the palm." (RX1, p.21). More to the point, after watching the video, Dr. Tulipan noted that "... there was no vibratory activity, no repetitive wrist flexion/extension, no prolonged positions of wrist flexion or extension, and no axial pressure on the palm." (RX1, p.25). As a consequence, Dr. Tulipan was of the opinion that Petitioner's carpal tunnel syndrome was not related to her work for Respondent; he also did not feel that there was enough repetitive wrist flexion/extension to be a contributory factor in this case. (RX1, pp.24, 27).

Currently, Petitioner noted that she was still using a brace about a month prior to trial and that she still has pain in her wrist. However, she characterized this pain as "rare" and usually brought on by something she does. She also stated that she cannot seem to get help with respect to her neck, and that she is still under active treatment for same.

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 alleges she suffered an injury to her cervical spine as a result of her work as a production team member working on a conveyor line placing dough balls on trays for further processing. Petitioner appears to claim that she later realized how she was holding her head to the left while placing the dough on the trays.

Petitioner visited Dr. Patel on September 12, 2006 (the alleged date of accident in claim 08 WC 3412) at which time he noted that Ms. McKenna presented on that date with complaints of neck discomfort. (PX3). Dr. Patel noted that "[t]he character of the pain is aching, moderate and sharp. The pain began 8 years ago. The pain is better with rest. The pain is located in the subscapular area and to the sides of the neck. Neck pain started after a MVA. Patient indicates ambulation worsens condition. Patient had mva 8 years ago which is when pain started. However, for past one year she has been working in a production job where she places dough balls with both hands. Denies one hand working more than other at work … Associated signs and symptoms include aching and altered sleep pattern. Factors that aggravate neck pain: turning neck to the left and right." (PX3). Dr. Patel's impression was neck sprain, spasm, noting no neurological abnormalities, and recommending conservative care, including physical therapy, as well as Naprosyn, Norco and Flexeril for two weeks. (PX3).

Petitioner testified that when she first saw Dr. Patel her neck was the focus but then her hands became a priority thereafter. In an office note dated September 26, 2006, Dr. Patel recorded that in addition to her neck complaints Petitioner now presented with increased right hand and right arm numbness. (PX3). Dr. Patel recommended continued physical therapy for the neck, which was reportedly improving, as well as an additional three weeks of Naprosyn, Norco and Flexeril. (PX3).

Petitioner was next seen at HealthWorks on October 11, 2006 at which time it was noted that "… she feels about 75% better. She is quite happy with her rate of progress and now states that she is able to sleep without difficulty." (PX2). Petitioner returned for a final visit at HealthWorks on October 18, 2006 at which time it was noted that "… she feels 100% better. No longer any paraesthesia or numbness. She is happy with the improvement and now states that she is able to sleep without any difficulty. She does feel that she would now be able to do her regular work." (PX2). Petitioner denied that she related that she was 100% better at that time, but did acknowledge that the splint helped. Petitioner was released to return to work without restrictions at that time, discharged from the clinic and instructed to continue to wear the splint while sleeping. (PX2).

Petitioner was discharged from ATI Physical Therapy on October 23, 2006 at which time it was noted that "Stacy called and notified office staff week of 10/10 that she was cancelling all remaining visits due to worsening of wrist condition which she is addressing with occupational health MD at her work." (PX3).

Petitioner eventually visited Dr. Rodrigo M. Ubilluz on November 18, 2006 at which time he related that "[t]he patient is a 31 y/o, left handed, known to me more than 10 years ago. She is now having severe numbness in the right hand and also the left hand, or more intensity on the right. She has been using a splint in the right hand. She does have neck pain, but she does not know, if this is related with her hands numbness. Weeks ago for a month she has been having pain in her neck and upper thoracic spine. This has been relieved, but she is still with some soreness. She does a lot of repetitive movements with her hands and arms, in a constant fashion. *No history of injuries in her neck* I saw her in the past because of a MVA. She had at that point an injury to her lip." (Emphasis added). (PX4). Dr. Ubilluz's differential diagnosis at that time was cervical radiculopathy versus spinal stenosis and CTS bilaterally. (PX4).

A cervical MRI performed on November 21, 2006 was interpreted as revealing a herniated disc at C6-C7 on the left as well as mild foraminal stenosis at C5-C6 on the right. (PX4).

In an office note dated March 27, 2007, Dr. Ubilluz indicated that the Fetanyl patches he gave Petitioner, which were supposed to last a month, only lasted two days, and that "[t]his patient clearly shows a drug seeking behavior." (PX4). Dr. Ubilluz noted that Petitioner had been referred to a pain management specialist, Dr. Durrani, to deal with her medication issue. (PX4). When questioned about these Fentanyl patches, Petitioner indicated that she was working in a cooler at the time and was all bundled up, and that the patches were not sticking and were depleting too fast. She also claimed that the reference in the doctor's notes to using a month's worth of patches in two days must have been a "typo" and that the doctor did not want to listen to her.

Petitioner subsequently sought and received treatment at Multispecialty Medical Center (MSMC) from March 29, 2007 through July 17, 2008, including trigger point injections, physical therapy, neck extensions and hand exercises. A report by Dr. Zia Durrani on March 29, 2007 noted that Petitioner "... claims that about 10 years ago she had some motor vehicle accident [and] because of that she started having some problem in the hand and pain in the back off and on. However, in the last six months the pain in her hand has gotten worse..." (PX7).

In a note dated February 8, 2008, Dr. Jordan Trafimow at MSMC recorded that "[t]he patient has had difficulty for approximately 16 months. She was apparently involved in an auto accident. Later on she was working at a job, which required a good deal of motion of her right arm and she thinks that overuse of the arm contributed to her difficulties. *Apparently, she has had two diagnosis [sic] made in the past, one is herniated disc. The only documentation I have seen on this is the MRI report. However, she says that the pain is very largely gone, she has only an occasional difficulty on the left side of her neck.*" (Emphasis added). (PX7). Dr. Trafimow went on to state that "[t]he real problem is on the right side where she has been diagnosed with carpal tunnel syndrome... The patient has still enough pain that she want[s] surgery and I agree that that surgery is a good idea. The patient wanted to be referred to Dr. Bartucci to have the surgery done and I gave her prescription to this effect." (PX7).

Dr. Bartucci thereupon treated Petitioner for her bilateral carpal tunnel syndrome, the subject of claim 08 WC 3411.

The Arbitrator reviewed the video job analysis submitted into evidence as part of Dr. Tulipan's evidence deposition. (RX1, "Petitioner's Ex.#1"). As previously noted, the Arbitrator noted several workers picking up and weighing balls of dough at about chest and/or shoulder level and placing the dough on trays at waist level, an activity that required the frequent and repetitive use of the hands and wrists. However, the Arbitrator noticed no similar frequent and repetitive turning of the head by the workers in the video, given that the dough they were handling was located directly in front of them.

More importantly, other than the claim that she would hold her head to the left while placing the dough, Petitioner provided no testimony as to the specific body mechanics relative to her neck, the frequency or even the duration of such an activity so as to reasonably conclude that her job was the cause of, or even an aggravating factor in her current cervical spine condition. Furthermore, the evidence shows that Petitioner has been involved in multiple motor vehicle accidents over the years, most if not all of which would seem to be a more likely factor in her current condition of ill-being relative to her neck.

Accordingly, the Arbitrator finds that Petitioner failed to prove by the preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment on September 12, 2006. Accordingly, her claim for compensation is hereby denied.

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 on the above, and the Arbitrator's determination as to accident (issue "C", supra), and in light of the dearth of any fully fleshed out medical opinion in support of her claim in this regard, the Arbitrator finds that Petitioner failed to prove by the preponderance of the evidence that her current condition of ill-being with respect to her cervical spine condition is causally related to the alleged accident on September 12, 2006. Accordingly, her claim for compensation is hereby denied.

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

In light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner failed to prove her entitlement to any permanent disability award. Accordingly, her claim for same is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF DuPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

14IWCC0137

Stacy McKenna,
Petitioner,
vs.

NO: 08WC03411

Domino's Pizza Distributors,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal conncection, temporary total disability, permanent partial disability, and 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 March 1, 2013 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: FEB 26 2014

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

MJB:bjg
0-2/11/2014
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0137

McKENNA, STACY
Employee/Petitioner

Case# 08WC003411

08WC003412

DOMINO'S PIZZA DISTRIBUTION
Employer/Respondent

On 3/1/2013, 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 0.13% 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:

1471 KARNO, MARK L & ASSOC
GINA KOSCAL
33 N LASALLE ST SUITE 2600
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
DOUGLAS S STEFFENSON
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

14IWCC0137

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

Stacy McKenna,
Employee/Petitioner

v.

Domino's Pizza Distribution,
Employer/Respondent

Case # **08** WC **3411**

Consolidated cases: **08 WC 3412**

An *Application for Adjustment 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 **Wheaton**, on **11/14/12**. After reviewing all 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 **9/6/06**, 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*** 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 relative to her right hand/wrist ***is*** causally related to the accident, but that her current condition of ill-being relative to her left hand/wrist ***is not*** causally related to said accident.

In the year preceding the injury, Petitioner earned **$24,950.64**; the average weekly wage was **$479.82**.

On the date of accident, Petitioner was **31** 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 **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$8,138.91** in non-occupational indemnity disability benefits, for a total credit of **$8,138.91**. (Arb.Ex.#1).

Respondent is entitled to a credit of **$513.35** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $319.88 per week for 12 weeks, commencing 2/28/08 through 5/21/08, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 9/7/06 through 11/14/12, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, for those expenses incurred up through May 21, 2008, as provided in Sections 8(a) and 8.2 of the Act. (Arb.Ex.#3).

Respondent shall be given a credit of $513.35 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. (Arb.Ex.#1).

Respondent shall pay Petitioner permanent partial disability benefits of $287.89 week for 30.75 weeks, because the injuries sustained caused the 15% loss of use of the right hand, as provided in Section 8(e)9 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.

Peter M Finley

Signature of Arbitrator

2/28/13

Date

ICArbDec p 2

STATEMENT OF FACTS:

Petitioner, a 31 year old production team worker, testified that her job involved removing balls of dough from an assembly line and placing them onto trays. A video job analysis for the position in question was submitted into evidence as part of Dr. Tulipan's evidence deposition. (RX1, "Petitioner's Ex.#1"). The Arbitrator has viewed this video (actually a DVD), which depicts several workers picking up and weighing balls of dough at about chest and/or shoulder level and placing the dough on trays at waist level. The Arbitrator notes that the conveyor belts on which the dough is first removed and then placed are moving at a fairly rapid pace. Petitioner testified that she had seen the video in question and that it was filmed at a facility in Missouri, given that the site Petitioner worked at had been shut down. Petitioner claimed that the line she worked on ran twice as fast as the one shown in the video and that the workers in the video were not pressing down on the dough as hard as she had to in order to make sure the dough stuck to the tray. Petitioner testified that she worked 4 days a week, 10 hours a day and she was supposed to be rotated every 2 hours and allowed 15 minute breaks between shifts. However, she noted that she could work up to 17 hours if there was a breakdown. She testified that there were other jobs in the rotation, but she was mainly kept on the production line because she was good at it. Other duties included moving and stacking dirty trays, and replacing the dirty trays with clean trays.

Petitioner noted that she began working for Respondent on August 22, 2005, and that prior to working for Respondent she managed a Quick Lube store for five years. Petitioner testified that she started noticing pain, numbness and tingling in her hands, as well as neck pain, during the year leading up to the date of the alleged injury.

Petitioner testified that by September 6, 2006 (the alleged date of accident in claim 08 WC 3411) she was experiencing major burning, numbness and tingling in her hands. Petitioner visited Dr. Kalpesh Patel on September 12, 2006 (the alleged date of accident in claim 08 WC 3412) at which time he noted that Ms. McKenna presented on that date with complaints of neck discomfort. (PX3). Dr. Patel noted that "[t]he character of the pain is aching, moderate and sharp. The pain began 8 years ago. The pain is better with rest. The pain is located in the subscapular area and to the sides of the neck. Neck pain started after a MVA. Patient indicates ambulation worsens condition. Patient had mva 8 years ago which is when pain started. However, for past one year she has been working in a production job where she places dough balls with both hands. Denies one hand working more than other at work … Associated signs and symptoms include aching and altered sleep pattern. Factors that aggravate neck pain: turning neck to the left and right." (PX3). Dr. Patel's impression was neck sprain, spasm, noting no neurological abnormalities, and recommending conservative care, including physical therapy, as well as Naprosyn, Norco and Flexeril for two weeks. (PX3).

Petitioner testified that when she first saw Dr. Patel her neck was the focus but then her hands became a priority thereafter. In an office note dated September 26, 2006, Dr. Patel recorded that in addition to her neck complaints Petitioner now presented with increased right hand and right arm numbness. (PX3). Dr. Patel recommended continued physical therapy for the neck, which was reportedly improving, as well as an additional three weeks of Naprosyn, Norco and Flexeril. (PX3). Dr. Patel also instructed Petitioner to use wrist splints at night. (PX3).

Petitioner testified that she subsequently went to HealthWorks on October 5, 2006 where she was seen by Dr. James T. John. (PX2). She indicated that she described her symptoms at that time, noting that her problems were more severe in her right hand. Dr. John's office note on that date related complaints of increasing numbness in the right hand over the past week, primarily in the third and fourth fingers, and that the symptoms were worse at night, often keeping her from sleeping. (PX2). Dr. John's assessment was right wrist strain and paraesthesia of the right hand. (PX2). He prescribed a cock-up type wrist splint to be worn at work and while

sleeping as well as Naproxen tablets. (PX2). Dr. John also indicated that Petitioner could return to work using the splint but that she was to avoid repetitive activities of the right wrist as well as heavy gripping with the right hand. (PX2).

Petitioner was next seen at HealthWorks on October 11, 2006 at which time it was noted that "... she feels about 75% better. She is quite happy with her rate of progress and now states that she is able to sleep without difficulty." (PX2). Petitioner returned for a final visit at HealthWorks on October 18, 2006 at which time it was noted that "... she feels 100% better. No longer any paraesthesia or numbness. She is happy with the improvement and now states that she is able to sleep without any difficulty. She does feel that she would now be able to do her regular work." (PX2). Petitioner denied that she related that she was 100% better at that time, but did acknowledge that the splint helped. Petitioner was released to return to work without restrictions at that time, discharged from the clinic and instructed to continue to wear the splint while sleeping. (PX2).

Petitioner was discharged from ATI Physical Therapy on October 23, 2006 at which time it was noted that "Stacy called and notified office staff week of 10/10 that she was cancelling all remaining visits due to worsening of wrist condition which she is addressing with occupational health MD at her work." (PX3).

Petitioner eventually visited Dr. Rodrigo M. Ubilluz on November 18, 2006 at which time he related that "[t]he patient is a 31 y/o, left handed, known to me more than 10 years ago. She is now having severe numbness in the right hand and also the left hand, or more intensity on the right. She has been using a splint in the right hand. She does have neck pain, but she does not know, if this is related with her hands numbness. Weeks ago for a month she has been having pain in her neck and upper thoracic spine. This has been relieved, but she is still with some soreness. She does a lot of repetitive movements with her hands and arms, in a constant fashion. No history of injuries in her neck. I saw her in the past because of a MVA. She had at that point an injury to her lip." (PX4). Dr. Ubilluz's differential diagnosis at that time was cervical radiculopathy versus spinal stenosis and CTS bilaterally. (PX4).

Petitioner subsequently underwent an EMG on November 28, 2006 which revealed evidence of bilateral carpal tunnel syndrome. (PX5). An earlier MRI of the cervical spine, performed on November 21, 2006, was interpreted as revealing a herniated disc at C6-C7 on the left as well as mild foraminal stenosis at C5-C6 on the right. (PX4). Petitioner was thereupon referred to Dr. Suresh Velacapudi at Castle Orthopaedics.

Petitioner visited Dr. Velacapudi on January 17, 2007 complaining of pain and tingling in both hands. (PX5). Dr. Velacapudi noted evidence of a C6-7 disc herniation as well as cervical radiculopathy. Dr. Velacapudi performed an injection to Petitioner's right wrist on January 19, 2007, in addition to a nerve block on March 27, 2007, with no relief. (PX5).

In an office note dated March 27, 2007, Dr. Ubilluz indicated that the Fetanyl patches he gave Petitioner, which were supposed to last a month, only lasted two days, and that "[t]his patient clearly shows a drug seeking behavior." (PX4). Dr. Ubilluz noted that Petitioner had been referred to a pain management specialist, Dr. Durrani, to deal with her medication issue. (PX4). When questioned about these Fentanyl patches, Petitioner indicated that she was working in a cooler at the time and was all bundled up, and that the patches were not sticking and were depleting too fast. She also claimed that the reference in the doctor's notes to using a month's worth of patches in two days must have been a "typo" and that the doctor did not want to listen to her.

Petitioner subsequently sought and received treatment at Multispecialty Medical Center (MSMC) from March 29, 2007 through July 17, 2008, including trigger point injections, physical therapy, neck extensions and hand exercises. A report by Dr. Zia Durrani on March 29, 2007 noted that Petitioner "... claims that about 10 years

ago she had some motor vehicle accident [and] because of that she started having some problem in the hand and pain in the back off and on. However, in the last six months the pain in her hand has gotten worse..." (PX7).

In a note dated February 8, 2008, Dr. Jordan Trafimow at MSMC recorded that "[t]he patient has had difficulty for approximately 16 months. She was apparently involved in an auto accident. Later on she was working at a job, which required a good deal of motion of her right arm and she thinks that overuse of the arm contributed to her difficulties. Apparently, she has had two diagnosis [sic] made in the past, one is herniated disc. The only documentation I have seen on this is the MRI report. However, she says that the pain is very largely gone, she has only an occasional difficulty on the left side of her neck." (PX7). Dr. Trafimow went on to state that "[t]he real problem is on the right side where she has been diagnosed with carpal tunnel syndrome... The patient has still enough pain that she want[s] surgery and I agree that that surgery is a good idea. The patient wanted to be referred to Dr. Bartucci to have the surgery done and I gave her prescription to this effect." (PX7).

Petitioner eventually sought treatment with Dr. Eugene J. Bartucci at Elmhurst Orthopaedics on February 19, 2008. At that time, she noted that she was experiencing burning, tingling and numbness in her arms. Dr. Bartucci recorded that Petitioner "... has had trouble with her hand since 2006. Right hand worse than her left hand. The left hand is getting better. She has worked in the same job since then and has had restrictions for the last year which have helped her cope with the problem. The bracing for 7 months has also helped. She is on medication." (PX8). Dr. Bartucci noted that the previous EMG in November of 2006 revealed bilateral carpel tunnel syndrome as well as left cervical radiculopathy, and that a cervical MRI performed in November 2006 showed a left sided C5-7 disc herniation. (PX8). Dr. Bartucci recommended a right carpal tunnel release, noting that "[t]he left hand is ok for now. It is likely that her symptoms are due to overuse syndrome from her work." (PX8).

Dr. Bartucci performed a right carpal tunnel release at Elmhurst Memorial Hospital on February 28, 2008. Petitioner indicated that the surgery went well, although she did suffer a superficial infection and was prescribed antibiotics as a result.

Petitioner followed up with Dr. Bartucci on March 24, 2008. On that date Dr. Bartucci noted that Petitioner had been involved in a motor vehicle accident on March 20, 2008 and that she as a result she suffered "... a *hyperextension injury to her neck and both hands, wrists impacted into the steering column*." (Emphasis added) (PX8). Dr. Bartucci provided Petitioner with a splint and noted that Ms. McKenna was to check with Dr. Koutsky for her neck problems. (PX8).

With respect to this car accident, Petitioner testified that she was rear-ended while she was driving, injuring her hands as a result, and that the incident "really set off [her] left hand." She indicated that she visited Dr. Bartucci right after the accident due to the fact that she was experiencing a lot of pain, presumably in both hands. She also agreed that she had been involved in a previous MVA in 1997 as well as one on July 23, 2007. In addition, Petitioner agreed that she had been involved in a few more car accidents since the one in March of 2008.

In a note dated April 2, 2008 Dr. Bartucci indicated that Petitioner's right wrist was getting better, that her strength was good but that she was still very sore and tender in the region of the scar and the hypothenar eminence, for which he prescribed physical therapy. (PX8). Dr. Bartucci also noted that "*[h]er left hand is bothering her. That was injured in a car accident on March 20, 2008.*" (Emphasis added) (PX8).

In a note dated April 8, 2008 Dr. Bartucci indicated that Petitioner had undergone an EMG which revealed severe carpal tunnel on the left side. (PX8). Dr. Bartucci went on to state that *"[s]he was having some mild symptoms before, but they has [sic] gotten much worse since her motor vehicle accident on March 20 and now*

she has a severe carpal tunnel on EMG." (PX8). (Emphasis added). Dr. Bartucci recommended surgery on the left wrist, but noted that Petitioner was still recovering from the right CTS release. (PX8).

Dr. Bartucci eventually performed a left carpal tunnel release on May 22, 2008. (PX8). Once again Petitioner experienced a superficial infection of the wound following surgery. Petitioner testified that she underwent physical therapy on the left hand thereafter, including massage, light weights and exercise. She also noted that she was taking pain medication for her neck during this time and received three epidural steroid injections in August of 2008.

Petitioner testified that she was off work following the initial surgery on February 28, 2008 and that she received short term disability benefits until her release to return to work by Dr. Bartucci on September 5, 2008. She indicated that she did not return to work for Respondent at that time, having been told that her position had been filled. Petitioner is presently not working.

Dr. Bartucci testified by way of evidence deposition on December 7, 2011. (PX12). Dr. Bartucci was asked to review the previously mentioned video job analysis. (PX12, p.18). Following his review of the video job analysis, Dr. Bartucci opined that if the activity shown was done over a period of time -- namely, a few hours a day for at least several months -- it could result in carpal tunnel syndrome. (PX12, pp.18-19). On cross examination, Dr. Bartucci agreed that as part of his analysis along these lines he did not attempt to ascertain the amount of wrist flexion required to move a dough ball from an upper conveyor to a lower dough tray or the weight of the dough balls involved in the process. (PX12, pp.24-25). In addition, Dr. Bartucci conceded that he had no idea as to the frequency of the repetitive activity in question, the amount of flexion that was required or the amount of force that was needed to perform this activity. (PX12, pp.25-26). Dr. Bartucci was also of the opinion that Petitioner would have needed a carpal tunnel release on the left side even if she had not been involved in a motor vehicle accident in March of 2008 given the positive EMG prior to that date. (PX12, p.21). However, on cross examination, Dr. Bartucci conceded that one of the reasons for the new EMG following the MVA was the involvement of Petitioner's wrist in said car mishap. (PX12, p.29). Finally, Dr. Bartucci noted that he did not place any restrictions on Petitioner at the time of his release in September of 2008, and that he did not restrict Petitioner from returning to her previous position at that time. (PX12, p.29).

At the request of Respondent, board certified orthopedic hand surgeon Dr. David J. Tulipan conducted a record review in this case. Dr. Tulipan testified by way of evidence deposition on June 27, 2012. (RX1). Dr. Tulipan was also able to view the aforementioned video/DVD. (RX1, p.20). Based on this information, Dr. Tulipan noted that "[i]t would seem that this would be a very low force-type job since they're light dough balls (weighing .67 pounds for a small one to 1.19 pounds for a large one) and they don't require any axial pressure on the palm." (RX1, p.21). More to the point, after watching the video, Dr. Tulipan noted that "... there was no vibratory activity, no repetitive wrist flexion/extension, no prolonged positions of wrist flexion or extension, and no axial pressure on the palm." (RX1, p.25). As a consequence, Dr. Tulipan was of the opinion that Petitioner's carpal tunnel syndrome was not related to her work for Respondent; he also did not feel that there was enough repetitive wrist flexion/extension to be a contributory factor in this case. (RX1, pp.24, 27).

Currently, Petitioner noted that she was still using a brace about a month prior to trial and that she still has pain in her wrist. However, she characterized this pain as "rare" and usually brought on by something she does. She also stated that she cannot seem to get help with respect to her neck, and that she is still under active treatment for same.

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 she began working for Respondent as a production team member on August 22, 2005, and that her duties included placing dough balls onto trays from a moving conveyor belt. She noted that during the year leading up to the alleged accident she started noticing pain, numbness and tingling in her hands, as well as neck pain. Prior to working for Respondent, Petitioner managed a Quick Lube store for five years. She noted that this was not a production line job, and that she did the training, payroll, hiring/firing and scheduling for the store.

Petitioner testified that she worked 4 days a week, 10 hours a day and she was supposed to be rotated every 2 hours and allowed 15 minute breaks between shifts. However, she noted that she could work up to 17 hours if there was a breakdown. She testified that there were other jobs in the rotation, but she was mainly kept on the production line because she was good at it. Other duties included moving and stacking dirty trays, and replacing the dirty trays with clean trays.

The Arbitrator reviewed the video/DVD which depicts several workers picking up and weighing balls of dough at about chest and/or shoulder level and placing the dough on trays at waist level. (RX1, "Petitioner Ex.#1"). The Arbitrator notes that the conveyor belts on which the dough is first removed and then placed are moving at a fairly rapid pace. Petitioner testified that she had seen the video in question and that it was filmed at a facility in Missouri, given that the site Petitioner worked at had been shut down. Petitioner claimed that the line she worked on ran twice as fast as the one shown in the video and that the workers in the video were not pressing down on the dough as hard as she had to in order to make sure the dough stuck to the tray.

Petitioner testified that by September 6, 2006 she was experiencing major burning, numbness and tingling in her hands. This is the alleged date of accident in the present claim (08 WC 3411).

Petitioner testified that when she first saw Dr. Patel on September 12, 2006 the focus was in regard to her neck, but that her hands then became a priority. Along these lines, Dr. Patel's office note dated September 26, 2006 recorded that in addition to her neck complaints Petitioner now presented with increased right hand and right arm numbness. (PX3).

The medical records show that Petitioner has a history of motor vehicle accidents. Indeed, it appears that Petitioner had previously treated for neck and hand complaints following a MVA eight (8) years earlier. However, there is no indication that Petitioner was actively treating for same during the period leading up to the accident, or that she had been diagnosed with bilateral carpal tunnel at any time prior to her employment with Respondent.

Therefore, based on the above, and the record taken as a whole, including the highly repetitive activity depicted in the job analysis video, the Arbitrator finds that Petitioner sustained accidental repetitive trauma type injuries to her right and left hands/wrists arising out of and in the course of her employment, and that this injury manifested itself as of September 6, 2006.

The question then becomes whether Petitioner's her current condition of ill-being with respect to her right and left hands/wrists are causally related to the accident in question.

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

Treating surgeon Dr. Bartucci, after reviewing the video job analysis, opined that if the activity shown was done over a period of time -- namely, a few hours a day for at least several months -- it could result in carpal tunnel syndrome, although he did concede that he did not know the amount of wrist flexion required to move a dough ball from an upper conveyor to a lower dough tray or determine the weight of the dough balls involved in the process. (PX12, pp.18-19,24-25).

Respondent's record review, Dr. Tulipan, also having reviewed the video job analysis, noted that "[i]t would seem that this would be a very low force-type job since they're light dough balls (weighing .67 pounds for a small one to 1.19 pounds for a large one) and they don't require any axial pressure on the palm." (RX1, p.21). More to the point, after watching the video, Dr. Tulipan noted that "... there was no vibratory activity, no repetitive wrist flexion/extension, no prolonged positions of wrist flexion or extension, and no axial pressure on the palm." (RX1, p.25). As a consequence, Dr. Tulipan was of the opinion that Petitioner's carpal tunnel syndrome was not related to her work for Respondent; he also did not feel that there was enough repetitive wrist flexion/extension to be a contributory factor in this case. (RX1, pp.24, 27).

Up to this point, the Arbitrator finds Dr. Bartucci's opinion to be more persuasive – namely, that Petitioner's job, as shown in the video, was sufficiently repetitive in nature so as to find that Petitioner's bilateral carpal tunnel condition was causally related to her employment. Then, after having undergone a right carpal tunnel release, and while still receiving physical therapy for the right hand, Petitioner was involved in yet another of her multiple motor vehicle accidents, this one on March 20, 2008. It is at this point that Petitioner's condition of ill-being with respect to her left wrist appears to become more severe.

While the EMG performed on EMG on November 28, 2006 (PX5) did indeed reveal evidence of bilateral carpal tunnel syndrome, the medical records reveal that the far more serious complaints were with respect to the right hand/wrist. Indeed, in a note dated April 8, 2008 Dr. Bartucci stated that Petitioner "... *was having some mild symptoms before (the most recent MVA), but they has [sic] gotten much worse since her motor vehicle accident on March 20 and now she has a severe carpal tunnel on EMG.*" (PX8). (Emphasis added). With respect to the motor vehicle accident itself, Dr. Bartucci recorded, in an office note dated four days after the MVA, that Petitioner had suffered "... a *hyperextension injury to her neck and both hands, wrists impacted into the steering column*." (Emphasis added) (PX8). In addition, in a note dated April 2, 2008, Dr. Bartucci indicated that Petitioner's right wrist was getting better and that "*[h]er left hand is bothering her. That was injured in a car accident on March 20, 2008.*" (Emphasis added) (PX8). Petitioner herself even conceded the fact that the March 2008 car incident "really set off [her] left hand" and that she visited Dr. Bartucci right after the accident due to the fact that she was experiencing a lot of pain, presumably in both hands.

This suggests, at least with respect to her left hand/wrist, that the motor vehicle accident on March 20, 2008 represented more than a temporary aggravation, as with the right hand/wrist, and as such amounted to an intervening event which effectively broke the chain of causation.

And while Dr. Bartucci did offer up the opinion that Petitioner would have needed a carpal tunnel release on the left side even if she had not been involved in a motor vehicle accident in March of 2008, given the positive EMG prior to that date (PX12, p.21), the fact remains that no such surgery had been recommended up until that point and that Dr. Bartucci himself had described Ms. McKenna's symptoms before the MVA as "mild."

Accordingly, the Arbitrator finds that Petitioner failed to prove that her condition of ill-being with respect to her left hand/wrist subsequent to the motor vehicle accident on March 20, 2008 was causally related to the accident on September 6, 2006. However, the Arbitrator finds that the MVA in question resulted in a temporary aggravation of her right carpal tunnel syndrome condition, given that Petitioner was undergoing active medical treatment on the right side at the time, in the form of physical therapy following surgery, and in light of the fact that there is no evidence to suggest her condition significantly worsened following the MVA in question.

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:

As noted above, the Arbitrator determined that Petitioner's current condition of ill-being with respect to her right hand/wrist remains causally related to the work related accident on September, but that Petitioner suffered an intervening accident on March 20, 2008 that broke the chain of causation with respect to her left hand/wrist.

Following the MVA, Dr. Bartucci, in a note dated April 8, 2008, indicated that Petitioner had undergone an EMG which revealed severe carpal tunnel on the left side. (PX8). At that time, Dr. Bartucci recommended surgery on the left wrist, but noted that Petitioner was still recovering from the right CTS release. (PX8). Thus, it would appear that Dr. Bartucci held off on the proposed left carpal tunnel release until such time as Petitioner had finished treatment relative to her right hand/wrist.

Dr. Bartucci eventually performed a left carpal tunnel release on May 22, 2008. (PX8). The Arbitrator finds this to be the date that Petitioner's treatment with respect to her left hand/wrist ceased being causally related to her employment.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses up through May 21, 2008 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act. Respondent shall be entitled to a credit for any and all amounts paid on account of this injury.

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, including the Arbitrator's determination as to causation (see issues "F" and "J", supra), the Arbitrator finds that Petitioner was temporarily totally disabled as a result of the bilateral carpal tunnel syndrome from February 28, 2008, the date of the right CTS surgery, through May 21, 2008, or the day before the left CTS surgery, for a period of 12 weeks (including the extra leap year day).

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

Currently, Petitioner noted that she was still using a brace about a month prior to trial and that she still has pain in her wrist. However, she characterized this pain as "rare" and usually brought on by something she does. Dr. Bartucci, for his part, noted that he did not place any restrictions on Petitioner at the time of his release in September of 2008, and that he did not restrict Petitioner from returning to her previous position at that time. (PX12, p.29).

Based on the above, and the record taken as a whole, the Arbitrator finds that as a result of the accident on September 6, 2006 Petitioner sustained permanent partial disability to the extent of 15% of the right hand pursuant to §8(e)9 of the Act. However, in light of the Arbitrator determination to the effect that Petitioner current condition of ill-being with respect to her left hand/wrist is not causally related to the accident in question, Petitioner's claim for permanency for same 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

Casey R. Czajka,

Petitioner,

14IWCC0138

vs. NO: 12 WC 33393

CBS Messenger Service, Inc.,
d/b/a Custom Brokers Supply, 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, temporary total disability and prospective medical care, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 22, 2014 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 $8,800.00. 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: FEB 26 2014

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

MJB:bjg
0-2/11/2014
52

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

14IWCC0138

CZAJKA, CASEY R
Employee/Petitioner

Case# **12WC033393**

CBS MESSENGER SERVICE
Employer/Respondent

On 4/22/2013, 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 0.09% 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:

4988 LAW OFFICES OF DAVID W CLARK
511 W WESLEY ST
WHEATON, IL 60187

4234 RIPES NELSON BAGGOT KALOBRATSO
PERRY GENTILE
2353 HASSELL RD SUITE 115
HOFFMAN ESTATES, IL 60169

14IWCC0138

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)

CASEY R. CZAJKA
Employee/Petitioner

v.

CBS MESSENGER SERVICE
Employer/Respondent

Case # **12** WC **33393**

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 **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **February 19, 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. X Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. X Is Petitioner entitled to any prospective medical care?
L. X What temporary benefits are in dispute?
☐ TPD ☐ Maintenance X TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other:_____

FINDINGS

On the date of accident, **02-08-2012**, 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 **$28,600.00**; the average weekly wage was **$550.00**.

On the date of accident, Petitioner was **35** years of age, *single* with **0** dependent children.

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

Respondent shall be given a credit of **$6,966.73** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$6,966.73**.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $366.30/week for 42-4/7 weeks, commencing 4-27-2012 through 2-19-2013, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $6,966.73 for temporary total disability benefits that have been paid.

Medical benefits

Respondent shall pay reasonable and necessary medical services of $111.33 to Elmhurst Orthopaedics for the August 2012 visit to Dr. Koutsky, in accordance with Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay for the reasonable, related and necessary prospective medical care from Elmhurst Orthopaedics that includes visits to Dr. Koutsky, medication and physical therapy as provided in Section 8(a) of the Act. Such payments shall be subject to Section 8.2 of the Act.

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

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

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

Signature of Arbitrator — Date: 4/21/13

ICArbDec19(b)

APR 22 2013

STATE OF ILLINOIS)
)SS
COUNTY OF COOK)

ILLINOIS WORKER'S COMPENSATION COMMISSION

CASEY R. CZAJKA	)	
Employee/Petitioner	)	
v.	)	**12 WC 33393**
CBS MESSENGER SERVICE	)	
Employer/Respondent	)	

ARBITRATION DECISION 19 (b) ADDENDUM

FINDINGS OF FACT

On February 8, 2012, petitioner was employed by respondent CBS Messenger Service in the maintenance department. He had been employed by respondent for 15 years originally hired as a delivery driver. In the months before the accident, petitioner had been working indoors dividing his time between maintaining respondent's fleet of cars (15-20 cars) and office work. Petitioner testified that between 1-2 hours a day was spent in the maintenance of respondent's vehicles and the remaining 6-7 hours per day was spent in the office.

On February 8, 2012, petitioner started his shift around 5:30 am. At approximately 6 am, petitioner was changing a tire on one of the respondent's vehicles when he noticed that something "popped" in his low back. Petitioner reported the accident to his supervisor and worked the rest of the day in pain. When the pain did not improve, he was sent by his supervisor to the Alexian Brothers occupational site where X-rays were taken and a light-duty return to work was given. The doctor at Alexian Brothers prescribed pain medication and also instructed petitioner to consult an orthopaedic doctor.

Petitioner returned to light-duty work with respondent on February 10, 2012, but when his low back pain did not improve, he went to see Dr. Kevin Koutsky at Elmhurst Orthopaedics. At his first visit was on February 29, 2012, petitioner reported the mechanism of his work injury and told the doctor that he felt a sharp pain radiating into his buttocks and thighs. PX 1. Dr. Koutsky reviewed the X-rays and noted that petitioner's 2006 spinal fusion at L4/5 and L5/S1 looked solid and further noted lower back pain and bilateral buttock and thigh pain from the 2-8-2012 work accident. Physical therapy pain medications, and an MRI were prescribed. PX1. Light-duty work restrictions were continued.

On March 14, 2012, MR images of petitioner's lumbar spine were taken. The following impression was offered:

1. Post surgical changes at the L4-5 and L5-S1 level as described above.
2. Mild diffuse disc bulging at the L3-4 level with bilateral foraminal narrowing as described above.
3. No disc protrusions or herniations seen. PX1.

On the March 28th visit with Dr. Koutsky, petitioner's medications were refilled and physical therapy was continued. An electrical stimulation unit was ordered and a discussion about epidural injections also took place. PX.1.

On the April 26, 2012 visit. Dr. Koutsky noted that petitioner had been attending physical therapy with limited improvement of his symptoms and that his PT had ended a week prior to the visit. Petitioner's medications were refilled and he was to do his home exercises while using his electrical stimulation unit which did provide some improvement to his symptoms. PX 1.Petitioner was again limited to light duty at work and continued to work until the next day (April 27th) when respondent sold its interest to another company. Petitioner was then informed that his light-duty restrictions could not be accommodated and he was started on TTD as of that date. PX1

Petitioner's next visit for his back was June 29th (petitioner had broken his ankle at his house in the interim and was still presenting to the clinic for this non-work injury from May-June). On this 6-29-12 visit, Dr. Koutsky noted that the one epidural injection received by the petitioner did provide some limited but temporary relief. Dr. Koutsky continued his recommendation for home exercises and pain medications. He also continued the light-duty release. PX1

The last approved visit with Dr. Koutsky occurred on August 10, 2012 at which time Dr. Koutsky noted that petitioner was "still having a fair amount of pain in the back and leg". Dr. Koutsky discussed surgery as well as conservative treatment. Petitioner elected to pursue conservative measures that included more physical therapy, but declined another epidural injection as the first one provided limited relief. Medications were again refilled and petitioner was released to a light-duty capacity. PX 1. A follow-up visit with Dr. Koutsky was scheduled for mid-September but petitioner was never allowed to attend this visit as respondent cut petitioner off from all medical and TTD benefits based on the report from respondent's Section 12 examining physician, Dr. Julie Wehner. RX1.

Petitioner testified that he waited two hours for Dr. Wehner's five-minute physical examination.

Petitioner testified he did not have health insurance so he could not see Dr. Koutsky after his worker's compensation benefits were terminated because he could not afford the visit. Petitioner further testified that he did not look for light-duty work as he did not want to start a job with light-duty restrictions only to take time off for more medical treatments. Lastly, Petitioner testified that he would like to follow up with Dr. Koutsky and also undergo physical therapy if the arbitrator approves such medical care.

CONCLUSIONS OF LAW

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

Petitioner testified that he was in good health until February 8, 2012. He had two prior back surgeries but six years had passed with no treatment for his back until the work accident. The Petitioner testified he was changing a tire as part of his regular job duties when he experienced a "pop" in his back. Such pop was followed by a stabbing, harsh pain in his back. This version of the accident was not disputed by respondent.

On March 19, 2012, petitioner was seen by Dr. Koutsky to review the MRI results. Dr. Koutsky opined: "The impression reads postsurgical changes at L4-5 and L5-S1, mild diffuse disc bulge at L3-4. No protrusions or herniations are noted. No abnormal enhancement." PX1.

The Arbitrator notes that the FINDINGS section of such MRI report reads: "Routine MRI of the lumbar spine was performed with and without intravenous contrast enhancement. Sagittal and axial images were obtained in various sequences." PX1.

Petitioner testified that his complaints of back pain in February 2013 are the same as those he had in August 2012.

Per the findings above, petitioner has offered the medical records of Dr. Kevin Koutsky wherein he finds: that petitioner suffered a low back injury at work on February 8, 2012; that petitioner's complaints are still present seven months post-accident; that petitioner should be at light-duty work restriction; and that petitioner needs further medical care and treatment. PX 1.

Dr. Koutsky's most recent diagnosis is "Lumbar spondylosis and stenosis, status post fusion." Please see the August 10, 2012 Progress Note in PX1.

Respondent submitted a Section 12 report by Dr. Julie Wehner that causally links petitioner's work injury to his low back complaints. "Therefore, the diagnosis of Mr. Czajka would be low back pain. The mechanism of injury would indicate a lumbar strain . . . the lumbar strain is causally related to the date of the February 8, 2012." See RX 1. Respondent did not offer any medical evidence that petitioner's current condition is due to a pre-existing medical condition nor did respondent offer any medical evidence of treatment for the low back in the five years prior to the accident.

Lastly, while Dr. Wehner opines that petitioner can return to work with "some prior work restrictions", she has failed to mention what, if any restrictions, petitioner had. Respondent has not offered any medical evidence of prior restrictions. The treating medical records in evidence are the records from Elmhurst Orthopaedics. Such records contain no mention of work restrictions before the February 2012 accident. Petitioner's testimony was that he had back surgery in 2000 and at another time, but that before February 8, 2012, his back was "fine." Petitioner's unrebutted testimony was that Dr. Julie Wehner's Section 12 exam lasted only five minutes.

In weighing the testimony and the evidence, the Arbitrator finds the medical opinions of petitioner's treating orthopaedic physician, Dr. Kevin Koutsky, to be more persuasive than those of respondent's examining orthopaedic physician, Dr. Julie Wehner. Please see International Vermiculite v. Indus. Comm'n, 77 Ill.2d 1, 394 N.E.2d 1166 (1979).

Based upon the foregoing, the Arbitrator finds that petitioner injured his back in an accident that arose out of and in the course of his employment with respondent on February 8, 2012 and that petitioner's current condition of ill-being of his back is causally related to such work accident.

J. Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Petitioner introduced Exhibit #2 which was a charge for the August 2012 visit with Dr. Koutsky with an outstanding amount of $111.33. PX 2. As this visit was before Respondent's September 2012 denial of benefits, the Arbitrator finds this bill is reasonable and necessary and should be paid by Respondent, in accordance with Section 8(a) and subject to Section 8.2 of the Act.

K. Is Petitioner entitled to any prospective medical care?

The Arbitrator has found Dr. Koutsky's opinions to be more persuasive than those of Dr. Wehner. Dr. Koutsky has recommended that petitioner receive further medical care. Please see the August 10, 2012 Progress Note. PX 1.

Dr. Wehner opined: "The radiologic findings show his preexisting surgical sites with no change. His neurologic examination is normal. He has had an adequate course of physical therapy and should be transitioned to a home exercise program."

Respondent has not conducted a utilization review, pursuant to the Act, as amended.

Therefore, the Arbitrator awards the reasonable, necessary and related prospective medical care that includes follow-up visits with Dr. Kevin Koutsky, additional physical therapy and medication.

L. What TTD benefits are in dispute?

Once respondent could not accommodate light-duty restrictions, they paid TTD benefits. The parties have stipulated that petitioner was temporarily totally disabled from April 27, 2012 through September 6, 2012 and that respondent paid $6,966.73 in TTD benefits.

Respondent's Section 12 report indicated that petitioner should return to work with restrictions although Dr. Wehner did not elaborate on what the restrictions were and seems to state - without reference to any medical records - that the work restrictions pre-dated the February 8, 2012 work accident.

Dr. Koutsky stated that the light-duty work restrictions should continue and respondent has not presented any evidence that light-duty work is available to petitioner. Petitioner testified that his condition of ill-being did not improve after the August 10, 2012 visit and continues through the date of the hearing on February 19, 2013.

The Arbitrator finds for petitioner on the issue of outstanding TTD.

Respondent shall pay Petitioner temporary total disability benefits of $366.30 a week for 42-4/7 weeks, which representing the time period from 4-27-2012 through 02-19-2013, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $6,966.73 for temporary total disability benefits that have been paid.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Leon Smith, Jr.,
Petitioner,
vs.

NO: 12WC 15569

14IWCC0139

Perry Broughton Trucking & Excavating,
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, benefit/wage rate, 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 March 8, 2013, 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: FEB 2 7 2014

Charles J. DeVriendt

Stephen Mathis

Ruth W. White

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CJD/jrc
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SMITH, LEON JR
Employee/Petitioner

Case# **12WC015569**

14IWCC0139

PETTY BROUGHTON TRUCKING & EXCAVATING
Employer/Respondent

On 3/8/2013, 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 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0149 WARREN E DANZ PC
710 NE JEFFERSON
PEORIA, IL 61603

0332 LIVINGSTONE MUELLER ET AL
KEN BIMA
620 E EDWARDS ST POB 335
SPRINGFIELD, IL 62705

14IWCC0139

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

Leon Smith, Jr.
Employee/Petitioner

v.

Perry Broughton Trucking & Excavating
Employer/Respondent

Case # 12 WC 15569

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **2/5/2013**. 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

On **4/12/2012**, 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.

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

On the date of accident, Petitioner was **25** years of age, ***single*** with **1** dependent child.

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

ORDER

Petitioner failed to meet his burden on the issue of causation. Determination of other disputed issues is moot.

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

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

D. D. McCarthy
Signature of Arbitrator

March 2, 2013
Date

MAR 8 - 2013

The Arbitrator finds the following facts:

Petitioner graduated high school in 2004. In 2006 he began working as a union laborer and union concrete finisher. Petitioner testified that working as a laborer and concrete finisher required repetitive physical use of his hands.

Petitioner testified that through the union he started working full time for respondent on 7/19/2011. Prior to that he worked for the respondent from 8/1/07 – 8/15/07. Petitioner first sought treatment for bilateral hand complaints in March of 2011. Petitioner testified that he was seen at an Express Care and at that time experienced a little pain and numbness in his hands. Petitioner testified that this pain would wake him up at night. Petitioner testified that he was prescribed an anti-inflammatory medication along with wrist splints. Petitioner on direct examination testified that after receiving the splints and anti-inflammatory medication the pain and numbness went away until he started working for the respondent.

Medical records from Memorial Express Care note that petitioner was seen on 3/7/2011. The history in that record states:

> "The patient presents with bilateral hand and wrist pain for over 6 months in a 24 year old male who is a concrete worker. He had not taken the time to deal with this until now. He denies an acute trauma. The pain is throbbing, worse at night and in the morning, and make it difficult to grip strongly at work."

Petitioner's physical examination revealed a positive phalens and tinnels signs. Petitioner was diagnosed with carpal tunnel syndrome and prescribed anti-inflammatory and pain medication. The petitioner was also prescribed cock-up wrist braces to be used at night. Petitioner was advised to establish with a primary care provider for follow up and possibly an orthopedic referral. (RX1).

Petitioner testified that after he was rehired by the respondent on 7/19/2011 he worked until 4/12/2012. Petitioner testified that he was hired as a concrete finisher but also worked as a laborer. During this time petitioner testified that he worked numerous jobs with the respondent including the YMCA, 5th and Cook Street, the airport, the fairgrounds, a strip mall in Sherman, and a hotel. Petitioner testified in detail as to his job requirements of a concrete finisher/laborer. This includes carrying steel forms, setting the forms, pouring the concrete, leveling the concrete, and tearing down after the job was completed. Petitioner testified to the use of numerous tools that he used in performing his job activities. Petitioner testified that his job requirements involved repetitive, physical use of his hands. (PX6, PX7).

Petitioner testified that two months into his employment with respondent the numbness and pain complaints in his hands returned. The petitioner testified that he told his supervisor, Mr. Ed Rainwater, of his hand

complaints. Petitioner testified that he was told to wait until he was laid off in the wintertime to see a doctor about it. Petitioner testified that on 4/12/2012 he reported to work and started loading steel frames into respondent's truck. Petitioner testified that as he was lifting a steel frame to the top of the truck he felt a sharp pain that he described as electricity shooting down his hands to his elbows. Petitioner testified that he dropped the form and advised his supervisor, Mr. Rainwater, that he needed to go to the doctor. Petitioner testified that he was not asked if he needed to complete an accident report. Petitioner testified that he sought treatment immediately at St. John's Express Care.

The medical records indicate that petitioner was seen at Priority Care on 4/12/2012. The history in that record states "Pain/numbness/tingling in bilateral hands for the past year at night at work. Seen at Express Care 5-6 months ago and given wrist splints. These are not helping." Due to the duration of the symptoms petitioner was referred to Dr. Edwards Trudeau for an electrodiagnostic study. There is no history of the petitioner sustaining a specific accident involving his hands on 4/12/2012. Contrary to petitioner's testimony there is no history of petitioner's bilateral hand complaints resolving after his diagnosis in March of 2011 and then reoccurring after his employment with the respondent. (RX2).

Petitioner's electrodiagnostic studies took place on 4/19/2012. The history in Dr. Trudeau's record states "The patient indicates in terms of chief complaint 'My wrists are having hand pain from my wrist to my fingers…fingers get tingly, wakes me up at night. It has been going on for over a year and I am a concrete laborer and can barely work due to pain…' " There is no history of the petitioner sustaining a specific accident involving both of his hands on 4/12/2012. Contrary to petitioner's testimony there is no history of petitioner's bilateral hand complaints resolving after his diagnosis in March of 2011 and then reoccurring after his employment with the respondent. (RX2). The electrodiagnostic study was interpreted as demonstrating bilateral carpal tunnel syndrome moderately severe on either side with the right being greater than the left. (PX3).

Petitioner returned to Priority Care and was seen on 4/30/2012. Based on the results of the electrodiagnostic study he was referred for an orthopedic consult. Petitioner was seen by surgeon, Dr. Christopher Maender, on 5/16/2012. The history in Dr. Maender's record states "This is a 26-year-old gentlemen kindly sent over by a physician assistant Kelly for evaluation of his bilateral hand numbness and tingling. He is right hand dominant. He states that he has had this numbness and tingling for greater than 8 months. He has been progressively getting worse, that bothers him significantly. It does wake him up at night…He has been doing construction work for quite a while with concrete finishing. He swings sledge hammers on a regular basis…He has tried a steroid taper, which only helped minimally. He has tried Naproxen, which does not really help. He has tried some wrist braces for the past 8 months with minimal help." There is no history of the petitioner sustaining a specific accident involving both of his hands on 4/12/2012. Contrary to petitioner's testimony there is no history

of petitioner's bilateral hand complaints resolving after his diagnosis in March of 2011 and then reoccurring after his employment with the respondent. (RX2).

Dr. Maender recommended bilateral carpal tunnel releases. On that date Dr. Maender restricted the claimant from "vibrational tools." (PX2). Dr. Maender proceeded with a right carpal tunnel release on 8/6/2012 followed by a left carpal tunnel release on 8/20/2012. Subsequently Dr. Maender allowed petitioner to return to full duty work starting on 10/25/2012. Dr. Maender last saw petitioner on 1/22/2013. On that date Dr. Maender noted that the claimant was "doing well" and released petitioner from his care. (PX2).

Petitioner testified that he has not returned to work. Petitioner testified that his hands are a lot better and he does not experience numbness, tingling, or pain. Petitioner testified that he experiences pain when performing pushups. Petitioner testified that he has been afraid to attempt work activities. Petitioner testified that he did go hunting in late October or November of 2012 with a compound bow.

Mr. Michael Emmons testified on behalf of petitioner. Mr. Emmons is a laborer/concrete finisher. He has worked off and on for the past 2 ½ years with the respondent. Mr. Emmons was working for the respondent when petitioner was. Mr. Emmons testified that the work for respondent was physically demanding on his hands and repetitive. Mr. Emmons testified that he could not recall a specific time when petitioner complained of hand pain. Mr. Emmons was working on 4/12/2012. Mr. Emmons testified that he was on top of the truck and couldn't see but guessed that petitioner dropped the form. Petitioner complained of hand pain and hurting his back.

Mr. Edward Rainwater testified on behalf of the respondent. Mr. Rainwater has worked for the respondent for 10 years. He works as a concrete working foreman. Mr. Rainwater usually worked with petitioner on a daily basis. Mr. Rainwater testified that within the first two weeks of petitioner's employment he started complaining of problems with his hands. Mr. Rainwater testified that he was working on 4/12/2012. Mr. Rainwater testified that he believes petitioner arrived at the respondent's at either 6:30 or 6:45 a.m. They then went to a different location to load steel forms. At around 7:15 a.m. while loading forms petitioner advised Mr. Rainwater that his hand was hurting. Based on respondent's procedures Mr. Rainwater asked petitioner if he wanted to complete an accident report and go to the doctor. Petitioner did not want to complete an accident report. Mr. Rainwater testified that petitioner indicated that he had problems with his hands prior. Mr. Rainwater testified that at no time did petitioner indicate that he got hurt on the job or that his hand problem was a result of his work for the respondent. Mr. Rainwater testified that he keeps a daily log. The 4/12/2012 entry noted that petitioner left to get his hand checked and that "It did not happen on job." Mr. Rainwater testified that after the incident he

reported to his supervisor that petitioner said he hurt his hand and he was going to the doctor but it did not happen on the job.

Mr. Jim Butler testified on behalf of the respondent. Mr. Butler has worked for the respondent for the past 30 years. He works as a supervisor. His job duties consist of coordinating the work and dealing directly with the foreman. Mr. Butler testified that he was on the job site on 4/12/2012 where petitioner was working. Mr. Butler testified that he had a conversation with Mr. Ed Rainwater concerning the petitioner. Mr. Butler testified that he documented that conversation in a daily work log for that date. Mr. Butler testified that log states "Leon went home, had a swollen hand when he showed up – showed up for work. Said not work related, did not happen on the job. Asked about an accident report, he said no, pre-existing injury."

At petitioner's request Dr. Christopher Maender testified via an evidence deposition on 10/2/2012. Dr. Maender has been board certified since 2010 and specializes in the treatment of hand and upper extremity conditions. Dr. Maender testified that based on his physical examination and review of the electrodiagnostic study he felt that petitioner had bilateral carpal tunnel syndrome. Dr. Maender testified that he performed bilateral carpal tunnel releases and that he last saw petitioner on September 26, 2012. Dr. Maender testified that petitioner provided him with a history of performing construction work for quite a while mostly with concrete finishing. Dr. Maender opined that petitioner's work activities were at least a contributing factor to his carpal tunnel syndrome. In response to a hypothetical question involving a specific accident on April 12th when petitioner was lifting a heavy form Dr. Maender testified that a single incident was not enough to cause carpal tunnel syndrome. Dr. Maender testified that it was likely more a symptom of his carpal tunnel syndrome than a causative factor in it. Dr. Maender testified that the only records that he reviewed in addition to his own was Dr. Trudeau's nerve conduction study. Dr. Maender was not aware of when petitioner was first diagnosed with carpal tunnel syndrome. Dr. Maender was not aware of when petitioner started working for the respondent. Dr. Maender agreed that there are certain stages of symptoms which indicate carpal tunnel syndrome is advanced. Dr. Maender agreed that an end stage complaint of carpal tunnel syndrome is loss of grip strength. (PX4). **Dr. Maender did not address the causal connection issue of what effect petitioner's employment with the respondent had on his pre-existing carpal tunnel syndrome.**

At the request of the respondent Dr. Michael Cohen performed a record review on 7/5/2012. As part of his review Dr. Cohen reviewed petitioner's complete medical records and was aware of when petitioner' employment started with the respondent. Dr. Cohen's evidence deposition proceeded on 10/17/2012. Dr. Cohen is a board certified orthopedic surgeon whose practice is limited to the upper extremity including the hand, wrist, elbow, and shoulder. Dr. Cohen testified that he has performed more than 1,000 carpal tunnel releases. Based on his review of the complete medical records Dr. Cohen testified that petitioner was diagnosed with

carpal tunnel syndrome 4 months before his employment started with the respondent. Regarding the issue of causal connection Dr. Cohen testified that even if you assume that petitioner's work for the respondent would be considered high risk for carpal tunnel syndrome petitioner's work for the respondent was not a causative factor in his carpal tunnel syndrome and need for surgery. Dr. Cohen further testified that "Therefore, my conclusion is that the – whatever job he was doing at Perry, did not alter the natural history of what I would have expected with a 26 year old gentlemen who smoked with bilateral carpal tunnel syndrome, what would have happened to him over the natural history. He followed it perfectly." Dr. Cohen testified that this was based on the fact that petitioner was diagnosed with carpal tunnel syndrome prior to his employment with the respondent and had symptoms for 10 plus months before he worked for the respondent. Dr. Cohen testified that even if the petitioner did not work for the respondent he would have ended up in the exact same place. Lastly Dr. Cohen testified that if petitioner sustained a specific accident on 4/12/2012 it would not be a causative factor in his carpal tunnel syndrome. (RX3).

Therefore the Arbitrator concludes:

First of all, the Petitioner has failed to prove a causal relationship between his specific accident of April 12, 2012 and his bilateral carpal tunnel syndromes. Dr. Maender testified that the event was not a causative factor in the condition, but produced symptoms of the condition already diagnosed. (PX 4 at 13)

A more difficult question is whether the Petitioner's work for the Respondent either caused or aggravated the condition. We know from the evidence that the work the Petitioner performed as a concrete finisher for the Respondent was strenuous and repetitive, and could, by all accounts aggravate a carpal tunnel. Dr. Maender testified that swinging the sledge hammer and picks required forceful gripping and produced impact on the hands which could be contributing factors.

The Petitioner must prove, by a preponderance of the evidence, that the work was in fact a causative factor. For the reasons stated below, the Arbitrator finds that the burden of proof was not met, and the claim is denied.

The Petitioner had a diagnosed symptomatic carpal tunnel syndrome on March 7, 2011, just over four months prior to when he began working for the Respondent. At the time, he complained to his doctor about throbbing pain, difficulty gripping at work and numbness and tingling. The examination showed positive Phalen's and Tinel's tests. The doctor diagnosed carpal tunnel syndrome and prescribed injections and splints.

While the Petitioner testified that the conservative treatment provided complete relief of his symptoms, his histories to his physicians who he saw a year later told a different story. He reported to his doctor at the HSHS Medical Group on April 12, 2012 that his symptoms had been present for the past year, and that the splints

provided to him earlier were not helping. He also told Dr. Trudeau about a week later that his symptoms had been present a year. Nowhere is there is history that he used the splints, got better, and got worse after working for the Respondent.

In addition, his work foreman, who admittedly could be biased, testified that the Petitioner complained of hand pain within two weeks from when his job began.

Also, while Dr. Maender testified that his work as a concrete finisher could have aggravated the condition, he was unaware that the condition had been diagnosed prior to the start of Petitioner's work for the Respondent.

Finally, when you compare the Petitioner's complaints, exam findings and diagnosis before and after he began working for the Respondent, you will see they a virtually the same. On April 12, 2012, as in March 2011, he had pain, numbness, tingling and weakness of grip. His exams showed positive Phalen's. The only differences were the positive electrical studies in 2012, as none were taken a year earlier. Given the above evidence, the Arbitrator simply cannot assume that if earlier tests were done, they would show anything less than what was seen on the actual tests.

This case is different than the numerous commission cases where there was pfoof of either improvement or worsening of the condition after work for a Respondent. It is different than the Oscar Meyer case, where subsequent electrical studies confirmed a worsening of the condition while a Petitioner continued working after the initial diagnosis. Oscar Meyer Company v. The Industrial Commission, 176 Ill. App. 3d (1988). It is also distinguishable from the Durand case, where a worker had symptoms but no treatment or diagnosis, kept working, and three years later began treatment. Durand v. The Industrial Commission, 224 Ill. 2d 53 (2006).

Under the facts of this case, the Arbitrator adopts the reasoning of Dr. Cohen. The Petitioner had carpal tunnel in March 2011, and it was the same carpal tunnel which was treated one year later. The Arbitrator cannot assume the Respondent's work aggravated the condition.

Petitioner's claim for compensation is denied. Determination of other disputed issues is moot.

The Arbitrator admits into evidence Respondent's Exhibit 5, pursuant to Rule 609 of the Illinois Rules of Evidence.

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

Silvia Pagaza,
Petitioner,
vs.

NO: 06WC 45434

14IWCC0140

Affinia Group,
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 25, 2013, 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 $7,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 27 2014
o022014
CJD/jrc
049

Charles J. DeVriendt

Stephen Mathis

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PAGAZA, SILVIA
Employee/Petitioner

Case# **06WC045434**

AFFINIA GROUP
Employer/Respondent

14IWCC0140

On 2/25/2013, 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 0.13% 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:

2573 MARTAY LAW OFFICE
DAVID MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERTE MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 2290
CHICAGO, IL 60606

14IWCC0140

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

Sylvia Pagaza
Employee/Petitioner
v.
Affinia Group
Employer/Respondent

Case # 06 WC 45434

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Granada**, Arbitrator of the Commission, in the city of **Waukegan**, on **December 28, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 7, 2006**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being *is* causally related to the accident as to the right leg, not the back.

In the year preceding the injury, Petitioner earned **$28,860.00**; the average weekly wage was **$555.00**.

On the date of accident, Petitioner was **47** years of age, *married* with **0** dependent children.

Petitioner *has* received all reasonable and necessary medical services based on stipulation .

Respondent *has* paid all appropriate charges for all reasonable and necessary medical services based on stipulation of respondent that they will pay the outstanding medical of $194.00.

Respondent shall be given a credit of **$21,352.78** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$21,352.78**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $333.00/week for 86 weeks, because the injuries sustained caused the 40% loss of the right leg, as provided in Section 8(e) of the Act.

Petitioner failed to prove that she is entitled to any additional temporary total disability benefits beyond that paid by the Respondent.

The petitioner failed to prove causal connection between current complaints of back pain and injury.

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

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

Signature of Arbitrator

2/22/13
Date

FEB 25 2013

14IWCC0140

Findings of Fact

The petitioner began working for the Respondent as a UPS Order Picker in 2005. On August 7, 2006, she was working in that capacity on a Prime Mover when her right leg became pinned between a steel rod and the Prime Mover. There is no dispute that the Petitioner sustained an accident on that day and that her injuries to her right leg are causally connected to the accident.

She was initially seen at the emergency room of Centegra Health System on the date of injury, with a history of her leg being pinned between a forklift and wall. The pain drawing showed that she was complaining of pain in the right thigh area. X-rays were taken of her right femur and pelvis. She was diagnosed with a right femur fracture and she came under the care of Dr. Timothy Havenhill. There is no mention of Petitioner having complaints of pain to her back. Dr. Havenhill on August 8, 2006 performed a right femoral intramedullary nailing for a preoperative and postoperative diagnosis of right femoral shaft fracture. The petitioner postoperatively developed problems, including postop anemia, intractable pain and significant soft tissue swelling around the fracture site. Doppler studies were performed, and they were normal, with no evidence of obvious deep vein thrombosis. The petitioner was discharged from the Hospital on August 19, 2006 with diagnosis of: mobility dysfunction, impaired activities of daily living and self-care activities; fracture of the right femur, status post intramedullary rodding, post-operative anemia, intraction pain and gastroesophageal reflex disease. There was no mention during the hospitalization of any injury to her back.

The petitioner thereafter followed with Dr. Havenhill August 23, 2006, September 22, 2006, September 28, 2006, October 27, 2006, November 27, 2006 and December 6, 2006. The petitioner during her visit on September 22, 2006, complained of tenderness in her right lower mid-lumbar region, with a negative straight leg raising. There was no mention of any back pain during the subsequent visits on September 28, 2006, October 27, 2006 and November 27, 2006.

During the petitioner's visit to Dr. Havenhill on December 6, 2006, she complained of doing a sitting job and having back pain. Dr. Havenhill, in his note of December 6, 2006, indicated that it was unclear exactly why sitting caused her back pain given that it was a sedentary job. He recommended some back stretching. The petitioner testified that she returned to work in December 2006 to a sitting job for one day.

The petitioner returned to Dr. Havenhill on January 8, 2007 and February 12, 2007, with the doctor feeling her back pain was secondary to altered gait. The doctor released her to light duty work. The attendance records offered into evidence showed that she did return to work on February 14, 2007. The petitioner testified that they returned her to work in the Receiving Department, putting labels on rotors (Tr. p. 30).

Ms. Effie Hoppe on behalf of the Respondent. Ms. Hoppe is an office manager, whose duties include human resource issues and overseeing workers compensation claims. She testified that the Respondent had a policy of returning employees who sustained work related accidents, to light duty pursuant to the treating doctor's restrictions. She testified that from February 14, 2007 through June 20, 2007, the petitioner was placed in Receiving, placing labels on the rotors or working in the rebox area, which she believed fell within the doctor's restrictions and was a regular job that people performed on a daily basis (Tr. pp. 54-58).

The petitioner returned to Dr. Havenhill on March 15, 2007 for diagnosis of right femur IM nailing and right medial knee pain. He indicated that as to her back complaints, that was coming from the gluteus muscle that is common with IM nailing surgery. In reviewing the doctor's handwritten notes, there was no mention of any

specific back pain. Dr. Havenhill on this date referred her to Dr. Nixon for evaluation of her right medial knee pain.

The petitioner was seen by Dr. Nixon on March 21, 2007. His diagnosis was right femur fracture and right medial knee pain. He had an MRI of the knee done that did not demonstrate clear evidence of any meniscal abnormality, although there was slight increase in fluid content.

The petitioner returned to Dr. Nixon on April 4, 2007, and he gave her a trial of intra-articular cortisone injection to the knee. He felt that she could continue with restricted duty. The petitioner returned on April 16, 2007, indicating that she noted some improvement with the injection, not quite 50%, with the plan to continue with the medication and for her to continue with light duty activities. The diagnosis was right medial knee pain, right knee neuritis. The petitioner returned to Dr. Nixon on May 14, 2007, and he suggested an MRI scan to see if there was a meniscal tear present and if so, arthroscopic surgery. The petitioner returned on May 21, 2007, and the MRI demonstrated a meniscal tear. Based upon her complaints, he had an MRI of the back done, which failed to reveal any evidence of herniation, nerve compression or mechanical pathology. The plan was to proceed with meniscal surgery to the right knee.

Dr. Nixon on June 21, 2007, performed an arthroscopy of the right knee with partial medial meniscectomy. The operative report indicates that the knee was normal except for a small marginal area split along the posterior medial corner, which was debrided. The petitioner, during this period of time, was kept off from work by Dr. Nixon until July 30, 2007, when he released her to sedentary work. Effie Hoppe testified that the petitioner was allowed to return to work within Dr. Nixon's restrictions (Tr. p. 58). The petitioner returned to Dr. Nixon on August 20, 2007, and he put a restriction on her to work 4-hour shifts for two weeks, and then 6-hour shifts for two weeks, then regular duty thereafter. Effie Hoppe testified that they followed those restrictions. Effie Hoppe testified that the petitioner was working in the office, Data Entry, working on Excel spreadsheets. Effie Hoppe testified that this was a regular routine job.

The petitioner then worked at Affinia 8 hours a day from September 15, 2007 through April 2, 2009. The petitioner asked to be removed from the office, and she was placed out on the packing line, working with small parcels. She worked either auditing orders where she would have to cut open the box and double check what was on the order with what was in the box, making sure it was accurate. Effie Hoppe testified that this was a routine normal job performed at Affinia, and that she worked with eight people on the line, with Sylvia being provided a stool. She testified that petitioner could sit or stand as needed. She testified that there was really no lifting involved as the boxes came down a conveyor that she would have to cut open, making sure that the parts were in the right box and that she was working with the 10-pound restriction (Tr. pp. 59-62).

During the period of time the petitioner was working, she was seen by Dr. Nixon on September 17, 2007 and October 22, 2007. There was a discussion on September 17, 2007 of whether the residual hardware implant could be the reason for her symptoms, with the doctor indicating it was unreasonable for her to pursue hardware removal. On October 22, 2007, Dr. Nixon indicated he did not see the pattern of her knee pain matching any irritation from the hardware. He recommended against removal of the hardware. He released her at maximum medical improvement.

On August 8, 2008, the petitioner sought a second opinion with Dr. Arif Ali. The petitioner at this time was complaining of thigh and upper leg pain. The impression was status post ORIF right femur fracture with retained hardware. He recommended that she consider having the hardware removed. In his report, he

indicated he could not give any assurances or guarantees that the procedure would give her full relief of her symptoms. There were no back complaints at this time.

The petitioner, as to the issue of hardware removal, was seen on September 2, 2008 for an independent medical evaluation with Dr. James Cohen. Dr. Cohen felt that the IM rod was in excellent position. He indicated there was no evidence of any stress reaction of the fracture; it completely healed in anatomical position. He indicated it was difficult to account for her pain, which appeared to be out of proportion to objective findings. He saw no reason to remove her hardware, nor recommend any additional care. He felt that she was at maximum medical improvement, and that she should continue to do her sedentary-type duties.

The petitioner continued to follow up with Dr. Ali, who continued to believe that her leg pain was due to the interlocking screws, but he could make no guarantees that she would get pain relief from removal of the screws and the IM hardware. The petitioner followed up with Dr. Ali on November 25, 2008, February 10, 2009, April 2, 2009. Again, the petitioner was insisting on the hardware removal, and the doctor wanted to perform same. There was no mention of any back pain. The petitioner took off from work, unexplained, on April 3, 2009 through April 30, 2009. She came back to work May 1, 2009. There was no off-work slip to support her being off work.

On May 8, 2009, the Company received a note from the physical therapist, asking that the petitioner be allowed to stand up and walk every two hours, as part of her physical therapy. Effie Hoppe testified that Affinia honored that restriction.

The petitioner worked until her hardware removal on July 29, 2009. The petitioner then was released by Dr. Ali on December 17, 2009, with a 10-pound restriction. Effie Hoppe testified that she honored those restrictions, and the petitioner worked on the packing line, again auditing and placing the packing list. Effie Hoppe testified that she stopped working March 2, 2010. She testified that the petitioner never complained to her of any problems with her job or working outside of her restrictions between December 18, 2009 and March 2, 2010 (Tr. p. 64).

The petitioner on February 5, 2010 submitted to a second IME evaluation with Dr. James Cohen. He indicated that he felt, as previously, that she had reached maximum medical improvement. He found it difficult to find a specific entity to account for her diffuse symptoms. He indicated that she had ill-defined pain and that a pain specialist would not be helpful for her condition. He indicated that his restriction regarding being able to sit approximately 15 minutes every 2 hours was based upon her complaints of pain. He felt that she was at maximum medical improvement, and that a lifting restriction of 15 pounds would be appropriate.

The petitioner did return to Dr. Ali on March 2, 2010. Dr. Ali's note shows "she presented to my office for a request to have an off-work slip." The Arbitrator would not that the petitioner requested the note and not necessarily that the doctor recommended same.

The petitioner testified that she never returned to work for Affinia after March 2, 2010, nor to any employment. Dr. Ali on April 13, 2010 recommended a functional capacity evaluation.

A functional capacity evaluation was done on July 30, 2010. The functional capacity evaluation revealed that the overall results of the evaluation represent a questionable and unreliable performance secondary to the submaximal performance demonstrated by Ms. Pagaza during her performance of a variety of functional tasks. It indicated she demonstrated inconsistent reliability, with the overall results not representing a true and

accurate representation of her overall physical capacities and tolerances. The indication was she failed 15 out of 29 objective validity criteria and demonstrated inconsistent reliability, with a physical demand level being unable to be determined based upon submaximal effort. It did reveal the ability to lift/carry 10 pounds floor to waist level representing the minimal amount she could perform.

The petitioner returned to Dr. Ali on August 24, 2010, with the doctor noting a full range of motion of the knee. He felt that she should not lift more than 10 pounds.

Effie Hoppe testified that the petitioner never brought in Dr. Ali's note of August 24, 2010, which gave her the same restrictions on August 24, 2010 that he gave her on December 17, 2009.

Effie Hoppe testified that they would be able to accommodate the petitioner's restrictions, and that if she wanted a job, they would be able to place her on the small parcel pack line, which she previously did, which fell within the doctor's restrictions (Tr. p. 72).

The petitioner was last seen by Dr. Ali on September 29, 2011. She was complaining of her right hip and femur pain. Dr. Ali indicated that she was at maximum medical improvement and no further intervention was needed as to her right hip and femur. As to the back, he noted that the MRI in 2006 was essentially negative, and he did not believe any new MRI would be covered by her workers' compensation claim.

The petitioner at the request of respondent was evaluated by Dr. Troy Karlsson on July 3, 2012 for purpose of the right leg (See RX 5) Dr. Karlsson performed a detailed evaluation to include review of records. He indicated she had a mid-shaft femur fracture, which is fully healed, and had a possible small medial mensical tear, which was treated with trimming out arthroscopically. He indicated that both of these are conditions that people uniformly recover well from and have no residual functioning deficits. There were no physical exam or test findings to correlate her subjective complaints. He found her at maximum medical improvement. He felt that she needed no work restrictions whatsoever regarding the right leg.

The respondent had the petitioner evaluated by Dr. David Fletcher regarding her back condition on September 19, 2002. He took a detailed history from the petitioner, reviewed the medical records and found that there was symptom magnification present and documented on functional testing. He agreed with Dr. Karlsson that there were no physical exam or test findings to correlate with her subjective complaints. He found her at maximum medical improvement and put no restrictions on her right lower extremity. He felt that she had a normal neurological examination and was not in need of any additional care or treatment for the back or any restrictions to the back. His diagnosis was ORIF right femur fracture with hardware removal and right knee arthroscopy. He disputed the work relatedness of the back condition.

Based on the foregoing, the Arbitrator makes the following conclusions:

1. The Arbitrator finds that the petitioner did sustain accidental injuries to her right leg, resulting in the right femur surgery and the right knee surgery. However, the Arbitrator finds that the Petitioner did not meet her burden of proof regarding whether the Petitioner sustained a work-related injury to her back. This is based upon the lack of any initial complaints to the back, the negative MRI of 2006, the lack of consistent complaints in the treating records, the comment by Dr. Ali in his last evaluation of September 21, 2011, and the exam findings and opinion of Dr. David Fletcher that the petitioner sustained no accidental injuries to her back. The Arbitrator notes the questions raised by the various treating physicians of having no explanation for her pain.

2. As a result of the injury to her right leg, Petitioner sustained 40% loss of use of her right leg. Accordingly, Respondent shall pay Petitioner $333.00 per week for 86 weeks pursuant to Section 8(e) of the Act.

3. Petitioner's claim for TTD benefits are denied. The Arbitrator notes that the respondent, on each and every occasion where the petitioner was given restrictions, found work for the petitioner within those restrictions. As to the first period of temporary total disability benefits claimed, April 3, 2009 through April 30, 2009, there is no off-work slip or opinion by any of the treating physicians that she needed to be off from work during this period of time. The petitioner was being provided work within the restrictions of her treating doctor. As to the period of temporary total disability benefits after March 3, 2010, the Arbitrator notes that the petitioner was working within the 10-pound restriction given to her by Dr. Ali on December 17, 2009, with those work restriction being confirmed by Dr. Cohen's second IME evaluation on February 5, 2010. The petitioner on March 2, 2010 went to Dr. Ali asking for an off-work slip, with Dr. Ali taking the petitioner off from work, despite having an inconsistent functional capacity evaluation done on July 30, 2010, showing the petitioner's minimal ability to work at 10 pounds. Dr. Ali released the petitioner on August 10, 2010 to the same restrictions which he gave on December 17, 2009 and which the Respondent was honoring. The Arbitrator notes that there were regular and usual jobs available to the petitioner within that 10-pound restriction, which they would have provided to the petitioner to perform and would, to this date, provide the petitioner to perform. The petitioner apparently did not want to return to work for the respondent after March 2, 2010, nor has she looked for work elsewhere.

4. As to the issue of unpaid medical, there were only two unpaid medical bills. One from Dr. Ali in the amount of $100.00 and one from McHenry Ortho in the amount of $94.00. Pursuant to the stipulation between the parties, the respondent shall pay these medical expenses subject to the Fee Schedule and in accordance with Sections 8(a) and 8.2 of the Act.

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

Annetta Chisholm,
Petitioner,

vs.

NO: 09WC 16027

14IWCC0141

Illinois State Toll Highway Authority,
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, notice, 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 February 8, 2013, 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: FEB 2 7 2014
o022014
CJD/jrc

049

Charles J. DeVriendt

Stephen Mathis

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CHRISHOLM, ANNETTA
Employee/Petitioner

Case# **09WC016027**

09WC016028
10WC006494

IL STATE TOLL HIGHWAY AUTHORITY
Employer/Respondent

14IWCC0141

On 2/8/2013, 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 0.11% 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:

2333 WOODRUFF JOHNSON & PALERMO
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0502 ST EMPLOYMENT RETIREMENT SYSTEMS
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SPRINGFIELD, IL 62794-9255

0210 GANAN & SHAPIRO PC
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST
13TH FLOOR
CHICAGO, IL 60601-3227

1024 IL STATE TOLL HIGHWAY AUTHRITY
WORKERS COMPENSATION CLAIMS
1 AUTHORITY DRIVE*
DOWNERS GROVE, IL 60515

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

FEB 8 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0141

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

Annetta Chisholm
Employee/Petitioner

v.

Illinois State Toll Highway Authority
Employer/Respondent

Case # **09WC 16027** _____

Consolidated cases: **09 WC 16028 & 10 WC 06494**

An *Application for Adjustment 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 **Wheaton**, on **December 10, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3/29/2009**, 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 $**37,093.16**; the average weekly wage was $**713.33**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **1** dependent children.

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

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

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

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

ORDER

Having found Petitioner failed to prove accident injuries arising out of and in the course and scope of her employment, the Arbitrator denies compensation.

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

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

Signature of Arbitrator

02-08-13
Date

FEB - 8 2013

STATEMENT OF FACTS

Petitioner began working for Respondent in April of 2007. She was originally assigned to Plaza #9, which was near Elgin. In either October or November of 2007, Petitioner testified she was assigned to Plaza #73, which was near Army Trail Road on I-355. At both locations, Petitioner worked as a toll collector, taking toll money from cars and trucks passing through the plaza.

Petitioner described the toll booth as "small" with glass windows on all sides. Petitioner testified some of the semi-trucks stopped with their air break, causing "smoke" to come out of the top of the truck. Petitioner testified the temperature within the booth fluctuated from 70 degrees to 90 degrees. When it was hot outside, she then opened the back door to the toll booth to allow in cooler air. She found the heat and summer brought more cars, trucks and RV's which in turn caused her breathing to be more "intense" and for her to experience more asthma attacks.

At times, Petitioner worked a "relief shift," which meant she went from booth to booth at the toll plaza in order to break the other toll collectors. When working a relief shift, Petitioner estimated she moved three to eight times in a shift. As all the booths were not on the same side of the highway, Petitioner at times walked an overhead or underground tunnel in order to reach the assigned booth. Petitioner testified she carried her tray, change bag, paperwork and water bottle to each booth. She estimated everything weighed 10 to 25 lbs. Each time she moved to a new booth, Petitioner estimated she walked between 500 and 1500 feet.

Petitioner primarily worked the 2nd and 3rd shifts, which covered the evening rush hour and the overnight hours. Petitioner acknowledged, after the evening rush, the traffic volume on the 2nd and 3rd shifts lessened. From October 13, 2007 through September 11, 2009, Petitioner usually worked between 6 and 8 hours a day. (Resp't Ex. No. 6 & 7) Petitioner worked 11 or more hours on only 20 days during the same period. (Id.)

The walkway at Plaza #9 went over the roadway. The distance of the walkway, end-to-end, was 286 feet. The distance from the main/annex office to each toll booth varied from 44 feet to 133 feet. The plaza had an elevator. Petitioner described the plaza and the booths as "newer" with a new ventilation system.

The walkway at Plaza #73 was an underground tunnel. The distance of the walkway, end-to-end, was 353 feet. The plaza did not have an elevator. At each end of the tunnel, there were 20 steps. The distance from the main/annex office to each toll booth varied from 57 feet to 124 feet. Petitioner testified there was no ventilation system in the tunnel, and she described a "moldy" smell in the tunnel. She acknowledged, though, she had no evidence mold was present in the tunnel. Petitioner described water leaking from what was previously a money vault with

puddles present in the tunnel. Petitioner estimated she walked through the tunnel three to eight times each shift.

Petitioner testified in January of 2009 she was diagnosed with asthma. Petitioner admitted she moved to a new home in January of 2009 as well. Petitioner also admitted her brother also had asthma.

Petitioner testified on March 29, 2009, a semi-truck came through the lane of her assigned toll booth, deployed its air break and black smoke appeared, which she then breathed in and became to cough. Petitioner testified she experienced chest pain, tried to work through it, but remained "barely able to breathe." She therefore sought medical attention.

At Alexian Brothers Medical Center on March 29, 2009, Petitioner was treated for an asthma attack, which reportedly began while she was working in a toll booth. Petitioner reported an increased cough and some chest tightness. The emergency room chart does not make mention of Petitioner breathing in fumes from a semi-truck after the air break was applied. Her past medical history was noted to be positive for asthma and hypertension.

On April 7, 2009, Petitioner presented to Dr. Jacqueline Moran at the Asthma & Allergy Center of DuPage Medical Group. Dr. Moran noted the diagnosis of asthma in January of 2009 with symptoms of shortness of breath, coughing and wheezing. Petitioner was then taking Advair, Asmanex 220 mg 1 puff daily and albuterol. The main triggers, as reported by Petitioner, were cleaners and walking. When describing the events of March 29, 2009, Petitioner did not mention breathing in fumes from a semi-truck. Instead, she reported walking through an underground tunnel with "water and mold damage." She reported by the time she reached her toll booth, she was coughing and felt like she "was sucking air through a straw." On examination, Dr. Moran noted Petitioner was morbidly obese and nasal turbinates 2+ bilaterally without discolored nasal drainage. Petitioner tested positive for allergins to trees, rag week, outdoor mod, cat and feather. Dr. Moran diagnosed allergic rhinitis and Dyspnea restriction with a positive bronchodilatory effect. She noted Petitioner's symptoms were out of proportion to the exam and spirometry. Petitioner's medications were adjusted and evaluation with a pulmonologist was recommended.

The pulmonologist, Dr. Villanueva, examined Petitioner on April 13, 2009. Petitioner now reported she changed toll plazas about seven months earlier due to unusual smells triggering her asthma.[1] Petitioner reported with the change she now walks through a damp tunnel. She reported symptoms of wheezing with asthma attacks, wheezing at night with coughing, snoring and chest tightness at night. The diagnosis remained Dyspnea and cough, asthma and fatigue,

[1] The Arbitrator notes this contradicts the testimony Petitioner provided for case numbers 09 WC 10628 and 10 WC 06494. In her testimony for the two cases, Petitioner testified she transferred from toll plaza #9 to toll plaza #79 in either October of November of 2007.

with snoring. Petitioner underwent a polysomonographic test on April 25, 2009, which demonstrated obstructive sleep apnea hypopnei syndrome. The test was obtained in response to Petitioner's complaints of loud and disruptive snoring, as well as fatigue.

Petitioner remained under Dr. Nelson's care for asthma. In a note dated May 27, 2009, Dr. Nelson indicated Petitioner's asthma had been well controlled until January of 2009 when she transferred to a new toll plaza and was required to walk underground. Dr. Nelson recommended Petitioner not be exposed to the tunnel, not walk more than 50 feet when carrying more than 25 lbs and limit her exposure to extreme temperatures to less than one continuous hour.

On May 20, 2009, Petitioner presented herself once again to the emergency room at Alexian Brothers Medical Center for shortness of breath and asthma. She now reported the symptoms began while she was at work and that she "works in a tunnel with auto fumes." Petitioner also reported she had problems with her asthma for the last 2 to 3 days and having run out of the albuterol the prior day. A nebulizer treatment was administered, and Petitioner was then discharged home.

Petitioner described an incident with her supervisor on May 29, 2009, which she testified was a disagreement over the nature of her work and her condition. Petitioner was later transported from home by ambulance to the emergency room at Alexian Brothers Medical Center where she reported a worsening of her asthma symptoms are arguing with her supervisor. The physician indicated Petitioner's symptoms were exacerbated by exposure to allergens (not identified in the records) and emotional stress. Petitioner was treated and released.

Petitioner underwent a second polysomnographic test on June 27, 2009, which demonstrated findings similar to the study obtained in April. The study, though, was limited by a lack of supine REM sleep. CPAP therapy was recommended. In the meantime, Petitioner was off work due to a condition of bilateral plantar fasciitis.

On August 2, 2009, Petitioner was again transported to the emergency room of Alexian Brothers Medical Center for reported problems with asthma due to fumes. Petitioner reported having difficulty breathing with tightness in her chest. Use of her inhaler only provided mild relief. Petitioner also reported the symptoms began the prior day. She was again treated for asthma related symptoms and released.

Petitioner testified she last sought treatment for her asthma on August 29, 2009 with Dr. Nelson. In a note dated August 11, 2009, Dr. Nelson stated Petitioner experienced significant exacerbations of her asthma since December of 2008 which caused impairment of her work place. She indicate, as Petitioner worked as a toll booth operator, she was exposed to extremes

of temperature, allergens and vehicular exhaust. Dr. Nelson therefore opined Petitioner was disabled from continued work as a toll booth operator.

An Ambient Air Screening assessment was conducted at Plaza 73 of the Tollway over a 24-hour period on February 2 and 3, 2010. The study was conducted by Gerry Trzupek, an environmental scientist. Trzupek testified the screening was conducted in order to assess the air quality at the toll plaza and determine whether more extensive testing was necessary. The screening was done with the use of three monitors: (1) the Testo 350XL; (2) the Foxboro TVA 1000B; and (3) the Met One E-Sampler. Monitoring was done on the northbound side of the road at the 2nd toll booth, as this was determined to be the booth with the heaviest concentration of traffic. Monitoring was also done in the underground tunnel. Trzupek testified the monitoring was done continuously, with monitoring being interrupted for just a few moments on one of the monitors in order to replace the hydrogen flame.

Trzupek testified two related standards/guidelines were utilized for comparison purposes. The two related standards were the National Ambient Air Quality Standard and the Illinois Department of Public Health Guidelines for Indoor Air Quality. For the toll booth, Trzupek testified the findings and results were within acceptable limits and the findings did not indicate a need for further investigation, testing or study. For the tunnel, Trzupek testified the findings and results were within acceptable limits and the findings did not indicate a need for further investigation, testing or study.

Dr. Jeffrey Coe of Occupational Medicine Associates of Chicago, Ltd. reviewed Petitioner's medical history/records, the findings of the Ambient Air Screening conducted at Plaza 73 on February 2-3, 2010 and the MSDS for the various cleaning products used by the Tollway. When reviewing the results of the Air Screening study, Dr. Coe noted the findings were within standard guidelines with no evidence of significant carbon monoxide exposure and limited to minimal exposure to volatile organic compounds. Regarding the cleaning products used by the Tollway, Dr. Coe noted the cleaning products were solvents with mild irritant properties, but that no allergens were contained in any of the compounds used in the work place.

There are two types of asthma – intrinsic and extrinsic. Dr. Coe opined Petitioner had intrinsic asthma, which is an airway hypersensitivity of no specific or known underling cause that often has a genetic predisposition. He noted an individual with intrinsic asthma is at risk for exacerbation or acute attacks with inhalational exposure to various substances, but the exacerbations are temporary and do not cause a permanent structural change in the lung or a permanent worsening of the asthma. In Petitioner's case, Dr. Coe noted Petitioner had a clear history of a slow onset of her symptoms, a family history of asthma and a lack of exposure to recognized allergens in her work place. In addition, Petitioner suffered from other medical conditions which impeded her respiratory function, including obesity, obstructive sleep apnea and chronic allergic rhinitis.

Dr. Coe therefore opined Petitioner's condition of asthma was not work-related, as there was no evidence from the sampling of the Ambient Air Screening and the MSDS that Petitioner was exposed to pulmonary irritants in the work place. Even if one presumed Petitioner was exposed to pulmonary irritants in the work place, Dr. Coe opined such exposure would only "exacerbate" Petitioner's condition in the sense she would experience asthma symptoms without permanently altering the structure of her lungs or worsening her asthmatic condition on a permanent basis. As exposure to such allergens can cause symptoms of asthma to manifest, the condition itself necessitated Petitioner avoid exposure to the allergens whether in the work place or outside the work place.

In support of the Arbitrator's Decision relating to C, did an accident occur that arose out of and in the course and scope of Petitioner's employment by Respondent, the Arbitrator finds the following:

It is Petitioner's burden to prove by a preponderance of the credible evidence all elements of her claim, including whether the accident arose out of and in the course and scope of her employment. *See*, Hannibal v. Industrial Commission, 38 Ill.2d 473, 231 N.E.2d 409, 410 (1967); Illinois Institute of Technology v. Industrial Commission, 68 Ill.2d 236, 369 N.E.2d 853, 12 Ill.Dec. 146 (1977). In the instance case, Petitioner failed to prove her condition of asthma was caused, aggravated or accelerated by the environmental conditions of her work place. The Arbitrator also finds Petitioner's testimony regarding the onset of her asthmatic episodes is not credible or consistent with what she reported to the medical providers when seeking treatment in 2009.

First, Petitioner testified the asthmatic symptoms she experienced on March 29, 2009 occurred after a semi-truck passed through her booth's lane, releasing its air brake and causing her to inhale the "dark smoke" the truck released. The only time such a history was provided by Petitioner was when she testified at the hearing. The emergency room records from March 29, 2009 do not specifically indicate what brought on Petitioner's symptoms, as the chart only notes she was working in a toll booth when the symptoms began. However, when she presented to Dr. Moran for evaluation on April 7, 2009, Petitioner indicated the symptoms on March 29, 2009 began when she was walking through an underground tunnel on March 29, 2009 and was exposed to "water and mold damage." Dr. Moran indicated the triggers for Petitioner were walking and exposure to cleaners. There was no mention of exhaust fumes or black smoke from a truck triggering Petitioner' asthmatic symptoms, making her trial testimony not credible and inconsistent with the history she provided when seeking medical treatment.

Second, Petitioner offered to no evidence of exposure in the work place to allergens or pulmonary irritants, which is necessary in order for her to meet her burden of proof. The evidence offered by Respondent, in contrast, including the findings of the Ambient Air Screening study and the MSDS sheets indicate the absence of pulmonary irritants and allergens at any significant level or at a level in excess of national and state standards. As noted by Dr. Coe, Petitioner suffered from intrinsic asthma, which is asthma of an unknown etiology with likely genetic predisposition. The condition was diagnosed in January of 2009. Petitioner admitted she moved into a new home at about the same tie the condition was diagnosed and she began to experience the symptoms. Petitioner also suggested to Dr. Nelson the onset of symptoms coincided with her move from Plaza number 9 to Plaza number 73; however, Petitioner testified she changed toll plazas in either October or November of 2007, not in January of 2009.

Finally, the Arbitrator finds the opinions of Dr. Coe more credible than the opinion of Dr. Nelson. When determining whether Petitioner's asthmatic condition was caused, aggravated or accelerated by a work-place exposure to allergens, Dr. Coe relied on the various histories

Petitioner described to her treating physicians, the findings of the Ambient Air Screening study and the MSDS information for the cleaning products utilized by Respondent. It is clear, in contrast, that Dr. Nelson did not review any of the environmental information when formulating her opinion. Moreover, the Arbitrator notes Dr. Nelson never actually opined there was a causal connection between Petitioner's asthmatic condition and a work place exposure to environmental allergens. Dr. Nelson relied only on the information provided to her by Petitioner, which as noted previously was inconstant with her trial testimony and is thus not credible.

Consequently, Dr. Coe's opinion Petitioner suffered from intrinsic asthma of no known etiology is more credible. While Petitioner may have experienced symptoms of asthma while at work, as a result of walking, from the smell of cleaners (or even truck fumes) or from stress (the alleged incident that sent her to the emergency room on May 29, 29), all she experienced was a manifestation of symptoms associated with asthma which incidentally occurred while she was at work. The work place conditions did not cause or otherwise alter the structure of Petitioner's lungs or permanently aggravate her condition of asthma. Petitioner must prove more than the symptoms occurred while she was at work; she must prove the condition was caused, aggravated or accelerated by the conditions of the work environment. With no evidence of exposure to pulmonary allergens at anything other than minimal levels and at levels within accepted national/state standards, Petitioner failed to prove a work related cause for her asthma.

Based on the foregoing, the Arbitrator finds Petitioner failed to prove she sustained accidental injuries arising out of and in the course and scope of her employment by Respondent. Having found Petitioner failed to meet her burden of proof, Petitioner's claim for compensation is denied. The Arbitrator need not address the remaining issues.

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

Annetta Chisholm,
Petitioner,

vs.

NO: 09WC 16028

Illinois State Toll Highway Authority,
Respondent,

14IWCC0142

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 8, 2013, 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: FEB 27 2014
o022014
CJD/jrc

049

Charles J. DeVriendt

Stephen Mathis

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CHRISHOLM, ANNETTA
Employee/Petitioner

Case# **09WC016028**

09WC016027
10WC006494

IL STATE TOLL HIGHWAY AUTHORITY
Employer/Respondent

14IWCC0142

On 2/8/2013, 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 0.11% 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:

2333 WOODRUFF JOHNSON & PALERMO
JAY JOHNSON
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0210 GANAN & SHAPIRO PC
MICHELLE L LaFAYETTE
210 W ILLINOIS ST
CHICAGO, IL 60654

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

1024 IL STATE TOLL HIGHWAY AUTHRITY
WORKERS COMPENSATION CLAIMS
1 AUTHORITY DRIVE*
DOWNERS GROVE, IL 60515

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

FEB 8 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0142

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

Annetta Chisholm
Employee/Petitioner

Case # **09WC 16028**

v.

Consolidated cases: **09 WC 16027 & 10 WC 06494**

Illinois State Toll Highway Authority
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson** , Arbitrator of the Commission, in the city of **Wheaton**, on **December 10, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0142

FINDINGS

On **10/12/2007**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**37,093.16**; the average weekly wage was $**713.33**.

On the date of accident, Petitioner was **40** 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 $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $ for other benefits, for a total credit of $**0.00**.

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

ORDER

Petitioner and Respondent agreed Petitioner was off work from October 13, 2007 through October 15, 2007, a period of three days. Pursuant to Section 8(b), Petitioner is not entitled to compensation for lost time benefits, as the period of disability did not last longer than the three day waiting period.

The Arbitrator finds Petitioner is entitled to receive and Respondent shall pay permanent partial disability of 2.05 weeks at $427.99/week to represent 1% loss of use of the left foot pursuant to Section 8(e)(11).

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

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

Signature of Arbitrator

02-08-13
Date

FEB - 8 2013

STATEMENT OF FACTS

Petitioner began working for Respondent in April of 2007. She was originally assigned to Plaza #9, which was near Elgin. In either October or November of 2007, Petitioner testified she was assigned to Plaza #73, which was near Army Trail Road on I-355. At both locations, Petitioner worked as a toll collector, taking toll money from cars and trucks passing through the plaza.

Petitioner described the toll booth as "small" with glass windows on all sides. She testified the floor was made of cement with rubber mats sometimes provided. She testified some toll booths contained multiple rubber mats while other toll booths contained no rubber mat at all. A stool was provided, which Petitioner testified was only to be used during times of low traffic volume. Petitioner estimated she stood for four to seven hours of each shift she worked.

At times, Petitioner worked a "relief shift," which meant she went from booth to booth at the toll plaza in order to break the other toll collectors. When working a relief shift, Petitioner estimated she moved three to eight times in a shift. As all the booths were not on the same side of the highway, Petitioner at times walked an overhead or underground tunnel in order to reach the assigned booth. Petitioner testified she carried her tray, change bag, paperwork and water bottle to each booth. She estimated everything weighed 10 to 25 lbs. Each time she moved to a new booth, Petitioner estimated she walked between 500 and 1500 feet. During her shift, Petitioner wore gym shoes, which she purchased. She acknowledged a particular type of footwear was not mandated by Respondent.

Petitioner primarily worked the 2nd and 3rd shifts, which covered the evening rush hour and the overnight hours. Petitioner acknowledged, after the evening rush, the traffic volume on the 2nd and 3rd shifts lessened. From October 13, 2007 through September 11, 2009, Petitioner usually worked between 6 and 8 hours a day. (Resp't Ex. No. 6 & 7) Petitioner worked 11 or more hours on only 20 days during the same period. (Id.)

The walkway at Plaza #9 went over the roadway. The distance of the walkway, end-to-end, was 286 feet. The distance from the main/annex office to each toll booth varied from 44 feet to 133 feet. The plaza had an elevator. The walkway at Plaza #73 was an underground tunnel. The distance of the walkway, end-to-end, was 353 feet. The plaza did not have an elevator. At each end of the tunnel, there were 20 steps. The distance from the main/annex office to each toll booth varied from 57 feet to 124 feet.

Mike Doyle, a supervisor with Respondent, testified he began working for Respondent as a toll collector. Doyle testified each toll booth was equipped with a fatigue mat and no booth was ever without a mat. He acknowledged, as mats became worn, multiple mats may be placed in one toll booth. Doyle testified each booth was equipped with a stool. While the stools were for periods of rest during times of lower traffic volume, Doyle testified in his experience, most toll

collectors sat throughout the majority of their shift. Doyle observed Petitioner on multiple occasions working as a toll collector. Doyle testified each time he observed Petitioner she was sitting, not standing, in the booth.

On October 12, 2007, Petitioner worked from 2 p.m. to 10 p.m. at Plaza #9. When exiting the assigned booth, Petitioner caught her left foot/ankle on the edge of the concrete, twisting her left ankle. Petitioner testified she immediately experienced pain to the left foot, ankle and heel. Petitioner reported the incident to Respondent.

On the morning of October 13, 2007, Petitioner presented to Central DuPage Hospital's emergency room for medical treatment. X-rays of the left ankle demonstrated no acute fracture or dislocation with moderate plantar calcaneal osteophyte formations. The physician diagnosed a sprain, provided Petitioner with crutches and prescribed Naprosyn. Petitioner was off work for three days after which she returned to work, as Respondent was able to accommodate her need to use crutches.

Petitioner did not seek any additional care for her left foot or ankle until December 14, 2007 when she presented to her family physician, Dr. Sara Nelson, at DuPage Medical Group for a regular physical examination.[1] During the physical, Petitioner reported complaints of increased pain in the bilateral heels with the right greater than the left. She recently discovered she had heel spurs, but had not had an opportunity to be evaluated by podiatry. She requested an injection to the heel, which was administered on the right. The diagnosis was a calcaneal spur.

Dr. Christina Brown, a podiatrist with DuPage Medical Group, examined Petitioner for the first time on December 19, 2007. Petitioner now reported having bilateral heel pain for approximately six months with the symptoms being worse in the right foot. She reported she spent approximately 45 hours each week on her feet. Dr. Brown diagnosed plantar fasciitis, tenosynovitis of the foot and ankle and a congenital valgus foot deformity. Dr. Brown recommended a supportive shoe, rest, icing the affected area each evening and administered another injection.

At her appointment with Dr. Brown on January 31, 2008, Petitioner reported she was 100% symptom free for one to two weeks after the December appointment, but the symptoms gradually recurred. She reported standing extensively at work with the pain prominent with initial weight bearing in the morning and evenings. Dr. Brown noted Petitioner suffered from a severe pes planus foot type. She noted localized tenderness at the plantar medical aspect of the heel with no pain on side-to-side compression of the heel and no Achilles involvement. The

[1] The Arbitrator notes Petitioner also presented to Dr. Nelson on November 30, 2007 with an unrelated incident of twisting her left knee while rapidly walking around a corner and her left knee "popping" out while she was shopping.

diagnosis was revised to include severe pronation syndrome, pes planus foot type and plantar fasciitis, bilateral, right greater than left. The treatment recommendations remained the same.

Three months later, Petitioner returned to Dr. Brown on April 14, 2008. She reported continued pain, plantar heel, right worse with initial weight bearing after rest. She reported, if at work, the symptoms are greatly aggravated. The diagnosis was chronic plantar fasciitis, right heel. Dr. Brown administered a cortisone injection and recommended orthotics, which Petitioner obtained on May 30, 2008. Petitioner also participated in physical therapy, which was discontinued before she achieved all goals due to her failure to attend the therapy sessions.

In July of 2008, Petitioner advised Dr. Brown she was working 12-hour shifts with little opportunity to sit down causing her to have difficulty controlling her heel pain. She also claimed she was unable to attend physical therapy, as Respondent would not allow her to take time off from work. Her physical examination and the diagnosis were unchanged. Dr. Brown administered yet another cortisone injection and recommended a ratio of 60/40 sitting to standing.

Petitioner did not return to Dr. Brown until January 6, 2009. She reported increased heel pain over the last several weeks "because a new job required her to do a lot of walking, carrying of packages and going up and down stairs as a requirement for her break several times per day." Petitioner reported, previously, she worked a position in which she did not require as much ambulation and allowed her to stay in one particular area. Dr. Brown recommended a new orthotic and physical therapy. When Petitioner picked up the orthotics on March 6, 2009, another cortisone injection was administered.

On June 10, 2009, Petitioner again began physical therapy. She reported constant pain with weight bearing with the pain being present for the last two years since she stepped into a hole. She claimed her symptoms were later aggravated by a job, which required standing for 12 hour days. She was discharged from therapy once again on July 29, 2009 without meeting her goals due to poor attendance and compliance issues.

A gap in care occurred, as Petitioner did not return to Dr. Brown until March 10, 2010. Petitioner then reported continued heel pain, but indicated her symptoms were somewhat improved while she had been off work. Dr. Brown recommended aggressive physical therapy and anti-inflammatory medications. A cortisone injection was also administered. An MRI was also consistent with plantar fasciitis. Dr. Brown saw Petitioner again in July and October of 2010. In October, Petitioner finally began physical therapy and reported it helped to improve her symptoms.

The parties deposed Dr. Christina Brown on March 7, 2011. Dr. Brown is a podiatrist, who is certified by the American Board of Podiatric Surgery. Dr. Brown testified Petitioner's activities

of working up to 12 hour days on her feet and carrying multiple bags or trays of coins/money weighing up to 25 lbs. could aggravate or accelerate a condition of bilateral plantar fasciitis. (Dep. at 26) However, she had no opinion as to whether the incident of October 12, 2007 in which Petitioner sprained the left ankle could cause, aggravate or accelerate the same condition. (Dep. at 25-6) Dr. Brown did not know whether a flat footed condition, obesity and gender contributed to the condition of plantar fasciitis. (Dep. at 28-30). Dr. Brown also did not recall whether a stool was provided in the toll booth, had no knowledge of the distances Petitioner walked while at work, had no knowledge of the number of stairs she climbed and had no knowledge as to the shifts Petitioner worked.

At Respondent's request, Dr. George Holmes, a board-certified orthopedic foot surgeon with MidWest Orthopedics at Rush examined Petitioner on December 10, 2009. Dr. Holmes described the difference between an orthopedic surgeon and podiatrist as being not only in the training, as the orthopedic surgeon goes to medical school while the podiatrist goes to podiatry school, but also that the orthopedic surgeon can perform a full, comprehensive medical examination of the patient and can admit patients to the hospital. (Dep. at 7) As part of his evaluation, Dr. Holmes was provided with the distance measurements for Plaza 9 and 73. (Dep. at Ex. No. 2)

In December of 2009, Petitioner reported bilateral ankle pain, swelling and increased pain after wearing high heels. Dr. Holmes testified wearing high heels increases the pressure to the foot with little to no cushion, causing greater impact and aggravation to the foot. (Dep. at 12) Dr. Holmes further testified the incident of October 12, 2007 did not cause the condition of plantar fasciitis, as the mechanism of injury and an ankle sprain are not consistent with the diagnosis. (Dep. at 18) Dr. Holmes testified his opinion was also supported by the lack of a temporal connection between the incident in October of 2007 and when she first sought treatment for the symptoms associates with plantar fasciitis on November 30, 2007. (Dep. at 19)

Dr. Holmes further opined Petitioner's activities, including the walking and standing she did as a toll collector, did not cause, aggravate or accelerate the condition of plantar fasciitis. (Dep. at 20-21) Dr. Holmes testified there is no scientific correlation between plantar fasciitis and activities of walking and standing. (Dep. at 20-21) In studies comparing the incidence of plantar fasciitis of those in sedentary occupations to those in occupations that required extensive standing/walking, Dr. Holmes testified, there was no scientific data to show a higher or increased incidence of the condition. (Dep. at 21-22) He further identified several risk factors for the development of the condition, which included obesity and pes planus deformity (flat footedness) as well as a higher incidence of the condition in women when compared to men. (Dep. at 22-23) Dr. Holmes also suggested an underlying enthesopathy needed to be explored in Petitioner's case due to the bilateral nature of her condition, suggesting a blood test was needed to assess whether there was an inflammatory process caused by a C-reactive protein, uric acid and sed rate. (Dep. at 23)

Petitioner testified she continues to experience a sharp pain in her heels. She testified she is unable to wear 2 to 4 inch heels and cannot walk around barefoot. She tries to do mall shopping, but cannot walk more than 200 feet comfortably. She estimated she talks about 800 mg of Ibuprofen 2 times a week.

In support of the Arbitrator's Decision relating to F, whether Petitioner's present condition of ill-being is causally related to the October 12, 2007 accident, the Arbitrator finds the following:

On October 12, 2007, Petitioner stepped in a hole when exiting a toll booth and twisted her left ankle. She sought treatment at Central DuPage Hospital on October 13, 2007 where she was diagnosed with an ankle sprain. She sought no further treatment for the injury.

On November 30, 2007 when Petitioner presented to her family physician, Dr. Nelson, for care, Petitioner did so for complaints of bilateral heel pain and not for symptoms associates with the ankle sprain she sustained on October 13, 2007. Petitioner was thereafter diagnosed with and treated for bilateral plantar fasciitis. Dr. Brown, the treating podiatrist, was unable to relate the condition of plantar fasciitis to the incident of October 12, 2007. (Dep. at 25-26). Dr. Holmes, Respondent's evaluating physician, opined the mechanism of injury and a sprained ankle were not consistent with the subsequent diagnosis of plantar fasciitis. (Dep. at 18-19).

Based on the testimony and opinions of Dr. Holmes, as well as the acknowledgement from Dr. Brown that she could not relate Petitioner's condition of ill-being to the October 12, 2007 accident, the Arbitrator finds Petitioner only sustained a left ankle sprain as a result of the October 12, 2007 accident and she only required treatment on October 13, 2007 for the condition. Petitioner's present condition of plantar fasciitis is not causally related to the accident of October 12, 2007.

In support of the Arbitrator's Decision relating to L, the nature and extent of injury, the Arbitrator finds the following:

Petitioner sustained a left ankle sprain as a result of the October 12, 2007 accident and reached maximum medical improvement by November 30, 2007 when she began to treat for an unrelated condition of bilateral plantar fasciitis. As Petitioner's only injury was a left ankle sprain, the Arbitrator finds Petitioner sustained permanent partial disability to the extent of 1% loss of use of the left foot pursuant to Section 8(e)(11).

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

Annetta Chisholm,
Petitioner,

vs.

NO: 10WC 6494

Illinois State Toll Highway Authority,
Respondent,

14IWCC0143

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, permanent partial disability, temporary total disability, medical, 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 February 8, 2013, 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: FEB 2 7 2014
o022014
CJD/jrc

049

Charles J. DeVriendt

Stephen Mathis

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CHISHOLM, ANNETTA
Employee/Petitioner

Case# **10WC006494**

09WC016028
09WC016027

IL STATE TOLL HIGHWAY AUTHORITY
Employer/Respondent

14IWCC0143

On 2/8/2013, 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 0.11% 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:

2333 WOODRUFF JOHNSON & PALERMO
JAY JOHNSON
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0210 GANAN & SHAPIRO PC
MICHELLE L LaFAYETTE
210 W ILLINOIS ST
CHICAGO, IL 60654

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

1024 IL STATE TOLL HIGHWAY AUTHRITY
WORKERS COMPENSATION CLAIMS
1 AUTHORITY DRIVE*
DOWNERS GROVE, IL 60515

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

FEB 8 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0143

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

Annetta Chisholm
Employee/Petitioner

v.

Illinois State Toll Highway Authority
Employer/Respondent

Case # **10WC 06494**

Consolidated cases: **09 WC 16027 & 09 WC 16028**

An *Application for Adjustment 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 **Wheaton**, on **December 10, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0143

FINDINGS

On **12/19/2007**, 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 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 $**37093.16**; the average weekly wage was $**713.33**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **1** dependent child.

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

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

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

Having found Petitioner failed to prove she sustained accidental injuries arising out of and in the course and scope of her employment by 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

02-08-13
Date

FEB - 8 2013

14IWCC0143

STATEMENT OF FACTS

Petitioner began working for Respondent in April of 2007. She was originally assigned to Plaza #9, which was near Elgin. In either October or November of 2007, Petitioner testified she was assigned to Plaza #73, which was near Army Trail Road on I-355. At both locations, Petitioner worked as a toll collector, taking toll money from cars and trucks passing through the plaza.

Petitioner described the toll booth as "small" with glass windows on all sides. She testified the floor was made of cement with rubber mats sometimes provided. She testified some toll booths contained multiple rubber mats while other toll booths contained no rubber mat at all. A stool was provided, which Petitioner testified was only to be used during times of low traffic volume. Petitioner estimated she stood for four to seven hours of each shift she worked.

At times, Petitioner worked a "relief shift," which meant she went from booth to booth at the toll plaza in order to break the other toll collectors. When working a relief shift, Petitioner estimated she moved three to eight times in a shift. As all the booths were not on the same side of the highway, Petitioner at times walked an overhead or underground tunnel in order to reach the assigned booth. Petitioner testified she carried her tray, change bag, paperwork and water bottle to each booth. She estimated everything weighed 10 to 25 lbs. Each time she moved to a new booth, Petitioner estimated she walked between 500 and 1500 feet. During her shift, Petitioner wore gym shoes, which she purchased. She acknowledged a particular type of footwear was not mandated by Respondent.

Petitioner primarily worked the 2nd and 3rd shifts, which covered the evening rush hour and the overnight hours. Petitioner acknowledged, after the evening rush, the traffic volume on the 2nd and 3rd shifts lessened. From October 13, 2007 through September 11, 2009, Petitioner usually worked between 6 and 8 hours a day. (Resp't Ex. No. 6 & 7) Petitioner worked 11 or more hours on only 20 days during the same period. (Id.)

The walkway at Plaza #9 went over the roadway. The distance of the walkway, end-to-end, was 286 feet. The distance from the main/annex office to each toll booth varied from 44 feet to 133 feet. The plaza had an elevator. The walkway at Plaza #73 was an underground tunnel. The distance of the walkway, end-to-end, was 353 feet. The plaza did not have an elevator. At each end of the tunnel, there were 20 steps. The distance from the main/annex office to each toll booth varied from 57 feet to 124 feet.

Mike Doyle, a supervisor with Respondent, testified he began working for Respondent as a toll collector. Doyle testified each toll booth was equipped with a fatigue mat and no booth was ever without a mat. He acknowledged, as mats became worn, multiple mats may be placed in one toll booth. Doyle testified each booth was equipped with a stool. While the stools were for periods of rest during times of lower traffic volume, Doyle testified in his experience, most toll

collectors sat throughout the majority of their shift. Doyle observed Petitioner on multiple occasions working as a toll collector. Doyle testified each time he observed Petitioner she was sitting, not standing, in the booth.

On October 12, 2007, Petitioner worked from 2 p.m. to 10 p.m. at Plaza #9. When exiting the assigned booth, Petitioner caught her left foot/ankle on the edge of the concrete, twisting her left ankle. Petitioner testified she immediately experienced pain to the left foot, ankle and heel. Petitioner reported the incident to Respondent.

On the morning of October 13, 2007, Petitioner presented to Central DuPage Hospital's emergency room for medical treatment. X-rays of the left ankle demonstrated no acute fracture or dislocation with moderate plantar calcaneal osteophyte formations. The physician diagnosed a sprain, provided Petitioner with crutches and prescribed Naprosyn. Petitioner was off work for three days after which she returned to work, as Respondent was able to accommodate her need to use crutches.

Petitioner did not seek any additional care for her left foot or ankle until December 14, 2007 when she presented to her family physician, Dr. Sara Nelson, at DuPage Medical Group for a regular physical examination.[1] During the physical, Petitioner reported complaints of increased pain in the bilateral heels with the right greater than the left. She recently discovered she had heel spurs, but had not had an opportunity to be evaluated by podiatry. She requested an injection to the heel, which was administered on the right. The diagnosis was a calcaneal spur.

Dr. Christina Brown, a podiatrist with DuPage Medical Group, examined Petitioner for the first time on December 19, 2007. Petitioner now reported having bilateral heel pain for approximately six months with the symptoms being worse in the right foot. She reported she spent approximately 45 hours each week on her feet. Dr. Brown diagnosed plantar fasciitis, tenosynovitis of the foot and ankle and a congenital valgus foot deformity. Dr. Brown recommended a supportive shoe, rest, icing the affected area each evening and administered another injection.

At her appointment with Dr. Brown on January 31, 2008, Petitioner reported she was 100% symptom free for one to two weeks after the December appointment, but the symptoms gradually recurred. She reported standing extensively at work with the pain prominent with initial weight bearing in the morning and evenings. Dr. Brown noted Petitioner suffered from a severe pes planus foot type. She noted localized tenderness at the plantar medical aspect of the heel with no pain on side-to-side compression of the heel and no Achilles involvement. The

[1] The Arbitrator notes Petitioner also presented to Dr. Nelson on November 30, 2007 with an unrelated incident of twisting her left knee while rapidly walking around a corner and her left knee "popping" out while she was shopping.

diagnosis was revised to include severe pronation syndrome, pes planus foot type and plantar fasciitis, bilateral, right greater than left. The treatment recommendations remained the same.

Three months later, Petitioner returned to Dr. Brown on April 14, 2008. She reported continued pain, plantar heel, right worse with initial weight bearing after rest. She reported, if at work, the symptoms are greatly aggravated. The diagnosis was chronic plantar fasciitis, right heel. Dr. Brown administered a cortisone injection and recommended orthotics, which Petitioner obtained on May 30, 2008. Petitioner also participated in physical therapy, which was discontinued before she achieved all goals due to her failure to attend the therapy sessions.

In July of 2008, Petitioner advised Dr. Brown she was working 12-hour shifts with little opportunity to sit down causing her to have difficulty controlling her heel pain. She also claimed she was unable to attend physical therapy, as Respondent would not allow her to take time off from work. Her physical examination and the diagnosis were unchanged. Dr. Brown administered yet another cortisone injection and recommended a ratio of 60/40 sitting to standing.

Petitioner did not return to Dr. Brown until January 6, 2009. She reported increased heel pain over the last several weeks "because a new job required her to do a lot of walking, carrying of packages and going up and down stairs as a requirement for her break several times per day." Petitioner reported, previously, she worked a position in which she did not require as much ambulation and allowed her to stay in one particular area. Dr. Brown recommended a new orthotic and physical therapy. When Petitioner picked up the orthotics on March 6, 2009, another cortisone injection was administered.

On June 10, 2009, Petitioner again began physical therapy. She reported constant pain with weight bearing with the pain being present for the last two years since she stepped into a hole. She claimed her symptoms were later aggravated by a job, which required standing for 12 hour days. She was discharged from therapy once again on July 29, 2009 without meeting her goals due to poor attendance and compliance issues.

A gap in care occurred, as Petitioner did not return to Dr. Brown until March 10, 2010. Petitioner then reported continued heel pain, but indicated her symptoms were somewhat improved while she had been off work. Dr. Brown recommended aggressive physical therapy and anti-inflammatory medications. A cortisone injection was also administered. An MRI was also consistent with plantar fasciitis. Dr. Brown saw Petitioner again in July and October of 2010. In October, Petitioner finally began physical therapy and reported it helped to improve her symptoms.

The parties deposed Dr. Christina Brown on March 7, 2011. Dr. Brown is a podiatrist, who is certified by the American Board of Podiatric Surgery. Dr. Brown testified Petitioner's activities

of working up to 12 hour days on her feet and carrying multiple bags or trays of coins/money weighing up to 25 lbs. could aggravate or accelerate a condition of bilateral plantar fasciitis. (Dep. at 26) However, she had no opinion as to whether the incident of October 12, 2007 in which Petitioner sprained the left ankle could cause, aggravate or accelerate the same condition. (Dep. at 25-6) Dr. Brown did not know whether a flat footed condition, obesity and gender contributed to the condition of plantar fasciitis. (Dep. at 28-30). Dr. Brown also did not recall whether a stool was provided in the toll booth, had no knowledge of the distances Petitioner walked while at work, had no knowledge of the number of stairs she climbed and had no knowledge as to the shifts Petitioner worked.

At Respondent's request, Dr. George Holmes, a board-certified orthopedic foot surgeon with MidWest Orthopedics at Rush examined Petitioner on December 10, 2009. Dr. Holmes described the difference between an orthopedic surgeon and podiatrist as being not only in the training, as the orthopedic surgeon goes to medical school while the podiatrist goes to podiatry school, but also that the orthopedic surgeon can perform a full, comprehensive medical examination of the patient and can admit patients to the hospital. (Dep. at 7) As part of his evaluation, Dr. Holmes was provided with the distance measurements for Plaza 9 and 73. (Dep. at Ex. No. 2)

In December of 2009, Petitioner reported bilateral ankle pain, swelling and increased pain after wearing high heels. Dr. Holmes testified wearing high heels increases the pressure to the foot with little to no cushion, causing greater impact and aggravation to the foot. (Dep. at 12) Dr. Holmes further testified the incident of October 12, 2007 did not cause the condition of plantar fasciitis, as the mechanism of injury and an ankle sprain are not consistent with the diagnosis. (Dep. at 18) Dr. Holmes testified his opinion was also supported by the lack of a temporal connection between the incident in October of 2007 and when she first sought treatment for the symptoms associates with plantar fasciitis on November 30, 2007. (Dep. at 19)

Dr. Holmes further opined Petitioner's activities, including the walking and standing she did as a toll collector, did not cause, aggravate or accelerate the condition of plantar fasciitis. (Dep. at 20-21) Dr. Holmes testified there is no scientific correlation between plantar fasciitis and activities of walking and standing. (Dep. at 20-21) In studies comparing the incidence of plantar fasciitis of those in sedentary occupations to those in occupations that required extensive standing/walking, Dr. Holmes testified, there was no scientific data to show a higher or increased incidence of the condition. (Dep. at 21-22) He further identified several risk factors for the development of the condition, which included obesity and pes planus deformity (flat footedness) as well as a higher incidence of the condition in women when compared to men. (Dep. at 22-23) Dr. Holmes also suggested an underlying enthesopathy needed to be explored in Petitioner's case due to the bilateral nature of her condition, suggesting a blood test was needed to assess whether there was an inflammatory process caused by a C-reactive protein, uric acid and sed rate. (Dep. at 23)

Petitioner testified she continues to experience a sharp pain in her heels. She testified she is unable to wear 2 to 4 inch heels and cannot walk around barefoot. She tries to do mall shopping, but cannot walk more than 200 feet comfortably. She estimated she talks about 800 mg of Ibuprofen 2 times a week.

14IWCC0143

In support of the Arbitrator's Decision relating to C, did an accident occur that arose out of and in the course and scope of employment, the Arbitrator finds the following:

It is Petitioner's burden to prove by a preponderance of the credible evidence all elements of her claim, including whether the accident arose out of and in the course and scope of her employment. *See*, Hannibal v. Industrial Commission, 38 Ill.2d 473, 231 N.E.2d 409, 410 (1967); Illinois Institute of Technology v. Industrial Commission, 68 Ill.2d 236, 369 N.E.2d 853, 12 Ill.Dec. 146 (1977). In this instance, Petitioner alleges she developed a condition of bilateral plantar fasciitis from standing and walking while at work. To establish entitlement to benefits for a repetitive injury, Petitioner must prove her physical structure gave way under the repetitive stresses of usual work tasks. *See*, Darling v. Industrial Commission, 176 Ill.App.3d 186, 530 N.E.2d 1135, 125 Ill.Dec. 726 (1st Dist. 1988).

It is Petitioner's contention she developed bilateral plantar fasciitis from either a specific trauma incident on October 12, 2007 (see the Arbitrator's Decision in the companion case of 09 WC 10628 for why Petitioner did not establish this to be the case by a preponderance of the credible evidence) or as a result of standing/walking required while she was at work. To support her position, Petitioner relied on the testimony of the podiatrist, Dr. Brown. Dr. Brown's opinion Petitioner's work activities either aggravated or accelerated a condition of plantar fasciitis was premised upon a hypothetical question presented to her during her deposition. Dr. Brown's opinion was therefore based on the understanding Petitioner spent up to twelve hours a day on her feet, worked 40 or more hours in a week, spent the majority of her day either standing or walking and carried "multiple" bags or trays of coins/money weighing up to 25 lbs. several times each day. The premise for Dr. Brown's opinion, though, was not supported by Petitioner's testimony or by the other evidence. *See, Carlson v. Caterpillar, Inc.*, 09 IWCC 0155, 2009 WL 686370 (2009) for comparison.

The Arbitrator finds Petitioner did not spend the majority of her day either walking or standing. Petitioner was employed as a toll collector. She worked in a toll booth where fatigue mats were on the floor of each toll booth and a stool was provided for her use. While both Petitioner and Respondent's witness, Doyle, testified the stool was to be used for breaks during lesser periods of traffic volume, Petitioner's attempt to establish she either stood or walked continuously with no breaks is simply not believable. Petitioner worked the 2nd or 3rd shifts. She acknowledged traffic volume was lower during the 2nd and 3rd shifts, which would provide her with ample opportunity to sit and rest on the stool. When Doyle observed Petitioner working, as with most toll collectors, he observed her sitting down, not standing in the toll booth. The position of a toll collector is sedentary. Moreover, the evidence shows Petitioner did not work 12 hour days as she reported to the medical providers or as presented to Dr. Brown in the hypothetical during her deposition. Instead, the evidence showed Petitioner worked on average 6 to 8 hour shifts. She only worked 11 or more hours on 20 different days during an almost two year period.

During her testimony, Petitioner suggested she primarily worked as a "relief" cashier, which required her to move from toll booth to toll booth to break the other toll collectors. However, when she returned to Dr. Brown on January 6, 2009, the history Petitioner provided suggests she had only recently begun working as the relief cashier. She reported to Dr. Brown a "new" job required her to now do a lot of walking, carrying of packages and going up and down stairs several times each day. Before the "new" job, Petitioner reported she was otherwise allowed to stay in one place for the day and not much ambulation was required. The history she provided to Dr. Brown on January 6, 2009 was inconsistent with Petitioner's testimony and suggests the degree of walking she performed in the work place before January of 2009 was substantially less.

Before and immediately after the incident on October 12, 2007, Petitioner had no complaints or symptoms consistent with plantar fasciitis. Following the incident, her activities were limited for a period of time by her need to utilize crutches. As her job was sedentary and Respondent was able to accommodate her need to use crutches, Petitioner continued working as a toll collector. She made no mention of symptoms consistent with plantar fasciitis when seeking medical treatment for the ankle sprain on October 13, 2007. She had no such complaints when seeking treatment for an unrelated knee condition on November 30, 2007. Suddenly, on December 14, 2007, Petitioner reported symptoms of bilateral heel pain with the right being worse than the left reporting the symptoms as part of a regular physical. When she then presents to Dr. Brown for the first time on December 19th, she contended the symptoms had been present for 6 months; yet, she never made mention of the symptoms in October or November when seeking medical treatment.

The Arbitrator recognizes Petitioner did do some walking and standing while working as a toll collector. Dr. Holmes recognized that the while the position was primarily sedentary, it did involve some walking and standing. However, as noted by Dr. Holmes the extent to which Petitioner walked or stood in order to perform her duties as a toll collector did not cause, aggravate or accelerate the condition of bilateral plantar fasciitis. It is also clear Petitioner did not stand on a hard concrete floor while working.

Based on the foregoing, the Arbitrator does not find Petitioner's testimony she constantly stood and walked while working as a toll collector on the 2nd and 3rd shifts credible. The Arbitrator therefore finds Petitioner failed to establish an accident arising out of and in the course of her employment by Respondent. There is no credible evidence to support Petitioner's contention her physical structure gave way to injury under the repetitive stresses of usual work activities.

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

Salvatore Suera,
Petitioner,
vs.
City OF Chicago,
Respondent,

NO: 12 WC 30623
14IWCC0144

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 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 8, 2013 is hereby affirmed and adopted.

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

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

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

DATED: FEB 2 7 2014

MB/mam
O:2/13/14
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SUERA, SALVATORE
Employee/Petitioner

Case# 12WC030623

14IWCC0144

CITY OF CHICAGO
Employer/Respondent

On 8/8/2013, 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:

JOHN W TURNER LAW OFFICES
132 W NORTHWEST HWY
ARLINGTON HTS, IL 60004

0010 CITY OF CHICAGO
NANCY SHEPARD
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

14IWCC0144

FDSTATE 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
NATURE AND EXTENT ONLY

Salvatore Suera
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **12** WC **30623**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **7/24/13**. By stipulation, the parties agree:

On the date of accident, **4/8/10**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**62,455.12**, and the average weekly wage was $**1201.06**.

At the time of injury, Petitioner was **59** years of age, ***single*** with **3** dependent children.

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

Respondent shall be given a credit of $**100,198.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**100,198.00**.

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

ORDER

Petitioner suffered an injury to his left shoulder. He is right hand dominant. He ultimately underwent surgery for a rotator cuff tear and biceps tendon tear. He was ultimately returned to work with 30 pound restrictions. He did an independent job search but was ultimately placed in vocational rehabilitation. During vocational rehabilitation, he decided "he did not want to work." (See Px. 4 pg 3). He retired on August 31, 2010 voluntarily and has not looked for work since that time. He testified to ongoing range of motion issues and strength issues with his left arm/shoulder. He did not testify to any pain or to taking any pain medications as a result of this injury. He does not plan to return to the doctor for this injury. Therefore the below is ordered by the Arbitrator.

Respondent shall pay Petitioner the sum of **$664.72**/week for a further period of 88.55 weeks, as provided in Section **8(d)(2)** of the Act, because the injuries sustained caused **17.71% loss of use person as a whole**.

Respondent shall pay Petitioner compensation that has accrued from **9/1/12** through **7/24/13**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

David A. Kane
Signature of Arbitrator

August 8, 2013
Date

AUG 8 - 2013

STATE OF ILLINOIS)
)
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

Scott Baker,
Petitioner,

vs.

NO: 92 WC 37355

14IWCC0145

City of Chicago,
Respondent.

DECISION AND OPINION ON PETITIONER'S SECTION 8(A) PETITION

On April 23, 1993 Petitioner, a 39 year old auto body shop foreman, sustained an accidental injury arising out of and in the course of his employment. As a result of the accident, Petitioner underwent a three level disc fusion surgery followed by a second surgery consisting of hardware removal. A third surgery was recommended but was declined by the Petitioner. On March 17, 2003 Arbitrator Fratianni awarded Petitioner $667.00 for vocational rehabilitation, $8,101.28 in medical expenses along with ordering Respondent to pay for a psychological evaluation prior to Botox injections and morphine therapy being given. The Arbitrator also found Petitioner was temporarily totally disabled from May 19, 1992 through January 29, 2003 for 553-3/7 weeks and as of January 30, 2003 Petitioner was permanently and totally disabled. No Review was taken of the Arbitrator's decision and the decision became final thirty days after the receipt by the parties.

On October 2, 2009 Petitioner filed a Section 8(a) Petition requesting reimbursement for additional medical expenses which he claims he incurred after the March 17, 2003 Arbitrator's decision was issued. The Section 8(a) Petition was continued numerous times from March 25, 2010 through January 30, 2013. On July 31, 2013 a Review Hearing was held on Petitioner's Section 8(a) Petition. The Commission, after reviewing the entire record, denies Petitioner's Section 8(a) Petition for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner testified since the January 30, 2003 Arbitration hearing he has received

medical treatment for his work-related low back injury and he has continued under the care of Dr. Earman, an orthopedic surgeon, as well as the APAC pain management doctors. Petitioner said he has been prescribed medications for his back by Dr. Earman and APAC. He identified Petitioner's PX1 as a spreadsheet reflecting various medications attached to a computer printout from Walgreen. He identified the computer printout as medications he received from Walgreens from January 10, 2003 through December 17, 2007. He testified that the computer printout has certain prescriptions highlighted in yellow. The prescriptions that are not highlighted are not related to his work injury and the ones highlighted in yellow are related to his injury. The column on the extreme right is labeled client paid, which he said reflected his out-of-pocket portion for those medications. He denied ever being reimbursed for those out-of-pocket expenses. Petitioner's PX2 is a similar document different in scope from PX1, the earlier document, only for the period of time it covers. It starts in 2008 and ends on September 30, 2010. On cross-examination, Petitioner claims he contacted Respondent many times regarding these prescriptions. He didn't attempt to pay them using a prescription card Respondent gave him and he denied having a prescription card. He claims he was paying for these prescriptions out-of-pocket from 2003 to 2010. He not sure when he contacted his attorney regarding reimbursement for the prescriptions. He doesn't have the actual receipts from Walgreens. Rather, he has a printout from Walgreens. He testified that the prescriptions that are not related to the work accident are for hypertension and sleeping pills.

2. Petitioner's PX1-PX2 exhibits are printouts from Walgreens for January 10, 2003 through December 17, 2007 and January 1, 2008 through September 30, 2010. The original exhibits contained in the file contain yellow highlights. The copies in the transcript are not highlighted. The prescriptions were issued by Drs. Pareja, Dolehide, **Jain**, Glasser, Goodman, **Venhuizan, Tata**, Adlaka, Matheu, **Salman,** Schlenker, **Chang**, Glynn, **Parameswar, King**, Cudecki, Hatfield, Pagni, **Beyranvand, Jamil, Murtaza, McNett** and Shah. The doctors noted in bold represent doctors with treatment records in Petitioner's PX4. If the doctors' names are not noted in bold above, the Commission was not given treatment records for these doctors. Petitioner's PX3 consist of medical records from Dr. Earman for dates of service May 6, 2003 through July 16, 2013.

Having reviewed the entire record, the Commission finds Petitioner did not provide the best evidence. The best evidence would have been the prescriptions themselves as well as the receipts for payment of the same. Instead, Petitioner provided printouts from Walgreens along with a spreadsheet that is not in chronological order. Secondly, Petitioner didn't supply all of the treatment records to cover these prescriptions. The Commission finds that the treatment records are limited to Drs. Jain, Tata, Venhuizan, Salman, Chang, Parameswar, King, Beyranvand, Jamil, Murtaza, McNett. There are no treatment records for Drs. Pareja, Dolehide, Glasser, Goodman, Adlaka, Mathey, Schlenker, Glynn, Cudecki, Hatfield, Pagni or Shah. Given the treatment records the Commission was given, the Commission finds that some of the prescriptions may possibly match up with the treatment records. However, again there is no indication that Petitioner received these prescriptions as a result of these treatment or

14IWCC0145

that Petitioner paid for the same. The Commission also reviewed Respondent's RX1 and found it was not helpful in demonstrating what was paid as no specifics were given and payment was for a range of dates. Given the evidence at hand, the Commission finds that it is Petitioner's burden to prove up each and every element of his case. The Commission further finds that the best evidence was not provided in this case. The Commission finds that while there are some treatment records that may match up with the prescription dates, it is difficult to match up the same and it would be pure speculation that the prescriptions correspond to the treatment records. As such, the Commission denies Petitioner's Sec. 8(a) Petition.

IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Section 8(a) Petition 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: FEB 2 7 2014

MB/jm

O: 1/16/14

43

Maria Basurto

David L. Gore

Michael J. Brennan

STATE OF ILLINOIS)
) SS.
COUNTY OF DEKALB)

☒ 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

Aaron Hernandez,

Petitioner,

vs.

NO: 08 WC 20590

LUNA,

14IWCC0146

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 16, 2011 is hereby affirmed and adopted.

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

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

DATED: FEB 27 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
O:2/13/14
43

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.*

AARON HERNANDEZ
Employee/Petitioner

v.

LUNA
Employer/Respondent

Case # **08** WC **20590**

DEKALB

14IWCC0146

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.

Signature of arbitrator or commissioner

6/16/11
Date

14IWCC0146

ILLINOIS WORKERS' COMPENSATION COMMISSION

FILED
2011 JUL 21 PM 3:21
ILLINOIS WORKERS' COMPENSATION COMMISSION

AARON HERNANDEZ, Petitioner,	)	
-vs-	)	NO: 08 WC 020590
LUNA EQUIPMENT INC. Respondent	)	

MOTION TO VACATE DISMISSAL FOR WANT OF PROSECTION

Petitioner, AARON HERNANDEZ, by his attorney, THE VRDOLYAK LAW GROUP, LLC, MICHAEL P. CASEY, and moves the Illinois Workers' Compensation Commission to Vacate Dismissal for Want of Prosecution entered June 16, 2011 and in support states:

1. This matter was set for hearing before Honorable Arbitrator Edward Lee on June 16, 2011 at the DeKalb Calendar.

2. Petitioner's office had inadvertently listed the matter as on the Chicago calendar.

3. Petitioner's attorney did appear before Arbitrator Pulia at the Chicago calendar that date for pending claims (Gonzalez v. El Cuaco 08 WC 20592).

4. Petitioner's attorney discovered that the Hernandez v. Luna was not on the call before Arbitrator Pulia but was in fact set before Arbitrator Lee in DeKalb. Consequently no one appeared before Arbitrator Lee.

5. Failure to appear was through inadvertence.

6. Therefore, Petitioner asks the Illinois Workers' Compensation Commission to reinstate the case to allow Petitioner to present his claim.

VRDOLYAK LAW GROUP, LLC

By: MICHAEL P. CASEY, Attorney for Petitioner

THE VRDOLYAK LAW GROUP, LLC
By: Michael P. Casey #2221
Attorney for Petitioner
741 N. Dearborn Street
Chicago, IL 60654
(312) 482-8200

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

Jacqueline Merritt,

Petitioner,

vs.

NO: 11 WC 12585
14IWCC0147

Brightside Adult Day Service,

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 1, 2013 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.

14IWCC0147

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,600.00. 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: FEB 2 7 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
O:2/13/14
43

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

MERRITT, JACQUELINE
Employee/Petitioner

Case# 11WC012585

14IWCC0147

BRIGHTSIDE ADULT DAY SERVICE
Employer/Respondent

On 7/1/2013, 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 0.10% 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:

2489 LAW OFFICE OF JIM BLACK & ASSOC
BRAD A REYNOLDS
308 W STATE ST SUITE 308
ROCKFORD, IL 61101

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
ARIK HETUE
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

14IWCC0147

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
19(b)

Jacqueline Merritt
Employee/Petitioner

v.

Brightside Adult Day Service
Employer/Respondent

Case # 11 WC 012585

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 J. Holland**, Arbitrator of the Commission, in the city of **Rockford**, on **June 11, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

IN AND BEFORE THE
ILLINOIS WORKERS' COMPENSATION COMMISSION

Jacqueline Merritt, Employee/Petitioner,	)	
v.	)	Case No. 11 WC 012585
Brightside Adult Day Service, Employer/Respondent.	)	

STATEMENT OF UNDISPUTED FACTS

Petitioner Jacqueline Merritt worked for Brightside Adult Day Service as a CNA. Petitioner worked for the Respondent for four years. Petitioner testified her primary duties as a CNA included: care for the elderly, taking residents to the bathroom, doing activities, and preparing lunch.

Petitioner testified that she sustained injury to her left wrist and left elbow on February 17, 2011. Ms. Merritt testified that the injury date was an activity date at the facility. Ms. Merritt described that one of the residents, who was 90 years old and weighed 200 pounds, tried to dance and the resident began to fall. Ms. Merritt, who is left handed, grabbed the resident with her left wrist and arm to hold him up so that he would not fall and break his hip. Ms. Merritt testified that she got the resident safely to a chair, but immediately her left hand became swollen. Ms. Merritt testified that when she grabbed the resident, she felt a burning sensation up to her left elbow and had swelling in her left wrist. Respondent does not dispute accident. See Arbitrator's Exhibit No. 1.

DISPUTED ISSUES

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

Initially the Petitioner was seen at the direction of her employer at Brookside Immediate Care. The nurse's note from February 17, 2011 records history that the Petitioner was trying to keep a patient from falling when she hurt her left wrist. PX 1. Petitioner was seen by Dr. Shuttari who noted similar history that the Petitioner was trying to prevent a patient from falling and in the process, she sprained her left wrist. PX 1. Physical examination of the left wrist showed tenderness over the radial aspect. Range of motion of the wrist was markedly limited. X-ray of the left wrist showed questionable distal radial fracture. PX 1.

The diagnosis was left wrist sprain with questionable fracture of the distal radius. Petitioner was placed in a Colles splint. She was given extra strength Tylenol and placed on a work restriction of right hand duty only. The patient was given 60 milligrams of Toradol. PX 1.

14IWCC0147

FINDINGS

On the date of accident, **2-17-11**, 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 **$17,576.00**; the average weekly wage was **$338.00**.

On the date of accident, Petitioner was **54** 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 **$3,637.47** for TTD, **$0** for TPD, **$0** for maintenance, and **$7,909.99** for other benefits, for a total credit of **$11,547.46**.

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

ORDER

The Respondent is ordered to authorize and pay for the surgeries to the left wrist and left arm prescribed by Dr. Charles Carroll.

The Respondent shall pay Petitioner $225.33 per week for a period of 118 &1/7 weeks from 3-7-11 through 6-11-13 for temporary total disability, and the Respondent shall be entitled to a credit of $3637.14 for payments already made.

The Respondent shall pay Petitioner $3006.00 for outstanding medical after 7-1-11, and be entitled to a credit of $7909.00 for medical paid prior to 7-1-11 pursuiant to Section 8(j) of the Act.

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

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

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

Douglas J Holland

Signature of Arbitrator

6-26-13
Date

ICArbDec19(b)

JUL - 1 2013

Subsequently, nurse's notes reflect that the Petitioner contacted Brookside Immediate Care on February 23, 2011 reporting that her **left arm** was killing her and she was asking to be seen. Petitioner was then seen on February 24, 2011. In the nurse's notes, it was noted that the Petitioner was being seen in follow-up of her left arm. Petitioner reported significant pain and complained of swelling of her left wrist, even after elevation. **Petitioner also complained of a burning sensation in her left arm in history given to the nurse.** PX 1.

Petitioner was seen by Dr. Shuttari on February 24, 2011. Dr. Shuttari noted her complaints of pain with markedly limited range of motion. Physical examination of her left wrist demonstrated significant tenderness over the distal aspect of the radius with marked limited range of motion. Poor left hand grip was also noted secondary to pain. PX 1. Repeat x-rays were performed. At that time, it was recommended that the Petitioner be evaluated by an orthopedic physician. She remained on work restrictions of right hand duty only. She was to continue with the Colles splint. PX 1.

Petitioner was next seen by orthopedic physician, Dr. Milos on March 2, 2011. Dr. Milos noted her history that she was helping a client from falling when she twisted her left wrist and sustained a direct injury. Dr. Milos noted no previous problems with the wrist. *Since the date of the injury, the Petitioner had pain in her left wrist, and also a burning pain in her forearm.* PX 2. Physical examination revealed tenderness to palpation over the radius distally of the left wrist. She had stiffness with range of motion, secondary to pain. X-rays were reviewed, which demonstrated what appeared to be an old distal radius fracture. Dr. Milos diagnosed a left wrist injury. PX 2. Dr. Milos recommended an MRI scan of the left wrist to rule out other abnormalities. She was kept on modified duty to only work with her right hand. PX 2.

In initial history taken by the nurse on March 2, 2011, it was noted that she was to be evaluated for left wrist upper extremity complaints to include her wrist and her arm. It was noted that she had sustained injury when a client she was caring for was falling and the patient had attempted to break the fall by using her left wrist to grab the patient and sustained a twisting injury. PX 2. Ms. Merritt was next seen by Dr. Milos on April 6, 2011. She continued to have significant complaints of pain in her left wrist. On physical exam, she had pain with movement of the **wrist and elbow.** The MRI was reviewed, which revealed some degenerative changes of the TFCC. Dr. Milos recommended physical therapy with modalities and desensitization exercises with the left wrist. PX 2. Dr. Milos was concerned of some early signs of chronic regional pain syndrome, which he felt could be addressed in physical therapy. She was continued on right-handed work only. Ms. Merritt then completed a course of physical therapy with little or no improvement in her symptoms.

On October 17, 2011, Dr. Milos recommended an FCE to determine final work restrictions. PX 2. She continued to remain on light-duty work under the care of Dr. Milos through November 17, 2011. PX 2. Petitioner was then examined for an IME by Dr. Hagman on October 6, 2011. A valid hearsay objection to Dr. Hagman's IME report was sustained. Thereafter, the Petitioner was sent for an IME arranged by the Respondent with Dr. Vender. As part of Dr. Vender's IME, an EMG of the left upper extremity was performed on June 29, 2011. The history noted in EMG was of intermittent second, third, and fourth digit tingling and burning with occasional radiation up the dorsal forearm, lateral arm/elbow with associated stiffness, and hand weakness following the work injury on February 17, 2011. PX 4. The EMG revealed mild left ulnar neuropathy across the left elbow and it was considered an abnormal exam. PX 4.

Dr. Vender performed an IME at the request of the Respondent on June 2, 2011. RX 2-3. Dr. Vender noted Petitioner's history of sustaining injury to her left upper extremity on February 17, 2011 when she was trying to catch a patient from falling and twisting her wrist. At the time of Dr. Vender's IME, Petitioner complained of mild pain in her wrist with more significant burning sensation in her forearm up to her elbow. Dr. Vender noted intermittent tingling in the index, middle, and ring fingers. RX 2. Physical examination revealed multiple areas of tenderness across the distal radius. There was also tenderness noted along the distal half of the ulnar border. X-rays showed a healed ulnar styloid fracture. Dr. Vender's diagnosis was status post injury left wrist. RX 2. Dr. Vender reviewed x-rays and previous diagnostic studies. Based on her complaints of forearm numbness and tingling as well as intermittent numbness in the fingers, Dr. Vender ordered an EMG. RX 2. Dr. Vender did not feel the MRI of the left wrist, which demonstrated some fraying of the TFCC, explained her symptoms. RX 2. Dr. Vender felt the Petitioner could work but if she was going to perform heavy lifting, she needed a wrist support. RX 2. Dr. Vender then issued a second report dated July 1, 2011, after review of the EMG. Dr. Vender noted the results of mild ulnar neuropathy at the left elbow, but opined that the Petitioner's injury was a twisting injury to the wrist and that would not contribute to ulnar neuropathy at the elbow. RX 3.

Respondent denies that Petitioner's current condition of ill-being regarding her left wrist and elbow are causally related to her February 17, 2011 work injury, based upon the IME opinions of Dr. Vender.

In support of causal connection, Petitioner offered the treating records of Dr. Charles Carroll. PX 5. Dr. Carroll first examined the Petitioner on September 14, 2012 after receiving authorization from the Respondent to do so. PX 7. Dr. Carroll noted Petitioner's history of injury on February 17, 2011, followed by pain and loss of function of Petitioner's left wrist and elbow after helping a patient from falling and twisting her left wrist. PX 5. Dr. Carroll noted Petitioner's ongoing complaints of a burning sensation in her left forearm and elbow, as well as numbness and tingling in her left hand. Dr. Carroll noted previous x-rays and EMG results. Wrist and elbow pain were described as disabling. Dr. Carroll reviewed medical records, as well as the IME opinion of Dr. Vender. PX 5. Dr. Carroll performed physical examination. Provocative testing for compressive neuropathy was positive at the ulnar nerve of the left elbow. Petitioner was tender over the left ulnar nerve and had a positive compression test to the groove. The neurological exam was positive for left sided carpal tunnel, left cubital tunnel, and radial nerve compression at the elbow. Phalen's and Tinel's tests of the median nerve were positive on the left. Elbow flexion tests in ulnar nerve compression tests at the elbow were positive. X-rays were obtained by Dr. Carroll on the initial date of consultation. Diagnosis was left CTS and left ulnar neuritis causally related to the February 17, 2011 work injury. PX 5.

Dr. Carroll placed the Petitioner on a work restriction of no lifting greater than 10 pounds and no forceful grasp. PX 5. Dr. Carroll recommended left carpal tunnel release and left ulnar nerve release. Dr. Carroll opined that additional conservative treatment, including additional therapy, would not alleviate the Petitioner's symptoms. PX 5. No additional testing was indicated. Dr. Carroll specifically opined that elbow surgery only would not solve the Petitioner's problems and that she would need carpal tunnel release as well. PX 5. Dr. Carroll opined that observation alone would not solve the Petitioner's left wrist and elbow problems. Only surgery of the left wrist and left elbow would resolve Petitioner's symptoms, according to Dr. Carroll. PX 5.

Dr. Carroll then re-evaluated the Petitioner on March 4, 2013. At that time, she still had tingling in the ulnar elbow and occasionally to her fingers of her left hand. Petitioner was ready to proceed with surgery upon approval by the Respondent. Her symptoms were unchanged. She remained on work restrictions of no use of her left arm at that time. PX 5. Physical examination of the left elbow revealed provocative testing for compressive neuropathy at the ulnar nerve at the elbow and positive ulnar neuritis on left compression, Tinel and Ulnar Nerve Compression tests. PX 5. Neurologically, Petitioner was positive for left CTS and left cubital tunnel syndrome with positive Phalen's and Tinel's tests. Diagnosis continued to remain lesion of the left ulnar nerve and left CTS following work injury. PX 5.

The Arbitrator finds that the Petitioner sustained her burden of proving her current condition of ill-being regarding her left wrist and left elbow are causally related to her February 17, 2011 work injury. Several reasons support this finding. First, Petitioner sustained injury to her left upper extremity after grabbing a 90 year old resident, who weighed 200 pounds, so that he would not fall. Medical records describe a twisting injury, which Petitioner sustained on February 17, 2011. The Respondent does not dispute accident.

Petitioner had no significant past medical history concerning her left upper extremity. Prior to the date of injury, Petitioner was not actively treating for her left wrist nor her left elbow. Petitioner was working full-duty in a heavy job without any work restrictions until the injury date. Petitioner's symptoms were immediate and contemporaneous with her work injury. She was seen on the date of injury with complaints of left wrist pain and swelling. Less than one week later, she called the occupational clinic and reported her left arm was killing her. In nurse's notes at her second visit to Brookside Immediate Care, she complained of left wrist and left forearm and elbow pain. Specifically, she reported swelling of her left wrist even after elevation **and** a burning sensation in her elbow. Left wrist weakness and diminished grip strength on the left were noted in her early on medical records, symptoms which were consistent with CTS.

When seen by Dr. Milos, on referral from the occupational clinic, it was clear that she was evaluated for left wrist and left arm (elbow) pain. Dr. Milos' physical exam on April 6, 2011 revealed positive pain at the wrist and the left elbow during provocative testing. Respondent's own expert noted her history of numbness of tingling in her fingers, and the EMG ordered by the Respondent's IME doctor was positive for left ulnar neuropathy. Taken together, the above facts demonstrate Petitioner's left wrist and elbow symptoms were the direct result of her February 17, 2011 injury.

Second, the Arbitrator is persuaded and credits the opinion of Dr. Carroll over that of Dr. Vender. Dr. Carroll considered Petitioner's mechanism of injury, all her prior records, and the opinions of Dr. Vender. Dr. Carroll, who is well reputed, noted positive clinical exam findings for the left wrist and left elbow neuropathies in addition to objective studies to support the same. The Arbitrator is persuaded by the opinion of Dr. Carroll and adopts it.

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

Respondent denied liability for any medical treatment after July 1, 2011, based upon the opinion of Dr. Vender. The Arbitrator finds the Petitioner sustained her burden of proving causal connection. There is no opinion offered by Dr. Vender or any other medical provider that treatment rendered to the date of the parties' hearing was unreasonable or unnecessary. The Arbitrator finds Petitioner's treatment was reasonable and necessary through the date of hearing to treat the Petitioner's condition of ill-being. Respondent is ordered to pay the following unpaid medical bills, pursuant to the Illinois Fee Schedule:

Medical Provider	Date(s) of Service	Unpaid Balance
Orthopedic Rehab Specialists (ORS)	10/27/11-11/18/11	$1,884.00
North Shore University Hospital	9/14/12	$674.00
Rockford Radiology	3/14/11-9/14/12	$448.00

Respondent is entitled to a credit in the amount of $7,909.00 for medical benefits previously paid to various medical providers for treatment prior to July 1, 2011, pursuant to 8(j) of the Act.

K. Is Petitioner entitled to any prospective medical?

The Arbitrator is persuaded by the opinions of Dr. Charles Carroll. Petitioner has a diagnosis of work-related left CTS and left ulnar neuropathy. Surgery to the left wrist and left elbow are recommended by the treating surgeon. The Arbitrator orders the Respondent to authorize both left wrist and left elbow surgery.

L. What temporary benefits are in dispute?

☐ TPD ☐ Maintenance ■ TTD

Respondent disputes liability for TTD based upon the opinions expressed by Dr. Vender. Respondent disputes the duration of TTD benefits based on Dr. Vender's opinion that the Petitioner could perform work with a wrist splint if it involved heavy lifting. Petitioner was treated at the direction of the employer at Brookside Immediate Care, where she was placed on a work restriction of no use of her left upper extremity- right hand work only. Petitioner is left hand dominant. When seen by Dr. Milos at Lundholm Surgical Group, she continued on a right hand work only restriction through October of 2011. When seen by Dr. Charles Carroll in September of 2012, Dr. Carroll continued to confirm that the Petitioner could not work full-duty, but required light-duty restrictions.

Petitioner testified that the Respondent failed to offer any light-duty work to her following the injury and while she remained on work restrictions. Petitioner testified that no light-duty work had been offered at any time by the Respondent prior to the parties' hearing date.

The Arbitrator finds that the Petitioner is not capable of performing full-duty work, based on the opinions expressed in Petitioner's treating records, as well as the opinion of Dr. Charles Carroll. When last seen on March 14, 2013, the Petitioner continued to remain highly symptomatic and she remained under the care of Dr. Carroll who was awaiting authorization for left wrist and left elbow surgery. Petitioner performs heavy work as a CNA. Petitioner is left hand dominant. The Arbitrator finds the Petitioner is not capable of full employment since the injury date until the time of the parties hearing. Based on the principals articulated in *Interstate Scaffolding v. The Illinois Workers' Compensation Commission* and since the Petitioner has not achieved MMI, the Arbitrator orders the Respondent to pay TTD benefits from March 7, 2011 through June 11, 2013, or 118 and 1/7 weeks of TTD. Respondent is entitled to a credit for TTD previously paid from March 7, 2011 through June 6, 2011 in the amount of $3,637.47.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Palermo,
Petitioner,
vs.
Proviso Township HSD #209,
Respondent,

NO: 12 WC 20320
14IWCC0148

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 expenses, 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 April 19, 2013 is hereby affirmed and adopted.

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

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

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

DATED: FEB 27 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
O:2/13/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PALERMO, JAMES
Employee/Petitioner

Case# 12WC020320

14IWCC0148

PROVISO TOWNSHIP HSD #209
Employer/Respondent

On 4/19/2013, 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 0.09% 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:

0311 KOSIN LAW OFFICE LTD
MARILYN KOSIN
134 N LASALLE SUITE 1340
CHICAGO, IL 60602

0863 ANCEL GLINK
ERIN BAKER
140 S DEARBORN ST 6TH FL
CHICAGO, IL 60603

14IWCC0148

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

James Palermo
Employee/Petitioner

v.

Proviso Township HSD #209
Employer/Respondent

Case # 12 WC 20320

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **March 6, 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

On **May 15, 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. In light of this finding, the Arbitrator views the remaining disputed issues as moot.

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

In the year preceding the injury, Petitioner earned **$55,763.78**; the average weekly wage was **$1,072.38**.

On the date of accident, Petitioner was **55** years of age, *single* with **0** dependent children.

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**.

ORDER

Petitioner lacked credibility and failed to prove he sustained an accident on May 15, 2012 arising out of and in the course of his employment by Respondent. Compensation is denied. The Arbitrator views the remaining disputed issues as 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.

Molly C Mason
Signature of Arbitrator

April 19, 2013
Date

APR 19 2013

James Palermo v. Proviso Township High School District #209
12 WC 20320

Arbitrator's Findings of Fact

Petitioner was 56 years old as of the March 6, 2013 hearing. T. 9. Petitioner testified he has worked for Respondent for 8 ½ years. T. 9. He began working at his present location, the Proviso Math & Science Academy, about 7 years ago. At that location, he has always worked as a night custodian. T. 10. His shift starts at 4:00 PM and ends at midnight. T. 10. His duties include cleaning and maintaining classrooms. As of May 2012, his supervisor was Calvin Taylor, Respondent's "night time custodian." T. 11.

Petitioner testified he felt "all right" before May 2012. T. 11. He acknowledged taking time off work on three or four occasions between January 1, 2012 and May 15, 2012. He took this time off due to low back pain and colds. T. 12. He completed forms in connection with these absences, per Respondent's protocol. He gave the forms to a receiving clerk who turned them in to the main office. T. 12-13. "Absence Request" forms offered into evidence by Respondent reflect that Petitioner took the following days off due to back pain between January 1, 2012 and May 15, 2012: February 22-24, March 29 and April 16.

Petitioner denied undergoing any low back treatment between January 1, 2012 and May 15, 2012. He did not have a personal physician during this period. T. 13.

Petitioner testified he reported for work at 4:00 PM on May 15, 2012. During the next three hours, he vacuumed, swept halls and cleaned the library and a couple of other rooms. He did all of this work on the third floor, his assigned work area. No other custodian was assigned to the third floor that evening. Other custodians worked on the first and second floors. T. 14-15.

Petitioner testified he customarily used a wheeled cart to transport his mop, broom, bucket and cleaning supplies. T. 16. The cart was about 3 ½ feet long and 2 ½ feet wide. The cart is shown in the photograph marked as PX 1. T. 17. He stored this cart in one of two closets on the third floor. Employees commonly referred to these closets as "kitchens" but the closets did not contain conventional kitchen appliances. T. 17-18. One of the third floor "kitchens" was about 10 feet by 10 feet in size. The other was smaller. Each "kitchen" contained a commercial sink (made of concrete, T. 33) and various supplies. The sinks were about 3 or 4 feet above the floor. The larger "kitchen" also contained a wheeled folding chair (depicted in PX 3) and a table. The legs of the chair angled slightly outward. The "kitchens" were kept locked. Petitioner and Respondent's other custodians had keys, as did the supervisors. T. 19.

Petitioner identified PX 2 as a photograph of the interior of the larger third floor "kitchen." PX 2 shows the sink, a bucket and a hose running from the sink faucet. T. 23-24. Petitioner testified he uses this hose to fill his mop bucket with water. T. 24.

Petitioner testified that his claimed work accident occurred at about 7:00 PM on May 15, 2012. Shortly before the accident, he mopped the north stairwell between the second and third floors. He then went to the larger third floor "kitchen" to change the water in his bucket. T. 26. Immediately before the accident, the double doors to the "kitchen" were open and the cart was positioned so that about half of it was inside the "kitchen." T. 27-28. He lifted the bucket and poured some dirty water down the sink drain. He did not spill any water on the floor when he did this. T. 28. He put the bucket on the cart. He then grabbed his mop with his left hand. T. 32. As he did this, his right foot got caught underneath the cart and his left foot got caught underneath the chair, which was to his left, about 2 or 2 ½ feet from the sink. T. 31. He was wearing work shoes when this happened. T. 38. The back of one of his shoes hit a wheel on the chair. T. 38. He "had no leverage" and fell "all the way back," striking his left shoulder, left elbow and neck against the sink. His head went inside the sink. T. 33. The photograph marked as PX 4 shows the sink and the area where he landed. He believes he lost consciousness. He was "in and out," awareness-wise, thereafter. T. 38-39.

Petitioner testified the bucket was about half full when he fell. He believes he must have knocked the bucket over when he fell because he was all wet when he "woke up." He was still holding the mop handle in his left hand when he came to. The mop had fallen between the supply rack and the drain. When he "came to," he saw his walkie-talkie and used it to call Calvin Taylor, another custodian. T. 39. He told Taylor, "come to the 'orange side' closet, I hurt myself." Taylor showed up about five minutes later. T. 39. Petitioner did not radio anyone else. T. 40. Petitioner testified he did not move between the time he fell and the time Taylor arrived. T. 40. He believes Taylor was alone when he arrived. He told Taylor he had fallen. T. 41. He thinks Taylor called Ron Anderson, the building manager. Anderson was on the premises because a board meeting was taking place in the auditorium at 7:00 PM that night. T. 41. Anderson arrived while Petitioner was still in the "kitchen." T. 42. Paramedics arrived at some later point and took Petitioner to Loyola University Medical Center via ambulance. T. 41-42.

Petitioner testified he "woke up" due to pain while en route to the hospital as paramedics inserted an IV line into his arm. T. 43.

The Loyola University Medical Center records show that paramedics from the Forest Park Fire Department brought Petitioner to the Emergency Room at 8:21 PM on May 15, 2012. The paramedic run sheet is not in evidence. One of the Emergency Room histories reflects that Petitioner "tripped and fell" and experienced a "questionable" loss of consciousness thereafter. Emergency Room personnel described Petitioner as alert, oriented and "speaking in full and clear sentences." Petitioner complained of "L shoulder pain, HA, neck pain and tinnitus." Petitioner rated his pain level at 8/10. Petitioner denied shortness of breath and chest pain. He also denied nausea, vomiting and dizziness. He was placed on cardiac and other monitors. Dr. Reingold, the Emergency Room physician, obtained the following history:

> "Pt presents to the ED with a CC: fall w/ injuries to head, neck L shoulder. Onset just prior to arrival,

severity mod, quality ache location: as noted. Pt slipped on wet floor. No pre-syncope. Doesn't remember whether he had LOC but thinks he might have. Denies injury to back or LEs or RUE. Some bilateral tinnitus that is new."

Dr. Reingold noted that Petitioner's medical history was significant for hypertension and diabetes. He administered an injection of Morphine for pain. He indicated Petitioner was wearing a cervical collar. On examination, he noted no ecchymoses to the head, no focal weakness to the face or extremities, no signs of intoxication, some tenderness to the neck, posterior left shoulder and left elbow and "nearly full pronation/supination of elbow." He ordered X-rays of the left shoulder and elbow and CT scans of the head and cervical spine along with an EKG and blood work. The X-rays were negative. The head CT scan revealed evidence of "chronic small vessel ischemic disease." [The radiologist noted he compared this CT with a head CT scan taken on January 4, 2010.] The cervical spine CT scan was described as negative, with a radiologist ruling out subluxation at C2-3. The EKG showed "80 bpm bigeminy, an effective pulse of 48, a T wave abnormality and a prolonged QTC." The interpreting physician compared this EKG with one performed on January 4, 2010 and noted that "ventricular premature complexes" had developed. At about 12:32 AM on May 16, 2012, Dr. Reingold noted that he discussed the need for hospitalization with Petitioner and warned of "the possibility of passing out or heart attack," but that Petitioner indicated he was able to walk around, "felt fine and wanted to go home and see his own cardiologist." Dr. Reingold indicated he told Petitioner "he needed to stay and there was a serious risk to his health." Regardless, Petitioner signed out "AMA" and left the hospital. The discharge time is recorded as 12:42 AM on May 16, 2012. A nurse indicated that, when Petitioner left, he walked with a "steady, strong and even" gait, "without any s/s of distress," and "provided self transport." PX 1.

Petitioner testified he underwent a cardiac bypass in 2000. T. 44. Petitioner further testified that a physician at the Emergency Room told him his heartbeat was irregular. T. 44. Petitioner indicated he felt able to leave the hospital and go home due to the effects of the Morphine, which he described as a miracle drug. T. 45. He felt "hurt and sore" but "didn't think it was that bad." T. 45. Per instructions he received at the Emergency Room, he called his cardiologist, Dr. Bajgrowicz, the next day and saw this doctor on May 17, 2012. Dr. Bajgrowicz is the physician who performed his cardiac bypass. T. 47.

Dr. Bajgrowicz's note of May 17, 2012 sets forth the following history:

"The patient is a 55-year-old male who presents to our office for evaluation after a fall at work. He states that this Tuesday while at work he fell backwards and now complains of having headache as well as left shoulder and left elbow pain. He was evaluated at Loyola's emergency room where [a] CAT scan and other X-rays were performed. According to the patient the tests were all negative. He now complains of having dizziness

and ringing in the ears. Denies any nausea, vomiting, blurred vision or double vision. He also complains of having cough productive of clear to yellow phlegm. He denies any chest pain. He denies syncopal episode."

Dr. Bajgrowicz also noted that Petitioner had undergone a coronary bypass in November of 2000 and had sustained a myocardial infarction on October 27, 2004.

Dr. Bajgrowicz noted no abnormal examination findings other than a Grade !/V! systolic ejection murmur at the left sternal border. He described Petitioner's neck as "supple." He did not indicate that Petitioner was wearing a sling or other device.

With respect to Petitioner's current complaints, the doctor diagnosed a "presumed mild concussion" and a "productive cough, most likely upper respiratory infection with possible component of bronchitis." He started Petitioner on a Z-Pak and instructed Petitioner to follow up with his primary care physician and return to the Emergency Room if he failed to improve. PX 8.

Petitioner testified that Dr. Bajgrowicz's receptionist completed an accident form at his request. T. 51. He testified he was unable to complete the form because he is left-handed and his left arm was in a sling. Petitioner identified PX 6 as this form. Petitioner testified that none of the handwriting on PX 6 is his. T. 52. The form, entitled "Employee's Report of Injury," reflects that Petitioner was injured at 7:30 PM on May 14, 2012 inside a "janitor's kitchen." Petitioner testified that the doctor's receptionist put the wrong date of accident on the form and that he advised Respondent of this error when he turned in the form. The mechanism of injury is described as follows: "put bucket in cart, stepped back & believe tripped over a chair." The form reflects that Petitioner injured his left shoulder, head, neck and back. The word "no" appears in response to the question: "have you ever injured the same part of your body before?" The word "yes" appears in response to the question: "have you ever injured any other part of your body before?" followed by a reference to a pelvic injury stemming from a car accident. [Petitioner testified that this accident occurred in 1995. T. 55] PX 6 is not signed. Respondent offered the same form into evidence as "Exhibit 1" to its response to Petitioner's petition for penalties and fees. RX 3. Exhibit 1 appears to bear Petitioner's signature and the date "5/17/12."

Petitioner testified that Dr. Bajgrowicz told him his heartbeat was fine. T. 48. Petitioner further testified that he had no personal physician as of May 17, 2012 and Dr. Bajgrowicz referred him to Dr. Dubin. T. 48. Petitioner testified he saw Dr. Dubin on May 22, 2012. Petitioner denied seeing Dr. Dubin at any point prior to May 22, 2012. T. 49.

Dr. Dubin's note of May 22, 2012 reflects that Petitioner "fell at work tripping over ralling [sic] chair" the previous week. The note also reflects that Petitioner complained of constant pain "from his neck down to lower back," ringing in his ears and difficulty walking. The

doctor noted that Petitioner had undergone imaging studies at an Emergency Room. He also noted a history of cardiac artery disease, hypertension, diabetes and hyperlipidemia.

Dr. Dubin described Petitioner as walking with an antalgic gait "due to evident back pain." On examination, Dr. Dubin noted an abnormal heel/toe walk, trigger points in the back and neck, a positive cervical compression test with radiation to both shoulders and mid-thoracic paraspinal tenderness with muscle spasm. He diagnosed post-concussion syndrome as well as cervical, thoracic and lumbar strains. He prescribed "home rest," a home exercise program, Vicoprofen, Fioricet and Flexeril. PX 9.

Petitioner returned to Dr. Dubin on June 5, 2012 and complained of persistent neck and lumbar pain, as well as persistent headaches and nausea. Petitioner reported that the prescribed medication was not controlling his pain.

Dr. Dubin's examination findings and diagnoses were essentially unchanged. He instructed Petitioner to discontinue the Vicoprofen, continue the Flexeril and start Norco. He also instructed Petitioner to stay off work and start therapy the following week. PX 9.

At the next visit, on June 12, 2012, Dr. Dubin noted essentially the same complaints and findings. He again diagnosed post-concussion syndrome and cervical, thoracic and lumbar strains. He prescribed therapy and an MRI [there is no indication as to which body part was to be scanned]. He added Gabapentin and Elavil to Petitioner's medication regimen and continued to keep Petitioner off work. PX 9.

Petitioner testified he did not undergo an MRI in connection with this claim. T. 61. No MRI report is in evidence.

Petitioner filed an Application for Adjustment of Claim on June 12, 2012 alleging a "trip and fall" of May 15, 2012 and injuries to the head, "entire back" and left shoulder. The Application lists a prior claim numbered 88 WC 1699 and describes this case as "settled." Arb Exh 2.

On June 19, 2012, Petitioner underwent an initial physical therapy evaluation at Gottlieb Memorial Hospital. A "physical therapy face sheet" reflects the following diagnosis: neck and low back pain. A "patient information form" signed on June 19, 2012 reflects that Petitioner complained of back pain and responded "yes" to a question asking whether he had fallen during the past sixty days. A "back evaluation report" dated June 19, 2012 reflects that Petitioner reported falling at work on May 15, 2012, suffering a concussion and striking his neck and back. Petitioner complained of pain in his neck and back as well as "occasional left upper extremity numbness and tingling." Petitioner began attending therapy following this evaluation. PX 10.

Petitioner returned to Dr. Dubin on June 26, 2012 and reported he was attending therapy and walking more easily but still experiencing headaches. The doctor's findings and

diagnoses were unchanged. He instructed Petitioner to continue attending therapy and taking the prescribed medication. He again kept Petitioner off work. PX 9.

On July 10, 2012, Petitioner complained to Dr. Dubin of constant headaches, leg weakness and fatigue. The doctor noted that Petitioner was progressing slowly with therapy. The doctor noted an antalgic gait and a limited arm swing. He also noted decreased strength, "left more than right." He added "insomnia" and "left L5 radiculopathy" to Petitioner's current diagnoses. He prescribed Zolpidem to help with sleep along with four more weeks of therapy. He continued to keep Petitioner off work. PX 9.

Petitioner continued attending therapy thereafter. On August 7, 2012, a therapist completed a progress report reflecting that Petitioner was still experiencing headaches and was complaining of upper trapezius and superior scapular pain. The therapist indicated Petitioner might benefit from four weeks of therapy. An illegible physician's signature appears at the bottom of this form, with the physician indicating Petitioner was to be discharged from therapy. PX 10.

On August 10, 2012, a physical therapist noted that Petitioner reported "relief with modalities" and indicated he was "eager to return to work." PX 10.

Petitioner testified he was still experiencing headaches as of August 10, 2012 but his left elbow pain was "gone" and his left shoulder was "workable." T. 58.

Petitioner returned to Dr. Dubin on August 13, 2012, with the doctor noting, for the first time, that Petitioner complained of "persistent left shoulder/neck pain radiating down to his elbow." The doctor also noted complaints of headaches and back pain. The doctor instructed Petitioner to continue his medications. He released Petitioner to return to work as of August 20, 2012. PX 9.

Petitioner testified that Dr. Dubin prescribed additional therapy and that he underwent a second round of therapy at the doctor's office from August 16, 2012 through October 19, 2012. T. 59. Petitioner testified that this second round of therapy differed from the first round in that it involved more E-stimulation and massage. The "progress notes" concerning this therapy consist solely of pre-printed coded forms showing the date of each session, the body parts addressed during each session and Petitioner's response to therapy (i.e., "same, better, worse, no pain.") PX 9.

Petitioner testified he resumed his regular work duties and shift on August 20, 2012. Petitioner testified he "had to return to work," income-wise. He felt "okay" on August 20, 2012 and was able to complete his duties until 11:00 PM, when he pulled a garbage bag out and "reinjured" his shoulder. T. 62-63.

Petitioner returned to Dr. Dubin on August 30, 2012. The note of that date makes no mention of any work-related re-injury. It does contain the following notation, however: "pull

the muscle in his left shoulder." It also reflects that Petitioner complained of persistent headaches, constant neck stiffness, overall fatigue and depression. Dr. Dubin prescribed additional therapy, home rest and continued medication. PX 9.

At the next visit, on September 20, 2012, Dr. Dubin noted the same complaints and made the same recommendations. PX 9. Petitioner continued attending therapy thereafter through October 19, 2012. PX 9.

Petitioner returned to Dr. Dubin on October 22, 2012 and reported improvement. Dr. Dubin noted that Petitioner "did not [follow up] with ortho referral and did not complete MRI evaluation of the cervical spine." He indicated Petitioner was still experiencing headaches but was sleeping much better and experiencing much less neck pain. At Petitioner's request, the doctor administered a flu shot. He found Petitioner to be at MMI. He instructed Petitioner to "accelerate home exercise program and be careful at work." PX 9.

Petitioner testified he last saw Dr. Dubin about a month prior to the hearing. He continues to follow up with the doctor for his claimed work injuries. The doctor has changed his pain medication. [The last treatment note in evidence is the note summarized in the preceding paragraph.] He has missed time since returning to work. T. 66. His left elbow and shoulder feel good. His neck still hurts. He experiences "sharp" neck pain when he first gets up. He takes pain medication on rising. He continues to experience about three or four headaches per week. He takes both Norco and Excedrin PM for his current symptoms. T. 67-68.

Under cross-examination, Petitioner admitted that no witnesses were present when his claimed accident occurred. T. 70. He fell straight backward but "smashed" his left elbow and shoulder due to the configuration of the sink. He was unable to get up. He used his right hand to reach for his work radio. He was unconscious during at least part of his Emergency Room stay. T. 71. He left the hospital against medical advice, despite being unable to move his left arm, because he only felt "sore" after being given Morphine. He hates hospitals. Hospital personnel transported him to the exit via a wheelchair. Once he got out of the wheelchair, he walked on his own. A hospital guard gave him a ride to Respondent's parking lot, where he had left his car. He was sore but was able to drive home. He lives only four blocks from the school where he works. T. 71-72. He denied re-entering the school that night. He did not undergo the MRI that Dr. Dubin recommended because he felt better and did not want to lose more time from work. Although PX 2 reflects that he did not previously injure the body parts involved in the May 15, 2012 accident, he did in fact injure his left shoulder before that date. In 1988, he sustained a slight tear to his left rotator cuff. T. 77. He filed a workers' compensation claim in connection with this injury. He considers a rotator cuff tear an injury to the "armpit" rather than the shoulder. T. 78. Dr. Dubin is now his personal care physician. He sees the doctor for regular check-ups. He is scheduled to return to the doctor in the latter part of March 2013. He is currently working full duty. T. 79.

On redirect, Petitioner denied undergoing any treatment for his left shoulder between the time he recovered from the 1988 injury and May 15, 2012. He has received no benefits to date in connection with the instant claim. T. 80.

Ronald Anderson testified on behalf of Respondent. Anderson testified he began working for Respondent in October of 2007. He worked as a night foreman for three years and was then promoted to his current job as building and project manager. He oversees custodians and their supervisors. He also oversees construction projects. T. 83-84

Anderson testified he has known Petitioner since October of 2007. Petitioner worked on May 15, 2012. T. 85. On that date, Anderson met with Petitioner, gave Petitioner a letter and advised Petitioner of an upcoming meeting with human resources concerning an incident in which Petitioner supposedly failed to perform his job as instructed and used vulgar language when talking to a supervisor. Petitioner was "on his last warning" and was facing possible termination. T. 87. It was within fifteen minutes of Petitioner receiving the letter that Anderson received a call from Calvin Taylor indicating Petitioner was lying on the floor inside one of the janitor closets. T. 88. Anderson testified he went to this closet after Taylor called him. The closet was about 10 feet by 7 feet in size. When Anderson arrived, he saw a chair in the doorway. The cart was outside the closet. A bucket was on top of the cart. Anderson testified he used his Respondent-provided cell phone to take pictures of the closet and Petitioner after he arrived at the scene. Petitioner was lying on his right side and holding his left wrist. Petitioner said he had hit his head on the mop and sink. Petitioner indicated he injured his head, neck, back and left shoulder. The sink was about 3 feet away from Petitioner. Petitioner was conscious and talking in a normal fashion. Petitioner was not bleeding. Petitioner's pants were wet. T. 93-95.

Anderson testified that "they" called 911. He did not see Petitioner again that night after the paramedics took Petitioner away. At midnight, he received a call from Corey Johnson, one of Respondent's custodians. Johnson told him he had seen Petitioner re-entering the school building. T. 95.

Anderson testified that Petitioner took time off from work due to pain before May 15, 2012. Respondent employees are required to complete "absence request" forms when they take time off due to illnesses or vacation. Anderson sees these forms in the course of his duties. Anderson identified seven different forms Petitioner completed in connection with taking time off due to back pain. Four of these forms relate to eight days Petitioner took off in 2010. The remaining forms relate to six days Petitioner took off in February and April of 2012. T. 96-98. RX 1.

Under cross-examination, Anderson tendered his cell phone to Petitioner's counsel so that she could see the photographs he took of Petitioner and the closet on May 15, 2012. These photographs are not in evidence. T. 102.

Anderson testified he went up to the third floor before 7:00 PM on May 15, 2012. The letter he gave to Petitioner bore a date earlier than May 15, 2012 but he was unsure of the date. Anderson testified he received this letter from Ronald Pearson via electronic mail. Anderson printed the letter out so he could hand deliver it to Petitioner. He was not required to personally deliver the letter but it was his practice to personally deliver letters of this sort. T. 104. No one else was around when he gave the letter to Petitioner. At that point, Petitioner was on the "third step" in terms of disciplinary action. No Respondent employee is "100% terminated" until the board votes on this. To date, Respondent has never terminated Petitioner. T. 106.

Anderson testified he went back to the board room after he delivered the letter to Petitioner. T. 107. It was fifteen minutes after he delivered the letter that he received the call from Calvin Taylor alerting him to Petitioner's situation. Anderson testified Taylor was present when he arrived at the scene. Anderson called an ambulance because Petitioner was lying on the floor. He made no attempt to move Petitioner. Brandon Gale, who is head of security for Respondent, also arrived at the scene. T. 108.

Anderson testified he never printed out the photographs he took via his cell phone. He used his phone to show the photos to Arlene Salvado, Respondent's benefits coordinator. T. 109.

Anderson testified he left the school building at 10:00 PM on May 15, 2012. The building is locked after hours but the maintenance employees have 24-hour access. Corey Johnson, the night custodian, was at the building until midnight on May 15, 2012. T. 110-111.

Anderson testified that all of Petitioner's requests for time off were approved. T. 111.

On redirect, Anderson testified he saw video footage taken May 16, 2012. This footage showed a car pulling up in front of the school, Petitioner entering the school building and Petitioner exiting the building via the back door. T. 111-112.

Under re-cross, Anderson testified the footage showed Petitioner using the "north entry" to enter the school, walking down a hall from the north lobby, going through the cafeteria and exiting the back door. He reviewed the footage after Johnson contacted him. He last saw this footage in 2012. He is positive that the footage was taken post-accident. It is Gale who "pulled" the footage. He has no reason to doubt the history of Petitioner's accident. T. 112.

On rebuttal, Petitioner testified he experienced intermittent low back pain after a 1995 motor vehicle accident. Anderson handed him the letter about five minutes before the accident, while Petitioner was headed toward the closet after mopping the stairwell. Petitioner testified he did not really read the letter. He put the letter in his pocket. The letter subsequently got wet. T2, 8-9. At some point after the accident, Petitioner attended a disciplinary meeting but not with human resources. At the meeting, Petitioner saw

photographs that were dated May 14, 2012. After the meeting, Petitioner was suspended for five days. He "took" the suspension. T2, 12.

Calvin Taylor then testified on behalf of Respondent. Taylor testified he has worked for Respondent for eleven years. During the last seven years, he has worked as a night custodian at the academy where Petitioner also works. He typically works from 4:00 PM to midnight. He cleans sixteen classrooms per night and does whatever else he is asked to do. His assigned work area is the fourth floor. Petitioner is assigned to a larger area on the third floor. T2, 16-17.

Taylor testified that a board meeting was held at the academy at 7:00 PM on May 15, 2012. Both he and Petitioner worked that night. At some point, Petitioner called him via walkie-talkie and said, "can you come to the third floor?" Taylor arrived at the third floor within seven or eight minutes of receiving this call. When Taylor arrived, he saw Petitioner lying on his right side inside a custodian's "kitchen", or closet. T2, 18. This closet was the larger of two closets on the third floor. Petitioner was conscious but was not talking normally. Petitioner was talking "like a hurt person." T2, 25-26. Taylor had seen Petitioner earlier the same night, at which point Petitioner was "fine." Taylor asked Petitioner if he was okay. Petitioner told Taylor he slipped and fell. Taylor called security so that security could summon an ambulance. T2, 34-35.

Taylor testified that, when he arrived at the scene, the door of the closet was open and there was a red chair halfway inside the closet. The chair was "straddling" the threshold. T2, 31-33. A cart was inside the closet, about two or three feet away from Petitioner. A bucket was on top of the cart. There was a built-in "slop sink" inside the closet. Petitioner was seven to nine inches away from the sink. T2, 33-34.

Taylor testified he did not examine Petitioner. At some point, Petitioner changed positions so that he was lying on his back rather than his right side. T2, 26-27.

Taylor testified that, earlier the same night, he had seen Petitioner being handed a letter. Petitioner acted in a "business as usual" fashion after he received this letter. T2, 29.

Taylor testified that, after the paramedics took Petitioner away, he did not see Petitioner again that night. T2, 35.

Under cross-examination, Taylor testified he did not see Anderson give Petitioner the letter. The letter was "waiting for" Petitioner in the first floor receiving office. T2, 36.

Taylor testified that, although he is not assigned to the third floor, he was on the third floor at 3:00 PM on May 15, 2012 in order to talk to Ms. Mason. T2, 38.

Taylor testified that the chair he observed "straddling" the threshold of the closet is red, has four wheels and can be folded. When he found Petitioner, Petitioner was inches away from

the base of the sink. He did not take any photographs. When the paramedics arrived, they brought a gurney and a stretcher. They had to move the red chair out of the doorway. They also had to move the cart in order to gain access to Petitioner. T2, 41. Taylor clarified that, when he arrived at the closet, he stood in the doorway. He did not enter the closet because of "all the stuff" that was already inside the closet. He was two to three feet away from Petitioner. He could see Petitioner. Nothing obscured his vision. He called security and Brandon Gale, Respondent's security manager, came to the scene. Gale did not enter the closet. T2, 44.

Taylor testified he has not seen the video footage that Anderson and Petitioner referred to. He was not able to recall exactly when Petitioner returned to work. Ron Pearson and Corey Johnson still work for Respondent. T2, 45.

On redirect, Taylor testified that the cart was about four to six feet away from the sink. The closet is "not very big" and everything is "tight" inside it. T2, 46.

Under re-cross, Taylor testified that the photograph marked as PX 5 shows the red chair he saw. T2, 47.

Petitioner then recalled Anderson, who testified he went to the third floor on May 15, 2012 and personally handed the letter to Petitioner. Anderson testified that disciplinary letters are not left in employees' mailboxes. Only duty-related letters are left in those mailboxes. T2, 49. The surveillance footage he saw is still on Respondent's security cameras. Only the director of security has access to these cameras. Anderson testified he saw this footage twice on May 16, 2012. T2, 50-51. The footage was obtained late at night, sometime between May 15th and 16th. Respondent would have access to Pearson's, Johnson's and Gale's current addresses. T2, 56-57.

In response to questions posed by Respondent's counsel, Anderson identified RX 2 as the letter he discussed with Petitioner. He received this letter from Ronald Pearson prior to the accident. T2, 58-59. The photos he took with his cell phone did not show any chair, cart or bucket. He was not the person who transferred the surveillance footage from the security cameras to a disc. T2, 62-63.

On further rebuttal, Petitioner testified he rolled over after the accident because he was uncomfortable and needed to reach his phone, which had fallen off of a clip. He does not know whether the chair rolled when the accident occurred. T2, 64-65. At the meeting he attended after the accident, he saw photographs of himself walking in and out of the building. The date "May 14" appeared in the corner of the photographs. T2, 65. It was about 1:30 AM when he was released from the Emergency Room and went to Respondent's parking lot. He was unsure whether Gale came to the scene of the accident. Corey Johnson and another employee named "Ted" came to the scene. Both of these individuals still work for Respondent. T2, 67-68.

In addition to the exhibits previously summarized, Petitioner offered into evidence bills from his providers (PX Group 11) and his Petition for Penalties and Fees, filed on October 29, 2012 (PX 12).

Respondent offered into evidence the letter that Petitioner acknowledged receiving from Anderson. RX 2. The Arbitrator sustained Petitioner's foundational objection to the admission of this letter and marked the letter as a rejected exhibit. Respondent also offered its Response to Petitioner's Motion for Additional Compensation and Attorney's Fees, filed on November 13, 2012. RX 3.

Arbitrator's Credibility Assessment

The Arbitrator finds credible Petitioner's testimony concerning his duties and the configuration of the closet where he allegedly fell. Calvin Taylor confirmed that the closet contained a built-in sink as well as other moveable objects.

Petitioner was not credible as to various other issues, however. Petitioner did not rebut Anderson's testimony concerning his disciplinary status. Petitioner acknowledged that Anderson, one of Respondent's managers, handed him a letter five minutes before his claimed accident yet testified he put the letter in his pocket instead of really reading it. This testimony did not ring true. Petitioner testified he did not spill any water when he drained the bucket before he fell yet Emergency Room personnel indicated he "slipped on a wet floor." Petitioner testified he fell backward, with his head actually going inside the concrete sink. Emergency Room personnel noted "no ecchymoses to head." Petitioner testified he was unconscious during some of his Emergency Room stay but hospital personnel consistently described him as alert, oriented and speaking in full sentences. Petitioner's decision to exit the hospital against medical advice does not square with his dramatic account of falling in such a way as to land with his head inside a concrete sink. When Petitioner initially sought follow-up care, it was with his cardiologist, Dr. Bajgrowicz, and in part because he had a respiratory infection. Petitioner testified he asked Dr. Bajgrowicz's receptionist to complete an accident form for him because his dominant left arm was in a sling. There is no evidence that Petitioner was given a sling at the Emergency Room. After he left the Emergency Room, Petitioner was able to drive his car home from Respondent's lot. Dr. Bajgrowicz did not note any sling usage on May 17, 2012. Petitioner denied any back injury at the Emergency Room and did not voice back-related complaints to Dr. Bajgrowicz but reported having injured his back to Dr. Dubin.

Did Petitioner meet his burden of proving he sustained an accident on May 15, 2012 arising out of and in the course of his employment?

The Arbitrator finds that Petitioner failed to meet his burden of proof on the issue of accident. A variety of factors, and not simply the timing and unwitnessed nature of the accident, call Petitioner's credibility into question. Petitioner did undergo Emergency Room care very shortly after the claimed accident but it appears from the records that it was his

underlying cardiac condition and abnormal EKG, rather than his reported injuries, which quickly became the focus of attention.

The Arbitrator denies this claim based on her assessment of Petitioner as a witness and her review of the treatment records. The Arbitrator acknowledges that some of the testimony given by Respondent's witnesses (i.e., Anderson's statement that he has no reason to doubt Petitioner's history and Taylor's statement that Petitioner "sounded hurt") can be viewed as supportive of Petitioner's claim. The Arbitrator gives no consideration to Anderson's testimony concerning the photographs he took and the video he saw. Respondent did not seek to admit the photographs or video into evidence. Anderson's testimony as to these items played no role in the Arbitrator's thinking.

Having found that Petitioner lacked credibility and failed to prove a compensable accident, the Arbitrator views the remaining disputed issues as 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 Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Samuel Gonzalez,
Petitioner,

vs.

NO: 12 WC 17551

14IWCC0149

Greenbrier Rail Services,
Respondent.

DECISION AND OPINION ON REVIEW

Petitioner appeals the decision of Arbitrator Cronin finding Petitioner failed to prove he sustained an accidental injury arising out of and in the course of his employment on April 30, 2012. The Issues on Review are whether Petitioner sustained an accidental injury arising out of his employment on April 30, 2012, whether Respondent was given proper notice of said alleged accident, whether there is a casual connection between the alleged April 30, 2012 accident and Petitioner's present condition of ill-being, and if so, whether Petitioner is entitled to reasonable and necessary current medical expenses as well as prospective medical expenses. The Commission, after reviewing the entire record, reverses the Arbitrator's decision and finds Petitioner sustained an accidental injury arising out of and in the course of his employment on April 30, 2012. Petitioner provided proper notice to Respondent of said accident. Petitioner's current condition of ill-being is causally related to the April 30, 2012 accident. Petitioner is entitled to $7,072.82 in current medical expenses and Respondent is ordered to pay all reasonable and necessary medical expenses for the surgery recommended by Dr. Lorenz. Lastly, Petitioner was temporarily totally disabled from May 1, 2012 to January 22, 2012 for 38 weeks under Section 19(b) of the Illinois Workers' Compensation Act, for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 38 year old machine operator, testified he lives in Gary, Indiana. He has worked for Respondent for six to seven years. His duties consist of recording numbers, loading machines and cutting metal on the wheels for freight cars. The wheels weigh between 28 tons to 125 tons, depending on the type. He takes the serial numbers down from the wheels. The wheels are on a

track. He pushes them into the machine. He has to make sure they are steady because if they aren't they will roll back on him.

2. On April 30, 2012, he worked the 2:00 p.m. to 10:00 p.m. shift. About ten minutes into his shift, he felt a pinch between his neck and his shoulder and pain that radiated down him arm and hurt his chest. He immediately stopped working and went to the front office. He spoke to Nate, the plant manager. Rick Benavidez and a couple of the secretaries were present in the office as well. He told Nate what happened. He told him he was loading the wheel set in the machine when he experienced a pinch in his neck and shoulder which radiated down his arm and his chest was in pain. Nate took him to the St. James Occupational Clinic. From there he was sent to the emergency room.

3. At the St James Emergency Room, Petitioner complained of right-sided trapezius and right shoulder pain that started while at work. He also complained of a tingling sensation that went down his right arm. An x-ray was taken and it showed a questionable non-displaced fracture through the superior glenoid and superior bony labrum. Petitioner was concerned about having a heart attack as there was a family history for the same. He underwent an EKG that was found to be negative. While the doctor's notes are partially illegible they indicate that Petitioner complained of right shoulder and neck pain after pulling and pushing. The nurse's notes indicated Petitioner reported right shoulder and back pain that radiated down the center of his chest at 1300 today. He also reported he took a 400 milligram Aleve at 1300 today. The final report indicated Petitioner reported chest pain and a pain in his right shoulder for three hours along with numbness in his right arm. There was no history of an accident given.

4. On May 1, 2012 Petitioner said he told the doctor at Occupational Health that his neck pain had gotten really severe and he still had numbness and pain in his shoulder. The doctor touched his shoulder and neck and wrote a prescription for muscle relaxers and pain killers. He also told him not to use his right arm. When he told Nate, Nate said you're off work now.

5. David Nesnidal testified he is the Maintenance and Environmental Health and Safety (EHS) coordinator for Respondent. His job is to perform safety training and complete accident reports along with inspecting the shop to see if anything needs to be repaired. Upon returning from the clinic on April 30, 2012, Petitioner said he had a fractured bone in his collar. Petitioner also reported that his shoulder started to hurt almost immediately after the shift began. Mr. Nesnidal identified PX1 as an incident report he wrote upon Petitioner's return from the clinic. He typed up what Petitioner related to him as to what had occurred. It is his wording but he asked Petitioner what had happened and that's how he wrote it up. He let Petitioner review the accident report after he typed it up. Petitioner didn't say they had to make any changes to the report. The report says employee complained of pain and numbness in right arm. There was" no specific event that occurred (or to be determined)". Mr. Nesnidal testified that the Petitioner didn't tell him specifically that he pushed the wheel set into the machine and that is what caused pain in his shoulder. He did type that Petitioner "was at the wheel lathe, loaded set in machine" when he complained of pain and numbness in his right arm and shoulder. The April 30, 2012 Injury Report was introduced into the record and it paralleled Mr. Nesnidal's testimony.

6. On May 1, 2012 Petitioner followed up at the St. James Occupational Health Center. It was

noted that Petitioner had experienced sharp pain and numbness in his right arm, chest and back while at work. He was seen in the emergency room where he was treated for a possible right shoulder fracture. Currently, he is complaining of a pain in his neck and right shoulder along with tingling in the right upper extremity and a burning pain over his right shoulder. On physical examination, it was noted that there was a normal spinal alignment with spinous and right paraspinal tenderness. Petitioner demonstrated a full range of motion of his neck. His right shoulder was tender over trapezius and anterior aspect. His range of motion was not checked as his arm was in a sling. An x-ray of his right shoulder showed a questionable non- displaced fracture through the superior glenoid and superior bony labrum. Petitioner was diagnosed with a cervical strain and a questionable right shoulder strain. He was instructed not to work with his right hand, to wear the arm sling when he worked, to take his medication and to undergo a right shoulder MRI.

7. On May 18, 2012 Petitioner was seen by Dr. Rhode at Orland Park Orthopedics. Dr. Rhode noted that Petitioner presented for consultation of neck and shoulder pain secondary to injury while at work "sustained April 30, 2000 fall". Petitioner reported he was working as a machine operator and was loading material into a machine when he felt a sudden pinching sensation along the posterior medial aspect of his right shoulder. He states that this single event caused a sharp pain from his neck all the way down the arm to the thumb and index finger. He was initially evaluated by an emergency room doctor who thought Petitioner was experiencing a heart attack. An EKG was performed and it was negative. Attention was subsequently directed toward the shoulder for which he was told he had a possible fracture. The Petitioner has continued to experience right-sided neck pain with radiation to the thumb and long finger. On physical examination, there is pain elicited over the cervical area bilaterally and the cervical paraspinous muscle. He demonstrated limited active range of motion of the neck with left lateral flexion to 35 degrees and right lateral flexion to 15 degrees along with a positive right Spurling test. His shoulder x-ray showed no evidence of glenohumeral changes with a centrally located humeral head. There is no evidence of an anterolateral sub-acromial spur and no greater tuberosity escrecence. The AC joint was without any degenerative changes or osteolysis. Dr. Rhode diagnosed Petitioner has having neck and shoulder pain along with cervical radiculopathy. He treated Petitioner with medication, a Medrol Dosepack, ordered a cervical MRI and told Petitioner to stay off of work. Dr. Rhode opined that the patient sustained a single event work-related injury secondary to loading a machine.

8. On May 21, 2012 Petitioner filed an Application for Adjustment of Claim with the Commission which states that he injured his right dominant shoulder at work while performing work activities. At the commencement of the January 22, 2012 Arbitration hearing, Petitioner amended his Application for Adjustment of Claim to include his cervical area as well.

9. The May 23, 2012 cervical MRI indicated Petitioner has a right-sided disc herniation at C6-7 into the ventral epidural space with moderate central canal compromise and mild cord compression off midline to the right and accompanying the right foraminal compromise. There was also uncinate spurs at C3-4 that mildly narrow the right neural foramina.

10. In a May 25, 2012 follow-up visit, Dr. Rhode instructed Petitioner to continue to stay off of work and he referred Petitioner to Dr. Lorenz. Petitioner was seen by Dr. Lorenz on August 30,

2012.

11. Dr. Lorenz noted Petitioner, a machine operator, was at work on April 30, 2012 and was pushing equipment when he felt a sharp pinch in his neck and he began feeling numbness down his right arm. He was also pulling an object with his right hand. Petitioner was initially sent to the emergency room and was then referred for evaluation of shoulder. The shoulder was worked up and a right shoulder MRI was obtained. On physical examination the Petitioner's range of motion in his neck is diminished to extension, which reproduces arm pain. He has a positive Spurling's maneuver to the right that radiates pain down his arm. He has profound weak triceps. He is right-handed. The cervical MRI shows a right-sided disc herniation which compresses the cord and compromises the right foramen at C6-C7. Dr. Lorenz diagnosed Petitioner with severe radiculopathy on the right side secondary to a right-sided disc herniation. Dr. Lorenz opined that the disc herniation was caused by the pulling the patient reported while at work. Petitioner said he has had no conservative treatment so we are going to treat this conservatively. He was placed him on Medrol Dosepak along with cervical traction and physical therapy. He was instructed to remain off work and recheck with the office in one week.

12. On September 6, 2012 Petitioner followed-up with Dr. Lorenz who noted Petitioner has had a trial of conservative care with follow up after the Medrol Dosepak. This had no effect on him at all. Due to the patient's profound weakness at this point and failing to respond to conservative care, his recommendation is for Petitioner to undergo an ACDF C6-C7 procedure on the right side. He noted Petitioner was to remain off work. He opined that the injury was "caused by the patient's attempt to close the doors which were quite heavy".

13. Ricardo Benavidez, Jr., testified he is the general foreman for Respondent. His duties include plant production and supervising the employees in the shop. He is familiar with Petitioner's job duties as he ran the same machine when he worked in the shop. The wheel sets are loaded into the machine by manually rolling them into the machine. The wheels are on rails and they roll pretty easily. It takes 15-16 pounds of pressure to get a wheel to start rolling. We measured it to see what it would take. Once the wheel starts rolling, it rolls pretty easily on the rail. He would consider this job to be at a medium physical level. He became aware of the fact that Petitioner had a pending workers' compensation claim about a week after the alleged incident. He was told about the same by Nathan, the plant manager. The Petitioner never told him he hurt his arm or neck while pushing a wheel set on April 30th. On cross-examination, Mr. Benavidez agreed that if a wheel need repair it doesn't run as smoothly as other wheels and that is why the wheel is going into the machine so that it can get ground down and smooth out. He agreed that it is possible that the wheels that have more warping would be harder to push.

14. Nathan Harbeck testified he is the plant manager for Respondent. He is responsible for the production of the shop, all of the inventory as well as taking an employee head count and insuring the employees' safety and well-being. Mr. Harbeck testified that it takes less than 20 pounds of pressure to start the movement on the wheel set. He noted that Petitioner hadn't worked the prior Friday leading up to the alleged April 30, 2012 accident. Petitioner has called in sick on that Friday. The Petitioner didn't work Saturday or Sunday either. He started working on Monday at 2:00 p.m. Approximately 20 minutes into his shift, the Petitioner came to the front office and complained of pain and numbness in his right arm and asked for someone to take him

to the doctor. Mr. Harbeck testified that he grabbed his keys and took the Petitioner to the doctor in his own car. The Petitioner said he was afraid the pain had something to do with his heart since he had heart issues in his family. The Petitioner didn't tell him he had pain and numbness caused by pushing a wheel set into the machine. He didn't say he had pain in his neck. After the Petitioner was diagnosed he said he had been told that he fractured his shoulder. The next day Petitioner came to the shop and his arm was in a sling. When he asked the Petitioner what happened the Petitioner told him he didn't know how he injured himself. He said it didn't happen at work and that's why we started filling in the short-term disability paperwork. He didn't become aware of Petitioner alleging that he hurt himself while performing his job duties until he received a letter from Petitioner's lawyer. He said that the Petitioner is always tight on money and he figured the Petitioner might have been looking for some kind of payout. Mr. Harbeck said he was aware of the fact that David Nesnidal had filled out an incident report. He testified that the company doesn't have a reward program for the plant manager or safety coordinator when there are less claims filed in a given year. The only incentive given is for the employees on the shop floor. He had not worked on that particular machine in question but he has rolled thousands of wheel sets in his time. He agreed that some wheel sets are more out of round than others. The 20 pound pressure to get a wheel set moving is a very close estimate for all of the wheel sets.

15. Petitioner was called as a rebuttal witness. Petitioner said he told Mr. Harbeck after the emergency room visit that the doctor said it was a possible fracture and that he has told the hospital that it happened at work. He denied telling him that he didn't get hurt at work. He told the hospital on April 30th that he felt pain in his shoulder and right arm while at work loading a machine. He also told this history to Drs. Rhode and Lorenz. He told Mr. Nesnidal after coming back from the emergency room and he told then in the Occupational medical department that on April 30th he experienced pain and numbness in his right arm while he was at the lathe. Petitioner said he injured his neck, right shoulder and right arm on Monday, April 30, 2012. He worked that Friday. He can't say he trusts what the emergency room personnel put down because he still had pain in his neck. He is certain that he told the emergency room personnel that he was rolling the wheel set when he felt the pain. He lives in Gary, Indiana and he saw Dr. Rhodes in Orland Park, Illinois. He agreed that it was a little bit of a drive. His fiancée drove him there. He was referred to Dr. Rhodes by Jamie Trapp, an attorney he first contacted. Mr. Trapp referred him to another attorney. He didn't meet Mr. Blum, his attorney until the first time they were there for court. He had a chance to review the Application for Adjustment of Claim before he signed it. He believes the Application for Adjustment of Claim was completed probably by Dr. Rhode. He filled it out in Dr. Rhode's office. Then Dr. Rhode's office sent it over to Mr. Blum to sign it. It listed injuries to right dominant shoulder at work while performing work activities. He didn't list neck until after Dr. Rhode's initially saw him and he ordered an MRI. This is the case even though he told him at the time how the accident occurred. He was able to review the incident report. He believes the report as typed up accurately reflected what he told Nate. If it wasn't accurate at the time, he would have asked him to change it. He is aware of the fact that it says employee complains of pain, numbness in the right arm, no specific event or to be determined. He doesn't know the meaning of specific event.

The Commission has reviewed all of the evidence and finds that based on the evidence Petitioner has sustained an accidental injury arising out of and in the course of his employment on April 30, 2012. While there were instances where no history of or slight inconsistencies were given regarding the accident, Petitioner's testimony and the majority of the histories given to his treating doctors indicate Petitioner was at work performing his job duties at the time of the accident. Petitioner initially reported to occupational health and the emergency room on the day of the accident with what he believed to be a heart attack. The initial work-up at the emergency room was for the purported heart attack and only after an EKG was performed and the heart attack was ruled out was the focus shifted to Petitioner's right shoulder. Although Petitioner reported neck, chest and back pain, Petitioner was only told that he probably had a questionable fracture of his right arm. Upon returning to the plant Mr. Nesnidal completed an injury report based on Petitioner's report of event. While it was noted that no specific event occurred, it was also noted that Petitioner was at the wheel lathe and was loading set into the machine. As such the Commission finds that Respondent was provided with proper notice of the accident. When Petitioner was asked what a specific event was he testified that he didn't know. When Petitioner was sees at occupational health the day after the accident he reported experiencing pain and numbness in his right arm, chest and back while at work and he also reported experiencing current complaints of neck and right shoulder pain. He was diagnosed with both cervical and right shoulder strains. As such the Commission finds that there is sufficient evidence to find that Petitioner sustained an accidental injury arising out of and in the course of his employment on April 30, 2012 that resulted in injuries to his right arm/shoulder as well as his neck. The Commission further finds that there is sufficient evidence to show that Petitioner's current condition of ill-being is causally related to the April 30, 2012 accident. Moreover, the Commission finds based on Petitioner's PX2-4 that Petitioner is entitled to $7,072.82 in current medical expenses and based on Dr. Lorenz's records that Respondent is ordered to pay all reasonable and necessary medical expenses for the surgery recommended by Dr. Lorenz. Lastly, the Commission finds Petitioner was temporarily totally disabled from May 1, 2012 to January 22, 2012 for 38 weeks under Section 19(b) of the Illinois Workers' Compensation Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $532.53 per week for a period of 38 weeks, that being the period of temporary total incapacity for work under Section 8(b), and that as provided in Section 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 $7,072.82 for current medical expenses and Respondent is ordered to pay all reasonable and necessary medical expenses for the surgery recommended by Dr. Lorenz 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.

14IWCC0149

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $27,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 7 2014

David L. Gore

Michael J. Brennan

MB/jm

O: 1/16/14

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DISSENT

I would respectively dissent from the decision of the majority of the Commission based on the reasons set forth below. I would affirm the Arbitrator's finding that Petitioner failed to prove he sustained an accidental injury arising out of and in the course of his employment on April 30, 2012. Contrary to Petitioner, Nathan Harbeck testified that Petitioner called in sick and did not work on the Friday, Saturday or Sunday before the alleged accident. Petitioner was only at work for 10 minutes prior to claiming he sustained an accident. At that time Petitioner believed he was having a heart attack with right shoulder pain. He reported the same to Nathan Harbeck who immediately drove him to the occupational health center. The clinic then sent him to the emergency room to rule out a heart attack. While at the emergency room, Petitioner reported he had taken an Aleve prior to starting work and he did not report a history of a work accident. Upon arrived back at the plant Petitioner completed an injury report where he again related that there was no specific event that occurred at the time. Petitioner returned to the occupational health department the following day and again he did not report that he sustained a work related accident. Mr. Harbeck testified that Petitioner told him the injury did not happen at work and as such he provided Petitioner with short term disability forms. Petitioner had four separate opportunities to tell others that he had a work related accident. Yet, Petitioner provided no such indication that he sustained a work related history. On May 16, 2012 Petitioner signed an Application for Adjustment of Claim stating he injured his right shoulder at work while performing work activities. According to Petitioner the Application was completed by Dr. Rhodes who was referred to Petitioner by an attorney. Only at that time was there an indication that Petitioner was relating the same to work and he provided a specific history of a work accident. The Arbitrator, having seen all of the witnesses, was in the best position to assess the credibility of the witnesses. Based on Petitioner's calling in sick and taking medication prior to the alleged accident, his failure to report a work accident to his employers on several

occasions, the lack of a history that Petitioner sustained a work accident in the contemporary medical records and the fact that the medical histories did not parallel Petitioner's testimony at trial until after he conversed with an attorney and went to the doctor recommended by the attorney, I would find that Petitioner failed to prove he sustained a work related accident on April 30, 2012.

Mario Basurto

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

Edward Kozlowski, Jr.,

Petitioner,

vs.

NO: 12 WC 20332

14IWCC0150

Town of Cicero,

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 extent of temporary total disability, whether Petitioner resigned his employment with Respondent, the motion for additional evidence and the motion to strike the statement of exceptions 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 exhibits be stricken from Respondent's statement of exceptions, and that any references to them are disregarded. All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 4, 2013 is hereby affirmed and adopted.

14IWCC0150

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 is bond required for removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 7 2014

MB/mam
O:2/6/14
43

Mario Basurto

David L. Gore

Stephen Mathis

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

KOZLOWSKI JR, EDWARD
Employee/Petitioner

Case# **12WC020332**

14IWCC0150

TOWN OF CICERO
Employer/Respondent

On 6/4/2013, 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 0.08% 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:

DAVID F SZCZECIN & ASSOC LTD
205 W RANDOLPH ST
SUITE 1801
CHICAGO, IL 60606

4217 DEL GALDO LAW GROUP LLP
GEORGE S SPATARO
1441 S HARLEM AVE
BERWYN, IL 60402

14IWCC0150

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)

Edward Kozlowski, Jr.
Employee/Petitioner

v.

Town of Cicero
Employer/Respondent

Case # 12 WC 020332

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 **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **November 14, 2012 and November 19, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0150

FINDINGS

On the date of accident, **5/29/2012**, 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 **$36,400.00**; the average weekly wage was **$700.00**.

On the date of accident, Petitioner was **34** years of age, *single* with **0** dependent children.

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

Respondent shall be given a credit of **$4,969.38** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$4,969.38**.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$466.67**/week for **23-1/7** weeks, commencing **5/30/2012** through **11/7/2012**, as provided in Section 8(b) of the Act.

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

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

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

Signature of Arbitrator

May 31, 2013
Date

ICArbDec19(b)

JUN - 4 2013

Findings of Fact

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

E. WAS TIMELY NOTICE OF ACCIDENT GIVEN TO RESPONDENT?

Respondent's disputes that Petitioner had a compensable accident on May 29, 2012 and that he failed to give timely notice of the accident to Respondent are without merit. Petitioner, while pursuing an offender, and jumping over a fence, pushed off with his right arm and immediately felt pain in the right shoulder.

Petitioner's Exhibit #1, which is entitled "EMPLOYEE'S REPORT OF INCIDENT" is signed by Petitioner and Sergeant Gilpin on May 29, 2012. The bottom section of the report, which is to be completed and signed to be signed by his supervisor, states: "If you have any doubts or variations with what was reported to you by the injured employee, please describe in detail. (Use additional paper if needed.)"

Sgt. Gilpin left blank the space at the bottom of the form. Sgt Gilpin signed the form.

By leaving the space blank, the Arbitrator draws the reasonable inference that Sergeant Gilpin had no doubts or variations with Petitioner's report.

Lieutenant Hatton and Deputy Commander Gonzalez both testified on behalf of the Respondent. On cross-examination, they admitted that they were aware that Petitioner sustained an accidental injury on May 29, 2012.

Therefore, the Arbitrator finds that on May 29, 2012, Petitioner sustained an accident that arose out of and in the course of his employment by Respondent. The Arbitrator further finds that Petitioner gave timely notice of said accident to Respondent.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner testified that following the accident of May 29, 2012, he was transported to Oak Park Hospital, which is located near Madison Street and Harlem Avenue. He underwent a physical examination. X-rays of his right arm were taken. The hospital provided a sling and an ice pack, advised him to follow up with an orthopedic surgeon, and discharged him.

Petitioner testified that he returned to the Cicero Police Department that same day. Lieutenant Cruz instructed Petitioner to fill out the "EMPLOYEE'S REPORT OF INCIDENT", conducted a urine and breath analysis and advised Petitioner to obtain Dr. Khanna's next available appointment.

Petitioner testified that on May 31, 2012, he came under the care of Dr. Khanna of Advanced Occupational Medicine Specialists ("AOMS") for a right shoulder injury. (Petitioner's Group Exhibit #4)

Petitioner submitted its record into evidence and it reflects, *inter alia*, that on May 31, 2012, he was diagnosed with a possible right glenoid labral v. rotator cuff tear. Petitioner underwent an MRI on June 1, 2012. Radiologist Choe offered the following impression of the MR images: (1) Tendinosis of the supraspinatus tendon and mild subacromial/subdeltoid bursitis, and (2) Findings suggesting a tear of the glenoid labrum with

possible associated small paralabral cyst. Dr. Khanna or Dr. Stewart of AOMS then referred Petitioner to Dr. Tu, an orthopedist at G & T Orthopaedics and Sports Medicine. (Petitioner's Group Exhibit #4)

Petitioner testified that both Dr. Khanna and Dr. Tu prescribed right shoulder surgery. Petitioner further testified that he did not undergo the surgery at the time it was prescribed.

Petitioner testified that between May 29, 2012 and November 6, 2012, he experienced constant pain in his right shoulder. He had a restricted range of motion of the right arm and could not lift beyond a certain point. He also noticed that he had no strength in his right hand.

Petitioner testified that he underwent surgery on his right shoulder on November 7, 2012.

Respondent's Counsel stated at hearing, on the record, that Petitioner had undergone rotator cuff repair on November 7, 2012, and that Respondent was going to resume payment of TTD as of November 8, 2012, and make payment of the medical incurred in connection with the surgery.

Medical testimony is not essential to support the conclusion that an accident caused a claimant's condition of ill-being. University of Illinois v. Indus. Comm'n, 365 Ill. App.3d 906, 912, 851 N.E.2d 72, 78, 303 Ill. Dec. 174 (2006).

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. Indus. Comm'n, 93 Ill. 2d 59, 63-64, 442 N.E.2d 908, 911, 66 Ill. Dec. 347 (1982).

Based on the foregoing, the Arbitrator concludes that Petitioner's current condition of ill-being of his right shoulder is causally related to the accident of May 29, 2012.

G. WHAT WERE PETITIONER'S EARNINGS?

In Arbitrator's Exhibit #1, Respondent agreed with Petitioner's claim that his "earnings during the year preceding the injury were $36,400.00, and the average weekly wage, calculated pursuant to Section 10 of the Act, was $700.00."

Yet, Respondent's Counsel kept this stipulation in place while he proceeded to cross-examine Petitioner on Respondent's Exhibits #7 and #8. Respondent's Exhibit #7 is the "EMPLOYEE EARNINGS HISTORY" for the period of January 6, 2012 through June 8, 2012. Respondent's Exhibit #8 is the "PAID INVOICE REPORT" which shows that Respondent issues six "WORKMEN'S COMP" checks. The amount of each check was $828.23 and the check dates were 6/20/12, 7/04/12, 7/18/12, 8/01/12, 8/15/12 and 8/29/12. The checks totaled $4,969.38.

Petitioner testified that he was a part-time officer with the Cicero Police Department and that he worked four days a week. He testified that on May 29, 2012, he worked from 3:00 p.m. to 11:00 p.m.

On cross-examination, Petitioner testified that he normally worked 32 hour weeks. Petitioner further testified that he *could* work a 40 hour week, but as a part-time policeman, he could not exceed a certain number of hours in one year.

Lieutenant Hatton testified that part-time police officers for Respondent could work a maximum of 1560 hours per year.

Deputy Commander Gonzalez testified that for a part-time police office, work is not available at Respondent if he has already worked 1560 hours that year.

The Arbitrator notes that Section 10 of the Worker's Compensation Act provides as follows:

> The compensation shall be computed on the basis of the "Average weekly wage" which shall mean the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury, illness or disablement excluding overtime, and bonus divided by 52; but if the injured employee lost 5 or more calendar days during such period, whether or not in the same week, then the earnings for the remainder of the 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted . . .

Petitioner testified that he has worked for Respondent for approximately 13 years. There is no evidence of Petitioner's earnings for the full 52 week period immediately preceding his accidental injury. There is no evidence of Petitioner's hourly wage in 2011.

Moreover, Respondent never withdrew their stipulation. The stipulation stands.

The language of Ill. Admin. Code tit. 50, §7030.40 indicates that the request for hearing is binding on the parties as to the claims made therein. Walker v. Indus. Comm'n, 345 Ill. App. 3d 1084, 804 N.E.2d 135 (4th Dist. 2004)

Therefore, the Arbitrator finds Petitioner's earnings in the year preceding the accident to be $36,400.00 and his average weekly wage to be $700.00.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE? TTD

The issue in this 19(b) hearing is non-payment of TTD for the period of August 14, 2012 through November 7, 2012.

Respondent paid TTD benefits from May 30, 2012 through August 13, 2012, at which time payment was terminated without explanation. Such action was not in accordance with Section 7110.70(b) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission.

A review of Petitioner's Group Exhibit #4 reveals that at no time was Petitioner able to return to his regular occupation as a police officer. He never reached maximum medical improvement, per the reporting. As a matter of fact, he was in need of, and was being scheduled for, surgery.

Petitioner testified on cross-examination that following his visit to AOMS on May 31, 2012, he returned to the police station and reported to Lt. Hatton and Deputy Commander Gomez. Petitioner told these gentlemen that he had seen a doctor for his shoulder. They told him that there was no light-duty work.

Both officers appeared for Respondent and denied that such conversation took place.

The Arbitrator finds that both of Respondent's witnesses were lacking in credibility.

The Arbitrator finds that Respondent never offered light-duty work to Petitioner.

Respondent's defense for terminating TTD benefits when they did is that Petitioner resigned his employment after charges were brought for his termination. The Petitioner testified that the charges were for matters that occurred prior to May 29, 2012.

Respondent argues that Petitioner resigned his employment and that they terminated TTD benefits on the basis that he took himself out of the labor market, he was on his own and he should look for work.

Petitioner denies that he resigned his employment. Any agreement as to resignation was never signed by the Respondent or the Petitioner. There is no basis for the termination of TTD for the period in question.

> "Whether an employee has been discharged for a valid cause, or whether the discharge violates some public policy, are matters foreign to workers' compensation cases. An injured employee's entitlement to TTD benefits is a completely separate issue and may not be conditioned on the propriety of the discharge . . . the determinative inquiry for deciding entitlement to TTD benefits remains, as always, whether the claimant's condition has stabilized. If the injured employee is able to show that he continues to be temporarily totally disabled as a result of his work-related injury, the employee is entitled to TTD benefits." Interstate Scaffolding v. Illinois Workers' Comp. Comm'n, 236 Ill. 2d 132, 149, 923 N.E.266 (2010).

Based on the foregoing, the Arbitrator finds that Petitioner is entitled to TTD benefits for the period of May 30, 2012 through November 7, 2012. Respondent is entitled to a credit for amounts previously paid.

The Arbitrator notes that Respondent's Counsel at the hearing, on the record, stated and represented that Respondent will be paying Petitioner TTD benefits commencing November 8, 2012 and continuing since he underwent surgery on November 7, 2012 and that the Respondent will be paying the medical in connection with the surgery.

M. SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT?

It is true that Respondent's disputes that Petitioner had a compensable accident on May 29, 2012 and that he failed to give timely notice of the accident to Respondent are without merit.

Yet, Respondent argues that Petitioner never presented himself for light-duty work, which Respondent had available. Respondent paid $4,969.38 in TTD benefits. Moreover, Respondent's Counsel has represented that they will restart TTD benefits after the November 7, 2012 right shoulder surgery and will pick up the medical in connection with the surgery.

Based on the foregoing, the Arbitrator finds that penalties and attorneys' fees are not warranted in this case.

O. MOTION TO STRIKE UNFILED SECTION 19(b)/MOTION TO STRIKE INCOMPLETE 19(b) PETITION

Before he commenced hearing the case on November 14, 2012, the Arbitrator denied Respondent's motions.

It is true that Petitioner did not file-stamp the 19(b) Petition. Yet, proof of service indicates that Petitioner's Counsel affirmed that he mailed, with proper postage, a copy of this Petition, at 5:00 p.m. on 9-19-12. (Respondent's Exhibit #1)

It is also true and that there are some blank spaces in such Petition. (Respondent's Exhibit #1)

In a letter dated September 20, 2012, Respondent's Counsel responded to the Petition. (Respondent's Exhibit #2) Among other things, Respondent's Counsel requested a copy of the Application for Adjustment of Claim.

The Commission file indicates that Petitioner filed the Application for Adjustment of Claim on June 12, 2012, and that on June 14, 2012, the Commission sent notice to "Town of Cicero, 4949 W. Cermak Rd., Cicero, IL 60804."

The Arbitrator's records indicate that he set this matter for pre-trial on October 24, 2012. On that date, he held a pre-trial with Petitioner's Counsel and Respondent's Counsel. At that time, there was a discussion with regard to the issues in dispute.

Thereafter, arbitration hearings were held on November 14, 2012 and November 19, 2012.

Section 7020.80(a)2 of the Rules Governing Practice Before the Illinois Workers' Compensation Commission states:

> "The Arbitrator to whom the case is assigned shall attempt to resolve the matter informally. If the matter cannot be resolved at that time, and the Arbitrator determines Petitioner is not receiving temporary total disability or medical benefits, said Arbitrator shall order the case to formal hearing on a date certain as soon as possible."

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

14IWCC0151

Anthony Sarlo,
Petitioner,

vs.

NO: 11 WC 28400

City of Chicago,
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 tota; disability, permanent partial disability, medical expenses, penalties credits/reimbursement to Respondent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 24, 2013 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: FEB 27 2014
KWL/vf
O-2/11/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0151

SARLO, ANTHONY
Employee/Petitioner

Case# **11WC028400**

CITY OF CHICAGO
Employer/Respondent

On 6/24/2013, 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:

0154 KROL BONGIORNO & GIVEN LTD
CHARLIE GIVEN
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

0113 CITY OF CHICAGO
NANCY J SHEPARD
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 14IWCC0151

Anthony Sarlo
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **11** WC **28400**

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 **Chicago**, on **May 8, 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 **credit/reimbursement to Respondent**

14IWCC0151

FINDINGS

On **June 3, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$70,257.72**; the average weekly wage was **$1,351.11**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$60,606.93** for TTD, **$0** for TPD, **$0** for maintenance, and **$81,158.39** for other benefits, for a total credit of **$141,765.32** as explained *infra*.

Respondent is entitled to a credit of **$2,924.00** under Section 8(j) of the Act as explained *infra*.

ORDER

As explained in the Arbitration Decision Addendum, Petitioner failed to establish that he sustained a compensable accident as claimed. Except as otherwise addressed in the Arbitration Decision Addendum, all other issues are moot and all requested compensation and benefits are denied. Petitioner's claim for penalties and fees is specifically denied.

Respondent shall be given a credit of $60,606.93 for temporary total disability benefits paid, $81,158.39 for other benefits paid, and a credit of $2,924.00 under Section 8(j) of the Act.

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

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

Signature of Arbitrator

June 24, 2013
Date

JUN 24 2013

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Anthony Sarlo
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **11** WC **28400**

Consolidated cases: **N/A**

14IWCC0151

FINDINGS OF FACT

The issues in dispute are whether Petitioner sustained a compensable accident, causal connection, Respondent's liability for certain medical bills, a period of temporary total disability benefits, penalties and fees pursuant to Sections 16, 19(k), 19(l), the nature and extent of Petitioner's injury, and Respondent's entitlement to certain credits. *See* Arbitrator's Exhibit ("AX") 1. The parties have stipulated to all other issues.

Background

Petitioner testified about, and the medical records reflect, a medical history remarkable for an endoscopic hemilaryngectomy on October 18, 2005 due to a T1 right true vocal cord squamous cell carcinoma. PX2 at 117-121. Petitioner is a former boxer. PX2 at 122.

Petitioner testified that he had no prior neck or right shoulder problems. On cross examination, Petitioner testified that he had no such problems and that he had never been to a doctor for neck pain or upper back or lower back complaints to his recollection. He also testified that he only had a minimal injury while working for Respondent in the past and that he has no prior workers' compensation claims for injuries.

Petitioner also acknowledged that he was involved in a motor vehicle accident 12 years ago which involved his right shoulder. Petitioner testified that this accident did not involve his neck although he did have some tension in the neck for which he took some muscle relaxers. Petitioner testified that he had rotator cuff surgery to the right shoulder after this car accident. The Arbitrator notes that Petitioner did not testify about this during direct examination, but did testify on re-direct examination that the accident was in 2000-2001 and did not result in any permanent restrictions or problems with the right shoulder or neck or upper back.

Petitioner testified that he began working for Respondent in January of 2000 and was employed with Respondent on June 3, 2011 as a truck driver in the fleet management department. On that date, Petitioner testified that he was checking the fluids in a bus which required him to pull the hood up and toward him from where it opens by the windshield. He testified that the hood is about 5' long and that he is 6'1 tall, so he has to reach with the full length of his arm to open the hood of the bus. Petitioner testified that when he opened the hood, he felt pain in his neck, right shoulder and down the right side of his back. Petitioner is right hand dominant. On cross examination, Petitioner testified that he did not report an injury to his neck, shoulder or right upper back on June 3, 2011 and that he did not go see a doctor that day.

Medical Treatment

On June 15, 2011, Petitioner saw his primary care physician, Dr. Patton, at Advocate Medical Center. PX2 at 78-80. Petitioner reported back pain that started at "bottom of his neck and extends to the lumbar spine[;] 6-7

years[;] Better with Flexeril, massage (Masseuse is better then [sic] chiropractor)[.]" Id. He also reported a motor vehicle accident 12 years ago and his understanding that he had arthritis. Id. He further reported: "Pain always returns and recently recalled findings 12 years ago[;] Pain coming more frequently, every few days[;] truck driver, does a lot of sitting[;] Occasionally pain is severe enough where pt can not turn his torso side to side[;] Not sure what makes the pain worse[;] No tingling or numbness[;] No bowel/urinary incontinence[;] No saddle anesthesia[; and] No radiation into legs." Id.

On examination, Dr. Patton noted that Petitioner's cervical, thoracolumbar, and lumbar spine showed no abnormalities and that his thoracic spine showed abnormalities "pin-point TTP [tenderness to palpation] at T3-4." Id. Dr. Patton diagnosed Petitioner with upper back pain and a backache. Id. She noted that it was a "likely progression of arthritis[,]" ordered x-rays of the thoracic spine to rule out fractures/compressions as Petitioner "is a truck driver; possible referral to Ortho[,]" prescribed Norco for acute pain, restricted Petitioner from driving while on the medication, and recommended physical therapy to guide work out "regime for back stabilization, weight loss[.]" Id. Petitioner's thoracic spine x-ray was normal. PX2 at 81.

On cross examination, Petitioner testified that this was his first treatment for the alleged injury and that he did not tell the doctor about the alleged incident at work because he did not think that it was that serious; he may have pulled a muscle. Petitioner also acknowledged that he worked from June 3, 2011 through June 15, 2011 during which time he was not placed off work by a physician.

On re-direct examination, Petitioner testified that he was unsure how he could be at work given the pain that he experienced in his neck and right shoulder during this period of time and that he was in severe neck and upper back pain.

On July 5, 2011, Petitioner went to the emergency room at Advocate Lutheran General Hospital reporting right sided back pain in the thoracic region which was ongoing since about a month ago and had worsened last week. PX2 at 22. The nursing triage note reflects that Petitioner's chief complaint was "RIGHT shoulder pain radiating down RIGHT arm x4 days, saw PMD, was prescribed Vicodin and Flexeril without relief. Pt tearful in triage." Id. He also reported that it hurt anytime he moved his shoulder, pain radiating from the right scapula or shoulder, and no numbness/tingling/paresthesias down the arm or neck pain. Id. on examination, Petitioner had paraspinal and midthoracic tenderness to the right lateral region, spasm in the muscle that is a trigger point for the pain which is aggravated by movement of the shoulder, full range of motion in the shoulders, no bony tenderness, intact motor at 5/5 in the right upper extremity, sensation intact to light touch, no mid line neck pain, and full range of motion in the neck. PX2 at 23. Petitioner received two trigger point injections in the paraspinal region of the thoracic back, received prescriptions for Norco, Valium, and an anti-inflammatory, and was discharged home. Id. Petitioner was restricted from driving and placed off work if this restriction could not be accommodated. PX2 at 77.

On cross examination, Petitioner testified that he worked through July 5, 2011 and went to the emergency room because of the pain in his neck, shoulder, and upper back. Petitioner testified that he told the emergency room staff that it was work related. Petitioner followed up with his primary care physician the next day and told her about the injury, but he did not think that it was that serious or that he messed up his neck that bad. Petitioner could not recall if he explained this in detail at the time.

On July 6, 2011, Petitioner followed up with Dr. Patton after his discharge from the emergency room. PX2 at 75-77. Petitioner reported: "Back pain mainly in the upper thoracic area[;] 6-7 years[;] Better with Flexeril, massage (Masseuse is better then [sic] chiropractor)[.]" Was here couple of weeks ago and had –ive thoracic

xray[;] Pain worsened yesterday, went to ED, was given Valium (taking q4)/hydrocodone (taking q4-6)/ibuprofen and had to Marcaine injections[;] Dialuadid did not provide any relief [;] Toradol helped a great deal[;] Pain was between the R scapula and spine with radiation into forearm[;] Obvious muscle spasm was seen[;] Currently pt states he is 100% better but still has some residual pain radiating into the R forearm[; and] Has not gone to PT as he only obtained referral yesterday." Id.

On examination, Dr. Patton noted tenderness to palpation over the right mid back peers spinal muscles without spasm. Id. She noted that Petitioner's thoracic spine was "ok" and that he had intact strength. Id. She also noted that Petitioner was better with direct injections to the muscle. Id. Dr. Patton noted that Petitioner likely had muscle spasms that required stretches, she emphasized the need for physical therapy, and reiterated the importance of not drinking alcohol while taking Norco or Valium and restricted him from driving a bus while taking Norco or Valium. Id.

Petitioner testified that he was referred to MercyWorks by his boss, Wayne Knato. On July 11, 2011, Petitioner went to MercyWorks and reported that on June 3, 2011 he lifted the hood of the bus with his right arm and felt posterior neck pain radiating to the shoulder and arm on the right side. PX4 at 4-5, 34. Petitioner denied numbness or weakness, reported persistent pain despite using Vicodin, and that he was seen by his primary doctor and had a normal back x-ray. Id. On examination of the neck, Petitioner had active range of motion, flexion to 60°, extension to 25°, rotation to 60° bilaterally, and a positive Spurling's test. Id. on examination of the shoulder, Petitioner had full active range of motion, negative Hawkins/Neer's/drop arm test's, intact neurovascular signs, and pain radiating from the posterior shoulder to the right trapezius and posterior to anterior shoulder and right arm anteriorly. Id. Dr. Aranas diagnosed Petitioner with cervical radiculopathy, prescribed Napralan and Vicodin, ordered a cervical spine MRI, and placed Petitioner off work. Id.

Petitioner returned to MercyWorks on July 14, 2011 reporting persistent pain with slight relief with prescription medication use and remained off work. PX4 at 5, 32-33. Petitioner underwent a cervical MRI without contrast on July 18, 2011. PX3 at 17-18. The interpreting radiologist noted the following: (1) central herniation C5-6 and right herniations C6-7 with foraminal narrowing; and (2) minimal bulge C3-4 and C4-5. Id. Petitioner returned to MercyWorks on July 19, 2011 reporting that his medicine did not work and increasing pain. PX4 at 5-6, 30-31. Dr. Aranas referred Petitioner to an orthopedic spine specialist and kept Petitioner off work. Id. Petitioner testified the specialist was Dr. Wehner.

On July 29, 2011, Petitioner saw Dr. Wehner reporting that he initially thought he pulled a muscle on June 3, 2011 "when he was pulling the hood up from his truck and injured his neck and right shoulder area." PX3 at 14-15, 20. He also reported pain radiating down his right arm to the dorsum of the hand with some associated numbness. Id. On examination, Dr. Wehner noted that Petitioner was in mild to moderate distress, was rubbing the right side of his neck and right arm and elbow constantly, full range of motion with a tendency to sit with his neck cocked to the left, increased pain with side bending to the right and side rotation to the right, some trace weakness of the right triceps, symmetric biceps/triceps/brachial radialis reflexes at 1+, and no atrophy or edema. Id. She reviewed Petitioner's MRI which she interpreted to show a focal disc herniation at C6-7 on the right and a smaller disc herniation at C5-6. Id. Dr. Wehner diagnosed Petitioner with cervicalgia and right radiculopathy with a radiologic findings of a right C6-7 herniated disc. Id. She recommended a Medrol Dosepak, some Neurontin, and Norco as needed, prescribed a short course of physical therapy, and placed Petitioner off work. Id.

On July 29, 2011, Petitioner's counsel sent a letter to Respondent on Petitioner's behalf indicating that he had not received temporary total disability benefits and asking for follow up on recommended medical care. PX6 at 1-3.

On August 1, 2011, Petitioner returned to MercyWorks reporting persistent pain temporarily relieved by prescribed medication. PX4 at 6, 28-29. Dr. Aranas kept Petitioner off work. Id.

On August 5, 2011, Petitioner's counsel sent a letter to Respondent on Petitioner's behalf requesting that it follow up on its investigation into Petitioner's claim and attaching updated medical records. PX6 at 4-13.

On August 12, 2011, Petitioner saw Dr. Wehner and reported being in constant neck and right shoulder pain which was no better. PX3 at 13, 16-17, 25. Petitioner also reported that he was unable to obtain the prescribed medications other than gabapentin and the Medrol Dosepak because Respondent would not approve it. Id. On examination, Dr. Wehner noted that Petitioner had full range of motion in the neck but he tended to hold it tilted to the left, full upper extremity strength, symmetric reflexes at 2+, and she noted that Petitioner continually rubbed his right trapezial area. Id. Petitioner requested to return to work full duty and Dr. Wehner noted that Petitioner's financial constraints and lack of insurance at the time. Id. She maintained her recommendations for medication and physical therapy, but released Petitioner back to full duty work based on her physical examination of him and noted that if Petitioner took Norco he should not do so while working. Id.

Petitioner also went to MercyWorks on August 12, 2011 reporting that he was still in pain but he had to go to work. PX4 at 6-7, 26-27. On examination of the neck, Petitioner had full range of motion. Id. on examination of the shoulder, Petitioner had range of motion on abduction to 120° and 5/5 strength bilaterally. Id. Dr. Soler noted that Dr. Wehner had released Petitioner to full duty work and had a physical therapy order as well. Id. He diagnosed Petitioner with a herniated disc in the neck, noted that Petitioner would continue in physical therapy for 3 to 4 weeks, and scheduled a follow-up visit. Id. Petitioner was released to full duty work effective August 15, 2011. Id.

Petitioner testified that he was referred to Dr. Koutsky by a friend and saw him for a second opinion. On September 23, 2011, Petitioner saw Dr. Koutsky for an evaluation of right upper extremity radicular pain and neck pain. PX1 at 111-112. He reported some numbness, tingling and weakness in the right arm. Id. Petitioner also described symptoms beginning on June 3, 2011 "after she sustained a work-related injury while working for the city of Chicago as a truck driver" when he was pulling, click to check fluids of an engine and noticed a sharp pain in his right shoulder as well as in his neck radiating down his right arm which included some numbness and tingling. Id. Dr. Koutsky examined Petitioner's right shoulder which showed a positive impingement sign, some weakness in the rotator cuff distribution, and a negative drop arm test and sulcus test. Id. Neurologically, Petitioner's right shoulder abductors and right triceps were weaker than on the left, he had some decreased and wreck sensation in the right middle finger compared to the left side, symmetrical deep tendon reflexes in the arms with exception of right tricipital reflex which was weak, positive right sided Spurling's test, negative L'Hermitte's test, no clonus noted, negative Hoffman sign, and some paracervical muscle tenderness and spasm to palpation with limited range of motion. Id.

Dr. Koutsky reviewed Petitioner's July 18, 2011 MRI scan of the cervical spine which he interpreted to show multiple levels of spondylotic changes, loss of normal cervical lordosis, and moderate right-sided disc herniation at C6-7, mild to moderate left sided disc protrusions at C4-5 and C5-6, and no evidence of any fracture. Id. He diagnosed Petitioner with cervical disc herniation with radiculopathy made a differential diagnosis of right shoulder pain rule out rotator cuff pathology. Id. Dr. Koutsky stated that Petitioner presented

with these conditions after a work related injury on June 3, 2011. Id. he ordered continued physical therapy, referred Petitioner to a pain clinic for cervical epidural injections for the disc herniation, prescribed pain medication, and kept Petitioner off work. Id.

Respondent issued a check dated September 23, 2011 to Petitioner for $4,375.02. PX6 at 14-15. Petitioner testified that he provided the July 12, 2011 and August 14, 2011off work slips to Wayne via fax, but this check was not issued until September 23, 2011.

On October 20, 2011, Dr. Koutsky diagnosed Petitioner with cervical spondylosis, stenosis, and radiculitis. PX1 at 110. He ordered continued physical therapy for the neck, and indicated his continued recommendation for a right shoulder MRI to rule out possibility of a rotator cuff injury. Id. In the interim, he refilled Petitioner's pain medications and kept Petitioner off work. Id.

On November 3, 2011, Dr. Koutsky reviewed Petitioner's right shoulder MRI scan which he noted showed evidence of supraspinatus tendinosis, some irregularity on the undersurface of the myotendinous junction consistent with a possible partial tear, no full thickness tear noted, some degenerative changes, and an intact labrum and biceps tendon. PX1 at 109.

On November 17, 2011, Petitioner saw Dr. Koutsky reporting a lot of disabling pain in the neck and right upper extremity and limited improvement of his symptomatology with one injection while awaiting approval of the second injection. PX1 at 108. Petitioner continued in physical therapy. Id. Dr. Koutsky noted that Petitioner's shoulder MRI scan shoulder a partial thickness rotator cuff tear. Id. He diagnosed Petitioner with cervical disc herniation and disabling cervical radiculopathy which was related to his injury at work. Id. Dr. Koutsky referred Petitioner to Dr. Brown for a neurosurgical evaluation, refilled Petitioner's medications, and kept him off work. Id.

On December 15, 2011, Petitioner saw Dr. Koutsky reporting a lot of disabling pain in the neck and right upper extremity and limited improvement of his symptomatology with two injections while awaiting approval of the third injection. PX1 at 107. He diagnosed Petitioner with cervical disc herniation which was work related and noted that Petitioner's MRI scan showed a herniated disc. Id. Dr. Koutsky also noted that Petitioner awaited approval for his third injection, continued physical therapy, and a neurosurgical consultation with Dr. Brown. Id. In the interim, he refilled Petitioner's medications and kept him off work. Id.

On January 19, 2012 and February 13, 2012, Petitioner saw Dr. Koutsky who diagnosed him with a cervical disc herniation and radiculopathy for which he noted conservative management had failed and recommended an anterior cervical decompression and fusion with instrumentation to be preceded by surgical clearance given Petitioner's medical history. PX1 at 105-106. In the interim, he refilled Petitioner's medications and kept him off work. Id.

Petitioner underwent the recommended surgery performed by Dr. Koutsky and Dr. Brown on March 21, 2012. PX1 at 104, 129-134. Pre-and postoperatively, Petitioner was diagnosed with chronic right C7 radiculopathy due to herniated disc at C6-7 on the right. Id. Drs. Koutsky and Brown performed an anterior cervical discectomy and fusion using a cage, allograft and plate at C6-C7. Id.

On April 5, 2012, Petitioner returned to Dr. Koutsky post operatively reporting a fair amount of discomfort and improvement in his arm symptoms. PX1 at 103. Dr. Koutsky diagnosed Petitioner as status post cervical

fusion, ordered continued hard collar immobilization, refilled Petitioner's prescriptions, ordered x-rays at his next visit, and kept him off work. Id.

On April 19, 2012, Petitioner saw Dr. Koutsky five weeks postoperatively reporting anxiousness to come out of his collar. PX1 at 102. Dr. Koutsky reviewed cervical spine x-rays which showed a solid fusion with instrumentation in a good position at C6-7. Id. He ordered discontinuation of the collar, physical therapy, refilled Petitioner's medications, kept him off work. Id. Petitioner testified that he underwent the recommended physical therapy.

On May 17, 2012, Petitioner saw Dr. Koutsky reporting a fair amount of discomfort including numbness and tingling down his right upper extremity and concern about residual arm symptoms. PX1 at 101. Dr. Koutsky reviewed cervical spine x-rays which showed a solid fusion with instrumentation in a good position at C6-7. Id. He diagnosed Petitioner with chronic cervical radiculitis status post cervical fusion, ordered an MRI of the cervical spine with contrast and continued physical therapy, and kept Petitioner off work. Id.

Petitioner underwent the recommended cervical spine MRI on June 8, 2012. PX1 at 113-114. The interpreting radiologist found following: (1) MR pattern compatible with anterior cervical fusion at C6 and C7 with discectomy; (2) prominent degenerative changes at C4-C5 with bilateral uncovertebral junction osteophytes and neural foraminal narrowing with suspected compression of the bilateral C5 nerve roots; and (3) degenerative changes of the cervical spine at C5-C6 with bilateral uncovertebral junction osteophytes and neural foraminal narrowing and suspected bilateral encroachment on the C6 nerve roots for which he recommended a clinical correlation. Id.

On June 18, 2012, Petitioner saw paste reporting some pain in the neck radiating to his right upper extremity. PX1 at 99. Dr. Koutsky reviewed Petitioner's June 8, 2012 MRI which he interpreted to show evidence of anterior cervical decompression and fusion at C6-7, some generalized left paracentral disc protrusions at C4-5 and C5-6, and no evidence of any right-sided nerve root impingement, or abnormal enhancement, fracture, or spinal cord impingement. Id. He ordered continued physical therapy, refilled Petitioner's pain medications, and kept Petitioner off work. Id.

On July 30, 2012, Petitioner reported fair amount of discomfort in his neck and upper extremity. PX1 at 98. Dr. Koutsky ordered continued physical therapy and, refilled Petitioner's medications, kept him off work. Id.

On August 27, 2012, Petitioner saw Dr. Koutsky reporting some progress in therapy and continued chronic radiculitis. PX1 at 97. Dr. Koutsky noted that Petitioner's MRI scan from a few months ago looked good and showed no evidence of active nerve root impingement. Id. However, given Petitioner's chronic radicular symptoms he recommended cervical epidural injections and kept Petitioner off work. Id. Petitioner testified that he received the recommended steroid injections on October 31, 2012, November 14, 2012, and December 10, 2012.

On September 27, 2012, Petitioner saw Dr. Koutsky reporting chronic radiculitis and inflammation of the nerve root as well as undergoing the recommended physical therapy. PX1 at 96. Dr. Koutsky noted that they were waiting for approval of the recommended cervical epidural injection. Id. He noted that Petitioner had chronic neuritis after his surgery and noted that Petitioner's last MRI scan looked good and showed no evidence of active compression. Id. Dr. Koutsky also noted that Petitioner had some chronic nerve root inflammation and reiterated his recommendation for cervical epidural injection and kept Petitioner off work. Id.

On November 8, 2012, Petitioner saw Dr. Koutsky reporting chronic radiculitis, having completed therapy a couple of weeks prior, taking medication on an as needed basis, and anxiousness to return to work. PX1 at 95. Dr. Koutsky noted that Petitioner was neurologically stable and that his recent MRI scan looked good. Id. He released Petitioner to return to work effective November 16, 2012. Id. Petitioner testified that he returned to full duty work on December 3, 2012.

On December 6, 2012, Petitioner saw Dr. Koutsky and reported some residual radicular symptoms, taking medicine on an as needed basis, and working full duty through his discomfort. PX1 at 94. Petitioner was to continue with his therapy at home and scheduled for a third injection. Id. Dr. Koutsky noted that Petitioner's residual radicular symptoms may never "clear up 100%," but in the interim he noted that Petitioner would continue to work full duty. Id.

On January 11, 2013, Dr. Koutsky noted that he thought Petitioner was at maximum medical improvement, but scheduled a final follow-up visit in one month. PX1 at 93. On February 15, 2013, Dr. Koutsky placed Petitioner at maximum medical improvement and returned him to work without restrictions effective February 18, 2013. PX1 at 35-37.

Regarding his current condition, Petitioner testified that he is in constant pain and has constant stiffness, and that it is difficult for him to do normal things (i.e., changing lights, washing windows at home, playing with his children, playing basketball as much as before his injury, playing lacrosse or football, starting a lawnmower, sleeping, etc). Petitioner testified that he stretches as much as he can.

Petitioner also testified that his current job is as a motor truck driver, the same position he held before his claimed injury, and that he receives the same rate of pay. Among other general responsibilities, Petitioner's job duties include delivery, checking vehicle fluids, and operating a lift gate. Petitioner testified that, while doing these activities, he has pain. Petitioner also testified that he is not responsible for off-loading. Petitioner testified that he takes over-the-counter medications now as needed and that he has not re-injured himself after June 3, 2011.

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 (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

The Arbitrator finds that Petitioner did not sustain an accident that arose out of and in the course of her employment with Respondent as claimed. In so finding, the Arbitrator notes various inconsistencies in Petitioner's testimony when viewed in light of the record as a whole and finds that the Petitioner's testimony is not credible.

Petitioner testified that he suffered an injury on June 3, 2011, but he did not report his injury right away because he did not think it was that severe. On cross examination, however, Petitioner testified about neck and right shoulder pain so severe that he was unsure how he managed to work full duty for weeks between the claimed

injury at work and his first doctor's visit. Moreover, while notice is not a disputed issue, it is notable that Petitioner did not notify his employer of the alleged accident on June 3, 2011 until July 11, 2011, 39 days later, and that he did not notify his employer or his primary care physician on June 15, 2011 about the alleged incident at work.

In fact, the June 3, 2011 through July 11, 2011 medical records are devoid of any reference to an incident, injury or accident at work on June 3, 2011. To the contrary, Dr. Patton's June 15, 2011 progress notes reflect Petitioner's stated history of a motor vehicle accident 12 years earlier and Petitioner's understanding that he had arthritis. Petitioner also reported that "*Pain always returns and recently recalled findings 12 years ago*[;] *Pain coming more frequently, every few days*[;] truck driver, does a lot of sitting[;] Occasionally pain is severe enough where pt can not turn his torso side to side[;] *Not sure what makes the pain worse....*" Id (*emphasis* added). After an examination, Dr. Patton noted that Petitioner's cervical, thoracolumbar, and lumbar spine showed no abnormalities and that his thoracic spine showed abnormalities "pin-point TTP [tenderness to palpation] at T3-4." Id. Dr. Patton diagnosed Petitioner with upper back pain and a backache. Id. She noted that it was a "likely progression of arthritis[.]" Petitioner did not report any right shoulder pain and no findings were made after a physical examination related to the right shoulder. In any event, the physical examination findings on this date are not reflective of the severity that Petitioner testified he felt pain on cross examination, which is further inconsistent with his testimony on direct and re-direct examinations.

Finally, the Arbitrator notes that Petitioner denied having any prior complaints regarding his neck, upper back or right shoulder on direct examination and only testified about this event which resulted in a right shoulder surgery and some, albeit minimal, neck complaints on cross examination.

Based on all of the foregoing, the Arbitrator finds that Petitioner failed to establish by a preponderance of credible evidence that he sustained a compensable injury at work on June 3, 2011 as claimed. Unless otherwise addressed herein, all other issues are rendered moot and all requested compensation and benefits are denied.

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

Given the facts presented in this case, the Arbitrator finds that Respondent had a reasonable dispute as to whether Petitioner sustained a compensable injury at work on June 3, 2011 as claimed and whether his claimed condition of ill being was causally related to any such accident. Respondent's conduct was not unreasonable, vexatious and/or in bad faith. Thus, Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act is denied.

In support of the Arbitrator's decision relating to Issue (O), credit/reimbursement to Respondent, the Arbitrator finds the following:

As noted above, the Arbitrator finds that Petitioner failed to establish by a preponderance of credible evidence that he sustained a compensable injury at work on June 3, 2011 as claimed. The evidence reflects the parties' stipulation that Respondent paid $60,606.93 in temporary total disability benefits to Petitioner. AX1. Respondent offered further evidence of payments made by Respondent to Petitioner's medical providers totaling $81,158.39 and of payments made by Blue Cross/Blue Shield totaling $2,924.00. RX1-RX2. No evidence to the contrary was produced at trial. Based on all of the foregoing, the Arbitrator finds that Respondent is entitled to a credit for these payments.

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

Anthony Berndt,

Petitioner,

14IWCC0152

vs.

NO: 12 WC 10057

Hribar Trucking, 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 temporary total disability, medical espenses 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 25, 2013 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 $41,800.00. 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: FEB 27 2014
KWL/vf
O-2/10/14
42

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

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

14IWCC0152

BERNDT, ANTHONY
Employee/Petitioner

Case# **12WC010057**

HRIBAR TRUCKING INC
Employer/Respondent

On 6/25/2013, 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 0.10% 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:

0013 DUDLEY & LAKE LLC
THOMAS LAKE
325 N MILWAUKEE AVE SUITE 202
LIBERTYVILLE, IL 60048

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
DANIEL R EGAN
10 S RIVERSIDE PLZ SUITE 1530
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)

14IWCC0152

Anthony Berndt
Employee/Petitioner

v.

Hribar Trucking, Inc.
Employer/Respondent

Case # 12 WC 010057

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Cook**, on **May 29, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the day of accident, 2/28/12, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**50,411.40**; the average weekly wage was $**969.45**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of $**19,155.54** for TTD, $**3,049.55** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**22,205.09**.

Respondent is entitled to a credit of $**37,582.60** under Section 8(j) of the Act.

ORDERS

Medical Expenses

The Arbitrator awards Petitioner the following medical expenses, subject to the fee schedule and with Respondent receiving credit for any payments made toward said expenses, as reflected in RX 2: 1) Dr. Maiman/Medical College of Wisconsin, $36,467.98; Froedtert Hospital, $38,505.44; MCMC Radiology Services, $1,352.00; and OccuCare, $2,993.00.

Temporary Total Disability

See pages 12-13 of the attached conclusions of law for an explanation of the Arbitrator's temporary total disability award. With respect to the disputed period, October 15, 2012 through May 29, 2013 [with October 15, 2012 through December 23, 2012 involving a claimed underpayment], the Arbitrator awards a total of $18,669.95 in benefits.

Prospective Care

The Arbitrator awards prospective care in the form of follow-up visits to Dr. Maiman and additional physical therapy as recommended by Dr. Maiman.

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

6/25/13
Date

ICArbDec19(b)

Anthony Berndt v. Hribar Trucking, Inc.
12 WC 10057

Arbitrator's Findings of Fact

The parties agree that Petitioner was injured on February 28, 2012 while working as a local deliveryman for Respondent. Arb Exh 1. Petitioner testified his job involved driving a semi from location to location, delivering and picking up ash and cement. He was required to climb stairs, pull and hook up hoses weighing 100 to 200 pounds and lift various items, with the heaviest being tires.

Petitioner testified he was in good health when he began working for Respondent on July 12, 2002. He denied having any neck problems or undergoing any neck treatment prior to his February 28, 2012 accident. Immediately prior to that accident, he was driving his work vehicle southbound on 294, near I-88, when traffic slowed. He brought his semi to a complete stop and was then rear-ended by another semi. He described the impact as forceful, referencing the photographs in Group PX 11. The semi that hit him pushed his 79,700-pound vehicle forward about a car length. He experienced stiffness in his neck, back and shoulders after the accident.

Petitioner testified he sought treatment on the day of the accident at Aurora Occupational. The brief treatment note from this facility sets forth a consistent account of the accident. Petitioner complained of a "brutal headache with neck and shoulder pain." Petitioner was referred to an Emergency Room. PX 6. No Emergency Room records are in evidence.

Petitioner testified he stayed home from work on February 29, 2012. On that day, he experienced numbness and tingling down his left arm into his fingertips. He had never experienced this sensation before. He resumed working on March 1, 2012 but experienced increased pain in his head, neck and shoulders while operating his semi. He sought treatment that day at United Occupational Medicine, where he saw Dr. Foster. The doctor's note sets forth a consistent account of the accident and subsequent care at Aurora Occupational. Petitioner reported that the impact was sufficient to cause the backside of his trailer to collapse. The doctor noted that Petitioner's symptoms increased that day after he resumed working and was "bouncing" in his truck. Petitioner complained of pain in his neck and "down triceps of L arm." He denied any previous injuries involving these areas.

Dr. Foster examined Petitioner and obtained cervical spine X-rays, which showed mild reversal of normal lordosis secondary to positioning or muscle spasm. The doctor diagnosed a cervical strain and possible radiculitis. He prescribed a short course of Prednisone. He noted that Petitioner was required to "handle hoses." He released Petitioner to light duty as of March 5, 2012, with no lifting over ten pounds and no commercial vehicle driving. PX 3.

Petitioner returned to Dr. Foster on March 7, 2012 and reported that his neck was "still very tight" and that he was occasionally experiencing mild headaches. On examination, Dr. Foster noted that Spurling's testing resulted in slight pain in the paracervicals. He noted that Petitioner expressed concern about being able to maneuver heavy 20-foot hoses at work. The doctor indicated he might require physical therapy. The doctor continued the previous work restrictions. PX 3.

On March 8, 2012, Petitioner called Dr. Foster's office and requested a muscle relaxant. The doctor prescribed Skelaxin. PX 3.

When Petitioner next saw Dr. Foster, on March 12, 2012, he denied improvement. He complained of pain in the back of his neck, increased by neck motion, occasional pain radiating down the back of his left arm and significant headaches. The doctor prescribed Celebrex and physical therapy. He continued the previous work restrictions. PX 3, 8.

Petitioner began a course of therapy at Sports Physical Therapy and Rehab Specialists on March 13, 2012. On that date, the evaluating therapist noted complaints of headaches and "neck pain with referred left UE pain." On examination, the therapist noted a positive Spurling's on the left "with referred pain into C7 distribution (5th finger/triceps)" and a "severe increase in cervical muscle tone bilaterally," left worse than right. PX 8.

Petitioner continued attending therapy thereafter. He testified the therapy caused his symptoms to worsen. On March 27, 2012, he returned to Dr. Foster and complained of a "very sore neck" and occasional headaches. The note reflects that Petitioner denied "radiation down arm" but pointed to a tender spot at C7. The doctor released Petitioner to light duty with no commercial vehicle driving. PX 3. On March 30, 2012, Petitioner's physical therapist noted overall improvement but continued localized pain with the "greatest pain along C7 to palpation." PX 8.

When Dr. Foster next saw Petitioner, on April 5, 2012, he described Petitioner as "difficult to assess" based on a lack of objective abnormalities. Due to Petitioner's "somewhat consistent" C7 complaints, however, he placed therapy on hold and prescribed a cervical spine MRI. PX 3. The MRI, performed at Kenosha Open MRI on April 16, 2012, demonstrated mild annular bulging of the C4-C5 disc with a "shallow focal disc protrusion midline and posteriorly effacing the spinal cord creating moderate vertebral canal stenosis without significant foraminal stenosis," a tiny focal disc protrusion at C5-C6 with mild effacement of the spinal cord creating moderate vertebral canal stenosis without significant foraminal stenosis, and annular bulging of the disc at C6-C7 "with broad-based protrusion midline and posteriorly creating mild to moderate vertebral canal stenosis without foraminal stenosis." PX 2.

On April 6, 2012, Petitioner called Dr. Foster's office and requested refills on his Skelaxin and Flexeril as well as pain medication for his headaches. The doctor prescribed Tramadol and Flexeril.

On April 9, 2012, Petitioner's physical therapist recommended that Petitioner undergo a cervical spine MRI due to "fluctuating progress" in therapy and Petitioner's concern about the level of his discomfort at C7. PX 8.

Petitioner returned to Dr. Foster on April 10, 2012. The doctor noted that Petitioner denied radicular symptoms but complained of tightness and occasional "massive" headaches. On examination, the doctor noted mild tenderness to palpation of C6-C7. He refilled the Skelaxin and made a notation concerning Dr. Didinski, a spine specialist. At the next visit, on April 17, 2012, Dr. Foster reviewed the MRI results and noted that Petitioner planned to see Dr. Maiman, a physician of his own choice, rather than Dr. Didinski. Dr. Foster recommended against surgery. He suggested that Petitioner undergo an epidural steroid injection. He broached the idea of Petitioner returning to his regular duties but held off after again noting that Petitioner was required to lift heavy hoses. Following a discussion with a case manager named "Jason," Dr. Foster imposed new restrictions: "may drive personal vehicle" and "can lift up to 15 pounds." PX 3.

On April 26, 2012, Petitioner saw Dr. Maiman, a neurosurgeon affiliated with the Medical College of Wisconsin/Froedtert Hospital. PX 1, p. 5. The doctor's initial note reflects that Petitioner experienced an immediate onset of largely left-sided neck pain, associated with headaches and pain in the trapezius, after being rear-ended by a semi on February 28, 2012. The doctor also noted a complaint of "occasional painful paresthesias going into the left arm." He indicated that Petitioner denied right arm and lower extremity complaints. He also indicated that Petitioner denied any previous history of significant spinal problems.

Dr. Maiman advised Petitioner to stop smoking.

On examination, Dr. Maiman noted a decreased cervical range of motion to the left "with severe paravertebral spasm throughout his neck and up into the trapezius musculature." Flexion was normal but extension was "limited to about 15 degrees, also with a severe paravertebral spasm." Motor and sensory examinations were normal. Left triceps jerk was decreased.

Dr. Maiman reviewed the MRI. He expressed concern with the largely passive nature of the therapy performed to date. He requested the therapy records and prescribed flexion-extension cervical spine X-rays. Those X-rays, performed the same day, showed no abnormalities. PX 7.

At Dr. Maiman's recommendation, Petitioner resumed therapy at Sports Physical Therapy & Rehab Specialists on May 8, 2012. By July 2, 2012, he had attended thirty-six sessions and was demonstrating the ability to perform within a light physical demand level. His therapist described his truck driver occupation as within the heavy physical demand level. PX 8.

Petitioner returned to Dr. Maiman on July 5, 2012. At that visit, the doctor described Petitioner as "clearly improved" but continuing to experience a fair amount of pain. On

examination, the doctor noted a near-full range of cervical spine motion but with mild paravertebral tenderness. He described his neurologic examination as unremarkable. He released Petitioner to light duty and instructed him to continue attending therapy. He noted that Petitioner expressed some concern about being able to pass a DOT exam. He released Petitioner to light duty with no lifting over 20 pounds, no repetitive bending/twisting and no overhead work. PX 7.

Petitioner continued attending therapy thereafter. In mid-July 2012, his therapist noted increased symptoms secondary to simulated work activity, "hose stacking," during therapy. The therapist asked Dr. Maiman to prescribe a home cervical traction unit. PX 8. On July 25, 2012, Petitioner reported that he was resuming light duty six hours per day. On July 27, 2012, Petitioner reported that his neck was "really sore from going back to work for office work, due to prolonged looking toward and cervical rotation with paperwork." On August 15, 2012, the therapist sent a re-evaluation note to Dr. Maiman indicated Petitioner had regressed during the preceding three to four weeks. PX 8.

On August 16, 2012, Petitioner returned to Dr. Maiman, with the doctor recording the following history:

> "Mr. Berndt came in today for follow-up of his cervical radiculopathy. In the interim, the therapist describes him as having deteriorated. He has been having increased pain, and increasing difficulties doing his exercise program, although he continues to do most of it. He denies any new trauma or other neurological abnormalities."

On examination, Dr. Maiman noted a decreased range of motion to the left with moderate paravertebral tenderness. He stated: "it appears to me that he does have some decreased sensation in the C7 distribution which is a new phenomenon." He recommended a cervical spine CT scan, noting that the previous MRI "does not define the foramen adequately." He put therapy on hold, continued the previous work restrictions and prescribed Vicodin for pain. PX 1.

Petitioner underwent the recommended CT scan at MCMC Radiology Services on August 27, 2012. The radiologist interpreted the scan as showing straightening of the cervical spine, indicating spasm, and a "mild posterior bulge of the C6-C7 disc abutting the thecal sac without evidence of central canal or neuroforaminal stenosis." PX 5.

On October 5, 2012, Dr. Maiman administered a left C6-7 transforaminal injection at Froedtert Hospital. PX 4. Soriano Dep Exh 2. Petitioner testified that this procedure did not relieve his symptoms. By the time he underwent this procedure, he was experiencing symptoms in both arms.

On October 10, 2012, a placement coordinator affiliated with an entity called "ReEmployAbility, Inc." sent a letter to Petitioner's counsel referencing Petitioner's work

restrictions and indicating that a transitional full-time job as a thrift store sales assistant had been located for Petitioner. In the letter, the coordinator indicated that Petitioner would be paid $16.00 per hour while working in the thrift store. The coordinator referred to the transitional job as an "extension" of Petitioner's employment by Respondent. The coordinator indicated Petitioner would have to meet with Jon Bender on October 17, 2012 and begin working at the thrift store the following Monday, October 22nd. RX 3.

On October 18, 2012, Petitioner saw Dr. Maiman again, with the doctor recommending a single level procedure at C6-C7. The doctor discussed two options with Petitioner: "artificial disc versus an ACDF with iliac crest bone." He informed Petitioner he would have to be nicotine free for at least three weeks prior to surgery. He released Petitioner to light duty with "no repetitive looking up or down."

At Respondent's request, Petitioner saw Dr. Soriano, a neurosurgeon, for a Section 12 examination on December 17, 2012. The doctor's report (Soriano Dep Exh 2) sets forth a consistent account of the accident of February 28, 2012. The report reflects that Petitioner was "pitched forward quite hard" at impact, with his hat flying off and his Bluetooth coming out of his ear. Dr. Soriano noted that the cab of Petitioner's semi was operable after the collision and that Petitioner drove the cab sixty miles back to Caledonia, Wisconsin.

Dr. Soriano noted that Petitioner complained of headaches, numbness and tingling in his arms and fourth and fifth fingers, shoulder pain and spasms down to his toes. He also noted that Petitioner was currently taking Flexeril and Vicodin, as well as Percocet for "really bad pain."

Dr. Soriano interpreted the August 27, 2012 CT scan as showing a "broad spur with calcification slightly towards the left foramen but without significant compression."

Dr. Soriano indicated he reviewed a First Report of Injury, records from United Occupational Medicine, an initial therapy evaluation and Dr. Maiman's records.

On examination, Dr. Soriano noted a normal gait, 5/5 strength in all motor groups of the hands and upper extremities, symmetrical reflexes at the biceps, triceps and brachioradialis, negative Tinel's signs at the elbows and wrists, a normal range of neck and shoulder motion, and no point tenderness or spasm in the neck, shoulders or arms.

Dr. Soriano opined that the rear-end collision of February 28, 2012 resulted in a cervical strain. He found no causal relationship between the collision and Petitioner's continued complaints of neck and trapezius pain. He described the MRI and CT findings as "consistent with mild degenerative changes at multiple levels" with "no evidence of neuroforaminal narrowing" and "no evidence of any acute aggravation or acute findings related to the accident." He described Petitioner's complaints as "bilateral in a non-dermatomal distribution and somewhat exaggerated."

Dr. Soriano found Petitioner to be at maximum medical improvement and capable of full duty. He described Dr. Maiman's surgical recommendation as "difficult to justify, at best." He indicated that Dr. Maiman was the only provider to have made a "very soft neurological finding," i.e., apparent decreased sensation in the C7 distribution. Soriano Dep Exh 2.

The parties agree that Respondent stopped paying workers' compensation benefits as of December 23, 2012. Arb Exh 1. PX 9. Petitioner testified he received benefits in the amount of about $218.00 per week from October 23, 2012 through December 23, 2012.

Petitioner testified that, in late December, after Dr. Soriano found him capable of full duty, he contacted Respondent's human resources representative about resuming employment. The representative instructed him to undergo a new DOT examination. He underwent this examination on January 5, 2013. The examining physician disqualified him due to his use of narcotic pain medication and the need for clearance from Dr. Maiman.

Petitioner returned to Dr. Maiman on February 7, 2013. The doctor noted Petitioner had resumed smoking because his workers' compensation benefits had been terminated and he did not have money to pay for the anti-smoking medication he had been taking. Dr. Maiman recommended that Petitioner contact him as soon as he was completely nicotine-free so that the surgery could be scheduled with Petitioner's group carrier. Petitioner testified he quit smoking "cold turkey" so that he could undergo the surgery and get back to work. With reference to the "negative IME," Dr. Maiman addressed causation as follows: "note that I have said previously, and continue to assert, that [Petitioner] has a herniated disc in the cervical spine which is directly related to the work injury in question. There is absolutely no reason to think otherwise and all evidence is very clear." PX 7.

On March 21, 2013, Dr. Maiman performed an anterior cervical decompression, fusion and stabilization at C6-7, using an ACF spacer and a 14-mm plate. The surgery took place at Froedtert Memorial Lutheran Hospital. PX 4, 7. Petitioner testified that, by the time the surgery took place, he was experiencing pain with any movement of his head.

On April 11, 2013, Dr. Maiman gave a deposition on behalf of Petitioner. PX 1. Dr. Maiman testified he obtained board certification in neurosurgery in 1985. He currently practices at the Medical College of Wisconsin, where he is Sanford J. Larson distinguished professor and chairman of the department of neurosurgery. PX 1 at 5. He performs 350 to 400 spine surgeries annually. About 40% of these surgeries involve the cervical spine. PX 1 at 6. He routinely interprets MRI and CT scans. PX 1 at 6.

Dr. Maiman testified he has an independent recollection of Petitioner. PX 1 at 6. He identified Maiman Dep Exh 2 as a copy of his outpatient notes concerning Petitioner. PX 1 at 7. He first saw Petitioner on April 26, 2012, at the referral of Dr. Jeranek, Petitioner's personal care physician. PX 1 at 8. Petitioner related that he was rear-ended by a semi on February 28, 2012. PX 1 at 8-9.

Dr. Maiman testified his initial examination findings of a significantly reduced range of motion and "a lot of neck spasm" into the back of the neck and trapezius were "consistent with muscle injury" in Petitioner's neck. PX 1 at 9. Petitioner's MRI, which he personally reviewed, showed three-level disc bulging, with the bulge at C6-7 "more prominent" and "in the midline, heading over to the nerve going to the left arm." PX 1 at 10-11. The MRI findings correlated with the examination findings. PX 1 at 11. Petitioner denied having any pre-existing cervical spine problems. PX 1 at 12.

Dr. Maiman testified he diagnosed a cervical radiculopathy, i.e., "irritation of the nerve root of the C6-7 nerve." Based on the history and examination, he opined that this condition stemmed from the motor vehicle accident. PX 1 at 12-13. He recommended therapy. Petitioner subsequently reported improvement. On July 5, 2012, he released Petitioner to light duty and told him to continue therapy. PX 1 at 14. As of August 16, 2012, however, Petitioner had deteriorated, per his physical therapist, and was "not doing well." Petitioner was experiencing numbness down his arm that he had not previously complained of. The numbness involved the same nerve, i.e., the C7 nerve root, that Petitioner had previously complained of. PX 1 at 16. Petitioner's condition as of August 16, 2012 was a "continuation of the same injury." PX 1 at 17. He obtained a CT scan because he needed to understand why Petitioner had gotten worse. The MRI showed a disc and foraminal narrowing but the narrowing was not catastrophic. He ordered a CT scan because MRIs do a "lousy job of bone definition." The CT scan was consistent with the MRI. It confirmed that there was disc bulging and compression of the C7 nerve. PX 1 at 19. The motor vehicle accident was a "principal factor" in this compression. PX 1 at 19-20. He held off on recommending surgery to see whether therapy would help. Petitioner did therapy faithfully for several months. Petitioner "got worse in spite of that and maybe, in part, because of it." PX 1 at 21-22. The need for the therapy stemmed from the motor vehicle accident. PX 1 at 22. He discussed surgery with Petitioner and presented him with two alternatives. Petitioner could either undergo an anteriocervical fusion or an artificial disc replacement. He told Petitioner that surgery was "not absolutely necessary in the sense that he was going to be paralyzed if he didn't have it" but he also told Petitioner his pain was not likely to improve without surgery. PX 1 at 23.

Postoperatively, Petitioner returned to Dr. Maiman on April 18, 2013. The doctor indicated Petitioner was "not doing as well as expected" in that he was complaining of trembling in his left hand as well as neck pain. On examination, the doctor noted a full cervical range of motion with minimal tenderness. Cervical spine X-rays showed good positioning of the fixation device and early incorporation of bone. The doctor refilled Petitioner's Flexeril and Percocet and noted that Petitioner was going to be starting therapy. PX 7.

Petitioner began a course of therapy at Accelerated Rehabilitation on April 18, 2013. The last therapy note in evidence is dated May 21, 2013. PX 8.

On May 28, 2013, Dr. Maiman's assistant, Steve Kisch, PA-C, issued a note indicating that Petitioner remained under Dr. Maiman's care and was to remain off work "until at least 6/20/13." PX 10.

Petitioner testified he is scheduled to undergo additional therapy, per Dr. Maiman. He wants to undergo this therapy. The surgery helped quite a bit in terms of his arm symptoms. He still has pain at the back of his neck as well as at the incision site but the pain is more localized than it was preoperatively. He feels he is continuing to improve. His current medications include Percocet and Cyclobenzeprine, a muscle relaxant. He started taking Percocet in December of 2012. He began taking Cyclobenzeprine in April of 2012. He is scheduled to return to Dr. Maiman on June 20, 2013. He is not sure when he will be released to work. Dr. Maiman has had him off work since the surgery. He wants to return to work for Respondent but has to pass a DOT examination in order to be able to do so.

Under cross-examination, Petitioner testified his truck was not equipped with airbags. At impact, his head bounced off the head rest behind him. He did not undergo any treatment at the scene of the accident. After the accident, he was able to drive back to Wisconsin. Between April and May of 2012, he performed light duty at Respondent. The light duty consisted of inventory work in Respondent's warehouse. He had to count batteries as part of this work. He was required to look down at times but, for the most part, the work was at eye level. While he was subject to restrictions per Dr. Maiman, Respondent offered him restricted work, through an entity called "Re-EmployAbility." At the point at which Respondent extended this offer, the work was within Dr. Maiman's restrictions. Petitioner testified he met with Jon Bender, the manager of the store where he was supposed to work, and told Bender he was seeing Dr. Maiman the following day. When he saw Dr. Maiman, the doctor added a work restriction, indicating he needed to keep his head in a neutral position. Petitioner testified he advised Bender of this added restriction, with Bender indicating he would have to check with human resources.

On redirect, Petitioner testified that, the week after Dr. Maiman added the work restriction, he contacted Bender again but never received an offer of employment from "Re-EmployAbility." Nor did he receive an offer of accommodated duty from Respondent. Dr. Soriano spent about an hour with him.

Respondent offered into evidence Dr. Soriano's deposition of May 21, 2013. Dr. Soriano became "board eligible" in neurosurgery in 1987. He achieved board certification in 1992. Soriano Dep Exh 1. He now concentrates on disorders of the spine and peripheral nerves. He stopped performing brain surgery about six years ago. RX 1 at 7. He devotes less than 20% of his practice to medical-legal work. He conducted 123 independent medical examinations in 2012 and 122 in 2011. RX 1 at 7. When he examined Petitioner, in December of 2012, Dr. Maiman was recommending a fusion at C6-7. RX 1 at 11. As of the examination, Petitioner was taking Flexeril and Vicodin. Petitioner complained of pain in his neck, mid-back and lower back as well as headaches and numbness/tingling in his arms and ring and small fingers. Petitioner indicated he was able to drive but spent most of his time reading or watching television. RX 1 at 12.

Dr. Soriano testified he reviewed treatment records and radiographic studies, including cervical X-rays and a cervical CT scan. RX 1 at 13. He reviewed an MRI report but not the actual MRI scan. RX 1 at 14. The CT scan showed a spur, or calcification, at C6-7, slightly to the left side of the disc. The spur was not causing any nerve root or spinal canal compression. RX 1 at 14-15. It takes at least a year or two for such a calcification to develop. A calcification develops in response to a bulging disc. RX 1 at 16. The MRI report documented a protruding or bulging disc at C6-7. The MRI was consistent with the CT scan. RX 1 at 15-16. There was no evidence of trauma in either the CT or the MRI. Both were consistent with "long-standing multi-level degenerative discs consistent with a 42-year-old spine." RX 1 at 17-18.

Dr. Soriano testified that Petitioner exhibited a normal gait and did not appear to be in distress. RX 1 at 13. Dr. Soriano described his examination of Petitioner as "completely normal." RX 1 at 14.

Dr. Soriano testified there were no objective findings to correlate with Petitioner's headaches or numbness/tingling. The tingling was into the ring and small fingers. "That would be the disc level associated with the C7-T1 disc" whereas the protrusion is at C6-C7. RX 1 at 18.

Dr. Soriano opined that the motor vehicle collision resulted in soft tissue whiplash-type injuries. He viewed Petitioner's initial symptoms as related to the collision. RX 1 at 19, 22. Petitioner's current symptoms, however, are non-anatomical and unrelated to the accident. RX 1 at 19-20.

Dr. Soriano testified that Petitioner "ha[s] a mild degree of central stenosis because of the breakdown of his discs from C3-C4 to C4-C5 to C5-C6 and at C6-C7." The terms "stenosis" is relative, however, because, in Petitioner's case, "it just means there is arthritis taking up some of the space where his spinal cord should be." RX 1 at 21. Petitioner has no evidence of foraminal stenosis. RX 1 at 21.

Dr. Soriano opined that Petitioner had reached maximum medical improvement as of the December 2012 examination. RX 1 at 22. He did not believe that Petitioner required surgery. He testified there is "no standard of care that would recommend surgery" to a person who has numerous complaints that are not reproducible or objective in nature. RX 1 at 23. Petitioner's complaints extend all the way to his feet and are clearly unrelated to the C6-C7 disc. RX 1 at 24.

Dr. Soriano testified that Petitioner is capable of driving a car and performing full duty. Petitioner has no neurological or mechanical deficits. RX 1 at 24. Petitioner exhibited a full range of neck motion and is thus capable of driving a truck. RX 1 at 24-25.

Under cross-examination, Dr. Soriano testified he charged $950 per examination and $1100 per hour for deposition time as of December 2012. RX 1 at 25. Of the independent examinations he performed in 2012, over 95% were for defendants. RX 1 at 25-26. He recalls some of Petitioner's history but, if he did not have Petitioner's picture available in his chart, he

would not be able to recall what Petitioner looked like. RX 1 at 26. He has offices in several locations. He currently has privileges at a surgi-center and at the following hospitals: St. Anthony's, Swedish American and Rockford Memorial. RX 1 at 26-27. He probably performed 25 to 30 cervical surgeries per year during the last several years. RX 1 at 27. He is familiar with an "anterior cervical approach" fusion. He spent about 5 to 10 minutes actually examining Petitioner. RX 1 at 28. Petitioner did not relate any history of pre-existing cervical problems. Petitioner's records do not reveal any such history. RX 1 at 28. It is his belief that Petitioner's cervical spine was asymptomatic prior to the accident. RX 1 at 28. Petitioner described his duties but he did not receive a formal written description of those duties. RX 1 at 28-29. He has not reviewed the operative report or any treatment records post-dating October 18, 2012. RX 1 at 29. He did not review the MRI films. He may have asked to see these films. It is his practice to review his patients' MRI films. RX 1 at 30-31. He believes Petitioner injured the soft tissues of his neck, not his cervical spine. RX 1 at 31. The family doctor's visits, the radiographic studies and the attempts at therapy and medication were reasonable and necessary. RX 1 at 31-32. It was reasonable for Petitioner to be restricted, work-wise, early on in March. Petitioner related bilateral complaints. RX 1 at 32. Dr. Maiman stated that it "seemed" to him that Petitioner had some decreased sensation in the C7 distribution. Dr. Soriano testified that using the phrase "it seems to me" is not a good way to word a medical finding. RX 1 at 34. He personally did not document decreased sensation when he examined Petitioner in December of 2012. RX 1 at 35. Since he has not seen Petitioner recently, he cannot comment on Petitioner's current condition or ability to work. RX 1 at 35. Petitioner did exhibit disc pathology. The pathology was a pre-existing bulging degenerative disc at C6-C7 that had already become calcified. That is consistent with the normal aging process. RX 1 at 36. The accident did not accelerate the degenerative process. RX 1 at 36-37. What is key is that Petitioner had a disc bulge, not a disc herniation. RX 1 at 37.

On redirect, Dr. Soriano testified that Petitioner does not require any lifting-related restrictions, based on his normal examination. RX 1 at 38. If the accident had aggravated Petitioner's disc pathology, the CT and MRI would have shown this. "No acute findings were even minimally suggested on the MRI scan." RX 1 at 39.

Under re-cross, Dr. Soriano testified he has no opinion as to whether Petitioner would be expected to improve, symptom-wise, following a cervical fusion. RX 1 at 39-40.

Arbitrator's Credibility Assessment

Dr. Foster described Petitioner as "difficult to assess" at one point but did not note any symptom magnification. Respondent's examiner, Dr. Soriano, described Petitioner's symptoms as non-anatomical but acknowledged that Petitioner exhibited disc pathology. Dr. Maiman, who has treated Petitioner over an extended period, did not note any inconsistencies.

Overall, the Arbitrator found Petitioner credible.

Did Petitioner establish a causal connection between his undisputed work accident and his current condition of ill-being?

The Arbitrator finds that Petitioner met his burden of proof on the issue of causal connection. Specifically, the Arbitrator finds that the undisputed work accident of February 28, 2012, in combination with subsequent flare-ups associated with attempts to resume working, led to the need for the cervical spine surgery that Dr. Maiman performed on March 21, 2013. In so finding, the Arbitrator relies on the following:

-Petitioner's credible account of the force associated with the collision of February 28, 2012
-Petitioner's credible denial of neck problems prior to the collision
-The lengthy duration of Petitioner's pre-accident employment by Respondent, with that employment involving the manipulation of heavy hoses
-Petitioner's credible testimony that he experienced numbness and tingling in his left arm the day after the accident
-The therapy notes of March 13, 2012 documenting a positive Spurling's and complaints in a C7 distribution
-Dr. Foster's documentation of a tender spot at C7 and subsequent referral to a spine surgeon
-The absence of any evidence of a specific re-injury after February 28, 2012
-Dr. Maiman's causation-related opinions

The Arbitrator finds Dr. Maiman more persuasive than Dr. Soriano. Dr. Maiman achieved board certification in neurosurgery in 1985. He is chairman of the department of neurosurgery at the Medical College of Wisconsin/Froedtert Hospital. PX 1, p. 5. He performs about 350 to 400 spinal surgeries annually. About 40% of these surgeries involve the cervical spine. PX 1, p. 6. Dr. Soriano, while also board certified in neurosurgery, performs only about 25 to 30 cervical spine surgeries annually. He devotes a portion of his practice to independent medical examinations, the vast majority of which are for defendants. Dr. Maiman treated Petitioner over an extended period while Dr. Soriano examined Petitioner once, with that examination lasting five to ten minutes. Under cross-examination, Dr. Soriano made two important concessions: Petitioner has disc pathology and was asymptomatic before the accident.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner seeks an award of medical expenses stemming from treatment provided by Dr. Maiman/Medical College of Wisconsin ($36,467.98), Froedtert Hospital (various charges from October 5, 2012 and March 2013 totaling $38,505.44), MCMC Radiology Services (CT scan, 8/27/12, $1,352.00) and OccuCare ($2,993.00 for post-operative therapy performed in 2013). PX 4-5, 7-8. Respondent offered into evidence a print-out of payments its workers' compensation carrier made to Petitioner and various providers, including the Medical College of Wisconsin and Froedtert Hospital. RX 2. The Arbitrator has reviewed both the bills and the print-out. It appears that many of Dr. Maiman's charges, as well as the October 5, 2012 bill

from Froedtert Hospital, were in fact paid by the workers' compensation carrier. The parties agree that other medical expenses were paid by the group carrier. Arb Exh 1.

Having found that Petitioner established causation, and noting Dr. Maiman's testimony as to the need for the surgery and Petitioner's testimony as to his post-operative improvement, the Arbitrator awards the medical expenses claimed by Petitioner, subject to the fee schedule, with the understanding Petitioner is not entitled to a double recovery and that Respondent is entitled to credit for any payments reflected on RX 2.

Is Petitioner entitled to temporary total disability benefits? Is Petitioner entitled to temporary partial disability benefits?

At the hearing, Petitioner claimed two intervals of temporary total disability: March 1, 2012 through April 18, 2012 and May 7, 2012 through May 29, 2013, the date of hearing. Respondent stipulated to the first claimed period and to a second period running from May 7, 2012 through October 14, 2012. Respondent claimed Petitioner was entitled to temporary partial disability benefits from April 19, 2012 through May 6, 2012 and from October 15, 2012 through December 23, 2012. The parties agreed that Respondent paid $22,205.09 in benefits (including $19,155.54 in temporary total disability and $3,049.55 in temporary partial disability) prior to the hearing. They also agreed that the disputed temporary total disability benefits totaled $18,669.95. Arb Exh 1.

Respondent's claim that Petitioner is entitled only to temporary partial disability benefits from October 15, 2012 through December 23, 2012 is premised on its argument that Petitioner failed to pursue an offer of alternative light duty as a thrift store sales associate through an entity known as "ReEmployAbility." That offer is further described in RX 3. Petitioner testified he presented to Jon Bender, the store manager, as required by Respondent, and made Bender aware he was returning to Dr. Maiman the following day. At the return visit, Dr. Maiman imposed an additional work restriction. Petitioner testified he promptly notified Bender of this restriction and followed up with Bender the following week but did not hear anything further from either Bender or Respondent. Respondent did not call any witness to refute Petitioner's testimony on these points. Records in evidence reflect that Respondent paid Petitioner $219.63 per week for ten weeks prior to December 23, 2012, at which point Respondent stopped paying benefits in reliance on Dr. Soriano.

The Arbitrator has elected to rely on Dr. Maiman rather than Dr. Soriano with respect to the issues of causation and work capacity. The Arbitrator finds that Petitioner acted in good faith in pursuing the possibility of a transitional light duty job with an entity other than Respondent. Petitioner continued to pursue this possibility even after Dr. Maiman imposed an additional work restriction on October 18, 2012. There is no evidence indicating that ReEmployAbility and/or Respondent offered work within Dr. Maiman's revised restrictions after October 18, 2012. Dr. Maiman continued to actively treat Petitioner after October 18, 2012.

At the hearing, the parties agreed that the amount of disputed temporary total disability (including the claimed $4,266.70 underpayment for the ten-week period preceding December 23, 2012) equals $18,669.95. Arb Exh 1. The Arbitrator finds that Petitioner's condition remained unstable and that he was temporarily totally disabled from October 15, 2012 through the hearing of May 29, 2013. The Arbitrator awards Petitioner $18,669.95 in temporary total disability benefits based on the parties' agreement and calculations.

Is Petitioner entitled to prospective care?

As of the hearing, Petitioner was continuing to undergo post-operative physical therapy per Dr. Maiman. Having found that Petitioner established causation vis-à-vis the surgery, and having elected to rely on Dr. Maiman, the Arbitrator awards prospective care in the form of follow-up visits to Dr. Maiman and additional physical therapy as recommended by the doctor.

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

14IWCC0153

Carlos Torres,

Petitioner,

vs. NO: 11 WC 15089

Integrated Industries,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 11, 2013 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.

14IWCC0153

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 $27,700.00. 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: FEB 27 2014
KWL vf
O-2/11/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

14IWCC0153

TORRES, CARLOS
Employee/Petitioner

Case# **11WC015089**

INTEGRATED INDUSTRIES
Employer/Respondent

On 2/11/2013, 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 0.11% 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:

0815 LUIS A ACEVES & ASSOC PC
EMILIANO PEREZ JR
33 N DEARBORN ST SUITE 2201
CHICAGO, IL 60602

1153 MARTIN, PATRICK W
203 N LASALLE ST
SUITE 2100
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)

14IWCC0153

Carlos Torres,
Employee/Petitioner

v.

Integrated Industries
Employer/Respondent

Case # 11 WC 15089

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **01/22/13**. After reviewing all 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 _____

14IWCC0153

FINDINGS

On the date of accident, **03/11/11**, 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 **$31,200.00**; the average weekly wage was **$600.00**.

On the date of accident, Petitioner was **22** 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 **$6,140.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$6,140.00**.

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 $400.00/week for 73 1/7 weeks, commencing August 30, 2011 through January 22, 2013, as provided in Section 8(b) of the Act, with Respondent receiving credit for the $6,140.00 in benefits it paid prior to arbitration.

Respondent shall pay reasonable and necessary medical services of $4,479.35, as provided in Sections 8(a) and 8.2 of the Act. PX 5A, 7A.

Respondent shall authorize and pay for prospective care in the form of the CT discogram recommended by Dr. Bergin.

For the reasons set forth in the attached conclusions of law, the Arbitrator declines to award penalties and fees in this claim.

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

2/11/13
Date

ICArbDec19(b)

FEB 11 2013

Carlos Torres v. Integrated Industries
11 WC 15089

14IWCC0153

Arbitrator's Findings of Fact

Petitioner, who is 24 years old, testified through a Spanish-speaking interpreter. He recalled working for Respondent for a year before his undisputed work accident of March 11, 2011. T. 14. He worked as a mechanic, changing tires and brakes on trailer chassis. T. 14. It was typical for him to change tires every day, sometimes five to ten times during the course of a day. A truck tire, including the rim, weighs about 120 pounds. T. 14.

Petitioner denied having any lower back pain or undergoing any lower back treatment prior to March 11, 2011. T. 29.

On March 11, 2011, Petitioner was working alone (T. 15-16), changing the brakes on a truck chassis. Because no lifting apparatus other than a jack was available, he had to "take out both tires with the rim simultaneously." T. 14-15. The tires and rim started falling toward him. He put his right foot back and tried to brace the tires and rim with his body weight so that they would not fall on his feet. He "made [this] effort just from [his] waist upwards." As he did this, he felt an immediate onset of pain in the center of his lower back. T. 16. He also felt pain radiating up to his neck. T. 17. He resumed working. About half an hour later, he started experiencing pain radiating down his legs. T. 17. He reported the injury to his supervisor that day. T. 17. [Notice is not in dispute.] At Respondent's direction, he went to the Clearing Clinic, which is part of MacNeal Hospital. T. 18.

Petitioner testified he saw a female physician at the Clearing Clinic on March 11, 2011. This physician lifted his shirt, looked at his back and asked where his pain was. She then gave him pain medication and released him to light duty. T. 18-19.

The Clearing Clinic records reflect that Petitioner saw Dr. Ellen Fertelmeister on March 11, 2011. The doctor noted that Petitioner injured his back while changing the brakes on a trailer. Petitioner complained of constant 5/10 lower back pain since that afternoon. Dr. Fertelmeister noted negative straight leg raising bilaterally. She also noted muscle spasm in the left paraspinous muscles and pain with movement of the cervical spine. Spurling's was negative. She obtained X-rays of the lumbar and cervical spine. The preliminary reading was negative. She diagnosed lumbar and cervical strains and indicated these conditions were "probably related to work activities." She prescribed a Medrol Dose Pak and Cyclobenzaprine. She released Petitioner to light duty with no twisting, no lifting over 20 pounds and bending up to 20 minutes per hour. PX 1. T. 19.

Petitioner testified he returned to work after leaving the clinic. He presented his restrictions to his boss but told his boss he could not resume working that day due to the severity of his pain. He returned to work the following day. T. 20. He testified that Respondent did not accommodate the restrictions. Instead, Respondent wanted him to continue his usual

heavy mechanic duties. A few days later, Respondent sent Petitioner home because his restrictions could not be accommodated. T. 21. Respondent called Petitioner back to work a few days after sending him home but again failed to provide him with accommodated duty. T. 21.

Petitioner returned to the Clearing Clinic on March 15, 2011. T. 21. On this occasion, Petitioner saw Dr. Ali. Petitioner complained to the doctor of constant, 7/10 lower back pain, "made worse by lifting, twisting and bending." He also complained of neck numbness and pain radiating to his legs. He indicated that the Medrol Dose Pak did not help. On examination, Dr. Ali noted a limited range of lumbar motion, negative straight leg raising bilaterally, tenderness to palpation of the cervical spine and a negative Spurling's maneuver. Dr. Ali diagnosed lumbar and cervical strains. He prescribed Skelaxin and physical therapy. He continued the previous work restrictions. PX 1. T. 21.

Petitioner underwent an initial physical therapy evaluation on March 21, 2011. The therapist noted complaints of 6-7/10 lower back pain and radicular symptoms in both legs. She also noted that Petitioner denied any significant past medical history. Due to some communication difficulties, she scheduled Petitioner to see a Spanish-speaking therapist. PX 1, p. 14.

Petitioner went back to the Clearing Clinic on March 22, 2011 and again saw Dr. Fertelmeister. Petitioner indicated his pain was worsening in severity. Dr. Fertelmeister noted that Petitioner was unable to squat and that straight leg raising was positive bilaterally. She prescribed Meloxicam and a lumbar spine MRI. She continued the previous work restrictions. PX 1, p. 9. T. 22.

On March 28, 2011, Angelica Diaz, a therapy assistant, noted that Petitioner complained of lower back and bilateral leg pain and was unable to tolerate many exercises. PX 1, p. 16.

On March 30, 2011, Petitioner underwent the recommended lumbar spine MRI at American MRI. The interpreting radiologist noted mild disc bulges at L3-L4, L5-L5 and L5-S1 "with associated slight neural foraminal narrowing at these levels." The radiologist indicated that the bulging disc at L4-L5 encroached on the exiting left L4 nerve root in the left neural foramen. He described Petitioner's central lumbar canal as "developmentally small in caliber" with "no superimposed acquired central canal stenosis." PX 2. RX 1.

The following day, Dr. Fertelmeister discussed the MRI results with Petitioner. She prescribed Tramadol and recommended a neurosurgical consultation. PX 1, pp. 21-22. She scheduled Petitioner to see Dr. Zelby. PX 1, p. 26. T. 22.

Petitioner saw Dr. Zelby on April 11, 2011, as scheduled. T. 23. Dr. Zelby is a board certified neurosurgeon. PX 3, p. 1. Dr. Zelby obtained a history of Petitioner's work accident and subsequent treatment. He noted complaints of pain in the lower back, posterior left leg

and posterior right thigh. He also noted that Petitioner complained of leg numbness and weakness. Petitioner denied any prior history of similar symptoms.

On examination, Dr. Zelby noted that sensation to pin was diminished in the anterior left thigh. He also noted inconsistent behavioral responses positive for pain on superficial light touch, pain on simulation and diminished pain on distraction.

Petitioner testified he was not sure whether Dr. Zelby had his MRI film available. T. 23. In his report, Dr. Zelby interpreted the MRI as showing degenerative disc disease at L5-S1, a "persistent S1-S2 disc" and a "broad-based and right disc protrusion at L5-S1" effacing the right S1 nerve root with no compression on the left S1 nerve root.

Dr. Zelby indicated that Petitioner "has back pain from his lumbar degenerative disc disease" as well as left leg pain. Because the MRI showed that the L5-S1 disc herniation was "more to the right," Dr. Zelby recommended an EMG to determine the source of the left leg pain. He commented that Petitioner would need a series of epidural injections if the EMG showed a clear radiculopathy and four weeks of work conditioning if it did not. He continued the previous work restrictions. PX 3, p. 4.

On April 15, 2011, Petitioner returned to the Clearing Clinic and saw Dr. Sorokin. The doctor noted Dr. Zelby's recommendations and ordered the EMG. He instructed Petitioner to continue taking Meloxicam, Skelaxin and Tramadol. He released Petitioner to restricted duty with no lifting over 20 pounds, bending up to 20 minutes per hour and no twisting. He indicated that Petitioner's symptoms were "probably related to work activities." PX 1.

Subsequent Clearing Clinic records reflect that Petitioner did not undergo the EMG.

On May 10, 2011, Petitioner saw Dr. Bergin, a physician of his own selection. Dr. Bergin is associated with Orthopaedic Surgery Specialists.

Dr. Bergin's note reflects that Petitioner was injured on March 11, 2011 while fixing brakes when he "tried to catch a tire and fell to the ground onto the right knee." Dr. Bergin indicated that Petitioner denied any previous back injury or treatment. He noted complaints of low back pain radiating to the right buttock and posterior thigh and occasionally into the calf.

Dr. Bergin noted that Petitioner "has been working full duty and is quite miserable."

On examination, Dr. Bergin noted some moderate lumbar paraspinal spasm, forward flexion of 40 degrees, extension to 20 degrees and negative straight leg raising bilaterally.

Petitioner testified he gave his MRI films to Dr. Bergin to review. Dr. Bergin interpreted these films as showing a "desiccated degenerative disc at L5-S1, with central protrusion more off to the right side contacting the right S1 nerve root." Dr. Bergin indicated that the radiologist

who interpreted the MRI noted "some other disc protrusions" but that he was unable to appreciate this.

Dr. Bergin obtained AP and lateral lumbar spine X-rays, which showed some "minimal disc space narrowing at L5-S1." He diagnosed degenerative disc disease at L5-S1 and a disc protrusion at L5-S1 with right S1 radiculopathy. He prescribed Celebrex and four to six weeks of physical therapy. He indicated Petitioner should be limited to light duty with "no lifting greater than 20 pounds occasionally, 10 pounds frequently, with limited bending and twisting." PX 5.

Petitioner underwent an initial therapy evaluation at ATI on May 17, 2011. T. 24. He began attending therapy on a regular basis thereafter. On June 27, 2011, the therapist noted that Petitioner was reporting increased pain after work "since he is being asked to perform activities outside of work restrictions." On July 14, 2011, the therapist noted that Petitioner demonstrated some improvement but was "on his feet all day at work which does not comply with his work restrictions." The therapist found Petitioner to be at a light physical demand level. She described his job as requiring heavy work. PX 5,

On July 19, 2011, Dr. Bergin noted that Petitioner reported some improvement but was still experiencing low back pain radiating into both legs. On examination, he noted forward flexion to about 70 degrees, extension to 20 degrees and negative straight leg raising bilaterally. He recommended that Petitioner undergo work conditioning five times weekly for four weeks. T. 24. He found it reasonable for Petitioner to work full duty "unless it interferes with his work conditioning." PX 5.

Petitioner testified he attended work conditioning at ATI for only one week. T. 25. During that week, he spent five hours per day in work conditioning and four hours per day working. His low back pain worsened during that week. T. 25. On August 2, 2011, Petitioner's work conditioning therapist described Petitioner as "very compliant" and "put[ting] forth a diligent effort." PX 5, p. 54. The next day, the therapist noted that Petitioner complained of increased back pain after using a jackhammer at work. A week later, the therapist reported that the weight Petitioner was using had decreased "during floor to chair lifting due to increased LBP sustained during work." The therapist also noted that Petitioner's capabilities were still falling below the heavy physical demand required by his job. PX 5, p. 61. On August 16, 2011, the therapist noted that Petitioner was making progress "within the light physical demand level." The therapist recommended an additional two to four weeks of work conditioning. PX 5, p. 72. On August 17, 2011, the therapist noted that Petitioner reported falling down stairs, hurting his lower back and right ankle. The therapist observed that Petitioner was limping and wearing a wrap around his right ankle. PX 5, pp. 79, 85.

Petitioner returned to Dr. Bergin on August 18, 2011 and indicated he started feeling "remarkably worse after the work conditioning started." On examination, Dr. Bergin noted positive straight leg raise on the right at about 70 degrees "reproducing pain from the buttock and posterior calf." Dr. Bergin placed work conditioning on hold. He prescribed a Medrol Dose

Pak and a repeat lumbar spine MRI. He indicated Petitioner could continue light duty. PX 5, p. 8.

The repeat MRI, performed without contrast on August 23, 2011, demonstrated a small left foraminal disc protrusion at L4-L5 resulting in minimal encroachment of the left neural foramen and a "small broad-based central disc protrusion at L5-S1 with mild facet arthrosis." The radiologist found no significant stenosis throughout the lumbar spine. PX 6. RX 2.

Petitioner returned to Dr. Bergin on August 30, 2011. T. 26. The doctor interpreted the repeat MRI as showing a "degenerative disc at L5-S1 with a herniated disc off to the right side, consistent with [Petitioner's] symptoms."

Dr. Bergin described Petitioner's gait as antalgic. On examination, he noted positive straight leg raising on the right at about 70 degrees reproducing pain in the buttock and posterior thigh into the calf. He kept Petitioner off work and referred him to Dr. Chang for a course of epidural steroid injections. PX 5, p. 9.

Petitioner returned to Dr. Bergin on September 27, 2011, with the doctor noting that no epidural injections had been approved as of yet. The doctor again noted an antalgic gait and positive straight leg raising on the right at 70 degrees. The doctor prescribed Tramadol. He again recommended that Petitioner stay off work and see Dr. Chang for injections. PX 5, p. 10. T. 26.

Petitioner testified he last received temporary total disability benefits on October 3, 2011. He denied working in any capacity after October 3, 2011. T. 29.

At Respondent's request, Petitioner saw Dr. Andersson for a Section 12 examination on October 4, 2011. In his report of the same date, Dr. Andersson indicated he reviewed an "injury report" which stated that Petitioner was lifting two tires on March 11, 2011 when he developed lumbar and cervical pain. He also indicated that Petitioner saw Dr. "Sorokin" on April 15, 2011, with this doctor stating Petitioner should consider an epidural injection "if the EMG was positive." Dr. Andersson did not reference any EMG report. He noted that "additional" epidural steroid injections were now under consideration.

Dr. Andersson noted that Petitioner complained of pain radiating down the right side of his back into the back of his right leg and calf and occasionally into his foot.

On examination, Dr. Andersson noted a mildly decreased range of lumbar spine motion with flexion to 40 degrees, extension to 20 degrees and lateral bending to 20 degrees. Straight leg raising was negative bilaterally.

Dr. Andersson indicated he personally reviewed the repeat MRI of August 23, 2011. He interpreted this study as showing mild degenerative changes at L4-L5, moderate degenerative

changes at L5-S1 and a right-sided bulge causing mild to moderate spinal stenosis foraminally at L5-S1.

Dr. Andersson found Petitioner's complaints and examination compatible with a "mild S1 nerve root irritation." He found it "unlikely that the alleged accident would be a cause of a herniation without causing significant radicular symptoms." He noted that Petitioner's symptoms were all left-sided when he saw Dr. Zelby and that his symptoms were "now on the right side." In his view, the "only factor in favor of this being related to the alleged work accident is that that is when [Petitioner] started having back pain." He stated that Petitioner currently exhibited only subjective abnormalities, i.e., tenderness, decreased range of motion and mild sensory changes. He indicated Petitioner would benefit from a transforaminal epidural steroid injection at L5-S1 on the right side, possibly followed by three to four weeks of therapy. He opined that Petitioner could work full-time but should be limited to ground work, minimum walking and lifting of only 10 pounds occasionally until a week after the injection. He projected that Petitioner would reach maximum medical improvement over the following three to four weeks. RX 3.

When Petitioner next saw Dr. Bergin, on October 25, 2011, the doctor again noted that Petitioner was awaiting approval of the recommended injections. The doctor's examination findings were unchanged. He kept Petitioner off work and again recommended injections by Dr. Chang. PX 5, p. 12.

Petitioner saw Dr. Chang on October 27, 2011. The doctor indicated that Petitioner was trying to lift a tire while changing brakes on March 11, 2011, when he "slipped and fell," developing back pain.

Dr. Chang described Petitioner's gait as antalgic. He noted that the range of lumbar spine motion was "limited to about 50% of normal in all directions." Straight leg raising was positive bilaterally at 30 degrees. Sensation was decreased in the posterolateral right thigh and posterior right calf.

Dr. Chang recommended a series of epidural injections. He administered the first such injection at the L4-S1 interspace, slightly right of midline. He prescribed Lyrica and Aleve and instructed Petitioner to return in two to three weeks. PX 7, pp. 2-3. T. 26.

Petitioner returned to Dr. Chang on November 17, 2011 and reported 20% improvement. The doctor administered a second epidural injection, again at L5-S1. T. 27. He noted that Petitioner had not yet started Lyrica or Aleve due to insurance issues. He again recommended these medications. PX 7, pp. 6-7.

On December 8, 2011, Petitioner returned to Dr. Chang and reported 50% lower back pain improvement and "more than 90%" improvement of his leg pain. The doctor recommended a third injection. The doctor administered this injection on December 23, 2011. T. 27. He instructed Petitioner to return to him in about a month. PX 7, pp. 9-10.

Petitioner testified that he experienced some pain relief after each injection, but only for about a week. T. 27.

On December 13, 2011, Dr. Bergin noted that Petitioner had undergone two injections to date and still complained of daily low back pain. The doctor recommended a six-week course of therapy. He kept Petitioner off work so he could avoid aggravating his condition. PX 6, p. 14.

Petitioner underwent additional therapy at ATI between December 19, 2011 and January 17, 2012. PX 5.

Petitioner returned to Dr. Chang on February 9, 2012 and reported that his symptoms worsened about two weeks after the third injection. He complained of back and bilateral leg pain. The doctor reviewed epidurograms from the injections and noted a "significant amount of adhesions with a very thin spread of the dye." He urged Petitioner to discuss his surgical options with Dr. Bergin. After Petitioner inquired about non-surgical options, Dr. Chang indicated Petitioner might benefit from a "caudal with lysis of adhesions procedure that causes the medicine to spread a lot better than previous injections." He also indicated Petitioner might need a discogram prior to surgery "since he has multiple levels of pathology." He prescribed Ultracet and indicated Petitioner should continue taking Lyrica and Naprelan. PX 7, pp. 10-11.

On February 21, 2012, Petitioner returned to Dr. Bergin and complained of back and bilateral leg pain, right much worse than left. Petitioner indicated he had undergone three injections "without any lasting relief."

On examination, Dr. Bergin noted moderate lumbar spasm, painful flexion and positive straight leg raising on the right at about 70 degrees reproducing pain into the calf.

Dr. Bergin noted that Dr. Chang had recommended a discogram. Dr. Bergin agreed with this recommendation. He prescribed a discogram at L5-S1 with L4-L5 as a control. He instructed Petitioner to remain off work until he could re-evaluate him following the discogram. PX 6, p. 15. T. 27.

On March 9, 2012, Petitioner's original counsel withdrew and Petitioner's current counsel substituted into the case.

On April 23, 2012, Petitioner's current counsel sent Respondent's counsel a letter requesting payment of temporary total disability benefits since October 3, 2011 and authorization of the recommended discogram. PX 8.

On May 31, 2012, Respondent's counsel sent Petitioner's counsel a letter citing Dr. Andersson's October 2011 report as a basis for contesting causal connection. RX 5, Exh A.

On November 29, 2012, Dr. Bergin again recommended the discogram and instructed Petitioner to remain off work. PX 4.

On January 3, 2013, Petitioner filed a Petition for Penalties and Fees referencing an agreement reached following a pre-trial held on October 30, 2012 and indicating Respondent would not agree to authorize the recommended discogram unless the discogram was performed at a facility of Respondent's selection. Petitioner requested that penalties and fees be imposed on Respondent. PX 10.

At Respondent's request, Dr. Andersson re-examined Petitioner on January 10, 2013. In his report of the same date, Dr. Andersson noted that Petitioner reported only transient improvement following three epidural injections and that Dr. Bergin had recommended a discogram. On examination, Dr. Andersson noted a decreased range of lumbar spine motion, negative straight leg raising bilaterally and "negative" non-organic signs.

Dr. Andersson reviewed the two MRI scans. He interpreted the August 23, 2011 scan as showing no evidence of a specific disc herniation but mild to moderate spinal stenosis foraminally at L5-S1.

Dr. Andersson opined that Petitioner's failure to respond to the injections was "not an indication to perform a discogram." He indicated he was having a "hard time" relating Petitioner's increased back pain to the work accident, based on the first MRI scan. He recommended that Petitioner undergo another lumbar spine MRI, given that the August 2011 scan was a year and a half old. He saw no indication for a discogram or fusion based on Petitioner's presentation and imaging studies. He found Petitioner capable of performing light duty, with lifting of 20 pounds occasionally and 10 pounds repetitively. He characterized this restriction as "temporary" and unrelated to the work accident. He found "no hard objective findings to substantiate [Petitioner's] subjective complaints or the fact he is still not working." RX 4.

Petitioner returned to Dr. Bergin on January 11, 2013. Petitioner complained of pain radiating from the middle of his lower lumbar spine into both buttocks. Petitioner also complained of numbness and tingling running down both legs. Dr. Bergin noted that he was waiting to receive written authorization of the previously recommended discogram.

On examination, Dr. Bergin noted negative straight leg raising, normal heel and toe walking, moderate lumbar tenderness to palpation and normal strength and sensation. He also noted that inconsistent behavioral responses were absent. He prescribed Tramadol, wrote out an order for a CT scan and discogram and instructed Petitioner to remain off work and return to him once these studies had been completed. PX 4.

On January 22, 2013, Respondent filed a Response to Petitioner's Petition for Penalties and Fees referencing Dr. Andersson's reports and alleging, inter alia, that it authorized a CT

discogram through "One Call Medical" and made a permanency advance of $3,500 following a December 7, 2012 pre-trial conference. RX 5.

Petitioner testified he has been off work since August 30, 2011 at Dr. Bergin's direction. When he last saw Dr. Bergin, on January 11, 2013, the doctor recommended a CT scan as well as a discogram. T. 28-29. Petitioner testified he wants to proceed with the CT discogram. T. 29. His back feels "bad" and he is still experiencing pain running down his legs. If he stands up too quickly, he feels as if something is "stuck" in his back. T. 30.

Under cross-examination, Petitioner was unable to recall exactly when Respondent hired him. T. 31. He was thus unable to agree with records showing a hire date of October 25, 2010. T. 31. His accident occurred in a rail yard known as "CN Harvey." T. 31. He did not know if anyone witnessed the accident. A lot of workers were at the rail yard but they did not all work in the same location. T. 31. He reported the accident to the yard manager, David Rescendiz. T. 32. He knows Edgar Diaz, the "company supervisor." T. 32. He presented his restrictions to Respondent on the day of the accident, immediately after leaving the Clearing Clinic. T. 33. He actually resumed working the next day, March 12, 2011. The job he returned to was not within his restrictions. He was still required to change tires and use vibratory tools such as air guns. It was painful to use the air guns. T. 33. His job duties remained the same thereafter. He continued working as a mechanic until August 30, 2011. He recalled being transferred to another location at some point. When asked whether Respondent suspended him for a week in June because he was not showing up to work, he testified he sometimes left work early due to the intensity of his back pain. When he did leave early, he always informed the person who was "in charge of that location." He saw Dr. Bergin because his original attorney recommended this doctor to him. The company doctors were not doing anything for him other than giving him pills. T. 36. He recalled Dr. Bergin allowing him to resume full duty as of July 19th. Whenever he received work restrictions from Dr. Bergin, he presented those restrictions to David Rescendiz but "they always wanted [him] to continue doing [his] job as if [he] didn't have any restrictions." T. 37. On September 27, 2011, he gave Edgar Diaz a slip from Dr. Bergin. The slip stated he was to be off work and would return to the doctor in four weeks. T. 38. When he next saw Dr. Bergin, in October, he received another slip keeping him off work four weeks. He gave that slip to David Rescendiz. He does not know whether Rescendiz gave this slip to Edgar Diaz because Diaz did not work in the yard where the accident occurred. Diaz worked in an office in Chicago. T. 39. The last two times he went to Dr. Bergin, he did not deliver any slip or paper to Respondent. T. 39. He did not recall talking with Diaz by phone at any point after August of 2011. T. 40. He did not quit his job with Respondent. He stopped going to work based on his doctor's instructions. T. 40. He has not looked for work since August 30, 2011. He has not returned to Respondent to request restricted duty because the type of job he has does not lend itself to restrictions. If Respondent could have accommodated him, it would have done so from the outset. T. 41. He has not filed claims for unemployment or Social Security disability benefits. He gets by because his live-in girlfriend, who is the mother of his child, works. His girlfriend's parents have also given him financial assistance. T. 41-43. His girlfriend works during the day. He sometimes takes care of his child during the day. His

child is a year and a half old. T. 43. There are times when his back hurts so much that he cannot take care of his child. T. 45.

On redirect, Petitioner testified he did not recall whether Dr. Bergin qualified his July 19, 2011 full-duty release in any way. He has not spoken with Diaz about his claim. T. 46-47.

Edgar Diaz testified on behalf of Respondent. Diaz testified he began working for Respondent in August of 2006. At that time, he supervised five mechanics. In late 2008, he was promoted to his current job, maintenance and repair manager. T. 49-50, 63.

Diaz testified he is familiar with Petitioner. Petitioner worked at Respondent's CN Harvey location. David Rescendiz was Petitioner's supervisor at that location. He (Diaz) is Rescendiz's supervisor. Diaz visited the CN Harvey location at least three times a week. T. 51. Petitioner worked as a chassis mechanic at CN Harvey.

Diaz testified he learned of Petitioner's accident from a second shift supervisor. The day after the accident, Petitioner gave him a note from the clinic stating he could not lift anything heavier than 20 or 25 pounds. T. 52. After Petitioner presented this note, he continued working as a mechanic but doing only "easy stuff." Petitioner was paired up with another man who performed any heavy lifting that might be required. T. 53-54. This went on for some months. In August of 2011, Diaz transferred Petitioner to Respondent's Elwood location because "the job [at CN Harvey] was getting a little more difficult for [Petitioner] to do." T. 54. Between the accident and the transfer, there were times when Petitioner would leave early or fail to advise Respondent he would be missing work due to a doctor's appointment. In June of 2011, Respondent suspended Petitioner for a week based on a violation of Respondent's "no call/no show" policy. T. 55. At the Elwood location, Petitioner worked inside and was only required to dispose of garbage and clean offices and bathrooms. T. 57. Petitioner did not have to do any heavy lifting. T. 55-56. During this time frame, Petitioner gave him light duty notes from his doctor. Respondent does not have a "policy" of providing light duty but Respondent will provide light duty if an "open space" is available. T. 57. Eventually, Petitioner produced a slip indicating he needed injections and was going to be off work for four weeks. Once those four weeks passed, Petitioner "was going to report back to" Diaz. Diaz recalled Petitioner giving him the "off work" slip in September. Petitioner never again reported to work. T. 58. Petitioner failed to show up after the four weeks passed. T. 58. In the early part of 2012, Petitioner called Diaz on his work phone and asked Diaz "if he still had his job and if he would be able to come back to work." Diaz told Petitioner "yes, just bring me a doctor's note so I can try to accommodate you." T. 60. Petitioner never appeared. If Petitioner had brought in a light duty note at that point, Respondent would have accommodated him. T. 61.

Diaz testified he has not spoken with Petitioner since their phone conversation. Petitioner's job has been filled by another mechanic. T. 61-62.

Diaz testified he interviewed Petitioner and hired Petitioner on October 25, 2010. T. 62.

Under cross-examination, Diaz testified that Rescendiz handed out job assignments to the mechanics and handled Respondent's day-to-day operations at the CN Harvey yard. T. 64. There were periods during which Diaz might not see a worker for a number of days during a particular week. T. 64. Diaz is always on call. He works "24/7" and has to be available to supervisors on two different shifts. If there are no "on call" situations, he works from 7:00 AM to 4:30 PM, Monday through Saturday. T. 65.

Diaz testified that changing a tire constitutes "heavy work." A tire, without the rim, weighs 65 pounds. With the rim, a tire weighs "a good 80 pounds." T. 66. Depending on the assignment, a mechanic might have to remove two tires. A brake job is "even heavier because there are two tires attached together." Those two tires would weigh around 140 pounds. T. 66.

Diaz acknowledged that he and Petitioner did not really have the same schedule and that he did not see Petitioner every workday. T. 67. Diaz testified he directed Rescendiz to accommodate Petitioner's restrictions. Diaz also discussed the restrictions on site with Petitioner when Petitioner presented the slips. T. 67. To the best of Diaz's knowledge, Rescendiz gave Petitioner "little" or "minor" stuff to do. T. 68. When Petitioner worked at the Elwood facility, he cleaned one big office and bathrooms. He also had to dispose of paper that was in bins that were about 1 1 /2 feet tall. T. 68. Diaz testified he transferred Petitioner to Elwood because Petitioner had a restriction indicating he could work only three or four hours per day. Petitioner worked at Elwood while he was undergoing work conditioning. Petitioner worked at Elwood for a week or two. T. 69, 72. Cleaning the bathrooms and disposing of garbage required a little bit of twisting and bending. T. 70. He knows it was Petitioner who called him in early 2012 because he had Petitioner's phone number stored in his cell phone and he had caller ID. T. 70. He was not aware that a doctor had Petitioner off work in early 2012. T. 71. Petitioner would have been required to present restrictions in order to receive light duty work. T. 72.

Diaz testified it was his understanding that Petitioner was given light duty assignments (such as changing a light rather than a tire) before Petitioner was transferred to Elwood. T. 73.

On redirect, Diaz testified that Petitioner never complained to him that his restrictions were not being accommodated. There were occasions, however, when Petitioner "would hurt more than other times." On those occasions, Diaz would tell Petitioner, "okay, take it easy." T. 73. Diaz never received information indicating that Petitioner's restrictions were not being accommodated. T. 74. When Petitioner presented an "off work" slip in September of 2011, it was Diaz's expectation that Petitioner would return in four weeks to present another slip. Petitioner did not return. Diaz did not hear from Petitioner again until 2012. T. 74-75.

Arbitrator's Credibility Assessment

There were discrepancies between Petitioner's and Diaz's accounts of the work duties Petitioner was required to perform following his accident. In the Arbitrator's view, David

Rescendiz was in the best position to testify concerning those duties since Rescendiz was Petitioner's direct, on-site supervisor. The Arbitrator finds it significant that Respondent called Diaz rather than Rescendiz. REO Movers, Inc. v. Industrial Commission, 226 Ill.App.3d 216, 223-224 (1st Dist. 1992). Diaz acknowledged he and Petitioner did not have the same work schedule and there could be days during each work week when he and Petitioner would not see one another.

While Petitioner had some difficulty recalling events, the Arbitrator found him credible overall. On the issue of Petitioner's post-accident work duties and communications with Respondent, the Arbitrator finds Petitioner more credible than Diaz. Petitioner's testimony that Respondent did not accommodate his restrictions at the rail yard is supported by the physical therapy records of June and July 2011.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between his undisputed work accident of March 11, 2011 and his current condition of ill-being?

The Arbitrator finds that Petitioner met his burden of proof with respect to the issue of causal connection. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible testimony that he had no back problems prior to the work accident; 2) Petitioner's ability to perform very strenuous truck mechanic duties during the months between his hiring and his work accident; 3) the abrupt change in Petitioner's condition following the accident; 4) the consistent accounts of the accident and post-accident complaints set forth in the treatment records; and 5) the causation-related opinions set forth in the treatment records.

The Arbitrator acknowledges that therapy records dated August 17, 2011 reflect that Petitioner reported having fallen, injuring his ankle and back. The Arbitrator does not view this fall as severing the chain of causation since Petitioner was reporting increased back symptoms secondary to work and work conditioning in June and July of 2011, prior to the fall.

The Arbitrator assigns little weight to Dr. Andersson's causation-related opinions. Dr. Andersson did not question Petitioner's credibility and recommended treatment/testing and work restrictions in both of his reports. RX 3-4.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims outstanding medical expenses from ATI Physical Therapy ($4229.35, PX 5A) and APAC Group (Dr. Chang, $250.00, 2/15/12 office visit, PX 7A). Respondent raised no objection to these bills. T. 81, 84.

Having found in Petitioner's favor on the issue of causation, the Arbitrator awards Petitioner reasonable and necessary medical expenses in the amount of $4,479.35 pursuant to Sections 8(a) and 8.2 of the Act.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims temporary total disability benefits running from August 30, 2011, the date on which Dr. Bergin took Petitioner off work, through January 22, 2013, the date of hearing. This is a period of 73 1/7 weeks. Respondent disputes this claim and maintains that Petitioner was temporarily totally disabled from August 30, 2011 through October 4, 2011, the date of Dr. Andersson's initial Section 12 examination.

In analyzing the issue of temporary total disability, the Arbitrator notes that, while Dr. Andersson questioned causation, he recommended work restrictions and treatment or testing in both of his reports. In his initial report, Dr. Andersson found Petitioner's complaints consistent with a "mild S1 nerve root irritation." He recommended an epidural steroid injection at L5-S1 on the right side and found Petitioner capable of ground level work with no lifting over 10 pounds and minimal walking. RX 3. In his second report, he noted that Petitioner experienced only transient improvement from three epidural injections. He recommended a repeat lumbar spine MRI and temporary work restrictions. RX 4.

The Arbitrator also notes that Dr. Andersson did not document any positive Waddell findings or other inconsistencies on either October 4, 2011 or January 10, 2013.

Based on the foregoing credibility- and causation-related findings, and in reliance on Dr. Bergin's "off work" notes and CT discogram prescription, the Arbitrator finds that Petitioner was temporarily totally disabled from August 30, 2011 through January 22, 2013, a period of 73 1/7 weeks. The Arbitrator views Petitioner's current condition as unstable. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010).

Is Petitioner entitled to prospective care?

Petitioner seeks prospective care in the form of a CT discogram, as recommended by Drs. Bergin and Chang. Respondent relies on Dr. Andersson, its Section 12 examiner, in arguing that Petitioner failed to prove causation and does not require such a study.

Having found in Petitioner's favor on the issue of causation, and noting that Dr. Andersson in fact recommended additional testing, albeit a lumbar spine MRI rather than a CT discogram, in January of 2013, the Arbitrator awards prospective care in the form of the CT discogram recommended by Drs. Bergin and Chang.

Is Respondent liable for penalties and fees?

In assessing Respondent's liability for penalties and fees, the Arbitrator has given consideration not only to the parties' pleadings but also to the August 17, 2011 therapy note, the change in attorneys, the opinions that Respondent solicited from Dr. Andersson, the advance that Respondent made prior to hearing and the representations Respondent made

concerning the discogram authorization. While the Arbitrator has elected not to adopt Dr. Andersson's causation-related opinions, the Arbitrator declines to award penalties and fees 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

James Robinson,
Petitioner,

vs.

NO: 10 WC 42796

14IWCC0154

Village of Schaumburg,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 5, 2013 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: FEB 27 2014
KWL/vf
O-2/10/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROBINSON, JAMES
Employee/Petitioner

Case# **10WC042796**

14IWCC0154

VILLAGE OF SCHAUMBURG
Employer/Respondent

On 3/5/2013, 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 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0787 FOOTE MEYERS MIELKE & FLOWERS LLC
RYAN P THERIAULT
3 N 2ND ST SUITE 300
ST CHARLES, IL 60174

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT ULRICH
10 S RIVERSIDE PLZ SUITE 2290
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 14IWCC0154

JAMES ROBINSON
Employee/Petitioner

v.

VILLAGE OF SCHAUMBURG
Employer/Respondent

Case # 10 WC 42796

An *Application for Adjustment 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 **OCTOBER 18, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **OCTOBER 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 **$62,764.00**; the average weekly wage was **$1,207.00**.

On the date of accident, Petitioner was **27** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $669.64/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.

Signature of Arbitrator

March 5, 2013
Date

MAR 5 - 2013

FINDINGS OF FACT

Petitioner is a police officer with the Village of Schaumburg. On October 14, 2010, his left ear was lacerated while effectuating an arrest. The Petitioner sought immediate treatment at St. Alexius Medical Center, where he received seven sutures, which were eventually removed. Petitioner testified that he experiences sensitivity in the area of the left ear, especially when wearing sunglasses. The Arbitrator noted a scar at the back the left ear lobe running behind the ear

lobe, from the top of the left ear lobe to the midpoint and a very slight bump on the inside of the top lobe of the left ear. The scar is not visible when facing the Petitioner.

CONCLUSIONS OF LAW

Is the Petitioner's present condition of ill-being causally related to the injury?

Petitioner testified that he experiences sensitivity and discomfort in the area of the left ear scar, especially when wearing sunglasses. Based upon that testimony, the Arbitrator concludes that the Petitioner's present condition of ill-being is causally related to the work accident.

What is the nature and extent of the injury?

Petitioner sustained a permanent scar behind his left ear. The scar is not visible when facing him, but he testified that he experiences sensitivity in the area of the left ear, especially when wearing sunglasses. Based upon the foregoing, the Arbitrator finds that Petitioner has sustained a permanent injury to the integumentary system of the body to the extent of 2% of the person as a whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

☒ 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

Richard Mosqueda,
Petitioner,
vs.

14IWCC0155

NO: 11 WC 42403

Jeff Heeren Trucking Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 6, 2013 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: FEB 27 2014
KWL/vf
O-2/10/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0155

MOSQUEDA, RICHARD
Employee/Petitioner

Case# 11WC042403

JEFF HEEREN TRUCKING INC
Employer/Respondent

On 3/6/2013, 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 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 LAW OFFICE OF JIM BLACK
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

0445 RODDY LEAHY GUILL & ZIMA LTD
PAUL KRAUTER
303 W MADISON ST SUITE 1500
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

14IWCC0155

Richard Mosqueda
Employee/Petitioner

Case # 11 WC 42403

v.

Consolidated cases: _____

Jeff Heeren Trucking 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 **Edward Lee**, Arbitrator of the Commission, in the city of **Rockford**, on **10/30/12 and 1/18/13**. After reviewing all 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 _____

14IWCC0155

FINDINGS

On **7/28/11**, 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 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 **$54,331.16**; the average weekly wage was **$1,044.83**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **4** dependent children.

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

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

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

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

ORDER

Denial of benefits

The Arbitrator denies benefits based upon finding of no accident and causal connection.

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

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

Edward Lee — Signature of Arbitrator

3/5/13 — Date

MAR 6 - 2013

FINDINGS OF FACT

The Petitioner, Richard Mosqueda, was employed with Jeff Heeren Trucking on July 28, 2011. Mosqueda believed that he worked for Jeff Heeren from April 1, 2011 through September 7, 2011. He stated that he was fired, placed on medical leave and then rehired from September 14, 2011 through October 15, 2011.

Mosqueda testified that he drove a flatbed semi for Jeff Heeren. He carried various products. (T. 8) He stated that on July 28, 2011, he was hauling mulch in Oskaloosa, Iowa. (T. 8) Mosqueda stated that at approximately 5:00 p.m. that day, he was finishing up loading the mulch. (T. 9) He testified that he was strapping the load down, there were pieces of mulch coming off the load, and a piece fell down into his glove. (T. 9) He felt a sharp sting and noticed a little lesion but he proceeded to strap down the load. (T. 9) Mosqueda stated that he then called Jeff and mentioned that he thought maybe he had gotten some poison ivy. He did not get any treatment at that time. (T. 9)

Mosqueda stated that over the next couple of weeks it started to spread over his arm. He testified that he was developing lesions between the webbing of his fingers. Then it went to the other arm. He stated that it spread from head to toe. (T. 10) Mosqueda indicated that the lesions were itchy. He stated that they looked like little mosquito bites or bumps. (T. 10)

While in Pennsylvania, Mosqueda stated that a black mite started coming out of his skin and he decided to seek medical attention. (T. 10) He went to a local walk-in clinic. (T. 11) Treatment began with Dr. O'Neil on August 19, 2011. Mosqueda stated that Dr. O'Neil prescribed scabies treatment, which was permathrin and hydroxyzine. (T. 12)

Records from Dr. O'Neil on August 19, 2011 indicate that Mosqueda was there to discuss a rash present for two to three weeks. The rash was itchy. The skin was described as multiple excoriated areas across forearm webspaces and lower abd-itching. (Px #1) The assessment was rash and skin eruption.

When he returned to Rockford, Mosqueda stated that he went to Physicians Immediate Care for medical treatment. (T. 13) He stated that he was given additional medication. Records from Physicians Immediate

Care on August 24, 2011 state Mosqueda developed an erythematous rash that was pruritic over a week ago. He reported continued pruritus whenever he got into his truck. (Px #2) It was noted that Mosqueda reported he saw another physician who prescribed treatment for possible scabies. On exam, he was noted to be an anxious male with multiple lesions on his scalp and right and left upper extremities, which were asymmetric. They were round and erythematous with maculopapular distribution. The assessment was scabies and he was prescribed medication. He was released to work full duty. (Px #2)

A few weeks later, Mosqueda went to Rockford Memorial Hospital emergency room on September 6, 2011. Mosqueda stated that he was in New York when he developed a fever that delayed his trip back to Rockford. (T. 14) That caused him to seek additional medical treatment. (T. 14) The records from Rockford Memorial on September 6 indicate Mosqueda complained of parasites in his skin for several weeks. He described small black flecks that crawl out of his hands. (Px #3) He brought in a bag with multiple Kleenex and various things he used to collect the presumed parasites. (Px #3) Dr. Bannen of Rockford Memorial examined the bag with a magnifying glass and noted there was no evidence of any obvious parasites, scabies or insect parts. (Px #3) In fact, he noted that one of these was a carcass of a dragonfly that was over one inch long. Mosqueda advised Dr. Bannen that he thought he was exposed to something on the road while working as a truck driver. He advised the doctor that he had been using multiple chemicals, including sulfur based petrolatum and organic bug spray. The records from Rockford Memorial indicate that Mosqueda advised Dr. Bannen that when he placed the chemicals on his skin, the bugs or parasites would jump out. He told the doctor that they would jump out of his feet and could be quite large. He also complained that one bug jumped out of the tip of his penis. (Px #3) Dr. Bannen explained to Mosqueda that sometimes stress can cause a sensation of parasitic infection. He could not find anything consistent with infestation. Dr. Bannen was more concerned that it was a manifestation of psychiatric disease, possibly delusional parasitosis. (Px #3) Mosqueda stated that he was referred to a dermatologist, Dr. Hartsough. (T. 14)

Mosqueda presented to Dr. Hartsough on September 9, 2011. (T. 14, Px #4) He reported having parasites all over his body that itched since July 28, 2011. The records of Dr. Hartsough noted that Mosqueda

had no evidence of burrows. (Px #4) He stated that they prescribed Permethrin and Ivermectin. (T. 15) Mosqueda stated that he noted some improvement.

Dr. Hartsough's records contain a memorandum regarding a phone conversation from September 12, 2011. (Px #4) It was noted by Dr. Hartsough that he was given medication on his September 9, 2011 visit on a preemptory basis and that there was no evidence of scabies. (Px #4)

He had his last medical treatment with Dr. Hartsough on November 2, 2011. (T. 15, Px #4) He was diagnosed with obsessive-compulsive disorder. (Px #4) It was also noted that he could have delusions of parasitosis. (Px #4)

Mosqueda stated that he feels like it's gone. (T. 16) He hasn't noted any recurring lesions or anything since the final medication. (T. 16) Mosqueda testified that he has some scars from the lesion on his left arm, belly, and inner thighs. (T. 17) He stated that since July 28, 2011, no family, friends, or anyone else he has been around has had scabies. (T. 18)

On cross-examination, Mosqueda testified that when he saw Dr. O'Neil on August 19, 2011, he not been itching or scratching himself. (T. 19) He told Dr. O'Neil that he thought he had scabies based upon internet research he did between July 28 and August 19. (T. 20) He agreed that Dr. O'Neil could not find any evidence of insects on his body. (T. 20) Mosqueda then stated that between July 28 and August 19, he was constantly itchy.

When he went to Physicians Immediate Care, Mosqueda told the doctor that he thought he had scabies. (T. 22) They did not find insects on his body. (T. 22) Mosqueda testified that he understood the only way to confirm the diagnosis of scabies was with a biopsy and that he never had one performed. (T. 22-23)

Mosqueda stated the he next received medical care on September 6, 2011 at Rockford Memorial Hospital. (T. 23) He stated that the black larvae had reinfested and starting coming out of his skin again. (T. 23) Mosqueda indicated that he was itchy the entire time but did not scratch. (T. 24) Mosqueda stated that he brought a bag with him to the hospital that he presumed contained parasites. He stated that he could not testify to what the doctor found or did not find. (T. 25) He denied telling the doctor that he had been using multiple

chemicals including sulfur based petroleum and organic bug spray. (T. 25) He did not recall telling the doctor that bugs jumped out of his feet. (T. 25) He did not recall the doctor telling him that sometimes stress can be a sensation of parasitic infection. (T. 27) He did not recall the doctor discussing that he was concerned this was a manifestation of psychiatric disease, possibly paranoid delusional parasitosis. (T. 28)

Mosqueda stated that he had not been back to Dr. Hartsough or any other physician for this condition since November 2, 2011.

Jeff Heeren testified on behalf of the respondent. He is the president of Jeff Heeren Trucking and has operated the company since 2000. (T. 31) Heeren stated that he had a phone conversation with Mosqueda in his office on August 19, 2011. (T. 32) He testified that Mosqueda told him he had a medical emergency while driving the truck in northeastern Pennsylvania. (T. 33) Heeren stated that Mosqueda advised him that he just found out his girlfriend and her children had scabies. (T. 33)

The petitioner called Michele Bastien to testify. (T. 39) Bastien stated that she had four children that all live with her. (T. 41) She dated Mosqueda for three weeks around July 28, 2011. (T. 41-42) Bastien denied that either she or her children had scabies around that time. (T. 41) She recalled Mosqueda having a skin condition with openings. She is a registered nurse for the county and had never seen anything like it before. (T. 42) Bastien testified that, in her opinion as a nurse, it was not scabies. (T. 43-44)

CONCLUSIONS OF LAW

WITH REGARD TO ISSUES "C" – "DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RSPONDENT?" and "F" – "IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?" – THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator denies both accident and causal connection based upon review of medical records and testimony presented at arbitration.

The medical records do not support a compensable accident or a diagnosis of scabies. Mosqueda admitted that when he first sought medical treatment on August 19, 2011, he had done internet research himself on scabies. (T. 20) The records from Dr. O'Neil on August 19, 2011 (Px #1) indicate that Mosqueda noted that

the rash was itchy. The arbitrator notes that on cross-examination, Mosqueda denied that he was itchy or scratching. (T. 19) It is noted by the Arbitrator that the assessment by Dr. O'Neil was not scabies. The assessment was rash and skin eruption. There was also noted to be multiple excoriated areas across the forearm web space and lower abdominal with the note of itching. (Px #1) Thus, the medical records appear to contradict the testimony of Mr. Mosqueda.

The records from Physicians Immediate Care do refer to scabies. However, the arbitrator notes it appears as though Mr. Mosqueda was the one who provided the diagnosis of scabies to Physicians Immediate Care. (Px #2)

The Arbitrator also places great reliance upon the records from Rockford Memorial Hospital. It is noted that on cross-examination, Mr. Mosqueda denied advising the doctor at the emergency room at Rockford Memorial that he had been using sulfur based petroleum or an organic bug spray. He did not recall mentioning that bugs were jumping out of his feet. He also did not recall the doctor telling him that sometimes stress could result in a sensation of parasitic infection. He also did not recall being advised that he could have paranoid delusional parasitosis. The Arbitrator notes that that testimony appears to be squarely contradicted by the medical records that Mr. Mosqueda offered into evidence. (Px #3) Those records specifically state that Dr. Bannen in the emergency room of that facility commented that Mosqueda told him he had been using multiple chemicals, including sulfur based petroleum and organic bug spray on his skin. Dr. Bannen also noted that Mosqueda advised him that bugs were jumping out of his feet. Dr. Bannen's records specifically state that he counseled Mr. Mosqueda that stress could sometimes cause the sensation of parasitic infection. They further note that Dr. Bannen was concerned that it could be a manifestation of psychiatric disease and possibly delusional parasitosis.

The Arbitrator also reviewed the medical records from Hartsough. This includes visits on September 9, 2011, a phone conference on September 12, 2011 and a follow-up visit on November 2, 2011. It does not appear as though Hartsough could ever confirm a diagnosis of scabies. In fact, at the last visit, they appeared to also agree that he had delusions of parasitosis.

Finally, the Arbitrator notes that Mr. Mosqueda presented Michele Bastien to testify. She indicated they had dated briefly in July of 2011. She noted that while he had some lesions on his skin, it was not what he thought it was. When specifically questioned by the Arbitrator, she indicated that she understood Mr. Mosqueda thought he had scabies and that in her opinion as a nurse, he was not suffering from that condition.

Based upon all of this testimony and the medical records, it is clear that Mr. Mosqueda did not suffer from scabies. Thus, there is no evidence that he had any type of accident that arose out of and in the course of his employment. There is further no evidence that whatever condition he had on his skin was in any way, shape or form was causally related to his employment. If anything, the medical records show some type of paranoid delusion about parasitosis, but again, nothing that was work related. Therefore, the Arbitrator denies both accident and causal connection.

WITH REGARD TO ISSUE "J" – "WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?" – THE ARBITRATOR FINDS THAT:

The Arbitrator denies all medical bills as submitted based upon denial of both accident and causal connection.

WITH REGARD TO ISSUE "L" – "WHAT IS THE NATURE AND EXTENT OF THE INJURY?"

The Arbitrator denies the Petitioner's request for permanent partial disability based upon failure to prove accident and causal connection.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL SWETLAND,,

Petitioner,

14IWCC0156

vs. NO: 11 WC 49176

STATE OF ILLINOIS-PINCKNEYVILLE CORRECTIONS CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of credit and the nature and extent of Petitioner's permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator awarded Petitioner a permanent partial disability award representing 5% loss of the use of the left leg. However, he found that the award was subject to a credit of 25% loss of the left leg in the previous settlement of 09WC11362. Therefore, the Arbitrator awarded no permanency.

Petitioner argues the Arbitrator erred in applying the credit of 25% loss of the use of the left leg in the previous settlement of 09WC11362 to negate the new award of 5% loss of the use of the leg in this case. He cites the Commission decision in *Lair v. State of Illinois – Menard Correctional Center*, 13 IWCC 592. We concur.

14IWCC0156

As the Commission pointed out in *Lair*, the Decision of the Arbitrator in this case would suggest that Petitioner's permanent partial disability of his leg is less now than it was after the previous accident; that suggestion is patently absurd. Credit should only apply when the current permanent partial disability is greater than the disability at the time the previous settlement/award was entered. Therefore, the Commission modifies the Decision of the Arbitrator to award Petitioner 30% loss of the use of the left leg and apply the 25% credit based on the settlement in 09 WC 11362 to arrive at a permanent partial disability award of 5% loss of the use of the left leg in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $663.04 per week for a period of 10.75 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of 30% use of the left leg and Respondent is given credit of 25% loss of the use of the left leg pursuant to the settlement in 09 WC 11362.

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

DATED: FEB 27 2014

Ruth W. White

Charles J. DeVriendt

Michael J. Brennan

RWW/dw
O-2/19/14
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0156

SWETLAND, MICHAEL
Employee/Petitioner

Case# 11WC049176

SOI/PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

On 9/6/2013, 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 0.05% 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:

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PKWY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0558 ASSISTANT ATTORNEY GENERAL
KYLEE J JORDAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

SEP 6 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

14IWCC0156

Case # 11 WC 49176

Michael Swetland
Employee/Petitioner

v.

State of Illinois/Pinckneyville Correctional Center
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Herrin**, on **August 16, 2013**. By stipulation, the parties agree:

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

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**57,463.00**, and the average weekly wage was $**1,105.06**.

At the time of injury, Petitioner was **44** years of age, ***single*** with **1** dependent child.

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

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

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

ORDER

As a result of Petitioner's accident, he sustained a 5% loss of use of his left leg. However, this award is subject to a credit against Petitioner's prior settlement of 25% loss of use of his left leg from case # 09 WC 11362. Therefore no permanency is awarded in this case.

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

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

Signature of Arbitrator

9/4/13
Date

SEP 6 - 2013

FINDINGS OF FACT

The parties stipulated to notice, accident, and causation.

Respondent has a credit of 25% for the left knee from a previous workers' compensation claim. 09 WC 11362.

On December 10, 2011 the Petitioner experienced an onset of pain. Petitioner broke up an altercation between inmates, and at one point fell to the ground and landed on his left knee.

Petitioner presented to Dr. George Paletta on January 4, 2012. Dr. Paletta had treated Petitioner's left knee in his prior claim. Dr. Paletta noted that his history was significant for a previous left knee surgery three years before.

Petitioner denied any significant swelling but reported pain anteromedially. On exam Dr. Paletta noted full range of motion in the knee. Good patellar mobility. No significant peripatellar tenderness. Patellar compression test was negative. Negative patellar apprehension test. Patellar tendon and quadriceps tendon are clearly intact. He had clear medial joint line tenderness. No lateral joint line tenderness. Ligament exam was entirely normal. Anterior Drawer, Lachman, and pivot shift are all negative. He had a solid endpoint on Lachman testing. Posterior Drawer is negative. No laxity or valgus stress testing. Neurovascular status is intact.

Dr. Paletta's impression was a possible medial meniscus tear versus mild medial collateral ligament sprain. He recommended an MRI scan of the knee. Dr. Paletta noted that if the MRI scan was negative then it was highly likely Petitioner's complaints would resolve on their own. This was Petitioner's only appointment with Dr. Paletta.

Petitioner had a MRI scan of the left knee on January 6, 2012. Dr. Paletta reviewed the findings. The impression was expected postop changes status post partial medial meniscectomy, patellofemoral chondrosis status post previous patellofemoral surgery, and early medial compartment chondrosis. Dr. Paletta noted that there was no evidence of any acute structural injury to the knee. Dr. Paletta further stated that the incident resulted in a temporary increase in symptoms related to his underlying pre-existing knee pathology.

Petitioner testified that he did not miss work nor did he have to work light duty as a result of this incident. Petitioner testified that he now has difficulty climbing stairs, playing with his daughter, and that sometimes his knee pops and swells. Petitioner testified that he has taken 400-600 milligrams of Ibuprofen every day since December 10, 2011. Petitioner testified that he has had a job evaluation from his supervisor since the accident and received a good evaluation. Petitioner further testified he has received no complaints from his supervisor regarding his job performance.

Neither party provided an AMA rating.

CONCLUSIONS OF LAW

Since the accident 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. Considering those factors, the Arbitrator notes the following:

14IWCC0156

(i) Occupation: Petitioner is employed as a Correctional Officer at Pinckneyville Correctional Center. He testified that he is working full duty, in fact he never missed any time from work for this injury. Additionally he testified that he has received a good performance evaluation since returning to work and has had no complaints from any of her supervisors.

(ii) Age: Petitioner was 44-years-old at the time of his injury.

(iii) Earning Capacity: Petitioner has continued to pursue the occupation of Correctional Officer as of the time of trial. No impairment of earning capacity is apparent.

(iv) Disability: Petitioner testified to having continued symptoms and to taking 400-600 milligrams of Ibuprofen every day since December 10, 2011. However, the only evidence of disability corroborated by the medical records are from Dr. Paletta. Petitioner saw Dr. Paletta for one visit, from which Dr. Paletta indicated Petitioner had a temporary increase in symptoms relating to Petitioner's pre-existing, underlying knee condition. The Petitioner's MRI was normal.

Based upon the foregoing, the Arbitrator finds that Petitioner has sustained 5% permanent partial disability to the left leg. However, because of the Petitioner's prior settlement of 25% of the leg, for which Respondent receives a credit, no permanency is awarded in this case.