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

DEREK GALLOWAY,

Petitioner,

vs. NO: 08 WC 48128

PRIME SOURCE BUILDING PRODUCTS,

Respondent.

14IWCC0641

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 (TTD), causal connection, medical, and permanent partial disability (PPD), and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Mr. Galloway sustained an accident arising out of and in the course of his employment on October 17, 2008.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent as it relates to all the alleged injuries. The Commission finds that Mr. Galloway proved that he sustained a work-related accident on October 17, 2008. As the result of his work-related accident, Mr. Galloway sustained a ventral hernia. Petitioner failed to prove that any other condition is causally related to his work accident. The Commission notes that the Petitioner received medical treatment to his back immediately following the accident. He underwent hernia repair and returned to work. He has worked since January 2009 and has not sought any medical treatment since 2010. The Commission finds that the Petitioner failed to prove that his back condition is causally related to the accident.

Mr. Galloway is entitled to TTD from October 27, 2008 through January 15, 2009,

representing 11-4/7 weeks. Petitioner is entitled to all reasonable and necessary medical expenses related to his hernia only through January 15, 2009. The Commission finds that Petitioner is entitled to three percent loss of use of the man-as-a-whole as the result of his work-related injury.

This matter was originally set for trial before Arbitrator Richard Peterson on April 29, 2010. Proofs were not closed at the end of the testimony. The arbitrator was not re-appointed prior to the close of proofs. Accordingly, the matter was re-assigned to Arbitrator Thompson-Smith for the completion of the case, as no Decision was issued and the April 29, 2010 transcript was never authenticated.

The Respondent subsequently filed a motion for a new trial. A hearing was held before Arbitrator Lynette Thompson-Smith on May 8, 2012. Respondent argued that it wanted the Arbitrator to personally view Mr. Galloway so she could judge his credibility. The Petitioner argued that Respondent wanted a second bite of the apple and that a new trial was not needed as it would be prejudicial to the Petitioner.

The Arbitrator issued an Order on June 22, 2012 granting Respondent's Motion for a New Trial. The Arbitrator cited *Anderson v. Kohler*, 376 Ill.App.3d 714, which held that "if the transcript is replete with contradictory evidence, a new trial must be had because it is imperative that the trier of fact be able to judge the credibility of the witness." The Arbitrator found the testimony of the Petitioner was completely contrary to that of the Respondent. The Arbitrator noted that as a general rule, in matters of this nature, a successor judge may not make findings of fact or conclusions of law without a trial de novo. *Trzebiatowski v. Jerome*, 24 Ill.2d 24, 25026. The Respondent's motion was granted.

At the arbitration hearing before Arbitrator Thompson-Smith on June 27, 2013, Petitioner stated that he wanted to "ask as an offer of proof to have a copy of the original transcript entered into evidence." T.11. The Commission finds however that Petitioner did not make an offer of proof regarding the prior transcript and neither the Respondent nor the Petitioner ever offered the prior transcript into evidence. In spite of this, the transcript was attached to the June 27, 2013 transcript.

Based upon the above, the Commission strikes the April 29, 2010 transcript from the record. The Commission's decision is based solely on the evidence offered during the June 27, 2013 hearing.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. According to the Application for Adjustment of Claim filed on October 31, 2008, Mr. Galloway was a 39 year old, married male with 2 dependants under the age of 18. He alleged an abdominal hernia, left shoulder, head, neck, back and left leg injury as the result of lifting while at work on October 17, 2008.

2. At the time of his accident, Mr. Galloway was employed as a merchandiser with PrimeSource Building Products. He had been employed with PrimeSource for 90 days. He would "downstock" 40 pound boxes of nails. While at work on October 17, 2008, Mr. Galloway was on a 12 foot ladder at a Home Depot store. He reached for a 40 pound box of nails located at the back of the shelf when he felt a sharp pain in his back. He finished working his shift and went home. T.17. Mr. Jon Kalal, Regional Director Specialist for the Respondent, testified that Mr. Galloway did work on the day of the alleged accident and acknowledged that Mr. Galloway's job involved lifting boxes that weighed up to 40 pounds. T.209.

3. Petitioner testified that he had a prior groin hernia surgery in 2007, but did not have any hernia issues between March 2007 and October 17, 2008. T.60. He testified that his October 2008 hernia was located at the top of the stomach. T.62.

4. Petitioner obtained a second opinion from Dr. Joseph Muldoon at Glenbrook Hospital on February 27, 2008 for his left groin pain following the hernia repair. He had a constant sharp, stabbing like pain in his left groin with some radiation into his left testicle. Examination of the abdomen was soft, non-distended and non-tender. The abdominal port site incisions were well-healed without hernia. The hernia repair was intact. It was noted that Petitioner "would delay hernia RX if ok with Dr. Muldoon." RX.6.

5. Petitioner was seen by Dr. Hugh Gilbert on March 5, 2008. It was noted Petitioner underwent a laparoscopic hernia repair on a left inguinal hernia in May 2007. The surgery was performed by Dr. Oswald at Central DuPage Hospital. He woke with swelling in his abdomen and had pain that radiated down to his left testicle. He had since had pain management issues and sought a consultation with an attorney for litigation. He had persistent pain in the left inguinal area that was worse with bending, twisting, and motion, side motion and walking. His pain was sharp and tender. Examination of the abdomen revealed a well-healed port site with no evidence of any hernia. There was no allodynia of hyperpathia in the groin area. There was significant inguinal ligament tenderness with the impression of swelling with no evidence of a specific tender point or trigger point. It was recommended Petitioner receive pulsed radiofrequency therapy directed to the T12, L2, and L1 nerve roots. He had mesh inguinodynia, which was an irritative phenomenon. Dr. Gilbert also recommended anticonvulsants and antidepressants with mild analgesics. RX.7.

6. Petitioner testified that he does not recall telling a doctor on March 5, 2008 that he had 10 months of pain and had not found a treatment modality that helped. T.98. He did not tell Dr. Muldoon that he had a constant, sharp stabbing like pain in his left groin with some radiation to the left testicle since his surgery. T.98.

7. Following the alleged work-accident, Mr. Galloway presented to Evanston Northwestern Healthcare at 2:28 a.m. on October 19, 2008. Petitioner complained of lower back and left buttock pain that had been present for the previous 2 days. Petitioner reported that his low back pain had been present since Friday when he

lifted a 40 pound box. Petitioner thought he had a cyst in his liver, causing his back pain. No acute or emergent abnormalities were identified in the abdomen or pelvis. Post surgical changes from the prior left inguinal hernia repair were noted. A CT scan of the abdomen and pelvis was performed without oral or intravenous contrast. There was a fat containing ventral abdominal wall hernia. There was extensive stranding in the herniated fat, suggesting possible inflammation or edema. Petitioner was apparently asymptomatic in this region and there was no evidence of herniated bowel. PX.9. Petitioner testified that he told the doctors that his pain happened at work. T.19.

8. Petitioner sent Mr. Kalal an e-mail on October 19, 2008 at 4:20 p.m. stating that he went to the ER last night due to a sharp pain in his lower back. He was diagnosed with a hernia and was taking pain medication, he could not drive. He would fax the paperwork to his e-mail address. RX.1.A. Mr. Galloway testified that he reported the accident to Mr. Kalal after he got out of the hospital at 1:00 a.m. on October 20, 2008. He left Mr. Kalal a voicemail advising him that he was injured on the job and was not able to come in for a couple days.

9. According to Mr. Kalal's phone record log, Mr. Kalal received a phone call from 847-812-2247 at 1:30 a.m. on October 19, 2008. He also received a phone call from 630-690-2814 on October 20, 2008 at 10:11 a.m. RX.9. Petitioner testified that the 847 phone number could have been his. The 630 number was his house number. T.246. Mr. Kalal testified that he did not get a voicemail from Mr. Galloway at 1:00 a.m. on October 19, 2008. T.217.

10. Petitioner testified he left Mr. Kalal a voicemail on October 21, 2008 between 8:00 a.m. and 8:30 a.m. T.24. He finally spoke to Mr. Kalal on October 22, 2008. T.26. He never filled out an accident report and never signed a statement denying he was hurt at work. T.56. He also never left a voicemail denying he was hurt at work. T.57.

11. On October 22, 2008 at 3:43 p.m., Mr. Kalal sent Jeff Hager and Rose Rush, Vice President of Human Resources and Risk, an e-mail stating that Petitioner's injury was not work-related. RX.1.b.

12. Petitioner testified that he went back to work full-duty on October 23, 2008. T.27. He told Mr. Kalal that he was still in pain, was still on medication and felt dizzy. T.29. He worked on October 24, 2008 and again told Mr. Kalal that he was in pain. T.30. Petitioner testified that Mr. Kalal told him that he could not protect his job and needed him to work. T.31.

13. On October 24, 2008, Mr. Galloway sent Mr. Kalal an e-mail asking if he received his prior e-mails as he never heard back from him. RX.1E.

14. Petitioner last worked on October 25, 2008. T.34. He did not work a full day due to pain. T.35. He stated that everything on his left side was hurting. His neck, legs, and shoulders were all in pain. His leg was numb and tingling, and felt like someone was sticking a needle in him. *Id.*

15. On October 27, 2008, Mr. Kalal e-mailed Petitioner stated that he received the prior e-mails and to advise of his schedule for today and the week. Petitioner responded that he would like to stay close to home as he was still in pain and could do one store per day only. RX.1F. Mr. Kalal testified that he never asked the Petitioner if he hurt himself at work. T.190.

16. On October 27, 2008, Ms. Rush sent an e-mail to Jeff Hager stating that they should get a doctor's opinion regarding Mr. Galloway's ability to work and drive. She recommended sending him to Concentra. RX.2A.

17. Petitioner sent Mr. Kalal e-mails on October 27 and 29 - 31, 2008 stating he would not be into work. Petitioner testified that his e-mails do not mention anything about his condition being work-related. T.117.

18. Petitioner was seen by Dr. Rahil Khan on October 30, 2008 for evaluation and treatment of a work-related injury. PX.6. Petitioner reported his accident and noted that he had constant low back pain that was 6 to 9 out of 10, constant neck pain that was 5 to 7 out of 10, and constant mid back pain that was 5 to 8 out of 10. His pain was better with rest, medicine, and therapy. His pain was worse with activity, bending, squatting, lifting and extensive sitting or standing. His past medical history included a prior left inguinal surgery in May 2007. Examination revealed spasms throughout the cervical lumbar spine. His cervical flexion was 25 degrees with pain and extension to 30 degrees. He had right and left rotation to 60/40 degrees with pain. The right and left lateral bending was 20/30 degrees with pain. There was a grade II-III myospam noted in the left suboccipital and left upper trapezius. His reflexes were 2+/2+. He had decreased sensation down the left upper extremity. His shoulder, elbows, wrists, and hand range of motion were within normal limits. Examination of the lumbosacral spine revealed flexion of 6 inches with pain. His extension was 15 degrees with pain. His right and left rotation was 15/10 degrees with pain. His right and left lateral bending was 15/10 degrees with pain. He had grade II-III myospasms in the bilateral lumbar paraspinal musculature, left greater than right. He had decreased sensation down the left lower extremity. He had a positive straight leg raise at 45 degrees on the left. He was diagnosed with a lumbosacral strain/sprain, cervico-thoracic strain/sprain, possible lumbar intervertebral disc bulge with radiculopathy on the left, stress, anxiety, depression secondary to the above and insomnia. He was taken off work for 30 days. An MRI of the lumbar spine, physical therapy and chiropractic manipulations were recommended. Dr. Khan opined that the signs and symptoms were consistent with a work-related injury as described. PX.6.

19. Petitioner testified that he left Mr. Kalal a message on Friday, October 31, 2008 and told him that he faxed to him the off work slips. T.38. He never received a call back from Mr. Kalal. T.39.

20. Mr. Kalal testified that he found out that Petitioner was claiming a work-related

accident on November 7, 2008. He filled out an accident report that day. T.206.

21. Petitioner presented for a follow-up examination with Dr. Khan on November 19, 2008. Petitioner now had pain going down his left leg and into the calf and back of his foot, but not to the toe. The MRI revealed a 3 mm disc protrusion, herniations at L1-L2 and L3-L4. The L3-L4 disc bulge was about 5 mm. Examination revealed lumbo-sacral strain/sprain, and left sided radiculopathy. He was to remain off work. PX.6. Petitioner's off work was continued for another 5 weeks on December 17, 2008.

22. Petitioner underwent a ventral hernia repair with mesh, excision of the left flank lipoma and removal of the left shoulder lipoma on December 23, 2008. The surgery was performed by Dr. Joseph Muldoon at North Shore University. PX.9.

23. Petitioner was seen by Dr. Vladimir Kaye on January 15, 2009 for a physical medicine and rehabilitation, neurologic, and orthopedic comprehensive evaluation. He reported his history of injury. Petitioner was diagnosed with a hernia and strains of the cervical, lumbar and thoracic spine. Examination of the cervical spine revealed no tenderness or spasms and a negative bilateral Spurling maneuver. The thoracic spine revealed no tenderness or spasms and no kyphosis or scoliosis. The lumbar spine revealed tenderness and spasms at L3-L4 and L4-L5 with positive muscle spasms. He had negative Waddell signs. He was diagnosed with a lumbosacral strain, lumbar discogenic disease and possible radiculopathy, hernia post exertional and thoracic and cervical strain, post traumatic. Dr. Kaye stated that absent evidence to the contrary, the mechanism of injury was consistent with what was described. PX.6.

24. Mr. Galloway testified that he did not work for respondent from October 27, 2008 through January 6, 2010. T.50. He worked for Premium Retail from January 2009 through April 2010 as a salesman. He trained Wal-Mart associates how to use HP product. T.53. He worked 6 hours a day, 5 days a week earning $16.00 per hour. Mr. Galloway testified that the job involved lifting up to 5 pounds. T.55. Petitioner testified that Premium Retail terminated him once they learned of his disability. T.75. He did not, however, file a retaliatory discharge claim. *Id.*

25. Petitioner testified that he currently works for Beam Team where he sets up displays at Home Depot stores. T.67. He stated this is not a heavy job. He drills into and hangs the OSB boards. T.71. He also puts up the price tags, which requires working with his arms above his head. T.74. He has to lift 3 pound boxes. T.77.

26. Petitioner testified that has no pain with his hernia. T.53. He is unable to perform his job with PrimeSource as it requires heavy lifting. T.55. He will get a cramp in his left side if he lifts a heavy object. *Id.* He would like continued medical treatment as he has not had any treatment since 2010. T.63.

The Commission is not bound by the Arbitrator's findings, and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the

evidence. *R.A. Cullinan & Sons v. Industrial Comm'n*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240, 159 Ill. Dec. 180 (1991). It is the province of the Commission to weigh the evidence and draw reasonable inferences therefrom. *Niles Police Department v. Industrial Comm'n*, 83 Ill. 2d 528, 533-34, 416 N.E.2d 243, 245, 48 Ill. Dec. 212 (1981). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Industrial Comm'n*, 51 Ill. 2d 533, 536-37, 283 N.E.2d 875, 877 (1972).

In order for accidental injuries to be compensable under the Act, a Petitioner must show such injuries arose out of and in the course of his employment. *Eagle Discount Supermarket*, 82 Ill. 2d at 337-38, 412 N.E.2d at 496; *Nabisco Brands, Inc. v. Industrial Comm'n*, 266 Ill. App. 3d 1103, 1106, 641 N.E.2d 578, 581, 204 Ill. Dec. 354 (1994)."Arising out of" refers to the requisite causal connection between the employment and the injury. In other words, the injury must have had its origins in some risk incidental to the employment. See *Eagle Discount Supermarket*, 82 Ill. 2d at 338, 412 N.E.2d at 496; *William G. Ceas & Co.*, 261 Ill. App. 3d at 636, 633 N.E.2d at 998. "In the course of" refers to the time, place, and circumstances under which the accident occurred. See *William G. Ceas & Co.*, 261 Ill. App. 3d at 636, 633 N.E.2d at 998. The determination of whether an injury arose out of and in the course of a claimant's employment is a question of fact for the Commission.

The Commission finds that Mr. Galloway sustained a work-related injury on October 17, 2008. The medical records reveal that Petitioner presented to Evanston Northwestern Hospital on October 19, 2008. He reported that his pain had been present since Friday when he lifted a 40 pound box. The Commission is not persuaded by Respondent's argument that the record contains no mention of a work-related accident and, as such, he failed to prove a compensable accident. While it is true the words "at work" or words to that effect are not in the medical record, the medical record does indicate that Petitioner had been experiencing pain since Friday and his pain occurred while lifting 40 pounds. Respondent's witness, Mr. Kalal, confirmed that Petitioner was working on Friday, October 17, 2008 and that Petitioner's job duties required him to lift 40 pound boxes. Additionally, the Petitioner testified that he attempted to contact Mr. Kalal via telephone after he was discharged from the hospital. Petitioner's testimony is corroborated by the phone logs, which demonstrate that the Petitioner attempted to contact Mr. Kalal on October 19, 2008. Further, Petitioner sent an e-mail to Mr. Kalal on October 19, 2008 advising that he was seen in the emergency room and was diagnosed with a hernia. He was going to fax the paperwork to him. While the Petitioner's e-mail does not specifically mention the injury occurring at work, the Commission finds that based on the totality of the evidence, Petitioner proved that he sustained an accident arising out of and in the course of his employment. The Respondent failed to offer any credible evidence to rebut accident.

The Commission finds that the Petitioner sustained a ventral abdominal wall hernia as a result of his accident. While Petitioner did have a prior hernia, the medical records from February 2008 and March 2008 do not make any reference to a ventral abdominal wall hernia. Rather, the record from February 27, 2008 reveals that the abdomen was soft and non-tender. The abdominal port incisions were well healed without a hernia. The Respondent offered no evidence that the Petitioner had any issues between March 2008 and October 2008. Further, Dr. Khan opined that the condition was work-related. Respondent offered no medical opinion to the contrary. Petitioner proved that he sustained a hernia as a result of the work-related accident.

The Commission finds, however, that Mr. Galloway's current condition is not causally related to his work-related accident. The Petitioner underwent hernia repair on December 23, 2008. The Petitioner was seen by Dr. Kaye on January 15, 2009. The treatment at that time was related to his back condition. Mr. Galloway testified that he has no current issue with his hernia. Mr. Galloway testified that he worked from January 2009 through April 2010. He earned $16.00 per hour and worked 6 hours a day, 5 days a week. Petitioner offered no evidence as to the exact dates of his employment with Premium Retail. He also offered no evidence that he had any issue with his back condition or hernia that precluded him from working during this period. Further, Mr. Galloway testified that he currently works for Beam Team and is able to perform his job duties. The Commission therefore finds Petitioner reached maximum medical improvement from the hernia on January 15, 2009. It was on this date that Petitioner's treatment focused on his back, not his hernia. Petitioner is entitled to TTD from October 27, 2008 through January 15, 2009. Petitioner is entitled to all reasonable and related medical expenses related for the hernia repair through January 15, 2009. Petitioner is entitled to receive compensation to the extent of 3% loss of use pursuant to Section 8(d)(2) (or Man as a Whole) for his work-related hernia injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 29, 2013, is hereby reversed as stated above.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $300.00 per week, representing 11-4/7 weeks, October 27, 2008 through January 15, 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 the sum of $270.00 per week for a period of 15 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the loss of use of three percent man-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses related to the hernia under §8(a) of the Act and subject to the medical fee schedule.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,600.00. 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: AUG 1 _ 2014

Michael J. Brennan

MJB/tdm
052
O: 6/24/14

Thomas J. Tyrrell

Kevin W. Lamborn

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

GALLOWAY, DEREK
Employee/Petitioner

Case# **08WC048128**

14IWCC0641

PRIME SOURCE BUILDING PRODUCTS INC
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:

2573 MARTAY LAW OFFICE
DAVID MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

2999 LITCHFIELD CAVO
JONATHAN E BARRISH
303 W MADISON ST SUITE 300
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)

Derek Galloway
Employee/Petitioner

Case # 08 WC 48128

v.

14IWCC0641

Prime Source Building Products, 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 Lynette Thompson-Smith, Arbitrator of the Commission, in the city of Chicago, on June 27, 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 _____

14IWCC0641

FINDINGS

On the date of accident, **October 17, 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 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 **$23,400.00**; the average weekly wage was **$450.00**.

On the date of accident, Petitioner was **39** years of age, **married** with **2** dependent children.

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

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

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

ORDER

The Petitioner has failed to prove, by a preponderance of the evidence, that an accident occurred which arose out of and in the course of his employment by Respondent, therefore, no benefits are awarded, pursuant to the Act. 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.

D. Thompson-Smith

Signature of Arbitrator

August 29, 2013

ICArbDec19(b)

AUG 29 2013

IN THE STATE OF ILLINOIS
BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Derek Galloway, Petitioner,	)	
v.	)	08 WC 48128
Prime Source Building Products Inc., Respondent,	)	14IWCC0641

Findings of Fact

The issues in this matter are 1) accident, 2) causal connection; 3) notice; 4) medical bills; 5) temporary total disability; 6) Section 8(j) credit; and 7) prospective medical treatment. *See,* AX1.

Arbitrator Petersen previously tried this matter. The matter was bifurcated to admit exhibits and close proofs. In the interim, the matter was transferred to Arbitrator Thompson-Smith. On December 27, 2011, Respondent's counsel filed a Motion for a New Trial, which after hearing, was granted by Arbitrator Thompson-Smith over the objections of Petitioner's attorney. The new trial was held on June 27, 2013, resulting in this decision. *See,* filed Order granting new trial.

Petitioner testified that he injured himself on Friday, October 17, 2008, at approximately 5:00 p.m., at a Home Depot Store before concluding his work. Following his alleged accident, the petitioner went home and took Tylenol. On direct-examination, the petitioner testified that he went to the emergency room of Glenbrook Hospital, on October 19, 2008, and was discharged on October 20, 2008. On cross-examination, the petitioner testified that he went to the emergency room on Saturday October 18, 2008 at about 11:00 p.m. and left at about 1:00 a.m. the following morning. The Arbitrator notes that the medical records from Glenbrook Hospital reflect that the petitioner arrived at the hospital on October 19, 2008 at 2:21 a.m. and was discharged that same day at 4:12 a.m. *See,* PX9 pg. 2 & Tr. Pgs. 17-21, 99.

The petitioner further testified that his injury occurred when he was reaching for a forty-pound box of nails and felt a sharp pain in his back. He testified that when he got to Glenbrook Hospital he told them that that he had hurt himself at PrimeSource and that he had a work injury. Although the petitioner testified that he injured himself while reaching for a box, the emergency room records have a history of the petitioner having

pain since the previous Friday after lifting forty-pound boxes. The Arbitrator also notes that although the petitioner testified that he told the hospital that he suffered a work injury and was injured at Prime Source, there is no mention in the emergency room records that the petitioner injured himself at work. In addition, the petitioner's medical bills for this visit were submitted to and paid for by his group health insurance carrier, Blue Cross and Blue Shield. *See*, PX1 & 9; Tr. pgs. 9-17, 103-104.

With regard to the manner and time that the petitioner allegedly reported his accident to the respondent, the petitioner testified that he did not report his accident on the day that it occurred. He testified that he was discharged from the hospital at approximately 1:00 a.m. At that time, the petitioner called his regional manager, John Kalal, leaving a voice mail message stating that he was injured on the job and was not going to be able to make it in to work for a couple of days. He also testified that he told Mr. Kalal that the doctor said that he had a pinched nerve and that he was on pain medication. When the petitioner was asked on cross-examination if he used his business cell phone to call Mr. Kalal he testified, "I can't remember. All I know is I called him from my house. That's all I know." The petitioner testified that he was living in Wheaton, Illinois in October of 2008. The Arbitrator therefore finds that it unlikely that the petitioner reported his alleged work injury, for the first time, by calling Mr. Kalal immediately after being released from the Glenbrook Hospital emergency room, if he made that call from the his house. *See*, Tr. pgs. 21-22, 100, 109.

The petitioner further testified that after leaving Mr. Kalal a voice message, on October 19, 2008 at 1:00 in the morning, he went to sleep and called Mr. Kalal again, after he woke up. That same day the petitioner sent Mr. Kalal an e-mail message at 4:20 p.m., which states, "John I had to go to the E.R. last night because I had sharp pain in my lower back. And when I walk the pain gets worst. My wife had them do a cat scan and they found out that I have a hernia in my stomach. I'm taking pain pills plus a course of steroids for the inflammation. I can't drive on the pain pills; I will fax the paperwork from the hospital to your e-mail address." *See*, RX1A & Tr. pgs. 115, 177.

Despite the fact that the petitioner testified that he left Mr. Kalal two voice messages in which he mentioned that he injured himself at work, the petitioner's e-mail message sent that same day makes no mention of a work accident. Moreover, the petitioner sent additional e-mail messages to Mr. Kalal on October 22, 24, 27, 29, 30, and October 31, of 2008. Although those e-mail messages state the petitioner's inability to come to work, none of them mention that the petitioner suffered a work injury. *See*, RX Group 1C; 1D; 1F; 1G; 1H; 1I; & 1J.

The Arbitrator takes particular note of the e-mail messages that Petitioner sent to Mr. Kalal on Friday October 24, 2008. The first e-mail that he sent at 6:31 a.m. states that

he would not be able to drive because he had taken pain pills. The petitioner then sent a second e-mail that day at 7:29 p.m. in which he wrote, "John did you get my e-mail. I was wondering because I never heard back from you."

The petitioner's testimony at the subject trial, regarding the manner in which he reported his alleged accident to Mr. Kalal on October 19, 2008, differs from his testimony at the prior hearing before Arbitrator Peterson. On April 29, 2010, the petitioner testified:

Q: Isn't it true that you sent John Kalal an e-mail advising him of your work injury?

A: Yes, sir.

Q: And on what date was that e-mail message sent?

A: That was on the 19th too. Yeah, it was on the 19th.

Q: October 19th

A: Yes, sir.

At the second trial on June 27, 2013, the petitioner testified that he never sent Mr. Kalal an e-mail saying that he injured himself at work. *See*, Tr. pgs. 87, 120.

The petitioner's testimony regarding telephone communications that he had with John Kalal, following his alleged accident, were also contradicted by documentary evidence and by Mr. Kalal's testimony. On direct-examination, the petitioner testified that he called Mr. Kalal on October 21, 2008, between 8:00 a.m. and 8:30 a.m., leaving a voice mail message. On cross-examination, the petitioner testified he called Mr. Kalal's PrimeSource cell phone on October 21, 2008 and spoke with Mr. Kalal that day. When Petitioner was asked what phone he used to place that call, he testified that he called from his home phone. The petitioner also testified that his home telephone number had an area code of 630 and that the last four digits were 2814 The phone records from Mr. Kalal's PrimeSource phone were introduced into evidence as Respondent's Exhibit 9. There is no entry in those records of an incoming call to Mr. Kalal on October 21, 2008, from a telephone number with a 630 area code and 2814 as the last four digits or any other number from the 630 area code. *See*, Tr. pgs 24, 123, 142 & RX9.

The petitioner further testified on direct-examination, that he spoke with Jon Kalal on October 22, 2008. At that time, he said that he told Mr. Kalal that he did not know if he would be able to make it into work. However, on cross-examination, the petitioner first testified that he did not remember making a call to Mr. Kalal on that date then later testified that he did speak with Mr. Kalal that day by phone. On rebuttal, the petitioner then testified that he called Mr. Kalal and left a voice mail message on his cell phone stating that he was in pain and taking Vicodin. On cross-examination on rebuttal, the petitioner testified that he could not remember if he spoke with Mr. Kalal over the

phone on October 22, 2008 and that he could not remember if he left Mr. Kalal a voice mail message that day. *See,* Tr. pgs. 124, 131, 248 & 256.

The petitioner's testimony regarding subsequent communications with Mr. Kalal was similarly contradictory. The petitioner testified on direct-examination that on October 23, 2008, he returned to work in a full duty capacity; and had a personal conversation with Mr. Kalal. However, on cross-examination the petitioner testified that he could not remember if he spoke with Mr. Kalal on October 23, 2008; and that nothing could help him refresh his recollection regarding whether he spoke with him that day. The petitioner then testified, on rebuttal, that he left a voice mail message for Mr. Kalal on October 23, 2008. In contrast, Mr. Kalal testified consistently that he never spoke with the petitioner personally, nor saw him between October 17, 2008 and April 29, 2010. The records from the PrimeSource cell phones issued to Petitioner and Mr. Kalal show that the petitioner and Mr. Kalal spoke for one minute on October 23, 2008. *See,* RX9 & RX10: & Tr. pgs 28-29, 133-134, 250 & 189.

The petitioner further testified that on October 24, 2008, he had a personal discussion with John Kalal at a store but could not remember which store. The petitioner testified that he spoke with Mr. Kalal that afternoon and said that he told Mr. Kalal that he was, "driving with painkillers." On cross-examination, the petitioner could not remember if he spoke with Mr. Kalal on October 24, 2008 and that nothing could help him refresh his recollection regarding whether he spoke with his supervisor that day. *See,* Tr. pgs. 29-31.

The petitioner also contradicted himself regarding whether he had a conversation with Mr. Kalal on October 25, 2008. On direct-examination he petitioner testified that he had a conversation with Mr. Kalal that day. On cross-examination, the petitioner first testified that he did not have a conversation with Mr. Kalal on October 25, 2008, then testified that he could not remember if he spoke with Mr. Kalal that day and that nothing could refresh his recollection regarding whether he did. *See,* Tr. pg 135.

The petitioner's testimony, regarding his prior medical condition, is contradicted by his medical records. Dr. Joseph Muldoon's medical records note that he saw the petitioner for a hernia on February 27, 2008. On that date, the petitioner gave a history of wanting a second opinion for persistent left groin pain that he had had since a laparoscopic inguinal hernia repair in May 2007. The doctor's record reflects that the petitioner said that his pain was worse with activity and with certain bending or twisting movements. At the subject trial, the petitioner testified that he did not have pain after his surgery in May of 2007. *See,* RX6 & Tr. pg. 96.

On March 5, 2008, petitioner was seen by Dr. Hugh Gilbert of Evanston Northwestern Healthcare Pain Clinic. According to the record, Petitioner had a history of hernia repair in May of 2007. The record indicates that when Petitioner awoke, he had swelling in his abdomen and pain radiating down to his left testicle. It further notes that since that surgery the petitioner had been in a pain management program and has sought consultation with an attorney for litigation. The petitioner reported persistent pain that was worse with bending, twisting, side-motion and walking. On advice of his attorney, the petitioner sought a second opinion with Dr. Joseph Muldoon who said that the petitioner might have nerve-associated pain due to irritation or entrapment. Dr. Muldoon referred the petitioner to Dr. Gilbert, whose record states that the petitioner underwent a CAT scan of his abdomen and was told that he had surgical clips, which were aligned in such a way that they might be contributing to his pain. The petitioner had ten months of pain and did not find any modality to alleviate it. *See,* RX7.

At trial, the petitioner denied stating that he had CT scan imaging after surgery or that he was told that there were surgical clips aligned in such a way that they might be a contributing factor to his pain. He also testified that he had no recollection of saying that he had ten months of pain and had not found a treatment modality to help. In fact, the petitioner denied ever being in pain. *See,* Tr. pgs. 98-99.

The Arbitrator believes that it is highly unlikely that two different doctors would cite information in their notes concerning the petitioner's history of pain following hernia surgery if the petitioner did not relay that history. Accordingly, the Arbitrator finds the petitioner's testimony on this issue not to be credible.

The petitioner testified that the only person from PrimeSource whom he spoke with after October 17, 2008 was, "a guy in the office to get the phone number for workers' compensation". On direct-examination, the petitioner also testified that he did not know Rose Rush. When he was asked, on cross-examination, if he ever spoke with a person named Roseann Rush, the petitioner testified that he had never heard of her. He did remember a Rose Rush from the corporate office in Texas, however, when he was asked again if he spoke with Ms. Rush any day after October 17, 2008, the petitioner testified that he did not talk to her. *See,* Tr. pgs. 57, 140-141.

Respondent's second witness, Ms. Roseann Rush testified that she is the Respondent's Vice President of Human Resources and Risk and was in that position on October 17, 2008. She has remained in that position as of the date of her testimony. Ms. Rush testified that the petitioner called her over the telephone on November 17, 2008. During that conversation, she tried to explain to the petitioner that he had been terminated for job abandonment; in that the respondent had not heard from him for ten days. The Arbitrator notes that a letter sent by Ms. Rush to the petitioner on November 20, 2008,

confirms the conversation. Having both observed Ms. Rush's demeanor when she testified and reviewed Ms. Rush's letter that was introduced into evidence as Respondent's Exhibit 12, the Arbitrator finds Ms. Rush's testimony that to be credible. *See*, Tr. pgs. 222-227; & RX12.

The petitioner's testimony concerning his receipt of an Employee Handbook also calls his credibility into question. Respondent's Exhibit 11, is an Employee Acknowledgement Statement, purported to be signed by Petitioner, acknowledging receipt of the PrimeSource Building Products, Inc.'s Employee Handbook. When shown this exhibit the petitioner denied that he signed it stating that he never signs his name as "Derek D. Galloway".

The Respondent introduced a three-page exhibit into evidence as Respondent's Exhibit 15. The first page of this exhibit is a US Department of Treasury W-4 Employee Withholding Allowance Certificate that was signed on August 1, 2008 "Derek D. Galloway". The second page of Respondent's Exhibit 15 is an authorization for Advantage Payroll to make deposits into the petitioner's account. It too is signed, "Derek D. Galloway," and a cancelled check of the account to which payroll deposits are to be made is for Derek D. Galloway. Ms. Rush testified that the documents in Respondent's Exhibit 15 would either have been received directly from the petitioner or from a manager who received them from the petitioner. She also testified that an employee cannot be set up in the respondent's payroll system until (s)he has executed these documents and as Petitioner was paid by the Respondent, Ms. Rush inferred that he had returned all of the appropriate paperwork for him to be set up in Respondent's payroll system. The petitioner offered no rebuttal to this testimony nor to the documents in Respondent's Exhibit 15, which were signed, "Derek D. Galloway". *See,* Tr. pgs. 153, 239-240. The Arbitrator notes that when asked by his counsel to state his name for the record at the beginning of the subject trial, the petitioner stated Derek D. Galloway.

The petitioner's testimony at trial regarding a prior workers' compensation claim further calls his credibility into question. At the subject trial, on June 27, 2013, the petitioner testified that before his alleged injury of October 17, 2008, he did not have a workers' compensation claim against Home Depot. However, in the prior trial, on April 29, 2010, the petitioner testified:

Q. Starting with Home Depot, what's the reason you left Home Depot?
A. I never left Home Depot. What happened I got injured on the job.
Q. Did you file a workers compensation claim?
A: Yes, we did.
Q. Did you receive an award or a settlement?
A. No.

Q. Why not?
A. They declined it. *See*, Tr. p. 83.

Respondent's first witness was Jon Kalal, who testified that on October 17, 2008, he was the Respondent's Midwest Instore Service Manager and that he is the supervisor to whom the petitioner reported. Jon Kalal also contradicted the petitioner's testimony when he testified that he received an e-mail from the petitioner on October 19, 2008 but did not receive a voice mail message from him on that date. After receiving the petitioner's e-mail on October 19, 2008, he testified that he did not think to ask the petitioner if he hurt himself at work because he received the e-mail on a Sunday. As the petitioner stated that he had injured himself the previous night, which was a Saturday, when Petitioner would not have been working, Mr. Kalal stated that he had no reason to believe that the petitioner went to the hospital because of something that had happened at work. Mr. Kalal further testified that between October 17, 2008 and November 6, 2008, the petitioner never reported to him that he had injured himself at work. *See,* Tr. pgs. 187-192.

The petitioner's last day on the job was October 27, 2008 and Mr. Kalal testified that he never spoke to the petitioner after that date, despite his attempts to contact him via e-mail and telephone. He also testified that after October 19, 2008, he knew that the petitioner was taking pain medications that could affect his ability to return to work and that the petitioner was supposed to let him know whether he was able to return. He further testified that he never heard from the petitioner between October 31, 2008 and November 7, 2008 and he finally called both the petitioner's cell and home phones between 9:00 am and noon, on November 7, 2008. He received a voice mail message from the petitioner later that night. *See,* Tr. 192-194 & 202-203.

Mr. Kalal was traveling on November 7, 2009 and he testified that when his flight landed, he called his voice mail at approximately 5:15 p.m. The petitioner left a voice mail message that said if Mr. Kalal wanted to talk with him, he should contact his lawyer. Before receiving this message, Mr. Kalal had no idea that the petitioner was claiming that he had injured himself while working for the respondent. *See,* Tr. 194-195.

Mr. Kalal's testimony is supported by his cell phone records, which reflect calls, on October 30, 2008 and November 4, 2008, to the cell phone issued to Petitioner. On November 7, 2008, Mr. Kalal's cell phone records indicate that he called the petitioner's cell phone at 9:17 a.m. and then called Petitioner's home phone at 11:20 a.m. The records also show that Mr. Kalal called his voice mail at 5:10 p.m. and 5:13 p.m. that day. Mr. Kalal also sent the petitioner e-mail messages on November 4, 2008, at 2:57 p.m. and November 7, 2008 at 9:20 a.m. *See*, RX Group 1K & 1L, RX 9, lines 187, 230, 270, 275, 278 & 280.

The respondent's internal e-mail, sent after the date of the petitioner's alleged accident, also supports Mr. Kalal's testimony that the petitioner did not report a work accident to him prior to November 7, 2008. E-mail messages sent on October 27, 2010, regarding the petitioner's work status, notes that the petitioner did not have a work related injury. If Petitioner had reported his alleged work injury on October 19, 2008, the respondent would have known that and that he needed time off for a work related injury. The fact that Respondent's internal e-mail messages reflect that they were operating on the belief that Petitioner's injury was not work related, supports Mr. Kalal's testimony that Petitioner never reported a work injury to him until he left a voice mail on November 7, 2008. Although this date is within forty-five 45 days of the petitioner's alleged accident, and therefore prohibits a notice defense, the fact that the petitioner did not report his accident to the Respondent on the date that he testified he reported it, calls into question whether the petitioner's accident actually occurred. *See,* RX Group 2 A & B.

The Arbitrator having both observed Mr. Kalal's demeanor at trial, the substance of Mr. Kalal's testimony and the documents corroborating it, finds that Mr. Kalal's testimony regarding his communications with the petitioner from October 19, 2008 until November 7, 2008 is credible.

Conclusions of Law

C. Did an accident occur that arouse out of and in the course of the 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). 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).

When an Arbitrator finds a Petitioner's testimony about a particular issue is not credible the Arbitrator may also find that the petitioner is not credible as to other issues. See, *Parro v. Industrial Commission*, 167 Ill.2d 385 (1995). In this case, the only evidence that Petitioner suffered a work related accident came from the petitioner.

The Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. *See, Caterpillar Tractor Co. v. Industrial Commission*, 83 Ill. 2d 213 (1980). However, a claimant's testimony must be considered with all of the facts and circumstances that might not justify an award. *See, Neal v. Industrial Commission*, 141 Ill. App. 3d 289 (1986). Moreover, a claimant's testimony will support an award of benefits only if consideration of all the facts and circumstances support the decision. *See, Gallentine v. Industrial Commission*, 201 Ill. App. 3d 880 (1990).

In this case, the only evidence that the petitioner injured himself while working for the Respondent was his testimony at trial and a subjective history of a work accident contained within some of his medical records. Accordingly, in order to find that this accident arose out of and occurred in the course of his employment with the respondent the Arbitrator must find the petitioner's testimony to be credible. Having considered all

of the facts of this case, the Arbitrator finds: 1) based upon the number of and substantive contradictions between the petitioner's testimony and his medical records; 2) the contradictions between his testimony and the testimony of witnesses called on Respondent's behalf; 3) and the contradictions between the petitioner's testimony during the subject trial and that of his prior trial heard by Arbitrator Peterson; that the petitioner's testimony is not credible and compensation is therefore denied.

Having found that the petitioner has not proven, by a preponderance of the evidence, that an accident arose out of and in the course of his employment by Respondent, the additional issues are moot and will not be addressed.

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

JOSEPH BARRETT,

Petitioner,

vs.

NO: 10 WC 16819

14IWCC0642

COOK COUNTY,

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 penalties, and 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.

Section 19(k) provides that the Commission may award additional compensation of up to 50% of the compensation award when there has been any unreasonable or vexatious delay of payment, intentional underpayment, or when frivolous proceedings are instituted by the party liable for compensation. *820 ILCS 305/19(k).*

The standard for awarding penalties and attorney fees under sections 19(k) and 16 of the Act is higher than the standard for awarding penalties under section 19(*l*) because sections 19(k) and 16 require more than an "unreasonable delay" in payment of an award. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 514-15, 702 N.E.2d 545, 552, 234 Ill. Dec. 205 (1998). It is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause. *McMahan*, 183 Ill. 2d at 515, 702 N.E.2d at 552. Instead, section 19(k) penalties and section 16 fees are "intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose." *McMahan*, 183 Ill. 2d at 515, 702 N.E.2d at 553. In addition, while

section 19(*l*) penalties are mandatory, the imposition of penalties and attorney fees under sections 19(k) and section 16 fees is discretionary. *Id.*

Where there is a delay in paying compensation, it is the employer's burden to show it had a reasonable belief the delay was justified. *Continental Distributing Co. v. Industrial Com.* (1983), 98 Ill. 2d 407, 414, 456 N.E.2d 847, 850. Whether the employer's conduct justifies the imposition of penalties is to be considered in terms of reasonableness and is a factual question for the Commission. *McKay Plating Co. v. Industrial Com.* (1982), 91 Ill. 2d 198, 437 N.E.2d 617.

The Commission finds that the Respondent established that its conduct was not unreasonable or vexatious pursuant to Section 19(k) of the Act. The Respondent obtained a utilization review pursuant to Section 8.7 of the Act. The utilization review certified 6 physical therapy sessions from January 13, 2011 through February 28, 2011. It did not certify 12 additional visits. The Respondent authorized the initial course of physical therapy. However, in reliance of the opinions contained in the January 26, 2011 utilization review, the Respondent did not authorize the additional physical therapy. The Commission finds that the Respondent's reliance on the utilization review was not unreasonable or vexatious. The Commission therefore modifies the Decision of the Arbitrator and finds Petitioner is not entitled to penalties pursuant to Section 16 and Section 19(k) of the Act.

The Respondent, however, provided the Commission with no guidance in its Statement of Exceptions and presented no argument as to why certain medical bills remain outstanding. In that respect, the Commission affirms the Arbitrator's award of Section 19(l) penalties.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 4, 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 $664.72 per week for a period of 96.75 weeks, as provided in §8(e)(12) of the Act, for the reason that the injuries sustained caused the loss of use of 45% of the left leg. Respondent is entitled to a credit for the prior settlement (04 WC 31310) represented 28% loss of use of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $8,260.02 for medical expenses under §8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner penalties of $10,000.00 as provided in Section 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

14IWCC0642

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: AUG 0 1 2014

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 7-8-14
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

BARRETT, JOSEPH
Employee/Petitioner

Case# **10WC016819**

14IWCC0642

COOK COUNTY
Employer/Respondent

On 7/5/2013, 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 0.08% 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
DAVID HUBER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0132 COOK COUNTY STATE'S ATTORNEY
ASA RICHARD CRUSOR
RICHARD DALEY CENTER RM 509
CHICAGO, IL 60602

14IWCC0642

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
PTD/O CORRECTED ARBITRATION DECISION
7-5-13

Joseph Barrett,
Employee/Petitioner

v.

Cook County,
Employer/Respondent

Case # **10** WC **16819**

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 **Chicago**, on **1/15/13 and 3/6/13**. 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 _____

14IWCC0642

FINDINGS pmo 7/5/13

On ~~7/18/08~~ 7/18/09, 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 **$80,226.00**; the average weekly wage was **$1,542.80**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$28,905.27** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$28,905.27**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,438.87 to Accelerated Rehabilitation, $5,124.43 to Dr. Lopez, $584.72 to Dr. Axe and $112.00 in out-of-pocket expenses, as provided in Sections 8(a) and 8.2 of the Act. (See Arb.Ex.#2).

Respondent shall pay Petitioner permanent partial disability benefits of $664.72 per week for 96.75 weeks, because the injuries sustained caused the loss of use of 45% of the left leg, as provided in Section 8(e)12 of the Act. However, Respondent is entitled to a credit for a prior settlement (04 WC 31310) representing 28% loss of use of the left leg (or 56 weeks based a maximum of 200 weeks for date of injury of 5/24/04), for a net award of 40.75 weeks, or approximately 18.95% loss of use of the left leg.

Respondent shall pay to Petitioner penalties of **$826.00**, as provided in Section 16 of the Act; **$4,130.01**, as provided in Section 19(k) of the Act; and **$10,000.00**, as provided in Section 19(l) 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 W. Finnerty
Signature of Arbitrator

~~5/22/13~~ 7/5/13 PMO
Date

JUL 5 - 2013

14IWCC0642

STATEMENT OF FACTS:

This claim was previously tried pursuant to §19(b) of the Act before Arbitrator Galicia on September 2, 2010. In the order section of his decision, filed September 24, 2010, Arbitrator Galicia determined that Petitioner sustained a left knee injury that arose out of and in the course of his employment on July 18, 2009 and that a causal relationship existed between Petitioner's current left knee condition and said date of accident. (PX4). Arbitrator Galicia also awarded prospective medical benefits, including prospective TTD, for treatment recommended by Dr. Lopez relative to Petitioner's left knee. (PX4). In the body of his decision, however, Arbitrator Galicia noted that "Petitioner has demonstrated a causal connection between Petitioner's left knee injuries and the treatment for those injuries and the current condition of ill-being in Petitioner's right knee." (PX4). Arbitrator Galicia then goes on to conclude that "Petitioner has established that medical treatment to his right knee is necessary and reasonable" and appears to order arthroscopic surgery for same as recommended by Dr. Lopez. (PX4). The Commission's computer records do not indicate that this decision was appealed. Since the subsequent surgery involved the left knee and in light of the fact that any condition relative to the right knee was not addressed during the course of the current proceedings, the Arbitrator can only conclude that either the prior Arbitrator's reference, in the body of his decision, to the right knee was in error or else the issue of the right knee is not part of the present claim. Petitioner did testify with respect to complaints relative to his right hip, possibly due to an altered gait. However, counsel for Petitioner, when questioned off the record by the Arbitrator, indicated that his client was not claiming that his right hip complaints were causally related to the accident in question. Thus, it appears that only the left knee is the subject of the current dispute.

At the time of the initial hearing on January 15, 2013 Petitioner testified that since the prior §19(b) hearing he underwent arthroscopic left knee surgery at the hands of Dr. Lopez on January 4, 2011. Surgery consisted of removal of 10 mm loose body, chondroplasty of the lateral patellar facet, partial lateral and medial meniscectomy, chondroplasty and microfracture of medial and lateral femoral condoyle. (PX2). Dr. Lopez recommended, and Petitioner underwent, physical therapy after surgery until authorization for physical therapy was refused by Respondent after seven visits by February 8, 2011. (PX2). Petitioner testified that physical therapy restarted in approximately March of 2011. He noted that he participated in about 18-20 sessions and that his knee improved as a result.

Petitioner returned to work on a light duty basis on July 11, 2011. He indicated that he eventually returned to full duty as a maintenance engineer on August 8, 2011. Petitioner noted that he has continued to work full duty since that time, performing the same duties as before the accident. He indicated that his knee sometimes affects his ability to perform his job. Specifically, he stated that he experiences pain walking in low tunnels and standing on ladders. He also noted that he does a lot of walking and standing during the day and that he has to be careful climbing on roofs. In addition, Petitioner testified that Dr. Lopez prescribed a neoprene sleeve for his knee which he wears to work and which he noted provides a little more stability. He indicated that his knee still swells, and that he ices it a few times a week. In addition, he uses a stimulator maybe six (6) times a month, particularly after a long day at work. Petitioner also noted that he takes pain medication in the form of Tylenol 3 on days that he works. He continues to see Dr. Lopez on a monthly basis at which time he receives injections to help alleviate the pain. Petitioner noted that these injections started in October of 2012 and that they have improved the function of his knee.

Petitioner last visited Dr. Lopez on December 3, 2012 at which time the latter diagnosed left knee osteoarthritis following surgery/injury to the left knee. (PX2). Dr. Lopez noted that Petitioner walks with an antalgic gait and has a valgus or 'bowlegged' deformity of the knees bilaterally. Petitioner agreed that Dr. Lopez has indicated that he has reached maximum medical improvement. He also indicated that he notices his knee is sore at the

end of the day and that his condition has altered his gait, resulting in hip pain. He is scheduled to see Dr. Lopez again on February 14, 2013.

Petitioner testified that he had previously injured his left knee on May 24, 2004. He indicated that he underwent arthroscopic surgery on his left knee at that time and missed one month of work. Petitioner agreed that he eventually settled a workers' compensation claim concerning this incident. The record shows that settlement contracts were approved for case 04 WC 31310 on September 14, 2006 and that the amount of the settlement was 28% loss of use of the left leg, or 56 weeks. Petitioner also testified that there was a third party action filed with respect to this previous incident, and that the County recouped its lien in those proceedings.

Claims adjustor Jason Henschel was called to testify by Respondent at the hearing held on March 6, 2013. Mr. Henschel indicated that he was assigned to Petitioner's file on May 16, 2011 and that he received a request for authorization of medical treatment – specifically, physical therapy -- on September 26, 2012. He noted that pursuant to protocol he submitted the request to Genex for utilization review. Mr. Henschel testified that he subsequently received a response in October of 2012 and that treatment was denied thereafter.

On cross examination, Mr. Henschel was questioned about a letter sent to defense counsel dated March 7, 2011. This letter was later admitted into evidence at PX5 with the understanding that it was being submitted solely for the purpose of showing that Respondent received the letter in question and not for the truth of the matters asserted therein. (PX5). Mr. Henschel noted that he was not aware of any request for physical therapy in March of 2011, although he agreed that this March 7, 2011 letter, as well as a separate letter and fax dated March 14, 2011, predated his employment and involvement in the case. He also conceded that even though physical therapy had been denied following the January 4, 2011 surgery, and after the prior §19(b) decision, Respondent had not requested an additional §12 examination since the one which took place, he believed, in May or June of 2010. Finally, Mr. Henschel agreed that he was not aware of any other factors other than the UR that was considered in denying physical therapy.

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 setting forth the amount of 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. (Arb.Ex.#2). Those amounts are as follows:

Arb.Ex.#2 --	Dr. Lopez, MD:	$ 5,124.43
Arb.Ex.#2 --	Dr. Axe, MD:	$ 584.72
Arb.Ex.#2 --	Accelerated Physical Therapy:	$ 2,438.87

In addition, Petitioner testified in regards to and submitted evidence of out-of-pocket prescription expenses in the amount $112.00 (PX3).

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses totaling $8,260.02 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act. Respondent shall be entitled to 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.

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

Petitioner testified he worked full duty, without restrictions prior to July 18, 2009. He did not have to take regular pain or anti-inflammation medication, perform exercises, or apply ice to his knee after engaging in activity. He was able to sit, stand and walk without limitation. Petitioner testified that since his July 18, 2009 injury, he experiences significant difficulty in using the left leg. He experiences pain with walking and sitting. He testified that the left knee swells with use. He testified that he requires prescription pain and anti-inflammatory medications, which he takes when he works. He uses an electronic stimulator prescribed by Dr. Lopez, which temporarily alleviates some pain symptoms, but does not relieve them. Petitioner has undergone 5 Supartz injections in the 8 months preceding hearing, which only partially alleviate some pain symptoms.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner sustained the permanent partial loss of use of 45% of the left leg (or 96.75 weeks), as provided in §8(e)12 of the Act. However, the Arbitrator finds that Respondent is entitled to a credit for a prior settlement (04 WC 31310) representing 28% loss of use of the left leg (or 56 weeks based a maximum of 200 weeks for date of injury of 5/24/04), for a net award of 40.75 weeks, or approximately 18.95% loss of use of the left leg.

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

In addition to failing to pay the above medical expenses, Petitioner also points to Respondent's refusal to authorize ongoing physical therapy as a basis for additional compensation and/or penalties pursuant to §§19(k), 19(l) and 16 of the Act.

In the decision of *Hollywood Casino-Aurora, Inc. v. Illinois Workers' Compensation Commission*, 967 N.E.2d 848; 359 Ill. Dec. 818 (March 16, 2012) the Illinois Appellate Court determined that the Commission had no statutory duty to award penalties pursuant to §19(k) by reason of the employer's unreasonable delay in authorizing the employee's battery replacement surgery noting that there was no provision in the Act authorizing such penalties against an employer that delayed in giving such an authorization. In making this ruling, the court referenced the language of §19(k) which provides, in pertinent part, that said penalties may be awarded "[i]n case where there has been any unreasonable or vexatious *delay of payment* or intentional *underpayment* of compensation ..." *Hollywood Casino-Aurora, Inc.*, 967 N.E.2d at 851. (Emphasis added by court). The court went on to state that the above referenced statute "... says nothing about any award of additional compensation (penalties) for an employer's delay in authorizing medical treatment, even assuming *arguendo* that an employer has an obligation to give authorization in advance of medical treatment for an injured employee." *Id.*, at 851.

The Arbitrator finds that the facts in the present case are distinguishable from those outlined in *Hollywood Casino-Aurora, Inc.*, supra. Firstly, there were unpaid, incurred medical expenses in this case (See issue "J", supra), in regards to which Respondent has offered no reason for its refusal to pay. Secondly, there had been an adjudication by the Commission on the merits in this case with respect to Respondent's liability. More to the point, the Arbitrator found that Petitioner's left knee injury was causally related to the July 18, 2009 date of accident and ordered "[p]rospective medical benefits, including prospective TTD, ... for treatment of Petitioner's left knee as recommended by Dr. Lopez." (PX4). Petitioner thereupon underwent the prescribed surgical procedure on January 4, 2011 and commenced physical therapy shortly there after, something one would think would be a logical adjunct to post-surgical treatment and would reasonably fall under the Arbitrator's award of "prospective medical benefits." Thus, we are not dealing with the scenario presented in *Hollywood Casino-Aurora, Inc.* wherein authorization was a prerequisite to the initiation of services. On the

contrary, services had already commenced, and those services had effectively been ordered by the Commission. To allow the Respondent in this case, or any other case, to unilaterally rescind such authorization, or in this case blatantly ignore the order of an unappealed decision of the Commission, would only, in this Arbitrator's opinion, result in a gross miscarriage of justice and allow unscrupulous insurers unlimited opportunities for abuse. Simply put, the parties in this case were past the question of authorization, and Respondent's conduct amounted to an unreasonable and unsubstantiated refusal *to pay for* (not simply authorize) the treatment in question.

Along these lines, the Arbitrator notes that the record contains no less than three (3) letters authored by Petitioner's counsel – one dated March 7, 2011 and two dated March 14, 2011 – directed to Respondent's counsel, and which Respondent's counsel acknowledges that he received, requesting approval for the reinstatement of physical therapy. The letters themselves were admitted into evidence with the understanding that they were being offered for the purpose of showing that Respondent received same, and not for the truth of the matters asserted therein. (PX5, PX6 & PX7). The Arbitrator is of the opinion that the receipt of these letters is what is important. The letters themselves, in plain English, request the approval of physical therapy. Respondent's counsel can argue semantics all he wants, and whether or not the request for therapy itself was warranted under the circumstances, but the fact remains that this was a demand for those services, plain and simple. To claim otherwise is to argue form over substance.

Respondent's claims adjustor, Jason Henschel, testified that he was assigned to the file on May 16, 2011, or two months after the aforementioned letters were mailed and faxed to Respondent's counsel. And while Mr. Henschel claims that he does not recall seeing these letters and that he was not aware of a request for physical therapy until September 26, 2012, the fact of the matter is that Respondent's counsel, as Respondent's representative, acknowledged receipt of those letters. More importantly, there was absolutely nothing that had transpired since the issuance of the Arbitrator's decision on September 24, 2010, ordering the surgery and "prospective medical benefits." that would have provided a basis for the denial of, or at least failure to approve, the ongoing physical therapy in question. Mr. Henschel admitted that there had been no new §12 examination since the one that had been performed prior to the §19(b) proceedings, and the Respondent did not receive its UR report on the question of continued therapy until October of 2012, or a full nineteen (19) months after physical therapy was ceased. (The Arbitrator notes that the only Utilization Review contained in the record is one dated August 23, 2011 which dealt with a request for an "IF Stim Unit with Flex Hip Garment," and which does not address any need or request for physical therapy. [PX2, pp. 106-109]). The Arbitrator finds this conduct, by its very nature, to be unreasonable and vexatious.

Based on the above, and the record taken as a whole, and light of Respondent's unreasonable and vexatious refusal to pay for medical expenses as well as continued physical therapy, the Arbitrator finds that Petitioner is entitled to additional compensation pursuant to §19(k) in the amount of $4,130.01 (50% of unpaid benefits, or .5[$8,260.02]), $10,000.00 pursuant to §19(l) (or the maximum amount, given that the period medical benefits were not paid exceeds 333 days), and attorneys' fees pursuant to §16 in the amount of $826.00 (20% of §19[k]).

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

VINCENT CARDINAL,

Petitioner,

vs.

NO: 13 WC 2553

14IWCC0643

ARAMARK,

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, temporary total disability and evidentiary rulings, 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 notes that the Arbitrator sustained the Respondent's objection to certain testimony that was to be presented by the Petitioner's father, Samuel Cardinal. This testimony was relative to a telephone conversation that occurred on October 21, 2013 between Samuel Cardinal and Petitioner's half-brother, Paul Cardinal.

The Arbitrator found the testimony to be elicited to be hearsay, and sustained the Respondent's objection. The Commission finds that the proposed testimony of Samuel Cardinal, as contained in Petitioner's offer of proof, was not hearsay, and reverses the Arbitrator's ruling regarding same. The Commission finds that the Arbitrator should have overruled the objection of the Respondent and allowed said testimony.

Though the Commission has found that the Arbitrator's ruling was in error, it believes the error to be harmless. Though that testimony of Samuel Cardinal was excluded it did not affect the substantive rights of the Petitioner, Vincent Cardinal. The Commission draws this conclusion

by careful consideration of the Petitioner's offer of proof.

The Commission has reviewed the excluded testimony, as contained in the offer of proof, and gives it little weight. Said testimony does not overcome the overwhelming evidence that Petitioner lacks credibility.

The Commission notes that the Respondent obtained lengthy surveillance video of the Petitioner. The Petitioner is seen performing acts inconsistent with his claimed level of disability. At no time during the surveillance does Vincent Cardinal appear limited by any alleged disability. The Commission finds that the surveillance negatively impacts Petitioner's credibility.

The Commission further notes that the Petitioner's testimony is contradicted by the medical records. The Commission affords more weight to the surveillance video and the medical records than the testimony regarding the telephone conversation of Samuel and Vincent Cardinal. Based on the totality of the record, the Commission affirms the Arbitrator's decision finding Mr. Cardinal failed to prove that he sustained an accident arising out of and in the course of his employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on November 6, 2013 is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that since the Petitioner failed to prove that his injury arose out of and in the course of his employment on December 11, 2012, his claim for compensation is hereby denied.

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: AUG 0 1 2014

MJB/tdm
O: 7-8-14
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

CARDINAL, VINCENT
Employee/Petitioner

Case# **13WC002553**

14IWCC0643

ARAMARK
Employer/Respondent

On 11/6/2013, 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:

1987 RUBIN & CLARK LAW OFFICES LTD
ARNOLD G RUBIN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

2337 INMAN & FITZGIBBONS LTD
G STEVEN MURDOCK
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

VINCENT CARDINAL
Employee/Petitioner

Case #13 WC 2553

v.

14IWCC0643

ARAMARK
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on September 25 and October 22, 2013. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☒ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

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

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On December 11, 2012, the respondent was operating under and subject to the provisions of the Act.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $74,687.08; the average weekly wage was $1,436.29.
- At the time of injury, the petitioner was 41 years of age, *married* with three children under 18.
- The parties agreed that the respondent paid $2,872.56 in temporary total disability benefits.
- The parties agreed to reserve the issues regarding the reasonableness and relationship of the medical services provided to the petitioner and any §8(j) credits for payments of the medical bills.

ORDER:

- The petitioner's request for benefits is denied and the claim is dismissed.

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

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

Robert E. Williams

Signature of Arbitrator

November 5, 2013

Date

NOV - 6 2013

FINDINGS OF FACTS:

The petitioner, a route sales representative, denied any prior back injuries, back surgeries and felony convictions at the time of his hire with the respondent in December 2010. He worked for the respondent through July 2012 and reapplied for the same position in September 2012, at which time he again denied any prior back injuries, back surgeries and felony convictions. On December 15, 2012, the petitioner hosted a family Christmas party at his home. In attendance were his brother, Paul, and Paul's daughter, who was not ambulatory.

On December 26, 2012, the petitioner sought medical treatment for his low back with Dr. Charles Cavallo at Schererville Immediate Care Center. The doctor noted that the petitioner was unclear when his injury occurred. Dr. Cavallo restricted the petitioner from truck driving for one week for his diagnosis of a back contusion. At a follow-up on January 2, 2013, the petitioner was advised to stay home.

On January 8th, the petitioner gave a telephonic statement to Ms. Melanie Hall of Sedgwick CMS indicating an injury while working for the respondent on December 11, 2012. Dr. Nikola Nenadovich at Lakeshore Bone & Joint saw the petitioner on January 14th and noted his report of progressive low back pain with right leg pain beginning on December 11, 2012, while working pulling a cage onto the lift gate of a truck. Dr. Nenadovich's diagnosis was a lumbar disc disorder and neuropathy. He prescribed Valium and Norco, no work and physical therapy. An x-ray examination of the lumbar spine showed a transitional anatomy at the L-S junction and mild degenerative disc disease at L4 – L5. An MRI on January 23rd showed a transitional lumbar sacral vertebra at L5 sacralized on the left and lumbarized on the right; a non-displaced, unilateral right

L5 pars inter-articularis defect; a small central L4-5 disc extrusion without neural impingement or significant canal narrowing; prominent chronic Schmorl's nodes at L1-2 and L2-3 levels; a small right extra-foraminal L1-2 partial annulus tear without herniation; and a right L3-4 laminectomy. On March 4th, the petitioner reported continuing back pain and left leg pain and right buttock pain. Dr. Nenadovich recommended a right L4-5 discectomy on April 15th. Dr. Alexander Ghanayem saw the petitioner on May 13th and opined that the petitioner had a transition-type vertebral body, which would lead to different doctors counting the levels in a different manner. Dr. Ghanayem said the petitioner's prior surgery was at L4-5, which is currently labeled L3-4 and the petitioner's current disc problem is new and is at L5-S1 currently labeled L4-5. He opined that former operative level did not have a recurrent herniation. Dr. Ghanayem recommended a lumbar laminotomy and discectomy at L5-S1 (currently deemed the L4-5 level).

At the respondent's request, Dr. Carl Graf performed an independent medical examination of the petitioner pursuant to Section 12 of the Act on April 19th. Dr. Graf opined that the petitioner was functioning outside of his permanent restrictions and that his injuries are secondary to his pre-existing lumbar condition. On July 3rd, Dr. Graf opined that the surgery recommendation by Dr. Ghanayem was reasonable for the petitioner's current condition.

The petitioner had a right-sided L4-5 laminotomy with partial medial facetectomy and discectomy by Dr. Ghanayem on October 20, 2008. A functional capacity evaluation of the petitioner on February 11, 2009, demonstrated a functional capacity consistent with the medium, physical demand level.

FINDING REGARDING WHETHER THERE WAS AN EMPLOYER/EMPLOYEE RELATIONSHIP BETWEEN THE PARTIES:

An employer/employee relationship existed between the petitioner and the respondent on December 11, 2012. The respondent failed to establish that there was an intentional, material misrepresentation by the petitioner that was relied on to its detriment so as to void the employment relationship *ab initio*. The petitioner intentionally lied about his prior back problems and his felony convictions while applying for employment with the respondent. However, his deceit was directed toward obtaining an employment relationship. Although the petitioner misrepresented his lumbar condition, he was not deceptive regarding his willingness to perform the job tasks. He performed his job duties and was considered one of their better workers. The petitioner's misrepresentation was intended to obtain employment and the intent of the respondent was to form an employer-employee relationship. There was no detrimental reliance by the respondent on the petitioner's misrepresentations since the petitioner entered into an employer-employee relationship with the respondent as was intended.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that he sustained an accident on December 11, 2012, arising out of and in the course of his employment with the respondent. At his Christmas party on December 15, 2012, the petitioner was able to carry his ninety-pound niece on his shoulder up to the next floor. Although the petitioner denied his brother's testimony, there was no reason for his brother to fabricate the incident. Nor can the petitioner's prior lack of veracity and misrepresentations be ignored. Also, when the petitioner sought initial medical treatment

on December 26, 2012, with Dr. Cavallo, he did not report a work injury and he was unclear when his injury occurred. Considering all the evidence presented, the petitioner is not believable. The opinion of Dr. Ghanayem is not consistent with the evidence and is not given any weight. All claims for benefits are 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

DAVE KORDZINSKI,

Petitioner,

vs. NO: 02 WC 30876

D&H ALTERNATIVE RISK SOLUTIONS,

Respondent.

14IWCC0644

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Cook County. Pursuant to the Circuit Court's Order dated November 1, 2011, Judge James C. Murray, Jr. remanded the case back to the Commission for findings of fact and conclusions of law regarding David Kordzinski's entitlement to repayment for medication and medical supplies for his diabetes and hypertension, and his entitlement to authorization for pain management and a weight loss program. Judge Murray, Jr. affirmed and confirmed all other issues of the Illinois Workers' Compensation Commission's Decision dated February 4, 2011 as not being contrary to the manifest weight of the evidence. The Commission notes that Petitioner has filed a separate 8(a) petition that is not involved in the current claim.

This matter was originally tried before Arbitrator Kurt Carlson on October 29, 2008. In his Decision dated January 8, 2009, the Arbitrator found that Mr. Kordzinski's lumbar disc pathology, right knee pathology, bowel obstruction, obesity, hypertension, sleep disturbance and diabetes arose out of and in the course of his employment on November 29, 2001. Petitioner was awarded temporary and total disability (TTD) benefits from November 30, 2001 through October 29, 2008, representing 360 – 6/7 weeks. Petitioner was found to be permanently and totally disable (PTD) as the result of his accident. He was entitled to PTD benefits in the amount of $733.33 per week commencing October 20, 2008. No appeal was taken.

Kordzinski filed a Petition for Review pursuant to Section 8(a) on June 21, 2010. Oral

arguments were held before the Commission on January 13, 2011. The Commission, in its Decision dated February 4, 2011, denied the §8(a) Petition. The Commission denied the medical bill from St. Margaret Mercy Hospital dated May 28, 2008 as it was incurred prior to the October 29, 2008 arbitration hearing and should have been presented at the original hearing. The Commission further denied the bills from Dr. Tonino and St. Margaret Mercy Hospital that were incurred after the original hearing. The Commission found those bills were incurred after Petitioner's right knee locking episode of May 27, 2008. The Commission noted that the Petitioner offered no evidence causally connecting the knee locking problem to his work-related accident of November 29, 2001. The Respondent, however, offered into evidence Dr. Cohen's opinion that Petitioner's current right knee condition was related to his tri-compartmental arthritis as well as his obesity and, as such, not related to his accident. The Commission found that the treatment rendered to the right knee subsequent to the locking episode was not related to the work accident. The Commission further denied the request for home modification finding that the brief mention by Petitioner's doctor that he would benefit from such changes was not enough to establish justification for such an award.

The parties filed a stipulation on July 23, 2014. Pursuant to the stipulation, Mr. Kordzinski is authorized to pursue medical care with Dr. Abusharif and/or Dr. Najera, or a physician associated with a university based medical center such as Rush Medical Center, Northwestern Medical Center or University of Chicago Medical Center for care associated with his diabetes, hypertension and chronic pain management. This shall include the authorization for a lumbar spine MRI and follow-up care as ordered by Dr. Najera. Further, the Illinois Insurance Guaranty Fund represents that it will authorize and approve the prescribed medical care and prescriptions subject to the limits of the fee schedule for a period of time through August 1, 2016. The Petitioner's incurred medical bills to date will be submitted for review and payment by Corvell and shall be subject to any limits that exist under the Act or the Fee Schedule.

The parties acknowledged in their stipulation that the following issues remain in dispute: 1) Petitioner's entitlement to additional weight loss programs; 2) Petitioner's entitlement to medical care involving the right leg and knee; and, 3) Petitioner's entitlement to assistive devices and home modification.

The stipulation at this trial removes from consideration of the Commission the issues relative to the diabetes, hypertension and pain management. After careful review of the Circuit Court's order, the only issue now before the Commission is Kordzinski's entitlement to a weight loss program. Any other issue relative to the care and well-being of the Petitioner has been adjudicated before the Circuit Court and therefore may not be considered by the Commission. The request for right knee expenses and for home modifications was previously denied by the Commission. The denial was confirmed by the Circuit Court. The Commission finds that Petitioner has failed to prove an entitlement to a weight loss program for reasons stated below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. Mr. Kordzinski presented to Saint Margaret Mercy Hospital on May 27, 2008

following his right knee giving out and causing him to fall. Petitioner requested that his blood sugars be tested. The clinical impression was right knee and right ankle contusion and lumbar strain. PX.7. Petitioner was billed $2,138.80 for the ER. PX.7.

2. Petitioner was seen by Dr. Charles Shaw of Family Care Associates on March 10, 2009 for chronic back pain syndrome, diabetes and hypertension. His high blood pressure was well-controlled. His blood sugars were noted to have been quite good lately. Dr. Shaw noted that Petitioner could not get much physical exertion and needed to cut his calories to make his sugars better. PX.2.

3. Mr. Kordzinski was seen by Dr. Shaw on July 8, 2009 for right knee pain. He reported that he was standing up turning and fell and twisted his right knee. His right knee was now locked in place. His blood sugar was in the 170 range. PX.2.

4. Petitioner was seen by Dr. Shaw on October 1, 2009 for his chronic back pain/pain syndrome, diabetes, hypertension, and degenerative joint disease of the knees. He was completely unable to exercise because of his syndrome. Dr. Shaw recommended swimming, but Petitioner indicated that he could not afford to join a swim club. His insulin was increased. PX.2.

5. Dr. James Cohen performed a Section 12 examination at the request of the Respondent on December 8, 2009. Dr. Cohen had originally examined Mr. Kordzinski on May 1, 2007 and did not relate Petitioner's right knee condition to the November 27, 2001 accident. As a result of the December 2009 examination, Dr. Cohen opined that Petitioner's current right knee condition was related to tri-compartmental arthritis as well as his obesity. It was not related to his work accident. Additional treatment was necessary but was not related to the accident. He recommended a trial of an intra-articular steroid and lidocaine injection from an orthopaedist. He may require total right knee replacement. His condition was related to a degenerative process, not the accident. RX.1.

6. Petitioner was seen by Dr. Pietro Tonino on February 22, 2010. His range of motion of the knee revealed full extension. He received an injection of Celestone. He was capable of independent exercise program. He was to avoid squatting, twisting, climbing and lifting more than 20 pounds. He also complained of debilitating low back pain. Dr. Tonino referred Kordzinski back to Dr. Alexander Ghanayem for his low back issues. PX.5. Petitioner was billed $75.00 for the office visit; $225.00 for the right knee injection; and, $47.00 for the right knee x-ray.

7. On February 23, 2010, Kordzinski presented to Saint Margaret Mercy Emergency Room for hyperglycemia and chronic back pain. He had complaints of chest pain and high blood sugars. His glucose level was 471. PX.4. Petitioner was billed $3,238.82 for the ER visit. PX.7.

8. Petitioner was seen by Dr. Ghanayem at Loyola University on March 26, 2010. Petitioner reported that his low back pain felt worse at times. The pain continued in

his back as well as into both legs. He had not been successful in losing weight on his own. Dr. Ghanayem found that Kordzinski had ongoing back and leg pain secondary to multilevel disc disease with recurrent lumbar disc herniations. There was nothing he could do surgically to help. He recommended a follow-up with a pain clinic close to his home. Petitioner reported difficulty with his stairs. Dr. Ghanayem noted that Petitioner may benefit from living in a single floor home and may benefit from other things such as an elevated toilet seat and support bars in the commode and shower to prevent him from falling. Weight loss was very important and professional help would be a benefit given he was against surgical intervention to help with weight loss. His back was clearly adversely affected by his weight and vice versa. He was essentially disabled from occupational activities. PX.6. Petitioner testified that Dr. Ghanayem never wrote him a prescription for a handicapped toilet seat or to live on one level. T.1753.

9. Mr. Kordzinski testified that he saw Dr. David Robertson on March 15, 2007 and bariatric surgery was recommended. T.1732. He then saw Dr. Ghanayem on January 30, 2008 and he recommended a lap band procedure. *Id.*

10. According to the nurse case manager notes from Phyllis Majka, RN, Petitioner was seen by Dr. Ghanayem on March 26, 2010. She noted Dr. Ghanayem told Petitioner that pain management would be beneficial and he wrote a prescription to see a pain management specialist. He further noted that the falling in his bath episode was a serious safety concern and he needed a handicap assessment. Dr. Ghanayem further noted Petitioner needed a weight reduction program such as Nutra System along with exercise. The treatment recommendations were pain management evaluation, weight reduction program, handicapped assessment and a scooter. RX.3.

11. Petitioner testified that Respondent has not made any modifications to his house and has not authorized him to see a professional for weight loss. T.1743. – T.1744.

12. Petitioner testified that he was examined by Dr. Shaun Kondamuri that was selected by the nurse case manager. He cooperated with the examination. Dr. Kondamuri did not select him as a patient. T.1737. According to the nurse case manager notes from Ms. Majka dated May 27, 2010, Dr. Kondamuri noted that if Kordzinski was serious about getting better he would need to be taken off Dilaudid and placed on non-narcotic long lasting medication. Petitioner needed to commit to an exercise and weight loss program. He needed to get into a health club and work at weight reduction and strengthening regardless if he had pain. RX.3.

13. Kordzinski testified that his right knee pain is worse than at the time of the original hearing. T.1716. He testified that he currently sees Dr. Shaw for his low back pain, diabetes and high blood pressure. T.1724. He has not had any new incidents or accidents that have injured or aggravated his low back or right leg. T.1725, T.1726. His lower back is getting extremely worse in his buttock and the side of his leg. The three front toes from right to left are extremely numb with shooting pain and he cannot feel the bottom of the ball of his right foot. T.1726. He stated that his right

knee is getting worse and is the size of a ping pong ball. T.1727. His knee and back has made it a lot harder to use stairs. *Id.* He stated that his pain is like a pitch fork going into his butt. He stated that an elevated commode is easier to use and a grab bar would be of 100 percent assistance in his bathroom. T.1729. He stated that he fell through his shower door when his right leg locked up. *Id.*

14. Petitioner testified that his diabetes is progressively getting worse and is causing dry mouth. T.1730. He cannot eat anything and basically stays inside. *Id.* His diabetes causes him to fall from the light headedness. *Id.* Dr. Shaw prescribed medication for his diabetes and hypertension that he pays for out of his own pocket. T.1731.

15. Petitioner testified that he is not able to ride his bike or run and walking causes back pain. T.1733. He stated that he would not consider swimming. T.1734. He eats pork chops, steak, salads with chestnuts, and lots of fruits. T.1735. He stated that a good day is when he can walk around the house and go to the garage, and a bad day is when he cannot go five feet from the bed. T.1736. Stretching in heat and cold sometimes helps for 30 minutes and pain patches provide some relief.

16. He pays out-of-pocket for his Glimepiride, Doxipin, Clonazepam, Lisinopril, insulin, Hydrochlorot for blood pressure, Carvedilol for blood pressure and Pravastatin for his cholesterol. T.1741.

Section 8(a) of the Act obligates employers to provide and pay for all the necessary first aid, medical and surgical services, and all necessary medical, surgical, and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury. 820 ILCS 305/8(a). The claimant has the burden of proving that the medical services were necessary and the expenses were reasonable. See *Gallentine v. Industrial Comm'n,* 201 Ill. App. 3d 880, 888, 559 N.E.2d 526, 532, 147 Ill. Dec. 353 (1990). What is reasonable and necessary is a question of fact for the Commission, and the Commission's determination will not be overturned unless it is against the manifest weight of the evidence. *Cole v. Byrd,* 167 Ill. 2d 128, 136-37, 656 N.E.2d 1068, 1072, 212 Ill. Dec. 234 (1995); *University of Illinois,* 232 Ill. App. 3d at 164, 596 N.E.2d at 830.

The Petitioner argues that he is entitled to a weight loss program. The Commission has reviewed the record in its entirety and finds that the Petitioner failed to prove the reasonableness and necessity of such a program. Mr. Kordzinski provided no proposal or plan for such a program. No evidence was submitted outlining with whom the Petitioner would treat, where he would receive such treatment, the duration and cost of such a program, and the obligation of the Petitioner while attending a weight loss program. While it is true that the conditions that necessitate the need for the program have been found to be causally related to the work accident and such programs have been mentioned by the treating doctors, there is no objective evidence demonstrating the reasonableness and necessity of such a program. The Commission therefore finds Petitioner is not entitled to enrollment in a weight loss program.

With respect to the right leg and knee, and home modifications, the Commission notes that those issues are not before the Commission. The Commission's Decision of February 4,

2011 found that Mr. Kordzinski offered no evidence causally connecting the right knee locking problem to his work-related accident of November 29, 2001. The Commission noted that Respondent offered into evidence Dr. Cohen's opinion that Petitioner's current right knee condition was related to his tri-compartmental arthritis as well as his obesity and, as such, not related to his accident. The Commission found that the treatment rendered to the right knee subsequent to the locking episode was not related to the work accident. The Commission further denied the request for home modification finding that the brief mention by Petitioner's doctor that he would benefit from such changes was not enough to establish justification for such an award. The Petitioner offered no evidence regarding the cost of the said home modification and offered nothing in the way of plans regarding these home modifications. The Commission's Decision was confirmed by the Circuit Court as not against the manifest weight of the evidence. As such, the issue relative to the right leg and knee, and home modification has been adjudicated by the Circuit Court and may not be considered by the Commission.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's request for a weight loss program 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: AUG 0 1 2014

MJB/tdm
O: 7/29/14
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

Dian Crabill,

Petitioner,

vs.

NO: 10 WC 46554

14IWCC0645

State of Illinois-Western Illinois University,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 11, 2013, is hereby affirmed and adopted.

DATED: AUG 0 1 2014
TJT:yl
o 7/29/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CRABILL, DIAN
Employee/Petitioner

Case# **10WC046554**

SOI-WESTERN ILLINOIS UNIVERSITY
Employer/Respondent

14IWCC0645

On 9/11/2013, 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 0.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2028 RIDGE & DOWNES LLC
JOHN E MITCHELL
415 N E JEFFERSON AVE
PEORIA, IL 61603

0499 DEPT OF CENTRAL MGMT SERVICES
WORKMENS COMP RISK MGMT
801 S SEVENTH ST 6 MAIN
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

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

SEP 11 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0645

☐ 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

Dian Crabill
Employee/Petitioner

v.

State of Illinois – Western Illinois University
Employer/Respondent

Case # 10 WC 46554

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 **Stephen Mathis**, Arbitrator of the Commission, in the city of **Peoria**, on **06/26/2013**. 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 _____

14IWCC0645

FINDINGS

On 02/16/2010, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned $30,107.75; the average weekly wage was $578.99.

On the date of accident, Petitioner was 52 years of age, *married* with 1 children under 18.

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 $30,221.22 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.

ORDER

Temporary Total Disability

Petitioner is not entitled to any more. Temporary Total Disability based on the evidence. Petitioner did sustain an accident that arose out of his employment however Petitioner's current condition of ill-being is not causally related to the accident.

Permanent Partial Disability

Petitioner is entitled to 3% loss of use to the person as-a- whole. Petitioner did sustain an accident that arose out of his employment however Petitioner's current condition of ill-being is not causally related to the accident.

Medical

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

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

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

8-22-13
Date

ICArbDec p. 2

SEP 11 2013

Petitioner, Dian Crabill, was a 52 year old bowling alley manager for Western Illinois University.

Petitioner had been working for the Respondent since June 29, 2009 and was responsible for performing various

managerial and mechanical job duties including maintaining records and repairing the equipment. Petitioner testified that on February 16, 2010 one of the lanes was not working properly due to a jammed pin in the pin setter. He testified that he lifted himself onto the machine which had a step up for his feet and handles to hold on to. Petitioner testified that he reached forward and then later noticed pain on the left side of his neck.

Petitioner did not seek medical attention until 02/19/210, when he sought treatment from his primary care physician Dr. Stortzom. Dr. Stortzum notes a history from Petitioner of persistent left upper back, shoulder, and neck pain after pulling himself up on a ladder at work. Dr. Stortzum notes a history of no prior back surgery or injury, diagnoses Petitioner with left upper back and trapezius strain, and recommends a cervical MRI should symptoms not resolve. Petitioner did undergo an MRI of the cervical spine on 02/23/2010 which showed degenerative disk disease from C4 through C7 with a mild eccentric broad based disk protrusion.

Petitioner next sought treatment at Springfield Clinic with Dr. Macgregor on 03/11/2010. The 03/11/2010 note indicated a significant history of disability in 2009, use of a can since January 2010, and significant difficulty with ambulation. There is no mention of neck pain or injury, but reference to neck treatment. Physical therapy was ordered and lumbar/pelvis MRIs and X-rays were ordered.

Petitioner next sought treatment with Dr. Macgregor on 04/05/2010 wherein it is noted that this is an initial evaluation of neck pain from a work injury. Dr. Macgregor noted a history of left side neck pain and left arm numbness that began on 02/17/2010. Dr. Macgregor noted prior cervical treatment and noted that Petitioner was currently in water therapy that predated the injury, which was described as physically strenuous. Dr. Macgregor reviewed the cervical MRI and X-ray and indicated a fresh disc herniation as the cause for his neck pain and proscribed physical therapy.

Petitioner returned to Springfield Clinic on 04/22/2010 wherein it was noted that Petitioner suffered from bilateral shoulder soreness and numbness on both the right and left side. It is also noted that neck extension causes sharp pain to shoot down his back and Dr. Vespa recommended an anterior cervical discectomy with fusion. On 06/15/2010 Petitioner underwent an anterior cervical decompression with arthrodesis, placement of a machined inner body fusion device, and plating at C5-C6.

Cervical X-rays indicated an uncomplicated C5-C6 fusion. Petitioner followed up at Springfield clinic and noted soreness in neck, but that his arms felt better. On 07/29/2010 it was noted that Petitioner's walking was getting worse and his wife wished for Petitioner to have another brain MRI. Petitioner continued to seek treatment with Dr. Macgregor and continued with physical therapy until being released at maximum medical improvement on 08/08/2011.

Throughout Petitioner's recovery, Dr. Macgregor noted significant problems with Petitioner's bilateral upper and lower extremities, but as of 11/18/2010 it is noted that Petitioner is no longer using his cane. The

physical therapy notes indicated a waxing and waning of Petitioner's upper extremity and lower extremity complaints with a good prognosis at the time of discharge. 14IWCC0645

On 09/12/2011 Petitioner was examined at the request of Respondent by Dr. Joseph Williams. Dr. Williams noted that the radiological films showed no acute changes, but rather showed chronic degenerative changes. He further noted that Petitioner suffered from pre-existing hemiplegia and that if Petitioner was able to perform his job prior to February 2010 then there is nothing resulting from the accident that would prevent him from performing his job duties today.

In Support of Arbitrator's decision relating to _C_ the Arbitrator finds the following facts:

The Arbitrator finds that Petitioner did suffer an injury that arose out his employment.based on his testimony and medical evidence.

In support of Arbitrator's decision relating to _F_, the Arbitrator finds the following facts:

Petitioner failed to prove that his current condition of ill-being is related to the alleged accident and not the result of his pre-existing condition of ill-being.

In support of causation, Petitioner submitted the deposition of Dr. Macgregor wherein Dr. Macgregor opined that causation existed since Petitioner was not symptomatic prior to 02/16/2011. However, Dr. Macgregor testified that the C5-C6 level had bulging/protrusions since 2004 and it was possible that the changes observed after the date of accident were of a degenerative nature. Further, Dr. Macgregor noted that she only saw the cervical MRI films from 2006 and 2010 and did not have access to the films or report from 2004.

In contrast to Dr. Macgregor, Respondent submitted the deposition and reports of Dr. Joseph Williams who opined that Petitioner's condition of ill-being was the result of his degenerative cervical disk disease. Dr. Williams' testified that, contrary to Dr. Macgregor, he viewed the three cervical MRI films from 2004, 2006, and 2010 which noted a progressing degenerative condition without acute change and therefore the alleged accident is not what necessitated the need for surgery.

The Arbitrator finds the opinion of Dr. Joseph Williams to be more credible. Dr. Macgregor admitted that she did not have access to Petitioner's complete cervical records including a prior MRI or knowledge of his cervical injury and treatment in 2009. Petitioner's testimony that the problems started as a result of reaching/grasping supports Dr. Williams conclusion that C5-C6 was at an advanced degenerative state that would explain the symptomology with little to no exertion by Petitioner.

The Arbitrator notes that 5 days prior to the date of accident Petitioner sought medical treatment from Dr. Stortzom which indicated that Petitioner struggled to ambulate and rise to the exam table. Dr. Stortzom

further noted Petitioner was reliant on a cane and indicated his fall 2009 physical therapy did not provide much improvement. The record shows that Petitioner sought physical therapy in fall 2009 after a cervical spine injury.

The Arbitrator finds that Petitioner's current condition of ill-being as outlined in the functional capacity exam pre-dates the injury and is not related to the cervical fusion. Both Dr. Macgregor and Dr. Williams opined that Petitioner's cervical fusion was successful and that his pre-existing condition would have been a bar to him performing his job at WIU. The tests performed by the vocational counselor were the same tests Petitioner took months prior to the date of accident and which he failed at that time as well.

The record shows that Petitioner was reliant upon a cane to ambulate just prior to the date of accident, but no longer required a cane after the cervical fusion. Petitioner testified that after the cervical fusion he did not need the cane again until mid-2012. Both Dr. Macgregor and Dr. Williams indicated that the use of the cane could explain arm and shoulder symptoms and that Petitioner's pre-existing brain lesions would account for Petitioner's current condition of ill-being.

The Arbitrator finds that Petitioner's alleged injury on 02/16/2010 did not necessitate the need for cervical surgery. Further, the Arbitrator finds that Petitioner's current condition of ill-being pre-dates the accident.

In support of Arbitrator's decision relating to __J__, the Arbitrator finds the following facts:

Based upon the finding with respect to causal connection, the Arbitrator finds the Petitioner is not entitled to further medical treatment.

In support of Arbitrator's decision relating to __K__, the Arbitrator finds the following facts:

Based upon the finding with respect to causal connection, the Arbitrator finds the Petitioner is not entitled to any further total temporary disability benefits.

In support of Arbitrator's decision relating to __L__, the Arbitrator finds the following facts:

Based upon the finding with respect to causal connection, the Arbitrator finds the Petitioner is entitled to 3% person-as-a-whole permanent partial disability.based on a strain to his neck. However his current condition is not related to the accident.

In support of Arbitrator's decision relating to __M__, the Arbitrator finds the following facts:

The Arbitrator finds that Respondent's actions were not unreasonable or vexatious and therefore penalties are not appropriate.

. The record shows that once Respondent had Petitioner's complete and accurate medical history an appropriate opinion was provided and reasonably relied upon. .

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

Joan Williams,

Petitioner,

vs.

NO: 12 WC 37857

14IWCC0646

State of Illinois Department of Revenue,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical expenses, temporary total disability, Section 8(j), and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

DATED: AUG 0 1 2014
TJT:yl
o 7/29/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

WILLIAMS, JOAN
Employee/Petitioner

Case# **12WC037857**

ILLINOIS DEPARTMENT OF REVENUE
Employer/Respondent

14IWCC0646

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

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

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

1816 FREDERIC W NESSLER LAW OFFICE
MATT KENNEDY
536 N BURNS LANE SUITE 1
SPRINGFIELD, IL 62702

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

4993 ASSISTANT ATTORNEY GENERAL
CHRISTINE J SMITH
500 S SECOND ST
SPRINGFIELD, IL 62706

0499 DEPT OF CENTRAL MGMT SERVICES
WORKMENS COMP RISK MGMT
801 S SEVENTH ST 6 MAIN
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0498 STATE OF ILLINOIS
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

OCT 22 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

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)

Joan Williams
Employee/Petitioner

v.

Illinois Department of Revenue
Employer/Respondent

Case # **12** WC **037857**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Urbana**, on **September 20, 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 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 not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**68,766.00**; the average weekly wage was $**1,322.43**.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and a general credit for any occupational or non-occupational disability benefits paid to Petitioner.

ORDER

The Arbitrator concludes that Petitioner has not met her burden to prove that her bilateral carpal tunnel syndrome arose out of or in the course of her employment with Respondent and further the Arbitrator cannot conclude that the current condition of ill-being is causally related to her work duties. No benefits are 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.

D. Dylan Mc Carthy
Signature of Arbitrator

Oct. 11, 2013
Date

ICArbDec19(b)

OCT 22 2013

MEMORANDUM OF DECISION OF ARBITRATOR

I. FINDINGS OF FACT

Petitioner worked for Respondent State of Illinois, Department of Revenue on October 21, 2011 as a Revenue Tax Specialist III. Petitioner testified that she worked for the State of Illinois for 39 years. Petitioner testified that her job involved resolving any problems with electronic fund transfers and reviewing and analyzing any suspended payments. Petitioner testified that approximately 1,000 suspended payments would come in a day and it was the job of her department to investigate why the payments were suspended, research the issue, and release the funds by 12:30 or 1:00 p.m. each day. (TX p. 13-14).

Petitioner testified that this job was done on her computer and that she was on her computer for 90% of each work day. Petitioner testified that Exhibit 5 is a true and accurate recollection of her job history with the State of Illinois and that the information contained therein was provided by her. (TX p. 15, 49). Petitioner testified that she used a 10 key calculator that required similar force to an old cash register and a stamper and a heavy duty stapler during the time period of 1974 to 1980 while she was a Clerk II and Clerk IV. Petitioner testified that she would have used the stapler and the stamper thousands of times a day. Petitioner testified that when she was a Service Rep IV from 1980 to 1991, she was using a 10 key calculator and a typewriter. Petitioner testified that from 1993 to 1997 when she was a Revenue Tax Specialist II, she moved to using a personal computer where her hands were placed on her desk. Petitioner demonstrated that during this time period while typing she held her hand and wrists on the desk and her wrists were in a position of extension. (TX p. 15-21).

Petitioner testified that from 1997 to 2000, she used the computer in the same fashion as a Revenue Tax Specialist I in audit support and also used the calculator. (TX p. 22). From 2001 to the present, Petitioner has been a Revenue Tax Specialist III and testified that she used the computer and the calculator in the same way she did in the prior positions. (TX p. 23). Petitioner testified that she was provided a gel pad for her wrist by Respondent in 1995 or 1996. Petitioner testified that she held her hand with her wrist resting down on the table in the same position that she demonstrated before. (TX p. 24).

On cross examination, Petitioner testified that her job duties with the electronic fund transfer involved researching in different databases why a payment was suspended and ensuring that the correct numerical information was entered into the various data fields. (TX p. 34). Petitioner testified that the electronic fund transfer portion of her job involved entering mostly numerical information. Petitioner testified that her other job duty of the taxpayer applications requires inputting information from a form into data fields on the computer such as name and address information. Petitioner testified that the largest data field would be the bank information containing the name of the bank and bank address and then she would switch to a different field. (TX p. 35-36). Petitioner testified that there were also times where she would be required to answer the phone and would not be typing during those times. (TX p. 38-39). Petitioner testified that would be 5 percent of her day. (TX p. 40).

Petitioner testified that after she received the gel pad in 1995 or 1996 that from that point forward, she held her wrists in a neutral position while typing. (TX p. 40). Petitioner testified that she provided Dr. Williams accurate information regarding her job duties and job description. (TX p. 41). Petitioner testified that 90% of her job was performing the release of suspended electronic fund transfers. (TX p. 44). Petitioner testified that she complained to her supervisor in 2006 that she was having problems with carpal tunnel again. (TX p. 47). Petitioner testified that from 2006 to 2011 she was experiencing symptoms constantly during work and after work. (TX p. 48).

Petitioner testified that since 1995 she has been symptomatic with carpal tunnel syndrome. Petitioner testified that on October 21, 2011, she had cramping and aching symptoms in her hands with the symptoms in her right hand traveling all the way up to her shoulder. (TX p. 25-26). Petitioner sought treatment with Dr. Sandercock and was diagnosed with carpal tunnel. (TX p. 27). Petitioner was then referred to Dr. Saadiq El-Amin. She was put on light duty with limited use of the hands and was ordered to wear a night splint which provided some relief. (TX p. 28). Dr. El-Amin provided Petitioner with work restrictions in October 2012 to type for 45 minutes and then take intermittent breaks. (PX 1, p. 25; PX 2,4). Petitioner then had an EMG and Dr. El-Amin recommended surgery. (PX 2, 4). Petitioner testified that at that time, she was suffering from pain and numbness in her fingers and her wrists would go numb at night and she was dropping things. (TX p. 29).

Dr. El-Amin performed a right carpal tunnel release surgery on April 10, 2013 and a left carpal tunnel release surgery on June 26, 2013. (PX 1, p. 11, Dep. Ex. 2, PX 2,4). When performing Petitioner's right carpal tunnel surgery, Dr. El-Amin noted that Petitioner's ligament was extremely thickened and the nerve was really compressed with some discoloration which could indicate nerve damage. (PX 1, p. 12-13). Dr. El-Amin testified that he did not know if Petitioner had permanent nerve damage because it takes one millimeter a week for regenerate. (PX 1, p. 13). Petitioner returned two weeks after the surgery and reported feeling better but had some weakness and decreased grip strength which Dr. El-Amin testified was normal for that time. He recommended physical therapy and follow up after six weeks. (PX 1, p. 14). He saw her again on May 23, 2013 and her right hand was feeling better with some residual pain and weakness.

Dr. El-Amin testified that she was progressing well at that point but had not returned to normal. (PX 1, p. 16). She reported experiencing symptoms in left hand and Dr. El-Amin scheduled her for a left carpal tunnel release. (PX 1, p. 15). Petitioner underwent left carpal tunnel release surgery on June 26, 2013. Dr. El-Amin testified that the left transverse carpal tunnel ligament was a lot tougher than the right and was hard to dissect through and that there was discoloration of the nerve on the left side as well. (PX 1, p. 18-19) Dr. El-Amin saw her for follow up on July 11, 2013 and at that point Petitioner reported that the right hand felt great but the left was still bothering her. Dr. El-Amin recommended physical therapy and pain medication and kept her off work. (PX 1, p. 20).

On August 8, 2013, Dr. El-Amin saw Petitioner and noted that she had sensation decrease in the fourth finger and still had decreased grip strength and tenderness on the left side. Dr. El-Amin was concerned at this time that the symptoms in the fourth finger could indicate cubital tunnel syndrome and referred her for an EMG. (PX 1, p. 22). The EMG did not show ulnar nerve entrapment or acute cervical radiculopathy. (PX 1, p. 23). After her surgeries Petitioner underwent physical therapy at SIU Hand Therapy. (TX p. 30). The right hand has recovered more quickly than the left and Petitioner is still undergoing physical therapy with the next appointment scheduled for October 24, 2013. (TX p. 30-31).

Petitioner testified that she continues to have symptoms of numbness in her fingers and it feels like something is sticking in them like a shock through her left hand. The left hand is the worst with pain at an 8 out of 10 continuously. The right hand is not bad at all but pain can be induced by movement. (TX p. 32-33).

Petitioner previously had a workers' compensation claim for carpal tunnel syndrome which was settled on or about July 23, 1996. (RX 4).

Petitioner testified that she went off work completely on December 20, 2012 and began receiving disability benefits in February, 2013. (TX, p. 49, RX 5)

Petitioner was sent for a Section 12 Independent Medical Examination by Dr. James Williams on February 20, 2013 and Dr. Williams issued a report dated the same day. (RX 1, Dep. Exh. 2). Dr. Williams is a board

certified physician specializing in Orthopedic Surgery with an advanced certification in hand surgery. (RX1, Dep. Ex. 1). On the date of his examination, Dr. Williams reviewed with Petitioner her health history and confirmed with Petitioner all of her job duties. Dr. Williams also reviewed the Demands of the Job form for Petitioner's job and the Position Description with Petitioner. Dr. Williams also reviewed photographs of Petitioner's work space. (RX 1, Dep. Ex. 3). Petitioner advised that she did not find any discrepancies. Dr. Williams also reviewed the Employee's Notice of Injury form and the Supervisor's Notice of Injury form. Dr. Williams also reviewed Petitioner's medical records and performed a physical examination.

Dr. Williams noted that Petitioner worked from 7:30 a.m. to 4:00 p.m. with a 1 hour lunch break and two 15 minute breaks. Petitioner answered the phone as part of her job duties. Petitioner explained her job as involving releasing of suspended payments and explained that it involves paid taxes however she needs to go in and change data when there is an error in entry or check problems. Petitioner explained that when she was entering applications she may have to enter the date 100 times per day. Petitioner stated that she had problems with carpal tunnel 15 years ago and was provided a new keyboard and wrist pad and did not do as much typing. Petitioner also stated that she rested her wrists while typing. (RX 1, Dep. Ex. 2).

Dr. Williams provided the opinion that Petitioner did suffer from right sided and left sided carpal tunnel syndrome. Dr. Williams stated,

> "I do not believe her work duties with (sic) either be aggravating and/or contributory to the patient's problems. I believe more so her postmenopausal status, her hypertension which on many visits was noted to be uncontrolled, her uncontrolled diabetes which has been proven on multiple glucose check on a BMP as well as on her hemoglobin A1Cs which have been consistently elevated would be more so likely and possibly being idiopathic than would her job duties. I did not find her work station to be non-ergonomic. She did have an adjustable chair. She had a good wrist pad for her keyboard as well as had a mouse pad. She also has an increased body mass index which could also be another risk factor. (RX 1, Dep. Ex 2.)

In Dr. William' deposition, Dr. Williams testified that when held for prolonged periods of time, the position of wrist flexion or extension can cause pressure on the carpal tunnel. (RX 1, p. 26). Dr. Williams explained that Petitioner's statement that she rested her wrists while typing indicated that she could not possibly hold her wrists in a flexed or extended position for any extended period of time while typing. (RX 1, p. 13). Dr. Williams also explained that while the medical evidence available suggests that typing alone does not cause or aggravate carpal tunnel syndrome, typing combined with poor ergonomics could lead to the development or aggravation of carpal tunnel syndrome. Dr. Williams explained that he reviewed the ergonomics of Petitioner's work station and did not find any factors that would aggravate CTS. (RX 1, p. 23-24). Petitioner has a wrist gel pad as well as a mouse pad, and also has a chair with armrests that goes up and down. Dr. Williams also explained that based upon his review of the available facts regarding Petitioner's work, her typing appeared to be intermittent throughout the day. (RX 1, p. 24).

Dr. Williams explained that Petitioner suffered from other comorbid conditions including a post-menopausal state which causes a hormone imbalance in the body that result in changes in the nerve which leads one to have a greater predisposition to developing carpal tunnel syndrome. (RX 1, p. 16). In addition, Petitioner also suffered from uncontrolled hypertension and uncontrolled diabetes. (RX 1, Dep. Ex. 2).

Dr. Sadiiq El-Amin, petitioner's treating physician and surgeon, was deposed and provided an opinion regarding the causal connection between Petitioner's bilateral carpal tunnel syndrome and her work. Dr. El-Amin is a board certified in orthopedics and children's sports medicine. His specialty is in shoulders, sports medicine and upper extremities. (PX 1, p. 5). He testified that he believed that Petitioner's symptoms were

caused or contributed by her repetitive manipulation as described to him by Petitioner over her 37 years with the State. (PX 1, 29).

Dr. El Amin testified that repetitive motion of typing, fine motor or anything in which you extend your wrist or put pressure on your wrist can cause symptoms of carpal tunnel syndrome. (PX 1, p. 31). Dr. El-Amin testified that over time due to compression or extended motion or repetitive motion, there will be inflammation which causes the soft tissue to flare up and narrows the area in the carpal tunnel that the nerve passes through. Nerves rely on getting fluid for electrical charges and if there is decreased fluid, this causes swelling, inflammation and adhesions and prevents the nerve from functioning properly. This causes an individual to lose grip and causes innervation to the muscles over time. (PX 1, p. 33).

Dr. El-Amin testified that he could not say that the duties of typing per se caused the narrowing of the carpal tunnel but rather the act of repetitive motion in typing and the pressure on the wrist. (PX 1, p. 33). Dr. El-Amin testified that the gel pad could help but that there's still pressure stating, "I do think they help at times, but I think a lot of times there's still pressure that still bothers people." (PX 1, p. 34-35). Dr. El-Amin testified that most people type with their palms and wrists down and fingers extended which over long periods of time can cause numbness and tingling. (PX 1, p. 36). Dr. El-Amin stated that he advised Ms. Williams to make some changes and that "[i]t's not about the typing and the position, it's the amount. So that's kind of why you can go back 45 minute intervals, rest, do different things, because you've got to use your hands. You can't go to work and not use your hands. So, you know, educating them about, you know, not about stop typing, but, you know, change your direction, take breaks, don't consistently do things for eight hours at a time." (PX 1, p. 37).

Other than typing, Dr. El-Amin did not know what other activities Petitioner performed at work that might have aggravated her carpal tunnel. Dr. El-Amin did not have any information about how long Petitioner typed per day, and he did not review her work station or a description of her job duties. Dr. El-Amin based his opinion on Petitioner's statements to him that she "does a lot of like typing work, a lot of fine motions, a lot of putting things away." (PX 1, p.43).

Dr. El-Amin testified that because Petitioner did not have peripheral neuropathy, he did not believe Petitioner's diabetic state was related to her carpal tunnel. (PX 1, p. 42).

Dr. El-Amin testified that Petitioner could go back to work as of September 3, 2013. (PX 1, p. 46). Dr. El-Amin testified that he would recommend a functional capacity evaluation to determine what restrictions Petitioner might need. (PX 1, p. 46). Dr. El-Amin did not believe that Petitioner was at maximum medical improvement as of September 3, 2013. (PX 1, p. 47). Dr. El-Amin testified that he could not provide an opinion that the potential diagnosis for cubital tunnel is related to Petitioner's job duties. (PX 1, p. 54).

II. CONCLUSIONS OF LAW

Issue C: Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? *and* Issue F: Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator finds that Petitioner's job duties with Respondent did not cause or aggravate her bilateral carpal tunnel syndrome and that her current condition of ill-being was not caused by her work duties.

An employee bears the burden of proof to establish the elements of the right to compensation. *Board of Trustees of University of Illinois v. Industrial Comm'n* (1969), 44 Ill.2d 207, 214, 254 N.E.2d 522, 526. In order for accidental injuries to be compensable under the Act, a claimant must show such injuries arose out of and in the course of his or her employment. *Caterpillar Tractor Co. v. Industrial Comm'n* (1989), 129 Ill.2d 52,

57, 133 Ill.Dec. 454, 456, 541 N.E.2d 665, 667. Repetitive trauma cases are compensable as accidental injuries under the Illinois Workers' Compensation Act. In *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d. 524, 505 N.E. 2nd 1026, 106 Ill.Dec. 235 (1987), 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 equally important that the medical experts have a detailed and accurate understanding of the Petitioner's job duties.

Petitioner is alleging that her job duty of typing caused or aggravated her bilateral carpal tunnel syndrome. While Petitioner presented evidence regarding her job duties prior to 1995, this information is not relevant to this claim as Petitioner settled a prior claim for bilateral CTS in 1996 and therefore the issues in this case relate to whether or not Petitioner's accident arose out of and in the course of her job duties from 1996 forward and whether or not those job duties caused or aggravated her current condition of ill-being.

Petitioner's testimony showed that her job as a Revenue Tax Specialist III required her sit at a computer for 90% of her day, however, her typing duties were intermittent and required very little actual typing. Petitioner testified that 90% of her job was releasing suspended electronic fund transfer payment and this entailed researching suspended payments in various different programs and systems to try to determine if numerical data was entered incorrectly and to correct that numerical data. Physically this would entail using the mouse to click into different programs and then entering the correct numbers by typing them into the number fields. Petitioner testified that this portion of her job involved primarily entering numerical information into data fields. This does not involve extended periods of rote typing as Petitioner would be required to move from field to field to research the problem and intermittently type to enter the correct information.

Petitioner testified that her other function of entering taxpayer applications requires inputting information from a form into data fields on the computer such as name and address information. Petitioner testified that the largest data field would be the bank information containing the name of the bank and bank address and then she would switch to a different field to add other information. This function involves entering only small bits of data at a time. Petitioner testified that 5% of her job was answering the phones and providing oral information to taxpayers. Petitioner testified that she did not type while performing this job function.

In addition, Petitioner testified that from 1995 to the present, she has had a gel pad. She testified that she still held her wrists on her desk and typed in a similar fashion as before obtaining the pads.

Petitioner's doctor, Dr. Sadiiq El-Amin testified that he never spoke with Petitioner regarding how she typed, never reviewed any information regarding her job duties, and never saw any photographs of her work station. He testified that he relied on Petitioner's statement that she typed and did fine finger manipulation for 37 years. Dr. El-Amin did not know how much of Petitioner's job required typing or how many hours a day she typed. Dr. El-Amin testified that typing for long periods of time or doing an activity repetitively for 8 hours a day could lead to CTS but that he had no information regarding how long or how often Petitioner typed.

In contrast, Dr. Williams obtained a detailed history directly from Petitioner regarding what her job entailed physically. Dr. Williams reviewed photographs of Petitioner's work station, the Demands of the Job form and the Revenue Tax Specialist III job description and Ms. Williams indicated to him that she did found no significant discrepancy. Dr. Williams testified that wrist flexion and wrist extension can cause pressure on the carpal tunnel if those positions are sustained for a prolonged period of time. Dr. Williams concluded, based upon the Petitioner's descriptions and the information that he reviewed, that Petitioner's typing was intermittent

throughout her various work tasks. Dr. Williams also noted that Petitioner suffered from numerous other co-morbid conditions including uncontrolled hypertension and uncontrolled diabetes as well as being postmenopausal.

Dr. El Amin did not have an adequate understanding of the Petitioner's job to form a credible opinion on causation. He testified that his opinion was based on the Petitioner telling him that she did a lot of typing work, a lot of fine motions, a lot of putting things away. (PX 1 at 43) He did not know that her typing work only involved using a mouse to switch screens, typing in numbers and occasionally names and addresses. Dr. Williams had a much better understanding of the job, and his opinions are entitled to more weight.

The Arbitrator finds that Petitioner has not met her burden to show that her bilateral carpal tunnel syndrome arose out of or in the course of her job duties as a Revenue Tax Specialist III and further the Arbitrator cannot conclude that the condition of ill-being is causally related to her work activities. Therefore all other issues are 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

Jeremy C. Pas,

Petitioner,

vs.

NO: 13 WC 3546

Village of Woodlawn,

14IWCC0647

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, 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 December 5, 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.

14IWCC0647

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: AUG 0 1 2014
TJT:yl
o 7/29/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

PAS, JEREMY C
Employee/Petitioner

Case# **13WC003546**

VILLAGE OF WOODLAWN
Employer/Respondent

14IWCC0647

On 12/5/2013, 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 0.10% 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:

4689 HASSAKIS & HASSAKIS PC
JOSHUA A HUMBRECHT
206 S 9TH ST SUITE 201
MT VERNON, IL 62864

0299 KEEFE & DePAULI PC
DENNIS O DOUGLAS
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

STATE OF ILLINOIS)
SS.)
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JEREMY C. PAS
Employee/Petitioner

v.

VILLAGE OF WOODLAWN
Employer/Respondent

Case # 13 WC 03546

Consolidated cases: N/A

14IWCC0647

An *Application for Adjustment 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 **October 3, 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 services?
K. ☒ Is Petitioner entitled to any prospective medical care?
L. ☐ What temporary benefits are in dispute?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other ___

FINDINGS

On the date of accident, **April 19, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

14IWCC0647

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

In the year preceding the injury, Petitioner earned **$36,036.59**; the average weekly wage was **$693.01**.

On the date of accident, Petitioner was **37** 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 **$N/A** for TTD, **$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 credit for payments made by petitioner's major medical coverage under Section 8(j) of the Act.

ORDER

Respondent shall authorize and pay for the surgery recommended by Dr. Freehill as well as any subsequent reasonable and necessary treatment related to petitioner's post-operative recovery.

Respondent shall pay reasonable and necessary medical services as provided in Sections 8(a) and 8.2 of the Act to OCSI, Mulvaney Rehab, InMed Diagnostics and Dr. Cox

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

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

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

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

Signature of Arbitrator

12/2/13
Date

DEC 5 - 2013

14IWCC0647

FINDINGS OF FACT

Petitioner Jeremy C. Pas filed his Application for Adjustment of Claim alleging he sustained injuries to his right shoulder while employed with respondent, Village of Woodlawn on April 19, 2012. At the time of his injury, petitioner was employed with respondent for approximately ten (10) years doing a variety of public works for the Village of Woodlawn.

Petitioner testified that on Thursday, April 19, 2012 at the end of his shift, he was attempting to exit and descend a backhoe. His left arm was on the handrail and his right arm was on the window space. As he stepped down the two stairs, he felt a pulling sensation in his right upper extremity's shoulder region. He testified that the bulk of his body weight rested on his upper extremities as he climbed. He testified he was over six feet tall and approximately 260 to 270 pounds. Petitioner's supervisor was in a work truck waiting for petitioner. Petitioner testified that he commented about the pull in his shoulder to Jerry Hart, his immediate supervisor, on April 19, 2012 as they were seated in the truck. He testified that Mr. Hart made no response. Petitioner testified that at the time he believed he simply pulled a muscle or tweaked something, but did not believe that he suffered serious injuries, let alone injuries that would necessitate surgery. He went home from work without further discussion of the incident.

Prior to his injury on April 19, 2012, petitioner scheduled a vacation days for Friday, April 20, 2012, Monday, April 23, 2012 and Tuesday, April 24, 2012. The purpose was that the weekend marks the beginning of turkey hunting season and this is something he does annually.

Petitioner testified when he awoke on Friday, April 20, 2012 his right shoulder was painful. He had limited range of motion. He iced his shoulder and took over-the-counter pain medication. He testified he did not go turkey hunting. His family physician, Dr. Cox, noted on April 25, 2012, "he wasn't able to do the activity he had intended for the day." (Px1). On Saturday, April 21, 2012 petitioner's arm was still very stiff and felt as though needles inside the upper arm were jabbing into his shoulder. That same day, a bruise appeared in the area of pain and as of April 25, 2012 the bruise had faded, but was still visible. (Px1) He spent those days largely resting. (Px1)

Dr. Cox's April 25, 2012 office note confirmed objective findings in Petitioner's right shoulder. Dr. Cox noted aging bruising and swelling. Dr. Cox noted pin point tenderness in the anterior shoulder as well with decreased range of motion. Dr. Cox ordered an MRI of the right shoulder, referred petitioner to an orthopedic specialist due to suspected biceps rupture and prescribed Ibuprofen 800mg. That same treatment note also stated that petitioner had a prior incident in August, 2011 involving his right shoulder. He did not file a claim. He did not seek medical treatment. Petitioner and his supervisor confirmed he never missed work and he never had any work restrictions or inability to perform job duties following the August, 2011 event.

Petitioner attended an appointment with Dr. Angela Freehill at the Orthopaedic Center of Southern Illinois on May 1, 2012. She reviewed the prior MRI. She recommended a regimen of therapy, light-duty restrictions and follow-up in two months time. Petitioner participated in structured therapy with Mulvaney Rehab from May 7, 2012 and through August 27, 2012. (Px5) On July 10, 2012, Dr. Freehill ordered a repeat MRI due to the poor quality of the first. The MRI was performed July 17, 2012. It showed evidence of a proximal biceps tendon rupture, probable subscapularis tear and a tear across the base of his superior labrum as well as glenohumeral joint effusion. Dr. Freehill recommended a fluoroscopic guided injection of cortisone. Surgery was discussed, but the election was made to continue conservative intervention. (Px2) On August 28, 2012 Dr. Freehill noted conservative efforts failed and she recommended an arthroscopy, with labral repair and/or subscapularis repair, if necessary. (Px2)

From April 25, 2012 through October, 2012, petitioner's care and treatment was authorized by respondent. At some point during the fall of 2012, respondent obtained a notification, from the Illinois Department of Natural Resources, that petitioner tagged a turkey on April 20, 2012. (Rx3) Respondent terminated all of petitioner's benefits. Respondent offered into evidence a printout from the Department of Natural Resources, which showed petitioner hunted and harvested three (3) deer between August, 2011 and December, 2011. (Rx3)

14IWCC0647

Petitioner testified that he was not turkey hunting on April 20, 2012. On that day, he struck a turkey with his automobile. He had a tag which he applied for months prior to his injury, so he tagged the turkey after he struck it with his automobile. He did not want to simply let what was an otherwise good animal go to waste. He believed that leaving it would be wrong. He testified that he reported the turkey in the afternoon. The Department of Natural Resources shows an entry April 20, 2012 at 2:58:45 P.M. (Rx3)

Petitioner testified he did not move anything, fall or otherwise suffer any type of injury to his shoulder following April 19, 2012. The only source of injury to his shoulder was the work event. There is no medical evidence in the record indicating that petitioner suffered an injury elsewhere, or that the work injury, as described by petitioner, happened in any way other than what is testified to and reported by petitioner.

Petitioner's supervisor, Jerry Hart testified regarding the timeline of events. He claimed that he did not recall petitioner telling him that he felt a pull in his shoulder on April 19, 2012 prior to the shift ending. He admitted that while in the truck petitioner's right shoulder would have been against the passenger side door, not facing toward him. Mr. Hart admitted that he had a hard time with hearing. At trial he demonstrated the same in response to a question by respondent's counsel when he provided an answer that was completely different than what was asked of him. Mr. Hart testified to alleged conversations on April 19, 2012 and April 25, 2012 but could not even recall whether petitioner was on a backhoe or not on April 19, 2012, yet admitted during that the pair were in a truck at the end of the day and that the truck was right next to the building where the backhoe is placed. Mr. Hart claimed that he first learned of the injury when petitioner came to him the morning of April 25, 2012. He claimed that petitioner was not sure what happened to his shoulder but then reappeared later in the day and stated it happened on the backhoe. Mr. Hart confirmed no documentation was ever made, nor was petitioner ever confronted about the alleged initial conversation when he allegedly stated "he did not know" what happened. Mr. Hart testified that on April 25, 2012 petitioner provided a history consistent with all the medical records (Px1, Px2 and Px5), Respondent's form 45 (Px7) and petitioner's version regarding how the injury took place. Mr. Hart also confirmed that prior to April 19, 2012 petitioner always performed all job duties asked of him and was not working under any restrictions whatsoever.

Sallie Mink handles the filings for workers' compensation claims for respondent. She testified that on April 25, 2012 petitioner provided the same history of injury consistent with all the medical records, petitioner's testimony and respondent's form 45. While she was suspicious of the timeline, (petitioner being on vacation), her suspicion was based on information from Mr. Hart - specifically, that petitioner never said anything to Mr. Hart on April 19, 2012. She conceded that she had no evidence that petitioner suffered any injury elsewhere.

Petitioner's wife testified that when her husband arrived home the evening of April 19, 2012 she learned of the incident on the backhoe. She knew he was hurt the day the incident took place. She also knew that the following day petitioner and a friend went to his friend's parent's house to retrieve a sling to elevate his arm. She testified that petitioner and his friend struck a turkey on the roadway between their home and the friend's parent's home and that the turkey was brought back to her house.

The parties stipulated to the admission of written reports from petitioner's treating physician, Dr. Freehill and respondent's §12 examiner, Dr. Richard C. Lehman, (Px6) and (Rx2) respectively.

Dr. Freehill provided an opinion letter which stated that an abduction type injury to the shoulder, with a sensation of pulling in the shoulder, caused petitioner's ultimate diagnosis of labral tear and biceps tendon rupture while descending the backhoe. She opined that surgery is an appropriate modality of treatment given the failure of conservative care. Her physical exam findings on May 1, 2012 were corroborated by the findings on his MRIs. It was her opinion that the tear in his shoulder was caused by the described work activity on April 19, 2012 and his current need for surgery is related. (Px6)

Petitioner attended an IME with Dr. Richard Lehman. Dr. Lehman opined in a report dated April 30, 2013 that the MRIs demonstrated a complete tear of the biceps tendon with distal retraction; subscapularis tendinosis with a small poorly defined tear at his bony insertion; a tear across the base of his superior labrum with poorly defined fraying and a tear in the superior posterior labral substance. He opined that the mechanism of injury described by petitioner is consistent with a

14IWCC0647

biceps tendon tear and possible rupture of the subscapularis tendon. He believed petitioner was a candidate for arthroscopic surgery. He believed it was "unreasonable" that petitioner waited six (6) days prior to seeking out treatment. If respondent's argument is that petitioner was injured on April 20, 2012 hunting (there is no evidence of that), which it appears to be, then in any event petitioner waited five (5) days, rather than six (6) days prior to seeking treatment. His belief that petitioner "would have sought treatment immediately" is given little weight. Clearly, this petitioner took a wait and see approach prior to going to a doctor. Petitioner's explanation was that he simply thought he pulled something or tweaked a muscle, and while painful, he did not immediately file a workers' compensation case or run to a doctor. That is not unreasonable conduct. He reported his injury within the statutorily required time period, which respondent stipulated to. Dr. Cox's office note dated April 25, 2012 clearly documented that petitioner struggled with his shoulder from April 20, 2012 through April 24, 2012. (PxI) Moreover, Dr. Lehman noted that an injury while turkey hunting would be necessary to attribute the findings on the MRI. The mere act of hunting a turkey would not, in and of itself, explain or cause the injuries demonstrated on petitioner's MRIs.

CONCLUSIONS OF LAW

1. Petitioner sustained his burden of proof that he suffered an accident that arose out of and in the course of his employment. The Arbitrator finds that the Petitioner credibly testified about the incident that occurred on April 19, 2012 and gave a credible explanation regarding the facts involving how he came upon a turkey on the weekend following his work accident. Respondent disputes this claim based on the testimony of Petitioner's supervisor, Mr. Hart, that Petitioner did not tell him about his injury on the date of accident. However, the Arbitrator is not persuaded by Mr. Hart's testimony in light of the facts that he admitted he is hard of hearing; he failed to document any of the alleged inconsistencies he claimed petitioner told him; admitted that he never confronted petitioner about what would amount to insurance fraud; and he was unable to even recall if petitioner was on a backhoe on April 19, 2012. The arbitrator is not convinced, nor does the evidence support, that petitioner staged an elaborate plot to commit insurance fraud by making up a series of events to have a compensable workers' compensation claim. The medical records corroborate the Petitioner's description of how he sustained his injuries. There is no evidence indicating an alternative time, source or place of injury. No medical record contradicts petitioner's version of events, or the timeline of events. Even assuming, *arguendo*, that petitioner did go hunting on April 20, 2012, respondent's own IME noted that even if petitioner were to have turkey hunted that day, there would have to be some "other injury" not just the mere act of turkey hunting itself. Petitioner's decision to utilize a turkey tag he had previously purchased from the State for marking road kill, while decidedly inconvenient and the cause of much dispute, does not amount to a finding that petitioner did not suffer an accident that arose out of and in the course of his employment. Conclusions cannot be based upon conjecture, guess or speculation, but must be supported by facts or evidence. The totality of the evidence supports that petitioner suffered an accidental injury on April 19, 2012.

2. The petitioner sustained his burden of proof regarding the issue of causation. The Arbitrator finds that the petitioner's current condition of ill-being is related to his injury on April 19, 2012. In support of this finding are the opinions of Dr. Freehill and Dr. Lehman. Both support that petitioner's injury is consistent with the mechanism of injury described. Dr. Freehill testified it was her opinion, to a reasonable degree of medical certainty that the shoulder injuries were causally related to the April 19, 2012 work event.

3. Based on the Arbitrator's findings regarding the issues of accident and causation, the petitioner's treatment to date is reasonable and necessary. Accordingly, the respondent shall pay any related medical expenses incurred to date subject to the fee schedule in accordance with Sections 8(a) and 8.2 of the Act. Respondent shall further authorize and pay for the surgical treatment as recommended by petitioner's treating physician.

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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KENNETH ROBINSON,

Petitioner,

vs.

NO: 13 WC 07510

14IWCC0648

STATE OF ILLINOIS / PINCKNEYVILLE CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident arising out of and in the course of the employment, causation, medical expenses and permanency, and being advised of the facts and the law, reverses the Decision of the Arbitrator as stated below.

The Commission finds, based on a review of all of the evidence in the record, that the Petitioner sustained accidental injury to his left middle finger arising out of and in the course of his employment on April 8, 2011. The Petitioner testified that he had been assigned to the inmate dining room, and when he went to pull a door open to the "dish room", it was stuck in some fashion, requiring him to pull it twice with two hands to get it open. At that time his left middle finger "dislocated or popped." (Tr. 12).

According to the Petitioner, the door to the dish room would become tight during meals due to the humidity generated inside. He testified that he previously put in a work order to shave the doors to prevent this, but was told there wasn't much that could be done because the doors

were steel. He also testified that he notified Respondent's Major Spiller about the problem with the door. The Respondent did not present any testimony with regard to the condition of this door.

The Central Management Services Notice of Injury (Respondent's Exhibit 2), dated April 8, 2011, states that Petitioner injured his left middle finger opening a dietary door, feeling a "pop" like the finger dislocated. The Supervisor's Report of Injury (Respondent's Exhibit 3) indicates the Petitioner injured his left middle finger pulling on the dining room entrance, and as to the cause of the accident, "none known but dietary doors are heavy". An incident report completed by Respondent on April 11, 2011 (Respondent's Exhibit 4) notes the Petitioner was pulling on the dietary door with both hands, and felt a snap in the middle finger and wrist.

He originally sought treatment at the Center for Medical Arts (Petitioner's Exhibit 3) on April 8, 2011, reporting that he injured his left middle finger that morning opening a door. He complained of pain, swelling and tingling up to his elbow. X-ray was negative for fracture. Petitioner then sought treatment with Dr. Davis at the Orthopedic Center of Southern Illinois on April 11th. Petitioner noted he had treated there a month prior for concerns regarding the ulnar nerve and carpal tunnel syndrome. (Petitioner's Exhibit 4). Left middle finger MRI on May 23, 2011 was unremarkable, but the study was limited by motion artifact. On June 17, 2011 the Petitioner saw Dr. Golz at the same facility, and the note states he was there for longstanding bilateral upper extremity complaints of dysesthesias, left greater than right, while Dr. Davis was treating Petitioner specifically for the left middle finger. On June 23, 2011 Dr. Davis indicated Petitioner was 80% improved, had a normal examination, and was working full duty. The diagnosis was MCP collateral ligament sprain. Dr. Davis stated: "I anticipate a full recovery without sequelae." By August 4, 2011, Petitioner was working without difficulty, and other than an occasional sharp twinge through the finger, was doing well. There was no swelling, he had good grip strength and he was released from care to follow up if he had recurrent symptoms.

Petitioner testified he continues to have ongoing stiffness, weakness and pain in the left middle finger, but has not sought treatment since his release from care. He no longer works at Pinckneyville following a transfer to a satellite boot camp facility.

The Petitioner was clearly in the course of his employment at the time of his injury. The Commission finds that the evidence supports a finding that the door Petitioner was opening on April 8, 2011 was difficult to open, regardless of whether it was due to the door sticking or due to the weight of the steel door, and that this difficulty increased the risk of injury as a result of his employment with Respondent. Given the increased risk, the Commission finds the Petitioner sustained accidental injury to the left middle finger which arose out of and in the course of his employment with the Respondent.

The Commission further finds that the Petitioner's left middle finger injury, involving an MCP collateral ligament sprain, is causally related to the April 8, 2011 accident. The chain of events indicates he had no specific prior problem with the left middle finger, felt a "pop" in the

finger when he opened the door with immediate pain and swelling, and subsequently underwent treatment for the finger until a final release from care on August 4, 2011.

Based on the findings of accident and causation, the Commission awards Petitioner the medical expenses listed in Petitioner's Exhibit 1 which relate specifically to the left middle finger treatment only. This award is subject to the limitations dictated by the Fee Schedule contained in Section 8.2 of the Act, and the Respondent is entitled to Section 8(j) credit for any of the noted bills that were previously paid pursuant to this section, if any.

The Commission finds that Petitioner has sustained no permanent disability to the left middle finger as a result of the April 8, 2011 accident. This injury involved a minor sprain that essentially resolved by August 4, 2011. The Commission notes with interest that, according to the parties, the Petitioner has a separate pending claim on review with regard to repetitive trauma injuries to the upper extremities which also involves symptoms in ulnar and median nerve distributions in multiple fingers bilaterally, left greater than right. (see Tr. 4-6, Dr. Davis' May 31, 2011 and Dr. Golz' June 17, 2011 reports in Petitioner's Exhibit 4).

Because the Respondent in this matter is the State of Illinois and the decision of the Commission is thus not subject to judicial review pursuant to Section 19(f)(1) of the Act, no bond is indicated in this decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator is reversed as indicated herein, as the Petitioner sustained accidental injury arising out of and in the course of his employment with the Respondent on April 8, 2011.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the causally related medical expenses contained in Petitioner's Exhibit 1 under §8(a) of the Act, subject to the Fee Schedule contained in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner failed to prove he sustained permanent disability pursuant to Section 8 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 is entitled to a credit, if any is applicable, under §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

14IWCC0648

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: AUG 0 1 2014
TJT: pvc
o 06/03/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Holly Comer,

Petitioner,

vs.

NO: 13 WC 14872

14IWCC0649

State of Illinois-IYC Harrisburg,

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, 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 December 5, 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.

14IWCC0649

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: AUG 0 1 2014
TJT:yl
o 7/29/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

COMER, HOLLY
Employee/Petitioner

Case# **13WC014872**

SOI/IYC HARRISBURG
Employer/Respondent

14IWCC0649

On 12/5/2013, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

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

0558 ILLINOIS ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

0498 STATE OF ILLINOIS
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

DEC 5 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0649

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)

Holly Comer
Employee/Petitioner

v.

State of Illinois/IYC Harrisburg
Employer/Respondent

Case # **13** WC **14872**

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 **October 3, 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 ___

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FINDINGS

On the date of accident, **8/2/12**, 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 $**70,380.00**; the average weekly wage was $**1,353.46**.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as outlined in Petitioner's group exhibit. Respondent shall have credit for any amounts previously paid through its group carrier and shall hold Petitioner harmless from any claims made by any healthcare providers for which Respondent is receiving this credit, as provided in §8(j) of the Act.

Respondent shall authorize and pay for the treatment recommended by Dr. Paletta.

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

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

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

Signature of Arbitrator

11/25/13
Date

ICArbDec19(b)

DEC 5 - 2013

14IWCC0649

FINDINGS OF FACT

Petitioner is employed as a Juvenile Justice Specialist at IYC Harrisburg. On August 2, 2012, Petitioner sustained traumatic injuries to her right arm and shoulder while reporting to her morning assignment. She was on her way to the control center when she slipped and fell on something "really slick" and tried to catch herself. Petitioner testified that she had no treatment, doctor visits, or workers' compensation claims for her right arm prior to the August 2, 2012 accident. Respondent disputes accident, causation and prospective medical care.

Petitioner completed and submitted an Employee's Notice of Injury on which indicates that she was "reporting to [her] assignment" when she "slipped on an unknown substance that was on the floor." (RX1). She characterized the floor as "very slick." (RX1). The Employer's first report of injury that was prepared by CareSys Inc. indicates that Petitioner was "walking to her post and slipped on furniture polish." (RX1). The "Object or substance responsible when illness or injury occurred" was listed as "Furniture Polish." (RX1). A witness report also documents that Petitioner "slipped on the wet floor in the control room area." (RX1). An incident report completed by the witness states: "On the above date & app. Time this JJ spec observed JJ spec Holly Comer slip & fall injuring her right arm/elbow while reporting to her control room assignment. The floor appeared to be wet/slippery. End of report." (RX1). The Workers' Compensation Preliminary Medical Report again documents Petitioner slipping in a substance on the floor: "Slipped on floor after stepping in unknown substance (polish) on floor." (RX1). Petitioner testified at arbitration that the polish referenced was Pledge that got on the tile floor as a result of the staff cleaning on second shift. She testified that to her knowledge, Pledge was never used prior to that day. She became aware of the identity of the substance by asking what was on the floor and was informed by staff that someone used Pledge.

Respondent called Officer Kurt Sutton as its witness. Officer Sutton is a Juvenile Justice Supervisor and has been employed at IYC Harrisburg for 23 and-a-half years. He testified that Pledge is not an allowed caustic substance within the facility. He testified, however, that he had no firsthand knowledge of the incident. (T.23). He further testified that he did not perform an investigation of the incident, as he was completely unaware that it occurred.

When Petitioner's symptoms persisted following the accident, Petitioner reported to Hardin County General Hospital Emergency Room on August 9, 2012 with right forearm pain and tenderness in her right biceps tendon. (PX3, 8/9/12). The records consistently documented the mechanism of injury and contain an initial workers' compensation medical which indicated that Petitioner slipped on a slick spot. *Id.* X-rays were negative. *Id.* Petitioner was referred for a physical therapy evaluation for a right forearm sprain and right biceps tendonitis. *Id.* She was given Naproxen for pain. *Id.* The physician work recommendation indicated that Petitioner was unable to return to her assignment due to her injury and the nature of her clerical job duties. *Id.* Petitioner, however, continued to work and did not claim TTD benefits.

Physical therapy and medication failed to resolve Petitioner's symptoms. (PX3, 2/15/13). On May 13, 2013, Petitioner reported to orthopedic specialist Dr. George Paletta. (PX5, 5/13/13). Petitioner had not missed a day of work since the injury. *Id.* at p.1. Dr. Paletta documented the history of Petitioner's injury her initial onset of symptoms. *Id.* Petitioner had no identifiable pre-existing elbow or shoulder conditions. *Id.* at p.3. He noted the gradual migration of Petitioner's pain from her elbow to her shoulder region with radicular pain into her forearm during physical therapy, and the absence of any associated neck complaints. *Id.* at p.1. He noted on the second page of his report that the extent of soft tissue contusion on her elbow may have overridden her shoulder pain. *Id.* at p.2. Physical examination revealed tenderness along Petitioner's bicipital grove, positive Speed's and Jorgenson's signs, positive impingement signs, including both the Neer and Hawkins signs, pain with

rotation above 140 degrees, discomfort on resisted supraspinatus testing and some tenderness at the common extensor tendon origin at the lateral epicondyle. *Id.* at p.1-2. Dr. Paletta's impression was mild right lateral epicondylitis and right shoulder pain with possible secondary biceps tendonitis. *Id.* at p.2. He noted that Petitioner's primary subjective complaints and physical exam findings appeared to be related to the shoulder and recommended an MRI. *Id.* at p.2. He believed that Petitioner's current right upper extremity complaints were causally related to the incident that occurred on August 2, 2012. *Id.* at p.2-3. The radiologist's report of the MRI done on May 20, 2013 demonstrated evidence of a type II SLAP tear, fraying of the anterior labrum, and a questionable small loose body in the inferior joint recess. (PX5, 5/24/13; PX6, 5/20/13). After reviewing the image personally, Dr. Paletta noted the existence of a large SLAP tear that would not likely improve with injection or physical therapy. Dr. Paletta has recommended surgery. (PX5, 5/31/13).

Petitioner testified at Arbitration to persistent aching in her arm with a burning sensation that radiates down her forearm. She wishes to undergo the surgery recommended by Dr. Paletta. Respondent did not have Petitioner examined under §12 of the Act, nor did it present any contrary opinion on the issue of causation.

CONCLUSIONS OF LAW

1. Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent. Petitioner's report of falling as a result of stepping in a slippery substance on Respondent's premises is consistent throughout the record and the occurrence of her injury is unrebutted. The Arbitrator gives great weight to the witness report which documents that Petitioner slipped on a wet floor, and a narrative incident report completed by the witness that states, "The floor appeared to be wet/slippery." (RX1). Although Respondent disputes that the substance was Pledge due to the fact that it is not an approved caustic substance on the premises, the identity of the substance has no bearing on whether Petitioner's are compensable or not. Respondent's witness testified that he did not perform an investigation of the incident, as he was completely unaware that it occurred. Thus, the Arbitrator relies on the uncontroverted evidence in Respondent's exhibits, which clearly indicates that Petitioner slipped on a substance and sustained accidental injuries that "arose out of" her employment with Respondent.

2. Petitioner's current condition of ill-being is causally related to her work accident. The evidence presented by Petitioner is credible and the record is void of any other explanation for Petitioner's current condition and symptoms. The Arbitrator therefore makes a conclusion based on the evidence in the record pursuant to §1.1(e) of the Act, and finds that Petitioner's current condition of ill-being is causally related to the accident of August 2, 2012. Petitioner had no treatment, doctor visits, or workers' compensation claims for her right arm prior to the August 2, 2012 accident. Dr. Paletta provided the only medical opinion supporting causation, which was not rebutted by Respondent.

3. Based on the Arbitrator's findings regarding the issues of accident and causation, Respondent is liable for the medical bills pertaining to Petitioner's work injury and shall continue to provide necessary medical care required to cure and relieve the effects of Petitioner's injury as required by §8(a) of the Act. The Arbitrator finds that Petitioner's care and treatment from the outset has been conservative and reasonable. Petitioner has attempted to resolve her symptoms with medication and several courses of physical therapy. (PX3). Physical therapy and medication failed to resolve Petitioner's symptoms. (PX3, 2/15/13). Petitioner testified at Arbitration to persistent aching in her arm with a burning sensation that radiates down her forearm. This is corroborated by her final physical therapy note. (PX3, 2/15/13). Dr. Paletta stated that Petitioner's SLAP tear would not likely improve with injection or physical therapy and consequently recommended surgery. (PX5, 5/31/13). Petitioner wishes to proceed. Respondent is hereby ordered to pay the medical bills contained in

14IWCC0649

Petitioner's group exhibit and to authorize and pay for the treatment recommended by Dr. Paletta, including but not limited to the surgery. Respondent shall have credit for any amounts previously paid through its group carrier and shall hold Petitioner harmless from any claims made by any healthcare providers for which Respondent is receiving this credit, as provided in §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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott Trone,

Petitioner,

vs.

NO: 07 WC 48620

14IWCC0650

Kiewit Construction Company,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of 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 August 20, 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.

14IWCC0650

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $34,300.00. 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: AUG 0 1 2014
TJT:yl
o 6/2/14
51

Kevin W. Lamborn

Michael J. Brennan

DISSENT

Respectfully, I dissent from the majority's decision in finding that the condition of ill-being in Petitioner's left knee necessitating mensical transplant and anterior cruciate ligament surgery were not causally related to his October 2, 2006 work accident.

This finding was made despite the fact that it was undisputed that Petitioner sustained a twisting accident with his left knee while doing his iron work on October 2, 2006. Also undisputed is the fact that Petitioner had a preexisting condition in his left knee, including an ACL tear and a medial meniscus that had been surgically repaired in 2002.

There is no evidence or testimony to dispute that Petitioner worked full duty as an ironworker from August 2002 through October 2006 without any medical treatment for his left knee. So, it boils down to whether or not the 2006 work accident aggravated the preexisting condition of the medial meniscus in his left knee, which led to the need for multiple surgeries and caused the current condition of that knee.

As in most cases, there are two different opinions, one offered by Petitioner's treating orthopedic surgeon Dr. Michael Merkley, and the other by Respondent's Section 12 examiner, Dr. Steven Mash. It became patently clear that the most logical and well reasoned opinion was offered by Dr. Merkley, the treating surgeon. A review of the testimony revealed that Respondent's Section 12 examiner, Dr. Mash, although familiar with, had never even performed a meniscal transplant procedure himself. He testified he would refer those in need to Rush University Hospital. Dr. Mash felt this procedure was for younger men. However, this injured worker was only 37 years of age. Despite the undisputed facts of the work injury, Dr. Mash maintained that Petitioner's current condition was not related to the 2006 injury. It boggles the mind and defies logic that a Section 12 examiner would take that position in light of the facts of this case.

14IWCC0650

Therefore, I urge the Commission to reconsider. I would insist on the employer paying all remaining and outstanding medical bills, and temporary total disability benefits after October 6, 2010. I would find that Petitioner is due temporary total disability benefits from November 4, 2006 through February 18, 2007 and from October 6, 2010 through March 7, 2011. Lastly, based upon all the medical records and testimony in this matter, including a meniscal transplant and ACL reconstruction, a finding that Petitioner has sustained a 60% loss of his left leg is fair and just.

Thomas J. Tyrrell, Commissioner

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TRONE, SCOTT
Employee/Petitioner

Case# **07WC048620**

KIEWIT CONSTRUCTION COMPANY
Employer/Respondent

14IWCC0650

On 8/20/2013, 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 0.07% 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

0410 PEREGRINE STIME NEWMAN ET AL
DALE BRUCKNER
221 E ILLINOIS ST BOX 564
WHEATON, IL 60187

14IWCC0650

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

SCOTT TRONE
Employee/Petitioner

v.

KIEWIT CONSTRUCTION COMPANY,
Employer/Respondent

Case # 07 WC 48620

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 20, 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: _____

14IWCC0650

FINDINGS

On **October 2, 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 alleged accident *was* given to Respondent.

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

In the year preceding the injury, Petitioner earned **$71,645.08**; the average weekly wage was **$1,377.79**.

On the date of accident, Petitioner was **35** years of age, *married* with **no** dependent children under 18.

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 **$13,212.05** for TTD, **$ 0.00** for TPD, **$ 0.00** for maintenance, and **$ 0.00** for other benefits, for a total credit of **$13,212.05**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$918.52**/week for **15-2/7** weeks, commencing **November 4, 2006** through **February 18, 2007**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$619.97**/week for **53.75** weeks, because the injuries sustained caused the **25%** loss of use of his **left leg**, as provided in Section 8(e) of the Act.

Petitioner is now entitled to receive from Respondent compensation that has accrued from **October 2, 2006** through **February 20, 2013**, and the remainder, if any, of the award is to be paid to Petitioner by Respondent 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 JOANN M. FRATIANNI

August 14, 2013
Date

AUG 20 2013

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

Petitioner testified he worked for Respondent as an ironworker. On October 2, 2006, while bolting a connection using impact bolts, he twisted his left knee. Petitioner experienced immediate pain, dropped his wrench and notified his supervisor. Following this, he continued to work the rest of his shift.

The next day Petitioner was given light duty work and experienced increased swelling in his left knee. Petitioner testified that he suffered a left knee injury 5 years ago while playing rugby. At that time Dr. Merkley diagnosed a left medial meniscus tear that was surgically repaired. Petitioner also suffered preexisting chronic anterior cruciate ligament laxity.

On October 5, 2006, Petitioner underwent x-rays at Pekin Hospital. Dr. Merkley reviewed the x-rays on October 13, 2006 and kept him on light duty. Petitioner continued to work light duty until November 13, 2006, when Dr. Merkley performed surgery in the form of an arthroscopic repair of the left medial meniscus. During that procedure, Dr. Merkley removed the torn portion of the posterior horn of the medial meniscus.

Post surgery, Petitioner underwent physical therapy and on February 16, 2007, Dr. Merkley released him to return to regular work as an ironworker with no restrictions. Petitioner testified that following this date, he continued to use a leg brace.

Petitioner returned to see Dr. Merkley 10 months later. During that time, he worked for a number of iron working firms, but not for Respondent. Petitioner testified that he experienced increasing pain in his left knee. Following this appointment, Petitioner did not see Dr. Merkley again until May 22, 2009.

On October 6, 2010, Petitioner underwent additional surgery to his left knee with Dr. Merkley in form of a anterior cruciate ligament repair and meniscal transplantation. Post surgery, he again underwent a period of therapy.

Petitioner last saw Dr. Merkley on June 20, 2011. On that date Petitioner was released to full duty work and was advised to return as needed.

Dr. Merkley testified by evidence deposition that it was his opinion that the surgery performed on November 13, 2006 was related to Petitioner's work injury of October 2, 2006. During that surgery, Dr. Merkley testified that he identified a focal chondral defect in the articular cartilage. The doctor indicated that he did not know if that chondral defect was caused by the October 2, 2006 accident. Dr. Merkley testified that Petitioner had a long-standing anterior cruciate ligament deficiency that he felt was not caused by the October 2, 2006 accident. Dr. Merkley felt that if Petitioner were to undergo a meniscal transplantation procedure, then that surgery would need to include an initial repair of the anterior cruciate ligament deficiency in order to stabilize the knee.

Dr. Merkley testified that long before the October 2, 2006 injury, he advised Petitioner of the benefits of a anterior cruciate ligament reconstruction. Because of the recovery period involved, Petitioner had previously declined to undergo such a procedure. Dr. Merkley was of the opinion that it would not be medically reasonable to transplant the meniscus without first treating the longstanding anterior cruciate ligament deficiency.

Dr. Merkley testified he would need to review an arthroscopic examination of the left knee before determining whether or not an anterior cruciate ligament reconstruction and meniscal transplantation would be appropriate. Dr. Merkley felt that as of February 16, 2007, Petitioner was able to return to work as an ironworker. On that date, Petitioner had no knee effusion and full range of motion with good quadriceps tone.

Petitioner then saw Dr. Merkley in June of 2008, May 22, 2009 and October 6, 2010. Examination in June of 2008 revealed mild tenderness over the medial joint line that Dr. Merkley felt was of no significance. Petitioner asked about changing jobs and Dr. Merkley felt he could work the new job he was seeking.

On May 22, 2009, Dr. Merkley mentioned the possibility of a meniscal transplant to Petitioner. Dr. Merkley felt that stress applied to the left knee over the course of the past two years while working elsewhere as an ironworker, placed increased strain on the knee joint. Petitioner reported pain that had noticeably increased over the past few weeks while working as an ironworker for a different employer. Dr. Merkley testified that Petitioner would require a repeat physical examination and diagnostic arthroscopy before consideration of a meniscal transplantation.

Dr. Merkley testified that meniscal transplants he previously performed over the past three years involved individuals younger than Petitioner. Dr. Merkley testified that he had previously performed 20 meniscal transplantations and described this surgery as being "huge."

Dr. Merkley testified that when he last saw Petitioner on June 20, 2011, he did not think any further treatment was necessary and he merely advised him to come back and see him if he had any problems.

Dr. Steven Mash testified by evidence deposition on behalf of Respondent. Dr. Mash was of the opinion that the meniscal transplantation surgery was not reasonable and necessary and was not caused by the October 2, 2006 accident. Dr. Mash testified he examined Petitioner on December 10, 2008. Dr. Mash testified that he was familiar with the meniscal transplantation surgery, but that he never had performed one. Dr. Mash testified that very few orthopedic surgeons who perform such a surgery, and such procedures are almost exclusively performed at academic medical centers. Dr. Mash testified this surgery is not experimental, but is part of an evolving technology and is not performed very often.

Dr. Mash testified that Petitioner suffered a prior anterior cruciate ligament deficiency due to a rugby injury five years earlier. Dr. Mash following examination on June 7, 2011, diagnosed chronic left anterior cruciate ligament insufficiency. Dr. Mash testified it was his opinion the first surgery performed on November 13, 2006 was appropriate. Dr. Mash testified it was his opinion the meniscal transplant surgery was quite an aggressive approach for a patient the age of Petitioner, and noted such surgery is typically reserved for young patients, mostly teenagers. Dr. Mash did feel that ligament reconstruction would have significantly reduced Petitioner's symptoms.

Dr. Mash felt it was possible the accident of October 2, 2006 might have aggravated an underlying condition, he felt within a reasonable degree of medical certainty there is not any probable causal connection to the underlying conditions.

Based upon the above, the Arbitrator finds the initial left medial meniscus tear and surgery to repair same on November 13, 2006 is causally related to the injury of October 2, 2006.

Based upon the above, the Arbitrator finds that the meniscal transplantation surgery performed on October 6, 2010 is not causally related to the injury of October 2, 2006.

Based further upon the above, the Arbitrator finds the anterior cruciate ligament stabilization surgery to address the ACL deficiency that existed since 2002, is not causally related to the injury of October 2, 2006, nor was this condition aggravated by this accident.

Based further upon the above, the Arbitrator finds the condition of the deficient ACL was not causally related to the injury of October 2, 2006, nor was this condition aggravated by this 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?

Petitioner introduced into evidence medical charges for the meniscal transplantation surgery and ACL reconstruction surgery. (Px4) All such charges were incurred after October 6, 2010.

14IWCC0650

See findings of this Arbitrator in "F" above.

Based upon said findings, all such charges for those procedures performed on or after October 6, 2010, are hereby denied.

K. What temporary benefits are in dispute?

See findings of this Arbitrator in "F" above.

Respondent disputes all periods of lost time claimed by Petitioner that commence on October 6, 2010. This lost time was incurred as a result of the medial transplantation surgery performed and a later ACL surgical repair. All claims made by Petitioner for benefits on and after October 6, 2010, are hereby denied.

Based upon the above, the Arbitrator finds that as a result of this accidental injury, Petitioner was temporarily and totally disabled from work only commencing November 4, 2006 through February 18, 2007, and is entitled to receive benefits from Respondent for this period of time. All other claims for temporary total disability benefits made by Petitioner in this matter are hereby denied.

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

See findings of this Arbitrator in "F" above.

Based upon said findings, the Arbitrator finds that as a result of this accidental injury, Petitioner sustained an injury to his medial meniscus that was surgically repaired including repair of a focal defect of the medial femoral condyle.

Petitioner testified that he experiences occasional swelling and very little pain in his left knee. Petitioner takes over the counter medication as needed for his symptoms and does not take any prescribed medication.

The Arbitrator finds this condition of ill-being to be permanent in nature at this time.

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

Jamie Lind,

Petitioner,

vs.

NO: 12 WC 39539

14IWCC0651

Corn Belt Energy Corp.,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disabiltiy, and permanent disablity, 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 notes that Section 8.1b of the Act states, in pertinent part, that "permanent partial disability **shall** be established using the following criteria" and then lists the criteria, which includes an AMA rating report. 820 ILCS 305/8.1b (2013) (emphasis added)

The Commission finds that a complete reading of this section of the Act indicates that a party is not required to provide an AMA rating report for the purpose of determining permanent disability. Instead, we find that the Act simply requires that if an AMA rating report has been provided, then the Commission must consider it, along with all the other criteria listed, when determining permanent disability.

In following the criteria laid out in Section 8.1b on review, the Commission notes that:

(i) *the reported level of impairment pursuant to subsection (a):*
An AMA report was not provided.

14IWCC0651

(ii) *the occupation of the injured employee;*
Petitioner worked as a lineman. As a lineman, Petitioner was required to drive out to different locations in order to string electrical wires. Because Petitioner was required to work at different locations in order to do his job, he would find himself parking, as he did on August 30, 2012, in ditches on the side of the road. As such, getting out of his truck was awkward, as in the day of the accident, when Petitioner had to twist his body in a certain way in order to exit his vehicle.

(iii) *the age of the employee at the time of the injury;*
Petitioner was 42 years old at the time of the accident.

(iv) *the employee's future earning capacity; and*
Petitioner testified that he now works as a serviceman and makes more than he did as a lineman. (T.21)

(v) *evidence of disability corroborated by the treating medical records.*
During his last visit with his chiropractor, Dr. Dennis Farrell, Petitioner complained of ongoing right lower lumbar pain and paresthesia that radiated into the right hip, thigh, knee and calf, which Petitioner described as mild, continuous burning. (PX2) Dr. Farrell recommended that Petitioner continue treatment. At hearing, Petitioner testified that he continues to have pain and discomfort in the low back and that his low back, on the right hip area, stiffens and becomes painful daily. (T.17, 19-20) Petitioner testified that his continued symptoms do not affect his ability to work, but explained that he now works as a serviceman, a different position than the one he worked when the accident occurred. (T.20) Petitioner testified that his new position does not require him to lift as much as before and is less stressful on his body that his previous job.

After considering the facts and following the criteria listed in Section 8.1b of the Act, the Commission agrees with the Arbitrator that Petitioner has suffered a 3% loss of use of the person as a whole under Section 8(d)2 of the Act. Therefore, the Commission affirms the Arbitrator's award of permanent disability benefits and medical expenses.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 15 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 3% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,480.00 for medical expenses under §8(a) & §8.2 of the Act. Respondent is entitled to credits of $390.91, paid by Respondent's Workers' Compensation Carrier, and $536.00, paid by Petitioner's group insurance. Respondent shall hold Petitioner harmless from any claims by an providers of the services for which Respondent is receiving credit under §8(j) of the Act.

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

14IWCC0651

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 $11,300.00. 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: AUG 0 1 2014
MJB/ell
o-06/02/14
52

Michael J. Brennan

Thomas J. Tyrrell

Dissent

I respectfully dissent from the decision of the majority. I disagree with the majority's interpretation of Section 8.1b of the Act. The lack of an AMA report regarding a level of impairment leaves the Trier of fact no evidence of level of impairment. To determine the level of disability in the present case, the weight and relevance of the remaining factors placed into evidence must be weighed. I find that petitioner has suffered a 1% loss of use of the person as a whole under Section 8(d)2 of the Act.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LIND, JAMIE
Employee/Petitioner

Case# **12WC039539**

CORNBELT ENERGRY CORP
Employer/Respondent

14IWCC0651

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.

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:

1097 SCHWEICKERT & GANASSIN
SCOTT GANASSIN
2101 MARQUETTE RD
PERU, IL 61354

1408 HEYL ROYSTER VOELKER & ALLEN
KEVIN J LUTHER
120 W STATE ST PO BOX 1288
ROCKFORD, IL 61105

14IWCC0651

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jamie Lind,
Employee/Petitioner

v.

Cornbelt Energy Corp.,
Employer/Respondent

Case # **12** WC **39539**

Consolidated cases: **n/a**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **Ottawa, Illinois**, on **September 26, 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 **August 30, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **$78,000.00**; the average weekly wage was **$1,500.00**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **2** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,480.00, less $390.91 paid by Respondent's Worker's Compensation Carrier and $536.00 paid by Petitioner's group insurance, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $536.00, as provided above, 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 $712.55/week for 15 weeks, because the injuries sustained caused the 3% loss of the person as a whole, as provide 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

October 28, 2013
Date

FINDING OF FACTS

On August 30, 2012, Jamie Lind, a/k/a James, was working as a lineman for the Respondent, Corn Belt Energy Corp. As part of his job, he was required to perform a number of tasks. These included the operation of bucket trucks for use in the installation and repair of elevated electrical wiring. On August 30, 2012, he was assisting in the stringing of primary heavy voltage electrical supply wiring on three spans to a transformer. Each span represents the distance between one utility pole and the next. Number 2 aluminum wiring was being placed between the poles and is about as thick as the Petitioner's pinkie.

On this day, the Petitioner drove a bucket truck with its trailer containing a spool of wire. In the days and weeks prior to the accident, Mr. Lind testified he had no complaints of pain or discomfort. However, this changed after he parked the bucket truck off the side of the road and in a ditch. This placed the bucket truck at a significant angle with the right side being lower than the left.

After parking the vehicle, the Petitioner said he attempted to get out of the same by turning his body and placing his right hand on the outside of the steering wheel closest to the driver's side window. His left hand was placed on the rear area of the door opening. The Petitioner then attempted to turn and pull himself out of the door opening at the same time. While doing this, he experienced pain principally in his back and neck.

Mr. Lind explained the pain he experienced immediately following the occurrence was noticeable but not severe. The Petitioner testified he reported this injury to Jerry Henning, his supervisor. The Petitioner continued his work but did so in pain and discomfort.

When Mr. Lind returned to his employer's shop, he wrote on his timecard that he was injured. He also testified to noting the injury in his work on the computer. This testimony was not rebutted.

Because the pain and discomfort continued to grow overnight in severity, the Petitioner reported to Dr. Farrell at Farrell Chiropractic on August 31, 2012. Px 2 & Rx 1.

At various times prior to the Petitioner's August 30, 2012 accident, he had seen Dr. Farrell for a variety of ailments. Id. He did not recall dates but testified almost two months prior, on July 6, 2012, he treated for pain in the center of his lower lumbar spine which was mild, intermittent and aching. Id. Pain on his last pre-accident visit was a 2 out of 10. Id. At that time, he was rendered chiropractic treatment and reported feeling better immediately. Id. Although he was told to return the following week, the Petitioner did not. Id. He states he felt better and did not seek additional care until after his August 30, 2012 work accident.

At the Petitioner's August 31, 2012 visit with Dr. Farrell, he complained of pain and paresthesia radiating into the left knee and down the lateral side of the left calf. Id. This pain was described as aching and sharp. Id. Pain, as well as, paresthesia with tingling was found throughout the entire neck and was moderate, intermittent and accompanied by soreness and stiffness. Id. Additional pain in the mid thoracic spine was reported. Id. Testing found issues at C2, C6, T4 and L5 spinal levels that included joint fixation, hypermobility and point tenderness. Id. After his examination, Dr. Farrell wrote the Petitioner had been better since his last visit, approximately two months prior, but experienced a marked deterioration of his condition due to an acute flare up. Id.

On September 5, 2012, Mr. Lind followed with his physician. Id. At that visit, Dr. Farrell wrote the Petitioner continued to experience pain and paresthesia in the center of his lower lumbar spine. Id. Since his last treatment, he felt somewhat better and rated his pain as a 5 out of 10. Id. He reported Mr. Lind's pain increases when moving from sitting to standing or from a laying down to a sit or stand position. Id. The Petitioner's pain and paresthesia is a constant ache that can be sharp at times. Id. His principle pain involved mid thoracic and cervical spine. Id. Subluxations, joint fixation, hypermobility and point tenderness at the C2, C6, T4 and L5 levels was found on examination. Id. Dr. Farrell reported Mr. Lind's condition showed improvement but it remained inadequately controlled. Id.

During Mr. Lind's September 10, 2012 visit, 11 days after his initial injury, he saw Dr. Farrell's notes failed to mention his work injury. Mr. Lind testified he then reminded Dr. Farrell about the accident. As a consequence, Dr. Farrell corrected his notes and provided a history of the Petitioner's August 30, 2012 work accident. Id. He wrote the Petitioner was injured getting out of his truck and twisting. Id. He felt pain at the time but it was not too bad. Id. By the time he woke up the next morning, it was severe. Id. His pain and paresthesia was moderate, intermittent and sharp. Id.

Mr. Lind revisited Dr. Farrell on September 7, 2012. Id. At that time, the Petitioner's pain and paresthesia was principally in the center of the lower lumbar spine. Id. Since his prior visit, he experienced some improvement in his low back pain. Id. His present pain was approximately a 4 out of 10 with discomfort occurring 50% of the day. Id. When laying down, his pain and paresthesia is constant with the pain principally located in his mid thoracic and lumbar spine. Id. The pain appeared to be centered at C2,

C6, T4 and L5 and demonstrated joint fixation, hypermobility and point tenderness. Id. Chiropractic manipulation was performed with the Petitioner reporting improvement.

During his September 10, 2012 visit, Mr. Lind reported his pain and discomfort to be a 4 out of 10. Id. The pain that had been going down his left leg was now gone. Id. His lumbar pain remained and was worse in the morning. Id. If he sits too long and tries to get up the pain is worse. Id. Testing demonstrated lumbar flexion and extension caused mild to moderate pain. Id. Kemp's testing was positive bilaterally with moderate lumbar pain. Id. Straight Leg Raising testing on the right was positive with mild pain located in the center of the Petitioner's lumbar spine. Id.

The Petitioner continued to follow with Dr. Farrell several times a week throughout September of 2012. Id. Thereafter, Mr. Lind's treatment regimen slowed as his condition improved. Id. By his visit of October 8, 2012, the Petitioner's subluxation, joint fixation and hypermobility with point tenderness was now limited to C6, T4, T 10 and L5. Id. However, his pain still could reach a 5 out of 10 with the pain and paresthesia being intermittent but sharp at times. Id.

By the Petitioner's October 15, 2012 visit, his lumbar and thoracic pain and paresthesia was mild and intermittent in nature. Id. He had continued complaints of pain in the cervical spine. Id. At this visit, Dr. Farrell reported subluxations at C6, T4 and L5 which he adjusted due to joint fixation, hypermobility and point tenderness. Id.

At his October 23, 2013 visit, Dr. Farrell wrote the Petitioner had pain and paresthesia in the center of his lower lumbar spine but indicated his low back pain was much improved. Id. Pain in the center of his mid thoracic spine was also improved but remained moderate and intermittent. Id. Cervical spine pain continued. Id. Dr. Farrell

reported the Petitioner felt improved after his last treatment but wrote his pain and paresthesia has been exacerbated. Id.

The Petitioner testified he continued to treat with Dr. Farrell through April 26, 2013 for his work injuries. Since that last visit, he has continued to experience pain which is principally located in his lower back. The Petitioner explained that since his last visit with Dr. Farrell, he has tried to live with his pain and discomfort.

Mr. Lind explained he has daily pain and discomfort in his lower back that he relates to the accident. Although he had pain at various points in his back prior to the accident, he indicated this was relieved by the chiropractic care and treatment received. Mr. Lind testified his work accident reinjured his spine and continues to cause pain through the present.

Mr. Lind testified his pain is now better than what it was after the accident but reports it occasionally backtracks. He does have pain on a daily basis and his low back stiffens up. He explained his pain does not hinder his ability to work and he has now transferred to another job that places less physical stress on him.

Following the Petitioner's injury, he treated with the Farrell Chiropractic Clinic and incurred bills of $1,480.00. Px 1. Of this amount, the Respondent has paid $391.00. Id. Petitioner's group insurance paid $536.00 in bills while Mr. Lind paid $40.00 out of pocket. Id. Discounts in billing of $42.35 have been provided. Id. There remains $470.74 in unpaid bills due the Farrell Chiropractic Clinic. Id.

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?

On August 30, 2012, the Petitioner was employed by the Corn Belt Energy Corporation. Prior to this date, he had multiple minor injuries to, among other things, his cervical and lumbar spine. Px 2 & Rx 1. To reduce the pain and discomfort from these injuries, the Petitioner obtained intermittent chiropractic care over the course of several years. Id. For a past injury or flare up, the Petitioner might see his chiropractor, Dr. Dennis Farrell, for a few visits. Id.

As a lineman for the Respondent, Mr. Lind was required to perform a variety of heavy physical tasks. This included climbing utility poles, placement of electrical wire, operating bucket trucks at various heights and working on high voltage wires. On August 30, 2012, the Petitioner was involved in stringing 3 spans of Number 2 aluminum wire to a transformer.

At his work site, Mr. Lind parked the Respondent's truck off the side of the road and in a ditch as depicted in the photographs contained within Petitioner's Exhibit 3. The vehicle was parked at a significant angle. This placed the passenger side of the utility truck at the bottom end of the angle and the driver's side at the top end. In order for the Petitioner to exit the truck, he unbuckled his seat belt and began his efforts to exit.

The Petitioner next opened the driver's side door and placed his left hand on the body of the vehicle just beyond his driver's seat. He also placed his right hand on the outside portion of the steering wheel that was furthest from him and closest to the

driver's side door. Mr. Lind then attempted to twist and pull himself up and out in a fluid motion. While attempting to pull his body toward the door and twist at the same time, he felt pain in his back and neck. Id. The accident was reported to his foreman, Jerry Henning, who was also at the job site. Mr. Lind documented this injury on his timecard and on a computer that tracked his work activities for the day.

As the Petitioner's pain continued to increase, he saw his chiropractic physician, Dr. Farrell, the next day. Id. Mr. Lind testified he discussed his work injury with his chiropractor. Dr. Farrell's notes indicate Mr. Lind's pain included the lower lumbar spine with pain and paresthesia radiating into the left knee and down the lateral side of the left calf. Px 2. It was described as a constant ache that could be sharp at times. Id. Pain and paresthesia throughout the entire neck was moderate, intermittent with accompanying soreness and stiffness. Id. An additional complaint of midthoracic pain reported. Id. Chiropractic testing confirmed subluxations in these areas of the spine. Id.

After his examination, Dr. Farrell provided chiropractic care and treatment. Id. He indicated Jamie Lind experienced an acute marked deterioration of his condition. Id. Although there is no initial reference in the doctor's records to the accident, 11 days later it was noted. Id. In the September 10, 2012 appointment notes, Dr. Farrell refers to Petitioner's August 30, 2012 work injury. Id. Dr. Farrell wrote the Petitioner's pain began on August 30, 2012 when he was getting out of a truck and twisted. Id. He felt pain after the occurrence but by the time he woke up the next morning, it was severe. Id. At this visit, he had moderate, intermittent and sharp pain at a 4 on a scale of 1 to 10. Id. Mr. Lind was having pain down the back of his left leg originally that was now gone. Id. His

remaining pain is worse in the morning. Id. If he sits too long and tries to get up and move, the pain becomes more severe. Id.

Additional testing at the Petitioner's September 10, 2012 visit demonstrated a positive Straight Leg test. Id. Pain and paresthesia continued in the same areas with ongoing subluxations noted in the cervical, thoracic and lumbar spine. Id. Chiropractic testing indicated joint fixation, hypermobility and point tenderness in these areas. Id. Chiropractic treatment on this date provided some relief. Id. The Petitioner continued to follow with Dr. Farrell 3 times a week. Id. This progressed to once a week and occasionally thereafter. Id.

Mr. Lind explained he last saw Dr. Farrell in April of 2013 for this injury. At that time, he was still having pain and discomfort. Px 2. Dr. Farrell noted the Petitioner received improvement from treatment following his accident but the condition has again manifested. Id. The Petitioner was noted to have continuing thoracic subluxations, cervical sprain/strain along with cervical subluxations. Id. He was provided chiropractic treatment and received some relief. Id.

Testimony of the Petitioner indicates he has not seen Dr. Farrell since April of 2013 for his work injury. He explained his present pain is better on some days and worse on others. He still has ongoing issues with his low back remaining stiff but a job change with the Respondent has had the effect of reducing his symptoms.

Following consideration of the testimony of the Petitioner and the medical records and bills in evidence, this Arbitrator finds the Petitioner did have an accident on August 30, 2012 that occurred and arose out of the course of his employment by the Respondent. The injury was in the form of a cervical, thoracic and lumbar strain along with

subluxations throughout his spine. Id. It is also found, following a review of the evidence, that Mr. Lind's current condition of ill-being is causally related to the injury.

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

On August 31, 2012, the day after the Petitioner's work accident, he sought medical care with Dr. Dennis Farrell, his chiropractic physician. Px 2. Dr. Farrell indicated Mr. Lind experienced a marked deterioration of his condition. Id. As a result of the Petitioner's injury, Dr. Farrell began a regimen of chiropractic care. Id. The cost of chiropractic services rendered totals $1,480.00. Px 1. Of this amount, the Respondent paid $391.00, the Petitioner's group insurance satisfied $536.00, discounts of $42.35 have been received and the Petitioner paid an additional $40.00 out of pocket. Id. There remains $470.74 in unpaid bills. Id.

Following consideration of the chiropractic records, Px 2 and Rx 1, this Arbitrator finds the medical services provided to the Petitioner were reasonable and necessary. The Respondent has not paid all appropriate charges for these reasonable and necessary medical services.

Consistent with this decision, the Respondent shall repay the Petitioner's out of pocket expense of $40.00 and satisfy the outstanding chiropractic bills of $470.74 pursuant to the Medical Fee Schedule. It shall further hold the Petitioner harmless from payments made by the Respondent's group insurance in the amount of $536.00. Id.

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

Following the Petitioner's work injury of August 30, 2012, he obtained chiropractic care and treatment in an attempt to relieve himself of the discomfort caused by his injury. Although he had prior minor work injuries, many of which no claim was brought, he testified that he had improved but would occasionally seek chiropractic care for a flare up.

It was after his August 30, 2012 work injury that he sought regular care and attention. Mr. Lind continues to report he lives with daily discomfort due to this accident. Because of a change in his job and his own efforts to deal with the continuing effects of his August 30, 2012 accident, he testified he has not felt it necessary to see his doctor for additional care.

Following consideration of the testimony and evidence presented, this Arbitrator finds the Petitioner experienced a loss of 3% loss of a man pursuant to Section 8(d)2.

M. Should penalties or fees be imposed upon Respondent?

Following consideration of the testimony and evidence presented, this Arbitrator finds the imposition of penalties is not warranted.

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

Luis Plata,

Petitioner,

14IWCC0652

vs.

NOS: 11 WC 18832
11 WC 18935
11 WC 18937
11 WC 18938

Eureka Locker Plant,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

14IWCC0652

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: AUG 0 4 2014
o7/23/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0652

PLATA, LUIS
Employee/Petitioner

Case# **11WC018938**

11WC018935
11WC018937
11WC018832

EUREKA LOCKER PLANT INC
Employer/Respondent

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:

1824 STRONG LAW OFFICES
SEAN D OSWALD
3100 N KNOXVILLE AVE
PEORIA, IL 61603

0980 HASSELBERG GREBE SNODGRASS ET AL
BOYD O ROBERTS III
124 S W ADAMS ST SUITE 360
PEORIA, IL 61602

14IWCC0652

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

LUIS PLATA
Employee/Petitioner

v.

EURKEKA LOCKER PLANT
Employer/Respondent

Case # **11** WC **18938**

Consolidated cases: **11 WC 18935, 11 WC 18937, 11 WC 18832**

An *Application for Adjustment 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 **12/20/12**. 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 _____

14IWCC0652

FINDINGS

On **1/25/10, 4/21/09, 4/13/10 and 1/13/09**, 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 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 $**26,151.06**; the average weekly wage was $**502.90.**

On the date of accident, Petitioner was **48** years of age, ***single*** 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 $**2,855.43** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

Respondent is entitled to a credit of $**532.11** under Section 8(j) of the Act.

ORDER

The Petitioner has failed to prove by a preponderance of the credible evidence that he sustained accidental injuries arising out of and the course of his employment by Respondent on January 13, 2009, April 21, 2009, January 25, 2010, and on April 13, 2010. In addition, the Petitioner has failed to prove by a preponderance of the credible evidence that his current condition of ill-being is causally related to any of his claimed injury dates. Lastly, the Petitioner's claims are barred for failure to provide his employer with adequate notice. The Petitioner's claim for compensation is denied.

No benefits are awarded.

Respondent shall be given a credit of $**2,855.43** for TTD, $**0.00** for TPD, and $**0.00** for maintenance benefits, for a total credit of $**2,855.43**.

Respondent shall be given credit for **$532.11** for medical benefits paid under Section 8(a) of the Act

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

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

ST Mathis

Signature of Arbitrator

3-11-2013

Date

MAR 14 2013

In support of the Arbitrator's Decision relating to ***(C). Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? and (F). Is Petitioner's current condition of ill-being causally related to the injury?****, the Arbitrator finds the following facts:*

To obtain compensation under this Act, an employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment. 820 ILCS 305/1(d). Accordingly, the burden of proof is on the Petitioner to establish that each of his alleged accidents arose out of and in the course of his employment with the Respondent. The Petitioner has alleged he sustained work-related injuries as a result of accidents occurring on four separate dates: an injury to his lower back on January 13, 2009; an injury to his shoulder on April 21, 2009; an injury to his back on January 25, 2010; and an injury to his head, neck and back on April 13, 2010. The four (4) cases have been consolidated for purposes of arbitration and each constitute a separate claimed accident.

The Petitioner's medical history indicates he only treated shortly after one of these alleged injuries. On January 16, 2009, the Petitioner treated with Dr. Agarwal at Heartland Health Clinic. (Petitioner's Exhibit #3) During the visit, The Petitioner reported a history of six to seven weeks of low back pain. (Petitioner's Exhibit #3) This six to seven week time frame would place the alleged work accident date prior to the alleged injury date of January 13, 2009 as alleged by the Petitioner.

Further, at the time he saw Dr. Agarwal, the Petitioner never specifically attributed his back pain to any work-related accident, but indicated he does lifting at work. (Petitioner's Exhibit #3) The Petitioner alleges he did not report the injury as work-related because the Respondent directed him not to let the doctor know the accident happened at work. (Transcript, page 18) No further treatment was sought for this injury despite Dr. Agarwal's recommendations (Petitioner's Exhibit #3). In fact, no further medical treatment was sought for any of the alleged injuries until after the Petitioner was terminated from his employment with Respondent, in January of 2011.

With regard to his back claim, the Petitioner first treated with Dr. Kube on May 24, 2011, approximately 13 months after his last alleged work-related accident. (Petitioner's Exhibit #10) Dr. Kube only treated the Petitioner with regard to his back and neck pain. When he first saw the Petitioner, the Petitioner could not provide a specific date of injury. (Petitioner's Exhibit #13, pages 34-35) Dr. Kube is not aware of anywhere in his records where the date of January 13, 2009, is specified as the injury date. (Petitioner's Exhibit #13, page 35).

Dr. Kube provided no written opinion as to whether Petitioner's condition of ill-being could have been caused by the Petitioner's alleged accidents; however, Dr. Kube did testify during his deposition that there was a causal relationship between the Petitioner's back injuries and the two separate incidents. Dr. Kube also testified that he thought it was unusual that Petitioner would have gone two-plus years without treating after the alleged January 13, 2009 incident and that if the Petitioner had not sought medical treatment for his lower back during this time, it could affect his opinion. (Petitioner's Exhibit #13, page 46). Further, Dr. Kube indicated that it is unusual that Petitioner would have gone two-plus years without physical therapy following his alleged injury. Had he treated Petitioner after the injury, he would have initiated physical therapy early on. (Petitioner's Exhibit #13, page 42). If Petitioner has not seen a physician between January 16, 2009 and January 24, 2011 for his lower back, this could affect Dr. Kube's causation opinion. (Petitioner's Exhibit #13, page 46). He indicated it would be unusual for somebody to go for a couple of years without a medical treatment if they are having severe pain. (Petitioner's Exhibit #13, page 46). At the time Dr. Kube saw Petitioner in May of 2011, Petitioner was having severe pain and his function level would not allow him to perform work. (Petitioner's Exhibit #13, page 46).

For his neck claim, the Petitioner did not begin treating with Dr. Kube until September 13, 2011 (Petitioner's Exhibit #13, page 49). Petitioner made no prior complaints to Dr. Kube about his neck while he was treating with Dr. Kube for his back. Dr. Kube also testified a patient would typically

seek medical treatment shortly after the type of incident described by the Petitioner as occurring on April 13, 2010, but the Petitioner did not treat during this time. (Petitioner's Exhibit #13, page 60).

For his shoulder claim, the Petitioner has alleged an accident date of April 21, 2009. (Transcript, Page 51). He did not seek treatment for this injury until he saw Dr. Moody in April 2011 (Transcript, page 51). Dr. Moody recommended physical therapy, which Petitioner did not undergo. Petitioner's Exhibit #4). Instead, the Petitioner somehow ended up with Dr. Hoffman, whom he had never seen before. From there, Dr. Hoffman referred him to Dr. Rhode. (Transcript, page 51).

Dr. Rhode initially saw the Petitioner on May 18, 2011 (Petitioner's Exhibit #12, page 5). At that time, the Petitioner gave Dr. Rhode a history of an injury from April 2005. (Petitioner's Exhibit #12, page 13). Dr. Rhode was not made aware of this incorrect injury date until just prior to his deposition by Petitioner's counsel. (Petitioner's Exhibit #12, page 18) Dr. Rhode did not recommend physical therapy but instead elected to proceed to surgery. Dr. Rhode initially diagnosed with the Petitioner as having a traumatic rotator cuff tear. (Petitioner's Exhibit #9) He did not see the Petitioner again until his surgery. The pre-operative diagnosis contained on Dr. Rhode's operative report is incorrect. (Petitioner's Exhibit #12, page 24). Prior to surgery, he diagnosed the Petitioner as having a full thickness rotator cuff tear, but postoperatively the petitioner was found to have a SLAP lesion with impingement. (Petitioner's Exhibit #9).

Dr. Rhode did causally relate the Petitioner's shoulder problems to the alleged work injury date of April 21, 2009. (Petitioner's Exhibit #12, pages 10-11). However Dr. Rhode also indicated that his opinions were predicated upon the subjective history provided to him by Petitioner. (Petitioner's Exhibit #12, pages 15-16). If the accident did not occur as alleged by Petitioner or if it did not occur at all, Dr. Rhode's opinions could change. (Petitioner's Exhibit #12, page 17).

The Petitioner submitted to two separate independent medical evaluations at the request of the Respondent. On October 11, 2011, Dr. O'Leary performed an independent medical evaluation of the Petitioner with regard to the Petitioner's neck and back complaints. (Respondent's Exhibit #2)

Dr. O'Leary testified that the mechanism of injury described by the Petitioner could have caused a back injury, but the fact the Petitioner did not treat until two years later makes it difficult to relate the Petitioner's current condition of ill-being to the alleged event. (Respondent's Exhibit #4, pages 26-27)

Further, the Petitioner did not indicate to Dr. O'Leary that he had previously treated for his injury with Dr. Agarwal. (Respondent's Exhibit #4, page 10) Regarding causation, Dr. O'Leary opined that Petitioner's pain complaints were not related to his work with Respondent. (Respondent's Exhibit #4, page 20-21) He based this on the extent of time prior to first seeking medical care and the difficulty to continue hard working conditions following the injuries. (Respondent's Exhibit #4, page 20-21) In addition, Dr. O'Leary felt that the Petitioner's failure to mention to him his treatment with Dr. Agarwal on January 16, 2009 is inconsistent with his medical history and the Petitioner's stated date of injury to Dr. Agarwal of six to seven weeks prior to January 16, 2009 is directly in conflict with his current claimed injury date. (Respondent's Exhibit #4, page 31) Lastly, Dr. O'Leary testified that the Petitioner did not even mention his April 13, 2010 neck injury during the course of his examination. (Respondent's Exhibit #4, page 45).

Dr. Marra performed an independent medical evaluation of the Petitioner on February 16, 2012. (Respondent's Exhibit #5) Dr. Marra opined that the Petitioner's shoulder injury was not related to the alleged work injury of April 21, 2009 given the length of time between the alleged accident dates and when the Petitioner first sought treatment. (Respondent's Exhibit #6, page 16) He further indicated that Petitioner's symptoms would have improved over a 1.5 year time span versus worsening, even if the Petitioner had not sought any treatment. (Respondent's Exhibit #6, page 16). He indicated that when patients develop acute tears they typically seek medical attention sooner rather than later. (Respondent's Exhibit #6, page 16). Waiting a year and a half is inconsistent with developing an acute tear in the shoulder. (Respondent's Exhibit #6, page 16). Had

Petitioner suffered an acute tear on the date alleged, his ability to perform his job would have been affected. (Respondent's Exhibit #6, page 16).

At arbitration, with regard to the alleged accident date of January 25, 2010, Petitioner testified that he injured his hands. (Transcript, Page 24) However, Petitioner did not testify as to any specific event or trauma that caused his alleged hand injury. In fact, the Petitioner later testified that all of the alleged accident dates were single-incident events that triggered pain symptoms, not repetitive trauma claims. (Transcript, page 70) Moreover, Petitioner also stated that none of his applications for adjustment of claim involved in this arbitration related to his alleged hand problems. (Transcript, page 71) A simple review of Petitioner's Exhibit #1 indicates that the January 25, 2010 injury dates involves a claim to the Petitioner's back due to lifting hogs, not his hands, as he testified.

Petitioner also testified that he originally reviewed, authorized, signed and filed an Application for Adjustment of Claim alleging an injury date of January 25, 2011. (Transcript, pages 61-62) That injury date would have been subsequent to his employment termination with Respondent. (Transcript, pages 61-62). As such, this Application for Adjustment of Claim was false. Later on, this was amended by Petitioner to reflect an alleged injury date which would have occurred while Petitioner was employed with Respondent.

An injury arises out of one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. v. Industrial Commission,* 58 Ill.2d 226, 317 N.E.2d 515 (1974). The burden is on the party seeking an award to prove by a preponderance of credible evidence the elements of the claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Hannibal, Inc. 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).

The Petitioner testified that he reported each alleged accident to his employer on the date of each accident; however, he never filed a written accident report. As such, there is no physical evidence documenting how these alleged accidents occurred, that they occurred in the course of the Petitioner's employment, or that they occurred on the specific dates alleged. Further, the Petitioner did not provide any witnesses to testify regarding any of the alleged accidents. The only evidence the Petitioner has provided to prove his alleged accidental injuries arose out of and in the course of his employment are his own testimony and his medical records.

With regard to the Petitioner's testimony regarding his alleged work accidents, the Petitioner's credibility should be called into question. As stated above, the Petitioner's failure to seek prompt medical attention, his continued work at a heavy duty job without incident or complaint, his inconsistent medical history, the timing of the filing of his claims, the gap in his seeking medical treatment and his inconsistent testimony as it relates to his specific injuries and his claimed injury dates all lead the arbitrator to conclude that the Petitioner lacks cedibility. With his credibility in severe doubt, the Petitioner's testimony should be disregarded in its entirety. Therefore, without being able to consider the Petitioner's testimony, the Arbitrator finds that the Petitioner has failed to meet his burden of proof.

Based on the lack of any physical documentation or eyewitness testimony of the alleged accidents, the Petitioner's inconsistent medical history, Dr. Kube's hesitant causation opinion, the IME reports and testimony submitted by Respondent, the testimony of petitioner's co-workers and employer, and the Petitioner's own testimony lacking credibility, the Arbitrator finds the Petitioner has not proven by a preponderance of the credible evidence that he has sustained accidental injuries arising out of and in the course of the employment and that his current condition of ill-being is causally related to his four (4) claimed accident dates.

In support of the Arbitrator's Decision relating to ***(E). Was timely notice of the accident given to Respondent?*** *the Arbitrator finds the following facts:*

Under 820 ILCS 305/6(c), an injured employee must give notice to the employer as soon as practicable but not later than 45 days after sustaining an accidental injury arising our of and in the course of the employment. The notice of accident must give the approximate date and place of the accident, if known, and may be given orally or in writing. *Id.* In the case at hand, the Petitioner testified he provided oral notice to his employer immediately following each alleged accident. Alternatively, the owner and supervisor of the Respondent testified the Petitioner never reported any work-related injury to him and that he was unaware of any alleged accident(s) until after the Petitioner was laid off from employment, well outside the 45 day time period during which the Petitioner is required by statute to give notice to his employer. It is undisputed that the Petitioner did not provide any written notice to his employer until the filing of his Applications for Adjustment of Claims.

Aside from the Petitioner's testimony, there is no additional evidence to support his allegation of providing oral notice to the Respondent following each alleged accident. The Petitioner testified he never filed an accident report with the Respondent or with the Respondent's insurance carrier following any of the alleged accident dates. (Transcript, page 48) He never sent correspondence to the Respondent regarding any of the alleged accidents. There is no evidence the Petitioner reported any alleged accident to a state health inspector, who is required by law to be on-site every day the facility is in operation.

Further, there are no medical records indicating the Respondent knew or should have known the Petitioner sustained a work-related injury on any of the alleged accident dates. The Petitioner treated only once with a medical provider prior to being laid off by the Respondent. The Petitioner testified he treated with Dr. Agarwal with the Heartland Health Clinic on January 16, 2009, three days after the alleged accident date of January 13, 2009. (Transcript, page 44) The Petitioner testified that during this visit, he did not specifically attribute his back pain to any incident at work, but only indicated he does lifting at work. (Transcript, page 44) This corresponds with Dr. Agarwal's record

dated January 16, 2009, which does not attribute the Petitioner's back pain as being related to a work accident on January 13, 2009. (Petitioner's Exhibit #3)

On the other hand, the Respondent has provided testimonies from Petitioner's co-workers and supervisor who all acknowledge the Respondent has procedures in place for reporting work-related accidents; they are to report accidents directly to their supervisor. Each witness testified there are workers' compensation posters displayed in the work place in a prominent area. (Transcript, Pages 88, 105, 117, 123) Each witness also testified that they were unaware of any work-related accident the Petitioner has alleged. (Transcript, Pages 86, 102, 111, 120) Further, one of the witnesses, Jeffery Rodgers, testified he sustained two separate injuries while working for the Respondent. (Transcript Page, 106) Each time, he reported the accident to the Respondent who sent him for medical treatment, which was paid through the Respondent's workers' compensation insurance. (Transcript Page, 106) Following one of these accidents, Mr. Rodgers was off work and received compensation for this time through workers' compensation. (Transcript Page, 107) These facts indicate the Petitioner knew or should have known how to report any work-related accidents and had he reported them, the Respondent would have provided medical treatment and benefits through its workers' compensation insurance.

The question of notice is a factual question for the Commission. *GTE Automatic Electric v. Foote,* 134 Ill.App.3d 9, 479 N.E.2d 1223, 89 Ill.Dec. 217 (2d Dist. 1985). In this case, the Petitioner has failed to prove he provided notice to the Respondent within 45 days of any of the alleged accidents as required by Section 6(c) of the Illinois Workers' Compensation Act. The evidence presented by the Respondent, including witness testimony provided at arbitration, is sufficient for the arbitrator to conclude the Respondent was not aware of any of the Petitioner alleged accidents within 45 days of the alleged accident dates. Failure of an employee to give notice will bar the claim. *Ristow v. Industrial Commission,* 39 Ill.2d 410, 235 N.E.2d 617 (1968). Accordingly, the arbitrator

concludes the Petitioner's claims are barred for failure to provide his employer with adequate notice so as not to substantially prejudice the employer's rights.

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? And (K) What temporary benefits are in dispute?*** *the Arbitrator finds the following facts:*

Based on the findings contained in (C), (E) and (F) above, the Arbitrator finds that the medical services provided to Petitioner were not reasonable and necessary and that Respondent has paid all appropriate charges for all reasonable and necessary medical services and temporary total disability. As the Petitioner's injury does not constitute an accident within the meaning of the Illinois Worker's Compensation Act, the Petitioner failed to provide Respondent with adequate notice and the injury is not causally related to his employment with the Respondent, the arbitrator finds these issues moot.

In support of the Arbitrator's Decision relating to ***(L). What is the nature and extent of the injury?*** *the Arbitrator finds the following facts:*

Based on the findings contained in (C), (E) and (F) above, the Arbitrator finds that the issue of nature and extent of the injury is rendered moot.

In support of the Arbitrator's Decision relating to ***(N). Is Respondent due any credit?*** *the Arbitrator finds the following facts:*

Pursuant to Respondent's Exhibit #8, Respondent paid to the Petitioner as and for Temporary Total Disability Payments the sum of $2,855.43. In addition, Exhibit #8 shows that Respondent paid $532.11 in medical expenses. This exhibit was stipulated to by the parties at trial and was unrebutted by Petitioner. For both sums, Respondent is entitled to a credit.

14IWCC0653

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

Norman Dowers,

Petitioner,

vs. NO: 08 WC 22437

Bunge Milling Corp,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, occupational disease, permanent disability, 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 October 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.

14IWCC0653

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $33,800.00. 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: AUG 0 4 2014
o7/22/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0653

DOWERS, NORMAN
Employee/Petitioner

Case# **08WC022437**

BUNGE MILLING CORP
Employer/Respondent

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

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

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

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

0734 HEYL ROYSTER VOELKER & ALLEN
BRAD PETERSON
P O BOX 129
URBANA, IL 61801

14IWCC0653

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

Norman Dowers
Employee/Petitioner

v.

Bunge Milling Corp.
Employer/Respondent

Case # **08** WC **22437**

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 **Urbana**, on **September 23, 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 _____

14IWCC0653

FINDINGS

On **May 31, 2006**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**39,969.36**; the average weekly wage was $**713.22**.

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $427.93 per week for 75.83 weeks, because the injuries sustained caused the 27.3% loss of the right ear and 48.53% loss of the left ear.

The Arbitrator finds that Petitioner's request for reimbursement for payment of the hearing aid in the amount of $1,226.00 is reasonable and necessary to cure or relieve the effects of the occupational disease/exposure.

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

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

October 18, 2013
Date

OCT 22 2013

14IWCC0653

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT AND CONCLUSIONS OF LAW

In regards to "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?, "F"- Is Petitioner's condition of ill-being causally related to the injury?, "J" – Were the medical services that were provide to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, and "L" - What is the nature and extent of the injury?, the Arbitrator finds the following facts:

Petitioner testified in a credible manner. He began working for the Respondent and its predecessor corporation, Lauhoff Grain, in 1970. During his testimony, he went into detail regarding the number of hours he worked as well as the number of days per week he worked. He worked a minimum of 8 hours per day. Petitioner testified he worked all over the plant as he was in the maintenance department. He testified that beginning in 1980 he wore Swedish wool hearing protection, but that protection caused ear infections and he later began wearing foam plugs. However, he did not wear hearing protection in the maintenance shop and removed it in order to converse with co-workers outside the shop.

With respect to exposure, the Petitioner testified that his maintenance work was done in the corn mill, the wedge building and in reprocessing. He was laid off from maintenance for a seven year period from1978 to 1985 during which time he worked exclusively in the corn mill. He testified that much of his job involved cutting holes in cement floors using a jackhammer.

He prepared a summary of his work history for Dr. Farrell, who he saw for an examination at his attorney's request on November 21, 2011. The summary, Exhibit 4 in Dr. Farrell's deposition, shows that the Petitioner worked in many areas of the plant. While performing his maintenance job, he worked in corn mill building 102-02 for two hours per day from 1985 to 1993. He worked from 1999 to 2002 in building 115-04, also in the corn mill, at least two hours per day. While laid off from maintenance, he worked in the corn mill in buildings 105-05 and 109-06. He testified that he was there the entire work shift. From 1971 to 1977, he reported working all over the plant in maintenance. He also spent six years as a janitor in the maintenance shop, and he was there when he retired in 2006.

Petitioner's Exhibit 5 contains noise level testing done by the Respondent between 1972 and 2003. Testing throughout nine buildings in the corn mill done in November 1976 shows noise levels ranging between 85 to 106 decibels.(PX 5 at 46,47) Of the 36 areas tested, all but 7 showed noise levels above 90 decibels. (Id) The Petitioner did not specify which buildings he performed his maintenance work during those years, but he said a lot of his work was done in the corn mill.

The studies also show some specific readings in areas where the Petitioner worked. Testing done between 1978 and 1982 in Building 105.05 showed noise levels from 93 to 96 decibels. (Id at 108, 117, 124) While the Arbitrator could not find specific noise levels in Building 102-02 between 1985 and 1993, testing done in December 1983 showed noise at 102 decibels. (Id at 132) Similarly, testing in Building 115 before and after the Petitioner worked there showed noise at 95 and 95.9 decibels. (Id at 161, 181)

Noise studies in the maintenance shop where Petitioner worked as a janitor were not offered into evidence. Petitioner did however testify that it was very noisy in the shop, due to his working in close proximity to air grinders, impact wrenches, table saws, punch presses and metal cutting shears.

Section 7 (f) of the OD Act specifies the noise exposure and the time of said exposure required to prove one's case. The Petitioner testified that when he was performing maintenance work in the corn mill in the early seventies, he would spend an entire day in that area. In is a reasonable assumption, given the noise levels throughout the corn mill, that the Petitioner was exposed to at least 95 decibels, four hours a shift.

Stronger proof was provided covering his work in the corn mill between 1978 and 1985, when he was not in the maintenance department. Building 105-05 produced noise between 93 and 96 decibels, and his regular shift would exceed the 3.5 to 5 hours required by the Act.

His greatest exposure was in Building 102-02, where he worked between 1985 and 1993. He testified, and also told Dr. Farrell, that he was exposed to noise in that building at least two hours per day.

Respondent argues that the hearing protection used reduced the noise levels to permissible levels. However, no evidence was offered concerning the efficacy of the ear protection. The Petitioner did say that the plugs had to be removed to hear normal conversation, but also said that he could still hear the noise from the machines when they were in place. Finally, the plus were not required nor used in the maintenance shop, and when in noisy areas outside the shop, he would still take them out to converse with co-workers.

Respondent tried to establish the plugs' value through cross examination of Dr. Farrell, but the doctor testified that since he did not know what type of protection the Petitioner used, he did not know of its effectiveness. He also said that in order for it to be effective, it had to be worn at all times. (PX 6 at 18, 33)

If you review the Petitioner's audiograms between 1978 and 2005, shortly before he retired, you see a steady progression of hearing loss. In February 1978, his loss average at 1000-2000-3000 frequencies was 26.66 on the right and 31.66 on the left. In December 2005, the right ear was at 46.66 and the left at 56.66 (PX 4, RX 2) If the Petitioner was using effective hearing protection, then why such a dramatic increase? It also should be noted that after his noise exposure ended, testing in 2007 and 2010 showed no increase in his hearing loss. (PX 2,7)

The Petitioner has proven exposure along with the time requirements of the Act. There is simply not enough evidence of attenuation by the hearing protection to rebut this proof.

The next issue is causation. Dr. Farrell testified by deposition. He is a board certified otolaryngologist. (Px6 @ p. 6). Dr. Farrell testified that Petitioner had a bilateral sensorineural hearing loss with the left ear which was worse than the right ear and that at least some component of that loss was likely related to noise exposure. (Px6, p. 10-11).

Dr. Farrell further testified that the bilateral hearing loss demonstrated a noise induced pattern. Dr. Farrell reviewed the past hearing tests or audiometric studies for Petitioner (Px4) as well as the noise level surveys dating back to as early as 1972. (Px5). Dr. Farrell testified it was his opinion that the sensorineural hearing loss suffered by Petitioner was at least in part caused by excessive noise exposure at work. (Px6, p. 12-14).

He also testified that there could be other causes of the condition, and that normally he would expect the loss to be about the same on each side. He did not, however, change his opinion on causation. The Appellate Court in 1993 explained that the standard of causation is the same for hearing loss as in all other claims. The exposure need not be the sole cause so long as it is a cause. Wagner Castings Co. v. The Industrial Commission, 241 Ill. App. 3d 584 (1993)

No evidence was submitted to rebut the causation opinion. The Arbitrator also finds significant the above referenced changes in the audiograms when the Petitioner was at work as opposed with those done after he retired.

The Arbitrator finds that the Petitioner has proven a causal connection between his occupational exposure and his hearing loss.

The Respondent also argues that the claim is barred by the statute of limitations. It claims is that the last date of exposure is the first day that hearing protection was used. The Arbitrator rejects that argument, citing again the Wagner Casting decision. Also, in support of his decision, the Arbitrator cites the Commission decision of Casolari v. Illinois Cement, 09 IWCC 801. Casolari involved a very similar set of facts concerning all of the issues in this case. The Commission found for the Petitioner, citing the Wagner Casting decision as its authority.

Petitioner retired in 2006 with his last day of work on May 31, 2006. The audiometric study performed April 16, 2007 is the first one performed after his exposure ended. In that audiometric study, Petitioner had a loss of 30 dB in the right and left ear at the level of 1000, a loss of 30 dB in the right ear and a loss of 55 dB in the left ear at the level of 2000 and a loss of 75 dB in the right ear and a loss of 85 dB in the left ear at the level of 3000. This results in a 27.3% loss of use of the right ear and a loss of 48.53% in the left ear.

Respondent shall pay Petitioner permanent partial disability benefits of $427.93 per week for 75.83 weeks, because the injuries sustained caused the 27.3% loss of the right ear and 48.53% loss of the left ear.

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

Jason O'Reilly,

Petitioner,

14IWCC0654

vs.

NO: 12 WC 13636

Houghton Pest Control,

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, medical expenses, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 20,2013, 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.

14IWCC0654

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 $17,600.00. 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: AUG 0 4 2014
o7/23/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF 19(b) DECISION OF ARBITRATOR

14IWCC0654

O'REILLY, JASON
Employee/Petitioner

Case# **12WC013636**

HOUGHTON PEST CONTROL
Employer/Respondent

On 12/20/2013, 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 0.09% 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:

0252 HARVEY & STUCKEL CHTD
J KEVIN WOLFE
101 S W ADAMS ST SUITE 600
PEORIA, IL 61602

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
TOM CROWLEY
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

14IWCC0654

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)

JASON O'REILLY
Employee/Petitioner

v.

HOUGHTON PEST CONTROL
Employer/Respondent

Case # 12 WC 13636

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 **Stephen Mathis**, Arbitrator of the Commission, in the city of **Peoria**, on **09/19/13**. 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 _____

14IWCC0654

FINDINGS

On the date of accident, **03/05/11**, 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 **$20,146.88**; the average weekly wage was **$38744**.

On the date of accident, Petitioner was **34** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary partial disability benefits of $98.79/week for 24 weeks, commencing 04/04/13 through 09/19/13, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $258.29/week for 57 4/7 weeks, commencing 02/28/12 through 04/03/13, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $281.20, as provided in Section 8(a) of the Act.

Respondent shall approve and pay for the left lateral epicondylar release and related subsequent treatment and therapy recommended by Dr. Mark Stewart.

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.

S J Mathis
Signature of Arbitrator

12-13-13
Date

DEC 20 2013

IN SUPPORT OF (F) - Causal Relationship: 14IWCC0654

Petitioner testified he worked for Respondent as a pest control technician handling six to eight "accounts" per day, spraying for pests. He carried two types of spray tanks, including a one gallon tank weighing 13 pounds and a one and a half gallon tank weighing 18 pounds. He would lift these tanks with his left arm and each account would take about 45 minutes. In addition he would be constantly lifting throughout each application as well as shaking and mixing the pesticides in the tank.

Petitioner further testified beginning around March 15, 2011 he began developing a numbing pain in his left elbow. This continued to worsen, and he eventually saw his family doctor, Dr. Ranilo Rabacal. Dr. Rabacal referred him to Dr. Tyson Cobb who, according to Petitioner, treated him with conservative modalities which were not successful in alleviating his elbow pain. He sought a second opinion from Dr. Mark Stewart, who recommended an epicondylar release on the left side. Petitioner wishes to proceed with this surgery in order for him to get back to his normal work.

Petitioner has continued to use pain medication prescribed by his family doctor, taking Tramadol two times per day. In addition he limits his lifting with his left arm within his restrictions he described coming from Dr. Rabacal of no lifting greater than 10 pounds. Petitioner testified Respondent was and continues to be unable to use him with his weight restriction. This was not contradicted by Respondent. He has looked for work through his local unemployment office, and has applied to 30 or 40 places of employment. He testified no one wants to hire him with his restrictions. He has not had any interviews. He eventually began work for a company called Sertoma, which is a company that hires persons with physical limitations, and does cleaning at rest areas along interstates, including the Mississippi Rapids rest area on Interstate 80 and Krisdala Baka rest area on Interstate 74. He works generally 24 hours and is paid $8.25 per hour. Sertoma has accepted his restrictions. He began working on April 4, 2013. He testified between the first week in June and the week of September 9, 2013 he worked 32 hours per week. None of this was rebutted by Respondent.

Petitioner has been examined by Dr. Mark Stewart and by Respondent's physician, Dr. Anup Bendre. Dr. Stewart last examined Petitioner on July 5, 2012. Dr. Stewart's opinion was Petitioner suffered a left lateral epicondylitis. (Pet.Exh.1,p.8). His opinion was his work was the cause of this condition. (Pet.Exh.1,p.13-14). He testified on cross examination the diagnosis has to be made from complaints and a physical exam, and that diagnostic tests can all be negative yet the bursal sac can still be inflamed or ruptured. (Pet.Exh.1,p.16-17). He further testified Petitioner's complaints were always consistent with the diagnosis. (Pet.Exh.1,p.19). Dr. Bendre agreed Petitioner suffered from a lateral epicondylitis and further agreed this was causally related to Petitioner's employment.

(Resp.Exh.1,p.8-9). A functional capacity exam, which is Respondent's Exhibit 5, did not change this diagnosis. (Resp.Exh.1,p.15).

Petitioner testified he currently has complaints of pain in his elbow for which he takes Tramadol. Petitioner saw Dr. Rabacal on May 9, 2013 in which he described chronic elbow pain. Dr. Rabacal's records indicate Petitioner is working at a rest area and is working three times a week and mostly uses his right arm. He's been taking Tramadol which seems to help. He has joint pain localized in the elbow and lateral epicondylitis of the left elbow. Dr. Rabacal prescribed continued use of Tramadol as well as a trial of oral Prednisone and further recommended he continue to follow up with his orthopedic doctor. (Pet.Exh.2). This is consistent with the records throughout Petitioner's visits with Dr. Rabacal.

Based upon the testimony of Petitioner, which this Arbitrator finds to be credible, as well as the testimony of both Petitioner's and Respondent's examining physicians, the Arbitrator finds Petitioner's current condition of ill being is causally related to his injury.

IN SUPPORT OF (J) - Medical Services

Based upon the findings set forth above and review of Petitioner's Exhibit 5, the past medical services that have been provided to Petitioner are reasonable and necessary for the conservative treatment of a left lateral epicondylitis which was caused by Petitioner's employment. There remains outstanding a balance of $114.00 for a date of service with Dr. Rabacal on May 9, 2013. That visit was for the left lateral epicondylitis and thus should be paid by Respondent as it was reasonable and necessary care for this condition. It appears Petitioner has paid $167.20 for his own care and treatment and that should be reimbursed to Petitioner as well, as those visits were also for the lateral epicondylitis condition.

IN SUPPORT OF (K) - Prospective Medical Care

The crux of the dispute if whether Petitioner should have surgery to relieve the left lateral epicondylitis. Dr. Stewart believes surgery is reasonable and necessary given the fact conservative treatment has not alleviated the elbow condition. (Pet.Exh.1,p.13-14). This surgery is a left lateral epicondylar release. (Pet.Exh.1,p.8). The surgery is outpatient, there is a one week follow up and it is anticipated return to work would be around four to six weeks after the surgery. (Pet.Exh.1,p.21).

Respondent's physician, Dr. Bendre, doesn't believe surgery will be helpful. He agrees Petitioner has the conditions; however, he reviewed the functional capacity exam of January 19, 2012 and found it was not valid and felt Petitioner should return to work without restrictions with no further treatment. (Resp.Exh.1,p.12-13). He further said there should be no surgery because

Petitioner's symptoms don't correspond to any single anatomic pathology. (Resp.Exh.1,p.9). However, Dr. Bendre ultimately said he was being extremely cautious about the surgery because of the extreme uncertainty Petitioner would get better as a result. He referred to his December 9, 2011 examination as "showing tenderness over the lateral and medial elbow in the origin of the common extensor and flexor pronator tendons" as "objective findings," and agreed there were objective and subjective elements to his examination. (Resp.Exh.1,p.16). Therefore, while Dr. Bendre disagrees with surgery because he says there is not a single anatomic pathology, he notes an anatomic pathology in his own examination. He agrees Petitioner has a condition and agrees Petitioner's condition was caused by work.

Petitioner has had conservative treatment which includes physical therapy at Hammond Henry Hospital which records are Petitioner's Exhibit 4. Initial evaluation notes Petitioner has increased pain in his left elbow with the increasing demands of the job as a pest control technician since Spring. Petitioner reported to physical therapy this is a recurring lateral epicondylitis over seven years of this job and he has always been able to treat himself in the past, but not on this occasion. (Pet.Exh.4). His discharge summary of September 20, 2011 noted he continued to have pain, decreased range of motion, tenderness to light touch, decreased grip and decreased ability to use his left arm. He did not meet his functional long term or short term goals. (Pet.Exh.4).

Respondent appears to be arguing Petitioner's complaints should be given no weight as they are not valid pursuant to a functional capacity exam, thus ultimately questioning Petitioner's credibility. This, however, does not comport with Respondent's own evidence of how they feel about their former employee. Records of Sertoma include statements of Shawn McGill of Houghton Pest Control of March 20, 2013 who, when asked if he would re-hire the Petitioner, stated he would if the Petitioner's arm was fixed and he was able to lift. (Resp.Exh.4). The pre-employment physical for Sertoma further showed Petitioner has a left elbow weight restriction of 15 pounds. This was completed by pre-employment physical conducted by physicians with Concentra. (Resp.Exh.4).

Petitioner has a condition causally related to his employment and it can be cured with a simple procedure and be limited to be off work for a maximum of six weeks. Because of Respondent's refusal to accept these complaints, approve a surgical procedure that is quite simple and bring Petitioner back to work, it has been delayed for too long.

Based upon all of the foregoing, the Respondent should be responsible for the surgical procedures recommended by Dr. Stewart and the surgery recommended by Dr. Stewart is reasonable and necessary and causally related to the accident in question.

IN SUPPORT OF (L) - Temporary Benefits

Petitioner has been under a restriction since his follow up visits with Dr. Stewart. Dr. Stewart's office notes, from his November 21, 2011 visit indicate Petitioner was unable to work until his next office visit "after surgery." In his July 5, 2012 visit Dr. Stewart was recommending an epicondylar release and stated "I will see him back once he has been approved for the surgery. Otherwise we will continue with his restrictions." (Pet.Exh.1). In Dr. Rabacal's visit of May 9, 2013 he continued the use of medication for the elbow joint pain and was awaiting surgery. Petitioner testified he had not been paid temporary total disability benefits since the end of 2012; however, the Request for Hearing sheet indicates the period of TTD as being February 28, 2012 through April 3, 2013, a period of 57-4/7 weeks. Petitioner is entitled to temporary total disability benefits for that period of time.

With regard to temporary partial disability benefits, Petitioner indicates he began working in a part-time, restricted duty capacity on April 4, 2013 and the records support that testimony. Utilizing his testimony and the records submitted by Respondent, it appears Petitioner would have worked 9 weeks at 24 hours per week at an hourly rate of $8.25 and 15 weeks at 32 hours per week at a rate of $8.25 per hour. Thus, during this period of time he earned $5,742.00. Had he been working for Houghton Pest Control and based upon his average weekly wage of $387.44 he would have earned $9,298.56. The differential is $3,556.56 and his temporary partial disability calculation would result in a payment of $2,371.04, representing a differential of $98.79 per week for 24 weeks. Because he is partially disabled as a result of injuries sustained and his current condition, the Respondent is responsible for that temporary partial disability payment.

IN SUPPORT OF (N) - Credit

Petitioner is not at maximum medical improvement. The Respondent is responsible for surgery. Any credit, which amount was stipulated to be $235.56, is deferred pending completion of the surgery and release from surgical care and is denied without prejudice in this instance.

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

Dorthy Negangard,

Petitioner,

14IWCC0655

vs.

NO: 12 WC 19949

State of Illinois Dept of Transportation,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

14IWCC0655

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: AUG 0 4 2014
o7/23/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NEGANGARD, DORTHY
Employee/Petitioner

Case# **12WC019949**

14IWCC0655

ST OF IL DEPT OF TRANSPORTATION
Employer/Respondent

On 9/27/2013, 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:

1909 ACKERMAN LAW OFFICES
JAMES W ACKERMAN
1201 S 6TH ST
SPRINGFIELD, IL 62703

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

0558 ASSISTANT ATTORNEY GENERAL
ERIN DOUGHTY
500S 2ND ST
SPRINGFIELD, IL 62701

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

1430 CMS BUREAU OF RISK MGMT
WORKERS COMPENSATION MANAGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

SEP 27 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0655

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

Dorothy Negangard
Employee/Petitioner

v.

State of Illinois Department of Transportation
Employer/Respondent

Case # **12** WC **19949**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield** , on **August 9, 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 _____

14IWCC0655

FINDINGS

On **December 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 **$64,105.60**; the average weekly wage was **$1,232.80**.

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

Respondent shall be given a credit for medical benefits that have been paid by its group health insurance, and Respondent shall hold petitioner harmless from any claims by any medical providers for any related medical. Additionally, Respondent shall pay Petitioner $2,607.63 for out of pocket medical.

ORDER

Temporary Total Disability: Respondent shall Pay Petitioner temporary total disability benefits of $821.86 per week for 10 2/7 weeks as provided in Section 8(b) of the Act.

Medical: Respondent shall pay Petitioner out of pocket medical in the amount of $2607.63.

Permanent Partial Disability: Respondent shall pay Petitioner permanent partial disability benefits of $695.78 per week for 125 weeks because the injuries sustained resulted in a 25% loss to 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.

D. Dan McCarthy
Signature of Arbitrator

Sept. 20, 2013
Date

SEP 27 2013

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

14IWCC0655

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dorothy Negangard,	)	
	)	
Petitioner,	)	
	)	
v	)	12 WC 19949
	)	
STATE OF ILLINOIS - IDOT,	)	
	)	
Respondent.	)	

MEMORANDUM OF DECISION OF ARBITRATOR
FINDINGS OF FACT

Petitioner Dorothy Negangard is 52 years old and has worked for the Illinois Department of Transportation for the last 35 years. (T, pg. 28). She currently works as an engineering technician, dealing with funding and cost analysis for other agencies. (T, pg. 28). Prior to that, she worked as an executive secretary. (T, pg. 33). She has worked at the IDOT Hanley Building, located at 2300 S. Dirksen Parkway in Springfield, since approximately 2006. (T, pg. 58). Petitioner's job duties are primarily composed of "desk work." (T, pg. 29).

Prior to her date of accident Petitioner had had a number of injuries. In 2006 she had surgery to repair a shattered disc in her neck. (T, pg. 29). She testified that she continued to experience pain after her surgery. In 1995 she had surgery to repair a ruptured disc in her lower back. (T, pg. 30). Petitioner continued to experience intermittent symptoms, which could last between minutes and days, after that surgery. (T, pg. 31). In 1978 Petitioner had a right knee related work accident, and eventually in 2005 she had a total knee replacement. (T, pg. 31). Prior to that replacement she experienced degenerative symptoms related to her right knee. (T, pg. 31).

On December 22, 2011 Petitioner testified that she was leaving the Hanley building around midday to attend a lunch time appointment with her ailing mother. (T, pg. 34). She

exited the Hanley building on the north end and proceeded out towards the parking lot. (T, pg. 35). Petitioner was parked in a general space north of the reserved parking in the executive bay. (T, pg. 33). Petitioner testified that as she was stepping into the lot a car quickly pulled out of the parking bay and sped towards her. (T, pg. 36). In her report to her supervisor after the accident Petitioner indicated that she was not hit by the car; rather, she jumped to avoid the car and fell down backwards in the process. (RX 1). At trial Petitioner stated that she wasn't sure if she was hit by the car or not. (T, pg. 41-42). She recalls falling back and hitting her head and then laying on the ground. (T, pg. 36).

Petitioner was initially assessed by James "Rusty" Edwards Jr., the assistant lead for CMS property management and a former first responder, who witnessed the accident. (T, 8). Mr. Edwards testified that there were no defects present in the parking lot that impacted the accident he witnessed on December 22, 2011. (T, pg. 22). Mr. Edwards testified that CMS owned the parking lot where the accident took place, but that individuals who worked for IEMA, IDOT, visitors to the buildings, and the general public using the nearby bike trail were all allowed to park in the lot. (T, pg. 14). Mr. Edwards additionally testified that the driver of the vehicle involved in the accident was a young woman who did not work for IDOT. (T, pg. 25). Mr. Edwards spoke to both the Petitioner and the driver at the scene. (T, pg. 11-12).

Petitioner refused to be treated by an ambulance at the scene. (RX 1, T. pg. 60). She sought medical assistance later on December 22, 2012 at the Memorial Medical Emergency Room. (PX 2). She was diagnosed with head and back contusions and a cervical sprain and was discharged the same day. (PX 2). No acute findings were made intracranially, cervically, or with regard to the right wrist. (PX 2). Petitioner returned to work on December 27, 2012, after the winter holiday. (T, pg. 45). Petitioner testified that she continued to experience back pain following her visit to the emergency room. (T, pg. 44). Petitioner underwent a lumbar microdiscectomy with Dr. Russell at Memorial Medical center on February 6, 2012. (PX 2). Petitioner was released to return to work on April 16, 2013. (RX 3, T, pg. 45). She was released to be seen on an "as needed" basis by Dr. Russell's office on June 11, 2013.

CONCLUSIONS OF LAW

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

Injuries which occur in parking lots owned by employers satisfy the "in the course of" requirement for compensability. The evidence shows that the Petitioner was injured in such a lot. While visitors to the building were also allowed to park in the lot, the area involved was designated for employee parking. (PX 10) The issue is whether the accident arose out of the employment.

The issue is whether the Petitioner's presence in the parking lot on that date and time resulted in an increased risk of accident over that faced by the general public. Evidence to establish an increased risk include the fact that the lot was not patrolled nor marked with traffic signs or signals and that visitors historically drive too fast for conditions in the lot. There was no evidence offered in rebuttal. The evidence also showed that the visitor who caused the Petitioner's accident was driving negligently, according to the Petitioner's supervisor. (RX 1) The visitor backed out of her parking spot, and proceeded east against the normal flow of traffic. Mr. Edwards, who witnessed the accident, said that she was driving "a little too fast." When she reached the road which would take her out of the lot, she turned north and almost hit the Petitioner. The Petitioner said that the visitor "whipped out" of the parking lane towards her. Mr. Edwards said that when she got out of her vehicle, the visitor was holding her cell phone.

The Arbitrator believes that the above evidence establishes that the parking lot was hazardous. The risk in such a lot that someone would disobey the suggested direction of traffic, drive too fast for conditions and/or fail to pay attention while driving is greater than what one would likely encounter on normal regulated roadways. The risk contributed to the accident.

In support of his decision, the Arbitrator cites the Appellate Court's decision in Hammel v. The Industrial Commission, 253 Ill. App. 3d 900 (1993)

In Hammel, the petitioner's car was struck by a semi-truck in a company parking lot. The configuration of the lot which allowed semis to cross with other traffic created a hazard to which the general public was not exposed, accordingly to the Court.

The Arbitrator finds that the Petitioner sustained an accident which arose out of and was in the course of the Petitioner's employment.

Issue (f): Causation

Prior to the accident, the Petitioner had treatment and symptoms involving her cervical and lumbar spine and her right knee. She had cervical disc and fusion surgery in 2006, a right total knee replacement in 2005 and lumbar disc surgery in 1995. She testified that her knee had been fine after surgery, but acknowledged some ongoing symptoms of pain and aggravations of both the cervical and lumbar injuries.

According to her testimony, corroborated by the emergency room records on the accident date, she sustained injuries to her neck, lower back, right wrist, right knee and head, as exhibited by headaches.

Her lumbar problems were the most serious. She was sent for an MRI on December 28, 2011. She complained of pain in the lower back radiating down the left leg. The MRI was interpreted as showing a small disc rupture at L5-S1 on the left impinging on the left S1 nerve root. Dr. Russell, when seeing her for the first time on January 20, 2012, reviewed the MRI and agreed with the radiologist's interpretation. He said that the disc appeared to be new and was causing her symptoms. When she did not respond to conservative treatment, he performed a microdiscectomy at that level on February 6, 2012. (PX 2)

The medical records show a continuous stream of treatment since the surgery without a complete resolution of the Petitioner's symptoms. Dr. Russell reviewed a subsequent MRI on June 6, 2012, and said that it showed scarring around the left S1 nerve root. When he last saw her on June 11, 2013, he said her strength and flexibility were good, while noting her ongoing chronic symptoms.

The Petitioner's testimony was consistent with what she told her doctors following her surgery. She now has a standing work station, because of problems with sitting. She has pain with normal activities of daily living, and she is forced to sleep on a couch for comfort.

With respect to her other injuries, the Petitioner complained of cervical pain with tingling to her fingers when seen in the emergency room. Dr. Chapa noted pain and swelling in the right

wrist and tenderness in the right knee. Finally, she complained of posterior headaches in the emergency room. (PX 2)

Her treatment records following her initial visit do not show any active treatment for her headaches, wrist or knee. This is somewhat understandable as she was treating for a herniated disc in the lower back. However, even after her back surgery, there is no indication that she received any treatment for those injuries. She did see her knee surgeon on April 4, 2013, but the office notes indicate the visit was a regular follow up related to her knee replacement. (PX 3) Dr. Russell does note symptoms of neck stiffness in his surgical follow-ups and, in his last office note, says she has chronic cervical spine issues. (PX 3)

The Petitioner testified that she has daily neck pain and headaches several times a week. She also said that her wrist bothers her when she lifts items around the home. She said that her right knee was fine.

Based upon the above evidence, the Arbitrator believes the Petitioner has shown that her injuries are causally related to her accident.

Petitioner's Earnings (Issue G)

The Petitioner's average weekly wage is $1,232.80. The document submitted by the Petitioner is her paystub – Salary Earnings Statement. It shows gross earnings, for the period ending December 15, 2011, of $61,640.21. It accounts for 50 of the weeks of the year. Petitioner was injured on December 22, 2011, so this accounts for almost an entire year of salary. It is good evidence of the Petitioner's average weekly wage. $61,640.21 divided by 50 is $1,232.80. The Respondent prepared the check without the litigation in mind.

The Respondent submitted a document called "Summary of Disability" for its evidence of Petitioner's average weekly wage. (Respondent's Exhibit #1). However, it is unclear where the Respondent gets the numbers. It was prepared when the Respondent knew there was a claim and there may be litigation. It has no documentation. It is unclear who filled out the form. The document does not say what day of the year it starts accruing information. Rather it indicates that it starts "07/11 – 12/11" Respondent could be starting its calculation July 1st or

July 30 of 2011 and going through December 1 of 2011 or December 30 of 2011. While Respondent may not have done that, Respondent drafted the summary (presumably). Respondent should have at least been clear about its calculations. Regardless, an unsigned, unverified, unclear "Summary of Disability" is not as reliable as the paycheck the Respondent gave the Petitioner before there was a claim.

Further, Respondent claims that the Petitioner made less in the entire year of 2011 ($61,422.00) than it put on the paystub it issued for 50 weeks ($61,640.21). Respondent wholly failed to explain the difference. Accordingly, Petitioner's average weekly wage is $1,232.80.

Issue (K) Temporary Total Disability

Petitioner was injured December 22. She was off work for 4 days initially. However, 2 days were holidays, so she is only entitled to the other two as TTD. She returned to work on the 27th of December. Her doctor took her off following her surgery, which occurred February 6, 2012. She returned to work on April 16, 2012. Petitioner is awarded 10 and 2/7 weeks of TTD.

Issue (J) Medical

Respondent shall be given a credit for medical benefits that its group health insurance paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services related to the injury. Additionally, Respondent is ordered to pay out of pocket expenses directly to the Petitioner in the amount of $2,607.63 as set forth in Petitioner's exhibit #12.

Issue (L): What is The Nature and Extent of the Injury?

The Petitioner's date of injury is January December 22, 2011, thereby subjecting her to the §8.1b guidelines of the Illinois Workers' Compensation Act. According to §8.1b(b) "the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of injury; (iv) employee's future earning capacity; (v) evidence of disability corroborated by treating medical records." Anecdotal evidence on non-work related

activities is no longer a factor for consideration regarding permanency under these new guidelines.

With regard to subsection (a) Respondent did not obtain an AMA rating, and Petitioner opted not to request an IME. With regard to subsection (ii) Petitioner is still working in the same capacity as an engineering technician. (T, pg. 28, 45). Her current job is clerical in nature, but she does not type as much as she did in her previous positions. (T, pg. 52). Her job duties are varied. (RX 1). Both parties agree that Petitioner was 50 years old at the time of her accident. (RX 1). Petitioner only missed two workdays after her accident, and was off work approximately 10 weeks, post-surgery. (PX 2, T, pg. 45). She returned to work on April 16, 2012. (PX 2). She testified that because of her ongoing lower back symptoms, she has changed her work station to allow her to stand to perform her job. With regard to subsection (v), she sustained a herniated disc which did not respond completely from her surgery. A post surgical MRI showed scarring around the left S1 nerve root which is consistent with her complaints.

As a result of her accident, the Petitioner has sustained disability to the extent of 25% Person As A Whole, with 22.5% being attributed to her lumbar injuries and 2.5% attributed to her cervical injuries. The Arbitrator does not find any permanent partial disability resulting from her other injuries.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Deborah Seeman,

Petitioner,

14IWCC0656

vs.

NO: 11 WC 473

Pontiac Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 20, 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: AUG 0 4 2014
O7/23/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SEEMAN, DEBORAH
Employee/Petitioner

Case# **11WC000473**

14IWCC0656

PONTIAC CORRECTIONAL CENTER
Employer/Respondent

On 8/20/2013, 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 0.07% 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 M STROW
110 E MAIN ST
OTTAWA, IL 61350

2502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PKWY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

5116 ASSISTANT ATTORNEY GENERAL
GABRIEL CASEY
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

AUG 20 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0656

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

DEBORAH SEEMAN,
Employee/Petitioner

v.

PONTIAC CORRECTIONAL CENTER,
Employer/Respondent

Case # 11 WC 00473

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

14IWCC0656

FINDINGS

On **December 13, 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 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 **$57,603.00**; the average weekly wage was **$1,107.75**.

On the date of alleged accident, Petitioner was **50** years of age, ***single*** with **no** dependent children under 18.

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

Petitioner failed to prove she sustained an accidental injury arising out of and in the course of her employment with Respondent on **December 13, 2010.** Petitioner further failed to prove that her current claimed condition of ill-being was caused by any activities performed on behalf of Respondent.

All claims for compensation made by Respondent in this matter 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 JOANN M. FRATIANNI

August 15, 2013
Date

AUG 20 2013

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

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

Petitioner was employed as a corrections officer for Respondent. Petitioner claims bilateral wrist injuries due to repetitive work activities that manifested on December 13, 2010. Petitioner testified that her job duties varied based on the area she was assigned to but included using keys, opening and closing doors and gates, using a computer, patting down inmates and visitors, inspecting vehicles, using the telephone, monitoring prisoners, escorting and restraining inmates, taking notes, checking ID cards, pushing a wheeled gate, securing the armory area, and serving meals through chuckholes in the cell doors. Petitioner testified that she most recently worked in the healthcare unit and the gatehouse.

Petitioner estimated that during an 8 hour shift she would turn more than 100 keys. While left handed, she also used her right hand to turn keys to open doors, cells and chuckholes.

Petitioner testified her first hand symptoms occurred in 2010 when she was assigned to the gatehouse, where she would process and pat down visitors and inmates entering and leaving the facility. She would also inspect vehicles and sign out weapons to guards leaving the facility, and lock, unlock and push a rolling gate. From 2007 to 2009, Petitioner worked at the healthcare unit, opening chuckholes at least 80 times a shift and occasionally restraining inmates for transport. Petitioner testified she also made written notations every 10-30 minutes.

Major Kevin Delong was called to testify by Respondent. Major Delong testified he is a relief shift commander. Mr. Delong testified that in the gatehouse, Petitioner was required to look up information on the computer system, check visitor IDs, pat down visitors and staff, access the weapons safe, use the telephone and push buttons. Major Delong testified that Petitioner process an average of 13 vehicles each day. Major Delong testified an average pat down takes 6-10 seconds, unless an officer feels a longer search is warranted.

Petitioner saw her primary care physician, Dr. Marlene Henze, on July 6, 2010. Dr. Henze noted Petitioner had been taking hyperthyroid medication since age 30, but stopped taking it for a year and gained weight in the interim. Petitioner returned to see Dr. Henzee on December 13, 2010 with complains of aching to her hands, dropping items and tingling. Petitioner was referred to see Dr. Lawrence Nord. (Px3)

Petitioner saw Dr. Nord on June 21, 2011. Dr. Nord testified by evidence deposition. (Px7) Dr. Nord testified he initially diagnosed bilateral carpal tunnel syndrome. Dr. Nord felt this syndrome was aggravated by Petitioner's job tasks, which he indicated was repetitive gripping and repetitive flexion-extension as aggravating factors. Dr. Nord testified the onset of Petitioner's symptoms were insidious, which meant a specific activity, time or date could not be pointed to as the cause of bilateral carpal tunnel syndrome.

Dr. Nord testified he performed carpal tunnel surgical releases on Petitioner on June 29, 2011 and July 27, 2011. During a post-operative visit on September 6, 2011, Dr. Nord noted that the patient was gratified with the relief obtained and had no complaints at that time.

Dr. Nord did admit that the was not aware what correctional officers do at the prison and did not know how much time she spent taking notes, feeding inmates or using keys. Dr. Nord also felt a person with hyperthyroidism who stops taking medication for a year would be at a higher risk of developing carpal tunnel.

Petitioner saw Dr. James Williams at the request of Respondent. Dr. Williams examined her on December 13, 2012. Dr. Williams discussed the job duties with Petitioner as a corrections officer, toured the Pontiac Correctional Center, and personally used keys and opened doors and locks she used. (Rx1) Dr. Williams indicated turning a key takes 10-15 seconds.

Petitioner reported her hyperthyroidism that was also reflected in medical records the doctor reviewed. She also smoked 3-5 cigarettes each day for 10 years and explained she was postmenopausal since 1991, has hypertension and her BMI was 29.9. (Rx1) Dr. Williams stated these factors increase Petitioner's risk of developing peripheral neuropathies, such as carpal tunnel syndrome. Dr. Williams was of the opinion that if Petitioner performed certain job tasks, like key turning with far more frequency and little rest, it could be a potential causative factor of bilateral carpal tunnel syndrome, but since she only turned 7-8 keys an hour, job-related manipulation was not a factor in her carpal tunnel syndrome. (Rx1)

Based upon the above, the Arbitrator finds the repetitive activities identified by Petitioner are but a small amount of the total types of activities she could possibly perform during a shift. In addition, Dr. Williams concluded after a plant inspection the job activities were not highly repetitive in nature. Dr. Williams concluded her job duties were neither causative nor permanently aggravating the upper extremity syndromes. Dr. Nord disagreed with Dr. Williams, but unfortunately had a lack of knowledge as to the specifics of Petitioner's job duties. In addition, Dr. Nord was not familiar with the duties of a corrections officer.

Based upon the above, the Arbitrator finds that Petitioner failed to prove that she sustained accidental injuries arising out of and in the course of her employment by Respondent in this matter.

Based further upon the above, the Arbitrator also finds that the conditions of ill-being complained of are not causally related to the work activities she performed on behalf of this 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?

See findings of this Arbitrator in "C" and "F" above. Based upon these findings, all claims made for medical expenses by Petitioner are hereby denied.

K. What temporary benefits are in dispute?

See findings of this Arbitrator in "C" and "F" above. Based upon these findings, all claims made for temporary benefits by Petitioner are hereby denied.

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

See findings of this Arbitrator in "C" and "F" above. Based upon these findings, all claims made for permanent partial disability benefits by Petitioner are hereby 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

Myra Wilke,

Petitioner,

14IWCC0657

vs.

NO: 10 WC 37340

E St Louis School District,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, 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 June 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.

14IWCC0657

The party commencing 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: AUG 0 4 2014
o7/22/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILKE, MYRA
Employee/Petitioner

Case# **10WC037340**

14IWCC0657

E ST LOUIS SCHOOL DISTRICT #189
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:

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0810 BECKER PAULSON HOERNER & THOMPSON
RODNEY W THOMPSON
5111 W MAIN ST
BELLEVILLE, IL 62226

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

Myra Wilke
Employee/Petitioner

v.

E. St. Louis School District #189
Employer/Respondent

Case # **10** WC **37340**

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 **Collinsville**, on **January 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 _____

14IWCC0657

FINDINGS

On **September 1, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$70,412.68**; the average weekly wage was **$1,354.09**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given credit for all payments that have been previously made as provided in the Act.

ORDER

Respondent shall pay any outstanding bills for the treatment that Petitioner has received as they were reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$664.72**/week for **126.5** weeks, because the injuries sustained caused the **50%** loss of the **left arm**, or **25.3%** loss of **man as a whole** as provided in Section 8 of the Act.

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

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

Deborah L. Simpson
Signature of Arbitrator

June 21, 2013
Date

JUN 25 2013

14IWCC0657

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Myra Wilke,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 10 WC 37340**
	)	
E. St. Louis School District #189,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on September 1, 2009, 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 and that the Petitioner's current condition of ill-being is causally connected to this injury or exposure. 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) were the medical services that were provided reasonable and necessary and has Respondent paid all appropriate charges for all reasonable and necessary medical services; (2) what is the nature and extent of the injury.

STATEMENT OF FACTS

The Petitioner testified that she is a 61-year-old Early Childhood Special Education Teacher. That she was employed by the Respondent, East St. Louis School District #189 in that capacity on September 9, 2009. She has been a teacher for nearly 30 years and worked for Respondent for four and one half years. At that time she had eight children with medical disabilities, each child had an individual lesson plan that she was responsible for. She had the children every day that they were not ill and they ranged in age from three to five years of age.

The parties stipulated that Petitioner was injured in the course and scope of her employment when an autistic male student who loved to swing on her arm. He would put both hands on her arm and swing until her assistant was able to remove him. On September 1, 2009, while he was pulling on her arm, she lost feeling when her arm dropped.

The parties stipulated to accident, notice, causation, reasonableness and necessity of medical care and treatment, Respondent's liability for medical bills and temporary total disability benefits. The only issue in dispute is the nature and extent of the injury.

Petitioner first reported to her primary care physician, Dr. Brett Winkler, who described limited range of motion and pain. He indicates in his medical notes that the Petitioner did not recall any acute injury. (P. Ex. 3) He recommended medication and an MRI. (P. Ex. 3) The MRI demonstrated a full thickness tear of the supraspinatus tendon at its insertion, a possible partial tear of the subscapularis tendon, rotator cuff tendonitis, and peritendinitis. (P. Ex. 4) Petitioner was referred to an orthopedic surgeon, Dr. Richard C. Lehman. (P. Ex. 3)

Dr. Lehman took a history of injury and opined that Petitioner's injuries were causally related to work. Dr. Lehman diagnosed rotator cuff pathology with nerve traction pain along with secondary adhesive capsulitis due to disuse. (P. Ex. 5) Dr. Lehman prescribed preoperative physical therapy to attempt to regain range of motion prior to operative care. Surgery was performed on December 11, 2009 which included a left shoulder arthroscopy, rotator cuff repair, acromioplasty, biceps tenodesis, and PRP injection after debridement of supraspinatus, and subscapularis repair. (P. Ex. 5, 7)

Following surgery, Petitioner progressed slowly and her range of motion was limited. (P. Ex. 5, 6) On February 24, 2010, after being diagnosed with frozen shoulder, Petitioner underwent a second shoulder procedure, closed manipulation of the left shoulder. Petitioner continued to undergo physical therapy was released to return to full duty on April 6, 2010. (P. Ex. 5, 6) Petitioner continued to return to Dr. Lehman with complaints of pain, tightness, weakness, and limited range of motion. Physical therapy, injections, home stretching and medication continued to be prescribed. (P. ex. 5, 7) Petitioner testified on cross examination that Dr. Lehman asked her to see another doctor for a second opinion and she agreed to do so.

On October 11, 2010, Petitioner sought a second opinion with Dr. Michael Milne. Dr. Milne took the history of Petitioner's work injury, initial surgery, second surgery, and current complaints. He reviewed her x-rays with her and conducted a physical examination. (P. Ex. 8) Petitioner was diagnosed with left shoulder adhesive capsulitis, left shoulder calcific tendonitis, and left shoulder calcium deposition after arthroscopy and manipulation. Dr. Milne opined that Petitioner required a repeat manipulation with arthroscopic debridement to regain her range of motion. He specifically noted that Petitioner was unable to work as she could not lift her arm more than 90 degrees. (P. Ex. 8)

Petitioner returned to Dr. Lehman, who concurred with Dr. Milne, and recommended an MRI which evidenced extensive tendinopathy of the supraspinatus tendon with intrasubstance tearing that extended to the bursal surface as well as significant bony hypertrophy in the lateral aspect of the shoulder. Petitioner had substantial soreness and crepitus, which had been ongoing. (P. Ex. 5) Dr. Lehman released the Petitioner to return to work full duty at that time as well. (P. Ex. 5)

On December 13, 2010, the Petitioner saw Dr. Richard F. Howard, D. O., at the request of the Respondent for an examination pursuant to Section 12 of the Act. (P. Ex. 9) Dr. Howard reviewed what he described as approximately 2 inches of medical records, took a history from the Petitioner, conducted a physical examination of the Petitioner had x-rays taken and reviewed

them. (P. Ex. 9) According to Dr. Howard the Petitioner's clinical picture had not improved much with the treatment that she has had so far. It was his opinion that her current condition was the result of the incident in September of 2009. He believed that she was not at MMI, could benefit from additional surgery, specifically a capsular release and excision of the heterotopic ossification followed by postop radiation and aggressive therapy. He further opined that it was unlikely that she would ever get a normal shoulder but her function was so poor currently she would benefit from additional treatment. He believed that she could work, however she needs to be limited to lifting no more than five pounds and no overhead work. (P. Ex. 9).

On 2/2/11, Petitioner underwent a third shoulder procedure, including a left shoulder arthroscopy, acromioplasty, capsular release, extensive debridement, resection of calcification lateral deltoid and subacromial space, extensive debridement under C-arm control, resection of calcification, and PRP injection. (P. Ex. 5) After surgery, Petitioner followed with Dr. Lehman and underwent an extensive course of physical therapy, stretching and strengthening program, and anti-inflammatory gel.

On June 2, 2011, Petitioner saw Dr. Lehman for follow-up. She was doing well, extensor and flexor mechanics were improving although she noted she had fairly aggressive pain at this point still. She was released to return to work light duty at that time. (P. Ex. 5)

On July 19, 2011, Petitioner again saw Dr. Lehman for follow-up. At that time the doctor reported that her range of motion was improving, as well as her extension and flexion. She had some soreness with rotation but her motion has gotten much better and she has made good strides. He released her to return to work full duty at that time. (P. Ex. 5)

Physical therapy records indicate that Petitioner made good effort and ultimately improved enough to be released to full duty work by Dr. Lehman. Petitioner testified that Dr. Lehman released her to return to work full duty at maximum medical improvement.

Petitioner testified that the treatment by Dr. Lehman helped her arm, but that she still continues to have residual problems and complaints. Petitioner has difficulty caring for her personal hygiene. She can no longer take a bath on her own because she cannot push herself out of the bathtub and it is difficult to shampoo or style her hair. Petitioner has her husband shave under her arm because she is physically unable to do so. Petitioner has difficulty putting on clothes and cannot wear a coat unless she has assistance to put it on, which is embarrassing for her. She cannot fasten her bra in the back so has to wear bras that fasten in the front. These undergarments do not provide her with adequate support, but they are the only type she can wear. Cleaning her home is difficult because she cannot push a sweeper with her left hand, cannot reach to clean mirrors, and cannot carry a basket of laundry. Sleeping is difficult because she has to keep her arm straight and cannot hold her husband. Petitioner testified that her arm goes numb in the middle of the night and she will have to wake her husband up to massage it so that the feeling comes back. She stated that this has been happening more often in the past six months. She testified that she is constantly in pain and uses a pain gel on her arm three times a day. Grocery shopping requires assistance to pick up heavy items and to load and unload her car. She is unable to reach or lift anything overhead.

On cross-examination, Petitioner testified that when she was allowed to return to work the first time, she had to pick up a child on April 16, 2010. It was painful when she did it, but she is not claiming that as a re-injury or as a second injury. She testified that she was laid off on May 25, 2010 by Respondent due to a reduction in force and has not been able to secure other employment. She testified that her limited use of her left arm has made it difficult for her to find alternative employment. Before her work injury, she had no other injury, evaluation or treatment for her left arm. Petitioner testified that she underwent extensive physical therapy, but that she had not been to physical therapy for two months and noticed that her arm was increasingly numb and weaker than before. Petitioner testified that she would likely need to continue to see Dr. Lehman indefinitely into the future.

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.

Were the medical services that were provided reasonable and necessary and has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The report of the Respondent's Section 12, examiner, Dr. Howard indicates that the Petitioner's current condition is the result of the accident she reported in September of 2009, that she has not had much improvement at this point, could benefit from additional surgery and medical treatment and physical therapy. He further opined that even given the additional treatment it is unlikely that she will regain full function of her shoulder. Based upon the medical records and opinions of all three doctors, Dr. Lehman, Dr. Howard and Dr. Milne the Arbitrator finds that the treatment that the Petitioner has received is reasonable and necessary and the responsibility for payment is the Respondent's pursuant to the Act.

What is the nature and extent of the injury?

Petitioner sustained serious and permanent injury to her left arm, resulting in extensive testing, aggressive physical therapy, multiple injections, and requiring three surgical procedures. Petitioner has suffered an impairment of function, including constant pain, limited range of motion, and limited activities. Petitioner credibly testified to limitations in reaching, lifting, pulling, pushing, and overhead activities. The doctors' notes and examinations support the ongoing complaints. Petitioner is unable to care for basic aspects of daily living, including cooking, cleaning, shopping, dressing, and caring for her personal hygiene. Therefore, as a result of Petitioner's physical impairment, Petitioner has sustained the loss of 50 % of her left arm or 25.3% loss of man as a whole.

ORDER OF THE ARBITRATOR

Petitioner is found to have suffered a permanent injury pursuant to Section 8(e) of the Act. Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for

126.5 weeks, because the injuries sustained caused the 50% loss of the left arm or 25.3% loss of man as a whole, as provided in Section 8 of the Act.

Respondent shall pay any outstanding bills for the treatment that Petitioner has received as they were reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Deborah L. Simpson
Signature of Arbitrator

June 21, 2013
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Doris Buxton,
Petitioner,

vs.

NO: 12 WC 13947

14IWCC0658

McLean County School District, Unit 5,
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 and permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 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: AUG 0 4 2014

Daniel R. Donohoo

Charles J. DeVriendt

o-07/22/14
drd/wj
68

14IWCC0658

DISSENT

I respectfully dissent from the majority opinion. I would have reversed the Decision of the Arbitrator and found that Petitioner did not sustain her burden of proving a compensable accident.

In order to be compensable, an accident must not only occur in the course of employment, it must also arise out of the employment. In order for an accident to arise out of a claimant's employment, the employment must put the employee at greater risk for such an accident than the general public. In *Caterpillar v. Industrial Commission*, 129 Ill. 2d 52 (1989), the claimant stepped off a curb leaving an exit used by employees to get to the employee parking lot and twisted his ankle. The Illinois Supreme Court held an idiopathic fall in an employee parking lot is not a compensable accident under the Worker's Compensation Act unless there is some defect or inherently unsafe condition in the area of the fall.

In the case now before the Commission, I carefully scrutinized the surveillance video showing the fall. There is absolutely no evidence of any defect or unsafe condition in the parking lot. Petitioner testified she was not hurrying and did not know why she fell. While she was holding a small bag holding the remnants of her lunch and wallet, it did not appear to have any effect on the mechanics of her fall whatsoever. I do not agree that the video shows that Petitioner's shoe caught on any part of the curb. In my opinion Petitioner's fall in this case was a classic idiopathic fall which is not compensable. There were no defects or unsafe conditions on the premises. Therefore, Petitioner's employment did not expose her to any greater risk of suffering a fall than a member of the general public. Under the Illinois Supreme Court holding in *Caterpillar*, I would have found Petitioner did not prove she sustained a compensable accident. For these reasons, I respectfully dissent.

Ruth W. White

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUXTON, DORIS
Employee/Petitioner

Case# **12WC013947**

McLEAN COUNTY SCHOOL DISTRICT UNIT 5
Employer/Respondent

14IWCC0658

On 10/8/2013, 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 0.06% 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:

0564 WILLIAMS & SWEE LTD
JEAN SWEE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0264 HEYL ROYSTER
JAMES J MANNING
124 S W ADAMS ST SUITE 600
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DORIS BUXTON,
Employee/Petitioner

v.

MCLEAN COUNTY SCHOOL DISTRICT UNIT 5,
Employer/Respondent

Case # **12** WC **13947**

Consolidated cases: _____

14IWCC0658

An *Application for Adjustment 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 **Bloomington**, on **9/18/13**. 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 _____

FINDINGS

On **3/1/12**, 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 **$11,586.97**; the average weekly wage was **$263.34**.

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

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

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

Respondent shall be given a credit of **$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 **$5,451.28** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $220.00/week for 4-6/7 weeks, commencing 3/2/12 through 4/4/12, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $220/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.

Respondent shall pay all unpaid reasonable and necessary medical services of the Town of Normal Fire Department, Primus Trauma, Advocate BroMenn Healthcare, Bloomington Radiology, Schnack Chiropractic Center, Advocate Medical Group, and McLean County Neurology, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $5,451.28 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.

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

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

10/1/13
Date

OCT 8 - 2013

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 61 year old bus driver, alleges she sustained an accidental injury that arose out of and in the course of her employment on 3/1/12, when she fell while returning to her bus to retrieve her bus log for the day. Petitioner has worked for respondent as a bus driver for 7+ years.

On 3/1/12 petitioner returned from her bus route at approximately 4:00 pm. After placing her "empty" sign in the back of the bus she exited the bus, and then stepped onto a concrete sidewalk that was located right behind the bus. The petitioner testified that the sidewalk was approximately 6 inches above the parking lot. While standing on the sidewalk petitioner plugged the bus battery into the charging unit. Petitioner then began walking on the sidewalk with two other bus drivers towards the building. After walking a few steps petitioner realized that she had forgotten her log notebook that she had to turn in before punching out for the day. Petitioner turned quickly and began walking back towards her bus to retrieve it. As she stepped down off the sidewalk onto the parking lot, her right heel got caught on the raised sidewalk as she stepped down with her right leg, and she fell to the ground. Petitioner testified that she does not know how she landed, but noticed that her head hurt.

Petitioner was carrying a sack when she fell. She testified that the sack contained a bottle of Pepsi, partial lunch and a billfold. Petitioner testified that these items were used for nourishment while she was driving the bus for respondent. Petitioner was also carrying car keys and a work ID card in a smaller billfold in her pocket.

Petitioner testified that she was directed by respondent to park her bus in the bus lot. Petitioner testified that the lot holds 156 buses. She further testified that the lot is not open to the public and is both gated and fenced in.

Petitioner testified that retrieving the log notebook was on her mind as she walked back to the bus. She testified that she was also concerned about checking out on time.

Petitioner had undergone a meniscus repair surgery to her right knee following another work related injury in 2010. Following post operative treatment petitioner was released to return to her full duty job as a bus driver without restrictions. Petitioner weighs 275 pounds and is 5'2" tall. Petitioner testified that although her knee gets stiff at times, she did not know what caused her fall on 3/1/12.

Following the injury petitioner was taken by ambulance to the emergency room at BroMenn Advocate Medical Center by the Normal Fire Department. The Normal Fire Department report noted a history that petitioner was "walking and stepped of a curb in the parking area and fell to the asphalt striking her head." Petitioner gave a history at the hospital "that she had forgotten her book on the bus, she turned around quickly to

go and get it and states that she tripped on the curb.." An abrasion to the posterior aspect of petitioner's scalp was noted. She also reported a mild headache. Petitioner gave a history of a prior cervical fusion at C5-C6. Following an examination and diagnostic tests petitioner was diagnosed with a cervical strain and closed head injury with scalp abrasion. A CT scan of the brain showed a focal right frontopanetal scalp hematoma. Petitioner was given Flexeril and Motrin and told to follow-up with her primary care physician. She was authorized off work through 3/2/12.

On 3/5/12 petitioner presented to AMG for follow-up after being seen in the emergency room on 3/1/12. Petitioner was seen by the nurse practitioner. Petitioner gave a history of falling on 3/1/12 and hitting her head on concrete. She complained of headaches on a scale of 2/10. Petitioner was examined and authorized to stay off work until reevaluation in 3 to 4 days. She was advised to continue taking her pain relievers and muscle relaxants. On 3/9/12 petitioner followed up at AMG. She reported that her headaches were the same and that she was experiencing dizziness with movement. She also complained of neck stiffness and an inability to turn her head left and right. Petitioner was continued off work due to decreased rotation of her neck due to pain. On 3/15/12 petitioner followed up at AMG. She reported that her headaches were the same. She also reported significant dizziness particularly with movement and with head turning. She also reported some intermittent blurred vision the day before, which resolved after a few seconds. Petitioner was authorized off work through 3/23/12.

On 3/20/12 petitioner began treating with Dr. Monica Schnack at Schnack Chiropractic Center. Petitioner gave a history of "slipped or tripped on curb going back to bus.." Petitioner reported that she could not turn her head both ways all the way and had episodes of dizziness. She also reported headaches that come and go. Dr. Schnack's Worker's Compensation Initial Evaluation Report notes "Ms. Buxton's injury occurred during a fall. Slipped on ice trying to board school bus and hit my head on concrete." Petitioner treated with Dr. Schnack through 9/24/12.

On 4/6/12 petitioner returned to full duty work for respondent.

On 9/20/12 petitioner presented to Dr. Fang Li, a neurologist, for evaluation of her head. Petitioner reported an onset of recurrent headaches after a head injury in early March of 2012. She reported that she slipped on the curb at work and hit her head. Thereafter she complained of frequent headaches, 2 to 3 times a week, mostly right-sided and sometimes radiating to the cervical region or bifrontal regions. Petitioner also reported some nausea with the headaches. She denied any dizziness. Petitioner reported that over-the-counter analgesics and Ultram seemed to somewhat help her headaches. Petitioner gave a history of occasional headaches in the past, but was never formally diagnosed with migraines. Following an examination and

diagnostic test, Dr. Fang Li's impression was recent onset of recurrent headaches/trauma likely due to postconcussive headaches. Dr. Fang Li prescribed low dose Topamax, 15 mg, at bedtime for a week, and titrate, up to 30 mg, at bedtime. Dr. Li also indicated that petitioner could use Ultram, 50 mg, no more than once a day on an as needed basis for headaches.

On 9/24/12 petitioner last followed up with Dr. Schnack. She complained of pain in the bilateral region of the neck, stiffness in the neck, muscle spasm in the neck, grinding/grating sounds in the neck, dull headaches, and lightheadedness.

On 10/5/12 petitioner presented to AMG and reported that she was treating with Dr. Li for her headaches. On 11/7/12 petitioner presented to AMG for unrelated problems. She made no mention of any problems with her respect to her neck or her headaches.

Petitioner last treated with Dr. Li on 1/23/13 for her headaches. Petitioner testified that she had gone off Topamax and had a lot of migraines. She was instructed to continue taking Ultram and restart Topamax. She was instructed to follow-up in 3-6 months. No further records from Dr. Li were offered into evidence.

Currently, petitioner testified that she is still taking Topamax to control her migraines. She testified that as long as she takes this medication she does not have any migraines. Petitioner complained of some discomfort when she turns her head to the right. She denied experiencing any migraines or concussions before the injury on 3/1/12.

Petitioner is currently working full duty for respondent and is able to perform all the duties of her job as a bus driver. Petitioner testified that she is no longer treating for her head/migraines as long as she takes her Topamax.

Petitioner testified that she does not recall if the fall was due to any defect on the concrete island. She denied that she lost her balance when she fell.

Joseph Adelman, Director of Operations for respondent, was called as a witness on behalf of respondent. In 2012 the Transportation Department was part of his duties. Adelman testified that at the time of the accident he was not aware of any defects in the island where petitioner fell. He testified that he went out within 24 hours to inspect island and found no defects in the concrete island.

Respondent offered into evidence a videotape that depicted petitioner's fall. The video depicts petitioner's right foot catching or slipping on the concrete island as she attempted to step down from the island to the bus parking lot.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner alleges that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 3/1/12 when she fell while stepping down off the concrete island to the bus parking lot.

It is unrebutted that the area in which petitioner fell was for the exclusive use of the respondent's employees, was fenced in and had a gate. No public access was allowed in this area. Petitioner fell while walking back to her bus to retrieve her log notebook that she needed to turn in before ending her shift. Petitioner fell as she stepped off a concrete island onto the bus parking lot.

Petitioner testified at trial that she was not sure what caused her to fall. It is unrebutted that at the time of the injury petitioner was carrying a sack with a Pepsi, partial lunch, and billfold. Petitioner testified that the food in the sack was for nourishment while she was driving the bus for the respondent.

The arbitrator finds the credible medical records most contemporaneous to the injury contain histories of how the injury occurred. Petitioner told the first responders that she was "walking and stepped of a curb in the parking area and fell to the asphalt striking her head." Petitioner gave a history at the hospital "that she had forgotten her book on the bus, she turned around quickly to go and get it and states that she tripped on the curb.." Petitioner gave the nurse practitioner at AMG a history of falling on 3/1/12 and hitting her head on concrete. On 3/20/12 petitioner gave Dr. Schnack a history of "slipped or tripped on curb going back to bus.." Dr. Schnack's Worker's Compensation Initial Evaluation Report notes "Ms. Buxton's injury occurred during a fall. Slipped on ice trying to board school bus and hit my head on concrete." On 9/20/12 petitioner reported the Dr. Li that she slipped on the curb at work and hit her head.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner was exposed to a greater risk than the general public. Having had an opportunity to view the videotape of petitioner's fall the arbitrator finds the petitioner's right foot slipped off the concrete island as she was stepping down to the parking lot to reenter her bus and retrieve her log notebook.

The arbitrator finds it significant that in Dr. Schnack's Worker's Compensation Initial Evaluation Report she noted that petitioner "slipped on ice trying to board the school bus and hit my head on concrete." The respondent offered no evidence to rebut the fact that there may have been some ice on the edge of the concrete island that caused petitioner to slip. Although Adelman testified that he examined the area where petitioner fell and found no defect, he could not recall when he examined the area other than the fact that it was within 24 hours of the injury. Based on Adelman's testimony, the arbitrator finds that if Adelman's examination of the

area was not until the next day, any ice that may have been present at the time of the fall may no longer be there. Neither party offered into evidence any weather reports for 3/1/12.

In addition to the above, the arbitrator finds it significant that petitioner reported to the emergency room staff at BroMenn Advocate Medical Center almost contemporaneously with the injury that "she turned around quickly to go and get [the log notebook] ", and was carrying a sack that had food items in it that she would use for nourishment while driving the bus or waiting for the students.

Based on Dr. Schnack's report, the accident history petitioner gave at the hospital, the fact that the accident occurred in an area where access was restricted to only respondent's employees, the fact that petitioner was carrying a sack with items she consumed for nourishment while working as a bus driver, and the fact that Adelman may not have inspected the area petitioner fell until the day following the injury, the arbitrator finds the petitioner has proven by a preponderance of the credible evidence that she was exposed to a greater risk than the general public, and sustained an accidental injury that arose out of and in the course of her employment by respondent on 3/1/12.

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.

The petitioner denied any migraines prior to the injury on 3/1/12. She also testified that she had no recent complaints of neck pain following her cervical fusion and prior to 3/1/12. Given respondent's failure to offer any evidence to rebut the causality of petitioner's migraines and neck pain following the accident on 3/1/12, the petitioner's unrebutted testimony that she did not experience any migraines prior to the accident on 3/1/12 or any recent neck problems prior to 3/1/12, the arbitrator finds the petitioner's current condition of ill-being as it relates to her migraines and neck pain is causally related to the accident she sustained on 3/1/12.

J. WERE 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.

As a result of the accident on 3/1/12 petitioner received medical treatment from the Town of Normal Fire Department, Primus Trauma, Advocate BroMenn Healthcare, Bloomington Radiology, Schnack Chiropractic Center, Advocate Medical Group, and McLean County Neurology. Respondent offered no evidence to rebut the reasonableness and necessity of this treatment.

Petitioner claims the following bills for treatment she received following the injury on 3/1/12 remain unpaid:

- Town of Normal - $291.10
- Primus Trauma - 48.00
- Advocate BroMenn Health Care - $507.58
- Bloomington Radiology - $278.00
- Schnack Chiropractic Center - $ 1,847.55
- Advocate Medical Group - $45.00
- McLean County Neurology - $45.00

Based on the above, the arbitrator finds the treatment petitioner received from the Town of Normal Fire Department, Primus Trauma, Advocate BroMenn Healthcare, Bloomington Radiology, Schnack Chiropractic Center, Advocate Medical Group, and McLean County Neurology from 3/1/12 through 9/18/13 was reasonable and necessary to cure or relieve petitioner from the injuries she sustained on 3/1/12. The respondent shall pay all unpaid bills from these providers pursuant to Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $5,451.28 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

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 alleges that she was temporarily totally disabled from 3/1/12 through 4/4/12, a period of 4-6/7 weeks. Although respondent claims that it is not liable for any TTD benefits, it did not dispute the time period claimed. Having found petitioner sustained an accidental injury that arose out of and in the course of her employment by respondent on 3/1/12 and that her current condition of ill-being is causally related to the accident, the arbitrator finds the petitioner has proven by a preponderance of the credible evidence that she was temporarily totally disabled from 3/2/12 through 4/4/12,a period of 4-6/7 weeks. The arbitrator sets the "begin date" at 3/2/12 because by statute, temporary total disability benefits cannot commence until the day after the accident.

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

As a result of the accident on 3/1/12 the arbitrator finds the petitioner sustained a 3% loss of her person as a whole pursuant to Section 8(d)2 of the Act. Pursuant to Section 8.1b of the Act the arbitrator, in determining the level of permanent partial disability, bases her decision 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.

In the case at bar neither party offered into evidence the reported level of impairment pursuant to subsection (a). Petitioner's occupation before the injury was that of a bus driver for respondent. Following the accident petitioner returned to her full duty job as a bus driver for respondent. Petitioner was 61 years old at the time of the injury. The petitioner offered no evidence that her future earning capacity is in any way affected by the injury. In fact, the petitioner is still working her regular full duty job as a bus driver for respondent. With respect to any evidence of disability corroborated by the treating medical records, on 9/24/12 when petitioner last followed up with Dr. Schnack she complained of pain in the bilateral region of the neck, stiffness in the neck, muscle spasm in the neck, grinding/grating sounds in the neck, dull headaches, and lightheadedness. On 11/7/12 petitioner presented to AMG for unrelated problems. She had no complaints with respect to her headaches or her neck. Petitioner last treated with Dr. Li on 1/23/13 for her headaches. Petitioner testified that she had gone off Topamax and had a lot of migraines. Petitioner was instructed to continue taking Ultram and restart Topamax.

Based on the above, the arbitrator finds the petitioner sustained a 2% loss of use of her person as a whole pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chad Ebers,

Petitioner,

vs.

14IWCC0659

NO: 11 WC 05726

State of Illinois/ Menard Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 7, 2014 is hereby affirmed and adopted.

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

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

DATED: AUG 0 7 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 7/31/14
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

EBERS, CHAD
Employee/Petitioner

Case# **11WC005726**

14IWCC0659

SOI/MENARD CORRECTIONAL CENTER
Employer/Respondent

On 2/7/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4075 FISHER KERHOVER & COFFEY LO
JASON COFFEY
1300 1/2 SWANWICK ST BOX 191
CHESTER, IL 62233-0191

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 7 2014

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

14IWCC0659

Chad Ebers
Employee/Petitioner

v.

State of Illinois/Menard Correctional Center
Employer/Respondent

Case # 11 WC 05726

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 December 12, 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 _____

14IWCC0659

FINDINGS

On January 24, 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 $57,528.00; the average weekly wage was $1,106.31.

On the date of accident, Petitioner was 32 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 3, as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule. Respondent shall 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 pay Petitioner permanent partial disability benefits of $663.79 per week for 12.65 weeks because the injury sustained caused the five percent (5%) loss of use of the right arm as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

February 3, 2014
Date

FEB 7 - 2014

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 January 24, 2011, and that Petitioner sustained repetitive stress/trauma to the right elbow/arm. Respondent disputed liability on the basis of accident and notice.

Petitioner worked for Respondent as a Correctional Officer for approximately 15 years. Petitioner testified that he worked seven and one-half years in the cell galleries and seven one-half years in the towers, health care unit door and kitchen area. Petitioner typically worked the 3:00 PM to 11:00 PM shift.

Petitioner testified that his work as a Correctional Officer required the repetitive use of both of his upper extremities but more of the right than left. While working in the cell galleries, Petitioner would engage in bar rapping which is when the individual runs a metal rod over the metal bars to determine if they have been tampered with or altered. Petitioner would use his right hand when bar rapping and would perform this task one time per shift. Petitioner used Folger-Adams keys in locks and he stated that it was common for the keys to get stuck and be difficult to turn. Petitioner also had to pull on heavy metal doors to make certain that they were securely locked. Petitioner also had to cuff/uncuff inmates and, when there was a lockdown, he would turn a crank that was used to secure all of the cell doors in a unit.

When Petitioner was working as a door officer in the health care unit and in the kitchen, he was not doing any bar rapping. He also agreed that for a 16 month period between 2002 and 2004, he worked as a tower officer and that he did not participate in any bar rapping or pulling on doors. Petitioner testified that he was the health care unit door officer from 2006 to 2010, and that he did not engage in bar rapping during that assignment either. Further, during this period of time, he used keys smaller than the Folger-Adams keys that he used in the galleries and that the locking mechanism in the door was much newer and easier to operate than the doors in the cell galleries.

Petitioner testified that over time he began to experience symptoms in the right elbow and the ring and little fingers of his right hand. Petitioner stated that he initially experienced numbness/tingling in the little and ring fingers of his right hand in 2007. Petitioner stated that he thought the symptoms were work-related; however, Petitioner did not seek medical attention until January 24, 2011, when he was seen by Dr. David Brown, an orthopedic surgeon. Petitioner was referred to Dr. Brown by his attorney.

When Petitioner was seen by Dr. Brown on January 24, 2011, he informed him that he had been a Correctional Officer since 1998 and that his job duties included bar rapping, keying locks, opening/closing doors and cuffing/uncuffing inmates. Dr. Brown examined Petitioner and opined that the symptoms and findings were consistent with right cubital tunnel syndrome. Dr. Brown referred Petitioner to Dr. Dan Phillips for nerve conduction studies which were performed that same day. The nerve conduction studies were positive for mild cubital tunnel syndrome more on the right than left. Dr. Brown prescribed conservative treatment which consisted of a splint, pad,

and medication. In regard to causality, Dr. Brown noted the lack of any non-occupational risk factors and opined that Petitioner's work activities were a possible aggravating factor (Petitioner's Exhibits 1 and 2).

On February 3, 2011, Petitioner completed a Workers' Compensation Employee's Notice of Injury in which he reported a work-related repetitive trauma injury to his right elbow. The form stated that Petitioner engaged in repetitive keying, opening/closing doors and bar rapping and that the injury was cubital tunnel syndrome of the right elbow (Respondent's Exhibit 1).

Dr. Brown saw Petitioner again on October 24, 2011, and Petitioner's right arm/hand symptoms had improved with Petitioner having less numbness/tingling in the fingers and some discomfort in the right elbow. On clinical examination, the range of motion of the elbow/wrist was normal and there was only a mildly positive Tinel's sign over the ulnar nerve. Dr. Brown recommended Petitioner continue to wear his splint at night and continued to take anti-inflammatory medication as needed (Petitioner's Exhibit 2).

Petitioner tendered into evidence a medical report dated April 29, 2011, prepared by Dr. Anthony Sudekum regarding a Correctional Officer at Menard Correctional Center and the deposition testimony of Dr. Sudekum taken in connection with same on June 13, 2011 (Petitioner's Exhibits 5 and 6). Dr. Sudekum did not perform a Section 12 examination of Petitioner. In both the narrative report and deposition, Dr. Sudekum opined that the job duties of a Correctional Officer at Menard Correctional Center, in particular, bar rapping, could be a possible aggravating factor in the development/progression of cubital tunnel syndrome.

At trial, Petitioner testified that he is no longer experiencing numbness in either the ring or little fingers of his right hand and that his pain symptoms have also resolved. He did state that he still experiences an occasional shock-type sensation in his elbow which occurs both when he is at work and not at work. Petitioner has lost no time from work as a result of this condition.

Conclusions of Law

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

The Arbitrator concludes that Petitioner sustained a repetitive trauma injury to his right elbow/arm arising out of and in the course of his employment for Respondent that manifested itself on January 24, 2011.

In support of this conclusion the Arbitrator notes the following:

Petitioner credibly testified that, while working as a Correctional Officer, he performed repetitive arm/hand activities including bar rapping, keying, pulling on doors and cuffing/uncuffing inmates.

There were periods of time during Petitioner's 15 years of working as a Correctional Officer that his level of repetitive use of his upper extremities varied; however, there was no evidence of any other factors that would cause or aggravate the condition of cubital tunnel syndrome.

While Petitioner initially developed these arm/hand symptoms in 2007, he did not seek any medical treatment or evaluation until January 24, 2011, when he was seen by Dr. Brown and Dr. Phillips. This was the first time that Petitioner was diagnosed with cubital tunnel syndrome and it is the date of manifestation.

Dr. Brown opined that Petitioner's work as a Correctional Officer was a possible aggravating factor for the development of cubital tunnel syndrome. While Dr. Sudekum never examined Petitioner, he did opine that the repetitive duties of a Correctional Officer at Menard Correctional Center could have been an aggravating factor for the development of cubital tunnel syndrome.

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

The Arbitrator concludes Petitioner gave notice to Respondent within the time limit prescribed by the Act.

In support of this conclusion the Arbitrator notes the following:

Petitioner's condition manifested itself on January 24, 2011, and Petitioner gave notice to Respondent on February 3, 2011, which is within the time limit prescribed by the Act.

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

The Arbitrator concludes that all of the treatment provided to Petitioner 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 3, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of five percent (5%) loss of use of the right arm.

In support of this conclusion the Arbitrator notes the following:

Petitioner was diagnosed with cubital tunnel syndrome, surgery was not recommended or performed, and, after a period of conservative treatment, most of Petitioner's right arm/hand symptoms resolved. Petitioner still has symptoms consistent with the injury that he sustained.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brett Klindworth,

Petitioner,

14IWCC0660

vs.

NO: 12 WC 35300

State of Illinois/ Pinckneyville Correctional Center,

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, wage rate, causal connection, medical expenses, prospective 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. 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 13, 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.

14IWCC0660

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: AUG 0 7 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 7/31/14
45

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

KLINDWORTH, BRETT
Employee/Petitioner

Case# 12WC035300

14IWCC0660

SOI/PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

On 2/13/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% 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:

0246 HANAGAN & McGOVERN PC
BRIAN McGOVERN
123 S 10TH ST SUITE 601
MOUNT VERNON, IL 62864

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

0558 ASSISTANT ATTORNEY GENERAL
FARRAH L HAGAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

0498 STATE OF ILLINOIS
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

FEB 13 2014

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
19(b)

14IWCC0660

Brett Klindworth
Employee/Petitioner

Case # 12 WC 35300

v.

Consolidated cases: n/a

State of Illinois/Pinckneyville Correctional Center
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on December 12, 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 _____

14IWCC0660

FINDINGS

On the date of accident, July 31, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $81,888.00; the average weekly wage was $1,547.77.

On the date of accident, Petitioner was 48 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 that Petitioner was paid service connected and extended time benefits for the period of TTD claimed by Petitioner and that Respondent is entitled to a credit.

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 4 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 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 the medical treatment recommended by Dr. Matthew Gornett including, but not limited to, L4-L5 disc replacement surgery and L5-S1fusion surgery.

Respondent shall pay Petitioner temporary total disability benefits of $1,031.85 per week for 51 1/7 weeks commencing September 20, 2012, through December 15, 2012, and March 15, 2013, through December 12, 2013, 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
ICArbDec19(b)

February 10, 2014
Date

FEB 13 2014

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 July 31, 2012. According to the Application, Petitioner was breaking up a right [fight] and fell to the floor sustaining injuries to the right knee and left hip. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. Respondent stipulated that Petitioner sustained a work-related accident on July 31, 2012; however, Respondent disputed that Petitioner sustained any injury to the low back as a result of the accident and denied liability for medical bills, temporary total disability benefits and prospective medical treatment in regard to any injury to the low back. In regard to temporary total disability benefits, the parties stipulated that Petitioner had been paid service connected and extended benefits during the time period for which temporary total disability was claimed and that Respondent was entitled to a credit for same.

At the time of the accident, Petitioner had worked at Pinckneyville Correctional Center for approximately 26 years and held the rank of Correctional Lieutenant. Petitioner testified that on July 31, 2012, he was in the dining room and that he had to break up a fight between two inmates. Petitioner stated that while he was breaking up the fight, he had one of the inmates in a headlock and he fell backwards landing on his right knee and left hip.

Shortly after the accident Petitioner completed and signed a Workers' Compensation Notice of Injury form. The form indicated that Petitioner struck his right knee on the floor and hurt his left hip while trying to separate/restrain two inmates who were fighting. There was no specific reference of an injury to the low back (Respondent's Exhibit 3). A Supervisor's Report of Injury was also prepared and the description of the accident was consistent with the preceding. Again, there was no specific reference to the low back having been injured (Respondent's Exhibit 4).

On July 31, 2012, Petitioner sought medical treatment at Family Medical Center where he was seen by PA Stephen Priebe. At that time, Petitioner's primary complaint was the posterior portion of the left hip but that there was no radiation of the pain. The assessment was described in the record as "hip pain" and PA Priebe recommended Petitioner take over-the-counter medication and apply ice/heat as needed (Petitioner's Exhibit 1).

Petitioner was seen again by PA Priebe on September 4, 2012, for left hip pain. An x-ray of the left hip was ordered and obtained that same day. The film indicated the possibility of a fracture of the left acetabulum. Because of the possibility of a fracture, a CT scan of the left hip was ordered and subsequently performed on September 19, 2012. The CT scan was negative for any fractures (Petitioner's Exhibit 1 and 2).

On September 27, 2012, Petitioner was seen again by PA Priebe and Petitioner advised that his left hip pain was worsening. Petitioner also complained of low back and left leg pain. The record from that visit indicated that the CT scan showed some severe degeneration of L5-S1 (this was not noted in the radiologist's report). In a report dated October 3, 2012, directed to Sue Zellers, PA Priebe opined that Petitioner had degenerative disc disease at L5-S1 that was exacerbated by

the work injury of July 31, 2012. He recommended that an MRI be performed and that Petitioner be seen by a back specialist.

An MRI scan of Petitioner's low back was performed on October 25, 2012, and it revealed severe degeneration of the L5-S1 disc with a small to moderate extradural defect thought to be a combination of disc bulging and a small osteophyte formation (Petitioner's Exhibit 2).

Petitioner returned to Family Medical Center on November 2, 2012, and, at that time, he was seen by Dr. John Fozard. Dr. Fozard's assessment was sciatic nerve lesion/piriformis syndrome and he prescribed medication and physical therapy. He saw Petitioner again on November 14, 2012, and referred him to Dr. Matthew Gornet, an orthopedic surgeon (Petitioner's Exhibit 1).

Dr. Gornet initially saw Petitioner on December 6, 2012. Dr. Gornet's record of that date contained the history of the work-related accident of July 31, 2012, and that Petitioner's initial symptoms were left buttock and hip pain. At the time of his evaluation with Dr. Gornet, Petitioner's complaints were left buttock pain, intermittent left leg pain radiating to the knee and occasional low back pain. Petitioner also informed Dr. Gornet that he had a back problem eight to 10 years prior for which he sought chiropractic treatment. Dr. Gornet examined Petitioner and reviewed the CT and MRI scans. Dr. Gornet opined that Petitioner had a bilobular disc herniation at L4-L5 on the left and a collapse at L5-S1. In regard to causality, Dr. Gornet opined that Petitioner's symptoms were related to the accident and he authorized Petitioner to be off work. He noted that "The absence of back pain should not be misinterpreted as an absence of spinal pathology." Dr. Gornet authorized Petitioner to work light duty with no inmate contact, that Petitioner have continued therapy and steroid injections (Petitioner's Exhibit 3).

Dr. Gornet referred Petitioner to Dr. Kaylea Boutwell, who administered epidural steroid injections to Petitioner at L4-L5 and L5-S1 on December 12, and December 26, 2012, respectively. Dr. Gornet saw Petitioner on January 28, 2013, and noted that the injections had temporarily relieved Petitioner's hip pain and that this was supportive of his conclusion that Petitioner's symptoms were originating in the back. He recommended that Petitioner have surgery consisting of disc replacement at L4-L5 and a fusion at L5-S1. He opined that the need for the surgery was related to the accident of July 31, 2012 (Petitioner's Exhibit 3).

Dr. Gornet saw Petitioner again on April 11 and August 12, 2013, and Petitioner's condition and work status remained unchanged. On April 11, 2013, Dr. Gornet ordered CT and MRI scans of the lumbar spine. The findings of these diagnostic studies were consistent with his diagnosis (Petitioner's Exhibit 3).

Petitioner continued to be seen at Family Medical Center, the most recent visit of which occurred on October 11, 2013. Petitioner has continued to complain of low back and left hip/leg pain and has been treated primarily with medication pending approval for surgery (Petitioner's Exhibit 1).

Dr. Gornet was deposed on September 30, 2013, and his deposition testimony was received into evidence at trial. Dr. Gornet's testimony was consistent with his medical records and he reaffirmed his opinion that Petitioner's low back condition was related to the accident of July 31, 2012, and that surgery was appropriate, specifically, disc replacement at L4-L5 and a fusion at

L5-S1. On cross-examination, Dr. Gornet testified that the disc pathology at L4-L5 was consistent with Petitioner's symptoms of left buttock and hip pain and that those symptoms began at the time of the accident of July 31, 2012. He also noted the fact that Petitioner's hip pain was temporarily relieved when he had the epidural injections in the low back and that this conclusively proved that Petitioner's pain was emanating from the back. Dr. Gornet did agree that the degenerative condition at L5-S1 pre-existed the accident; however, he opined that the accident aggravated it (Petitioner's Exhibit 5).

Petitioner testified that he previously had low back problems for which he received chiropractic treatment, the most recent treatment was in 2000. He still has complaints of back, left hip and left leg pain and wants to proceed with the surgery as recommended by Dr. Gornet.

Conclusions of Law

In regard to disputed issues (C) and (F) 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 July 31, 2012, and that the conditions of ill-being in both the left hip/leg and low back are causally related to same.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained a work-related accident on July 31, 2012, to his left hip and right knee. Respondent disputed causality in regard to the low back.

PA Priebe opined that Petitioner's degenerative disc disease at L5-S1 was exacerbated by the accident of July 31, 2012.

Dr. Gornet opined that Petitioner's low back condition was causally related to the accident of July 31, 2012. Dr. Gornet's opinion was based on his examination of Petitioner, his review of the diagnostic studies and the fact that when Petitioner received epidural injections to the low back, they relieved his hip complaints.

Respondent's basis for disputing causal relationship in regard to the low back is based on the lack of any immediate complaints in the low back at the time of the accident and that Petitioner did not have any low back complaints until approximately two months thereafter, when he was seen on September 27, 2012, by PA Priebe. There was no expert medical opinion that Petitioner's low back condition was not related to the accident and, further, Dr. Gornet observed that the absence of back pain should not to be misinterpreted as an absence of spinal pathology.

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

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

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 4, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes that Petitioner is entitled to prospective medical treatment including, but not limited to, disc replacement surgery at L4-L5 and fusion surgery at L5-S1, as recommended by Dr. Gornet.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 51 1/7 weeks commencing September 20, 2012, through December 15, 2012, and March 15, 2013, through December 12, 2013.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nathaniel Hodges,

Petitioner,

14IWCC0661

vs.

NO: 13 WC 06855

Wal-Mart Associates, 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, 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 specifically adopts the findings of fact and conclusions at law of the Decision of the Arbitrator. 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 30, 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.

14IWCC0661

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 $21,300.00. 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: AUG 0 7 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 7/31/14
45

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

HODGES, NATHANIEL
Employee/Petitioner

Case# **13WC006855**

14IWCC0661

WAL-MART ASSOCIATES INC
Employer/Respondent

On 1/30/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0560 WIEDNER & McAULIFFE LTD
MARY SABATINO
ONE 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
19(b)

14IWCC0661

Nathaniel Hodges
Employee/Petitioner

v.

Wal-Mart Associates, Inc.
Employer/Respondent

Case # **13** WC **06855**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **December 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. ☒ 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 14IWCC0661

On the date of accident, **January 22, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$16,989.96**; the average weekly wage was **$326.73**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $220.00/week commencing January 23, 2013 through December 17, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of **$11,000.00**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent is additionally ordered to provide to Petitioner prospective medical treatment including, but not necessarily limited to, the course of treatment prescribed by Dr. Gornet with regard to Petitioner's lumbar spine condition as it relates to the January 22, 2013 accident.

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.

Edul Lee
Signature of Arbitrator

1/22/14
Date

ICArbDec19(b)

JAN 30 2014

Findings of Fact

On January 22, 2013, Petitioner was a 55 year old night stocker for Respondent at its Carlyle facility. (AX2). He testified that on the evening of January 22, 2013 and into the morning of January 23, 2013, he was working the midnight shift and assigned the task of pulling and stacking pallets in Respondent's warehouse. (T.10). Petitioner testified that he was attempting to pull a pallet full of soda, water and gallon-sized jugs of liquid off a shelf when he began to notice pain and soreness in his lower back. (T.11). He indicated that he was often asked by other employees to help pull heavy pallets off of higher shelves since he is a taller individual. (T.11).

Petitioner testified that after he finished lifting the pallet, he informed his supervisor, Liz Navarro, that he had injured himself and asked her to take him to the hospital. (T.12). When she refused, Petitioner left the store and went to bed since he had to report to work the following evening. (T.13). Petitioner testified that around 9 PM on January 23, 2013, he attempted to get ready to report to work, but indicated that he was unable to get out of bed due to pain. (T.13). Specifically, he testified, "I was trying to get dressed, and I couldn't even—I couldn't even put my shoes on. I couldn't bend over to put my shoes on. So I just kind of slid some shoes on and managed to get to the store, and I told...Liz what was going on. I said, I'm sore. I can't work tonight." (T.13-14).

After informing his supervisor that he was unable to work, Petitioner testified that he left the store and went directly to St. Joseph's Hospital in Breese, Illinois. (T.14).

Petitioner presented to St. Joseph's Memorial Emergency Room on January 23, 2013 with complaints of back pain. One history describes that Petitioner "threw out" his back yesterday when he "went to turn and bend at the same time and had pain." (PX3, St. Joseph's Memorial Hospital, 1/23/13).

Another history taken at the Emergency Room states that Petitioner presented with acute back pain and "at home today he bent over to pick up a piece of paper and developed severe back pain. He states his symptoms occurred at 9:30." (PX3, St. Joseph's Memorial Hospital, 1/23/13).

A CT scan of Petitioner's lumbar spine was taken, which revealed multilevel spondylosis, with right-sided neural foraminal stenosis from L3-S1, and right paracentral and central broad based disc bulge at L3-L4. *Id.* The radiologist recommended further evaluation with an MRI. *Id.* Petitioner was ultimately released from the emergency room and instructed to follow up with his primary care physician, Dr. Gagen. He was prescribed 600 mg of ibuprofen as well as 50 mg of Tramadol for pain and instructed to return to the emergency room if his pain did not resolve. (PX3, St. Joseph's Memorial Hospital, 1/23/13).

At trial, Petitioner testified that he told the physicians at the emergency room when he presented on January 23, 2013 that he injured himself at work. (T.14). He specifically testified that he subsequently reviewed the records of St. Joseph's Hospital, which indicated that he had injured himself at home while picking up a piece of paper. (T.15). When asked at trial if this was what he told the emergency room physicians, he testified unequivocally, "No, it's not." (T.15).

Additionally, upon learning of this inaccuracy in the records, Petitioner testified that he went to the hospital and asked to have the records corrected to reflect the history he gave to the emergency room physicians that day. (T.15-16). At trial, Petitioner identified a portion of Petitioner's Exhibit 3, with the heading "Emergency Room Record requested by patient Nathaniel Hodges," which stated:

> Mr. Hodges requested to make the following clarification to the History of Present Illness as stated on the Physician's notes titled "ER Provider Documentation": Left work at 7 AM on January 23, 2013 with soreness and pain in the middle to lower back. Went to sleep at home. Woke up at 9:00 PM to go to work at 10 PM. Could hardly get out of bed, could not bend over to pick up a piece of paper, could not tie shoes, put them on and left them untied. Went to work and told supervisor that I couldn't work. Left work and went to the Emergency Room. (PX3, St. Joseph's Hospital, Addendum to the Emergency Room Record).

Petitioner testified credibly and without rebuttal that this addendum was an accurate reflection of the history he gave the emergency room physicians not only on January 23, 2013, but when he presented to the hospital to have the record corrected. (T.16).
On January 28, 2013, as his symptoms had not resolved, Petitioner followed up with Dr. Erin Gagen, his primary care physician. Dr. Gagen took the history of Petitioner's injury as follows:

> Patient here today for ER follow up for low back pain. States he had previously driven trucks and in past had pain and back would go out. Would get cortisone shots and improve. Pain always in low back but usually didn't get pain in legs. Used to be seen at People's Clinic in St. Louis. Started this time with pain last Tuesday morning. Lifts at work and usually from 1-100 pounds and lifts and moves items at Walmart as a night stocker. By Wednesday pain increased and going down both legs from knees upward and into the thighs. (PX5, Dr. Gagen, 1/28/13).

Dr. Gagen discussed conservative care with muscle relaxant, prednisone and Tylenol, and recommended an MRI if Petitioner's symptoms continued. *Id.* Petitioner was also given a prescription for Prednisone and Flexeril. *Id.*

Petitioner was then referred to Dr. Timothy Beaty by Respondent, who saw Petitioner on January 30, 2013. (T.19). At that time, Dr. Beaty took the following history: "Starting having back pain while pulling pallets at work on 1/22. Persistent pain to lower back since that time. Does go [sic] to legs at time with tingling to upper legs." (PX6, Dr. Beaty, 1/30/13). Dr. Beaty prescribed Petitioner Fioricet and kept him off work until he "finishes medication. Then if not improved will need MRI." *Id.*

Petitioner returned to Dr. Beaty on February 6, 2013 with continued complaints of back pain radiating into both legs without any improvement. (PX6, Dr. Beaty, 2/6/13). Since Petitioner had not improved, he recommended an MRI and again kept Petitioner off work until the results of the MRI were obtained. *Id.* Specifically, Dr. Beaty's note reads that Petitioner was unable to

return to work from January 22, 2013 and suspected that he would not be able to return until at least March 1, 2013. *Id.*

On February 7, 2013, Petitioner underwent an MRI at St. Joseph's in Breese, which revealed a right paramedian disc protrusion at L4-L5 with abnormal signal seen along the posterior aspect of L5, which most likely represented a sequestered disc fragment, as well a diffuse disc bulging at L3-L4 with right-sided foraminal narrowing. *Id.*

Based upon the results of the MRI, Dr. Beaty wrote on March 4, 2013, that "MRI shows lumbar disc herniation and therefore [Petitioner] needs release by neurosurgeon before can return to work." (PX6, Dr. Beaty, 3/4/13).

Petitioner testified that he has ultimately come under the care of Dr. Matthew Gornet, a board certified orthopedic spine specialist, who he first saw on May 20, 2013. (T.19; PX7, Dr. Gornet, 5/20/13). Dr. Gornet took the following history from Petitioner:

> This is the first visit and spinal examination for Nathaniel Hodges. The patient is a 55-year old whose main complaint is neck pain with headaches, pain to his upper back, tingling into both arms into his hands and low back pain to both sides and both legs. He states his current problem began on 1/23/13. He was working at Walmart. He stated that he completed the ten to seven shift and during that night he pulled a large pallet that he felt weighed over a ton and he developed increasing pain. He went to the emergency room literally that day, where he was seen, treated and released. We do have the note available. He had an MRI shortly thereafter. He stated that he has been working with heavy lifting for quite some time at Walmart and never had any significant issues or treatment. His symptoms are constant and worse with bending, lifting, prolonged sitting or standing and is better with a neutral position or lying down. (PX7, Dr. Gornet, 5/20/13).

After reviewing the MRI report and prior medical records, Dr. Gornet's impression was as follows:

> I have discussed with the patient that if his history is factually supported by other emergency room notes such as a triage note from the nurse or any other statements, then I would support the belief that his symptoms are causally connected to his work related activity as described. He understands that the medical record I have seen is a medical record that is electronically generated and if the wrong box is "clicked" then a patient can have different symptoms generated that are perpetuated in the medical record in spite of having a history that is contrary to this. It is for this reason, we take a long written history so that the notes are available for later use. Our recommendation at this point would be to obtain the full set of emergency room records as well as his MRI scan. Certainly, an acute disc herniation is not a chronic condition and tends to be consistent with

> what was described by the patient. I will see him back after he has obtained the medical records I have requested. *Id.*

At that point, Dr. Gornet released Petitioner to return to work light duty, with restrictions of no lifting greater than twenty (20) pounds, no repetitive bending and no repetitive lifting. *Id.*

Petitioner returned to Dr. Gornet on July 1, 2013. Dr. Gornet's note reads as follows:

> Nathaniel brought in numerous emergency room records. Obviously, we still have the pre-printed physician records. Again, Mr. Hodges clearly disputes this. He states that again he worked from 11:00 p.m. until 7:00 a.m. He went home and went to sleep and he woke up and had significant pain and felt that he could barely bend over. The emergency room record from 1/23/13 clearly states that the patient had severe back pain and that he "threw it out yesterday." This notation of yesterday would clearly indicate a problem that occurred the day before and not the morning of the ER visit, as indicated in the physician's note. The nurse's note states that his back usually "goes out every four or five years." This again is different than a chronic condition as stated by the physician there. At this point, based on the information I have, it appears as if Mr. Hodges is quite truthful to me. His mechanism of injury is consistent with this. The fact that he has an acute large disc herniation is also consistent with an acute injury and not a chronic condition. At this point, he feels that there is work video that would support that he was injured at the time, although this video is not being released. At this point, it is my opinion that his symptoms are causally connected to his work-related injury as described. I would recommend injections at L4-5 and L5-S1 on the left. I have also recommended an MRI of his cervical spine. We will attempt to get approval for this, but based on the information I have, I believe he suffered a disc injury at L4-5 with a large, fairly massive herniation as well as aggravation of what may be some preexisting disc degeneration at L5-S1. (PX7, Dr. Gornet, 7/1/13). [Emphasis added].

Dr. Gornet also kept Petitioner off work until September 9, 2013. *Id.*

Petitioner next followed up with Dr. Gornet on September 9, 2013. (PX7, Dr. Gornet, 9/9/13). Dr. Gornet continued to believe that Petitioner's symptoms were causally connected to his work injury that occurred on or about 1/22/13-1/23/13. *Id.* He reiterated his recommendation for injections at L4-5 and L5-S1, but indicated that treatment had been denied. *Id.* Dr. Gornet noted that Petitioner was "somewhat miserable." *Id.* He opined that Petitioner remained temporarily totally disabled until his next follow up appointment on November 11, 2013. *Id.*

Dr. Gornet saw Petitioner again on November 11, 2013, and noted that he continued to have symptoms in his low back for which he had recommended injections, which continued to be denied by his employer. (PX7, Dr. Gornet, 11/11/13). Dr. Gornet opined that Petitioner remained temporarily totally disabled. *Id.*

Petitioner testified at trial that Dr. Gornet has recommended Petitioner undergo injections, which have not been completed to date, and that he wishes to have the medical treatment recommended by Dr. Gornet. (T.19, 21).

At trial, Petitioner candidly acknowledged that he had some prior lower back symptoms approximately six or seven years ago, for which he received treatment and some injections. (T.20). However, Petitioner testified that on January 22, 2013, he was not under the care of any doctor for low back pain or symptoms, and was working full duty without any restrictions. (T.20-21).

Petitioner testified that he has been unable to return to work since the accident occurred, and specifically that when he was given light duty restrictions from Dr. Gornet, which included no lifting greater than twenty (20) pounds, no repetitive bending and no repetitive lifting, that he presented to Respondent ready, willing and able to work within these restrictions but was told that no light duty work was available for him. (T.22).

Conclusions of Law

With regard to disputed issue "C," the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner has met his burden of proof regarding the issue of accident. Petitioner testified as a credible witness on his own behalf that on the evening of January 22, 2013/the morning of January 23, 2013, he was lifting a heavy pallet full of various liquids off a shelf and felt pain in his lower back. (T.12).

Petitioner also reported this incident immediately to his supervisor, Liz Navarro, informed her that he was unable to finish his shift, and asked her to take him to the hospital. (T.12). He reported to St. Joseph's Emergency Room later that day after lying down to sleep did not improve his condition.

The Arbitrator notes that Respondent appears to base its dispute with regard to accident on a single physician's note from the emergency room which indicates that Petitioner injured himself "at home" while bending over to pick up a piece of paper. (PX3, St. Joseph's Hospital, 1/23/13). However, the Arbitrator also notes that Petitioner consistently testified that this history was inaccurate, and even requested that an addendum be issued to the emergency room records with the correct history attached once he discovered the mistake. (T.15-16). The Arbitrator also finds Petitioner's testimony to be credible in light of the fact that a similar or identical history of a lifting injury at work was given to each of Petitioner's treating physicians, including Dr. Gagen, Dr. Beaty, and Dr. Gornet. (PX5, PX6, PX7). In fact, Dr. Gornet, Petitioner's treating spine specialist, found Petitioner to be "quite truthful."

In support of his decision finding that Petitioner sustained an accident which arose out of and in the course of his employment, the Arbitrator notes that pursuant to Illinois law "the word 'accident' is not a technical legal term, and has been held to mean anything that happens without

design, or an event which is unforeseen by the person to whom it happens...Compensation may be allowed where a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel Co. v. Indus. Comm.*, 6 Ill.2d 296 at 300, 128 N.E.2d 718, 720 (Ill. 1955) citing *Baggot Co. v. Industrial Comm.*, 290 Ill. 530, 125 N.E. 254.

In light of Petitioner's credible testimony on his own behalf, as well as the corresponding medical records of Dr. Gagen, Dr. Beaty and Dr. Gornet, the Arbitrator finds that Petitioner sustained an accident which arose out of and in the course of his employment with Respondent on January 22, 2013.

With regard to disputed issue "E," the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner has met his burden of proof on the issue of notice. Petitioner testified credibly and without rebuttal that he provided notice of his injury to his supervisor, Liz Navarro, immediately after it occurred on January 22, 2013. He also testified that he returned to Respondent's facility the next day, on January 23, 2013, and again informed Ms. Navarro that he was unable to work due to his injury and that he was seeking medical attention for his injuries. (T.13-14). Respondent did not call any witnesses or provide any documentation to contradict Petitioner's credible testimony regarding notice.

Based upon Petitioner's credible testimony, the Arbitrator finds that Petitioner provided proper notice of his injury to Respondent pursuant to Section 4 of the Act.

With regard to disputed issue "F," the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner has met his burden of proof on the issue of causality. In support of this decision, the Arbitrator relies on the causation opinion of Dr. Gornet, Petitioner's treating orthopedic surgeon and finds his opinions to be persuasive. Dr. Gornet took the history of Petitioner's injury, reviewed the prior emergency records, and noted that the mechanism of injury was consistent with the pathology discovered upon examination and upon reviewing the MRI films. Dr. Gornet diagnosed Petitioner with an acute disc injury at L4-5 with a large, fairly massive herniation as well as aggravation of what he felt may be some preexisting disc degeneration at L5-S1. (PX7, Dr. Gornet, 7/1/13). The Arbitrator also notes that Dr. Gornet's medical opinion with regard to causation is the only one in the record.

Petitioner candidly acknowledged that he had prior symptoms in his low back and had occasionally received treatment for these symptoms; however, he indicated that any prior treatment occurred approximately six to seven (6-7) years prior to the January 2013 accident. (T.20). He similarly indicated that at the time of the accident, in January of 2013, he was working full duty without any restrictions whatsoever. (T.20-21).

The Arbitrator also notes that pursuant to Illinois law, when a preexisting condition exists, recovery may be had if a claimant's employment is a causative factor in his or her current condition of ill-being. *Sisbro, Inc. v. Industrial Commission*, 797 N.E.2d 665 (Ill. 2003). The

claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *St. Elizabeth's Hospital v. Workers' Compensation Commission*, 864 N.E.2d 266, 272-273 (5th Dist. 2007). The employer takes the employee as he or she is found. If a preexisting condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65, 67-68 (Ill. 1967); *see also Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 362 N.E.2d 339 (Ill. 1977).

At the very minimum, the Arbitrator finds that Petitioner sustained an aggravation of a pre-existing condition, which is compensable under the Act pursuant to the *Sisbro* doctrine. In further support of this finding, the Arbitrator also notes that Respondent did not have Petitioner examined by a physician of its own choosing and provided no contrary medical evidence other than the single emergency room note which indicates Petitioner injured himself at home.

With regard to disputed issues "J" and "K," the Arbitrator makes the following findings of fact and conclusions of law:

An employee is entitled to medical care that is reasonably required to relieve the injured employee from the effects of the injury. 820 ILCS 305/8(a) (2011). This includes treatment that is obtained to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 758 N.E.2d 18 (1st Dist. 2001).

As Petitioner has met his burden of proof on the above issues, the Arbitrator finds that Petitioner's medical care and treatment has been reasonable and necessary to date and reasonably required to cure or relieve the injured employee from the effects of the injury. Dr. Gornet has recommended Petitioner undergo injections at L4-5 and L5-S1 in an attempt to treat his lumbar spine condition conservatively.

The Arbitrator also finds that Respondent is liable for payment of the medical bills submitted in Petitioner's Exhibit 1 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. However, if Petitioner's group health carrier requests reimbursement, Respondent shall indemnify and hold Petitioner's harmless.

The Arbitrator also finds that Petitioner is entitled to receive prospective medical care pursuant to Section 8(a) of the Act. Dr. Gornet has recommended that Petitioner undergo injections, and Petitioner testified that he desires to have these performed. (T.19,21). Respondent is therefore ordered to authorize and pay for the prospective treatment recommended by Dr. Gornet including, but not limited to, the recommended injections and all treatment related to Petitioner's lumbar spine condition.

With regard to disputed issue "L," the Arbitrator makes the following findings of fact and conclusions of law:

As Petitioner has met his burden of proof on the issues of accident, causation, notice, and reasonableness and necessity of medical care and treatment, the Arbitrator also finds that Petitioner has met his burden of proof in determining that he is entitled to receive temporary total disability benefits for the period of January 23, 2013 through December 17, 2013.

Dr. Beaty, who was referred to Petitioner by Respondent, took Petitioner off work from January 22, 2013, until he was able to be evaluated and released by a neurosurgeon/specialist. (PX6). He was ultimately seen by Dr. Gornet on May 20, 2013. (PX7, Dr. Gornet, 5/20/13). Dr. Gornet initially gave Petitioner restrictions of no lifting greater than twenty (20) pounds, no repetitive bending and no repetitive lifting. *Id.* Petitioner testified that he took this light duty slip to Respondent, who sent him home and informed him that no light duty work was available. (T.22). Dr. Gornet has subsequently kept Petitioner off work from July 1, 2013 until the present. (PX7, Dr. Gornet, 11/11/11).

Therefore, Respondent is ordered to pay Petitioner temporary total disability benefits in the amount of $220.00/week commencing from January 23, 2013 to December 17, 2013, for a total period of 47 weeks 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.

STATE OF ILLINOIS)
) SS.
COUNTY OF LA SALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Montez Webster,

Petitioner,

14IWCC0662

vs. NO: 11 WC 02534

Singley Construction Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, prospective medical expenses, causal connection, wage rate, 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 January 8, 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.

14IWCC0662

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 $69,500.00. 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: AUG 0 7 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 7/31/14
45

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

WEBSTER, MONTEZ
Employee/Petitioner

Case# **11WC002534**

14IWCC0662

SINGLEY CONSTRUCTION INC
Employer/Respondent

On 1/8/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% 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:

1097 SCHWEICKERT & GANASSIN LLP
SCOTT J GANASSIN
2101 MARQUETTE RD
PERU, IL 61354

2461 NYHAN BAMBRICK KINZIE & LOWRY
THOMAS MALLERS
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC0662

Montez Webster,
Employee/Petitioner

v.

Singley Construction Inc.,
Employer/Respondent

Case # 11 WC 02534

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 **George Andros**, Arbitrator of the Commission, in the city of **Ottawa, in the city of New Lenox and in the city of Geneva**, on **1/8/13, 5/24/13, 8/24/13 & 9/19/13**. 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, **December 27, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $ 879.75 for 3 days; the average weekly wage was $ 439.87

On the date of accident, Petitioner was **40** years of age, ***single*** with **3** dependent children.

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

Respondent shall be given a credit of **$14,425.60** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$14,425.60**.

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

ORDER

Respondent shall be given a credit of $10,129.17 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 $293.25/week for 141 3/7 weeks, commencing December 28, 2010 through September 19, 2013, the date proofs were closed, this total already includes a reduction of 3 days for Petitioner's failed return to work attempt, as provided in Section 8 of the Act.

Respondent shall be given a credit of $14,425.60 for temporary total disability benefits that have been paid.

Respondent shall pay all reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,365.00 to Dr. George DePhillips, $2,901.00 to St. Mary's Hospital, $23,550.00 to Pain & Spine Institute, $276.00 to St. James Radiology, $567.00 to Morris Hospital, $1,193.07 to OSF St. Joseph Medical Center, $193.00 to Joliet Radiology, $810.00 to Joliet Headache, $1,695.00 to Joliet Open MRI, $14,134.68 to EQMD, $649.00 to Dr. Jason Bergandi, and $4,254.00 to Dr. Michel Malek, as provided in Sections 8(a) and 8.2 of the Act. The Arbitrator finds failure in coding in some bills which is the responsibility of providers not litigants.

Pursuant to Section 8(a) of the Act, the Respondent is ordered to provide the care recommended by Dr. Patrick Sweeney which initially includes a laminectomy and foraminotomy at L5-S1. Should this not resolve the Petitioner's lumbar condition as per below , a fusion at L5-S1 shall be considered subject to evaluation at that time. The Respondent shall also provide all ancillary care necessitated by the treatment which has been ordered.

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.

/s/ George J Andros
Signature of Arbitrator

December 27, 2013
Date

ICArbDec19(b)

JAN 8 - 2014

FINDINGS OF FACT & CONCLUSIONS OF LAW 11 WC 2534

On December 27, 2010 Petitioner Webster was hired by Respondent as a concrete finisher. He was working for the Respondent performing work at the Wal-Mart Superstore then under construction. This occurred in Streator which becomes notable below.

By this date, Montez Webster had already worked two days as a concrete finisher; Petitioner testified he was called by his business agent to work for the Respondent at its Wal-Mart jobsite. The Petitioner explained this project was near its beginning with foundation walls then being poured. The Petitioner testified the Respondent was to construct more than just the foundation. It was also required to build the floors, curbs, gutters, sidewalk and anything having to do with concrete. Respondent's two witnesses testified they were only one of two subcontractors for part of the entire job. Much testimony about the layout of the entire project was given. The lack of the safety box was forthcoming after both sides portrayed the deep hole a little differently is trying to establish and defend the accident body mechanics.

The Petitioner explained to build the footings, there is a lot of digging by hand, sledgehammer use and the placement of 4 x 8 forms about 12 feet below ground. Each of these concrete forms weighed 80 to 100 pounds.

Mr. Webster testified he was required to strip these forms off the concrete that had been previously poured between the forms to create the foundation walls. As the Petitioner was approximately 12 feet below the grade of the earth, after pulling off a form, he would turn with it and move toward the wall of the trench. In a fluid motion, Mr. Webster would "chuck" or project the form upward to a laborer who was waiting at the top of the ditch. The laborer would then grab the form and pull it over the top of the ditch where it was stacked. Mr. Webster's lifting action was similar to a "military press". This explanation is deemed logical given the worker is Deep in a narrow hole without OSHA required wall supports.

The Petitioner explained he was injured on the morning of December 27, 2010 while moving one of these forms. He was at the bottom of a trench and standing in an area that was a mix of ice and mud. Later testimony touched upon the frost line, mud and dirt and residuals of snow all over the macro-job site.

Mr. Webster explained while attempting to chuck a form upward, both feet slipped out to his sides, his back twisted from the waist up and he felt a sharp pain in his lower right back. The Petitioner stated when he experienced this pain, he was unable to remain standing and fell against the foundation wall. The form he was attempting to lift was still in his arms. He pushed that off him toward the wall. After a moment, Mr. Webster stood up and tried to once again lift the form resulting in pain. The Petitioner indicated the laborer at the surface of the trench saw the accident as it occurred. The Petitioner explained he then tried to get out of the hole but was told by his coworker to hold on, he was getting the foreman. In the interim, the Petitioner started, with difficulty, to climb a ladder to exit the ditch when the foreman, Joe Cleveland, arrived.

Mr. Webster said he talked to the foreman and told him he slipped while moving a form. The foreman then called Mr. Jeff Singley, a company exectutive, to come to the site. In the meantime, the Petitioner sat in his vehicle for approximately 30 minutes in the hope that his pain would reduce. It did not. This worker projected a high work ethic and interest in pursuing his trade at the jobsite in question.

Mr. Singley arrived at the scene and shortly thereafter took the Petitioner to the St. Mary's Hospital Occupational Health Department in Ottawa, Illinois. The medical facilities in Streator were notably avoided.

At the St. Mary's Occupational Clinic Health Department, their records indicate the Petitioner, a concrete finisher for Singley Construction, was lifting and pushing an object when he slipped and felt pain in his right lower back. Px 2. The records report slight radiation of pain into the Petitioner's gluteal area and back pain while walking. Id.

The Petitioner also voluntarily submitted to a drug screen. This was positive for marijuana and cocaine at low levels. Id. All witnesses who testified and who were present at the time of the accident reported no unusual behavior or impairment by the Petitioner or in the manner he performed his work. Mr. Webster explained that two weeks prior to the accident, he had used these drugs at a party but since had suffered no ill effects and was not under the influence of the drugs at the time of the accident. No lay witnesses indicate the Petitioner was impaired or in any way under the influence of drugs at the time of the accident.

At the company clinic Petitioner was initially diagnosed with a lumbar strain, provided over the counter pain medication and was told to use ice. Id. He was released to modified work of no bending or lifting greater than 20 pounds. Id. Of course, this initial clinical diagnosis was based upon the initial presentation.

Petitioner returned to the jobsite and performed the light duty work of sweeping out the Respondent's job trailers. Mr. Webster explained while doing this light work, his pain continued to worsen and included his neck, right knee and low back into his right buttocks. As a result of his increasing pain, he returned to St. Mary's Occupational Health Department. Following an examination, it was indicated that due to the Petitioner's December 27, 2010 work injury he suffered a lumbar, right knee and cervical strain. He was prescribed Naprosyn, Flexeril, Vicodin and modified work. The Petitioner testified no light duty or modified work was provided him at that time. No recordation of symptom magnification (to use a nurse case manager phrase) was seen.

On the referral of his fiancé, the Petitioner was next seen by Dr. George DePhillips, a neurosurgeon, on January 6, 2011. This is his first choice of medical treatment under the Act. Petitioner complained of injuries from his December 27, 2010 work accident. Px 4.

Dr. DePhillips recorded Petitioner was lifting a concrete form and was going to hoist it out of the ditch when his right leg slid on mud and he twisted his lower back in an effort to keep the form from falling. He immediately felt severe low back pain. He next consulted with St. Mary's Occupational Health Department and was placed on light duty. Since the injury, the Petitioner complained of low back pain radiating into his right buttock, posterior thigh to the knee with pain also in the right ankle and Achilles region with associated tingling. Mr. Webster reports 80% of his pain is in the lower back and on a scale of 1 to 10, it could reach a 10. Id. Visit notes also reflect deep tendon reflexes were reduced at the Petitioner's right ankle. Straight leg raising provoked right buttock and thigh pain at 45 degrees. Dr. DePhillips reported that the Petitioner had radicular pain and diminished ankle reflexes with indications of nerve root impingement. Id. He ordered an MRI of the lumbar spine to rule out a disc herniation with nerve root impingement prior to beginning a conservative course of treatment. Id. In the meantime, the Petitioner was ordered off work and provided pain medication. Id.

A January 24, 2011 MRI at St. Mary's Hospital was read as showing degenerative changes in T11 to T12. On a January 31 re -visit he continued to complain of low back pain radiating to the buttock, posterior thigh and calf to the ankle. Id. With extension, his low back pain was exacerbated. Id.

Following an examination, Dr. DePhillips reported a differential diagnosis which included a lumbar sprain/strain injury versus Bertolotti's Syndrome, a form of back pain associated with an anatomical variation of the 5th lumbar vertebrae found in his post accident radiographs. The Petitioner was ordered off work and to undergo physical therapy. CT cat scan of the lumbar spine was ordered to rule out abnormal articulation of the tranverse process at L5 or L6 of the sacrum.

On February 4, 2011 the Petitioner began a treatment program of physical therapy at Champion Fitness in Streator, Illinois. Px 8. He remained in physical therapy at that location until April 6, 2011.. As of his February 28, 2011 appointment with Dr. DePhillips, the Petitioner's low back pain continued and could reach as high as a 9 on a scale of 1 to 10. Occasional tingling occurred in the right foot. Physical therapy included lumbar disc decompression treatments but did not provide significant relief. Px 4. A CT scan was again recommended to rule out spondylolysis and Bertolotti's Syndrome. In the meantime, physical therapy was continued and the Petitioner was ordered to remain off work per Doctor's order.

On March 21, 2011 visit Dr. DePhillips reported the Petitioner's pain continued to vary and could reach an 8 out of 10. There was increased tingling in the sole of his right foot and complaints of pain to the right posterior calf. In the interim, at the request of Dr. DePhillips, the Petitioner consulted with Drs. Sharma and Patel regarding pain management. Dr. Patel's records demonstrate the Petitioner was injured on December 27, 2010 while lifting at work. Px 3. Since that time, the Petitioner has experienced lumbar radiculopathy and back pain. He reported the Petitioner was currently off work and instituted pain management.

At his April 4, 2011 visit with Dr. DePhillips, the Petitioner reported his right leg gave out and caused him to fall. Px 4. The Petitioner's low back pain is now at a 10. Dr. DePhillips reported the Petitioner's pain was myofascial, facet mediated or related to his sacroiliac dysfunction. He felt surgery was not then an option and ordered Mr. Webster to return to Dr. Patel for diagnostic trigger point injections.

He released him to work at sedentary physical demand or office work for 3 days a week at a maximum of 8 hours per day. Id. The Petitioner was provided with a job beginning April 7, 2011. To do this work, he traveled 1 hour and 45 minutes each direction to Polo, Illinois. He reported this travel exacerbated his pain which was sharp and included a burning type sensation in the low back and right leg.

Mr. Webster explained he was only able to do this work for 3 days before being precluded from it by pain. Px 4. At a May 23rd Dr. De Phillips appointment, he wrote the Petitioner's return to work failed due to increased complaints of pain from the long commute. Id. His pain is now in the right buttocks shooting down the posterolateral thigh and calf to the ankle. Id. He reported the Petitioner had undergone a diagnostic right SI joint injection by Dr. Patel which provided no relief. Id. It was felt Dr. Patel might want to pursue facet or myofascial trigger point injections. Id. In the meantime, Dr. DePhillips kept the Petitioner off work and an EMG of the right lower extremity was ordered. By his June 27, 2011 follow up appointment, an EMG had yet to be approved by the Respondent.

Dr. DePhillips continued his recommendation of an EMG of the right lower extremity and indicated the Petitioner should remain off of work while considering an additional diagnostic SI joint injection and a possible radiofrequency rhizotomy procedure versus an SI joint fusion. Dr. DePhillips wanted to rule out SI joint dysfunction as the Petitioner indicated the most recent SI joint injection provided significant temporary relief.

By August 8, 2011 follow up, he was still experiencing low back pain radiating to the right lower extremity.

An EMG had now been performed by Dr. Zabiega confirmed possible right L5 radiculitus that also correlated with his clinical symptoms of L5 radiculopathy. Px 4 & 9. The differential diagnosis at this point included right sacroiliac dysfunction and L5 radiculopathy secondary to L4-L5 disc tearing. Px 4. A follow up MRI was recommended and the Petitioner was kept off work.

At his next appointment with Dr. DePhillips of August 22, 2011, the Petitioner's lumbar MRI was reviewed and revealed mild facet arthropathy at L4-5 and L5-S1 which was not appreciated by the radiologist. Id.

Following a review of the MRI and an examination, Dr. DePhillips explained to Mr. Webster his pain could be discogenic and that the work injury aggravated his facet arthropathy. Id. As a result, diagnostic facet injections were recommended. Id. If the injections confirm his pain is facetogenic, he may be a candidate for radiofrequency ablation or facet fusion.

In his follow up appointment of September 26, 2011, Mr. Webster reported he underwent diagnostic medial nerve branch blocks. The first injection gave him approximately 70% relief for 6 hours which was consistent with a long acting anesthetic. The second injection of Lidocaine gave him 2 hours of relief but only at 40%. Dr. DePhillips reported that because the response was concordant in nature and consistent with the anesthetic used, it was reasonable to proceed with radiofrequency rhizotomies. Id. He further explained a significant component of his pain is facet mediated. Id. He also wrote he may consider a lumbar discography. The Petitioner remained off of work in the interim.

In October, November and December, the Petitioner continued to follow with Dr. Patel for pain management. Px 3. By his December 8, 2011 visit, the Petitioner reported some improvement but it was limited in nature. Eleven days later, Dr. DePhillips saw the Petitioner. Px 4. His notes indicate the Petitioner continues to experience back pain shooting into his right lower extremity. After an examination, various options were discussed with the Petitioner.. Following the same, a lumbar discogram was ordered. A discogram performed on January 26, 2012 demonstrated concordant results at L5-S1. Id. A CT scan that followed found annulus tearing at L3-4 and L5-S1. However, the L3-4 finding was later confirmed not to be an annular tear but due to an intra-annular injection occurring during the discogram. At the above visit Dr. DePhillips opined plus explained an *anterior lumbar interbody fusion was appropriate* to deal with Mr. Webster's pain. Id. *However, prior to proceeding, a second opinion was recommended. As a result, the Petitioner next met with Dr. Jason Bergandi, an orthopedic spine surgeon. Px 7.* (emphasis added).

On February 16, 2012, Dr. Bergandi the spine surgeon has his consultation second opinion with Petitioner for his work related accidental injuries. This consulting doctor explained the discogram was positive for a Grade III annular tear at L5-S1 with related concordant pain. Id. He also documented there appears to be possible right lower extremity radiculopathy. Id. Following his examination and review of the radiographs, Dr. Bergandi agreed the discogram provided evidence of significant pathology at L5-S1. Id. Prior to surgical remediation Petitioner was to continue activities as tolerated. Dr. Bergandi suggested Norco and Soma for pain until an anterior longitudinal interbody fusion could be completed. Both parties emphasis selective parts o f this doctor's records. The point is that Dr. Bergandi found pathology. The precise method of treatment evolved over the duration of treatment.

Following his visit with Dr. Bergandi, the Petitioner continued to treat with Dr. DePhillips who continued to keep him out of work due to his work injury. Px 4. Dr. DePhillips continued to follow the Petitioner and kept him off of work through his last visit with him on October 29, 2012. Id.

On that day, an off work slip was issued and the Petitioner was referred to Dr. Patrick Sweeney, an orthopedic surgeon with Minimally Invasive Spine Specialists in the far south suburbs of Chicago. This referral is still in the chain of referrals of Petitioner's first choice of providers.

Dr. Sweeney met with the Petitioner on December 6, 2012. Px 13. Mr. Webster provided a history indicating he was removing foundation forms and lifting them to a coworker above him when he slipped, fell backwards and twisted his low back region. Id. He reported low back pain at the time and followed with occupational health, Dr. Patel for a series of epidural steroid injections and Dr. DePhillips, his neurosurgeon who recommends a lumbar fusion.

An examination by Dr. Sweeney revealed forward flexion of 65 degrees and extension to 20, lateral bending at 20 degrees bilaterally. Id. Pain was noted with axial loading and with extension rotation on the left greater than the right. Id. Sensation was diminished in the right anterior thigh, posterior and later calf, as well as the dorsum of the right foot. Id. There is a positive straight leg raise on the right for both the posterior thigh and back pain.

A review of the MRI and CT discogram demonstrates partial thickness tearing at L5-S1 with L5-S1 foraminal narrowing and nerve root compression. The doctor noted the Petitioner suffers from entirely right sided pain with symptoms in his L5 distribution. After an examination and review of the testing, Dr. Sweeney indicated that although fusion is an option, he recommended a right L5-S1 laminectomy / foraminotomy prior to undergoing a fusion procedure for this work related accident which has failed conservative care.

The last treating physician seen by the Petitioner was Dr. Michel Malek on August 7, 2013. Px 14. The Petitioner was also referred there by Dr. George DePhillips who by then had relocated his practice out of State. Dr. Malek explained the Petitioner was injured in 2010 while approximately 10 to 12 feet below the surface while stripping concrete and moving forms. He was lifting those foundation forms weighing 80 to 100 pounds with both of his hands under the form to raise it out of the hole to another coworker. While doing this, the Petitioner's legs were far apart and spreading further. He then twisted his back.

Dr. Malek's history is consistent as much as I see in scrivener recordation by all doctors. He wrote the Petitioner presently uses Soma, Valium and Norco and that extensive conservative treatment, including injections, have failed. Id. Drs. DePhillips, Sweeney and Bergandi have recommended L5-S1 surgery (according to Dr. Malek). Px 4, 7 & 13. *Dr. Malek wants additional testing before surgery. Px 14.* Emphasis added.

Mr. Webster's treating records demonstrate no prior back surgery. Px 3, 4, 7, 13 & 14. Examination by his physicians show no Waddell signs and that on examination he has pain in the back of the right thigh on straight leg raising at above 40 degrees.

A CT / discogram demonstrates partial thickness tearing at L5-S1 and L5 proximal nerve root compression. Id. An EMG/NCV study by Dr. Zabiega confirmed possible right L5 radiculitis which correlates with the clinical symptoms of right radiculopathy. Px 9.

Dr. Malek noted Mr. Webster continues to suffer from his work injury of December 27, 2010 where he had a thoracolumbar sprain / strain which has now resolved. Px 14. He also has right lumbar radiculopathy clinically in the L5 distribution. Id. Dr. Malek also felt that the last MRI may have been misread as the patient appeared tilted in the MRI unit which showed asymmetry in the foramen. Id. That MRI is not correlated by the post-discogram cat scan. Id. Dr. Malek wrote the MRI does suggest a lateral disc herniation at L5-S1 which needs to be confirmed. Id. As such, the patient should repeat the discography at L5-S1 with a post CT scan to follow along with an EMG/NCV and an updated MRI. Id.

Dr. Malek opined that based upon the existing studies, he did not believe there is an indication for a lumbar fusion. However, after reviewing the updated testing, a decision could be made at that time. The Arbitrator finds the pathology exists yet matching the pathology to best method and timing of surgical remediation remains a work i.e treatment in progress.
This Arbitrator is overjoyed by the lack of rush to surgery in this case as compared to most cases I have encountered in this supervenue. Defining the exact site(s) of pathology, the choice of surgery as a remedy, and the technique as a best practice is what was going on over time by all the doctor's involved –none of whom defined this construction worker as a malingerer, symptom magnifier and alike. Secondary gain being off work is illogical for a highly paid tradesman anticipating weeks and weeks at this large project in a county devoid of such projects.

On August 16, 2013, the Petitioner underwent a repeat discogram. Following the discogram, Dr. Malek indicated that it demonstrated L5-S1 was the likely pain generator. Id. No signs of symptomatic magnification or malingering were recorded. A post-discogram and CT scan of the lumbar scan that was conducted and found a L5-S1 posterior disc protrusion / herniation indenting the ventral service of the thecal sac.

Craig Pikul testified he was one of the Respondent's employees and a coworker of the Petitioner on December 27, 2010. Mr. Pikul reports he was scheduled to work full time for the Respondent but, due to poor weather, there were several days the job was shut down. Mr. Pikul explained that while working for the Respondent, he worked along side the Petitioner. He stated Mr. Webster was a hard working jolly individual. On December 27, 2010, Mr. Pikul indicates the Petitioner was on time for work as he usually was. He states the Petitioner was approximately 12 feet below grade and located on a trench floor containing ice and mud. He was moving concrete forms. He explained he did not see the actual injury to the Petitioner but saw him immediately following. He stated the Petitioner appeared pale and in pain. He also explained the Petitioner slipped while lifting and moving a 100 pound concrete form. He withstood insightful cross examination. Mr. Pikul testified Mr. Webster and he are now friends and that he has seen him after the accident. This witness reports the Petitioner appears to continue to experience ongoing pain that he first noticed following the accident.

Thomas Mullady testified that on December 27, 2010 he was employed by the Respondent as a union laborer. He reported he is a friend of Montez Webster and was present on December 27, 2010 when the Petitioner was injured. Mr. Mullady testified that in the days leading up to December 27, 2010, the Petitioner appeared to have no physical problems or other impairments. He was just a hard worker that did his job. Mr. Mullady indicated on December 27, 2010, he and Mr. Webster were stripping 4 x 8 foot concrete forms that had been sprayed with diesel fuel so the concrete would not adhere to them.

The forms would be lifted from where he and Mr. Webster were located below the ground to a worker above who would then reach for and take the form that was being lifted. He explained Mr. Webster was lifting these forms during the morning of December 27, 2010 in a manner similar to that of a "military press". His legs would be bent and compressed and then decompressed and extended while pushing the forms upward to the individual located above the ground.

Mr. Mullady indicates he saw a concrete form begin to go up and then come down before it reached the surface. He next saw Mr. Webster with his back against the bank of the excavation they were in. He did not look well. The witness asked if Mr. Webster was okay and the Petitioner responded that he thought he tweaked his back. Mr. Webster stopped working at that point due to being in pain. He reports the Petitioner next exited the trench. He later noticed Montez Webster sitting in his vehicle.

This witness also indicated there were no time cards on this job and that Joe Cleveland, the jobsite foreman, was supposed to keep track of the hours worked. This witness was shown time sheets created by Joe Cleveland and copied onto another document by Joe Singley. The document created by Joe Cleveland, Rx 12, page 2, shows Montez Webster worked 6 hours and the term "hurt" was located next to his name. On the sheet prepared by Jeff Singley, Rx 12, page 1, it shows Montez Webster worked 6 ½ hours and the term "hurt" was no longer present. Id. The document also shows Mr. Mullady not present on the date of Petitioner's work injury. Id. Mr. Mullady indicates those records were wrong as he was present.

Jeff Singley testified he is executive vice president and he runs the jobs in the field. He reports that his firm strictly does concrete work and was located at the Wal-Mart construction site on the date of the accident. He explained the Respondent was contracted to do foundations, floors and sidewalks for the new facility. The Respondent was also subcontracted with Chief Construction to do a portion of the work Wal-Mart had hired them to do.

After this occurred, the cement finishers union was contacted and Mr. Webster was sent to work at the Streator Wal-Mart construction site. Mr. Singley asserted Mr. Webster was only needed 3 days on this jobsite that was expected to last approximately 6 months. Mr. Webster testified his understanding was that he was expected to be on this jobsite for its duration.

Mr. Singley also indicated that he did not guarantee a 40 hour work week because of potential weather issues and explained the work week was Monday through Saturday with the start time being 7:00 a.m. and ending at 3:30 p.m. with a half hour unpaid lunch. This provided 48 hours a week unless weather issues presented themselves.

Mr. Singley stated on December 27, 2010 at approximately 7:45 a.m. he asked his foreman where Montez Webster was located. Joe Cleveland, the jobsite foreman, indicated he was hurt and sitting in his vehicle. After hearing this, the witness talked to Mr. Webster who indicated he was hurt while moving forms and hoped he could be given 15 to 20 minutes to sit. Mr. Webster hoped he would then feel good enough to return to work. Mr. Singley stated no, we can't do that. Mr. Singley asserts he then talked to various witnesses at the jobsite.

After talking with these witnesses, he contacted the hospital and explained that he had "a guy that was hurt on my job and that we were going to head to the hospital". He testified that instead of going to the hospital emergency room, Mr. Webster was taken to occupational health. The access to care and urgency of the condition was determined by a company executive.

Mr. Webster arrived at the occupational health department at about 10:40 a.m. Px.2. He was examined and provided a drug screen. Id. The Petitioner was then released for light duty work which Mr. Singley reports he provided Mr. Webster. Id. He had been told to clean out the jobsite work trailers. Mr. Singley testified he was with Mr. Webster following his accident and drove him to occupational health and remained with him while he was there and returned him to jobsite after treatment. He did not testify that the Petitioner appeared intoxicated or under the influence of drugs at any time that day or any other day.

Mr. Singley reports the Petitioner did return to work the following day, or maybe a couple days later, with his business agent who indicated it was appropriate to offer Montez Webster light duty since he was injured on the project. Mr. Singley explained since there was no light duty at the Streator jobsite, light duty was then offered at the company's shop in Polo, Illinois. He states Mr. Webster later performed 3 days of light duty but he could not recall the dates.

The Respondent called Joe Cleveland, a 10 year employee of Singley Construction, Inc. to testify. On December 27, 2010 he was the job foreman at the site in question. He testified he spoke with Jeff Singley about hiring help for 3 days, one finisher and two laborers. As a result Montez Webster was hired.

On the morning of December 27, 2010, he reports Mr. Webster, along with two others, were removing 2 x 8 concrete forms from a trench. Mr. Cleveland states he did not see Mr. Webster's accident, but arrived shortly after. He stated Mr. Webster indicated he was hurt but did not want to go to the doctor. The Petitioner hoped he would improve and be able to return to work in a few minutes. Mr. Cleveland then contacted Jeff Singley, his boss, and let him know that Mr. Webster was injured and sitting in his vehicle.

Mr. Cleveland claims he inspected the area of trench where he believed Mr. Webster was working at the time of his injury. He had not seen Mr. Webster at the time he was working but felt he knew the location. He reviewed the site and claimed the area he believed Mr. Webster had been working was not icy or slippery. He asserted Mr. Webster was working next to a concrete footing which was about 9 feet wide with about 4 feet of work area on either side of a wall in the center. He reports the wall of the trench was only inches away from the edge of the footing. He also indicated there was no steel cage or other device used to hold the walls back from caving in on people. The Arbitrator notes the trench was not sealed off from ground moisture and alike in the winter thus the degree of moisture or somehow a strict lack thereof on wood exposed 24/7 to the elements at the time of this observation is not determinative of the accident issue. The Arbitrator takes judicial notice of the OSHA requirements for wall supports when the hole is that deep et cetera, prior inspection and alike.

On rebuttal, Montez Webster testified his physicians, Dr. DePhillips, Dr. Sweeney, and Dr. Bergandi all have suggested surgery. Px. 4,7 & 13. Dr. Malek would like to do additional testing before proceeding.Px.14. He also reports that despite the request for surgery by so many physicians, he is not receiving TTD currently. He continues to have low back pain with that pain going down his leg to the ankle. The Petitioner prefers to undergo treatment with Dr. Sweeney and would like to undergo an L5-S1 laminectomy, foraminotomy and follow up care he recommends. Px.13.

The Respondent engaged Dr. Alexander Ghanayem to perform medical evaluations under section 12 of the Act on February 23, 2011 and April 26, 2011. The first report indicates that Mr. Webster, a cement finisher, was injured on December 27, 2010 when lifting foundation forms. Rx.1 He experienced pain principally on the right side of his lumbar area. Id. He has intermittent leg symptoms but the back pain is most prevalent. . On examination of the lumbar spine, the Petitioner experiences discomfort at the right lumbar base without muscle spasm. Range of motion was felt to be normal. Id. An MRI was also felt to be normal. In this doctor's one page report Dr. Ghanayem indicates the Petitioner needs no additional diagnostic studies but does require an additional two weeks of physical therapy to treat his lumbar strain. It was felt by future projection and forecast this worker would then be at MMI and able to return to regular duty. In the interim, the Petitioner was to be provided light duty with a 10 pound lifting restriction. Future forecasts such as this has been rejected time and time by the IWCC without a contemporaneous exam by the doctor making such forecast.

A second section 12 about 60 days later was performed by Dr. Ghanayem on April 26, 2011. Rx.2. Dr. Ghanayem noted the Petitioner was experiencing right lumbar back pain with it being referred into his right buttocks, posterior thigh and calf. Rx 2.

Since then, he has been involved in physical therapy and told he needs a CT scan. The examination is suggestive of tenderness to palpation of his right lower lumbar base. . He indicated the Petitioner did have positive Waddell signs but did not indicate the number, type, or if they affected any opinion as to whether he is or is not a surgical candidate.

Dr. Ghanayem felt lumbar x-rays and MRIs appeared to be essentially normal and reported it still remains his belief that the Petitioner suffers a lumbar sprain. He reported no further medical care was needed and he could return at MMI to his employment.

The Respondent also obtained the services of Dr. Conibear, an occupational medicine physician who did not meet with the Petitioner prior to preparing his report of November 21, 2011. Rx.6 Dr. wrote the medical record she reviewed while preparing her report was a drug screen that was collected from the Petitioner on December 27, 2010 which showed marijuana and cocaine metabolites. Id. Dr. Conibear indicated the Petitioner had some level of intoxication from marijuana and cocaine use hours or even days prior to his accident that would have left him with the symptoms of fatigue, lethargy and depression. She wrote the Petitioner's fall may have been made more likely due to the use of these substances possibly days before. At no time did she indicate the use of these substances was the proximate cause of the Petitioner's December 27, 2010 work injury.

The Petitioner obtained the section 12 opinion of Dr. Robert Eilers, a board certified physical medicine and rehabilitation physician from a June 4th, 2012 exam. Px 10. This evaluation indicated the Petitioner was injured on December 27, 2010 while moving 4 x 8 concrete forms from where he was below the surface of the ground to someone above ground. While lifting one of these forms, he indicated his legs started to go out from underneath him like he was doing the splits. He tried to stabilize himself but experienced a sudden onset of pain in the low back while twisting. He reported the condition to his foreman who allowed him to sit in the Petitioner's truck before being taken to the occupational health department.. He was evaluated there and thought to have a muscle strain. Mr. Webster also provided a urine sample which was positive for trace drug findings. He was told initially there was no work and then later permitted to do 3 days of employment. Other than that, he has not been back to work since his injury.

Dr. Eilers reported the Petitioner has seen Dr. DePhillips for neurosurgical management and has been scheduled for a fusion which has yet to be carried out. He reports his continuing symptoms are significant and continuous with pain shooting down his right leg to the back of the knee and calf. The bottom of his right foot has a somewhat sleepy feeling on a constant basis and that he also complains of continuing low back and right sided pain that extends into the buttocks, leg, ankle and foot. Injections and physical therapy have provided little relief.

Dr. Eilers indicates he has reviewed the multiple radiographs including an MRI and cat scan performed. It was noted the Petitioner also had a cervical strain but that has resolved. His reflexes are intact. Mr. Webster has a loss of lumbar lordosis and profound myofascial trigger points over the lumbosacral paraspinals on the right side with mild tenderness over the tensor fascia lata with significant findings over the piriformis.

Mr. Webster weight shifts to his left lower extremity. Dr. Eilers felt the Petitioner had a positive L5-S1 discogram which was evidenced by concordant pain at the right lower back at this level. There were changes at L3-4 but those were not significant. Significant myofascial pain over the lumbosacral paraspinals and associated chronic pain in this area continues. It was determined that the Petitioner has not yet reached MMI and L5-S1 surgery is recommended.

Dr. Eilers reported the Petitioner's medical care and treatment has been reasonable and appropriate and related to the Petitioner's work injury. His time off work has been reasonable. Dr. Eilers also reviewed the Petitioner's use of cocaine and marijuana that occurred a week prior.

He reports the measured metabolites do not reflect any degree of intoxication and felt the drugs were not a contributing factor to this injury. He also stated the Petitioner's injuries were, and continue to be, work related.

CONCLUSIONS OF LAW

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; K. Is Petitioner entitled to any prospective medical care?

On December 27, 2010 he was required to work in a trench at a depth, depending on the testimony, of between 8 and 12 feet below the surface. ; He was handling 4 x 8 concrete forms weighing 80 to 100 pounds each.

The testimony consistently indicates the Petitioner had no trouble performing his work or moving these forms prior to this injury. The Petitioner was required to move these forms from the ditch to another employee who was standing on the surface above the Petitioner's head.

The Petitioner explained that while lifting one of these heavy forms in the manner of a "military press", his feet began to slide on the icy and muddy soil below him. As he continued to lift the form upward and slide, he lost his footing, twisted and experienced pain in his right low back. The Petitioner explained he reported his accident to both his jobsite foreman, Joe Cleveland, and one of the owners of the company, Jeff Singley. Both Mr. Cleveland and Mr. Singley testified the Petitioner did inform them he was injured on the job. After being provided a brief break after the injury, hoping the Petitioner's condition would improve, he was brought to the Occupational Health Department of St. Mary's Hospital by Jeff Singley, an exectutive. Rx 2.

Notably he was not brought to the emergency room in the town where injured by rather to an occupational clinic in a different town. Petitioner attempted to work cleaning job site trailers as he was told by the occupational doctor he could return to light duty. Although he made an effort to perform these functions, Mr. Webster suffered substantial pain and was permitted to leave early. The determination of the degree of slipperiness of wood fittings deep below the surface of the earth even over a limited time in the cold winter and the Gettysburg issue of the time recordation does not create an imbalance of this preponderance in favor of the Respondent.

Except for 3 days in April where Mr. Webster was allowed to return to light duty work at the Polo, Illinois office of the Respondent, the Petitioner has not worked since the day of the accident. It is noted with some dispute that the Respondent's office in Polo, Illinois is approximately 1 hour and 45 minutes from the Petitioner's home. The Arbitrator reasonably infers that the numbness in the back/leg of the worker over a prolonged drive time, regardless of stop watch accuracy in duration to Polo, is a credible complaint given the doctor's findings.

Due to the distance traveled and the ongoing pain while trying to perform light duty, Mr. Webster was taken out of work by his physician at that time, Dr. George DePhillips. Px.4. His other physicians have kept him off since. Px.4, 7, 10, 13 & 14.

The Petitioner has received very comprehensive , and exact, focused and exhaustive medical care and treatment including physical therapy, medication, injections, multiple radiographs and other diagnostic tests, including EMGs, MRIs, cat scans and a discogram. Px 2, 3, 4, 7, 10 & 12. This patient has had the great benefit of the opinions of various doctors with a variety of background specialties. In this case the only outlying opinion is that of Dr. Alex Ghanayem. Again, that opinion is not adopted at bar. Dr. De Phillips bills in part lack proper coding and office prescription charges are deemed excessive.

Following multiple visits with Dr. George DePhillips, Dr. Bergandi and Dr. Sweeney, it was determined the Petitioner has an operable condition caused by the accident. Id. After failure of conservative care Petitioner continued to suffer from what appears to be right lower extremity radiculopathy. As a result Mr. Webster has been recommended to undergo a right L5-S1 laminectomy and foraminotomy. Px 13. Dr. Sweeney indicates that if this fails, a fusion at the same level could be performed. The discogram performed of the Petitioner on August 16, 2013 supports that L5-S1 is his likely pain generator.

Based upon the totality of the evidence and preponderance thereof, including inter alia consideration of the testimony of the Petitioner, occurrence witnesses, the medical records and expert testimony obtained, this Arbitrator finds as a matter of fact and as a conclusion of law the Petitioner in the case at bar did sustain a compensable accident that occurred on December 27, 2010 that arose out of and in the course of the Petitioner's employment by the Respondent.

Further, based upon the totality of the evidence including the opinion of Dr. Gerald Sweeney, spine surgeon, the Petitioner's current condition of ill-being is causally related to this accident at bar. The Arbitrator adopts the opinions of Dr. Sweeney as to the need for surgery although the actual technique is under the medical judgment of the chosen surgeon. The overwhelming medical evidence places the opinion of Dr. Ghanayem is this particular case as being of significantly less weight and persuasiveness. This determination is limited to the facts at bar and is not precedential for this Arbitrator.

Further, this Arbitrator finds the Petitioner requires prospective medical care to cure or alleviate the sequelae of his injuries that occurred as a result of the December 27, 2010 accident at bar . There have been consistent conservative efforts to treat this condition but they have now failed.

Based upon the totality of the evidence, the Arbitrator finds as a matter of fact and as a conclusion of law the Respondent herein is ordered to authorize in writing and provide the recommended care and surgical treatment proscribed by Dr. Gerald Sweeney, his treating physician, in particular, a L5-S1 laminectomy and foraminotomy. The Arbitrator finds this surgery and choice of techniques should be performed by Dr. Sweeney.

In the event that this procedure does not provide the desired level of relief and function as determined by the clinical determination between doctor and patient , this Arbitrator further orders consideration and evaluation at that time by the Respondent to provide the Petitioner with a fusion at the same level based upon the well documented clinical judgment of Dr. Gerald Sweeney. The Respondent shall further provide all ancillary, reasonable and necessary care, treatment and maintenance under section 8(a) required consistent with this order.

As to the Petitioner's use of marijuana and cocaine a week or so prior to his accident, there is insufficient evidence to support a claim he was intoxicated or under the influence of these drugs at the time of his accident. Although this Arbitrator, Commission and the State do not support the use of these drugs in anyway, their level and effect here does not remove this particular worker from the protection of the Act.

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

Following the Petitioner's injury, he sought treatment with the St. Mary's Occupational Health Department. Px 2. He also sought care and treatment at St. Mary's Hospital from time to time for physical therapy, radiographs and other testing ordered by his various treating physicians. Px 2-14. This substantial conservative care received by the Petitioner has been reasonable and appropriate to try and relieve the Petitioner of the pain and discomfort flowing from his various injuries that included his right knee, leg, cervical and lumbar spine. Px 2, 3, 4, 5, 7, 8, 9, 10, 12, 13 & 14.

Based upon the totality of the evidence and as indicated in the treating records of the Petitioner, the need for this medical care and treatment was reasonable and necessary under section 8 plus causally related to his work injury of December 27, 2010.

Following consideration of the testimony and medical records presented, this Arbitrator finds the medical care and treatment provided to the Petitioner following his work related injury of December 27, 2010 was reasonable and necessary. Px 1.

The Respondent shall by order pay all appropriate charges for this reasonable and necessary medical care pursuant to the medical fee schedule. There remains unpaid medical bills of $52,587.75 (Dr. George DePhillips: $2,365.00, St. Mary's Hospital: $2,901.00, Pain & Spine Institute: $23,550.00, St. James Radiology: $276.00, Morris Hospital: $567.00, OSF St. Joseph Medical Center: $1,193.07, Joliet Radiology: $193.00, Joliet Headache: $810.00, Joliet Open MRI: $1,695.00, EQMD: $14,134.68, Dr. Jason Bergandi: $649.00 and Dr. Michel Malek: $4,254.00). The medical bills related to services performed at LakeShore Open MRI, LakeShore Surgery Center and Western Anesthesia have yet to be received. Issues, if any, regarding payment of these bills are reserved for future hearing. The Arbitrator finds the bills of Dr. De Phillips to be missing proper coding and excessive relative to drug charges given the coding.

Worker's compensation insurance has paid $10,129.17. This resulted in discounts of $12,526.68. Id. The Petitioner should also be reimbursed his out of pocket expenses of $500.00 paid to Dr. Patrick Sweeney.

G. What were Petitioner's earnings; L. What temporary benefits are in dispute? TTD.

The first modern Act in 1973 attempted to define wages under section 10. Thirty three years after the 1980 enactment of the section 10 whose purpose was to clarify the determination of wages in part for the trades, all of us in the industry have yet to agree on methodology. Issues such as the one at bar are ultimately resolved on Review by the full Commission.

Given the facts at bar, the Arbitrator finds his total wages for the two weeks he was employed are $879.75. The worker earned $33.50 per hour. The Arbitrator finds as a matter of law the average weekly wage is $439.87. Given the testimony and Respondent records - to find otherwise allows too much inference and at worst, is speculative.

Based upon the totality of the evidence and the preponderance thereof, including the medical evidence supra, the Arbitrator finds as a matter of fact and law this Petitioner is entitled to temporary total disability for 141 &3/7ths weeks under section 19(b) and section 8.

M. Should Penalties be Awarded under sections 16 and 19?

Following consideration of the testimony, evidence presented and issues at hand, this Arbitrator finds Respondent counsel presented a good faith challenge under Avon and Brinkman to the payment of compensation.

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

Kirk L. Mosley,

Petitioner,

vs.

NO: 11WC 28324

14IWCC0663

Dot Foods, 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 causation, temporary total disability, 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 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.

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 $21,700.00. 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: AUG 1 1 2014
o072214
CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

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

MOSLEY, KIRK L
Employee/Petitioner

Case# **11WC028324**

14IWCC0663

DOT FOODS INC
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:

2046 BERG & ROBESON
JOHN D SIMMONS
1217 S 6TH ST
SPRINGFIELD, IL 62703

0265 HEYL ROYSTER VOELKER & ALLEN PC
DAN SIMMONS
3731 W WABASH AVE
SPRINGFIELD, IL 62711

14IWCC0663

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
19(b)

KIRK L. MOSLEY
Employee/Petitioner
v.
DOT FOODS, INC.
Employer/Respondent

Case # 11 WC 28324

An *Application for Adjustment 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 **Springfield**, 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

FINDINGS

On the date of accident, **06/30/2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$24,901.50**; the average weekly wage was **$478.87**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$10,672.08** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$10,672.08**.

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 $319.25/week for 101 weeks, commencing 07/01/2011 through 11/08/2011, and from 11/14/2011 through 06/11/2013, the date of trial, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $10,672.08 for temporary total disability benefits that have been paid.

Respondent shall authorize and pay for the MRI recommended by Dr. Russell, follow-up treatment with Dr. Russell regarding review of that MRI, and for a secondary surgical opinion, should Dr. Russell and Petitioner still find the same to be appropriate following the procurement of the MRI (as per Dr. Russell's recommendation of September 19, 2012), pursuant to Section 8(a) of the Act, and subject to the medical fee schedule, 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

07/02/2013
Date

ICArbDec19(b)

JUL 15 2013

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

KIRK L. MOSLEY
Employee/Petitioner

v. Case # 11 WC 28324

DOT FOODS, INC.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Kirk L. Mosley, was employed by Respondent, DOT Foods, Inc., on the stipulated date of accident, June 30, 2011. Petitioner was in a stand-up forklift performing his duties as a dry goods warehouse order picker on this day when an estimated 150 to 200 pounds of wet insulation fell approximately 30 feet, striking him in the back of his head and neck. Petitioner was struck with such force that he was knocked out of the forklift in which he was standing, and fell to the ground.

Petitioner presented to the Passavant Area Hospital emergency room on the date of accident. Petitioner was restricted from returning to work activities by the physician at Passavant Area Hospital, pending the advice of Petitioner's primary care physician. (Petitioner's Exhibit (PX) 1). On July 6, 2011, Petitioner started a course of treatment with Dr. John Malcott, his primary care physician, of Springfield Clinic. (PX 3, p. 31). Dr. Malcott diagnosed a muscle spasm, and referred Petitioner for occupational therapy commencing on July 26, 2011. (PX 3, p. 31; PX 2). Petitioner underwent the occupational therapy (PX 2), but testified that the therapy did not help to reduce his symptoms of pain in his neck and head.

On August 8, 2011, Petitioner underwent a MRI of the cervical spine. (PX 6; PX 3, p. 47). Petitioner's history at that time included complaints of left arm pain and weakness in the digits of his left hand. (PX 6; PX 3, p. 47). The MRI revealed foraminal narrowing at C5-6, mild left greater than right foraminal narrowing at C6-7, and mild right greater than left foraminal narrowing at C7-T1. (PX 6; PX 3, p. 47). Based on the results of the MRI, and Petitioner's continuing symptoms, Dr. Malcott referred Petitioner to a neurologist, Dr. Koteswara Narla. (PX 3, p. 21). Dr. Malcott's diagnosis at the August 16, 2011 visit was cervicalgia. (PX 3, p. 21).

Dr. Narla diagnosed Petitioner as having C5-6 central disc protrusion and C6-7 left-sided disc protrusion with numbness in the fourth and fifth digits. (PX 3, p. 20). Dr. Narla approved a treatment plan, including referral to a surgeon, a home exercise routine, and a prescription for hydrocodone. (PX 3, p. 20). On September 6, 2011, Dr. Narla performed nerve conduction studies that indicated mild to moderate C6 radiculopathy. Dr. Narla also noted that there could be some component of C7 involvement as well. (PX 3, pp. 36-38). Dr. Narla then referred Petitioner to Dr. Brian Russell for a surgical opinion. (PX 3, pp. 11, 38). Dr. Russell noted the MRI identified some disc disease at C5-6, as well as degenerative changes and narrowing of the foramen at C6-

7. Dr. Russell reported that, clinically, it was hard for him to discern "clear cut evidence of radiculopathy." Dr. Russell suggested that conservative treatment be exhausted before surgery was considered, and further that a second opinion regarding surgery may want to be obtained. Per Dr. Russell's referral, Petitioner opted to pursue treatment by way of epidural steroid injections. (PX 3, p. 12).

The record indicates that these injections were not performed until February 14, 2012 and March 6, 2012. (PX 3, pp. 20-23, second[1]). Petitioner testified that he received no relief from his symptoms due to the February 14, 2012 injection, and a very short period of relief of his symptoms after the March 6, 2012 injection. (See also PX 4, p. 8; PX 5). Dr. Malcott withdrew as Petitioner's treating physician on February 16, 2012, citing "concerns raised during recent interactions" with his office, as well as Petitioner's "drug seeking behavior." (RX 2). Petitioner believed this withdrawal was based on a misunderstanding. Petitioner testified that he was to inform the "insurance nurse" about each visit with a physician. In order to get prescription medications refilled, Petitioner testified that he had to be present at an appointment. Petitioner canceled an appointment, but told the insurance nurse he would be out of prescription pain medications by the end of that month. According to Petitioner, the nurse then apparently called the doctor's office at that time, making it appear as if he was requesting more medication at that very time, instead of at the end of the month when he stated his medications would have been depleted. It was his belief that the nurse must have misunderstood his intention.

Petitioner has treated with Dr. Narla and Dr. Russell since Dr. Malcott's withdrawal. Petitioner testified that he has attempted to secure a primary care physician to replace Dr. Malcott, but has found that physicians are unwilling to accept him as a patient due to his lack of insurance and the pendency of this workers' compensation claim.

Petitioner presented again to Dr. Russell on September 19, 2012. Dr. Russell noted that Petitioner had rather severe foraminal stenosis at C5-6, and C8 root symptoms. He further reported that Petitioner's EMG testing suggested C6 root irritation. Dr. Russell was uncertain whether he could make Petitioner better with surgery, and ordered a repeat MRI to determine if there is anything at the C7-T1 level. Dr. Russell also reiterated that a second opinion should be obtained before operative intervention is pursued. (PX 5). Respondent disputes Petitioner's need for a MRI, and has refused to pay for said treatment. Petitioner has yet to undergo this prescribed MRI, and further testified that he last saw Dr. Narla in February 2013, and that he has another appointment with Dr. Narla scheduled in August 2013.

Dr. Malcott restricted Petitioner from returning to work until November 14, 2011. (PX 3, pp. 48-52). On November 14, 2011, Petitioner was released to return to light duty work, with lifting restrictions of 5 pounds, but then that same day was also restricted from returning to work until he had the neck injections recommended by Dr. Russell performed. (PX 3, pp. 48-49). The Arbitrator notes that the referenced injections were performed on February 14, 2012, and March 6, 2012. (PX 3, pp. 20-23, second). According to the record, only Dr. Malcott would restrict Petitioner's work activities, and the Arbitrator notes that Dr. Narla explicitly refuses to address Petitioner's ability to perform work functions per his policy. (PX 4, p. 8).

Petitioner testified that he attempted to return to work in November 2011, and that Respondent afforded him light duty work that involved standing and walking on concrete for long periods of time. Petitioner testified that he was unable to perform the duties of this position because the acts of standing and walking on concrete

[1] The Arbitrator notes that Petitioner's Exhibit 3 features 52 sequentially numbered pages, and then a certification and a further 23 pages where pagination starts over at 1. This reference is to the second set of paginated pages, or what is approximately the 74th page in the exhibit.

exacerbated his symptoms. Petitioner testified that his symptoms have not gotten better in the period of time in which he has been seeking the MRI recommended by Dr. Russell.

On October 12, 2011, Petitioner was examined at Respondent's request pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq.* (hereafter the "Act") by Dr. Andrew Zelby. Dr. Zelby diagnosed Petitioner with cervical spondylosis. The doctor did not recommend surgery. (RX 1, p. 21). Dr. Zelby opined that Petitioner was neurologically normal with no radicular findings, and that the electrophysiologic finding was of no clinical consequence. (RX 1, pp. 21-22). Dr. Zelby thought that four-to-eight weeks of physical therapy followed by four-to-six weeks of work conditioning with a trial of epidural steroid injections would be recommended. According to the doctor, Petitioner would then be at a level of maximum medical improvement (MMI). (RX 1, p. 23). Dr. Zelby thought that Petitioner could go back to light duty work until completing that course of treatment, and then would be able to return to work without restriction. (RX 1, pp. 23-24).

After reviewing additional records on May 4, 2012, Dr. Zelby concluded that Petitioner would be at MMI after pursuing three-to-four weeks of work conditioning or work hardening. Petitioner would then be able to return to work without restrictions according to Dr. Zelby. (RX 1, p. 29). Dr. Zelby also opined that Petitioner would also not require any additional diagnostic studies or medical treatment after that. (RX 1, pp. 29-30). Dr. Zelby testified that Petitioner's ongoing subjective complaints would be difficult to explain irrespective of cause, but that they are certainly not a manifestation of any work injury or the sequelae of a work injury. (RX 1, p. 30). Dr. Zelby testified that Petitioner's condition was not accelerated by the work injury. Dr. Zelby testified that the MRI showed no acute abnormalities, with only degenerative changes. According to Dr. Zelby, nothing was accelerated biomechanically, functionally or structurally as a result of the injury. (RX 1, p. 31).

CONCLUSIONS OF LAW[2]

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

Petitioner's current condition of ill-being is causally related to the injury. Respondent does not dispute that the accident occurred as described by Petitioner, rather Respondent relies upon the opinions of Dr. Zelby that Petitioner's injury does not include Petitioner's complaints of radicular symptoms, or the conditions discovered on the MRI of August 8, 2011, located at C5-6, C6-7, and C7-T1 of Petitioner's spine.

The Arbitrator concludes that Petitioner's complaints of symptomatology have been consistent since the date of his injury. Petitioner described a traumatic injury including a very heavy weight falling from a height of 30 feet and striking him in the back of the head and neck. Petitioner described that the force of this impact was such that he was knocked out of a forklift and fell to the ground, and that he lost consciousness for a period of time. There is no evidence that Petitioner suffered any symptoms of pain in his cervical spine or numbness in the fourth and fifth digits of his left hand prior to this injury. Between the newness of these symptoms, the consistency of their appearance in his medical records, and Petitioner's description of the acute nature of his accident, the Arbitrator finds that his current condition of ill-being is causally related to the June 30, 2011 injury.

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[2] Arbitrator's Exhibit 1 indicates that Petitioner is claiming to be entitled to penalties and attorney's fees pursuant to Sections 19(k), (l) and 16 of the Act. However, no penalty petition was offered into evidence, and the parties confirmed on the record that the only issues in dispute concerned causal connection, prospective medical treatment and entitlement to TTD benefits.

As to Dr. Zelby's opinions, the doctor opined that Petitioner suffered an injury, but claimed it only required work hardening and/or physical therapy. (RX 1, 29). Dr. Zelby's explanations as to why the condition of Petitioner's spine is not related to his current condition of ill-being are unpersuasive. Dr. Zelby contradicts himself by claiming that Petitioner had no radicular symptoms (RX 1, pp. 21-22), and that Petitioner was "neurologically normal." In the same breath, Dr. Zelby also acknowledges that an EMG found a mild to moderate C6 radiculopathy. (RX 1, p. 22). He classified Petitioner as having no spinal cord compression (RX 1, p. 22), but acknowledged that the MRI of August 8, 2011 demonstrated spinal cord compression at the C5-6 level. (RX 1, p. 18). Dr. Zelby acknowledged that Petitioner's complaints in his left fourth and fifth digits would be consistent with a "C8 nerve root distribution." (RX, p. 39). However, despite the doctor's testimony that he personally reviewed the MRI films of Petitioner (RX 1, p. 38), Dr. Zelby failed to address the condition of Petitioner's spine at C8 in his report.

Further, while Dr. Zelby alludes to malingering, and Dr. Malcott withdrew his medical services due to Petitioner's supposed "drug seeking behavior," the Arbitrator notes that Petitioner's explanation regarding this withdrawal was reasonable and un-rebutted, and further gives said evidence only little weight concerning relevancy in light of the foregoing discussion concerning causal connection.

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

Dr. Russell has referred Petitioner for a repeat MRI to determine if there is anything at the C7-T1 level. (PX 5). Dr. Russell's record indicates that such a MRI will allow him to re-evaluate whether surgery will assist the recovery of Petitioner, as well as to obtain a second opinion regarding a surgical solution. The Arbitrator notes that the MRI of August 8, 2011 indicates that there is "[s]ome artifact on this exam due to technical factors." (PX 6). In addition, the records indicate that other conservative forms of treatment, including pain management, epidural steroid injections, and physical therapy have failed to help improve Petitioner's symptoms.

Accordingly, the Arbitrator concludes that the MRI ordered by Dr. Russell is reasonable and necessary to treat Petitioner's condition, as well as follow-up treatment with Dr. Russell to review said MRI, and also including a second surgical opinion should Dr. Russell and Petitioner agree that such is desirable.

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

Petitioner claims he has been disabled since the date of his injury, June 30, 2011, excluding the period from November 9, 2011 through November 13, 2011. (See Arbitrator's Exhibit (AX) 1). Respondent agrees that Petitioner is entitled to temporary total disability (TTD) benefits from July 1, 2011 through November 8, 2011, but not thereafter. (See AX 1).

Dr. Zelby has opined that, as of May 4, 2012, Petitioner required three-to-four weeks of work conditioning/hardening before returning to work. (RX 1, Dep. Exh. 3). This was reaffirmed on May 21, 2012, during Dr. Zelby's evidence deposition. (RX 1, pp. 51, 56). Petitioner was temporarily and totally disabled until at least June 18, 2012, four weeks after Dr. Zelby's opinion was given. However, the work conditioning recommended by Dr. Zelby never occurred. Based upon the restrictions originally issued by Dr. Malcott, and supported by Petitioner's testimony of his own capabilities, and the affirmation of Dr. Zelby, the Arbitrator concludes that Petitioner is entitled to TTD benefits from July 1, 2011 through November 8, 2011, and then again from November 14, 2011 through the date of hearing, June 11, 2013. Respondent is entitled to a credit for TTD benefits paid in the amount of $10,672.08. (See AX 1).

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

Dorsey Douglas,

Petitioner,

14IWCC0664

vs.

NO: 10 WC 41865

State of Illinois Department of Corrections, Stateville,

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 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 18, 2014 is hereby affirmed and adopted.

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

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

DATED: AUG 12 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 8/7/14
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DOUGLAS, DORSEY
Employee/Petitioner

Case# **10WC041865**

14IWCC0664

SOI DEPT OF CORRECTIONS STATEVILLE
Employer/Respondent

On 2/18/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% 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:

1554 LAW OFFICES OF ALBERT R PINO LTD
GERALD CONNOR
3900 MERCY DR
McHENRY, IL 60050

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
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 PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

FEB 18 2014

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 14IWCC0664
Case # 10WC41865

Dorsey Douglas
Employee/Petitioner

v.

Consolidated cases: None

State of Illinois Dept of Corrections, Stateville.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **New Lenox, Illinois**, on **12/13/13**. 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

14IWCC0664

On **10/13/10**, 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 $56,598; the average weekly wage is $1088.42

On the date of accident, Petitioner was **43** years of age, ***Married*** with **1** dependent child.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and $442.48 (Service Connected leave) for other benefits, for a total credit of **$442.48.**

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 $16,733.12 for necessary medical services, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $653.05 for 57.59 weeks, because the injuries sustained caused the 10% loss of the person as a whole (50 weeks), as provided in Section 8(d)2 and 3% loss of use of the right arm (7.59 weeks), as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from October 13, 2010 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

2/17/14
Date

FEB 18 2014

ICArbDec p. 2

14IWCC0664

FINDINGS OF FACT:

Petitioner testified that he was injured on the job while working as a correctional officer for the State of Illinois. Petitioner stated that he was injured while preparing to transport a prisoner to a parole hearing on October 13, 2010. Petitioner provided that when the cell was opened, the prisoner became hostile, came out of his cell and attacked him. Petitioner testified that he was struck in the face, rib cage and his back. Petitioner restrained the prisoner while watching the other prisoner in the cell for safety. Petitioner testified that the altercation lasted approximately two minutes before additional help arrived. Petitioner stated that he immediately experienced pain in his hand, wrist, elbow, upper arm, neck, shoulder and the right side of his body. Petitioner sought transportation to the hospital; however, he was told by employees at the facility that there was no one to facilitate said transport. As a result, Petitioner drove himself to the emergency room at Provena St. Joseph Hospital.

Petitioner presented to the Emergency Department with complaints of pain to the right side of the body, including right arm, hand, wrist, elbow, ribs, and right chest pain. X-rays of the chest, wrist, hand, and elbow were obtained. Petitioner was diagnosed with "Hand/wrist elbow pain" and "Chest wall contusion/myalgia." (PX 4) The doctor proscribed Flexeril, Norco, and Naprosyn for the pain. The doctor ordered Petitioner to wear a splint and an ACE wrap for the right elbow. Petitioner was advised to follow up with his primary care provider in one to two days. (PX 4)

On October 15, 2010, Petitioner presented to Advanced Physical Medicine with complaints of mid back pain, right forearm pain, and right hand pain. Petitioner was diagnosed with thoracolumbar sprain/strain resulting in intervertebral spinal motor unit disrelationships as well as right hand and elbow contusions. It was noted that Petitioner's complaints were consistent with his clinical findings. Petitioner was placed off work and prescribed physical therapy for 2-4 times a week, electrical muscle stimulation, spinal manipulation and intersegmental traction three times a week for four weeks. (PX 5)

On October 28, 2010, Petitioner was evaluated by Dr. Aleksandr Goldvekht of Advanced Physical Medicine. The doctor noted Petitioner reported that he had been experiencing severe pain in the right shoulder with radiation into the right side of the neck. Petitioner also reported pain in the elbow and right wrist. After performing an examination, Dr. Goldvekht assessed right rotator cuff tendonopathy, right shoulder sprain strain, a cervical spine strain/sprain, and lateral epicondylitis. The doctor continued physical therapy and Petitioner's off work status. (PX 5)

Petitioner continued treating at Advanced Physical Medicine. On March 17, 2011, Petitioner reported major difficulty performing activities over shoulder level, pushing, pulling and computer work. He reported pain levels of 6/10 in the resting phase and also reported popping in the shoulder when reaching. Dr. Goldvekht recommended and performed a shoulder joint injection for an indication of persistent right shoulder pain secondary to joint rotator cuff tendonitis. On April 4, 2011, Dr. Goldvekht performed a right sided trigger point injection without complication. Petitioner was declared off work on both dates. (PX 5)

On April 18, 2011, Petitioner presented to Dr. Goldvekht stating that although his physical therapy was helping, he was still experiencing tightness in the right shoulder and into the neck. Dr. Goldvekht returned Petitioner to light duty work with restrictions of no lifting greater than 20lbs, no activities over shoulder level,

no pushing, and no pulling greater than 20 lbs. (PX 5) Petitioner testified that he was not allowed to return to his position with such limitations.

On May 2, 2011, Petitioner reported to Dr. Goldvekht with continuing shoulder complaints. The doctor administered another trigger point injection and prescribed work conditioning three times a week for two weeks. Petitioner was also to remain off work. Petitioner underwent subsequent injections performed by Dr. Goldvekht on May 23, 2011, and August 8, 2011. During that period a FCE was prescribed. According to Dr. Goldvekht's notes from June 20, 2011, the FCE was completed on June 1, 2011 showing Petitioner was limited to lifting 30 - 40lbs. and no repetitive activities. Petitioner was referred to an orthopedic specialist. (PX 5)

On July 6, 2011, Petitioner presented to Dr. Ira B. Kornblatt, of the Illinois Bone and Joint Institute at Instant Care. Petitioner presented with complaints of right posterior cervical pain and pain about the right shoulder. Dr. Kornblatt assessed "...ongoing complaints of chronic right shoulder pain since October of last year following a work-related injury." Dr. Kornblatt felt Petitioner's problems appear to be mainly cervical as opposed to shoulder. The doctor recommended an MRI of the right shoulder and cervical spine. (PX 6)

Petitioner underwent a MRI of the right shoulder on August 1, 2011. The study showed mild inferior hypertrophic spurring measuring 3-4 mm with probable mild impingement in the AC joint. The rotator cuff appeared mostly intact with some inflammatory fluid surrounding the distal supraspinatus tendon which the doctor felt was probably representative of tendinitis, tendinitis, and or bursitis. (PX 6)

Petitioner continued physical therapy at Advanced Physical Medicine with his last visit being on October 14, 2011. The soap notes from that visit show Petitioner reported no complaints that day. At that time it was felt Petitioner was reaching maximum medical improvement. (PX 5) Petitioner testified that he returned to full duty and continued to work in said capacity.

Petitioner testified that as a correctional officer he is sometimes required to work mandatory overtime. He also testified that some of overtime is voluntary.

Petitioner testified that he continues to experience right sided body pain. He stated that he occasionally experience difficulty with the right elbow and hand and "every now and then," his chest. Petitioner has difficulty performing activities that he did prior to the accident. These activities include weight lifting, playing sports, intimacy with wife, sleeping, playing catch with son, and lifting objects. Petitioner also testified that he is no longer part of the "Tact Unit" at work.

With respect to (G.) What were the Petitioners earnings, the Arbitrator finds as follows:

Petitioner submitted a "Salary Earnings Statement" for the pay period ending August 31, 2010. The paystub submitted shows that for the period of August 31, 2010, Petitioner's base pay was $2,586.96. The statement also shows Petitioner earned $1,020.79 in overtime payments during the period. As part of the Respondent's case, the State entered into evidence a summary of disability showing Petitioner earned $56,598.00 for the year preceding the injury, or an average weekly wage of $1,088.42.

There is no dispute Petitioner earned $56,598.00 per year, absent overtime, or an average weekly wage of $1,088.42. The dispute lies as to whether Petitioner's overtime hours work are mandatory. Petitioner testified that correctional officer are "mandated" and are sometimes required to work overtime. He also testified that some of overtime is voluntary. The only evidence to support his position is the "Salary Earnings Statement" for

the pay period ending August 31, 2010. In addition to his base pay, the statement showed he earned $1,020.79 in overtime payments during the two week period ending August 31, 2010. There is no way for the Arbitrator to determine if said overtime payment was mandatory or voluntary. As noted above, Petitioner testified that some of the overtime worked is mandatory and some is voluntary. Furthermore, the Arbitrator also notes that only one paystub was submitted as evidence of overtime. Same is not sufficient to corroborate Petitioner's contention. Petitioner has failed to prove that any overtime worked should be included in his average weekly wage.

Based on the above, the Arbitrator finds that Petitioner earned $56,598.00 for the year preceding the injury and that his average weekly wage was $1,088.42.

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, the Arbitrator finds as follows:

As discussed above, the facts in this case show beyond a preponderance of the evidence that Petitioner was operating as a correctional officer when he was assaulted by an inmate. The circumstances in this case show that the medical treatment Petitioner received was reasonable and necessary. Therefore, Respondent is liable for the medical bills accrued up to the date of Petitioner's release to work.

Below is a list of Petitioner's medical bills, or Petitioner's Exhibits 1-3. The Arbitrator awards Petitioner the following medical bills pursuant to the fee schedule.

List of Medical Bills	Start Treatment	Stop Treatment	Charges	Balance
1. Provena Saint Joseph Medical Center	10/13/10	10/13/10	2,471.77	0.00
2. Advanced Physical Medicine	10/15/10	10/14/11	17,996.34	16,462.12
3. Instant Care	7/6/11	08/01/11	1,688.48	271.00
		Totals	**22,156.59**	**16,733.12**

With respect to (F), Whether Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner's current conditions to the back and pain to the right side of his body, including the right shoulder, ribs, elbow, arm, hand and wrist, are casually related to the injury. The medical records of Provena Saint Joseph, Advanced Physical Medicine and Instant Care support Petitioner's testimony regarding his current condition of ill-being.

Upon arrival to the Emergency Department of Provena Saint Joseph, the record states "Patient reports that he was at work at the prison when an inmate became out of control and the patient attempted to restrain the [inmate] and he hit his hand and was punched to the right ribs." (P. Ex. 4). Petitioner complained of injuries to his right side, where the record states, "right arm pain . . . right ribs . . . right hand /wrist, elbow . . . chest wall contusion." Petitioner then began therapy at Advanced Medicine three to four times per week.

On July 6, 2011, nearly nine months post-accident, Petitioner visited an Orthopedic Specialist. The objective findings of the Orthopedic Specialist are consistent with Petitioner's testimony regarding his current condition of ill-being. The record states, "Impression: The patient has had ongoing chronic right shoulder pain since October of last year following a work-related injury . . . the problems appear to be mainly cervical."

On October 14, 2011, one year after the accident, Petitioner was discharged from care at Advanced Physical Medicine. Petitioner testified that he still experienced pain to his back and right side of his arm, but felt therapy could no longer improve his condition. The record states, "Reaching MMI/PT goals. Medical reassessment for further PT recommended."

Based on the foregoing, the Arbitrator finds that Petitioner's current conditions of ill-being are causally related to the injury.

With respect to (F), What is the nature and extent of the injury, the Arbitrator finds as follows:

The medical and testimonial evidence in this case show that Petitioner was diagnosed after the accident with thoracolumbar sprain/strain as well as right hand and elbow contusions. Later, Petitioner was also diagnosed lateral epicondylitis and a right rotator cuff tendonopathy. According to the medical records, the pain in Petitioner's hand and forearm largely resolved. However, Petitioner still complaints of pain in his cervical spine and shoulder area. Dr. Kornblatt opined that "[Petitioner's] problems appear to be mainly cervical as opposed to shoulder." (PX 6) Petitioner underwent a series of injections and an extensive course of physical therapy that significantly improved Petitioner's condition. On October 7, Petitioner presented to Advanced Physical Medicine for physical therapy. The notes from that visit read "Ptnt. Says he is feeling good today. The note from the October 10, 2011 visit reads, "Ptnt. Reports overall improvement with mild occasional shoulder stiffness ... return to work." (PX 5) Petitioner presented to physical therapy for the last time on October 14, 2011. Notes from that visit read, "Ptnt. Reports no complaints today... return to work." On October 23, 2011 Petitioner was released to full duty work without restrictions. Petitioner has not sought any medical treatment since his release from care.

Based on the above, the Arbitrator finds that Petitioner has suffered 10% loss of use of the person as a whole for his cervical, shoulder and rib conditions of ill-being. The Arbitrator further finds that Petitioner has suffered a loss of 3% loss of use of the right arm for his right elbow and hand conditions of ill-being.

With respect to (M), Should penalties be imposed, the Arbitrator finds as follows:

Petitioner currently has a balance of $16,733.12 in unpaid medical bills. These bills have gone unpaid for over two years. The Arbitrator takes judicial notice of the financial problems facing the State of Illinois. They have been well-publicized. Although the Arbitrator feels that Respondent is not above reproach, he does not feel that the imposition of penalties is warranted in this case. Respondent has shown proof of payment or pending payment of medical bills on Petitioner's behalf. Accordingly, there will be no award of penalties or attorney fees.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEBRA WINKLER,

Petitioner,

14IWCC0665

vs.

NO: 09 WC 24546

STATE OF ILLINOIS/ DEPARTMENT OF CHILDREN & FAMILY SERVICES,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both the Petitioner and Respondent herein, and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses and permanent partial disability, 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.

1. Petitioner suffered a stipulated accident on September 22, 2008 when she stepped on a staircase, which broke. This caused Petitioner to suddenly drop to her feet, sustaining a significant jarring motion. After conservative care, Petitioner underwent an anterior lumbar fusion and anterior decompression at L4-5.

2. Petitioner underwent surgery on June 23, 2009. After surgery she complained of severe pain, numbness and burning in both legs. Her doctor, Dr. Gornet, told her that it would soon subside. Over the next few months all the pain shifted to Petitioner's left leg. Occasionally she lost feeling in her leg while walking and fell down.

3. Petitioner last saw Dr. Gornet on August 11, 2011. Dr. Gornet opined that the pain was probably related to her nerve injury, and kept Petitioner off of work.

4. Ms. June Blaine has been a Rehabilitation Counselor for 30 years. She evaluated Petitioner's medical records and a Functional Capacity Evaluation (FCE) that Petitioner underwent. Ms. Blaine opined that Petitioner could perform clerical work. She recommended that Petitioner improve her computer skills, focusing on Microsoft applications. Ms. Blaine also opined that, in the Southern Illinois market, even with improved computer skills, Petitioner would likely earn between $9 and $10 per hour.

5. Petitioner's transferable skills include interviewing skills, developmental planning, setting up goals, counseling, customer service and personal service.

6. Ms. Blaine recommended Petitioner pursue a Masters Degree in Social Work or Rehabilitation. If she were able to get her Master's, she would likely be able to earn a salary similar to that of her former job. Petitioner has yet to apply for additional education.

7. Petitioner conducted a job search. However, 95% of the employers she contacted were not hiring. She also failed to complete an ADA packet under the Americans with Disabilities Act, and never attempted to find employment as a Consultant with the Department of Childcare and Family Services (DCFS-a position mentioned by Ms. Blaine).

8. Petitioner also refused to pursue part-time employment. She also did not believe she was capable of earning additional education, as she would find it difficult to sit through classes due to her ongoing left groin/leg pain.

The Commission affirms the Arbitrator's rulings on the issues of causal connection, permanent partial disability and medical expenses.

The Commission, however, reverses the Arbitrator's ruling on vocational rehabilitation services. One of the factors to be considered in making the determination of whether vocational rehabilitation is appropriate is the employees' ability and motivation to undertake the program. Petitioner's actions indicate that she was not acquiescent to rehabilitation. She failed to comply with instructions provided by her rehabilitation counselor. She refused to apply to part-time positions, did not seek entrance into a Master's program, did not complete an ADA packet under the Americans with Disabilities Act, and never attempted to gain employment as a Consultant with DCFS. Accordingly, the Commission finds that Petitioner's behavior does not warrant an award of vocational rehabilitation services.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 200 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused a 40% loss of use of her person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for all reasonable and necessary medical expenses under §8(a) of the Act.

14IWCC0665

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 Petitioner is not entitled to any vocational rehabilitation services provided by Respondent.

DATED: AUG 1 2 2014
O: 5/28/14
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WINKLER, DEBRA
Employee/Petitioner

Case# **09WC024546**

14IWCC0665

DEPT OF CHILDREN & FAMILY SERVICES
Employer/Respondent

On 7/12/2013, 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 0.07% 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 RICH NALEFSKI & CLARK PC
THOMAS C RICH
#6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0499 DEPT OF CENTRAL MGMT SERVICES
MGR WORKMENS COMP RISK MGMT
801 S SEVENTH ST 6 MAIN
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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 12 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

14IWCC0665

Debra Winkler
Employee/Petitioner

Case # 09 WC 24546

v.

Consolidated cases: _____

Department of Children & Family Services
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Herrin**, on **June 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 **date of MMI; maintenance; vocational rehab; cleaning services; exceeded choice of physicians**

14IWCC0665

FINDINGS

On **September 22, 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 with respect to the right leg *is* causally related to the accident. Petitioner's current condition of ill-being with respect to left leg and groin is not causally related to the accident In the year preceding the injury, Petitioner earned **$65,070.20**; the average weekly wage was **$1,251.35**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$for all TTD that has been paid to date** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$all TTD that has been paid to date.**

Respondent is entitled to a credit of **for all medical that has been paid** under Section 8(j) of the Act.

ORDER

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 **$664.72/week** for **200** weeks, because the injuries sustained caused the **40%** loss of use of man as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, outlined in Petitioner's Exhibit #1, as provided in Sections 8(a) and 8.2 of the Act,

Respondent shall receive a credit for all medical bills previously paid.

Respondent shall provide Vocational Rehabilitation Services to Petitioner if she requests them pursuant to the Act.

The Petitioner's request for cleaning services 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.

Deborah L. Simpson
Signature of Arbitrator

July 12, 2013
Date

JUL 12 2013

14IWCC0665

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Debra Winkler,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 09 WC 24546**
	)	
Illinois Department of Children And Family Services,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on September 22, 2008, 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) Is the Respondent liable for any unpaid medical bills contained in Petitioner's Exhibit 1; (3) What is the nature and extent of the injury; (4) Has Petitioner reached MMI and if so what date; (5) Is Petitioner entitled to maintenance and vocational rehabilitation; (6) Is the Petitioner entitled to reimbursement for cleaning services; and (7) did the Petitioner exceed her choice of physicians.

STATEMENT OF FACTS

This case was previously heard on a 19(b) before Arbitrator John Dibble on December 16, 2009. The issues at the 19(b) hearing were medical services and penalties and fees. At the 19(b) hearing, the parties stipulated that Petitioner sustained accidental injuries on September 22, 2008. While working for the State of Illinois as a case worker for the Department of Children & Family Services, she stepped on a staircase when a wooden step broke and gave way causing her to suddenly drop to her feet. (P. Ex. 16, 17) Petitioner had a history of scoliosis diagnosed at age eleven and a low back injury approximately twenty years ago for which she had physical therapy and intermittent chiropractic care. At the time of the accident, Petitioner was working full duty without restriction. Petitioner first sought treatment in the emergency room, then she saw her chiropractor and her family physician. Her family physician referred her to Dr. Allan

Gocio, a neurosurgeon who recommended surgery. (P. Ex. 16, 17) Petitioner saw Dr. Robsen at the request of the Respondent. Then Petitioner sought another opinion from Dr. Matthew Gornet, on the advice of Mr. Rich, because she was not happy about the other doctors that she had seen. Petitioner ultimately underwent an anterior decompression and fusion of L4-5 performed by Dr. Gornet on June 23, 2009. (P. Ex. 16, 17) This was the evidence and findings presented at the hearing on December 16, 2009. The time to raise an objection based upon exceeding choice of physicians was at this hearing when the payment of medical fees was in issue. Respondent did not raise the number of physicians as an issue at the hearing on December 16, 2009.

Petitioner initially filed her Application for Adjustment of Claim on June 9, 2009, alleging injury to her "back and right leg". An amended application for Adjustment of Claim was filed on September 12, 2011, changing the injuries to her "back, right and left legs" more than two years after the first application, almost three years after the accident and more than one and one-half years after the hearing on the 19b motion.

On June 23, 2009, the Petitioner had an anterior decompression and fusion of L4-5 which was performed by Dr. Gornet. (P. Ex. 8)

On July 9, 2009, Petitioner returned to Dr. Gornet three weeks post surgery. Petitioner reported some increasing leg pain bilaterally as well as back pain. Dr. Gornet believed that this was normal. (P. Ex. 8)

On August 13, 2009, Petitioner returned to Dr. Gornet for her scheduled follow-up, post surgery. Petitioner seemed to be doing well. Her old pain was gone, but she was having difficulty sleeping and was tearful. Dr. Gornet noted that her medical doctor put her on some anti-depressants. Radiographs looked excellent. Dr. Gornet saw no significant problems. Dr. Gornet advised Petitioner to begin walking and doing some abdominal strengthening. (P. Ex. 8)

On October 8, 2009, Petitioner returned to Dr. Gornet for follow-up. Dr. Gornet noted that Petitioner's mood was better, but she was having some left hip pain and also stated some ankle pain that becomes more severe with walking. Dr. Gornet noted that Petitioner had recently been put on Topamax for headaches. Petitioner complained of some numbness in the anterior thigh, as well as the vaginal area on the left side. Dr. Gornet noted this could be related to the surgical exposure. Dr. Gornet believed it would improve with time. Petitioner was asked to stop her walking for now. His concern was that Petitioner may have developed a stress fracture. Dr. Gornet noted that if it wasn't better in four weeks, he would refer her to Dr. John Krause for evaluation of her ankle. Petitioner was to begin physical therapy. Dr. Gornet noted that Petitioner had a gym membership and he sent her to the gym to use an exercise bike. The radiographs looked excellent. CT scan showed that she was probably going on to a solid fusion. Dr. Gornet noted that she seemed clinically improved regarding her previous back pain. (P. Ex. 8)

On December 16, 2009, a 19(b) hearing was held before Arbitrator John Dibble.

On December 17, 2009, Petitioner returned to Dr. Gornet 6 months post surgery. Petitioner states that the surgery helped her but she has had now new onset left groin pain. left

inter thigh pain as well as numbness and tingling in her anterior thigh. Dr. Gornet noted that some of this may be related to the exposure but this was generally an unusual presentation. Dr. Gornet recommended a MRI. Dr. Gornet also noted that Petitioner's low back pain, right buttock pain and right leg pain had dramatically improved. (P. Ex. 8)

On January 8, 2010, Petitioner returned to Dr. Gornet 7 months post surgery. Petitioner reported that she had some left-sided groin pain and thigh pain with numbness and tingling in her anterior thigh. Dr. Gornet reviewed the new MRI scan. He did not see any significant lesion on the left side. Dr. Gornet noted that Petitioner had what appeared to be a small foraminal protrusion on the left at L4-5 as well as some facet changes on the left at L5-S1 encroaching up onto the nerve root. Dr. Gornet recommended a transforaminal injection at L4-5 on the left. Dr. Gornet noted that Petitioner may require decompression in this area, only time will tell. (P. Ex. 8)

On March 18, 2010, Petitioner returned to Dr. Gornet 9 months post surgery. Petitioner reported continued numbness in her left thigh and groin area. Dr. Gornet noted that her groin numbness is consistent with inguinal nerve issues which may be related to spoke exposure. Dr. Gornet also noted that he has not seen these of any significance before but her description seems consistent with it. Dr. Gornet reported that Petitioner felt her left leg pain was identical to her right leg pain before surgery, but her right leg pain completely went away with surgery. Dr. Gornet did not see any issue with nerve compression. The transforaminal injection at L4-5 did not relieve any of her symptoms even temporarily, so Dr. Gornet did not believe it was nerve compression. Dr. Gornet opined that it was quite possible because of her leg pain that he may end up having to place fairly significant permanent restrictions on her. (P. Ex. 8)

On May 20, 2010, Petitioner returned to Dr. Gornet. Petitioner reported continued left leg pain in her anterior thigh that does not go below the knee, as well as numbness. Petitioner reported her groin numbness was improving. Dr. Gornet noted that the left leg pain may limit her activities and overall response to care. Dr. Gornet ordered a functional capacity evaluation. **Dr. Gornet noted that he did not feel the symptoms were consistent with any nerve entrapment or other problems at the L4-5 level. He noted that her fusion looked solid.** (P. Ex. 8)

On July 1, 2010, Petitioner returned to Dr. Gornet. She had not completed the FCE. Dr. Gornet's general suspicion was that Petitioner would probably require some permanent restrictions more sedentary in nature. (P. Ex. 8)

On September 9, 2010, Petitioner returned to Dr. Gornet who reviewed the FCE. Dr. Gornet believed her restrictions should be no lifting greater than 10 pounds, she may occasionally lift up to 25 pounds. She must be able to alternate between sitting and standing. No repetitive bending. Dr. Gornet recommended that these restrictions be permanent. Petitioner was to follow-up as need. (P. Ex. 8)

On September 30, 2010, Petitioner returned to Dr. Gornet. Petitioner reported severe pain with ambulation in her left thigh into her groin. Dr. Gornet wrote,"It is unclear to me the source of this." (P. Ex. 8) Dr. Gornet noted that this could be related to surgical exposure or

some other nerve entrapment, but he had not been able to find this particular problem. Dr. Gornet recommended a new MRI scan. Dr. Gornet noted that he restricted her further. She must take a ten minute break every hour. "Petitioner stated that her back was overall doing great. She has minimal back pain. It was more the nerve issue, and therefore this makes it even more frustrating for us." (P. Ex. 8)

On December 2, 2010, Petitioner returned to Dr. Gornet. He reviewed the new MRI. He did not see any new changes, abnormalities or such that would require further treatment. Dr. Gornet noted permanent restrictions of no lifting greater than 10 pounds, occasionally up to 25 pounds. She must be able to alternate between sitting and standing and no repetitive bending. Petitioner was noted to be searching for a job. The plan was to follow-up with her as needed or in June of 2011 if she desires. (P. Ex. 8)

On August 11, 2011, Petitioner returned to Dr. Gornet. Her radiographs showed a solid fusion at L4-5. (P. Ex. 8)

On September 6, 2011, Petitioner signed an Amended Application for Adjustment of Claim. She now alleged injuries to her back, right and left legs. (Arb. Ex. 1)

Ms. June Blaine, a rehabilitation counselor, was called as a witness for Petitioner. Ms. Blaine testified that Petitioner had the following transferable skills: interviewing skills, developmental planning skills, setting up goals, counseling, customer service and personal service. Ms. Blaine testified that Petitioner had a Bachelor's degree. Ms. Blaine confirmed that the permanent restrictions imposed by Dr. Gornet would allow Petitioner to work in a sedentary job. Ms. Blaine recommended Petitioner either takes a computer class which would open up jobs starting in the $9.00-$11.00 per hour range.

Ms. Blaine alternatively recommended Petitioner to obtain a Master's degree in Social Work or Rehabilitation. Ms. Blaine explained that obtaining a Master's degree paired with the number of years she had been employed with DCFS would increase her skill and background. This would potentially eliminate field work if she focused on a supervisory position or some type of an intake office related position. Ms. Blaine testified that if Petitioner obtained her Master's degree in Rehab or Social Work, Petitioner might be able to earn similar to what she was earning before. Ms. Blaine also testified that being a consultant case worker might be another avenue for her to consider.

Ms. Blaine testified that she looked at some of the job searches that the Petitioner had completed. Ms. Blaine testified that some of the jobs Petitioner was looking for in the job search fit within her restrictions, but some were outside her restrictions. Ms. Blaine testified that she did not see any restrictions by Dr. Gornet which would limit Petitioner's work to part-time.

Petitioner testified that she previously testified at the 19(b) hearing on December 16, 2009. Petitioner testified that after her surgery she had severe pain and numbness and burning in both legs. Petitioner testified that she was advised by her doctor that it was to be expected and that it should subside. Petitioner testified that approximately a couple months after her surgery, all the pain shifted to her left side. She testified that it would be similar to if you drew a line

down the center of her body from the groin area down midway to her left leg, a burning stinging sensation like being stung by a wasp is the only thing she could connect it to. Petitioner testified that it was also numb on the outside. Petitioner testified that periodically her leg does not function in the way that it should. Petitioner testified that when she is walking, in her mind it's coming with me and it's not and she falls. Petitioner testified that the pain will shoot through to the joint out her left hip and through the bottom of her lower left back, and it has maintained a fairly severe level of pain since that time.

Petitioner testified that she did not attempt to return to work at her former position. Petitioner testified that she attempted to apply for work through the Alternative Employment Program through the State of Illinois by calling a phone number that her attorney gave her. Petitioner testified that the person she spoke to told Petitioner that she could not help Petitioner, but gave Petitioner a phone number to someone else. Petitioner testified that she attempted to call that person, but never received a response.

Petitioner testified that on December 5, 2011, she met with Joan Jablonski-Baxter on the request of the State of Illinois for a vocational assessment. Petitioner testified that she never saw a report from Ms. Baxter. She stated that Ms. Baxter informed her that she was unemployable. Petitioner testified that she never received an offer of accommodation or re-employment at her former occupation.

Petitioner testified that she began a self-directed job search on September 20, 2010. She prepared a list of weekly job searches which were entered into evidence as Petitioner's exhibit 18. She testified that she looked for five separate jobs each day, not including Saturday and Sunday. Petitioner testified that she completed a variety of attempts. She applied for jobs through CMS that were open through the State. She has gone to some of the place of employment and filled out applications and she has called numerous employment opportunities, she has sent in resumes and applications for jobs that she found in the newspaper. Petitioner testified that no one has offered her a job, and she has not turned down any job offers. Petitioner testified that she had never been contacted for an interview based on her job search. Petitioner also testified that she has never received a call back. Petitioner admitted that maybe 95% or more of the places she applied at or contacted were not hiring at the time she contacted them. Petitioner testified that her job search would be maybe 3% of the jobs that she applied for have been in the newspaper ads that were hiring. Petitioner testified that at times she would drop off her resume when the place of employment wasn't hiring but asked for her resume. Petitioner testified that she didn't always send in her resume when she would call an employer and they said they didn't have any openings but were always taking applications for later. Petitioner testified that she did not apply to jobs when she found out they were only hiring part-time.

On the September 23, 2010, weekly job search log, Petitioner noted that she received a call from McDonald's for an interview on September 24, 2010, but was advised that the job was not really full-time, no one started full-time to avoid over-time. Petitioner explained the reason she applied for a job with Learn & Play School, after she had been told that they could not accommodate her restrictions, was that it was just an accident. Petitioner testified that she did not apply to jobs via Monster.com, the internet or e-mail although her husband was helping her to find jobs through the internet to find jobs in the state of Illinois and in the area where they

lived. Petitioner testified that she did not complete the additional computer training that Ms. Blaine recommended. Petitioner testified that she did not apply for additional education through Master's work either online or at the college level. Petitioner testified that she did not fill out an ADA packet under the Americans with Disabilities Act. Petitioner testified that she never tried to work as a consultant with DCFS. Petitioner testified that she did not specifically ask for computer training from the State of Illinois or to obtain a Master's Degree from the State of Illinois.

Petitioner testified that she experiences a constant pain through her lower left back and the top of her left leg. If she stays in one position too long, her muscles have muscle spasms or it increases the intensity of the pain. There are times when she lays down for ten minutes every hour because of the pain. Moving around a little bit relieves some of that. Petitioner listed her medications to include Ambien to help her sleep, Cymbalta which works as an antidepressant, Ativan for anxiety and Topamax and Imitrex for migraines. Petitioner testified that she is not taking any pain medications. Petitioner testified that her pain in her leg is a 3 to 4 on a scale of 1 to 10. However, Petitioner testified that she does not take any prescription medication or over-the-counter medication for her leg pain. At the time of the injury and before the surgery the pain was in her right side. It was after the surgery that the pain moved to the left side. Her pain on the right side is completely gone since she had the surgery. It is the pain on the left side that is causing the issues now.

Petitioner testified that this has been depressing, nerve wracking and upsetting. Not working makes her feel like she is not providing for her family. Petitioner testified that she has worked since she got out of college, first at Catholic Charities and then at DCFS until the accident.

Dr. Gornet had recommended she try a yoga class. Petitioner testified that she hadn't been able to locate a yoga class in her area.

Petitioner subpoenaed Joan Jablonski-Baxter, a supervisor for Division of Rehabilitation Services. Ms. Jablonski-Baxter testified that she interviewed Petitioner. Ms. Jablonski-Baxter testified that the time that she interviewed Petitioner she was not employable, but now she could be. Ms. Jablonski-Baxter would have to go through an assessment. Ms. Jablonski-Baxter explained that Petitioner was very angry and had a chip on her shoulder when she first met with her. So, she tried to break the ice. Ms. Jablonski-Baxter testified that she recommended that Petitioner go to mental health counseling to talk about the situation she was in and her frustration before she began looking for a job. Ms. Jablonski-Baxter stated that she was afraid that Petitioner's anger would come out during interviews with the prospective employer and the employer would pick up on the anger.

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 injured employee can establish the entitlement to PTD benefits under the Act in one of three ways, namely: by a preponderance of medical evidence; by showing a diligent but unsuccessful job search; or by demonstrating that, because of age, training, education, experience, and condition, there are no available jobs for a person in his circumstance. *Federal Marine Terminals, Inc.v.Illinois Workers' Compensation Comm'n* 371 Ill.App.3d 1117, 1129, 309 Ill.Dec 597, 864 N.E.2d 838 (2007).

Is Petitioner's Current Condition of Ill-being Causally Related to the Injury?

The Petitioner's left leg symptoms are not causally related to the accident of September 22, 2008, based upon the medical records. While Petitioner testified that her left leg symptoms occurred immediately after the surgery, the medical records of Dr. Gornet from December 17, 2009, notes that Petitioner now has **a new onset of left thigh/groin pain.** This was well after the surgery of June 23, 2009, and one day after the 19(b) hearing. It should be noted that the 19(b) decision has no reference of left leg symptoms.

The medical records note that on July 9, 2009, when Petitioner returned to Dr. Gornet three weeks post surgery she reported some increasing leg pain bilaterally as well as back pain. Dr. Gornet believed that this was normal. By August 13, 2009, Petitioner returned to Dr. Gornet for her scheduled follow-up, post surgery and seemed to be doing well. Her old pain was gone, but she was having difficulty sleeping and was tearful. The medical records indicated that her family doctor had put her on anti-depressants.

Throughout her visits with Dr. Gornet, when she complained of symptoms in her left leg, Dr. Gornet ordered tests and procedures to determine the cause of the pain which was not present before the surgery. By March 18, 2010, Dr. Gornet noted that Petitioner felt her left leg pain was identical to her right leg pain before surgery, but **her right leg pain completely went away with surgery**. Dr. Gornet did not see any issue with nerve compression. The transforaminal injection at L4-5 did not relieve any of her symptoms even temporarily, so Dr. Gornet did not believe it was nerve compression. On May 20, 2010, Dr. Gornet noted that he did not feel the symptoms were consistent with any nerve entrapment or other problems at the L4-5 level. He noted that her fusion looked solid.

On September 30, 2010, Petitioner returned to Dr. Gornet reporting severe pain with ambulation in her left thigh into her groin. Dr. Gornet noted "it is unclear to me the source of this," it could be related to surgical exposure or some other nerve entrapment, but he had not been able to find this particular problem. No causal connection opinion has been expressed with respect to the left leg and groin pain and no cause of the pain has been determined or documented.

Is the Respondent liable for any unpaid medical bills contained in Petitioner's Exhibit 1? Has Petitioner reached MMI and if so what date?

According to the medical records of Dr. Gornet, it appears that the Petitioner reached MMI by December 2, 2010. Dr. Gornet had reviewed the new MRI, did not see any new changes, abnormalities or such that would require further treatment. He noted permanent restrictions of no lifting greater than 10 pounds, occasionally up to 25 pounds. She must be able to alternate between sitting and standing and no repetitive bending. The plan was to follow-up with Petitioner as needed or in June of 2011 if she desires.

Respondent is responsible for all reasonable and necessary medical bills that are contained in Petitioner's Exhibit number 1, pursuant to the Fee Schedule in the Act.

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.

What is the Nature and Extent of the Injury?

Petitioner sustained an injury to her lower back on the right side and her right leg. She received medical care and treatment, including surgical repair in the nature of an anterior interbody fusion at L4-5. Prior to the surgery Petitioner reported daily pain on the right side and to the right leg, pain so serious she was unable to perform daily tasks like taking care of her son or herself. She was not able to work, ride in a car or sit up. After the surgery the pain in her right side and leg completely went away. After the surgery she developed pain in her left leg. The cause of the pain has not been able to be determined by her treating physicians including Dr. Gornet. No causal opinion has been presented by Dr. Gornet. Dr. Gornet noted that this may be related to the exposure but this was generally an unusual presentation. Further testing and treatment lead Dr. Gornet to conclude that the fusion was solid and the symptoms were not consistent with any nerve entrapment or other problems at the L4-5 level.

In December of 2010, Dr. Gornet imposed permanent restrictions on the Petitioner of no lifting more than ten pounds, occasionally up to 25 pounds, alternate between sitting and standing and no repetitive bending. Dr. Gornet does not specify whether the restrictions are as result of the injury to the right leg and back, the current complaints with respect to the left leg and groin or a combination of both. These restrictions limit the availability of employment for the Petitioner.

Petitioner is found to have suffered a permanent injury of 40% 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 $664.72/week for 200 weeks, because the injuries sustained caused the 40% loss of use of man as a whole, as provided in Section 8(d)2 of the Act.

Is Petitioner entitled to maintenance and vocational rehabilitation?

In this case, Petitioner engaged in an unsuccessful job search. She contacted employers in person and by telephone. She testified that more than 95% of the places where

she applied for a job, they were not hiring at the time. She testified that some of the places asked for a resume to keep on file for when they were hiring but she did not always comply with the request. She also testified that she was called back for at least one interview, with McDonalds but did not go to the interview because it was a part time position, as all their positions are in the beginning.

Both Ms. Blaine and Ms. Baxter testified that Petitioner was unemployable at the time they were dealing with her, in the absence of additional training or education, however Petitioner never followed up with them or inquired about the possibility of obtaining that education or training. Both Ms. Blaine and Ms. Baxter indicated that she would need to look for jobs that were sedentary in nature and that they could be found. Ms. Blaine furthered that if Petitioner opted for computer training, the training would put her in a market where Petitioner could expect to start out with a $9-$10 per hour job. If Petitioner opted to work on getting her Masters in Social Work or Rehab, coupled with her experience she would be eligible for supervisory work with Respondent and similar agencies.

Petitioner testified that she did not even contact Respondent with respect to trying to come back to her previous job, or another job with accommodations due to her condition since the fall. She also admitted that she did not follow up with the suggestion of Ms. Blaine that Petitioner check into information regarding Americans with Disabilities.

Petitioner has not presented enough evidence to establish that she made a good faith effort to find a job or that she falls into the "odd lot" category to shift the burden to the Respondent to show that some kind of suitable work was regularly and continuously available to the Petitioner.

Is the Petitioner entitled to reimbursement for cleaning services?

No. Petitioner is not entitled to cleaning services under the Act.

Did the Petitioner exceed her choice of physicians?

The time to raise an objection based upon exceeding choice of physicians was at this hearing when the payment of medical fees was in issue. Respondent did not raise the number of physicians as an issue at the hearing on December 16, 2009. The issue was waived.

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 **$664.72/week** for **200** weeks, because the injuries sustained caused the **40%** loss of use of man as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, outlined in Petitioner's Exhibit #1, as provided in Sections 8(a) and 8.2 of the Act,

Respondent shall receive a credit for all medical bills previously paid.

Respondent shall provide Vocational Rehabilitation Services to Petitioner if she requests them.

The Petitioner's request for cleaning services is denied.

Deborah L. Simpson
Signature of Arbitrator

July 12, 2013
Date

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

14IWCC0666

Sam Pozzie,
Petitioner,
vs.

NO: 12WC 36277

UPS,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, medical expenses, "denial of UR" 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 22, 2014, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $15,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 12 2014
o072814
MJB/bm
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

POZZIE, SAM
Employee/Petitioner

Case# **12WC036277**

UPS INC
Employer/Respondent

14IWCC0666

On 1/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1097 SCHWEICKERT & GANASSIN LLP
SCOTT GANASSIN
22101 MARQUETTE RD
PERU, IL 61354

2284 LAW OFFICE OF LAWRENCE COZZI
MARK ZAPF
27201 BELLA VISTA PKWY #410
WARRENVILLE, IL 60555

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Sam Pozzie,
Employee/Petitioner

v.

UPS, Inc.,
Employer/Respondent

Case # 12 WC 36277

Consolidated cases: n/a

14IWCC0666

An *Application for Adjustment 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 **Ottawa, Illinois**, on **October 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. ☐ 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

14IWCC0666

On **August 17, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$66,639.28**; the average weekly wage was **$1,487.48**.

On the date of accident, Petitioner was **38** years of age, *married* with **2** dependent children.

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

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

Respondent shall be given a credit of **$24,790.83** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$24,790.83.**

Respondent is entitled to a credit of **$8,009.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $3,540.00 to IVCH, $441.00 to Hospital Radiology, $12,772.00 to Prairie Pain & Spine Institute, $9,825.00 to Prairie SurgiCare and $10.00 to Rockford Spine Center, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $3,360.42 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, which is already reflected by a reduction of the outstanding bills by this amount and through discounts, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $712.55 (maximum)/week for 30 weeks, because the injuries sustained caused 6% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

1/21/14
Date

ICArbDec p. 2

JAN 22 2014

FINDINGS OF FACT:

Petitioner, Sam Pozzie, testified that he had been an employee of Respondent, UPS, Inc., for approximately 18 years. He is and principally has been a service driver. This position requires Mr. Pozzie to drive a UPS box type truck over a route where he delivers and picks up packages from Respondent's customers through a shift that may last 9 ½ to 10 hours a day. Petitioner testified that while performing these pick-ups and deliveries, UPS requires its drivers to lift up to 150 pounds per package.

Mr. Pozzie testified that he is also a semi-tractor trailer driver for Respondent. In this role, he would fill in for UPS drivers that operate this type of truck. If a semi driver went on vacation, Petitioner would often be taken off his normal job as a service driver. He would then be required to operate a semi-tractor trailer.

Mr. Pozzie testified that on August 17, 2012, he was substituting as a semi-tractor trailer driver. As part of this job, it was necessary for him to first perform a pre-trip inspection of the truck and trailer. Petitioner testified at length as to what his pre-trip inspection required. This included inspection of the vehicle's lights, tires, brakes, springs, shackles, air tank, air lines and hydraulic lines located on the vehicle. Thirteen photographs were entered into evidence that illustrate the manner in which Petitioner would be required to bend, twist and stretch while performing a pre-trip inspection. (PX 6)

Petitioner testified that on August 17, 2012, as part of his pre-trip inspection, he was bent at his waist and knees to a height that allowed him to stretch and reach under Respondent's trailer to check the brake pads. Petitioner provided that as he bent, twisted and extended his body further under the truck to perform this inspection, he felt a pain in the lower right side of his back into his buttocks.

Mr. Pozzie reports he tried to walk off the pain but the back pain and discomfort continued. Petitioner provided that he finished his pre-trip inspection and went to make his delivery where his truck was unloaded for him.

Mr. Pozzie testified that he reported the injury to Respondent's Center Team through an electronic messaging system located in his truck. Respondent did not reply immediately. Mr. Pozzie indicates that before UPS responded, he traveled to his next stop. At this location, he was unable to assist with the unloading due to severe pain. Two and a half hours passed before UPS responded to his report of injury. At that time, Petitioner reported his accident and described his pain and discomfort.

Petitioner's pain and discomfort continued. The following week he reported to Illinois Valley Community Hospital Occupational Health Department ("IVCH") on August 22, 2012. Petitioner testified that Respondent directed him to IVCH. Records submitted show he reported that he was injured on August 17, 2012 and that he experienced lumbar pain, radicular symptoms and lumbar spasms. Petitioner was placed on work restrictions of 10 pounds of lifting, minimum bending and stooping with frequent position changes. He was prescribed a Medrol Dose Pack along with Vicodin and Flexeril. Petitioner was ordered not to work or drive while he was taking Flexeril or Vicodin. (PX 2)

Mr. Pozzie testified that he was provided restricted work by Respondent consistent with his restrictions. He next visited the Occupational Health Department on August 27, 2012. At that time, Petitioner reported continuing lumbar pain, spasm and radicular symptoms. IVCH records demonstrate the spasm he was

experiencing had been reduced through the use of Flexeril and the application of heat. His right low back pain continued to radiate into the right buttock and posterior thigh. There was also an associated sharp sensation radiating into the left lateral calf and arch of the left foot. Mr. Pozzie provided that his discomfort was aggravated with sitting or standing. His pain was relieved by lying supine with his feet elevated. Forward flexion of his lumbar spine was reported as painful. Petitioner was referred to physical therapy for evaluation and treatment and told to continue Vicodin, Flexeril, ice and heat application. Mr. Pozzie's work restrictions continued. (PX 2)

Petitioner was next seen at IVCH on September 13, 2012. At this visit, it was noted that his symptoms had not improved since his last visit. Pain in his right low back radiated into his right posterior thigh, right calf and the arch of the right foot. It was aggravated with activity and sitting. Prescription medications had not provided relief. The mechanism of injury was reported as being his pre-trip check of the semi on August 17, 2012. An examination demonstrated tenderness on palpation over the lumbar vertebrae and right paraspinal muscles along with the right sacroiliac joint. Straight leg raising testing was positive on the right. Forward flexion was found to be limited in the lumbar spine. It was further noted that Mr. Pozzie was uncomfortable while sitting. The diagnosis/impression from IVCH was that of lumbar pain with radiculopathy. Mr. Pozzie was prescribed a MRI of the lumbosacral spine due to a lack of improvement with conservative care.

On September 14, 2012, x-rays were performed at IVCH showing mild scattered osteophytic spurring in the lumbar spine. The prescribed lumbar MRI was performed on September 28, 2012 demonstrating mild degenerative disc disease in the lumbar spine most pronounced at L4-5 and L5-S1 with annular tearing and slight disc protrusion at L5-S1 centrally and in the right lateral location at L3-4. There was disc bulging occurred on the right at L3-4 and L4-5 with slight mild nerve root effacement. (PX 2)

Petitioner testified that after obtaining his lumbar MRI from IVCH, he sought the medical attention of Dr. Christopher Sliva of the Rockford Spine Center on October 3, 2012. Records show Petitioner provided a consistent history of accident. He presented for an evaluation of his low back and right leg pain. The doctor noted that since the accident, Petitioner had been on light duty and had tried therapy and medication. Dr. Sliva reviewed the MRI and felt the L5-S1 level demonstrated an annular tear with minimal nerve root encroachment on the right side. He noted degenerative disc disease at L4-5 and L5-S1 and explained Petitioner also suffered from piriformis syndrome. Dr. Sliva ordered physical therapy and further suggested a piriformis injection along with epidural steroid injections. It was also suggested that a home therapy program be established. (PX 4)

Petitioner testified that he decided to seek a second opinion. As a result, he saw Dr. Richard Kube, an orthopedic surgeon at the Prairie Pain & Spine Institute in Peoria. At his November 1, 2012 visit, Dr. Kube wrote Petitioner was an employee of UPS and was injured on August 17, 2012 while performing a Department of Transportation inspection. He experienced right sided low back pain that traveled through his right buttock. The doctor noted Mr. Pozzie obtained a massage that provided him with no relief and then sought medical assistance initially with IVCH. Physical therapy and work hardening increased his pain. Upon examination, Petitioner was noted to have sensory deficits consistent with a right L5-S1 condition as well as point tenderness in the low back. X-rays at this visit demonstrated minimal loss of disc height and minimal degenerative disc disease from L4 through S1. Dr. Kube also reviewed the previously taken MRI indicating same revealed a small annular tear at L3-4 which was right sided and an annular tear at L5-S1 which was also right sided and contacts the right S1 nerve root. Less contact on the left S1 nerve root was also noted. Dr. Kube wrote Mr. Pozzie suffers from disc placement of a lumbar intervertebral disc, lumbosacral neuritis and/or radiculitus along with spinal stenosis. An epidural steroid injection was also recommended. (PX 5)

On November 12, 2012, Petitioner underwent a transforminal lumbar steroid injection, right sided,

L5-S1 (PX 5)

On November 13, 2012, Petitioner followed-up at the Prairie Spine & Pain Institute. Petitioner was provided with a continuing light duty restriction. (PX 5)

Dr. A.J. Cummings from the Prairie Spine & Pain Institute followed with Petitioner after his November 12, 2012 lumbar spine injection. On December 4, 2012, Dr. Cummings noted that initially the injection did not provide significant relief. However, after a few days Petitioner indicated he began experiencing some relief reporting a 15% improvement. An additional injection was recommended. (PX 5)

On December 7, 2012, Petitioner underwent a transforaminal epidural steroid injection, right, L4-5 and transforaminal epidural steroid injection, right, L5-S1. (PX 5) Petitioner testified that he experienced some relief from the same.

On January 3, 2013, Petitioner returned to Dr. Cummings. Petitioner still had pain in his back down the right leg. Petitioner reported that the latest epidural injections improved his symptoms an additional 15%. Petitioner indicated had a total relief of 30%. It was thought Petitioner should undergo a month of vigorous work conditioning and then obtain an FCE. (PX 5)

A functional capacity evaluation was performed on January 10, 2013 at IVCH. The evaluator provided that Petitioner gave full effort on all test. The FCE found Petitioner had significant deficits with lift and carry over 60 pounds, lift from floor to center over 60 pounds, lift from center to shoulder over 35 pounds and low level activities. Based on the FCE findings and Petitioner's job demands, it was felt he would benefit from four to six weeks of work conditioning. (PX 2) Therapy was ordered consistent with the FCE recommendations.

Respondent had Utilization Reviews (URs) performed on some of Petitioner's treatment. The first Utilization Review dated January 18, 2013 determined whether or not the request for an initial work conditioning evaluation, and 19 work conditioning sessions to the lumbar spine five times a week for four weeks for a total of 20 visits, was medically necessary. The examiner, Dr. Anup Sanghvi, opined that based on the clinical information submitted and the ODG guidlines, the requested treatment was not medically necessary. The examiner noted that details of the functional capacity evaluation (FCE) report were not specified in the records submitted and that per the ODG guidelines, a functional capacity evaluation should be completed prior to entering his work conditioning or work hardening program. Additionally, the examiner noted that the ODG recommends up to 10 work conditioning/hardening sessions over four weeks, 30 hours total when deemed necessary. The examiner felt the request goes beyond the cited guidelines. (RX 4)

The second Utilization Review dated January 22, 2013 was obtained to determined whether the November 12, 2012 transforaminal lumbar epidural steroid injection, right L5-S1 was medically necessary. The examiner, Dr. Elena Antonelli, determined that the November 12, 2012 lumbar epidural steroid injection was not medically necessary. According to the Utilization Review, the ODG guidelines support an injection when there is evidence of radiculopathy. The examiner found that there was no evidence of radiating pain consistent with radiculopathy on physical examination. That there was no EMG which demonstrated radiculopathy as reported. No focal neurological defects consistent with radiculopathy were reported. The MRI of the lumbar spine did not demonstrate nerve root compression. The examiner also noted that it was not clear whether Petitioner had exhausted all other reasonable treatment for his symptoms or whether he was involved in an ongoing rehabilitation program. The examiner concluded that the medical necessity for the injection had not been clearly demonstrated. (RX 3)

The third Utilization Review, also dated January 22, 2013, addressed the necessity of the second epidural injection completed on December 7, 2012. The UR examiner, Dr. Elena Antonelli, felt that the previous injection on November 12, 2012 had a less than optimal response to initial epidural steroid injection and the duration of the relief was not stated; there was no evidence of radiating pain that was consistent with radiculopathy on physical examination and imaging study and no EMG demonstrating radiculopathy. The examiner also noted that it was not clear whether Petitioner had exhausted all other reasonable treatment for his symptoms or whether he was involved in an ongoing rehabilitation program. The examiner concluded that the medical necessity for a repeat injection had not been clearly demonstrated. (RX 3)

According to the records of Dr. Cummings, a "Phone Note" dated January 25, 2013, shows Dr. Cummings made attempts to contact Dr. Elena Antonelli. The note indicates, "Dr. Antonelli was called again…Dr. Antonelli called me earlier in the week. I have returned her calls four to five times now and left messages in an attempt to contact her for a peer-to-peer review. I will continue to await her return call or keep trying to get in contact with her." A second "Phone Note" from Dr. Cummings records dated January 28, 2013 reads as follows: "Dr. Antonelli was again called today at 2:57 p.m. A message was left on her answering machine to call me back regarding a peer-to-peer review." (PX 5)

Petitioner continued physical therapy through April of 2013. Records demonstrated a valid effort with him obtaining a score of 9 out of 9 on the consistency level. (PX 2) On April 24, 2013, Dr. Kube examined Mr. Pozzie and reviewed these records. Following the same, Petitioner was released to return to full duty work. (PX 5)

Mr. Pozzie testified that since his return to work for Respondent, he continues to perform both jobs, a semi-tractor trailer driver and a service delivery driver. He reports continued low back pain that travels into his right buttocks, leg and foot. Mr. Pozzie states he has pain every day. It is only the intensity of the pain that differs. He explained that outside of his job, he now sleeps in a different bed than his wife because he cannot get consistent sleep because of the pain he experiences while lying down. He tosses and turns and feels it better to sleep on the couch.

During work, Mr. Pozzie explained he tries to be very cautious about what he does to avoid increased pain and reinjury. Mr. Pozzie states he continues to lift by hand 7,000 to 10,000 pounds a day. Prior to his accident, he could lift that much and beat the time standards established by UPS for deliveries by often an hour a day. However, since his injury, he is regularly a half hour over the standards established by UPS for daily deliveries.

During cross-examination, Mr. Pozzie confirmed that during a year approximately 8 weeks of the time he works as a semi driver for Respondent. He explained that as a semi driver, he also is required to lift packages as he would driving the normal delivery van/truck. On the semi, the loads are larger but fewer stops.

At the request of Respondent, Petitioner attended a medical evaluation with Dr. Joseph Monaco on March 29, 2013. Dr. Monaco noted he reviewed the MRI report which he indicated revealed no significant nerve root impingement. Dr. Monaco, following his examination of Petitioner, opined Petitioner suffered from non specific low back pain with radicular complaints with a normal objective examination of his lower back. The doctor opined that based on his review of the medical records and his examination, the incident as described was a material contributory factor to the onset of Petitioner's condition. The doctor also indicated that medical evidence does not support such minor back trauma as a cause for long term disabling low back pain. Dr. Monaco provided that Petitioner had a completely normal examination of his lower back with no neurologic deficits, negative tension signs, and no evidence of radicular symptoms or radiculopathy. Dr. Monaco opined

that Petitioner had reached a healing plateau. The doctor noted that although Petitioner had some complaints of low back pain with a pins-and-needles sensation in a sleeve-type distribution in his right thigh, he was much improved, had reached maximum medical improvement and was capable of working without restrictions. (RX 2)

In addition to performing a Section 12 examination, Dr. Monaco also performed an impairment rating. The doctor determined that Petitioner experienced 1% loss of a whole person.

During the course of Petitioner's care and treatment, gross medical bills of $44,658.00 were incurred (IVCH: $20,587.00, Hospital Radiology: $441.00, Prairie Spine & Pain Institute: $13,126.00, Prairie SurgiCare: $9,825.00 and Rockford Spine Center: $679.00). (PX 1) Of this amount, Respondent paid $3,360.42 while Mr. Pozzie's insurance paid $8.009.00. Insurance discounts of $6,670.58 were received. Petitioner also represented that he paid $30.00 out of pocket and $26,588.00 remains unpaid (IVCH: $3,540.00, Hospital Radiology: $441.00, Prairie Spine & Pain Institute: $12,772.00, Prairie SurgiCare: $9,825.00 and Rockford Spine Center: $10.00).

With respect to (F.) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Based on the sequence of events, Petitioner's credible testimony, and the medical records submitted, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injury of August 17, 2012. The Arbitrator also relies on the opinion expressed by Respondent's examining physician, Dr. Monaco, who indicated Petitioner's accident of August 17, 2012 was a material contributory factor to the onset of the Petitioner's condition. The Arbitrator notes that Petitioner continues to complain of pain in his low back with radiating symptoms into his right foot. These same complaints are reflected in Dr. Monaco's report and the records of his treating physicians, Dr. Sliva and Dr. Kube.

Following consideration of the testimony and evidence presented, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injury of August 17, 2012.

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, the Arbitrator finds as follows:

The services that Petitioner obtained were at first directed by the Occupational Health Department at IVCH. This is where Petitioner was sent to by Respondent for his initial care. After initially obtaining care and treatment at IVCH, Petitioner sought the assistance of Dr. Sliva at the Rockford Spine Center and then Dr. Richard Kube of the Prairie Spine & Pain Institute. Each provided that Petitioner required additional medical care and treatment, including injections. Physical therapy was also recommended by Dr. Kube. Additionally, Dr. Kube prescribed work hardening after Petitioner received some initial benefit from the epidural steroid injections that were provided. Mr. Pozzie believed it was these injections prescribed by Drs. Sliva and Kube that eventually allowed him to return back to work.

Respondent, through its utilization review reports, indicated the injections and work conditioning were not necessary or related to the accident. The Arbitrator has considered these opinions but finds the records of the treating physicians and the testimony of Petitioner to be persuasive.

With respect to the URs, a functional capacity evaluation was performed on January 10, 2013 at IVCH. The evaluator provided that Petitioner gave full effort on all test. The FCE found Petitioner had significant deficits with lift and carry over 60 pounds, lift from floor to center over 60 pounds, lift from center to shoulder over 35 pounds and low level activities. Based on the FCE findings and Petitioner's job demands, it was felt he would benefit from four to six weeks of work conditioning. Respondent obtained a UR to determined whether or not the request for an initial work conditioning evaluation, and 19 work conditioning sessions to the lumbar spine five times a week for four weeks for a total of 20 visits, was medically necessary. In the Utilization Review dated January 18, 2013, the examiner, Dr. Anup Sanghvi, opined that based on the clinical information submitted and the ODG guidlines, the requested treatment was not medically necessary. The examiner noted that details of the functional capacity evaluation (FCE) report were not specified in the records submitted and that per the ODG guidelines, a functional capacity evaluation should be completed prior to entering his work conditioning or work hardening program. Additionally, the examiner noted that the ODG recommends up to 10 work conditioning/hardening sessions over four weeks, 30 hours total when deemed necessary. The examiner felt the request goes beyond the cited guidelines.

As noted above, the examiner noted that details of the functional capacity evaluation (FCE) report were not specified in the records submitted and that per the ODG guidelines, a functional capacity evaluation should be completed prior to entering his work conditioning or work hardening program. It is quite clear from the evidence submitted that Petitioner had in fact undergone the FCE prior to the referral (January 17, 2013) for the utilization review and the determination dated January 18, 2013.

With respect to the second and third Utilization Reviews, both dated January 22, 2013, the UR examiner, Dr. Elena Antonelli, opined that the injections on November 12, 2012 and December 7, 2012 had a less than optimal response; there was no evidence of radiating pain that was consistent with radiculopathy on physical examination and imaging study and no EMG demonstrating radiculopathy. The examiner also noted that it was not clear whether Petitioner had exhausted all other reasonable treatment for his symptoms or whether he was involved in an ongoing rehabilitation program.

A review of the evidence show Petitioner reported to Illinois Valley Community Hospital Occupational Health Department on August 22, 2012. Petitioner complained of lumbar pain, radicular symptoms and lumbar spasms. He was prescribed a Medrol Dose Pack along with Vicodin and Flexeril. At his next visit with the Occupational Health Department on August 27, 2012, Petitioner reported continuing lumbar pain, spasm and radicular symptoms. IVCH records demonstrate the spasm he was experiencing had been reduced through the use of Flexeril and the application of heat. His right low back pain continued to radiate into the right buttock and posterior thigh. There was also an associated sharp sensation radiating into the left lateral calf and arch of the left foot. Forward flexion of his lumbar spine was reported as painful. Petitioner was referred to physical therapy for evaluation and treatment. On August 31, 2012, Petitioner was seen at IVCH Physical Therapy Department for a general evaluation. The physical exam revealed Petitioner was listing to his right during the course of the evaluation. Petitioner was next seen at IVCH on September 13, 2012. It was noted that his symptoms had not improved since his last visit. Pain in his right low back radiated into his right posterior thigh, right calf and the arch of the right foot. An examination demonstrated tenderness on palpation over the lumbar vertebrae and right paraspinal muscles along with the right sacroiliac joint. Straight leg raising testing was positive on the right. Forward flexion was found to be limited in the lumbar spine. The diagnosis/impression from IVCH was that of lumbar pain with radiculopathy. A MRI of the lumbosacral spine was prescribed due to a lack of improvement with conservative care. The prescribed lumbar MRI was performed on September 28, 2012 which was interpreted to show mild degenerative disc disease in the lumbar spine most pronounced at L4-5 and L5-S1 with annular tearing and slight disc protrusion at L5-S1 centrally and in the right lateral location at L3-4. There was disc bulging occurred on the right at L3-4 and L4-5 with slight mild nerve root effacement.

Petitioner next sought the medical attention of Dr. Christopher Sliva of the Rockford Spine Center on October 3, 2012. Dr. Sliva reviewed the MRI and felt the L5-S1 level demonstrated an annular tear with minimal nerve root encroachment on the right side. He noted degenerative disc disease at L4-5 and L5-S1 and explained Petitioner also suffered from piriformis syndrome. Dr. Sliva ordered physical therapy and further suggested a piriformis injection along with epidural steroid injections. On November 1, 2012, Petitioner came under the care of Dr. Richard Kube, an orthopedic surgeon at the Prairie Pain & Spine Institute. Upon examination, Petitioner was noted to have sensory deficits consistent with a right L5-S1 condition as well as point tenderness in the low back. X-rays at this visit demonstrated minimal loss of disc height and minimal degenerative disc disease from L4 through S1. Dr. Kube also reviewed the previously taken MRI indicating same revealed a small annular tear at L3-4 which was right sided and an annular tear at L5-S1 which was also right sided and contacts the right S1 nerve root. Less contact on the left S1 nerve root was also noted. Dr. Kube wrote Mr. Pozzie suffers from disc placement of a lumbar intervertebral disc, lumbosacral neuritis and/or radiculitus along with spinal stenosis. An epidural steroid injection was also recommended.

Petitioner continued treating at Prairie Spine & Pain Institute where he followed with Dr. A.J. Cummings. He ultimately underwent transforaminal epidural steroid injections on November 12, 2012 and December 7, 2012. On January 3, 2013, Dr. Cummings noted Petitioner reported a total relief of 30%. Petitioner also reported to Respondent's Section 12 examiner that he "definitely feels better – about 60% better." The Arbitrator is not persuaded by the conclusions rendered by the UR evaluators. It appears that Dr. Elena Antonelli, the UR evaluator, was only provided with a portion of the medical documentation. Also of note are the records from Dr. Cummings dated January 25, 2013 and January 28, 2013, wherein the doctor made several attempts to contact Dr. Elena Antonelli for a peer-to-peer review. It doesn't appear that Dr. Antonelli ever responded.

Following consideration of the testimony and evidence presented, the Arbitrator finds the medical services that were provided to Petitioner were reasonable and necessary. The services that were rendered to Petitioner total $44,658.00 and include IVCH: $20,587.00, Hospital Radiology: $441.00, Prairie Spine & Pain Institute: $13,126.00, Prairie SurgiCare: $9,825.00 and Rockford Spine Center: $679.00. Of this amount, Respondent has paid only $3,360.42 (IVCH: $3,240.72 and Prairie Pain & Spine Institute: $119.70). Petitioner's personal insurance paid $8,009.00 (IVCH: $7,705.00 and Rockford Spine Center: $304.00). Discounts were received of $6,670.58 with Petitioner also paying $30.00 out of pocket. There remain unpaid bills of $26,588.00 (IVCH: $3,540.00, Hospital Radiology: $441.00, Prairie Spine & Pain Institute: $12,772.00, Prairie SurgiCare: $9,825.00 and Rockford Spine Center: $10.00).

Respondent shall pay these charges which were reasonable and necessary medical services. Said payments shall be made consistent with the Medical Fee Schedule.

With respect to (L.) What is the nature and extent of the injury, the Arbitrator finds as follows:

For injuries occurring after September 1, 2011, permanent partial disability pursuant to 835 ILCS 305/8.1(b) shall be assessed 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 the 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.

Applying this standard to this claim, This Arbitrator concludes as follows:

(i): Dr. Joseph Monaco found a PPI rating of 1% of the whole person. Dr. Monaco noted that Petitioner's range of motion measured 80 degrees of forward flexion with good reversal of the normal lumbar lordosis and 30 degrees of extension and 30 degrees of lateral bending each way with no pain. He found the straight leg raising test was negative at 80 degrees bilaterally. The deep tendon reflexes are 2+ and equal bilaterally at the knees and ankles. Motor function was at 5 of 5 for all muscles tested in both lower extremities. The muscles test include the extensor halluces longus, anterior tibialis, gastrocsleus, quadriceps and hamstrings. Sensation was grossly normal in both lower extremities. The deep tendon reflexes were 2+ an equal bilaterally at the knees and ankles. Measurements of both low extremities were identical. And, there is a full range of motion of both hips without pain.

(ii): Petitioner has been employed as a Feeder Driver and Package Car Driver for Respondent and has returned to his usual employment.

(iii): Petitioner was 38 years old on the date of the injury. The Arbitrator considers Petitioner to be a younger individual and is thus more likely to live and work longer than an older individual with the same injuries.

(iv): Petitioner has returned to his pre-injury job and continues to work in that capacity at the same rate of pay.

(v): Petitioner has returned to work full duty and has not had medical treatment for his injury since May of 2013. Petitioner returned to his regular job as April 13, 2013. Petitioner passed the functional capacity evaluation with the evaluator noting that he exceeded the job requirements. Petitioner testified that he did receive some relief for the injuries sustained, but said relief was incomplete. He continues to suffer from pain and numbness that occurs daily. He provided that the amount of pain and numbness differs from day to day. Petitioner testified this injury continues to affect his ability to sleep and function at work. The Arbitrator finds Petitioner to be credible.

Based on all the above, the Arbitrator finds that as a result of the accident sustained, Petitioner is permanently disabled to the extent of 6% under Section 8(d)2 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

Jaime Salgado,

Petitioner,

14IWCC0667

vs.

NO: 12WC 44665

Boley Tools & Machine Works,

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, 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 December 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.

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 $5,600.00. 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: AUG 12 2014
o072914
MJB/bm
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

SALGADO, JAIME
Employee/Petitioner

Case# **12WC044665**

14IWCC0667

BOLEY TOOLS & MACHINE WORKS
Employer/Respondent

On 12/23/2013, 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 0.09% 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:

0225 GOLDFINE & BOWLES PC
ATTN: WORK COMP DEPT
124 S W ADAMS ST SUITE 600
PEORIA, IL 61602

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

14IWCC0667

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)

JAIME SALGADO
Employee/Petitioner

v.

BOLEY TOOLS & MACHINE WORKS
Employer/Respondent

Case # **12** WC **44665**

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 **STEPHEN MATHIS**, Arbitrator of the Commission, in the city of **PEORIA, ILLINOIS**, on **09/23/2013**. 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 5, 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 **$25,298.00**; the average weekly wage was **$486.50**.

On the date of accident, Petitioner was **42** years of age, ***married*** with **4** 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 **$N/A** under Section 8(j) of the Act.

ORDER

Petitioner is awarded T.T.D. benefits from May 8, 2013 through August 25, 2013, or the sum of $324.33 per week for 15 2/7ths weeks.

Petitioner is awarded his unpaid medical bills in the amount of $584.00.

Pursuant to Section 8(a), Petitioner is prospectively awarded the right shoulder surgery recommended by Dr. Johnson.

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.

S J Mathis
Signature of Arbitrator

12-13-13
Date

ICArbDec19(b)

DEC 23 2013

ATTACHMENT TO ARBITRATOR'S DECISION

Jaime Salgado vs. Boley Tools & Machine Works

IWCC No.: 12 WC 44665

In Support of the Arbitrator's decision regarding **(C) Did an accident occur that arose out of and in the course of the Petitioner's employment by the Respondent,** and **(F) Is the Petitioner's present condition of ill-being causally related to the injury,** the Arbitrator notes as follows:

Petitioner, Jaime Salgado, began working for Respondent, Boley Tools & Machine Works, in May 2010 as a driver. Boley Tools manufactures various engine parts for Caterpillar and Komatsu. After a few weeks of employment, Petitioner switched positions to become the "leak tester". This job involved setting fixtures in a water tank and then forcing air through engine parts such as manifolds, headers, and pumps, while they are held under water by the fixture. If air bubbles out, then the part is not sealed and fails the test.

Petitioner used a hoist and chain to transport and place the various fixtures into the tank. The fixtures are too heavy to be lifted manually. Various parts of all sizes, shapes and weights were then bolted in the fixture, using from 1 bolt to as many as 10 bolts to secure the part. Some parts weighed up to 100 pounds and required a strap and hoist to place them. A piece of rubber was placed between the part and the fixture in order to secure a water and air tight seal. The bolts were three quarters inches thick and had to be bolted tightly. An air hose was then fastened to the part, blowing pressurized air through the part. After the test was completed, the bolts had to be loosened and removed and the part was then manually lifted from the fixture and placed in a metal bin for packaging, or was marked "bad". Before placing each part in the fixture, Petitioner had to hand-grind a small smooth area and hammer a stamp print onto each part. Petitioner is 5'9" tall (Petitioner Exhibit 1, p.3) and is right-hand dominant. He stood on a step next to the tub as he lifted, bolted, tested, and unbolted

each part. The tank height was over Petitioner's navel. Petitioner typically used a snake wrench to loosen and tighten the bolts. Both Petitioner, and Respondent's witness, Jay Douglas, agreed that force is required for the last tightening turns and the initial loosening turns with the wrench.

Petitioner eventually brought in an air wrench to show his supervisor, but he continued to manually wrench the bolts. The bolts were located in various locations on the fixtures, requiring different angles and positions by Petitioner. Petitioner lifted the parts with both hands and arms, as several of the parts weighed 20 pounds or more, but he used only his right arm to grind, hammer, and wrench. Petitioner demonstrated his "wrenching" by holding his arm out forward from his body at shoulder level. Petitioner worked this job from May 2010 until approximately January 5, 2012, or for 1 year and 8 months.

Petitioner's Exhibit 8 is a hand-drawn diagram of Petitioner's work area. It includes Petitioner's drawing of parts such as pumps, heads, and oil pans.

Petitioner's Exhibit 7 is a group exhibit of ten photographs taken by Petitioner in January and February 2012. Photo "A" shows a metal fixture with a part in it. Photo "D" shows a worker at the test tank with the hoist above him. Photo "F" shows a hook device that came into use after Petitioner's right shoulder injury. This device was used with the hoist to lift parts from the metal bins for testing. Photo "I" shows three manifolds packed together. These manifolds are one of the parts that were tested. Respondent produced no documentary evidence of the weights involved or job tasks. Their witness testified to some of the weight of the parts. Their witness uses an air wrench to do the bolt tightening and loosening, and admitted that he never observed how Petitioner did the job before he was injured. Mr. Douglas is 6'3" tall and testified that the leak tester job does not require reaching above waist height for him.

Beginning in December 2011, Petitioner began to notice dull and sometimes sharp pain in his right shoulder. He associated this pain with lifting and using the wrench repetitively. He complained to his supervisor and was sent by Respondent to their doctor at IWIRC. (Petitioner Exhibit 1, Respondent Exhibit 2)

At IWIRC, Petitioner gave a history on January 5, 2012, as follows: "...states this injury occurred 3 weeks from January 5, 2012 at an unknown hour. Patient states that he tightens bolts all day everyday like a mechanic...states that he continuously lifts, tightens bolts, etc..." (Petitioner Exhibit 1, p.3) A physician's assistant diagnosed him with "DJD of the right shoulder – not work related...". Light duty restrictions were given, and Mr. Salgado was directed by IWIRC to follow up with his primary care physician for his non-work related shoulder pain. January 5, 2012 is the date of Petitioner's shoulder diagnosis and is Petitioner's date of manifestation.

Mr. Salgado saw his primary care physician initially on January 13, 2012. (Petitioner Exhibit 2, p.18) He gave a history that "...3 weeks ago pain started. pain o[illegible]r past week. Works using tools @ factory...". He saw his clinic physicians periodically throughout 2012, receiving physical therapy and ultimately a right shoulder MRI on November 1, 2012. (Petitioner Exhibit 3) The MRI revealed a tear of the supraspinatus tendon.

On November 19, 2012, Dr. Jessica Hanks at the OSF Clinic authored a narrative report. (Petitioner Exhibit 2, pp.1-2) In the report, she states, "...the patient had progressive strain on the shoulder from repetitive movements with wrenching of the right hand...it appears that his shoulder pain has been persistent throughout the last 11 months...It is my impression that Mr. Salgado has had the same injury throughout the course of our treatment as his exam has not changed and he has been refractory to all conservative treatment. At this time we have recommended him to be seen by an orthopedic surgeon...".

Likewise, Dr. Doolittle at the OSF Clinic also treated Mr. Salgado for his right shoulder injury. He stated that the right shoulder pain was "induced by overuse at work". (Petitioner Exhibit 2, p.8) Dr. Doolittle noted on April 4, 2012 that Mr. Salgado was continuing to work light duty. His assessment on April 4, 2012 was, "right shoulder pain secondary to overuse injury". (Petitioner Exhibit 3, p.9) On March 12, 2012 Dr. Doolittle authored a letter regarding Mr. Salgado's injury and its likely cause. (Petitioner Exhibit 3, pp.10-13) He noted Petitioner's job description as full time factory work consisting of repeatedly tightening and loosening bolts requiring frequent right shoulder use that produced a progressively painful shoulder without any acute injury. Dr. Doolittle then opined, "Given that the patient describes that he is frequently lifting forty-eight pounds of material up to the shoulder level and then he is ratcheting bolts in tighter, the motion is also near the shoulder level that requires the use and exacerbation of the pain of his right shoulder. I suspect that the twelve months of repetitive movement has caused an overuse injury".

Mr. Salgado initially saw Dr. Brent Johnson, an orthopedic surgeon, on December 19, 2012 after his MRI. (Petitioner Exhibit 4) There, he completed a medical history form indicating that he had a work injury related right shoulder injury that began around January 5, 2012 due to "wrenching". (Petitioner Exhibit 4, p.12) He gave the same history directly to Dr. Johnson. (Petitioner Exhibit 4, p.5) At that visit, Dr. Johnson diagnosed Mr. Salgado with a torn right rotator cuff and recommended surgery.

Dr. Johnson was deposed by the parties. (Petitioner Exhibit 5) Dr. Johnson is a board-certified orthopedic surgeon, specializing in knee and shoulder surgery, who has been practicing in Peoria for ten years. (Deposition, p.4) Dr. Johnson performs two to four Independent Medical Exams per week, mostly for insurance companies. (Deposition, p.5) Dr. Johnson personally reviewed the MRI, diagnosing minor degenerative changes with a partial or full-thickness tear of the supraspinatus tendon. (Deposition, pp.9-10) Dr. Johnson

opined that it would be "...very unlikely" for a 43 year old to have a completely degenerative age-related tear. (Deposition, p.11) Dr. Johnson saw Mr. Salgado a second and final time on January 30, 2013 and put a five pound lifting restriction with the right arm on Mr. Salgado. (Deposition, pp.15-16) Based upon a lengthy hypothetical which was consistent with Petitioner's testimony at Arbitration, Dr. Johnson opined as to causal connection, "Yes. I feel the hypothetical you described his activity of wrenching could have contributed to the injury to his rotator cuff. I definitely think it would have aggravated his condition of the rotator cuff causing him to seek treatment." (Deposition, pp.17-18) Dr. Johnson also testified that the work activities were one of the reasons for the need for the recommended surgery of a scope and rotator cuff repair. (Deposition, p.19)

Mr. Salgado was sent by Respondent for an I.M.E. with Dr. Richard Lehman in St. Louis on April 23, 2013. (Respondent Exhibit 1) Dr. Lehman was deposed by the parties. Dr. Lehman, like Dr. Johnson, is a board-certified orthopedic surgeon. (Deposition, pp.6-7) Mr. Salgado's history to Dr. Lehman was consistent with his testimony at Arbitration. (Deposition, p.10) Dr. Lehman agreed that the November 2012 MRI showed a partial rotator cuff tear and impingement syndrome, although he thought these were degenerative and chronic. (Deposition, p.19) Dr. Lehman characterized the degeneration as "significant". (Deposition, p.20) Ultimately, Dr. Lehman diagnosed Mr. Salgado with degenerative joint disease, impingement, and arthritis. (Deposition, pp.24-25) These conditions were <u>not</u> related to the work activities because there was "significant" degenerative arthritis and no specific history of a "true" injury. (Deposition, p.25) Dr. Lehman also felt that a rotator cuff strain would only be caused if Petitioner's arms were elevated at more than 90 degrees from his body, and that Petitioner's job did not require that. (Deposition, pp.28-29) Finally, Dr. Lehman felt that Petitioner should try an injection <u>before</u> having rotator cuff surgery. (Deposition, pp.29-30) On cross-exam, Dr. Lehman admitted that there was no evidence of

any prior medical treatment to Petitioner's right shoulder. (Deposition, p.44) Dr. Lehman also admitted that the wrenching activities "may have caused him to manifest the soreness in his degenerative shoulder...". (Deposition, p.48)

To summarize the conflicting medical opinions, Dr. Johnson agreed with the radiologist that there is minimal degeneration and a torn rotator cuff that requires surgery and which is work-related. Dr. Lehman feels there is significant degeneration and arthritis in this 43 year old man, and that Mr. Salgado's symptoms were caused by the wrenching, but that the underlying arthritic process was not.

The Arbitrator notes that Petitioner's histories are entirely consistent between all medical examiners and his Arbitration testimony. The Arbitrator notes that the work activities involved forceful pulling and pushing with the right arm away from the body and at shoulder height or higher for this 5'9" tall Petitioner. Respondent's expert witness actually agrees with Petitioner's allegation that his work activities caused his symptoms. There is no evidence whatsoever that Petitioner had any prior right shoulder injury. The Arbitrator also agrees with Dr. Johnson that Petitioner's right shoulder has evidence of only minor degeneration, and no significant degeneration and arthritis as opined by the independent examiner.

Based upon the above, the Arbitrator finds that Petitioner did sustain a repetitive trauma accident to his right shoulder which manifested itself on January 5, 2012. The Arbitrator also finds that Petitioner's torn rotator cuff is causally related to that repetitive trauma.

In Support of the Arbitrator's decision regarding **(J) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services,** and **(K) Is Petitioner entitled to any prospective medical care,** the Arbitrator notes as follows:

Having found the issues of accident and causal connection in favor of the Petitioner, it logically follows that his related outstanding medical changes and the proposed surgery by Dr. Johnson should also be awarded.

Petitioner's Exhibit 6 consists of two outstanding charges at the OSF Clinic and Midwest Orthopedic Center (Dr. Johnson). These bills in the amount of $584.00 are awarded.

The Arbitrator also finds Dr. Johnson's proposed right shoulder arthroscopy and rotator cuff repair to be a reasonable and causally related surgery and awards this pursuant to Section 8(a).

In Support of the Arbitrator's decision regarding **(L) What temporary benefits are in dispute, T.T.D.,** the Arbitrator notes as follows:

Respondent provided Mr. Salgado with restricted work until May 8, 2013 when Petitiioner and a co-worker were both fired for an altercation at work. Petitioner testified that the fight was provoked by his co-worker. Petitioner requests T.T.D. benefits after this date, pursuant to the Illinois Supreme Court's Decision in Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission, 236 Ill. 2d 132, 923 N.E.2d 266, (Ill 2010) (copy attached), which held that an employer's obligation to pay T.T.D. benefits does not cease because the employee has been discharged – whether or not the discharge was "for cause". The Arbitrator finds that Mr. Salgado's condition had not stabilized and that he continues to require restrictions, as opined by both doctors herein, and is therefore entitled to T.T.D.

benefits beginning May 8, 2013 and running until Petitioner began a new job at McDonald's on or about August 25, 2013.

The T.T.D. awarded totals 15 2/7ths weeks.

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

Marvin Dobkins,
Petitioner,

14IWCC0668

vs.

NO: 10WC 37932

State of Illinois, Danville Correctional Center,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, 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 January 22, 2014 is hereby affirmed and adopted.

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

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

DATED: AUG 12 2014
o072814
MJB/bm
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DOBKINS, MARVIN Case# **10WC037932**
Employee/Petitioner

ST OF IL DANVILLLE CORRECTIONAL CENTER
Employer/Respondent

14IWCC0668

On 1/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0139 CORNFIELD & FELDMAN LLP
JIM M VAINIKOS
25 E WASHINGTON ST SUITE 1400
CHICAGO, IL 60602

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

4993 ASSISTANT ATTORNEY GENERAL
CHRISTINE J SMITH
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

JAN 22 2014

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0668

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

MARVIN DOBKINS
Employee/Petitioner

v.

STATE OF ILLINOIS, DANVILLE CORRECTIONAL CENTER
Employer/Respondent

Case # **10** WC **37932**

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 **Urbana**, on **November 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 _____

14IWCC0668

FINDINGS

On **July 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 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 **$77,887.00**; the average weekly wage was **$1,497.83**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit of under Section 8(j) of the Act for any medical bills paid under Respondent's group health insurance plan.

ORDER

Petitioner has failed to prove that he sustained an accidental injury to his left and right hand and wrist due to work activities that arose out of and in the course of his employment with Respondent and he has failed to prove that his current condition of ill-being in his hands/wrists is causally related to any alleged accident on July 15, 2010. Petitioner's claim for compensation is denied. No benefits are awarded and 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.

Nancy Lindsay
Signature of Arbitrator

1-17-14
Date

ICArbDec p. 2

JAN 22 2014

Dobkins v. State of Illinois, Danville Correctional Center, 10 WC 37932

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner alleges repetitive trauma injuries to his upper extremities as a result of his job duties for Respondent. He alleges an accident date of July 15, 2010. Disputed issues are accident; causal connection; medical expenses; temporary total disability benefits; and nature and extent.

The Arbitrator finds:

On May 14, 2010, Petitioner sought treatment with the Carle Physician's Group-Department of Family Practice for hand symptoms. According to the medical records, at that time, Petitioner reported that he had "acute" numbness and tingling in his hands, right worse than left. It is noted in the medical records that the "tingling and numbness in his hand started gradually a couple of months ago and it is progressively getting worse. Now it is to the point where he reaches for his keys which are on his belt at work and he has a hard time disconnecting them. Yesterday, he dropped them when he thought he had them in his hand. He does not seem to be having any trouble lifting things. It hurts when he rotates the keys in doors. He works as a prison guard and so he carries a fairly heavy set of keys and he had to turn lots of keys and open lots of heavy doors...." (PX 1) Petitioner also noted some symptoms on the outside of his elbow. The doctor further recorded that Petitioner had noticed symptoms while bowling this season but bowling was now over and he was still experiencing symptoms. Petitioner denied any other repetitive motion work. Petitioner also acknowledged having to do some keyboarding with his job but he didn't feel it was prolonged. Petitioner denied any nocturnal symptoms. Petitioner's left hand symptoms were much less than the right ones, but reportedly the same. On physical examination Petitioner was a "little tender" in the area of the lateral epicondyle, but the doctor described it as nothing "exquisite." Tinel's was negative but a little bit of tingling and "heaviness" of this third, fourth, and fifth fingers were noted pre-testing. The doctor could not perform a Phalen's test because Petitioner reported it hurt too much to flex his wrist. (PX 1) The assessment on this date was carpal tunnel symptoms, right worse than left and Petitioner was prescribed a wrist splint. While it was noted that Petitioner probably couldn't wear it at work because he couldn't wear anything that would impair his ability to move quickly and grab keys and doors, he was instructed to wear it around the house and at nighttime. He was also told to continue using Ibuprofen. (PX 1)

Petitioner returned to Dr. Marganski's office on June 2, 2010, reporting "absolutely" no improvement in his right wrist pain. The doctor's nurse noted, "he is sure that he is worse" as after only a couple of hours of wearing the wrist splint his wrist pain increased and he stopped wearing the splint. Petitioner's examination was unchanged. Petitioner was referred to Hand Orthopedics. (PX 1)

On June 17, 2010, Petitioner was seen at Carle Hand Orthopedics Center. Physician's Assistant James Berkes examined Petitioner noting a history of bilateral numbness and tingling for several months worsened by use of a wrist splint. On the left upper extremity, Petitioner had a slightly positive Tinel sign over the median nerve at the wrist, a slightly positive median nerve compression test and a negative Phalen's test. On the right extremity, Petitioner's primary complaints were noted to be with the middle, ring and small fingers and Petitioner had a positive Tinel over the ulnar nerve at the elbow and a positive elbow flexion test. Petitioner had a mildly positive Tinel over the median nerve at the wrist, a positive median nerve compression test and a positive Phalen's test. Petitioner's lateral epicondyle was tender and Petitioner had pain with extension of his wrist against resisitance. Mr. Berkes' assessment was lateral epicondylitis and possible carpal and cubital tunnel

syndromes bilaterally. Petitioner was also noted to have a healing abrasion about his right elbow. Mr. Berkes declined offering a steroid injection at the elbow in light of the abrasion; however, he did recommend a Heelbo pad. EMG studies were also ordered. (PX 1)

On July 13, 2010, Petitioner underwent the EMG studies, the results of which indicated mild bilateral carpal tunnel syndrome, right hand affected slightly more than left. No evidence of any ulnar neuropathy was noted. (PX 1)

On July 15, 2010, Petitioner returned to see Mr. Berkes. The EMG study was reviewed. Mr. Berkes' notes indicate Petitioner was reporting considerable problems at work. Mr. Berkes' notes state, "He first noticed the issue when performing [his] usual work duties as a prison guard at the Danville prison. He has to turn keys and locks and he finds that that causes him quite a bit of pain and causes the numbness to occur in his hands. He noticed that he was starting to drop the keys and that is when he decided to seek treatment." (PX 1) Use of a night splint had not helped. They discussed treatment alternatives including a steroid injection and surgery and Petitioner elected to think about the matter for awhile. (PX 1)

Petitioner signed his Application for Adjustment of Claim on August 29, 2010, alleging repetitive trauma to his upper extremities. (AX 2)

Petitioner returned to his primary care doctor on October 25, 2010 for the purpose of undergoing a pre-operative consultation. Petitioner was scheduled to undergo a right carpal tunnel release on November 4, 2010. Dr. Marganski noted, Petitioner was a correctional lieutenant at the prison in Danville and has had increased symptoms with trying to turn keys in locks and using his computer at work. "This is considered a workman's compensation case." (PX 1)

On November 4, 2010, Petitioner underwent a right carpal tunnel release performed by Dr. Sobeski. Dr. Sobeski reported no complications with the surgery. During the procedure the doctor inspected Petitioner's median nerve, noting no abnormalities. (PX 1)

Petitioner followed up with Dr. Sobeski's office on November 18, 2010. Petitioner reported that most of his arm pain had resolved although a little bit of numbness and tingling remained. Petitioner was released to light duty at work with no lifting over one to three pounds with his right hand. Petitioner was still symptomatic in the left hand and was planning on proceeding with a release on it once he had recovered from the right side. (PX 1)

On December 9, 2010, Petitioner returned to Dr. Sobeski's office for a recheck on his right hand and reported that he was doing very well and that the numbness and tingling had resolved and his only residual pain was from the surgery itself and even that pain was quickly going away. Petitioner was released to work without restrictions. (PX 1)

On January 6, 2011, Petitioner underwent left carpal tunnel surgery performed by Dr. Sobeski. Intra-operative examination of Petitioner's median nerve revealed no abnormalities. Dr. Sobeski's notes indicate that Petitioner suffered no complications. (PX 1) On January 20, 2011, Petitioner returns for a re-check of his left upper extremity and was released to work with a 1-3 pound lifting restriction for the left hand. (PX 1)

On February 10, 2011, Petitioner returned to Dr. Sobeski's office for a re-check on both hands and it was noted that he was doing very well and had full range of motion with minimal discomfort. Petitioner was

returned to work with no restrictions and was released from care and reported to be at maximum medical improvement. (PX 1)

At the request of his attorney, Petitioner was examined by Dr. Jeffry Coe on November 22, 2011. Dr. Coe met with Petitioner and reviewed a number of Petitioner's medical records, including those of the treating physician. After the examination, Dr. Coe issued a written report. (PX 2) In his report, Dr. Coe detailed the history provided to him by Petitioner noting that Petitioner had worked for the Department of Corrections for 26 ½ years and remained so employed at the time of their meeting. Petitioner had been a correctional officer for six years, correctional sergeant for eight years, and correctional lieutenant for more than thirteen years. Petitioner described his work activities as opening and closing cell doors using manual keys (both a "regular" key and a larger "Folger Adams key") and opening and closing metal fence gates. Petitioner described the keys as often being difficult to turn and requiring forceful gripping and twisting. The cell doors reportedly weighed 130 pounds. Petitioner also described the fence gates as weighing between 300 and 400 lbs and being 15 feet long by 12 feet tall. Petitioner stated that his hand movements were performed on a daily basis and that he performed more than 750,000 key turns in his work career with Corrections. Petitioner also added that as a correctional lieutenant, Petitioner was responsible for computer data entry, reports, counts and cell moves which required an estimated 80,000 key strokes. (PX 2)

Petitioner denied any significant injuries or symptoms in his wrists or upper extremity nerves prior to his work activities for the Department of Corrections. Petitioner believed that his symptoms came on over time with his work activities. Petitioner had previously fractured his right fifth finger and undergone right shoulder surgery. Petitioner complained of post-operative scarring on both hands, an aching discomfort at the base of each palm with forceful gripping or squeezing, and slight weakness of both hands. Petitioner's pre-operative numbness and tingling had resolved. Dr. Coe's examination revealed slight tenderness to the palm scars with deep palpation and decreased sensation over and immediately surrounding the palm scar lines. Petitioner was noted to be right hand dominant. Both range of motion and grip strength measurements were taken with Dr. Coe concluding they showed residual weakness in Petitioner's right hand to grasp and pinch grip. (PX 2)

Based upon his knowledge of Petitioner's job as described by Petitioner, his review of Petitioner's medical records, and Petitioner's history of having developed numbness and tingling in both hands as he carried out his work activities, Dr. Coe opined that there was a causal relationship between Petitioner's repetitive strain injuries to his hands and his current symptoms and state of impairment. He further opined that Petitioner's repetitive strain injuries had caused permanent partial disability to both hands. Dr. Coe noted Petitioner described repetitive and forceful use of both upper extremities in his job as a correctional officer. More specifically, Dr. Coe stated that the repetitive strain activities of forceful gripping and twisting of keys and opening and closing of doors and gates was a "factor causing the development of [Petitioner's] bilateral carpal tunnel syndrome." (PX 2)

The deposition of Dr. Coe was taken on June 29, 2012. (PX 3) Dr. Coe is board certified in occupational medicine. Dr. Coe testified consistent with his written report. In addition, Dr. Coe explained that his causation position was based upon the general description of cumulative numbers provided to him by Petitioner. Dr. Coe testified as follows:

Q: How much, I suppose then if we don't know how many key strokes he makes a day or how much cumulative time this eighty thousand key strokes represent how much does this factor into your causation opinion?

A: What's important in my opinion regarding causation in Mr. Dobkin's case is the totality of what he did. So his work with keys, his work opening and closing cell doors and gates, his work completing reports including computer data entry, it presents a picture of someone who used their hands repeatedly and also forcefully throughout the workday. That's what significant to me.
(PX 3, p.34:5-17)

Q: Doctor, would it be fair to say then that we don't know on his daily life, on his daily life activities at work, his daily work activities, I suppose I should say, that we do not know the frequency, intensity or duration of the work that he does?

A: We only know the general description of his work with the nature of the work itself, the mechanical nature of the work. That's the gripping and twisting of the keys, gripping of gates and so on. So we don't have numbers other than the numbers that Mr. Dobkins put together as to the number of times he might do something. We have to extrapolate, as you've just done, to what this might represent over the course of a working day, a working month or a working year. That's really all we have to go on in this matter.

Q: Okay. But we don't know the actual number of key turns or key strokes he makes a day?

A: That's right. We only have his general estimates.
(PX 3, p. 35:8-36:6)

Dr. Coe also testified about his understanding of Petitioner's work duties. The following exchange occurred:

Q: Doctor, you've indicated that he had bilateral carpal tunnel releases. You've also indicated that he told you about key turning. How is it that both hands are involved in the situation?

A: Mr. Dobkins, as you'll recall, told me that the keys were large, particularly the Folger Adams keys. He told me that it was hard to turn the keys; that it was forceful gripping of the cell doors and the large gates and so on. Mr. Dobkins developed symptoms more in his right hand than his left. He did use both hands in these activities. So he was required to use both hands to carry out his work activities, particularly as he developed symptoms in his right hand. And the condition in his right hand was more severe than his left.

Q: And that's in line with what you would expect?

A: Yes. That's consistent with a right hand dominant individual carrying out forceful, repetitive, heavy activities using his hand.
(PX 3, p. 23:21-24:19)

Dr. Coe also explained the results of his physical examination of Petitioner stating that he had "well-healed surgical scars of each palm…that remained slighter tender at the time I examined Mr. Dobkins." Dr. Coe testified that he "went on to measure the range of motion of Mr. Dobkins' wrists looking for stiffness. Let me summarize this for you by saying I found full range of motion of each wrists [sic]". Dr. Coe found no compression of the median nerve but found mild weakness in Mr. Dobkin's right hand. (PX 3, p.20:7-23:20).

With respect to Dr. Coe's opinion on Petitioner's outcome, Dr. Coe testified as follows:

Q: Okay. With regard to his condition when you saw him on the date of your exam, I believe it was November 22, 2011, would you say that he had an excellent surgical outcome?

A: I would. He had a fine outcome. His initial presenting complaints of carpal tunnel syndrome, numbness and tingling, pain in his fingers, that had fully resolved. He had scarring of his hands with some residual scar sensitivity. This is in my opinion an excellent outcome. (PX 3, p. 36:14-37:l)

Dr. Coe provided some additional information regarding Petitioner's current condition at his examination:

Q: Doctor Coe, when you were discussing the petitioner's current condition at the time you examined him did he have any complaints about his hands?

A: Well, he did. Mr. Dobkins still had some complaints when I saw him of November 22nd of 2011. He did tell me that he did have the scars of his hands. And there was some what he described as an aching discomfort at the base of each palm particularly with forceful gripping or squeezing. Now, this discomfort that he's describing, this is in the area of the scar. That's at the base of the palm. So this is some of his scar discomfort. But beyond that Mr. Dobkins did tell me that he did still have slight weakness he felt of both hands. Though on my measurements, I was able to document weakness in the right hand, which is his dominant hand. And then finally with regard to the nerve entrapment, as I've described for you here today, Mr. Dobkins did tell me that the tingling and the numbness of his hands that he had had before the surgery had then resolved after the surgery. So that's the very long way to answer your question. But basically he's got some residual scar tenderness in each palm, which is common after carpal tunnel release surgery. And he does have the weakness that he feels is in both hands that I was able to document in his right hand.
(PX 3, p. 41:13-42:21)

On December 12, 2012, Respondent sent Petitioner for a Section 12 Independent Medical Evaluation with Dr. James Williams of the Midwest Orthopedic Center. Dr. Williams is board certified in orthopedics and has an additional certification in hand and upper extremity surgery from the American Board of Orthopedic Surgery.

On December 12, 2012, Dr. Williams discussed Petitioner's job duties with Petitioner in great detail and was provided approximate estimates for key turns and key strokes by Petitioner for each position held by Petitioner during the different time frames that Petitioner was working for the Department of Corrections. Dr. Williams obtained a detailed description of the facility, the various position requirements for all of the jobs held by Petitioner, *i.e.*, Correctional Officer, Correctional Sergeant, and Correctional Lieutenant, prior to his alleged injury, and a detailed description of his hours and requirements for each shift during each time period. Petitioner's description of his job duties were recorded by Dr. Williams in his IME report. (RX 1, Dep. 2)

Dr. Williams also reviewed all of the workers' compensation forms submitted by Petitioner and his employer, the Position Description of Correctional Lieutenant, the demands of the job form, the job duty sheet, Petitioner's medical records and Petitioner's medical records. Dr. Williams also performed a physical examination of Petitioner during this appointment. Dr. Williams was unable to provide an opinion regarding causation after that visit because he required the results of Petitioner's blood testing prior to rendering an opinion. The requested results were provided to Dr. Williams and on March 7, 2013, Dr. Williams provided an

addendum report where he advised that he had reviewed the records and confirmed that Petitioner was not diabetic.

Dr. Williams opined that Petitioner suffered from bilateral carpal tunnel syndrome and that Petitioner successfully underwent reasonable and necessary treatment with no reported continued problems. Dr. Williams stated,

> "In regards to causation, I do not feel that his work duties based upon my own experience of having been to Pickneyville Correctional Center, Illinois River Correctional Center, as well as Pontiac Correctional Center where I myself have cuffed and uncuffed an officer, I have opened and closed a chuck hole, I have used large Folger Adams keys as well as smaller keys in order to open up doors in segregation, as well as regular cell doors. I have also done bar rapping at Pontiac and I do not feel in light of this, on the work activities of which he stated to me, that his work duties would have either been aggravating or contributory to the problem of which he currently complains." (RX 1, Dep. Ex. 2)

Dr. Williams also stated that "I feel more likely that the etiology would be idiopathic rather than related to his work duties. I based this on the activities of which he did which involved intermittent rest; they were not continuous and did not involve any significant vibration and/or impact to the hands..." (RX 1, Ex. 2) Dr. Williams noted Petitioner's other risk factors of increased body mass index of 37.7 and explained that while Petitioner did bar rapping at one time, he had not done that in the prior 10 years. (RX 1, Ex 2)

Dr. Williams' deposition was taken on April 26, 2013. (RX 1) In his deposition, Dr. Williams explained his position regarding causation as follows:

Q: What is your opinion to a reasonable degree of medical certainty as to whether or not Petitioner's job duties causes, contributed to, aggravated or accelerated his bilateral carpal tunnel syndrome?

A: I did not feel they did, Ma'am, based upon the information of which I had.

Q: Okay. And can you explain for the arbitrator how you reached that conclusion?

A: Essentially based upon the most recent literature which has not found gripping, pinching and/or repetitive use of the hands to either be aggravating and/or contributing to the condition of carpal tunnel. Vibration, idiopathic and inheritable natures are the only things that were found to be significant. And the American Society for Surgery of the Hand themselves has come out with a position statement in 2010 supporting those findings.
(RX 1, p. 15:16-16:11)

Dr. Williams was also asked about vibration or impact in Petitioner's job and explained his position as follows:

Q: And in the history of job duties the Petitioner gave you, did the Petitioner explain to you or note any job duties that involved significant vibration or impact to the hands?

A: He did, Ma'am.

Q: Okay. And what were those?

A: Essentially, the biggest things he had done previously, it had been ten years prior to him working at his latest facility, that he had done bar rapping I believe in Pontiac, and that he noted all the places he had worked. And that was the biggest issue with vibration. He said they did bar rapping for the shower area, and that was done about ten years prior. He said now there was, quote-quote, expanded metal in that area. And that was the biggest issue with any kind of vibration or significant impact.

Q: Was there any vibration or impact to the hands noted in the job duties for the ten years prior to your date of examination.

A: Not significant, no, Ma'am. The other thing he said he had done, he had been on the tactical team which he'd been on since 1999. He said that they used batons which he felt involved vibration, which are oak solid or hickory, but he said they did that, and they did gun qualifications. He was a firearm instructor, which he had been since January of 2012, and they had done that one time per year.
(RX 1, p. 10:5-11:11)

At his arbitration hearing Petitioner testified that on July 15, 2010 he was employed by Respondent as a Correctional Lieutenant at the Danville Correctional Center. Prior to that, Petitioner had worked as a Correctional Officer and a Correctional Sergeant. Petitioner testified that as of 2010 he had worked for Respondent 25 years.

Petitioner testified he was hired by Respondent on July 18, 1985 and remains so employed. From 1985 to May of 1991, Petitioner worked as a correctional officer. He worked the 7 a.m. to 3 p.m. shift. Petitioner estimated that during this time frame, his daily key turns were approximately 250 per shift. (RX 1, Deposition Ex. 2-IME Report) This shift involved Petitioner working in the cell house wings where he would do an informal count to ensure that all inmates were in their cells. Petitioner would go through and open 56 cells ensuring that all inmates were in their cells. The cell doors are solid steel doors with a security vision panel and a chuck hole. The doors require regular size keys. Petitioner testified it did not take a lot of pressure to turn the key in the door. The chuck holes in the segregation unit required use of a Folger Adams key to provide meals to inmates. (RX 1, Dep. Ex.2)

Petitioner testified that from May 1991 to January 16, 1999, he was a correctional sergeant. In this position, he estimated that he had approximately 200 key turns per shift. (RX 1, Dep. Ex. 2)

From 1999 to the time of his alleged accident in 2010, Petitioner was in the position of a Correctional Lieutenant where he worked the 3 p.m. to 11 p.m. shift. He estimated that in this position he had approximately 70 key turns per shift. From 1999 to the present, he was also required to type reports daily taking approximately 30 minutes per day and that intermittently throughout the day, for a total of one hour, he would enter information into a computer regarding institutional moves, counts, or prisoners going in and out. During the entire time period from 1991 to 2011, Petitioner estimated that he typed approximately 200 keystrokes per day. Petitioner also estimates that during this time period, approximately 20 times a day he would push or pull open heavy steel doors and/or gates. (RX 1, Dep. Ex. 2). Of these 20 times, 2 to 3 would be opening the fence gate which had a pad lock and is on wheels so the gate rolls open.

Petitioner testified that from 1999 to July 15, 2010 approximately 20 percent of his key turns would have been with the Folger Adams key. Petitioner testified that these key turns would be made intermittently throughout the day and that it took approximately one second to turn the key and between one and three seconds to open the door. Approximately 10% of the doors are difficult to open. Petitioner testified that he would open heavy doors a couple of times a day.

According to Petitioner, from 1999 to 2011, Petitioner periodically worked in the administration building where his job was to put counts of inmates into the computer system and make sure all the counts were accurate. (RX 1, Ex 2) If inmates needed to be moved from one area of the facility to another, he would monitor that and make sure the computer system reflected that inmates were in the proper cells. Petitioner also needed to keep track of transfers of inmates in and out of the facility. This computer process is referred to as "turning movement on and off." Petitioner's computer duties were intermittent throughout the day. In the administration building, Petitioner was stationed within the armory where he was also responsible for supervising the armory officer, passing out and receiving keys, passing out and receiving radios, and signing out equipment. As a lieutenant, Petitioner was also required to monitor inmates during the one meal on the 3p.m. to 11 p.m. to make sure there was no fighting or stealing and also had to open the doors for inmates bringing trays out to the line. Petitioner testified that he assisted with meals in segregation several times a week.

As a lieutenant, Petitioner supervised approximately 42 officers on a shift on any given day and was also responsible for the health care unit, the admin building, the visiting area, the main gate, segregation and the receiving area. Petitioner would make tours to make sure the officers were doing their jobs, and do periodic checks to make sure the cleaning was up to par. Petitioner testified that his baton use was limited to practices with the tactical team where officers would simulate inmates slinging things that would have to be blocked with the baton. Petitioner testified that at one point the practices were 4 times a month but then they were moved down to 2 times a month around 2005 or 2008. Petitioner agreed with the material duties of his job as they were listed in Respondent's Exhibit 5.

Petitioner was off work from November 4, 2010 to November 17, 2010 and again from January 6, 2011 to January 19, 2011. Petitioner testified that he was granted five service-connected days for his injury where he was paid his full salary and did not utilize any benefit time. Petitioner then used five personal days for his first surgery and 10 personal days for his second surgery.

Petitioner testified that since returning to work after his carpal tunnel surgeries, he has not experienced any difficulties in performing the material duties of his job. Petitioner testified that he had pain of about 1 to 2 on a scale of 10 on a daily basis. Petitioner testified that since returning to work, he has been promoted from lieutenant to major and he has received a pay raise. Petitioner testified that his carpal tunnel syndrome has not prevented him from advancing in his career. Petitioner testified that he had not returned to the doctor since February of 2011 for any carpal tunnel symptoms.

Petitioner provided information regarding his work duties to Respondent's IME doctor Dr. James Williams and the parties have stipulated that these duties were accurately summarized in Dr. Williams' report and are a true and accurate representation of his duties. Petitioner testified that he provided true and accurate information to Dr. Williams regarding his job duties and that he reviewed the report and did not note any discrepancies.

On cross-examination Petitioner testified that he understood the importance of providing true and accurate information to Dr. Williams and that he did, in fact, provide true and accurate information to Dr. Williams and emailed Dr. Williams specific numbers of key turns and keystrokes after he had time to calculate those numbers.

Respondent has paid $7,795.73 pursuant to the Medical Fee Schedule for Petitioner's medical bills to Carle Foundation Hospital, Carle Physicians Group and Carle Clinic. (RX 4)

Petitioner has submitted bills in the amount of $15,750.14 from Carle Foundation Hospital, Carle Physicians Group and Carle Clinic. (PX 4)

A SRS "Job Duty Statement" for a correctional lieutenant position indicates that the position involves use of hands for gross manipulation and fine manipulation 0 to 2 hours per day. (RX 3)

A CMS "Position Description" for a correctional lieutenant position dated March 8, 2010 sets forth the essential functions of the position including supervising of staff, daily inspection, arbitration of inmate disputes, establishing and maintaining complete training records on all security personnel, complying with key and lock control and tool control procedures, and reporting and monitoring compliance. (RX 5)

The attorneys stipulated at the arbitration hearing that the job duties given to Dr. Williams were accurate.

The Arbitrator concludes:

ISSUE C: DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT? *AND* ISSUE F: IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner is alleging an accidental injury to his left and right hands and wrists due to repetitive work activities that manifested itself on July 15, 2010. In *Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d. 524, 505 N.E. 2nd 1026, 106 Ill.Dec. 235 (1987), 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 claimant's work activities, including the frequency, duration, manner of performing, etc. It is equally important that the medical experts have a detailed and accurate understanding of the claimant's job duties.

In the instant case the parties do not seem to dispute the manifestation date. Rather, the focus of the dispute is whether Petitioner's bilateral carpal tunnel syndrome arose out of Petitioner's employment with Respondent and was causally connected to his job duties for Respondent.

In analyzing Petitioner's job duties and the medical causation opinions in this case, it is important to note at the outset that Dr. Sobeksi, Petitioner's treating orthopedic surgeon, did not provide an opinion regarding causation and was not deposed in connection with this case. The context within which Dr. Marganski's statement in his October 25, 2010 office note[1] was given is unclear. Thus, the Arbitrator does not view it as an expert opinion on the issue of causal connection. Consequently, the Arbitrator is faced with causation opinions between two examining physicians.

At the outset the Arbitrator notes that while neither doctor questioned whether Petitioner had bilateral carpal tunnel syndrome it is interesting that Petitioner's initial complaints focused on his middle, ring, and pinky fingers – an area of the hand innervated by the ulnar nerve rather than the median nerve, that the EMG noted Petitioner's electrodiagnostic evidence of bilateral carpal tunnel syndrome was mild, and that during both surgical procedures the surgeon found no abnormalities with respect to Petitioner's median nerves. Despite

[1] "This is considered a w/comp case."

surgery, Petitioner continues to complain of pain in both hands which is exacerbated by gripping, twisting, and cold weather.

At trial, Petitioner provided testimony documenting his job duties. He also testified that he provided true and accurate information to Respondent's IME doctor, Dr. James Williams, who detailed those duties in his report. Petitioner reviewed this report and found no significant discrepancies in the job duties as documented by Dr. Williams and the numbers of key turns and keystrokes that were recorded by Dr. Williams. The job duties were broken down by Petitioner for each different position he has held and the time period he worked in each position.

From 1999 to the time of his alleged accident in 2010, Petitioner was in the position of a Correctional Lieutenant where he worked the 3 p.m. to 11 p.m. shift. He estimated that in this position he had approximately 70 key turns per shift. Petitioner testified that from 1999 to the July 15, 2010 approximately 20 percent of his key turns would have been with the Folger Adams key. Petitioner testified that these key turns would happen intermittently throughout the day and that it took approximately one second to turn the key and between one and three seconds to open the door.

Taking the Petitioner's estimates, Petitioner would be performing the allegedly repetitive activity of key turning for approximately one minute and ten seconds a shift. Considering this amount of time, combined with the fact that there were periods of intermittent rest in between each key turn and in a seven and a half hour shift, large periods of rest, makes Petitioner's claim that these activities are "repetitive" questionable. Further, Petitioner stated that approximately 20% of the key turns would have been with the Folder Adams key meaning approximately 14 key turns a shift might be with a larger, heavier key. However, Petitioner also testified that the only place where these keys are used is in the chuck holes in Segregation and that, as a lieutenant, he only worked in Segregation a couple of times a week. Therefore, there would be even larger periods of rest between the times that he would be required to use the larger keys which he alleges require more force to use.

At trial Petitioner also alleged that the activity of opening the doors after turning the keys was repetitive in nature and contributed to his condition. Petitioner testified that it would take between one and three seconds to open the doors. This would mean that Petitioner would spend between one minute and 10 seconds (70 seconds) and three minutes and 30 seconds (210 seconds) opening doors in a seven and a half hour shift. Of these doors, approximately 10% of the doors were difficult to open and a "couple" were heavy. This would mean that seven to 10 times a day, Petitioner is opening doors which do not open easily or require more force to open. Petitioner also estimated that during this time period, approximately 20 times a day, he would intermittently push or pull open heavy steel doors and/or gates. (RX 1, Dep. Ex. 2) Of these 20 times, 2 to 3 would be opening the fence gate which has a pad lock and is on wheels so the gate rolls open.

Turning to Petitioner's keyboarding activities, from 1999 to the present, Petitioner testified that he was required to type reports daily taking approximately 30 minutes per day and that intermittently throughout the day for a total of one hour, he would enter information into a computer regarding institutional moves, counts, or prisoners going in and out. During the entire time period from 1991 to 2011, Petitioner estimates that he typed approximately 200 keystrokes per day. 200 keystrokes amounts to a few lines of type. If an average word is approximately 4.5 characters long, 200 keystrokes is less than 45 words-- far less than a single paragraph. Even Petitioner described his typing duties to his doctor as "not prolonged."

Petitioner also had responsibility for supervising over 40 people on each shift, managing all of the movement of prisoners throughout the building, and overseeing all of the incoming and outgoing equipment in the armory. Taking into account Petitioner's other responsibilities in combination with the time estimates

counts (20%). In addition, Dr. Williams has visited numerous state prison facilities, and personally performed the job duties required of Petitioner.

Based upon this, Dr. Williams concluded that Petitioner's job duties as described by the Petitioner would not have caused or aggravated his carpal tunnel syndrome. He explained that, "I based this on the activities of which he did which involved intermittent rest; they were not continuous and did not involve any significant vibration and/or impact to the hands..." (RX 1, Ex. 2). Dr. Williams further supported his opinion "[b]ased upon the most recent literature which has not found gripping, pinching and/or repetitive use of the hands to either be aggravating and/or contributing to the condition of carpal tunnel. Vibration, idiopathic and inheritable natures are the only things that were found to be significant. And the American Society for Surgery of the Hand themselves has come out with a position statement in 2010 supporting those findings." (RX 1, p. 15:16-16:11)

In summary Petitioner failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his hands and wrists due to repetitive work duties. Petitioner's tasks at work were not repetitive nor did they constitute a major portion of his job duties. Petitioner's job duties with Respondent did not cause or aggravate his bilateral carpal tunnel syndrome and Petitioner's current condition of ill-being in his hands and wrists was not caused or aggravated by his work duties.

Petitioner's claim for compensation is denied. All other issues are moot. No benefits are awarded.

****

provided by Petitioner, it would appear that Petitioner's key turns of 70 times a shift and keystrokes of 200 a shift, were not repetitive but were merely incidental to his other job duties. Performing the activity of turning keys for less than five minutes a shift and entering 200 keystrokes intermittently during a shift does not rise to the level of a repetitive activity.

With respect to baton use, Petitioner testified that batons were used in practices for the tactical team. Petitioner testified that his baton use was limited to practices with the tact team where officers would simulate inmates slinging things that would have to be blocked with the baton. Petitioner testified that at one point the practices were 4 times a month but then they were reduced to 2 times a month around 2005 or 2008. This is not an activity that was performed on a regular basis and Petitioner never had to use his baton on a prisoner or while working a shift at the facility. There was no evidence submitted that this limited baton use could cause or aggravate Petitioner's conditions and Petitioner's IME doctor never mentioned or considered this baton use in his causation opinion.

The Arbitrator also notes that Petitioner's testimony at trial in which he asserted the repetitive nature of his many job duties was contrary to what he initially told the doctor on May 14, 2010. At that time he specifically denied any aspect of his job (other than turning keys and opening doors) was repetitive. (PX 1)

With respect to the examining physicians, the Arbitrator finds Dr. Williams' opinions more persuasive than those of Dr. Coe. Dr. Williams is board certified in orthopedic surgery and has a specialty in upper extremity surgery. Dr. Coe lacks those qualifications. Furthermore, Dr. Williams' opinions were based upon more complete and accurate details and information than those of Dr. Coe. Petitioner's doctor, Dr. Coe, had a fundamental misunderstanding of Petitioner's job duties and based his opinion on the belief that Petitioner's job duties required him to "use his hands repeatedly and also forcefully throughout the workday. That's what [is] significant to me." (PX 3, p.34:5-17) In addition, the information provided to him was merely cumulative numbers. He was never provided a breakdown per shift or per time period or per job description of what the number or key turns or keystrokes pertained to. This results in an inaccurate and incomplete picture of the Petitioner's job duties in the decade prior to his injury. While Petitioner's descriptions for Dr. Coe contain similar approximate numbers for the cumulative job duties over the course of 25 years, Dr. Coe was never provided a breakdown for the time periods that Petitioner was performing various duties per shift. This becomes significant because for the last 11 years of his career as a lieutenant from 1999 to 2011, Petitioner performed less of each activity than he did in the years prior.

In addition, Dr. Coe was only provided with partial information on significant topics. Petitioner reported to Dr. Coe that he was required to move large gates weighing 300 to 400 pounds which required forceful gripping. However, Petitioner failed to mention that these large gates were actually on wheels and rolled open. It is unclear what "forceful gripping" would be required in this process, however, even if it was, Petitioner testified that this activity was performed 2 to 3 times a shift and therefore could not possibly have been repetitive, nor was it performed for any significant period of time. Dr. Coe also understood that Petitioner "used his hands continually throughout his workday". (PX 3, p.13: 5-6) and that "it was hard to turn the keys; that it was forceful gripping of the cell doors and the large gates and so on..." (PX 3, p. 23:21-24:19) However, at trial Petitioner testified that it did not take a lot of pressure to turn the key in the door.

In contrast, Respondent's IME doctor, Dr. Williams, had a detailed understanding of the Petitioner's job duties broken down by each job title, each time period the job title was held and each shift worked. Dr. Williams also reviewed the formal job description for a Correctional Lieutenant (RX 5) which indicates that the primary job duties are to supervise subordinate staff (35%) and make daily inspections of the prison and monitor

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

Janice Burns,
Petitioner,
vs.
State of IL DOC IYC Joliet & Dan Rutherford As State Treasurer, ET AL,
Respondent,

NO: 05 WC 13848
14IWCC0669

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 13, 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: AUG 14 2014

MB/mam
o:7/10/14
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BURNS, JANICE
Employee/Petitioner

Case# **05WC013848**

14IWCC0669

ST OF IL DOC IYC JOLIET & DAN RUTHERFORD AS STATE TREASURER ET AL
Employer/Respondent

On 12/13/2013, 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 0.09% 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:

0924 BLOCK, BLOCK & KLUKAS PC
MICHAEL D BLOCK
19 W JEFFERSON ST SUITE 100
JOLIET, IL 60432

5132 ASSISTANT ATTORNEY GENERAL
STACEY R LASKIN
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 PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

DEC 13 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0669

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

JANICE BURNS
Employee/Petitioner

v.

STATE OF IL DOC IYC JOLIET & DAN RUTHERFORD AS STATE TREASURER, ET AL
Employer/Respondent

Case # **05** WC **13848**

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 **ROBERT FALICIONI**, Arbitrator of the Commission, in the city of **NEW LENOX**, on **10/15/13, 11/14/13 and 11/21/13**. 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. ☒ 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 **01/05/2005**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$72,863.96**; the average weekly wage was **$1,401.23**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$385060.59** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$385060.59**.

Respondent is entitled to a credit of **$89,459.91** under Section 8(j) of the Act.

ORDER

Credits

Respondent shall be given a credit of **$385060.59** for TTD, **$0** for TPD, and **$0** for maintenance benefits, for a total credit of **$385060.66**.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $934.15/week for 417 6/7 weeks, commencing 01/26/05 through 02/23/05 – 04/26/05 through 07/25/05, and 09/16/05 through 05/1/2013, as provided in Section 8(b) of the Act. Respondent to receive credit for all sums previously paid hereunder.

Medical benefits

Respondent shall be given a credit of $89,459.91 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services including recovery firms (Pet's Ex. 39 Resp. Ex. 6) for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Permanent Total Disability

Respondent shall pay Petitioner permanent and total disability benefits of $ **934.15**/week for life, commencing 05/02/2013, as provided in Section 8(f) of the Act.

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

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

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

Signature of Arbitrator

December 9, 2013
Date

DEC 13 2013

14IWCC0669

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JANICE BURNS, Petitioner, vs. STATE OF ILLINOIS DOC IYC JOLIET & DAN RURTHERFORD AS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE RATE ADJUSTMENT FUND Respondent,	)	No.: 05 WC 13848 Arbitrator: ROBERT FALCIONI

RIDER TO ABITRATOR'S DECISION

FINDINGS OF FACT REGARDING ALL ISSUES:

Petitioner, a 24 year employee of the Department of Corrections, had worked her way up from Correctional Officer to Assistant Warden of Programs at IYC Joliet when on January 5, 2005 she fell on snow covered ice. She tried to get up several times and fell again, and finally, after rescuers were unable to traverse the ice, a van came, got her in, and took her to Provena St. Joseph Medical Center. (Pet. Ex. 1)

At the hospital, they treated both knees and her upper spine (Pet. Ex. 1, Pet. Ex. 2 p1). She had undergone prior left knee surgery, but never had prior right knee surgery. X-rays taken the hospital were unremarkable, although slightly limited (Pet. Ex. 4, p35). Five days later, January 10, 2005, she presented to Dr. Verghese at Community Orthopedics, which later became part of Meridian Medical Group, with a confirmatory history that she fell at work, hitting her head, went to get up and fell forward twice on her knees and was unable to get up by herself, requiring assistance, hearing crunching and popping noises and using crutches for ambulation. (Pet. Ex. 4, p2). The diagnosis was post-traumatic chondromalacia of both patellas. (Id. P 1) Petitioner had been referred to Community Orthopedics by workers' comp coordinator of Respondent. She followed up with treatment at Brightmore Physical Therapy (Pet. Ex. 5). In the physical therapy evaluation of February 10, 2005, the therapist treated Petitioner for a muscle strain/scoliosis in the cervical and thoracic spine. (Pet. Ex. 5)

By Petitioner's testimony, her job duties required extensive walking, having to basically cover the entire premises for multiple assignments. The facility was a maximum security male juvenile facility with six living units when she started, eight at the time of her injury. She would be on her feet eight plus hours a day, doing daily living inspections for the inmates and monitoring the school, dietary, recreational, confined areas, mental health areas and other activities. Petitioner testified that although in management, she had extremely

limited computer skills, not even social networking, but she could email and do small research. In approximately 1980 she got a Bachelor's Degree in Psychology, but that does not allow her to practice psychology or counseling, and the only counseling she did was under supervision at IYC through a certificate, not a license. All her employment since age 24 was for the State of Illinois in Corrections.

On January 18, 2005 she began treatment with an orthopedist of her own choice, Parkview Musculoskeletal Group. (Pet. Ex. 6 – 16) In the initial visit approximately two weeks post accident, the doctor noticed findings both of the cervical and thoracic spine, as well as continued pain in the right knee, for which he ordered an MRI. (Pet. Ex. 6, pp1-3) ATI took over physical therapy March 22, 2005. They treated both the right knee and her upper spine (Pet. Ex. 19, pp1-5). She continued having upper back problems in the therapy, which began January 5, 2006 (Id. 17-19).

In the therapy visit of March 23, 2006, her knee actually gave out and she fell downstairs, noting her low back was very sore from the fall (Id. P32). Petitioner's therapy continued regarding her upper back into February, 2006 (Pet. Ex. 19, pp37-124, 127). Thereafter, most of the therapy is directed to the multiple surgeries for her knee, noting August 21, 2006 that she became emotional during her assessment, crying and complaining with frustration about symptom aggravation with minimal activity (Id. 109). Following a positive MRI (Id. P 8-9), she underwent her first ever right knee surgery by Dr. Giridher Burra April 26, 2005 for a partial medial meniscectomy and lateral release of the right knee. (Pet. Ex. 14) Petitioner was examined by Dr. J. F. Player at Respondent's request July 25, 2005 (Resp. Ex. 3). Dr. Player found casual connection on the knee and failed to opine on causal connection regarding the upper back condition, evidencing he felt it was causally related as well, although his diagnosis was upper back strain currently resolved (Resp. Ex. 3, p15, Opinions 1-3). Dr. Player felt Petitioner could work sedentary light duty with limited walking and stair climbing (Id. p. 4). Petitioner returned to light duties the next day. On October 7, 2005, she underwent a second surgery by Dr. William Farrell of the same group (Pet. Ex. 15) following a repeat MRI of August 24, 2005 which was positive (Pet. Ex. 18). The second surgery by both Petitioner's testimony and most the notations in the operative report was for the right knee, which was an arthroscopy with debridement and chondroplasty of the patella and distal medial femoral condyle, noting typographical errors also indicating "left" within the report. (Pet. Ex. 15) Following the second surgery Petitioner underwent more physical therapy at ATI through December 6, 2006 (Pet. Ex 19). She then had a third surgery July 19, 2007, the second performed by Dr. Farrell, which consisted of additional arthroscopy of the right knee with debridement of the medial compartment and patella femoral compartment chondromalacia, which was described by the doctor as Grade III (Pet. Ex. 16). She had physical therapy in the interim from April 4, 2007 through May 17, 2007 at ATI (Pet. Ex. 20).

Subsequently, on March 11, 2008, she saw Dr. Farrell, noting chronic swelling and weakness and giving way of the knee, the last surgery of July 2007, being the third, and noting that she had been through every conceivable

conservative option, including orthovisc physical therapy, arthroscopy times three, braces, and the like, and accordingly scheduled total knee arthroscopy for May of 2008 (Pet. Ex. 11, p 33).

With therapy records showing abnormal gait through the present time, Dr. Farrell noted that Petitioner also had an intermediate low back condition as of March of 2008 (Id. p34) for which he ordered an MRI April 8, 2008. Dr. Farrell noted that Petitioner's MRI of her low back revealed degenerative disc disease and scoliosis, which was a chronic finding, but that she also had signs of a right L4 nerve irritation and L2 accounting for her left groin pain and right low limb pain. He recommended an epidural injection for the low back. By December 3, 2008, the records show that Dr. Farrell requested workers' comp authorization for a right total knee replacement from March 11, 2008 (Pet. Ex. 11, p33) as well as April 8, 2008 (Id. 35-36) May 6, 2008, even recommending an IME and noting cane ambulation and possibly her own health insurance paying the bill (Id. 37) and June 6, 2008, noting that doing an epidural injection would help with the low back pain. (Id. 38) July 9, 2008, Dr. Farrell noted that Petitioner had two epidurals for her back, not positively affecting her knee pain, and that she was scheduled for a third at the end of the month. If there was no positive affect with respect to her knee and lumbar radicular symptoms, he would schedule a knee replacement as discussed at length and documented in the past (Id. 39).

On August 13, 2008, regarding causation on the low back, and the long period of time for which right knee replacement was not being approved, Dr. Farrell noted that Petitioner continued to experience pain and swelling, taking narcotic medication, and that she was being seen for back condition and that the pain management physicians asked her to see a neurosurgeon to rule out a radicular component that would account for her right knee pain. Dr. Farrell noted: "I believe that by past history and by examination that they are two separate entities. They may indirectly affect each other." (Id. 40). October 8, 2008, Dr. Farrell noted: "At this point she is going to discuss a possibility of knee replacement surgery before the weather turns to the cold and she will alert me accordingly. I believe that the patient can do the recap post-knee replacement surgery. On the positive side if it does help her back pain then obviously it is the right area to address first as oppose to the back." It is again clear that Dr. Farrell felt that the problems Petitioner was having with the knee were affecting her low back, and that surgery could help (Id. 42). December 3, 2008, Dr. Farrell again continued Petitioner off work, noting: "It is our opinion that the long standing problem with her knee is contributing to her symptoms for the back at this time." (Id. 44) Petitioner testified that her back symptoms arose while walking with an altered gain, with assistance and bent over.

On December 10, 2008, Petitioner saw Dr. Chowdry for evaluation of back and leg pain. (Petitioner's Exhibit 29A). Petitioner stated that she believed her problems began after the January 5, 2005, work accident. *Id.* However, Dr. Chowdry noted that Petitioner has a known history of scoliosis and that medical providers had discussed the possibility of surgery to treat Petitioner's scoliosis prior to the January 5, 2005, work injury. *Id.* The medical history reviewed on that

visit also included x-rays of her back from 2002 and 2004, taken after Petitioner reported pain related to driving. *Id.* Petitioner further stated that most of her back problems actually began in February of 2007 and have been progressively worse since February 2008. *Id.* Petitioner indicated that her neurosurgeon, Dr. Hurley, believed that her scoliosis was responsible for her pain, and not the work fall. *Id.* Petitioner stated that she could walk only two blocks at a time with a cane. *Id.* However, Petitioner said she tries to remain active and does yoga and water exercises. *Id.* Dr. Chowdry diagnosed low back pain, adult scoliosis, and degenerative disc disease, and did not indicate that any of these conditions are related to the January 5, 2005, work injury. *Id.*

April 17, 2009, Dr. Farrell noted that Petitioner's right knee gave out causing her to fall down some stairs at Inwood (where she testified she regularly exercised by swimming) and that she fell and struck her left knee, with x-rays negative for fracture and diagnosis of contusion (Id. 48, 50). June 23, 2009, although Dr. Farrell was repeatedly faxing his office notes to the Illinois Youth Center, he was still awaiting approval for right total knee arthroplasty (Id. 52). Finally, July 22, 2009, surgery was approved (Id. 53-54). A total knee revision was performed by Dr. Farrell September 17, 2009 at Silver Cross Hospital (Pet. Ex. 23).

In the interim, Petitioner was seen by a neurologist, Dr. V. Paul Bertrand who noted Petitioner's pain but opted against surgery, had been to physical therapy, and was doing yoga rehab. Petitioner had also been referred to pain management and began treating with Health Benefits Pain Management, beginning July 20, 2010. (Pet. Ex. 24). She was treated by Dr. Udit Patel, a pain management doctor, who repeatedly noted Petitioner to be status post work injury on January 5, 2005, treating her for right knee pain and low back pain with right lower extremity pain and employing conservative care, including shots with occasional relief.

Dr. Patel noted that low back pain had increased due to compensation. (Pet. Ex. 24, p19) This was August 7, 2012, at which time doctor discussed getting a new MRI to check out other issues. This also was following Petitioner's second knee replacement, which was performed June 6, 2012 by Dr. Britt Levine of Midwest Orthopedics at Rush at Rush Oak Park Hospital. (Pet. Ex. 30A-30C) An MRI was done August 28, 2012, and revealed moderate right foraminal narrowing at L4-5 related to disc bulge and facet hypertrophy which appeared increased compared to the prior study of July 27, 2010, evidencing a worsening during the time period in which Petitioner's total knee replacement was being denied, requiring her to continue to walk with an altered gait. Following the third surgery and rehab at Rush Oak Park Hospital, Petitioner then did rehab at Provena St. Joseph Medical Center, with the records being in reverse order, from June 28, 2012 through November 27, 2012. (Pet. Ex. 2, pp21-42) In the final visit, the therapist noted right knee pain present 7 out of 10, the worse being 9 out of 10 and the best being 5 out of 10, with still a need to increase leg strength, range of motion and flexibility. (Pet. Ex. 2, p21)

Additionally, following the second total knee revision, and per the referral from Dr. Patel, Petitioner saw Dr. Cary Templin, a spine surgeon at Hinsdale Orthopedics for neck and back pain. He noted low back pain that extends across lower back into the right leg in what appears to be the L4 distribution, and some neck pain that extends into the right arm and some to the left but more predominantly on the right. Petitioner's history included that her altered gait was contributing to the problem and she wanted to be further evaluated, and she brought in the lower back MRI of August 28, 2012 and the cervical MRI done in 2010. His assessment and plan were a 55 year old female status post a fall injury with neck pain and multi level spondylosis. He did not believe Petitioner was a surgical candidate for the neck. In regard to the lumbar spine, he noted "Given the significant foramenal stenosis she has to the right side which may have been aggravated by her fall, I would recommend the patient get a transforaminal injection of the L4 nerve root and see what benefits she gets. If she did have considerable benefit, one would consider either fusion at the 4-5 level or decompressing the foramen. He referred her back to Dr. Patel for the shot and deferred work status to those who have been treating her for her knee. He noted insofar as the spine, if there were any restrictions, it would be 20 pounds lifting with bending and twisting to tolerance and no overhead activity, but he believe at this point she was off work from the knee standpoint and that will likely continue. (Pet. Ex. 32A, pp1-3)

At approximately the same time, on May 1, 2013, Petitioner returned for follow up to Dr. Farrell relative to her right knee, experiencing chronic pain and swelling in the knee, noting: "Certainly she has been a trooper in terms of exercising it and aggressively so in trying to make it well." He noted chronic inflammation, ambulating with a cane, and Petitioner trying to do pool therapy as she testified. He also noted she tried to increase her activities in terms of walking but continued to struggle on a daily fashion because of pain and swelling in the knee. Dr. Farrell at that time found Petitioner at maximum medical improvement, and filled out a form for permanent disability. (Pet. Ex. 12, p1)

Respondent then had a Section 12 Exam, this time choosing a different examiner, Dr. Boone Brackett. (Resp. Ex. 2) Dr. Brackett, an orthopedist, reviewed all the medical records, and among his other findings, noted causal connection between the accident of January 5, 2005, and her knee condition: "Which, despite appropriate treatment, continued to remain symptomatic leading piece meal to the good faith efforts to grant her surcease from her knee pain, albeit however ineffective." (Id. 4) He continued: "I would say that her treatment has been appropriate at each stage..." (Id) Dr. Brackett also noted that the extensive physical therapy was appropriate. Regarding work, he noted Petitioner would not be able to return to her duties as an Assistant Warden, or: "What would be characterized as sedentary work, with limited episodic walking and no prolonged walking or standing." Regarding other employment, he also noted that she could only consider: "other gainful employment which does not require her prolonged standing, walking, or climbing." (Id) He further noted: "I think that this lady has had excellent care, despite the fact that the result has not been heartwarming." (Id p. 5) Finally, he noted:

> "I may say that this lady appears honest, straight forward and does not appear to be magnifying her condition in any way. The condition, which is difficult to explain on a medical basis but cannot be faked by the patient, is the recurrent swelling, at this point of unknown etiology." (Id p. 5)

Dr. Farrell then reviewed Dr. Bracket's report when Petitioner returned for a follow up examination June 5, 2013, and noted: "Again, she remains permanently disabled from any form of occupation based on her back condition and her bilateral knee condition." (Pet. Ex. 13a, p1)

In the State's disability form, filled out six days later, Dr. Farrell limited Petitioner regarding standing, climbing, walking, and noted a severe limitation of functional capacity, incapable of minimum (sedentary) activity, and that in his opinion she was permanently and totally disabled for employment. (Id p3)

By both the records and Petitioner's testimony, at no time since Petitioner's first visit has any doctor at Parkview Orthopedics released her for full duties. She was off from January 6, 2005 through February 23, 2005, at which time she returned to light duties until her surgery of April 26, 2005. She was then off from then through July 25, 2005 when she was released to light duty. (Arb. Ex. 1) Petitioner then worked light duty again July 26, 2005 through September 15, 2005, at which time she was terminated by the State of Illinois. Since she was in management she was an at will employee. She has not worked since September 15, 2005, and no physician has released her for full duties. The state has never offered her vocational rehabilitation.

Petitioner testified as to significant symptomology and inability to perform even activities of daily living such as house cleaning, walking any distance, that she required use of the cane, and even limited activity would produce swelling. Her knee has difficulty allowing her to bend or stoop, and it will be unstable and lock up.

Regarding driving, Petitioner testified even moving the right leg back and forth between the accelerator and the brake pedal for more than 15 or 20 minutes, which is the maximum she drives, causes locking up which puts both herself and others in danger for an auto accident due to inability to quickly get to the brake.

The Arbitrator also observed the Petitioner's right knee compared to the left. Petitioner testified that the knee was not as swollen as it sometimes gets. The Arbitrator noted very significant swelling both in the front of the knee and the back, as well as an approximately 12 inch scar the width of a pencil running from above the top of her knee to below the bottom of her knee.

Petitioner testified she tried volunteer work, and after a couple of hours went home and her knee was swollen again. She remains under pain management taking Norco, Darvocet and Vicodin, as well as anti inflammatory drugs which has to change every so often. She also testified she was avoiding narcotics to the extent she could. She also used transdermal patches daily.

IN SUPPORT OF THE ARBITRATOR'S FINDINGS REGARDING "F" (CAUSAL CONNECTION), THE ARBITRATOR MAKES THE FOLLOWING FINDINGS AND CONCLUSIONS:

All doctors who have opined on the issue, including both of Respondent's Section 12 Examiners, found causal connection between Petitioner's right knee condition and the accident in questions (Resp. Ex. 2, 3). Regarding her spine condition, Dr. Farrell found that Petitioner's ultimate low back condition was from her altered gait and knee condition. The evidence shows that Petitioner had suffered from an altered gait for quite an extended period of time awaiting approval for her total knee replacement, corroborating the likelihood that her altered gait made her back symptomatic. Respondent's current Section 12 Exam of Dr. Brackett, Exhibit 2, does not address causal connection regarding the spine, and accordingly the Arbitrator adopts the findings and opinions of Dr. Farrell that there is a causal connection between the accident and the knee and spine conditions.

IN SUPPORT OF THE ARBITRATOR'S DECISION REGARDING "L" (NATURE AND EXTENT OF THE INJURY), THE ARBITRATOR MAKES THE FOLLOWING FINDINGS AND CONCLUSIONS:

Both the report and deposition of Edward Steffan, a certified vocational counselor, were admitted. In Mr. Steffan's Report (Pet. Ex. 32b) he reviewed a number of the salient features of the medical reports. He then performed a interview of Ms. Burns, reviewed her education and vocational abilities, and concluded that Petitioner did not appear to be a candidate for long term training in relationship to National Tea Guidelines, given Dr. LeVine's October 29, 2012 and Dr. Farrell's July 3, 2013 reports that Petitioner was unable to return to any work. He opined that Ms. Burns was not a candidate for vocational rehabilitation services to assist her to return to work and that it would be unreasonable to believe that Petitioner had the access to potential employers that would hire her, or a reasonably stable labor market. (Id. 6)

In his deposition (Pet. Ex. 32c), Mr. Steffan explained that with the restrictions of Drs. LeVine and Farrell, vocational rehabilitation would not be a consideration. Assuming the restrictions of Dr. Brackett, Mr. Steffan noted that even in sedentary work there a lot of walking around, and that Dr. Brackett was basically saying sedentary except she is going to have problems walking around, which is part of the responsibilities of sedentary markets, so it closes the available and existing job market. (Pet. Ex. 32c, p 11) The same would be true with respect to her use of narcotics and her use of a cane. (Id. 11-12) Mr. Steffan testified that with Petitioner not having worked for six years, her entire working career being in corrections, lacking computers skills, on top of the other factors mentioned, that this would preclude Ms. Burns for being seriously considered for gainful employment. (Id. 13) The same would be true with respect to the geographical area if her knee inhibits her ability to drive as Petitioner testified (Id. 13).

Mr. Steffan opined that a labor market does not exist for Petitioner, and that Petitioner, with using a cane and ambulating slow would be an extreme fall

risk and that they could reinjure themselves or possibly others depending on where and how they fall, which bodes poorly for employment (Id. 15-16) Mr. Steffan explained with respect to sedentary jobs, there is a large pool that employers have to pick from. Without computer skills she would be at entry level non-skilled positions and those are the types of positions that have the largest available population of prospective hires for potential employers, and it makes it very easy for the employer to consider other people because they have immediately a basis for their decision (Id 17). He also mentioned that Petitioner's former high wage would work against her (Id 18-19) with respect to prospective employers.

Finally, Mr. Steffan reviewed the August 9, 2013 Blind Transfer Skills Analysis / Labor Market Survey of Respondent's certified vocational counselor, Charlotte Bishop. It listed four potential employment categories, human resources assistant, administrative assistant, volunteer coordinator and community organizer, all of which Mr. Steffan opined would not be the types of jobs with reasonable long term continuous employment that would be available for Petitioner, even assuming the accuracy of Dr. Brackett's restrictions, as she doesn't have the physical ability to perform the jobs, nor does she have the administrative skills and abilities, including the lack of computer skills which would preclude serious consideration for those types of jobs (Id 20-21) Mr. Stefan also testified that if Ms. Burns were able to secure any type of employment, it would be in the $12.00 per hour range. (Id 22) But even if one assumes that Ms. Burns were employable, then there would be the issue of placeability which in Mr. Steffan's opinion would almost automatically preclude Petitioner from consideration. (Id 23-24) Mr. Steffan also noted all the types of jobs identified by Ms. Bishop require some level of computer skills. (Id 25)

In reviewing Respondent's Exhibit 1, the Report of Ms. Bishop, which she herself labeled as "blind", those were the aforesaid four jobs she identified for Petitioner. The Arbitrator notes that he has never seen vocational rehabilitation where a Petitioner was placed in any one of those four categories.

Petitioner also testified that her knee precludes the operation of her car for anything besides short distances, because moving her leg sideways from brake to pedal or back will cause swelling, severe pain, lockup, and be dangerous. Almost all the jobs in Respondent's Exhibit 1 are out of town and to require Petitioner to travel to these jobs first in a car, and then during winter with the ice and snow of the area, would put Petitioner at high risk for a vehicular collision due to her impaired ability to get to the brake pedal, and also for a fall in slippery conditions and further injuries.

The Arbitrator finds that substantially all of the jobs listed by Respondent's vocational counselor, assuming the accuracy of Dr. Brackets' restrictions, would not be realistic for Petitioner.

While Respondent has offered evidence in the form of its labor market survey, it is not persuasive, and therefore Respondent has not met its burden under *Ceco*. Further, Respondent's failure to provide actual vocational assistance leads to the inference that there is no stable labor market for Petitioner. .

Accordingly the Arbitrator concludes that Petitioner is permanently and totally disabled and has proved her disability . Dr. Farrell found MMI and total disability May 1, 2013, and the Arbitrator adopts his findings and opinions.

In Support of the Arbitrator's Decision regarding "J" (Medical Expenses), the Arbitrator makes the following findings and conclusions:

Total bills were admitted into evidence in the sum of $332,497.07 for seven years of treatment, including multiple significant surgeries. The only dispute regarding the medical bills was regarding certain physical therapy where Respondent conducted a utilization review (Resp. Ex. 4). The Arbitrator has reviewed that document and notes that the author relied on the OAD Guides. By the entire medical evidence in the case, including the Section 12 Exam by Dr. Brackett, the injury to Ms. Burns's knee has been catastrophic. The records of Dr. Farrell show that he has tried to do everything he can to improve the result, and was doing so until May 1, 2013. Under the circumstances of such a catastrophic result it is not unreasonable that Petitioner should be allowed to pursue all avenues to improve herself to the extent she can, and especially avenues such as conservative physical therapy care, and accordingly the Arbitrator finds that the physical therapy was reasonable and necessary. In fact, as noted earlier, Dr. Brackett for Respondent described Petitioner's care as "excellent and "appropriate at each stage",. Accordingly, the Arbitrator awards all the medical bills. Regarding credits, group insurance paid $89,459.91 towards the medical bills. Respondent shall have a credit for the amounts paid as to each bill as set forth in the Exhibits, and shall hold Petitioner harmless with respect to the credits awarded, including reimbursement claimed by First Recovery Group (Pet's. Ex. 39). Further, Respondent shall have a credit to the extent it has previously paid any of the medical bills directly to the providers. The parties stipulated that medical payments may be made directly to the providers so Respondent may avail of the fee schedule or any other available discounts.

In Support of the Arbitrator's Decision regarding "K" (Temporary Total Disability), the Arbitrator makes the following findings and conclusions:

Pursuant to the Stipulation Sheet, Arbitrator's Exhibit 1, and the testimony, the only temporary total disability actually in dispute was from September 16, 2005 through October 6, 2005 as Respondent picked up TTD again October 7, 2005 and paid it through the date of hearing, either as temporary total disability, maintenance, or permanent and total disability. On September 16, 2005, Petitioner was working light duty for Respondent, she had clearly not reached maximum medical improvement, and was terminated by Respondent, who only picked up temporary compensation three weeks later after her second surgery of October 7, 2005. Accordingly, Petitioner is awarded temporary total disability in addition to what has been previously paid, of an additional three weeks. The total temporary total disability awarded is from January 26, 2005 through February 23, 2005 when she returned to light duty; April 26, 2005 the date of her first right knee surgery, through July 25, 2005, with Petitioner returning to work light duties July 26; and September 16, 2005 following her termination through May 1, 2013, the date of MMI, for a total of 417 6/7 weeks. Respondent shall

have a credit for TTD paid that entire period except for the three additional weeks which are awarded as stated herein above. Sums paid after that date by Respondent shall be credited as payments of permanent and total disability, (Resp. Ex. 5), which the parties stipulated are current.

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

Edward Valade,
Petitioner,

vs.

NO: 10 WC 16873
14IWCC0670

ABF Freight Systems,
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 permanency 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 views this case differently than the Arbitrator and finds Petitioner is permanently partially disabled to the extent of 10% man as a whole under Section 8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,055.20 per week for a period of 21 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner $4,207.75 in temporary partial disability benefits under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 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 10% loss of a man as a whole.

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

14IWCC0670

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit fin the amount of $22,159.41 for payment of temporary total disability benefits and $4,207.75 in temporary permanent disability benefits paid 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 $33,300.00. 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: AUG 1 4 2014

MB/jm

O: 7/10/14

43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VALADE, EDWARDS
Employee/Petitioner

Case# **10WC016873**

14IWCC0670

ABF FREIGHT SYSTEMS
Employer/Respondent

On 10/21/2013, 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 0.15% 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:

0222 GOLDBERG WEISMAN & CAIRO LTD
GERALD J DOLL
ONE E WACKER DR 38TH FL
CHICAGO, IL 60601

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
SEAN C BROGAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

EDWARDS VALADE
Employee/Petitioner

v.

ABF FREIGHT SYSTEMS
Employer/Respondent

Case #10 WC 16873

14IWCC0670

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on October 2, 2013. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

K. ☐ What temporary benefits are due: ☐ TPD ☐ Maintenance ☐ TTD?

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

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

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On August 3, 2009, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $82,305.86; the average weekly wage was $1,582.81.
- At the time of injury, the petitioner was 60 years of age, *married* with no children under 18.
- The parties agreed that the petitioner received all reasonable and necessary medical services.
- The parties agreed that the respondent paid $22,159.41 in temporary total disability benefits and $4,207.75 in temporary partial disability benefits.
- The parties agreed that the petitioner is entitled to temporary total disability benefits for 21 weeks from November 30, 2009, through June 31, 2010, and temporary partial disability benefits for 5-1/7 weeks from April 26, 2010, through May 31, 2010.

ORDER:

- The respondent shall pay the petitioner the sum of $664.72/week for a further period of 75.9 weeks, as provided in Section 8(d)2/8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 15.18%/30% loss of use of the man/arm.

- The respondent shall pay the petitioner compensation that has accrued from August 3, 2009, through October 2, 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.

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert E. Williams

Signature of Arbitrator

October 21, 2013
Date

OCT 21 2013

FINDINGS OF FACTS:

The petitioner, a left-hand dominant over-the-road driver, fell injuring his left shoulder on August 3, 2009. He treated with Dr. Milton Gasparis on August 31st, who gave him an injection into his shoulder. X-rays of his left shoulder on September 19th revealed moderate arthritic changes of the AC joint with spur formation and were negative for an acute fracture or dislocation. The radiologist opined that the findings were suggestive of a small Hill-Sachs deformity of the humerus, which suggested a previous anterior glenohumeral dislocation. Dr. Anthony Levendan's assessment of the petitioner on September 24th was a questionable Hill-Sachs lesion, possible mild asymptomatic acromioclavicular joint arthritis and a type III acromion with impingement. The doctor administered a cortisone injection into the petitioner's left shoulder. An MRI of the petitioner's left shoulder on September 29th revealed a full-thickness tear of the supraspinatus tendon, a partial-thickness undersurface tear involving much of the infraspinatus tendon, small effusion and small incidental lipoma within the deltoid muscle.

On October 1st, Dr. Levenda recommended a rotator cuff repair and subacromial decompression, which he performed on November 30th plus a left biceps tenodesis and subpectoralis. The petitioner began physical therapy at Lakeshore Bone and Joint December 2nd. On January 5, 2010, Dr. Levenda noted that the petitioner was doing well and only complained of external rotation. The doctor discontinued the sling, continued formal therapy and gave the petitioner sedentary-work restrictions with no use of the left arm. The petitioner reported continued improvement at later follow-ups. On April 6th, he

reported to the therapist a popping feeling in his biceps and achiness, which he voiced again on April 15th.

The petitioner returned to light-duty work on April 26th and saw Dr. Levenda on April 27th and reported only some weakness and mild biceps muscle tenderness. On May 25th, Dr. Levenda noted that the petitioner had full range of motion, a bit of crepitus and improving strength. He released the petitioner to work without restrictions. On August 2nd, Dr. Levenda noted that the petitioner had full range of motion, no evidence of weakness and intact strength. Dr. Levenda opined that the petitioner was at maximum medical improvement.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner experiences stabbing pain with certain movements. He can't hammer due to weakness and has difficulty lifting.

The respondent shall pay the petitioner the sum of $664.72/week for a further period of 75.9 weeks, as provided in Section 8(d)2/8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 15.18%/30% loss of use of the man/arm.

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

Michael Sagen,
Petitioner,

vs.

NO: 01 WC 64399
03 WC 32508

Jewel Food Stores,
Respondent,

14IWCC0671

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, permanency and additional compensation and attorneys' fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof with the exception of finding Petitioner is entitled to $1,879.32 for the medical expenses for Midwest Neurosurgery. The Commission finds that the remaining alleged medical expenses either showed a zero balance or that no medical bills were submitted into evidence.

IT IS THEREFORE ORDERED BY THE COMMISSION that, with the exception noted above, the Decision of the Arbitrator filed July3, 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: AUG 14 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/jm
O: 7/17/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SAGEN, MICHAEL R
Employee/Petitioner

Case# **03WC032508**

01WC064399

14IWCC0671

JEWEL FOOD STORES
Employer/Respondent

On 7/3/2013, 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 0.08% 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:

0343 R DEAN IRWIN LTD
1755 PARK PLACE
SUITE 200
NAPERVILLE, IL 60563

0560 WIEDNER & MCAULIFFE LTD
CATHERINE MaFEE LEVINE
1 N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

14IWCC0671

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

Michael R. Sagen
Employee/Petitioner

v.

Jewel Food Stores
Employer/Respondent

Case # **03 WC 32508**

Consolidated case: **01 WC 64399**

An *Application for Adjustment 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 7, 2013** and **April 16, 2013** and **April 24, 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. ☐ Did an accident occur that arose out of and in the course of 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 _____

14IWCC0671

FINDINGS

On **12-02-02**, Respondent ***was*** 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 **$ 51,799.52**; the average weekly wage was **$ 995.76**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit for TTD benefits paid from 12-02-02 through present date.

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, commencing on 04-24-13, of **$ 278.93** /week for the duration of disability, because the injuries sustained caused the loss of earnings, as provided in Section 8(d)(1) of the Act.

No penalties are awarded in this matter.

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

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

07-03-13
Date

JUL 3 - 2013

FINDINGS OF FACT

SAGEN, MICHAEL V. JEWEL FOOD STORES, INC.
Consolidated claims 01 WC 64399 and 03 WC 32508

The petitioner is 53-year-old male who was employed By Jewel Food Stores as a Journeyman Meat Cutter. Petitioner testified that he belonged to a union to guard his wages. Petitioner testified that as a Journeyman Meat Cutter, his typical day involved breaking down loads of meat for the freezer and the counter and cutting meat for counter sales. Petitioner testified that on April 6, 2001, he was breaking down a load and noticed low back pain. Petitioner testified that he received initial medical treatment from his Dr. Nelson, his primary care physician. (Petitioner's Exhibit No. 1) Dr. Heller recommended physical therapy, medication and ordered an MRI of the lumbar spine. An MRI of the lumbar spine was performed on April 19, 2001 and revealed a herniated disc at L4–5 and L5–S1. (Petitioner's Exhibit No. 4). Petitioner testified that Dr. Nelson referred him to Dr. Barbara Heller for epidural steroid injections which he received on 5/9/01 and 5/16/01. (Petitioner's Exhibit No. 1).

Dr. Heller referred petitioner to Dr. Jerome Kolavo who recommended a lumbar myelogram and post myelogram CT and as well as physical therapy. A lumbar myelogram was performed on May 30, 2001 and revealed a small central bulging disc at L4–5 and additional bulging into the right L4–5 neural foramen with no signs of significant foramenal stenosis. The myelogram failed to reveal any significant extrinsic compression of exiting nerve roots at any leave. Dr. Kolavo opined that petitioner had minimal disc pathology and was not a candidate for surgery. (Petitioner's Exhibit No. 2)

Dr. Heller recommended work disability and physical therapy for discogenic pain. Dr. Heller authorized petitioner to return to light duty work on July 26, 2001. By August 15, 2001, Dr. Heller authorized an increase in petitioner's workload to six hours per day with a gradual work up to eight hours per day. At a follow-up visit on September 12, 2001, Dr. Heller noted that petitioner's exam was negative and she placed him at maximum medical improvement. Petitioner was released to return to full duty work. (Petitioner's Exhibit No. 1). Petitioner testified that he did return to full duty work as Journeyman Meat Cutter.

On December 2, 2002, petitioner presented to Dr. Nelson with complaints of lower back pain with an onset date of 12/1/02 while at work. Petitioner denied any specific inciting event but indicated that he had been working more hours during the holiday. Petitioner reported that his low back pain radiated to the buttock and into the right leg. Dr. Nelson noted a history of lumbar disc disease and opined that petitioner's pain appeared to be an exacerbation of his prior pain. Dr. Nelson prescribed medication, exercises and one week of work disability. Petitioner returned on December 12, 2002 reporting pain in the right lower back which started 15 days earlier. Dr. Nelson again noted that petitioner appeared to have exacerbated his previous disc disease. Petitioner was authorized to return to work beginning 12/23/02 and was referred to a neurosurgeon for further care. Dr. Nelson's records reveal that petitioner worked two and a half hours on 12/31/02. (Petitioner's Exhibit No. 1).

On December 15, 2002, an MRI of the lumbar spine was performed at Central DuPage Hospital and revealed a moderate bulging disc at L4–5 and a small disc herniation at L5-S1. The radiologist noted that this MRI was consistent with the prior MRI obtained on April 19, 2001. (Petitioner's Exhibit No. 4)

Petitioner returned to Dr. Nelson's office on December 19, 2002 reporting pain in his right lower back that started 18 days prior. Petitioner noted that he works as a butcher and had worked more hours during the holiday season. Petitioner denied any specific inciting event other than stating his pain started at work on 12/1/02. Dr. Nelson assessed petitioner with chronic low back pain with exacerbation and referred petitioner to Dr. Douglas Johnson, a neurologist with Dupage Neurosurgery. (Petitioner's Exhibit No. 1).

On January 21, 2003, petitioner was evaluated by Dr. Douglas Johnson. (Petitioner's Exhibit 5) Petitioner complained of low back and bilateral leg pain. Dr. Johnson assessed petitioner with low back pain, lumbosacral spondylosis with myelopathy and bilateral pain in the lower limbs. He recommended epidural injections and physical therapy. Dr. Johnson suggested that surgery may be necessary and he referred petitioner to Dr. Michael Rabin for a second surgical opinion.

On January 22, 2003, petitioner was seen by Dr. Michael Rabin for a second surgical opinion. (Petitioner's Exhibit 6) Dr. Rabin assessed petitioner with multiple disc bulges and recommend epidural steroid injections. Petitioner testified that he refused the injections as he did not feel they worked. Petitioner was given Tylenol, a prescription for physical therapy and authorized to remain off work. Petitioner testified that he received physical therapy at Yorkville Physical Therapy. (Petitioner's Exhibit No. 7)

On March 3, 2003, petitioner was seen by Dr. Steven Mash for an Independent Medical Examination. Dr. Mash's initial assessment was discogenic low back syndrome. He requested an opportunity to review complete medical records before rendering a final opinion. (Respondent's Exhibit No. 1)

On March 28, 2003, Dr. Rabin recommended surgery but noted he was unclear as to whether surgical intervention would provide significant relief. Petitioner expressed a desire to proceed with surgery and on May 14, 2003, petitioner was admitted to Edward Hospital at which time Dr. Rabin performed a decompressive lumbar laminectomy from L4-S1 with bilateral foraminotomies and a right L4–5 microdiscectomy. (Petitioner's Exhibit No. 6)

On July 2, 2003, petitioner was reevaluated by Dr. Rabin and reported that he was doing extremely well and all pre-operative symptoms were gone with the exception of some numbness in his right big and second toe. Dr. Rabin recommended additional physical therapy and suggested that the therapist should determine whether petitioner was capable of returning to work. Petitioner was advised to return on an as-needed basis.

On September 30, 2003, petitioner participated in a Functional Capacity Evaluation ATI which was determined to be valid. Petitioner was deemed capable of working in the Light

physical demand level. Petitioner's job as a Meat Cutter required functioning at the Heavy physical demand level and as such, he was unable to return to work at this time.

When petitioner was reevaluated by Dr. Rabin on October 1, 2003, he reported that his pain was completely gone except when lifting heavy objects. Dr. Rabin recommended a work conditioning program to improve petitioner's lifting capabilities. Petitioner participated in work conditioning and in October 2003, Dr. Rabin opined that petitioner should participate in vocational rehabilitation. In November 2003, Dr. Rabin imposed permanent light duty restrictions

On September 19, 2003, petitioner was reevaluated by Dr. Steven Mash at which time he reviewed records from Dr. Rabin. Dr. Mash assessed petitioner with status post laminectomy or spinal stenosis and degenerative disc disease. Dr. Mash opined that petitioner had been "well-rehabilitated" and should be discharged from physical therapy. Dr. Mash further opined that petitioner was at a point of maximum medical improvement and was capable of lifting up to 20 pounds with avoidance of repeat bending and stooping. Dr. Mash agreed that petitioner was not capable of returning to full duty work as Meat Cutter but opined that he was capable of working within the light duty restrictions he outlined. Dr. Mash also recommended that petitioner undergo instruction on a home exercise program. (Respondent's Exhibit No. 3)

On May 19, 2004, petitioner was reevaluated by Dr. Rabin at which time he reported that he was "doing quite well". Dr. Rabin stated that petitioner required Norco refills basically every one-two weeks. Dr. Rabin recommended evaluation at a pain clinic for additional care. Dr. Rabin noted that petitioner's physical exam did not reveal any new deficits and that his original symptoms "appear to be largely gone". Other than the pain clinic referral, Dr. Rabin noted that petitioner will be followed on a "P.R.N. basis". (Petitioner's Exhibit No. 6)

Eight months later, on January 10, 2004, petitioner was seen by Dr. Charles Kim, pain management specialist with Duke Specialists. (Petitioner's Exhibit No. 11) Dr. Kim assessed petitioner with failed back syndrome. He recommended a right SI joint injection and medications to include Ultram, Lidoderm Patch, Vicodin, Ocycontin, Soma, Ibuprofen, Actiq and Norco.

On July 19, 2004, petitioner had a repeat MRI of the lumbar spine which revealed postsurgical changes at the L5 laminectomy site with enhancing granulation tissue; a small broad based central/left paracentral disc protrusion superimposed on a generalized bulging disc at L5–S1 without significant central canal stenosis or neural foraminal narrowing; mild neural foraminal narrowing bilaterally at L5–S1 and generalized bulging at L4–5.

On September 9, 2004, petitioner was reevaluated by Dr. Mash complaining of increased discomfort in his low back without radicular symptomology. Petitioner complained of diminished activity level and constant lumbar pain with an inability to participate in the simplest activities of daily living. Petitioner's physical examination was negative for any focal neurological deficits in the lower extremities. Dr. Mash assessed petitioner with post lamenectomy syndrome and that spinal instability was possible in petitioner's case. Dr. Mash recommended that petitioner return to his surgeon (Dr. Rabin) for further care. Dr. Mash noted

that petitioner was not at a point of maximum medical improvement and should seek further care with Dr. Rabin. (Respondent's Exhibit No. 4) Dr. Mash prepared a subsequent report dated September 13, 2004 after his review of records from DuPage Valley Pain Specialists (Dr. Charles Kim) and surveillance tapes taken on August 15, 2004 and June 28, 2004. Dr. Mash retracted his previous opinion that petitioner required further evaluation with his surgeon based on the activities petitioner was performing in the videotape. Dr. Mash opined that petitioner participated in various activities without demonstrating pain behaviors which was completely inconsistent with the vigorous complaints he made during his examination on September 9, 2004. (Respondent's Exhibit No. 6)

When petitioner was reevaluated by Dr. Rabin on November 8, 2004, he opined that petitioner was at maximum medical improvement unless further workup (a surgical fusion) was performed. At this time however, Dr. Rabin opined that petitioner was not a surgical candidate but would require continued treatment with Dr. Kim to manage his pain complaints. In a December 6, 2004 addendum report, Dr. Mash agreed that petitioner was not a surgical candidate but would require analgesic medication under the guidance of an individual skilled in pain management techniques. Dr. Mash elaborated that petitioner may need occasional care at the direction of Dr. Kim. Dr. Mash further opined that vocational rehabilitation would be appropriate for Mr. Sagen. (Respondent's Exhibit No. 6). Petitioner continued to receive TTD and medical benefits.

On June 21, 2005, a Labor Market Survey was prepared by Concentra with the goal of identifying employment openings compatible with petitioner's employment history, educational background and physical capabilities. The study identified several jobs at the sedentary-light duties level ranging from $10.41 per hour up to $12.95 per hour. Vocational rehabilitation services did not advance forward at this time based on petitioner's ongoing subjective pain complaints and continued use of narcotic medications. (Respondent's Exhibit No. 7).

Petitioner remained under Dr. Kim's care throughout 2007 which primarily consisted of periodic renewal of prescription medications to include the Fentenyl Patch which by 2007, petitioner had developed a dependency on. (Petitioner's Exhibit No. 11). On January 31, 2007, Dr. Glen Babus, a Board Certified physician in Pain Management, Pain Medicine, and Anesthesiology, opined in a Utilization Review report, that petitioner did not meet the ODG guidelines for continued use of the Fentenyl Patch since no overall improvement in function was shown despite use of the Patch dating back to 2002. Despite Dr. Babus' opinion, respondent continued to authorize the Fentenyl Patch as well as other opiate medications, and paid TTD benefits without interruption.

Dr. Rabin's records reflect that petitioner was not personally examined between November 8, 2004 and October 22, 2007. Nevertheless, Dr. Rabin periodically provided narrative reports commenting on petitioner's condition, work capabilities and the possibility of a future spinal fusion without personally examining petitioner. (Petitioner's Exhibit No. 6, *See Dr. Rabin's reports dated 10/23/05, 1/20/06 and 1/30/07).*

Petitioner testified that his pain treatment was taken over by Dr. Paul Manganelli at the end of 2007 when Dr. Kim left the practice. (Petitioner's Exhibit No. 11). Dr. Manganelli opined

that petitioner's pain complaints required use of chronic opiate management and perhaps further diagnostic and therapeutic intervention such as imaging studies (Petitioner's Exhibit No. 11). Petitioner's TTD and medical benefits remained ongoing at this time.

On June 27, 2008, petitioner was evaluated by Dr. Richard Noren. (Respondent's Exhibit No. 11). Petitioner complained of intermittent episodes of severe pain that debilitate him for one to seven days at a time. After reviewing medical records and conducting a physical examination, Dr. Noren assessed petitioner with degenerative disc disease and post-laminectomy pain syndrome. Dr. Noren opined that petitioner's activities as demonstrated on a videotape surveillance, which showed him carrying out activities that one would not expect based on his severe pain complaints to his physicians at that time, were inconsistent with his physical examination. Dr. Noren further noted that he was unable to explain petitioner's unusual pain syndrome of complete debilitation between episodes of relatively no pain. Dr. Noren noted that petitioner was at a risk for narcotic dependency. As such, he opined that the use of medications such as Aptiq, Norco, Oxycontin and Oxycodone, should only be prescribed with the understanding that random urine drug surveillance would be needed to confirm petitioner's compliance with this treatment. Dr. Noren opined that the use of Duragesic would be appropriate to treat petitioner's subject pain complaints. Dr. Noren emphasized that he would not recommend any type of break-through medication based on petitioner's relatively normal physical examination and primarily subjective complaints. Dr. Noren further opined that petitioner was capable of functioning in a light-duty capacity based on his review of a valid Functional Capacity Evaluation performed on September 30, 2003. Dr. Noren pointed out that his opinions were consistent with those of petitioner's treating physician (Dr. Rabin), on October 31, 2003, regarding petitioner's ability to work in a light-duty capacity and participate in vocational rehabilitation. (Respondent's Exhibit No. 11).

Petitioner remained under Dr. Manganelli's care for pain management and when he was reevaluated on August 20, 2008, he reported a weight loss of 65 pounds since January. (Petitioner's Exhibit No. 11).

Dr. Steven Mash presented himself for his evidence deposition on three occasions, May 15, 2008, July 31, 2008 and September 11, 2008 respectively. (Respondent's Exhibits 10, 12 and 13). In his depositions, Dr. Mash consistently testified that each time he evaluated petitioner, he presented with a history of being dramatically incapacitated from performing just about any activity of daily living secondary to back pain. However, Dr. Mash concluded that petitioner was capable of working in a light-duty capacity and was not a candidate for any further surgery to include a lumbar fusion based on his review of surveillance videotape depicting petitioner mowing his lawn, fishing, and bending from the waist without difficulty. Dr. Mash testified that petitioner may require additional pain management under the guidance of a physician.

On November 5, 2008, Dr. Richard Noren authored a report outlining his opinion regarding concerns associated with petitioner's longstanding use of various narcotic medications. (Respondent's Exhibit No. 14). While Dr. Noren agreed with use of the medication Duragesic for long-term management of petitioner's objective complaints, he opined that the use of Actiq, Norco, Oxycontin, Oxycodone and additional oral Schedule II and Schedule III narcotic

analgesics, should not be used in the treatment of petitioner's pain as these medications were not indicated for chronic, non-malignant pain. (Respondent's Exhibit 14).

Petitioner remained under Dr. Manganelli's care throughout 2009 for ongoing opiate pain management. On April 8, 2009, petitioner reported that he was feeling much better after starting to work out again and with weight loss. Petitioner was assessed with post-laminectomy lumbar syndrome and he was given a refill for his medications. By July 29, 2009, petitioner reported a 110-pound weight loss to Dr. Manganelli and only being bedridden for three days a month secondary to pain. Petitioner testified that he asked Dr. Manganelli for information regarding implantation of a spinal cord stimulator based on a positive outcome experienced by a friend. Dr. Manganelli referred petitioner to Dr. Rabin for further discussion regarding a trial implantation of a spinal cord stimulator.

On November 13, 2009, petitioner was reevaluated by Dr. Rabin at which time he diagnosed failed back syndrome and opined that petitioner was most likely a good candidate for a trial of a spinal cord stimulator. (Petitioner's Exhibit No. 6).

On January 29, 2010, a repeat MRI of the lumbar spine was performed revealing post-operative changes in the lower lumbar spine without evidence of recurrent or residual disc herniation at L5-S1; diffuse disc bulge at L4-5 and with a suggestion of a superimposed small central disc protrusion. Dr. Manganelli recommended proceeding with a trial of a spinal cord stimulator and subsequent permanent implantation if the trial run was successful. In the meantime, petitioner remained under Dr. Manganelli's care for pain management through opiate medications. During this time, petitioner's TTD and medical benefits remained intact.

On June 16, 2010, petitioner was reevaluated by Dr. Richard Noren at respondent's request regarding the reasonableness and necessity of a spinal cord stimulator. (Respondent's Exhibit No. 16). Dr. Noren opined that petitioner's diagnosis remained post-laminectomy pain syndrome. Dr. Noren noted that petitioner had been able to decrease his dependency on various narcotic analgesics for treatment of his neuropathic pain. Dr. Noren opined that this was not an appropriate scenario to determine if the trial implantation of spinal cord stimulator would be effective in treating petitioner's pain given his unusual pain syndrome, the fact that by history, he had minimal pain on most days and was only severely disabled (approximately one time per month). Dr. Noren recommended that petitioner continue to be monitored and treated with palliative medication for his subjective pain complaints only. Dr. Noren opined that petitioner was able to function in a light-duty capacity. (Respondent's Exhibit 16).

Petitioner testified that he remained under Dr. Manganelli's care and on July 16, 2010, he expressed an interest in discontinuing all opiate medications and decreasing the Fentanyl Patch. Petitioner testified that on February 12, 2011, he participated in a psychiatric evaluation to determine if he was psychologically fit to undergo implantation of a spinal cord stimulator. Petitioner testified that on March 7, 2011, he underwent a spinal cord stimulator trial at the hands of Dr. Manganelli. Petitioner testified that his pain was much better and he was able to move around better after the trial spinal cord stimulator was implanted. Petitioner was thereafter, referred to Dr. Matthew Ross for permanent implantation of a spinal cord stimulator.

Petitioner was initially evaluated by Dr. Matthew Ross on March 18, 2011. (Petitioner's Exhibit No. 12 and Respondent's Exhibit No. 17). Dr. Ross opined that based on the petitioner's back and leg symptoms despite surgical decompression, he was an appropriate candidate for permanent implantation of the spinal cord stimulator given his favorable response to the trial run. On April 1, 2011, respondent's third-party administrator (SRS), sent letter to Dr. Ross a letter, confirming their agreement to authorize the permanent spinal cord stimulator implantation procedure and any reasonable charges associated with the procedure. (Respondent's Exhibit No. 17)

On April 8, 2011, petitioner was admitted to Central DuPage Hospital at which time Dr. Ross implanted a permanent spinal cord stimulator. (Respondent's Exhibit No. 17) Petitioner was re-evaluated by Dr. Ross on April 21, 2011 and reported that he was "delighted with the result". Petitioner reported complete relief of his leg symptoms and partial alleviation of low back pain. Dr. Ross opined that petitioner was making excellent recovery from surgery. He indicated that he would have the Medtronic technical expert determine if better coverage for back pain could be achieved through reprogramming the device.

Petitioner testified that he participated in an opiate detoxification program at Linden Oaks Hospital from June 18, 2011 through June 24, 2011 (Petitioner's Exhibit No. 13 and Respondent's Exhibit No. 18). At trial, petitioner testified that the Linden Oaks program was successful in weaning him off all opiate medications and that he has not requested this type of medication since his discharge.

Dr. Ross' records reflect that petitioner cancelled two office visits on 5/19/11 and 5/31/11, respectively. Petitioner was last seen by Dr. Ross on August 11, 2011 at which time he was four months status post insertion of a permanent spinal cord stimulator for management of chronic back and leg pain. On this date, petitioner advised Dr. Ross that he had successfully weaned himself off all narcotic medications under a program supervised by a physician at Linden Oaks Hospital and that he was pleased to be off the medications. Petitioner advised Dr. Ross that he did not notice any increase pain without the narcotic therapy. Physical examination by Dr. Ross revealed a normal gait with toe and heel walking performed well. Petitioner had full range of motion of the lumbar spine and his motor strength was full throughout. Dr. Ross opined that petitioner made an excellent recovery from surgery and advised him to return on an as-needed basis.

Petitioner was reevaluated by Dr. Manganelli on August 2, 2011 and the doctor's records reflect that petitioner was making excellent progress following permanent implantation of a spinal cord stimulator. Petitioner reported significant reduction in his leg pain and 40% reduction in low back pain at that point. Petitioner was advised to continue with physical therapy. By October 5, 2011, Dr. Manganelli advised petitioner to return on an as-needed basis. (Petitioner's Exhibit No. 11). Petitioner testified that at the time of the arbitration hearing, he did not have any medical appointments scheduled.

Petitioner testified that he contacted Dr. Rabin's office for an examination and was told Dr. Rabin wanted him to undergo a Functional Capacity Evaluation before he would see him. On March 21, 2012, petitioner presented to Milder & Associates for a Functional Capacity

Evaluation at Dr. Rabin's referral. (Respondent's Exhibit No. 19). The test taker (James Milder), stated that petitioner was fully cooperative with testing and delivered consistent results with no indication of symptom magnification or malingering on testing. Petitioner demonstrated the physical ability to work at the Medium physical demand level for lifting and carrying at waist level, lifting from floor to waist level, lifting from waist to shoulder level, pushing/pulling and hand grip. Mr. Milder further indicated that petitioner was unrestricted for repetitive hand activity and hand coordination activities such as light assembly work. Mr. Milder noted that petitioner's former position as a Meat Cutter fell within the Very Heavy physical demand level of work and the FCE results demonstrated that petitioner was not capable of returning to work as a Meat Cutter without significant restrictions. (Respondent's Exhibit No. 19) At trial, petitioner testified that he was in bed for 3 days after the FCE. Petitioner testified that he did everything the physical therapist told him to do during the FCE and suspected this was why he felt increased back pain after the FCE testing.

On April 25, 2012, petitioner was independently evaluated by Dr. Jesse Butler (Respondent's Exhibit No. 20). In his history, petitioner advised Dr. Butler that he no longer takes narcotic medication, that he has only residual low back pain and occasional leg symptoms. Petitioner reported being in bed for two days after the FCE. Dr. Butler assessed petitioner with lumbar spinal stenosis, high blood pressure, heart disease and arthritis. Dr. Butler opined that petitioner should perform a home exercise program focused on weight loss and stop smoking for health reasons. Other than maintenance care for the spinal cord stimulator, Dr. Butler opined that petitioner was at a point of maximum medical improvement from a surgical standpoint. Dr. Butler reviewed a written job description for a Journeyman Meat Cutter (Respondent's Exhibit No. 21), and opined that in light of the FCE results, certain job modifications would be necessary in order for petitioner to resume work as a Meat Cutter. Specifically, Dr. Butler opined that petitioner should limit his lifting up to 40 pounds on a seldom basis. Moreover, Dr. Butler opined that the stock cart utilized by a Meat Cutter would have to be kept below 50 pounds; petitioner should not handle material over 50 pounds with a pallet jack; and that petitioner would need to take 5-10 minute breaks from continuous standing every two hours. Dr. Butler opined that the remaining duties of a Meat Cutter were manageable without restrictions. Dr. Butler concluded that petitioner's restrictions were permanent. (Respondent's Exhibit #20).

On June 19, 2012, petitioner's attorney (R. Dean Irwin), authored a letter to Dr. Michael Rabin after previously faxing him a copy of Dr. Butler's IME report and the March 21, 2012 Functional Capacity Evaluation performed by James Milder. In his cover letter, attorney Irwin states that the opinions of Dr. Butler and Mr. Milder are contrary to Dr. Rabin's prior opinions and reports dated back to 2007, as well as his evidence deposition testimony dating back to February 20, 2008. Attorney Sagen also provided information that is not contained in Dr. Rabin's medical records regarding petitioner being confined to bed for three days with severe and debilitating back pain after the FCE on March 21, 2012. In his cover letter to the doctor, attorney Irwin indicates that he attached copies of certain excerpts from Dr. Rabin's prior evidence deposition testimony on February 20, 2008. Various questions were then posed to Dr. Rabin by Mr. Irwin to include whether the petitioner is at maximum medical improvement from a surgical standpoint, whether petitioner is capable of returning to work in some capacity, most notably, his assessment of Dr. Butler's IME report and the FCE performed by Mr. Milder.

In response to attorney Irwin's letter, Dr. Rabin authored a letter dated June 20, 2012. In the letter, Dr. Rabin provided a current diagnosis of failed back syndrome. Dr. Rabin opined that petitioner is at MMI from a surgical standpoint. Dr. Rabin further opined that he did not feel petitioner was capable of returning to work secondary to the pain that work evokes. Dr. Rabin went on to state that petitioner performed a Functional Capacity Evaluation and was found to be capable of work but he was unable to get out of bed for three days after that. Based on the foregoing, Dr. Rabin opined that it would not be reasonable for petitioner to work and suffer from the pain as the patient stated he did. Dr. Rabin specifically indicated that he did not review opinions, conclusions or recommendations made by Dr. Butler or Dr. Milder and would reserve comment should the need arise at a later time. At trial, petitioner testified that Dr. Rabin did not personally evaluate him before or after he wrote his June 20, 2012 report. Dr. Rabin's records reflect that petitioner has not been evaluated since November 13, 2009.

On July 6, 2012, a Labor Market Survey was prepared by Julie Bose with Med Voc Rehabilitations, Ltd. (Respondent's Exhibit No. 22). Ms. Bose reviewed Dr. Butler's report, as well as the March 21, 2012 Functional Capacity Evaluation and a report from DuPage Medical Center dated May 29, 2012 which confirms petitioner's current use of an H-wave unit and spinal cord stimulator and discontinuation of all opiate medications. As part of the Labor Market Survey, Ms. Bose contacted 45 prospective employers and 15 agreed to participate in the Survey. According to Ms. Bose's report, 15 prospective employers indicated that petitioner had the vocational background and physical capabilities that were necessary to perform work for their organizations. Ms. Bose determined that petitioner had acquired skills that could transfer to other positions such as that of a meat purveyor, meat market manager, grocery store clerk, grocery store manager trainee, meat salesman, or customer service representative. The Labor Marker Survey indicates that 9 prospective employers confirmed that there were currently hiring in the positions Ms. Bose identified. The prospective employers provided entry-level median wage ranges between $14.78 to $16.78 per hour. The mean wage of the positions was $15.78 per hour. (Respondent's Exhibit No. 22).

The petitioner testified that he is a member of a union to protect his wages – the United Food and Commercial Workers' International Union. At trial, The Retail Meat Cutters Contract for Local 1546, was admitted into evidence. (Respondent's Exhibit No. 23). On Page 9 of the Contract, the current wage rates for a Journeyman Meat Cutter are listed in Section 3.1, Paragraph B. Petitioner was hired by respondent in 1982 and at the time of his injury, he was a Journeyman Meat Cutter. If petitioner was currently working for respondent as a Journeyman Meat Cutter for respondent, he would be earning $22.955 per hour. (Respondent's Exhibit No. 23).

ARGUMENT

IN SUPPORT OF THE ARBITRATOR'S FINDINGS RELATED (N), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner contends that he is permanently and totally disabled. The Illinois Appellate Court held in *ABC C-E Services v. Industrial Commission*, 316 L. App.3d 745, 737 N.E. 2d 682 (5th Dist. 2000), that there are three ways by which a claimant can demonstrate permanent and total disability: (1) by a preponderance of the medical evidence, (2) by showing a diligent but unsuccessful job search, or (3) by showing that because of his age, training, education, experience, and condition, no jobs are available to a person in his circumstances.

The Illinois Appellate Court held in the case of *Robert Schoon v. Industrial Commission*, 259 L. App.3d 587, 630 N.E. 2d 1341, that an employee is totally and permanently disabled under workers' compensation law where he is unable to make some contribution to industry sufficient to justify the payment of wages to him. An employee must show, for practical purposes, unemployable. A person need not be reduced to a state of total physical helplessness, but is totally disabled when he cannot perform services except those that are so limited in quantity, dependability, or quality that there is no reasonably stable market for them. Conversely, if an employee is qualified for and capable of obtaining gainful employment without seriously endangering his health or life, such employee is not totally and permanently disabled. The claimant has the burden of proving the extent of permanency of his injury by a preponderance of evidence.

In the present case, the Arbitrator finds that the only medical evidence presented by petitioner in support of his claim that he is permanently and totally disabled is contained in a June 20, 2012 report prepared by Dr. Rabin at the request of petitioner's attorney, Dean Irwin. The Arbitrator further notes that Dr. Rabin's opinion was not provided in the context of an updated physical examination or his assessment of the Functional Capacity Evaluation he personally ordered as a prerequisite to an updated examination of petitioner (which never occurred). Rather, Dr. Rabin's June 20, 2012 report was prepared at the request of petitioner's attorney.

The Arbitrator does not find Dr. Rabin's opinions regarding petitioner's inability to return to work "secondary to the pain that work invokes" credible based on the fact that he did not personally evaluate petitioner in conjunction with rendering his opinion regarding work his capabilities. In fact, there is no evidence that Dr. Rabin personally evaluated petitioner since October, 2007. Dr. Rabin clearly based his opinions on hearsay evidence contained in a cover letter prepared by petitioner's attorney dated June 19, 2012 (Petitioner's Exhibit No. 6). The Arbitrator does not find Dr. Rabin's opinions regarding petitioner's work capabilities credible based on the fact that he admittedly did not review the results of James Milder's March 21, 2012 Functional Capacity Evaluation which he personally ordered, or Dr. Butler's IME report. Based on the foregoing, Dr. Rabin stated he was not able to provide any comments about the opinions, conclusions or recommendations made by them.

The Arbitrator also notes that Dr. Rabin failed to discuss the impact of petitioner's successfully weight loss in excess of 100 pounds through a combination of dietary weight loss, gastric bypass surgery at Life Way Beriatrics, and a daily exercise regime that petitioner testified he performs at his gym for approximately 3 hours per day, 5 days a week. Dr. Rabin also failed to comment on the impact of petitioner's successful completion of a detoxification program which resulted in a discontinuation of all opiate medications and petitioner's almost complete resolution of leg symptoms and significantly reduced low back pain secondary to implantation of a permanent spinal cord stimulator by Dr. Matthew Ross on April 8, 2011.

The Arbitrator agrees that petitioner is not capable of returning to full duty work as a Journeyman Meat Cutter. However, based on review of the evidence presented as a whole, the Arbitrator does not find petitioner permanently and totally disabled from all employment activities pursuant to Section 8(f) of the Act.

At trial, petitioner testified that he does not have any pending medical appointments. Petitioner testified that he is not taking any narcotic pain medication and only takes Tylenol if he has a headache. Petitioner testified that he experiences break-through pain from time to time; approximately once a month. Petitioner testified that cold weather tends to be a trigger for his pain and when this occurs, he is able to increase the controls on his spinal cord stimulator as needed. Petitioner testified that he had never seen a copy of the Functional Capacity Evaluation ordered by Dr. Rabin and performed by James Milder on March 21, 2012. Petitioner also testified that he was unaware if Dr. Rabin had ever reviewed the FCE.

The Arbitrator notes that petitioner testified that on a typical day, he gets out of bed in the morning but at no specific time. Petitioner testified that he drinks a protein shake and goes to the Health Plex five days a week, for approximately three hours per day. Petitioner testified that he typically gets home after working out at his health club around lunchtime and spends the remainder of his day watching TV and reading. Petitioner testified that he has had one bottle of Tylenol in his bathroom for several months and typically uses the same for headaches.

With respect to the issue of nature and extent, looking at the entire medical evidence presented, the Arbitrator finds that in all likelihood, the Petitioner is permanently at the light physical demand level for work. Petitioner's last FCE is an outlier when compared and contrasted with the rest of the medical record.

Consistent with the above, The Arbitrator adopts the findings of the original Labor Market Study prepared on June 21, 2005. (Respondent's Exhibit Number 7). This eight year old study identified work ranging from $10.41 per hour up to $ 12.95. And since the study is dated, the Arbitrator adopts the figure of $12.50 as a baseline to compute the wage differential award and not the average of the two figures.

In sum, the Arbitrator further finds that petitioner is not permanently and totally disabled based on a preponderance of the medical evidence. The Arbitrator further concludes that petitioner failed to produce any evidence of a diligent but unsuccessful job search or evidence that because of his age, training, education, experience, and condition, no jobs are available for a person in his circumstances. Likewise, no real commitment to vocational rehabilitation was ever

initiated by Respondent. The Arbitrator concludes that reviewing the entire evidence, petitioner has the physical capabilities and transferrable skills to find work in the current labor market within the light physical demand level. As a result, he is entitled to a wage differential award pursuant to Section 8(d)1 of the Act. Journeymen meat cutters currently earn $22.96 per hour. (Respondents Exhibit No. 23).

J. IN SUPPORT OF THE ARBITRATOR'S FINDINGS RELATED TO (J), HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR STATES AS FOLLOWS:

No bills were offered into evidence by petitioner. As a result, no award is made.

M. IN SUPPORT OF THE ARBITRATOR'S DECISION RELATED TO (M), SHOULD PENALTIES OR FEES BE IMPOSED UPON RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that petitioner is not entitled to Attorney's Fees pursuant to Sections 16 and 16(a), or Penalties pursuant to Sections 19(k) and 19(l) of the Act. Based on a review of the evidence as a whole, the Arbitrator finds that respondent paid all reasonable, necessary and causally related medical treatment dating back to the petitioner's first work injury on April 6, 2001, a period of 12 years, including multiple MRI studies, multiple courses of physical therapy/work hardening, multiple M.D. visits, multiple injections, lumbar surgery on 5/14/2003, over a decade of pain management treatment to include authorization for numerous opiate medications despite numerous IME reports/Utilization Review reports to the contrary, and payment of all costs associated with a trial implantation and permanent implantation of a spinal cord stimulator. The Arbitrator further notes that petitioner has received TTD benefits uninterrupted since December 2, 2002 despite the fact that he has been placed at maximum medical improvement. The Arbitrator finds that respondent's willingness to continue to pay for ongoing medical treatment and TTD benefits in light of the fact that petitioner's medical condition has been stable since he was discharged by Dr. Ross on August 11, 2011, and placed at maximum medical improvement by Dr. Butler on April 25, 2012, does not support an award of Penalties or Fees in this matter.

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

Margaret Coryell,
Petitioner,

vs.

NO: 09 WC 31964
09 WC 31990

Dyno Nobel, Inc.,
Respondent.

14IWCC0672

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, temporary total disability and permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof with the exception of finding, contrary to the findings of the Arbitrator, that the evidence in the record and specifically the accident reports completed by the Petitioner indicate that Petitioner addressed the right elbow and shoulder symptoms prior to being laid off.

IT IS THEREFORE ORDERED BY THE COMMISSION that,with the one exception noted above, the Decision of the Arbitrator filed December 2, 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 in the amount of $7,283.18 for temporary total disability paid to or on behalf of the Petitioner on account of said accidental injury.

14IWCC0672

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,900.00. 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: AUG 14 2014

MB/jm

O: 6/26/14

43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CORYELL, MARGARET
Employee/Petitioner

Case# **09WC031964**

09WC031990

DYNO NOBEL INC
Employer/Respondent

14IWCC0672

On 12/2/2013, 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:

LAW OFFICES OF FOLEY & DENNY
TIMOTHY D DENNY
PO BOX 685
ANNA, IL 62906

1433 McANANY VAN CLEAVE & PHILLIPS PC
STEVE McMANUS
515 OLIVE ST SUITE 1501
ST LOUIS, MO 63101

14IWCC0672

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

Margaret Corvell
Employee/Petitioner
v.
Dyno Nobel, Inc.
Employer/Respondent

Case #s **09** WC **31964**
and **09** WC **31990**

An *Application for Adjustment 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 **October 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 reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **December 17, 2008 and on January 12, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice ***was*** given to Respondent.

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

The parties stipulated that the petitioner earned **$37,164.66**; the average weekly wage is $714.71.

On the dates of accident, Petitioner was **60** 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 is entitled to a credit for all benefits paid under Section 8(j) of the Act.

ORDER

For reasons set forth in the attached decision, the conditions of ill-being in the elbow and shoulder are not causally related to her employment. Expenses incurred for medical services provided which are related to those conditions are denied.

The respondent shall pay TTD benefits of $476.47 for 15 & 2/7 weeks, from April 6 through June 8, 2009, and September 1 through October 13, 2009, inclusive, as that is the period the petitioner would not have been able to work pursuant to Section 8(b).

The respondent shall pay PPD benefits of $428.83/week for a further period of 20.5 weeks, as provided in Section 8(e) of the Act, as the injuries sustained caused permanent loss to the petitioner's right hand to the extent of 10% thereof.

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

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

Nov. 24, 2013
Date

DEC 2 - 2013

14IWCC0672

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARGARET CORYELL,	)		
	)		
Petitioner,	)		
	)		
vs.	)	**No.**	**09 WC 31964**
	)		**09 WC 31990**
DYNO NOBEL,	)		
	)		
Respondent.	)		

ADDENDUM TO ARBITRATION DECISION

Prior to the hearing, the parties requested a singular decision to encompass both claims; given the overlapping issues between the two cases, the Arbitrator concurs this would be the most appropriate approach.

STATEMENT OF FACTS

The petitioner is a right hand dominant woman, 64 years old as of the date of trial in October 2013. She initially worked at the respondent while employed by a temporary agency, Manpower, beginning in 2003, and was then hired by the respondent in January 2006. She testified that from 2003 through 2008 she worked in the primer department, and in January 2008 she transferred to the booster department. She worked there until she was laid off in January 2009, and never returned to work for the respondent.

At Dyno Nobel the petitioner assembled non-electric detonators for construction. This involved filling cylindrical canisters with TNT and was a three stage process: set-up, pouring, and packing. The canisters came in sizes as small as two to three inches long and approximately one inch in diameter, up to large canisters approximately three feet long and five to six inches in diameter. She testified the three stages were done on a rotating basis throughout a work shift. The set-up rotation involved placing the empty canisters on 3' x 5' tables. The pouring rotation involved dispensing TNT into the canisters via a hose with a clamp on the end that she would draw down and squeeze to release the chemical. The hose was overhead and was height-adjustable. It would be drawn down to the canisters and then retracted to head level. The final rotation required cleaning any excess from the canisters and packing the canisters into packaging. She testified she would alternate these rotations throughout the day, usually involving three to six pours per shift depending on the length of the shift. She usually worked an eight hour shift but sometimes longer depending on overtime. She testified she began having right hand and arm symptoms in 2008.

The petitioner first sought medical care on March 4, 2009, when she presented to Dr. Straubinger at St. Francis Medical Center. See generally PX1. She reported a smoking history of 40 years duration and was diagnosed with diabetes in 1990. X-rays noted some osteopenia but no acute fracture. She reported pain in the right forearm and hand which she stated had begun in December 2008. She reported no finger numbness and no left-sided complaints. Dr. Straubinger noted "miniscule" findings with negative Tinel's sign, and assessed "very low level" epicondylitis. He recommended stretching and ice, as well as recommending smoking cessation and over the counter medication. On March 12, 2009, the petitioner again noted pain in the right wrist and forearm. Splinting and stretches had not helped. She demonstrated inconsistent pain in the epicondyle on examination as well as exaggerated pain levels. Dr. Straubinger noted "a paucity of findings, subjective only, and is most likely at her baseline." He recommended against further intervention and opined she was medically stable. He suggested she should continue to use a splint, suggested an IME might be productive, and released her without evidence of impairment. See PX1.

The petitioner saw Dr. Deisher on April 6, 2009. See PX2. She reported pain and tenderness in the right forearm and denied numbness in the right hand. Tinel's was again negative over both the cubital and carpal regions. He noted "most likely this is mild forearm tendinitis" and recommended injection, ice and anti-inflammatories, as well as 10-pound lifting restrictions.

On April 27, 2009, she returned to Dr. Deisher and reported 20-30% improvement since the last visit, but reported that in the interim, she was using a go-cart at home and sustained second degree burns to the right forearm. Carpal and cubital tunnel exam remained negative. Dr. Deisher told her to follow up. Work restrictions were maintained. On May 18, 2009, Dr. Deisher noted the burn had healed, but she reported a funny feeling or itching along the fourth web space, especially when pushing a lawn mower. He provided steroidal injections to the forearm and told her to follow up. PX2.

On May 28, 2009, she reported no improvement despite the injection, and Dr. Deisher reported he did not have a solid explanation for her complaints. He opined she might have cubital or radial tunnel syndrome and referred her for EMG testing. PX2.

EMG testing was done on June 2 and 5, 2009; both right and left sides were done for comparison. The overall impression was mild right peripheral neuropathy of the radial nerve consistent with demyelination. PX3.

On June 8, 2009, the petitioner followed up with Dr. Deisher. He reviewed the EMG results and noted no significant ulnar neuropathy. He assessed "very mild carpal tunnel syndrome" and released her to work without restrictions. He told her to follow up in six weeks for evaluation. PX2.

Dr. Deisher next saw the petitioner on July 17, 2009. She reported no improvement and now asserted complaints in the shoulder and upper arm as well as occasional numbness. He performed an injection into the right carpal tunnel, maintained

her at full duty work abilities, and instructed her to follow up. PX2. On August 14, 2009, Dr. Deisher noted minimal improvement with conservative care and suggested carpal tunnel release surgery might prove of benefit. He did not believe elbow surgery was warranted at that point. He maintained her on full duty work pending surgery. PX2.

On September 1, 2009, Dr. Deisher performed a right carpal tunnel release. No complications were noted. PX4. She underwent a routine course of postoperative care relative to the carpal tunnel, and on October 14, 2009, Dr. Deisher noted mild soreness around the scar site with full range of motion and normal sensation. He released her to full duty work at that point. PX2.

On November 11, 2009, Dr. Deisher noted no tenderness around the scar and improving strength. She continued to complain of soreness along the forearm and should, but Dr. Deisher opined those symptoms were not related to the carpal tunnel. He maintained her at full duty. On January 6, 2010, she reported excellent sensation and was very happy with the results. He opined she was at MMI for the carpal tunnel syndrome and could work full duty. He noted she could see an orthopedist for any shoulder complaints, but did not suggest there was a causal connection to her work. PX2.

On February 9, 2010, the petitioner saw Dr. Lehman at the request of her attorney. She complained of right elbow and shoulder pain. On examination, he noted grinding in the shoulder consistent with impingement and recommended MRI studies of the elbow and shoulder and suggested she should only do one-handed work. PX5.

MRI studies were performed on March 15, 2010. The right elbow MRI noted tendinosis and bursitis as well as edema without full thickness tearing of the tendon or ligament. The shoulder MRI noted rotator cuff tendinosis without tearing. Fluid was observed in the bursa and degenerative findings were noted in the AC joint. PX7.

On March 16, 2010, Dr. Lehman reviewed the MRIs and recommended she be reevaluated. On April 1, 2010, the petitioner saw Dr. Lehman. He noted elbow and shoulder tendonitis and recommended physical therapy, which she underwent. PX5, PX7.

On April 13, 2010, Dr. Lehman authored a causal connection report diagnosing the petitioner with right elbow tendonitis (golfer's and tennis elbow) and shoulder tendonitis. He opined the pathology was acute superimposed on preexisting changes and recommended surgical intervention. PX5.

On April 22, 2010, Dr. Howard evaluated the petitioner at the respondent's request pursuant to Section 12 of the Act. See generally RX1. He reviewed medical records and her job history and on examination noted diffuse complaints of pain and soreness around the forearm and elbow but did not find specific focal points of tenderness. Ultimately, Dr. Howard concluded her physical exam was not compatible with epicondylitis, that she could work full duty and required no further treatment.

Dr. Lehman subsequently performed right elbow arthroscopy on September 10, 2010, to address epicondylitis, resect a bone spur and release the radial and ulnar nerves. PX6. The petitioner underwent postoperative physical therapy. PX5.

Dr. Lehman saw the petitioner postoperatively on October 12, 2010. She was doing much better and he released her to full duty work as of November 2, 2010. PX5. On January 20, 2011, the petitioner presented doing "exceptionally well" and "really could not have done any better." Dr. Lehman placed her at MMI and discharged her from care. PX5.

Dr. Lehman testified in deposition on May 9, 2012 and on July 10, 2013. He acknowledged the findings of tendinitis in the elbow and shoulder would not be uncommon for a woman of the petitioner's age. PX10 p.28. He further noted the tendon breakdown in her elbow was degenerative in nature. PX10 pp. 28-29. He noted the impingement syndrome in the shoulder was likely related to spur formation in the shoulder, which was an age-related process. PX10 p.29-31.

Dr. Lehman noted edema in the shoulder and elbow being identified on the March 2010 MRI scans. See PX5. He confirmed that finding in his deposition testimony, and further noted that the edema was linked to an acute problem. He then testified "for her to have acute fluid in her medial elbow, you know, I think three to four months would be the longest." PX10 p.41. He further noted that the fluid in the epicondyle and subacromial fluid in the shoulder were both acute findings. PX10 p.58.

Dr. Lehman testified in his initial deposition that it was his understanding that the petitioner had continued to work at the respondent until he first saw her in February 2010. PX10 p.58. He agreed that the relationship of the identified pathology to her work was "less likely the further out she is from her job activities." PX10 p.59.

Dr. Howard testified in deposition on September 30, 2013. RX1. He testified that the petitioner's nonspecific, poorly localized pain was not consistent with epicondylitis. He also noted that her persistent pain despite not working in the allegedly provocative position suggested that the pain was not related to work stressors. He further noted that the fluid buildup observed on the MRI had to be comparatively recent and could not be related to her work, because she had ceased working over a year earlier.

OPINION AND ORDER

Accident and Causal Relationship

The respondent conceded the right carpal tunnel surgery, and disputed liability for the right elbow and shoulder. A review of the exhibits and depositions submitted shows that the petitioner is relying on a repetitive trauma theory, as opposed to an acute injury. In cases relying on the repetitive trauma concept, the claimant generally relies on medical testimony to establish a causal connection between the claimant's work and the claimed

disability. See, e.g., *Peoria County Bellwood*, 115 Ill.2d 524 (1987); *Quaker Oats Co. v. Industrial Commission*, 414 Ill. 326 (1953). When the question is one specifically within the purview of experts, expert medical testimony is mandatory to show that the claimant's work activities caused the condition of which the employee complains. See, e.g., *Nunn v. Industrial Commission*, 157 Ill.App.3d 470, 478 (4th Dist. 1987). In this case, the claimant has failed to prove to a medical and surgical certainty via expert testimony that the elbow and shoulder conditions are causally linked.

The Arbitrator first observes that the petitioner never sought medical treatment for any of these conditions during her employment with the respondent. It is also notable that she related no symptoms relative to the shoulder or upper arm until six months after she ceased working for the respondent.

The first doctor with whom the petitioner sought treatment, Dr. Straubinger, noted miniscule findings with non-work related osteopenia and inconsistent and exaggerated symptoms. She only complained of forearm pain and made no complaints of any symptoms at the level of the elbow or upper arm. He made no causal connection finding.

The petitioner next treated with Dr. Deisher. During his initial treatment, he assessed forearm tendinitis, and did not note elbow complaints or symptoms consistent with epicondylitis. He eventually targeted the wrist for treatment and did not address the elbow; his examination showed no significant ulnar problems and he had specifically noted that he did not believe elbow surgery was warranted during his care.

The petitioner was Dr. Lehman by her attorney. He testified in support of a causal connection. However, Dr. Lehman was quite clear in his reports and testimony that the pathology identified by the March 2010 MRI scans of the shoulder and elbow was acute in nature, superimposed on age-related degeneration. He noted "acute" would have been within three to four months (PX10, PX11), which would have produced a time frame of about one year after she ceased working for the respondent. Dr. Lehman was unaware of her actual work history, and in fact had based his causal opinion on an incorrect one. He testified (PX10 p.41):

> Q.: So if she actually wasn't working at Dyno Nobel for three to four months before March 15 of 2010, that would be less likely to say that work was the cause of those acute findings, correct?
> A.: I'd agree with that.

In contrast, Dr. Howard was provided a much more thorough background of the petitioner's work history when he evaluated her. He did agree with Dr. Lehman that the fluid notable on the MRIs was acute, and believed that the timeframe for it to arise would have been two to four months. RX1 p.25. Dr. Howard and Dr. Lehman both further agree that the petitioner did have additional risk factors that could explain the conditions arising, including both age-related degenerative processes as well as diabetes and smoking (see PX10 pp.42-43; RX1 p 10). However, Dr. Howard noted that the petitioner's physical examination was not consistent with epicondylitis and that the EMG

was not suggestive of significant pathology, and further noted that if the petitioner's symptoms were in fact related to her employment, her absence from those stressors would in all likelihood have relieved her symptoms. The petitioner disputed this in her testimony, and in fact the medical records suggest that her condition in fact progressed and worsened in the absence of any alleged physically stressful job conditions or duties.

The evidence depositions clearly show that Dr. Lehman's opinion was based on an incomplete and inaccurate description of the petitioner's employment history. His analysis of the kinds of stressors the petitioner was exposed to was based on flawed information. In contrast, Dr. Howard specifically noted the petitioner's job history and work duties. He was given a far more accurate and complete description of the petitioner's work and medical history, and is similarly more consistent with the petitioner's testimony. The gap in time between her work and the complaints reflected in the medical records also does not lend credence to the argument that her condition was work related. The Arbitrator finds no accidental injury or causal connection relative to the elbow, shoulder or upper arm to have been credibly demonstrated.

Medical Services

The medical services provided regarding the carpal tunnel surgery appear undisputed. The Arbitrator's review of the medical bills submitted by the petitioner show expenses incurred for that treatment have zero balances, with the remaining balances relating to the elbow and shoulder. As these are not causally related, they are denied.

Temporary Total Disability

The respondent has stipulated TTD to be due and owing from April 6, 2009 through June 8, 2009, as well as from September 1, 2009 through October 13, 2009, inclusive. The petitioner asserts TTD to be due and owing from April 6, 2009 through January 20, 2011. The Arbitrator first notes that even if the claimant had successfully proven accident and causal relationship, the petitioner had been released to full duty work by her own treating physicians on October 14, 2009, and was not medically restricted from work until February 9, 2010. She was thereafter released to full duty work as of November 2, 2010. As such, the petitioner's position would not be demonstrated even if their causal connection argument had otherwise proven credible and compelling.

The above findings as to accident and causal connection control relative to this issue. The Arbitrator awards the periods of April 6 through June 8, 2009, and September 1 through October 13, 2009. This produces a total TTD liability of 107 days, or 15 & 2/7 weeks. The claimant's average weekly wage of $714.71 produces a TTD rate of $476.47, for total TTD liability of $7,283.18. The parties stipulated that the respondent has previously paid that amount, satisfying their TTD liability.

Nature and Extent of the Injury

The petitioner's work-related accident was causally related to the carpal tunnel release surgery in the right hand despite a negative EMG and minimal symptoms in the fingers being related to her physician. Following a brief rehabilitative course, the petitioner was released to unrestricted job duties by her treating physician. She admits no or at most minimal ongoing symptoms in her hand. Considering all evidence presented, the petitioner having reached maximum medical improvement, respondent shall pay the petitioner the sum of $428.83/week for a further period of 20.5 weeks, as provided in Section 8(e) of the Act, as the injuries sustained caused the permanent loss of use the petitioner's right hand to the extent of 10% thereof.

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

Martha Lynn Denham,
Petitioner,

14IWCC0673

vs. NO: 11 WC 42331

Pap-R-Products,
Respondent.

DECISION AND OPINION ON REVIEW

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

14IWCC0673

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 $1,300.00. 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: AUG 14 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-07/23/14
drd/wj
68

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

14IWCC0673

DENHAM, MARTHA LYNN Case# **11WC042331**

Employee/Petitioner

PAP-R-PRODUCTS

Employer/Respondent

On 10/24/2013, 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:

2847 TAPELLA & EBERSPACHER LLC
DANIEL JONES
PO BOX 627
MATTOON, IL 61938

0180 EVANS & DIXON LLC
MARILYN C PHILLIPS ESQ
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

14IWCC0673

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)

MARTHA LYNN DENHAM
Employee/Petitioner

v.

PAP-R-PRODUCTS
Employer/Respondent

Case # **11** WC **042331**

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 **Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **August 26, 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 _____

14IWCC0673

FINDINGS

On the date of accident, **July 6, 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 **$20,216.91**; the average weekly wage was **$420.00**.

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

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

Petitioner received any temporary total disability benefits due and owing prior to January 14, 2013. Respondent shall be given a credit of **$7,840.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$7,840.00,** for benefits paid on lost time incurred prior to January 14, 2013.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $280.00/week for 32 1/7weeks, commencing January 14, 2013 through August 26, 2013, as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for prospective medical care in the form of wrist replacement surgery as recommended by Drs. Naam and Schecker.

Petitioner's petition for penalties and attorneys' fees 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

10.21.13
Date

ICArbDec19(b)

OCT 24 2013

Petitioner alleges she injured her right wrist and arm on July 6, 2011 while "organizing stacks of paper." (AX 2) At the time of arbitration, the disputed issues were accident, causal connection, medical bills, temporary total disability, prospective medical care, and penalties and attorney's fees. Petitioner was the sole witness testifying at the hearing.

The Arbitrator finds:

At the time of arbitration Petitioner had worked for Respondent approximately seven years. Respondent manufactures paper products such as coin wrappers, cash register receipts, napkin bands, and tapes. On July 6, 2011 Petitioner was working as a "jogger." As Petitioner explained it, paper traveled down a conveyer belt to be cut and she would pull the cut paper off the conveyor belt in stacks of 250 sheets and sort/shuffle them into neat stacks. She would then pull off another 250 sheets and repeat the process and stack them on top of the previous pile.

Petitioner denied having any problems with her wrist prior to July 6, 2011 and denied having ever experienced a pop in her wrist prior to July 6, 2011. Petitioner testified that between 12:30 and 2:30 p.m. on July 6, 2011 she was "jogging" when she went "ough" and felt something pop and hurt. Petitioner described it as a shooting pain in her wrist. Petitioner testified that it affected her ability to squeeze her hand and her fingers did not want to move.

Petitioner testified that she immediately reported what happened to a co-worker as well as her line supervisor. Petitioner's line supervisor asked her if she was okay and Petitioner denied same but indicated she was going to try and make it through her shift which ended at 4:30. Petitioner further testified that she continued jogging until her 2:30 break after which she moved to a "cutting" job. Petitioner testified that the "cutting" job required her to pick up sheets of paper and place them into a machine for cutting. At the hearing Petitioner demonstrated that she had difficulty picking up the sheets of paper with her hand so she relied more on her arm. Petitioner testified that lifting was very painful. By the end of the shift her wrist was very sore. Petitioner went home and iced her wrist.

Petitioner testified that her work week concluded on Thursdays and that July 6, 2011 was a Wednesday. Petitioner testified that she returned to work on Thursday but found herself unable to work as a jogger. Petitioner testified she informed her line supervisor that she was going to go home and ice her arm in the hope that it would feel better after a long weekend's rest.

Petitioner testified she "babied" her arm over the weekend and reported for work on Monday. Petitioner testified that she tried "jogging" but was, again, unable to perform her job. Petitioner spoke with her line supervisor who referred her to Kurt Linton, the maintenance supervisor, who is the person to whom employees go to if they have had an accident. Petitioner testified she and Mr. Linton completed a Report of Injury or Illness form on July 11, 2011. According to Petitioner's description of the incident, Petitioner was "[j]ogging paper, turned wrist, felt pain instantly, then noticed knot on wrist (right)." (RX 3) The "Incident Details" were consistent with Petitioner's testimony. (RX 3)

Mr. Linton took Petitioner to see Dr. Richards. Petitioner testified that Dr. Richards and Dr. Davis, her personal physician, worked together at Clark County Family Medicine. According to

Petitioner, she often saw the nurse and not one of the doctors. On this occasion, she was examined by Dr. Richards as Dr. Davis wasn't there.

According to Dr. Richards' office note of July 11, 2011 Petitioner presented with complaints of wrist pain, swelling on the right dorsal surface, and limited range of motion secondary to pain. Petitioner gave a history of having injured her right wrist at work on the previous Wednesday while "juggling paper at work." Dr. Richards noted a knot on the dorsal medial surface. On physical examination Petitioner had tenderness over the distal ulna and pain in that same area with pronation/supination, flexion/extension, and ulnar deviation of Petitioner's wrist. Edema was noted in the distal dorsal forearm. A right wrist x-ray was taken but reportedly negative for evidence of a fracture. Dr. Richards suspected Petitioner had sustained a soft tissue sprain and immobilized Petitioner's wrist, recommended Ibuprofen and ice, as needed, and took Petitioner off work until the following Monday. (PX 6, pp. 8-9)

Petitioner returned to see Dr. Richards on July 18, 2011 at which time he noted ongoing pain and swelling at that time. Petitioner's physical examination was unchanged. Dr. Richards ordered an MRI. (PX 6, pp. 6-7)

The MRI was performed on July 18, 2011. It revealed: (1) an osteochondral impaction injury proximal lunate; (2) evidence of injury involving the volar ligament of the distal radioulnar joint; and (3) mild volar subluxation of the extensor carpi ulnaris with respect to the ulna. (PX 6, p. 10)

After the MRI, Petitioner followed up with Dr. Richards on August 2, 2011. Petitioner reported ongoing right wrist pain. Her examination was unchanged and Dr. Richards, having reviewed the MRI, referred Petitioner to Dr. McGuirk to determine if any further treatment was needed to help Petitioner heal more quickly. Petitioner's work restrictions remained in effect. (PX 6, p. 3)

Petitioner presented to the office of Dr. Douglas McGuirk on August 5, 2011 . Petitioner was noted to be left hand dominant. Dr. McGuirk recorded a history of Petitioner working on July 6, 2011 when she experienced a sharp pain in the ulnar side of her right wrist. According to the nurse's note, Petitioner was moving a stack of paper (250 sheets) and was in the process of turning her right wrist when she felt a pop and some pain. Petitioner had been wearing a brace for three weeks and felt her wrist was getting "somewhat" better. She denied any pain at rest but complained of ulnar-sided pain with motion. Petitioner denied any numbness or tingling in her hand. Petitioner's history of an ORIF right clavicle fracture was also noted. On physical examination Petitioner was noted to have full range of motion of her elbow along with full supination and pronation with pain along the ulnar wrist. She also displayed mild tenderness to palpation at the extensor carpi ulnaris tendon at the wrist and "fovea." Minimal swelling was noted along with mild prominence of the distal ulna. Right wrist x-rays taken that day showed a slight ulnar positive variance and minimal prominence of the ulna dorsally. Dr. McGuirk reviewed Petitioner's MRI which he summarized as showing a partial volar radial ulnar ligament tear at the distal radioulnar joint and volar subluxation of the extensor carpi ulnaris tendon at the wrist. Dr. McGuirk's diagnosis was right ulnar-sided wrist pain, a right volar radial unlar ligament tear at the distal radial ulnar joint, and right extensor carpi ulnaris tendinitis at the wrist. Dr. McGuirk ordered a custom Munster splint to help with supination of Petitioner's forearm and wrist and prescribed work restrictions of no lifting, pushing, or pulling, and use of the splint while at work. (PX 8)

Petitioner underwent a Hand & Wrist Evaluation at Kinetic Rehab on August 30, 2011. According to the initial form, Petitioner injured her right wrist at work on July 6th while rotating a paper and she tore a ligament. Petitioner had initially been braced for 2 ½ weeks and then a cast was applied for three weeks. At the time of the evaluation Petitioner was wearing a brace. (PX 11)

Despite conservative care, Petitioner remained symptomatic. Dr. McGuirk noted on September 20, 2011 that Petitioner was reporting worsening pain with activity and difficulty tolerating occupational therapy. Dr. McGuirk modified Petitioner's work restrictions to that of no use of the right arm. Therapy was stopped. Dr. McGuirk also recommended surgery which was performed on September 26, 2011. Petitioner underwent a right wrist arthroscopy with debridement, extensor carpi ulnaris tendon centralization in the right wrist, open reduction percutaneous pinning of the right distal radial ulnar joint, and application of a right long arm splint. The post-operative diagnosis was right distal radial ulnar joint subluxation, extensor carpi ulnaris subluxation with tendonitis, volar distal radial ulnar ligament tear, and a triangular fibrocartilage complex tear. (PX 8, 11)

Petitioner was taken off work as of September 22, 2011. (AX 5)

Petitioner testified that the pins which had been placed in her wrist during surgery were very painful. As a result she underwent hardware removal on November 18, 2011. Dr. McGuirk recommended physical therapy at Kinetic Rehab. According to the office note, "This is a w/c case, nurse is Karen Heath...." Ms. Heath verbally approved the therapy while in the office. (PX 8, 11)

Petitioner underwent therapy on January 3, 4, and 6, 2012. Petitioner reported feeling "70%" better but she was yet to pick up anything or really use the extremity for any activities. (PX 11)

As of January 6, 2012, Petitioner had been undergoing occupational therapy three times a week and her complaints were limited to some stiffness in her forearm and wrist. (PX 11) Petitioner denied any elbow pain. Occupational therapy was subsequently reduced to two times a week and she was given work restrictions of no lifting, gripping or grasping greater than five pounds with her right hand. She was told she could wear her splint, as needed. Petitioner was also advised to continue with aggressive range of motion exercises. (PX 8)

Petitioner testified that she returned to work with restrictions around January 30, 2012 and worked cleaning and washing windows using her left hand. She received her regular salary during this time.

Petitioner underwent therapy on February 7, 8, 14, and 16, of 2012. Petitioner reported feeling "70 % back to normal;" however, she stated she could not turn her arm to read a watch. Increased pain was noted while using the computer mouse. Range of motion and strength was still limited. (PX 11)

When re-examined on February 17, 2012, Petitioner reported popping in her right index finger. Petitioner explained that the symptoms had been ongoing for about two to three weeks. Dr. McGuirk was of the opinion Petitioner was suffering from a trigger finger and recommended occupational therapy. He noted, "These symptoms are directly correlated with her work injury and postoperative recovery secondary to swelling." Work restrictions of no lifting, gripping or grasping greater than 15 pounds were given. Formal therapy for Petitioner's wrist and forearm was noted to no longer be necessary. (PX 8, p. 8)

Petitioner returned to work on February 19, 2012. (AX 5)

Petitioner underwent physical therapy on February 21, 22, and 24, 2012. The therapist noted Petitioner reported having trouble at work with her arm, hand, and fingers swelling up so bad they wouldn't move. Petitioner's progress was noted to be slow with little "setbacks" and the therapist explained to her that the swelling occurs when she uses the extremity and will for awhile. (PX 11)

Petitioner returned to see Dr. McGuirk on February 28, 2012. At that time her complaints included increased swelling in her right thumb and radial wrist area of one week's duration. Petitioner reported the ability to perform normal daily activities but complained of night-time stiffness in her wrist. Petitioner also complained of some ulnar-sided wrist pain with activity. After examining Petitioner's right wrist, Dr. McGuirk's impression was right de Quervain's tenosynovitis, right wrist and thumb pain, osteoarthritis of the right thumb carpometacarpal joint, and resolved right index trigger finger. Petitioner was given a thumb spica splint for both day and night-time use for three weeks. She was also shown aggressive supination and pronation exercises for her wrist and forearm. Petitioner was to return in one month. (PX 8)

Petitioner was off work as of February 28, 2012. (AX 5)

Petitioner testified that she decided to seek another opinion and an appointment was scheduled with Dr. Nash Naam. A visit was authorized by workers' compensation. (RX 2)

According to Dr. Naam's medical records, Petitioner presented to Dr. Naam on March 15, 2012 for a second opinion. Petitioner advised Dr. Naam that she had a torn ligament that was repaired and pulled in place and that she was in a cast until December of 2011 at which time she was given a splint and began physical therapy. Petitioner further reported that she had returned to work on February 27, 2012 and noticed wrist and thumb swelling thereafter. Petitioner had been off work since March 5, 2012. Petitioner's current complaints were pain on the ulnar side of her wrist, severe stiffness of her right forearm, minimal rotation ability of her forearm, and some degree of numbness involving her entire wrist and hand. Petitioner reported less strength in her hand than before and the inability to use her hand in normal daily activities. On examination Dr. Naam noted a well-healed surgical scar and minimal swelling of the dorsoulnar aspect of her right wrist. Petitioner displayed no evidence of atrophy in her forearm or hand. Examination of Petitioner's forearms revealed marked limitation of active pronation and supination of the right forearm. Active range of motion between Petitioner's right and left forearms was markedly different. Petitioner's right wrist displayed some degree of tenderness along the dorsoulnar aspect of the right right and ulnar aspect of the wrist distal to the ulna styloid. Differences in Petitioner's active range of motion between the right and left wrists were noted. Differences in Petitioner's grip strengths were noted. Dr. Naam reviewed Petitioner's medical records but not Petitioner's x-rays or MRIs. The doctor ordered an x-ray that day which showed generalized osteoporosis, multiple radiolucenies involving the scaphoid, lunate and triquetrum, and a small hole in the inferior part of the head of the ulna (which the doctor was uncertain if it represented a radiolucent lesion or a hole made during surgery). Dr. Naam requested the previous MRIs and x-rays to review. They discussed alternative lines of treatment but no specifics were noted in the doctor's record. His impression was chronic pain of the ulnar side of the right wrist and marked limitation in active pronation and supination of the right forearm. (PX 10)

At Dr. Naam's request, a right wrist MRI was performed on March 19, 2012. It revealed recurrent subluxation of the extensor carpi ulnaris and dorsal subluxation of the ulna with respect to the radius. No normal volar ligament of the distal radioulnar joint was observed. Osteoarthritis at the trapezium/1st metacarpal articulation was associated with a joint effusion and subchondral cyst formation in the trapezium. A 3mm. cyst was present centrally in the scaphoid. Subchondral cyst formation in the proximal lunate was less pronounced on this exam; however, a distal radioulnar joint effusion was observed. Marked thinning of the triangulofibrocartilage with perhaps focal full thickness perforation at its radial insertion is associated with a joint effusion involving the radiocarpal joint was noted as well. A mid-carpal joint effusion was also observed. Focal perforation of the scapholunate ligament was suspected. Prior repair of the distal radioulnar joint was also apparent. (PX 10)

Petitioner returned to work on April 2, 2012. (AX 5)

Petitioner followed up with Dr. McGuirk on April 17, 2012. Petitioner had been wearing her thumb spica splint. She complained of some thumb pain, but no radial wrist pain. She reported stiffness in her forearm and wrist, and some ulnar-sided wrist pain. Petitioner was working with restrictions. On physical examination Dr. McGuirk found minimal swelling along the base of Petitioner's thumb and dorsal ulnar wrist. She lacked any tenderness to palpation along her radial wrist and minimal tenderness to palpation at the thumb base. Dr. McGuirk also noted mild tenderness to palpation about the dorsal distal ulna, ECU tendon and fovea, stability with palpation about the distal ulna and no crepitance with passive wrist circumduction. Petitioner's wrist extension was 60 degrees, flexion was 50 degrees, radial deviation was 20 degrees, ulnar deviation was 40 degrees, supination was 60 degrees and pronation was 55 degrees. (PX 8)

Dr. McGuirk showed Petitioner aggressive forearm and wrist range of motion exercises; told her that she did not need to wear the thumb spica splint; asked her to perform strengthening exercises; and, allowed her to work with a 15 pound lifting, gripping and grasping limitation on the right arm. While Dr. McGuirk felt Petitioner no longer needed to wear her thumb spica splint, he prescribed a pronation/supination splint due to her forearm stiffness. He asked her to return in six weeks. (PX 8)

Petitioner testified that Dr. McGuirk gave her a "Dyna" splint to use three times a day, turning its buttons to make her arm rotate for a certain number of repetitions, but she only used it twice because it was too painful.

Dr. Naam was subsequently provided with Petitioner's MRI on May 2, 2012. Based upon it, as well as an x-ray taken May 2, 2012, Dr. Naam believed the two films showed a complete dorsal subluxation of Petitioner's ulna at the distal radioulnar joint, marked thinning of the triangular fibrocartilage, a possible focal thickness perforation of the radial attachment of the triangular fibrocartilage, and volar subluxation of the extensor carpi ulnaris. Dr. Naam's diagnosis was persistent chronic dislocation of the distal radioulnar joint of the right wrist, volar subluxation of the extensor carpi ulnaris tendon of the right wrist, and marked limitation of the active rotation of her right forearm. Dr. Naam advised Petitioner that treatment would be difficult given her previous surgery. He wished to consult with Dr. Brain Adams (an associate of his with experience in that area) regarding options which might include reconstructing the distal radial ulnar joint (DRUJ) with a tendon graft, Scheker prosthesis, or a Darrach resection. Petitioner was to return in two weeks. (PX 10)

Petitioner returned to see Dr. Naam on May 16, 2012, and reported no improvement with use of the splint. Her exam was unchanged. No changes were made in Petitioner's restrictions. (PX 10)

Dr. Naam re-examined Petitioner on June 7, 2012 at which time her symptoms remained unchanged and she reported "constant" pain. Petitioner, on exam, had no active movement at the distal radioulnar joint level and complete loss of pronation and supination of the right forearm. Dr. Naam recommended replacement of the distal radioulnar joint and a referral to Dr. Luis Scheker in Louisville, Kentucky who (he noted) had had the best experience in the country with total distal radioulnar joint replacement. Again, no changes were made in Petitioner's work restrictions. (PX 10)

Dr. Luis Scheker examined Petitioner on July 2, 2012. In conjunction with the examination Petitioner completed a Health Information Sheet in which she referenced her July 6, 2011 accident and described what occurred. Petitioner reported that her injury was preventing her from performing needed daily activities and/or activities she enjoyed such as getting on her horse, doing dishes, and sweeping. Petitioner expressed her belief that her injury was due to her job duties for Respondent. Dr. Scheker noted Petitioner did not bring any records with her; however, she provided a history of having dislocated her right wrist on July 6, 2011 and undergoing ligament reconstruction surgery thereafter. Petitioner reported persistent pain and dysfunction, including numbness and tingling in all of her fingers. Swelling was also noted. He diagnosed Petitioner with post-traumatic right DRUJ arthritis and right cubital tunnel syndrome. He recommended an EMG/NCV study on the right side, a release of the right cubital tunnel and replacement of Petitioner's right DRUJ. Petitioner was given work restrictions prohibiting use of her right arm. (PX 12)

At the request of Respondent Petitioner was examined by Dr. Rotman on August 13, 2012. Petitioner told Dr. Rotman she injured and dislocated her right wrist jogging paper on July 6, 2011. She described jogging as picking up a stack of 250 sheets of paper and standing it on a vibrator for straightening. She described the job as requiring supination and pronation of the wrist. Petitioner denied any specific trauma to her wrist. She complained of pain over the entire dorsal aspect of the wrist and along the ulnar aspect of the wrist, and of occasional numbness and tingling in her fingers. According to Dr. Rotman, Petitioner's March 15, 2012 x-ray revealed no major abnormalities other than disuse osteopenia and a small circular lesion on the proximal aspect of the ulnar head. There was no widening of the lunotriquetral joint or scapholunate joint. There was a subluxation of the distal ulna which appeared to be well aligned with the radius. (RX 1, Dep Ex. 2)

Reviewing Petitioner's records, Dr. Rotman noted that her complaints prior to surgery were not isolated to the distal radioulnar joint or the extensor carpi ulnaris, and her MRI findings were not clearly related to an injury. He explained that the position between the radius and ulna can change depending on how the arm is rotated when the MRI is taken. According to Dr. Rotman, Petitioner's operative note did not describe a procedure normally related to an injury. Her extensor carpi ulnaris had not dislocated or popped out of alignment. (RX1, Dep Ex. 2; RX 1, 9-11)

According to Dr. Rotman's report, Petitioner was hesitant to move her wrist during the course of the exam, and refused to pronate or supinate her forearm; however, when distracted, he noted she supinated (70 degrees) and pronated (80 degrees) her forearm quite well. He noted nonphysiologic responses such as complaints of pain over the right cubital tunnel during arm elevation, and dorsal ulnar wrist and distal radioulnar joint pain during Speed's testing, and give-way

weakness on the right with supraspinatus testing. He found her forearm and biceps circumference consistent with a left-handed individual with a normally functioning right upper extremity, and explained that lack of atrophy suggested she was using her upper extremity fairly well. (RX 1, Dep. Ex. 2)

Dr. Rotman found no crepitus or clicking, no evidence of joint instability, and smooth distal radioulnar joint motion. X-rays of the right wrist taken that day showed an ulnar 1 mm. variance, and no significant arthritic changes of the distal radioulnar joint. (RX 1, Dep Ex. 2; RX 2, 14-17)

In Dr. Rotman's opinion, jogging paper would not cause a disabling injury to the distal radioulnar joint or extensor carpi ulnaris. He thought the MRI scan triggered the surgery, and the surgical findings were not related to any type of injury. He found that her present x-rays showed minimal changes more postoperative than anything else. He determined that there was no indication for the prosthesis Dr. Scheker recommended, explaining that the procedure was contraindicated in the face of her symptom magnification and complete lack of effort. He recommended a return to full duty "using her wrist as much as possible." He did not believe Petitioner needed any restrictions. He determined that Petitioner did not sustain an injury caused by jogging at work on July 6, 2011. (RX 1, Dep Ex. 2; RX 2, 11-12, 23-24)

According to an office note found in Dr. Naam's records, a conference call was held between Dr. Naam and Petitioner's attorney on October 2, 2012. Petitioner was to make another appointment. (PX 10)

Petitioner was re-examined by Dr. Naam on October 11, 2012. She reported having been seen by Dr. Scheker who recommended a total joint replacement and then undergoing an examination with Dr. Mitchell Rotman in St. Louis who believed Petitioner was exaggerating her symptoms and had no evidence of any condition in her wrist warranting surgical intervention. He reportedly did not feel Petitioner had any limitations in her ability to pronate and supinate. Dr. Naam noted he had read Dr. Rotman's report. Petitioner reported to Dr. Naam a significant degree of right wrist pain and an inability to pronate or supinate her forearm. Petitioner reported difficulty grasping objects and moving her fingers. She had been using a splint. Petitioner's x-ray, taken that day, showed complete dislocation of the distal radioulnar joint and total loss of congruity of the articular surfaces of the distal radioulnar joint. Dr. Naam reviewed Petitioner's MRIs. The one performed in July of 2011 showed persistent dorsal subluxation of the distal radioulnar joint. The March of 2012 MRI showed persistent dorsal subluxation or actual dislocation of the distal radioulnar joint. Dr. Naam's diagnosis was persistent dislocation of the distal radioulnar joint of the right wrist. He "strongly recommended" the surgical procedure recommended by Dr. Scheker for total joint replacement of the distal radioulnar joint as Petitioner "simply does not have a congruent distal radioulnar joint" making it "impossible" for her to have normal pronation and supinationas a dislocated joint can never have normal range of motion. Dr. Naam wrote, "Therefore, Dr. Rotman's observation that the patient has normal pronation and supination seems somewhat difficult to understand based on the clinical, radiographic, and MRI findings." (PX 10)

Petitioner testified that she continued working throughout this time until January 10, 2013 when she completed her shift and was then advised by Jerome Williams that she was expected to report to work on Monday full duty and without her brace "or else."

Petitioner saw Dr. Richards the next day. According to his office note, Petitioner was still experiencing pain and swelling in her right wrist accompanied by limited range of motion. Petitioner reported having some "issues with work comp denying her work restrictions," and was still having trouble with movement in her wrist and getting conflicting reports from specialists. Petitioner did not yet feel ready to return to duty with her right hand in the shape it was. Dr. Richards noted tenderness over the distal ulna and pain in that area with pronation/supination, flexion/extension and ulnar deviation of the wrist. He also noted edema in the distal dorsal forearm and a "significant step off from the distal ulna and radius to the carpal bones." Dr. Richards prescribed Vicodin and suggests she continue her work restrictions of no use of the right hand until definitive treatment plans could be made for her wrist. Petitioner was given a written work restriction slip. (PX 5, RX 2) Petitioner presented the slip at work on January 14, 2013 at which point she was sent home. Petitioner asked if she was being fired and was told "no." Petitioner testified at arbitration that she was willing to work light duty.

Petitioner's attorney filed a Petition for Penalties and Attorneys' Fees on February 7, 2013 contending that Respondent should be assessed penalties pursuant to Sections 19(k) and 19(l) as well as attorneys' fees pursuant to Section 16 due to Respondent's failure to pay weekly compensation and medical care as set forth in Petitioner's Petition for an Immediate Hearing which had been filed. (PX 1,2) Petitioner's Petition for Immediate Hearing alleged that Petitioner had given her employer (vis a vis its supervisor, Roy Sanders) an off work slip/ restricted duty slip on January 14, 2013 at which point she was told she needed to go home. Petitioner alleged she remained willing and able to perform light duty work as her doctor had advised she could do; however, Respondent would not allow her, sent her home, and has refused to pay her salary or temporary total disability benefits since then. (PX 1)

Dr. Rotman issued a supplemental report on February 28, 2013. He did not re-examine Petitioner at that time. Rather, he was asked to review x-rays and an MRI. Dr. Rotman's opinions were unchanged by his review of Petitioner's x-ray of July 11, 2011 and her MRI of July 18, 2011. He indicated he would like to see the photographs taken at the time of the arthroscopy. (RX 1, Dep Ex. 3)

Dr. Naam's deposition was taken on April 23, 2013. Dr. Naam is a board certified hand surgeon who practices in Effingham, Illinois. He initially examined Petitioner at her request for a second opinion. (PX 4, p. 6) That occurred on March 15, 2012. (PX 4, p. 7) Dr. Naam testified regarding his care and treatment of Petitioner as reflected above.

Dr. Naam also testified that Petitioner always gave full effort on testing, (PX 4, pp.16,35) However, he acknowledged such testing measurements are subjective, (PX 4, p. 45) Dr. Naam explained that Petitioner's x-ray findings of March 15, 2012 were consistent with generalized osteoporosis which is generally due to lack of normal use. (PX 4, p. 17) Her x-ray findings also included evidence of a small hole in her carpal bones and a small hole in the head of her ulnar probably due to her earlier surgery. (PX 4, p. 17)

Dr. Naam testified that Petitioner returned to see him on May 2, 2012 and brought her earlier MRI with her. According to Dr. Naam, the MRI showed a complete dorsal dislocation of the ulna at the distal radioulnar joint and a thinning of the triangular fibrocartilage with possible peroration of

the regular attachment of the triangular fibrocartilage and also volar subluxation of the extensor carpal ulnaris tendon. (PX 4, p. 19) Dr. Naam explained that the distal radial ulna joint allows for rotation of one's forearm. (PX 4, p. 20) Dr. Naam further testified that based upon the MRI the tendon which Dr. McGuirk had tried to centralize into place still hadn't centralized; instead, it had moved back to an abnormal position. (PX 4, pp. 21-22)

Dr. Naam felt Petitioner was suffering from persistent chronic dislocation of the distal radioulnar joint of her right wrist and volar subluxation of the extensor carpi ulnaris tendon of the right wrist resulting in marked limitation of the active rotation of Petitioner's right forearm. (PX 4, p. 22) In lay terms, Dr. Naam meant that some part of Petitioner's joint was physically out of its socket which would cause pain and, more importantly, significant limitation of the movement of that joint. (PX 4, p. 24)

Dr. Naam further explained by referring to Petitioner's MRI and a normal MRI that Petitioner's extensor carpi ulnaris was located on the opposite side of where it should be. (PX 4, p. 28) He further explained that Petitioner's MRI in March of 2011 and the one taken on July 18, 2011 both showed that Petitioner's ulna was dislocated dorsally and the extensor carpi ulnaris tendon was dislocated volarly. Dr. Naam testified that he explained to Petitioner that her problem was a complex one, especially in light of the passage of time and it was beyond his area of expertise; however, he wished to consult with Dr. Adams, a good friend of his, who specialized in a method of tendon reconstruction that might help Petitioner as well as Dr. Luis Scheker an experienced surgeon in joint replacement in that area, the latter of which might be necessary since Petitioner had been dealing with this problem for ten months. Dr. Naam testified that he ultimately intended to refer Petitioner to one of those doctors for further treatment. (PX 4, pp. 29-30) As of May 2, 2012 Dr. Naam believed Petitioner needed one-handed work for two weeks. Petitioner was also referred to Working Hands for a special splint. (PX 4, pp. 31-32) Dr. Naam extended the restrictions when he saw Petitioner again on May 16, 2012 and June 7, 2012. (PX 4, pp. 32-33)

Dr. Naam further testified that he spoke with Dr. Adams who told him that due to the passage of time it would be very difficult to get Petitioner's ulna to remain in place because the space would be filled with scar tissue and the joint would never be normal. Dr. Scheker, however, could replace the joint completely. (PX 4, pp. 33-34)

According to Dr. Naam Petitioner did go and see Dr. Scheker because he received a report from him. When he next saw Petitioner on October 11, 2012 she advised him that she had been examined by Dr. Rotman in St. Louis. (PX 4, p. 34) Dr. Naam was aware that Dr. Rotman did not believe Petitioner needed any surgery. His exam of Petitioner on October 11, 2012 was consistent with earlier ones and he thought Petitioner was giving full effort on testing. She still had complete dislocation of her ulnar joint. (PX 4, pp. 34-35) He never saw any symptoms of symptom magnification. (PX 4, pp. 40, 42) Dr. Naam was still of the opinion Petitioner needed the total joint replacement as recommended by Dr. Scheker. (PX 4, p. 36) Dr. Naam disagreed with Dr. Rotman's report as the MRI clearly shows Petitioner's joint is out. Dr. Naam even showed the MRI to his colleagues to see if he was being unreasonable and they agreed it showed Petitioner's joint was out. (PX 4, pp. 37-40) Dr. Naam expressed the desire to sit down with Dr. Rotman and show him the MRI which "obviously isn't normal." (PX 4, p. 40)

Dr. Naam was of the opinion Petitioner's symptoms were consistent with her MRI findings. (PX 4, pp. 47-48) He testified that while he had not focused on the mechanism of her injury, he thought Petitioner was turning bundles of paper and turning her forearm when she felt popping followed by pain. (PX 4, pp. 47-48) He stated that Petitioner's condition was caused by trauma, not repetitive activity. (PX 4, pp. 47- 48) In his opinion, Petitioner had not yet reached maximum medical improvement. (PX 4, pp. 47-48)

On cross-examination Dr. Naam was asked to restate his diagnosis regarding Petitioner to which he replied, "Number 1, chronic dorsal dislocation of the distal radioulnar joint of the right wrist....Number 2. Chronic volar dislocation of the extensor carpi ulnaris tendon." (PX 4, p. 43) Dr. Naam acknowledged that he has not diagnosed Petitioner with cubital tunnel syndrome. (PX 4, p. 43) Dr. Naam had not reviewed any records pertaining to Petitioner pre-dating July 6, 2011. (PX 4, p. 44) He did feel the volar dislocation and dislocation of the distal radioulnar joint were present on the MRI obtained before surgery. (PX 4, pp. 44-45) Dr. Naam was also asked about symptom magnification and pointed out that his testing did not show any and, furthermore, Petitioner did not know the trilogy of what the distal radioulnar joint did for the wrist and yet she pointed out that it was her rotation that was affected, not the ability of her wrist to go up and down consistent with her condition. (PX 4, pp. 46-47) Dr. Naam also disagreed with Dr. Rotman's opinion that Petitioner needed no treatment. (PX 4, p. 51) He felt Petitioner had Petitioner has sustained a dislocated joint and, like a dislocated elbow, the joint cannot function when dislocated. It must be put back; otherwise, the elbow will not function. In Petitioner's case, the joint must be put back in place and "reconstruct the rope" to hold it in place or replace the joint so it can move like a normal joint. The last option, and most drastic, is to cut the end of the ulna completely and/or remove the head of the ulna. Dr. Naam explained that joint replacement surgery has been around for ten years. (PX 4, pp. 51-52)

Petitioner was under video surveillance on April 26-27, 2013. Petitioner is shown engaging in a number of activities including driving a vehicle, walking, and clearing/burning brush. She is also seen running very briefly. Petitioner is seen sitting in a vehicle and driving it, using her left hand. Petitioner was seen walking towards her vehicle with her right arm hanging to her side. She opened the truck door with her left hand. While at a post office at approximately 12:30 p.m. on the 26th she is seen bending her right arm at the elbow. Throughout the video Petitioner is wearing a long-sleeved jacket. After exiting the post office Petitioner is seen waiving with her right hand, walking to her truck, opening the truck door with her left hand, and driving away. In a later section after an ambulance leaves an area, she is seen holding glasses with her right hand and running. Video taken on the 27th centers around activities being performed in the country and looks like Petitioner and someone else were clearning brush and burning it. Petitioner stands, walks, and bends. There is very limited activity involving Petitioner's right hand although she occasionally holds a walking stick with it and uses her right hand to put something in her back pocket. She is seen crossing a fence but she uses her left hand to do so and does nothing with her right hand. (RX 4; RX 5)

Dr. Rotman's deposition was taken on May 21, 2013. (RX 1) Dr. Rotman is a board certified orthopedic hand surgeon. (RX 1, p. 4) Dr. Rotman testified consistent with his earlier reports. In his opinion, Petitioner did not really sustain an accident in July of 2011 as she was performing her regular work activities and simply felt something happen to her wrist. Petitioner did not fall nor did she hit

anything. It might be a strain or tendinitis but it wasn't a joint dislocation or something torn in her wrist. Rather, Petitioner developed pain while performing her regular work activities. (RX 1, pp. 8-9) Dr. Rotman further testified that Petitioner's pain was "ill-defined" and wasn't isolated to her distal radial joint. As he explained it, Petitioner's treatment changed after the MRI scan at which time she began receiving treatment for the MRI findings rather than her pain complaints. (RX 1, p. 9) He could not relate any of her medical treatment to feeling pain while she was performing her regular work duties. (RX 1, p. 10)

The doctor testified that Petitioner demonstrated almost full supination and pronation when distracted, and her limited range of motion on examination was volitional. (RX 2, 14-15) On cross-examination, Dr. Rotman agreed that Petitioner was faking her symptoms. (RX 2, 35, 38) He opined that one reason for symptom magnification was seeking monetary gain. (RX 2, 35)

Petitioner was under video surveillance July 11 -12, 2013. (RX 5) During this period Petitioner was videotaped at an agricultural fair. Petitioner is seen walking, sitting, and engaging in a variety of activities. She does occasionally use her right hand to hold some papers and put things in her right back pocket. She is seen taking tickets and carrying a bucket with her left hand. (RX 5)

Dr. John Richards was deposed on July 18, 2013. (PX 3) Dr. Richards is a board certified physician in family medicine. Dr. Richards testified that when he initially examined Petitioner on July 11, 2011 she complained of swelling in her right wrist, pain in her right wrist, and reported "a popping sound which she related [to] manipulating large bales of paper at work." (PX 3, p. 7) Dr. Richards testified that he observed a palpable, visible knot on Petitioner's right wrist. (PX 3, pp. 8-9) Petitioner's physical examination was positive for tenderness over her distal ulna, and pain with pronation and supination, flexion and extension of the wrist and ulnar deviation of her wrist. (PX 3, p. 9) The doctor also noted swelling. (PX 3, p. 10) Dr. Richards suspected Petitioner had a soft tissue injury and recommended immobilization, ice, non-steroidal anti-inflammatory drugs, and rest. (PX 3, p. 10) Petitioner was taken off work until the following Monday to allow her to rest the limb. (PX 3, pp. 10-11)

Dr. Richards testified that Petitioner remained symptomatic when she returned on July 18, 2011 and her exam was very similar to the previous one. (PX 3, pp. 11-12) Dr. Richards ordered an MRI. (PX 3, p. 12)

Dr. Richards further testified that the MRI revealed an osteochondral impaction injury to Petitioner's proximal lunate – ie., a bone bruise or edema in the lunate which is a carpal bone within the wrist. (PX 3, p. 13) The MRI also revealed an injury to the volar ligament of her distal radioulnar joint – ie., an injury to the ligament which ties the ulnar and radius together and which is located on the palmar side of one's wrist. (PX 3, p. 14) The MRI also revealed mild volar subluxation of the extensor carpi ulnaris (a muscle) with respect to the ulna that runs through the tendon sheath of the palm. According to Dr. Richards, Petitioner's extensor carpi ulnaris had been displaced from the back side towards the palm side of the wrist. (PX 3, pp. 14-15) Dr. Richards testified that after he reviewed the MRI he felt Petitioner needed to be seen by a hand specialist as the MRI revealed a more extensive injury than he initially believed Petitioner had sustained and "since this was an injury that happened while she was at work, [he wished to] make sure it was taken care of appropriately." (PX 3, p. 15)

Dr. Richards re-examined Petitioner on August 2, 2011 and noted she was about the same and did not feel ready to return to work. Petitioner's exam remained the same and he referred her to a hand specialist, Dr. McGuirk. (PX 3, pp. 16-17) Dr. Richards testified that he believed he had Petitioner on work restrictions. (PX 3, p. 17)

Dr. Richards testified that he saw Petitioner once again on September 19, 2011 at which time he noted the therapy which he believed Dr. McGuirk had initiated was not working. Her condition remained unchanged. (PX 3, pp. 19-20)

Dr. Richards was of the opinion that Petitioner's condition in her right wrist and as reflected on the MRI, were related to her injury at work. (PX 3, pp. 20-22) He explained that his causation opinion relied upon the history given to him by Petitioner. (PX 3, p. 25) Dr. Richards further opined that he believed Petitioner's reports of pain were genuine. (PX 3, p. 21)

On cross-examination Dr. Richards acknowledged that he is neither a hand surgeon or hand specialist. (PX 3, p. 24) He also acknowledged that prior to July 11, 2011 he had never treated Petitioner for any right wrist complaints. (PX 3, p. 24)

Medical records pre-dating Petitioner's alleged accident were admitted into evidence. Records dated November 13, 2003 indicate Petitioner saw Dr. Davis at that time for neck and wrist pain in the ulnar styloid area. Petitioner was diagnosed with tendinitis and told to wear a wrist splint. (RX 2) In June of 2005 Petitioner was seen for bilateral tingling in her feet and hands. (RX 2)

Petitioner testified at arbitration that she is still not working. Petitioner expressed the desire to proceed with the surgery as recommended by Dr. Scheker and understood that receiving a "fake wrist" might result in some limitations; however, she presently cannot turn her right arm over and wants to proceed with surgery to gain movement and less pain in her arm.

With regard to her August 13, 2012 examination with Dr. Rotman, Petitioner testified it lasted between thirty and forty-five minutes of which approximately fifteen minutes was spent with Dr. Rotman. Petitioner, who was accompanied by her brother and sister-in-law, walked into the examining room where a male nurse measured her arm and had her squeeze "something." A nurse took her to x-ray and then she returned and waited for the doctor. According to Petitioner when the doctor arrived he tried to move her arm in certain positions and "squeezed things." Petitioner testified she requested pain medication but the doctor told her he couldn't do that. Petitioner testified that she gave her best effort during testing just as she had when undergoing similar tests with Dr. Naam.

Petitioner testified that she has not worked since being sent home on January 14, 2013.

On cross-examination Petitioner explained that she was holding papers with her right hand when she heard the pop. Petitioner recalled saying "yow – that hurt." Petitioner acknowledged she had performed various jobs for Respondent after she began working for it in October of 2006. According to Petitioner one might perform a job for a month and then move around. Petitioner acknowledged that RX 3, the report of injury, states nothing about popping and that the reference to "juggling" in Dr. Richard's July 11, 2011 report should be "jogging."

On further cross-examination Petitioner was asked several questions about events preceding July 6, 2011, most of which centered around her activities on/about July 4, 2011 during which time the Martinsville Agricultural Fair was underway. Petitioner acknowledged that she went to the parade and rode her horse in it. She acknowledged she attended the fireworks display and the fair and that she worked in the office at the fair counting money and taking tickets for horse racing. Petitioner also attended some of the horse races.

Petitioner testified that she and her husband both own and take care of one horse and a donkey. There are some goats on their property but Petitioner denied that she owns them. Petitioner testified that she occasionally dumps feed buckets. She and her husband tend to her horse which she had last ridden two weeks before the arbitration proceeding. Petitioner explained that she cannot mount her horse on her own; rather, her husband pushes her up. Petitioner also testified that she only rides her horse at a walking pace as cantoring or galloping jars her arm and hurts her wrist.

Petitioner acknowledged that she had previously undergone right shoulder surgery due to a motor vehicle accident in which a seat belt broke part of her collar bone. Petitioner, however, denied any right arm or hand problems before July 6, 2011.

Petitioner did not recall a visit with Dr. Davis in November of 2003 at which time she complained of some neck and wrist pain.

Petitioner testified that she drives a car without using her right hand and opens soda bottles with her left hand. She acknowledged RX 4 contained photographs of herself and that one of them showed her crossing a fence. On re-direct examination Petitioner agreed that the photographs contained in RX 4 did not show her hand being used. Petitioner also testified that she had never experienced pain like she did on July 6, 2011 and she was adamant there was a "pop."

After Petitioner's testimony concluded there was a brief recess during which time the parties viewed the video surveillance. (RX 5)

The Arbitrator concludes:

1. Petitioner's credibility. Respondent contends that Petitioner is not a credible witness, noting the inconsistencies between her complaints and her physical abilities as observed by its examining physician, Dr. Rotman, and as revealed on the surveillance DVD (RX 5). The Arbitrator disagrees and finds Petitioner to be a very credible witness. Nothing about her demeanor or conduct during the arbitration hearing or on the surveillance DVD diminished the believability of her testimony.

2. Accident (Issue C). Petitioner sustained an accident on July 6, 2011 that arose out of and in the course of her employment with Respondent. Petitioner credibly testified that she felt a "pop" in her right wrist while "jogging" paper at work on July 6, 2011. She immediately reported the incident to her supervisor. While there is no mention of a "pop" in her accident report she did indicate she felt instant pain and noticed a knot on her right wrist. Petitioner did mention a "pop" when initially seen by Dr. McGuirk on August 6, 2011 less than one month after the accident. Petitioner's testimony was unrebutted. Medical records and the accident report corroborate her testimony.

3. Causal Connection (Issue F). Petitioner's current condition in her right wrist is causally connected to the July 6, 2011 accident. Petitioner's current condition in her right elbow (diagnosed by Dr. Scheker as cubital tunnel syndrome) is not causally connected to the July 6, 2011 accident. These conclusions are based upon a chain of events and the opinions of Dr. Richards and Dr. Naam, Petitioner's treating physicians, whose opinions are found to be more persuasive than that of Dr. Rotman, an examining physician.

The records and testimony also reveal that Petitioner's current condition of ill-being in her wrist is causally related to the accident. Dr. Richards testified to a reasonable degree of medical certainty that the MRI taken of Petitioner on July 18, 2011, less than 2 weeks after her injury, showed an osteochondral impaction injury to the proximal lunate in Petitioner's right wrist, as well as injury to the right volar ligament of the distal radioulnar joint, and a volar subluxation of the extensor carpi ulnaris (PX 3, pp. 13-15, Richards Dep. Exh.3) He further testified that these injuries were all caused by the accident Petitioner suffered at work on July 6, 2011 (PX 3, pp. 20-22) Dr. Naam further testified that Petitioner suffers from a persistent chronic dislocation of the distal radioulnar joint of the right wrist, and volar subluxation of the extensor carpi ulnaris tendon of the right wrist, resulting in marked limitation of the active rotation of the forearm (PX. 4, p. 22) He also testified that these injuries were seen on the MRI taken of Petitioner's wrist on July 18, 2011, a period less than 2 weeks after her work injury but before her surgery with Dr. McGuirk on September 26, 2011, and were also seen on the MRI taken on March 19, 2012 (PX 4, pp. 26-29; Naam Dep. Exhs. 3, 4) In forming his first report in this matter, Dr. Rotman admits that he did not review any MRI scans before making the report, although he admitted that it is important to have all of the relevant information prior to rendering an opinion, and that the MRI reports would have been important information for him to have (RX 1, p. 30) When shown Naam Exhibit 3, an MRI of Petitioner's wrist taken on March 19, 2012, Dr. Rotman admitted in his deposition that the ulna was subluxed dorsally, meaning it was partially out of the socket (RX. 1, pp. 42-43) When shown Naam Exhibit 4 at the same deposition, an MRI of Petitioner's wrist taken on July 18, 2011, Dr. Rotman again admitted that the ulna was subluxed (RX 1, p. 45)

The Arbitrator was able to observe Petitioner while she attempted to raise and lower her arms and forearms in different positions during the hearing. The Arbitrator noted such exertions caused effort on Petitioner's part. Petitioner's treating physicians, who have had numerous chances to see and observe her, did not find any evidence of symptom magnification. Dr. Richards testified that Petitioner's reports of pain were genuine (PX 3, p. 21) Dr. Naam opined, to a reasonable degree of medical certainty, that Petitioner is not magnifying her symptoms (PX 4, pp. 16, 35, 40, 42) These opinions of treating physicians who have repeatedly treated Petitioner are more credible than the findings of a non-treating examiner who observed Petitioner on a single, 15 to 20 minute visit. Dr. Rotman's opinions seem centered on the fact he simply did not believe Petitioner sustained any type of injury at work nor did he believe Petitioner. Dr. Rotman did not believe Petitioner torque, twisted or fell on her wrist. However, the medical records and accident report corroborate Petitioner's testimony that she was turning her wrist when she felt instant pain and noticed a knot.

Lastly, the surveillance video taken of Petitioner (RX 5) does not provide any evidence of symptom magnification by Petitioner. Petitioner admitted during the hearing that she is able to drive, but does not use her right hand. The surveillance video shows Petitioner driving, but also shows that she opens the door every time with her left hand, and steers the truck with her left hand (RX. 5) Petitioner also testified that she worked at the recent Martinsville Agricultural Fair taking tickets, counting money, and taking entries. The video footage taken of Petitioner at the fair shows her taking tickets, and carrying a bucket with her left hand around the fairgrounds (RX 5) The only activity that Petitioner does with her right hand is hold a few papers, which she occasionally puts in her back pocket. Respondent's Exhibit 4 consists of 3 pages of photographs (RX 4) Petitioner's right arm is not even visible on the photos on two of the pages, and the only thing Petitioner does with her right arm in the other photo is hold it out in the air, with her brace visible (RX. 4) The surveillance video reveals that Respondent's Exhibit 4 are still frames of video of Petitioner climbing over a fence (RX 5) However, that video footage reveals that Petitioner uses her left hand to hold onto a shovel while she swings her legs over the fences (RX 5) Petitioner is seen doing nothing with her right arm while climbing over the fence other than swing it in the air (RX 5) The video footage in Respondent's Exhibit 5 shows that Petitioner is forced to use her left arm for almost everything, from driving, to emptying feed buckets for the animals on her farm, to carrying things like shovels and buckets used to collect tickets at the fair (RX 5) The Arbitrator concludes that nothing in Respondent's Exhibit 5 to disprove Petitioner's claim that she is injured to the extent claimed.

With regard to a chain of events analysis, the Arbitrator notes Petitioner had no problems with her right wrist prior to July 6, 2011 except for one or two isolated visits to her family doctor between 2003 and 2005. Petitioner was working full duty for Respondent without any evidence of problems with her right wrist immediately prior to the accident. The Arbitrator cannot conclude Petitioner's right cubital tunnel syndrome (as diagnosed by Dr. Scheker) is causally connected to the accident as Petitioner displayed no evidence of cubital tunnel syndrome prior to her first visit with Dr. Scheker and no other doctor examining Petitioner prior to that time had diagnosed Petitioner with same or suspected she might be experiencing cubital tunnel symptoms.

Additionally, the Arbitrator notes that Dr. Naam testified that not only did he feel Petitioner's MRI showed Petitioner's joint was out of place but, concerned that he might be wrong in light of Dr. Rotman's report, he showed the MRI to his colleagues who agreed with him regarding Petitioner's joint.

4. Prospective Medical Care (Issue K). Pursuant to Section 8(a) of the Workers' Compensation Act, Petitioner is entitled to the prospective medical care proposed by Dr. Naam and Dr. Scheker. Dr. Naam testified at length as to his decision to refer Petitioner to Dr. Scheker for a replacement surgery, as opposed to Dr. Adams in Iowa for a reconstruction surgery (PX 4, pp. 30-34; PX 12) Due to the length of time it has taken to have this surgery, and the scar tissue that has developed in Petitioner's wrist, Dr. Naam testified that it is no longer practical to do a reconstruction surgery, and that replacement is the best way to proceed (PX 4, pp. 33-34) The wrist replacement surgery suggested by Dr. Naam and Dr. Scheker should be authorized. The costs of such surgery,

along with any pre-surgical procedures, and any follow-up medical care and therapy, as defined by Section 8(a) of the Act, should be paid by Respondent, per the applicable fee schedule.

5. Temporary Total Disability Benefits (Issue L). At the time of arbitration, Petitioner's attorney was unsure as to the exact periods for which he sought temporary total disability (TTD) benefits. While the period subsequent to January 14, 2013 was clearly disputed (AX 1), the parties agreed Petitioner could submit his full claim for temporary total disability benefits when he submitted his proposed decision and it would be made a part of the record. That was done and the e-mail sent by Petitioner was made a part of the record. Respondent also provided an e-mail concerning its position on the periods of temporary total disability. (AX 5)

   Petitioner maintains she has been entitled to temporary total disability benefits for the following time periods: (1) September 22, 2011 through February 19, 2012; (2) February 28, 2012 through April 1, 2012; and (3) January 14, 2013 through August 26, 2013. (AX 5) Petitioner has further stipulated that Petitioner received temporary total disability benefits for the first two periods of time. (AX 5; AX 1) Respondent submits Petitioner received TTD benefits from July 11, 2011 through July 24, 2011; September 22, 2011; September 26, 2011 through February 19, 2012; and February 28, 2012 through April 1, 2012. While the parties do not completely agree on the periods of temporary total disability prior to January 14, 2013, Petitioner has represented that any amounts due and owing before that date have been paid and the parties agree on the amount that was paid. (AX 1, AX 5) Thus, it appears that only the last period remains in dispute.

   Petitioner is awarded temporary total disability benefits commencing January 14, 2013 through the date of arbitration (August 26, 2013), a period of 32 1/7 weeks. Petitioner presented to work on January 14, 2013, with a note from her physician saying she could not use her right arm at work, but was willing to perform light duty. Rather than have Petitioner perform light duty work, Respondent sent Petitioner home. Petitioner is awarded Temporary Total Disability payments at a disability rate of $280.00 per week for the foregoing period.

6. Penalties and Attorneys' Fees (Issue M). Penalties and attorneys' fees are denied. Respondent reasonably disputed liability for prospective medical care and temporary total disability benefits based upon the reports and testimony of Dr. Rotman. While the Arbitrator has not relied upon Dr. Rotman's reports and testimony in reaching her decisions herein, Respondent reasonably relied upon his opinions and reports and, therefore, the Arbitrator cannot conclude Respondent's conduct herein has been vexatious, unreasonable, intentional, or performed in bad faith or without good cause.

****

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

Ricardo Solis,
Petitioner,
vs.

14IWCC0674

NO: 10WC 36623

Canteen-Compass Group USA, 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 medical, causal connection, temporary total disability, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 20, 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 $10,600.00. 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: AUG 14 2014
o080614
CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0674

SOLIS, RICARDO
Employee/Petitioner

Case# **10WC036623**

CANTEEN-COMPASS GROUP USA INC
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:

0226 GOLDSTEIN BENDER & ROMANOFF
ARTHUR GERMAN
ONE N LASALLE ST SUITE 2600
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
JULIE M SCHUM
210 W ILLINOIS ST
CHICAGO, IL 60654

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

14IWCC0674

RICARDO SOLIS
Employee/Petitioner

Case #10 WC 36623

v.

CANTEEN-COMPASS GROUP USA, 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 Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on February 27, 2013. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

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

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

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On August 12, 2010, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $36,397.40; the average weekly wage was $699.95.
- At the time of injury, the petitioner was 33 years of age, *married* with three children under 18.
- The parties agreed that the respondent paid $3,431.93 in temporary total disability benefits.

ORDER:

- The petitioner's claim for temporary total disability benefits after September 3, 2010, is denied.
- The respondent shall pay the petitioner the sum of $419.97/week for a further period of 25 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 5% loss of use of the man as a whole.
- The respondent shall pay the petitioner compensation that has accrued from August 12, 2010, through February 27, 2013, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner through September 3, 2010, was reasonable and necessary. The medical care rendered the petitioner after September 3, 2010, was not reasonable or necessary and is denied. The respondent shall pay the medical bills in accordance with the Act and the medical fee schedule. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act, and any adjustments, and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- The petitioner's request for benefits for his mid and low back 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.

Robert E. Williams — 3/20/13

Robert Williams — Date

MAR 20 2013

FINDINGS OF FACTS:

On August 12, 2010, the petitioner, a merchandise delivery driver, injured his right hip when soda cases fell from his hand cart onto his right side and hip. He received immediate care at Concentra and reported pop falling on his right side while pulling a hand cart, hurting his right leg and hip. The diagnosis was a hip contusion for which medication, icing, crutches and light duty was planned. The petitioner reported moderate stiffness in his right hip on August 14th and continued pain on the 18th. He started physical therapy on the 18th, and reported right hip pain with occasional right knee pain to the therapist. At his last visit with the doctor at Concentra on September 1st, the petitioner reported that the pattern of symptoms were improving, continued right hip pain exacerbated by walking and the ability to ambulate with one crutch. At his last therapy session on September 3rd, the petitioner reported continued soreness in his right hip but doing well with light-duty work.

The petitioner saw Dr. Lambiasi of Centro Medico La Villita on September 7th for right hip pain, low back pain and tingling in his legs and feet. The petitioner started chiropractic care with Dr. Irene Ma of Activa Chiropractic Clinic on September 7th and reported low back, mid back and right hip pain. He followed up frequently for chiropractic care through April 13, 2013. Dr. Lambiasi gave the petitioner six iontophoresis treatments from September 14th through October 6th. The doctor treated the petitioner approximately bimonthly through April 13, 2011, with Tramadol, Flexeril and Gabapentin. An MRI of the petitioner's lumbar spine on September 16th showed disc bulging at L4-5 and a suspected right-sided disc protrusion at L5-S1 effacing the right S1

nerve root. An EMG/NCV on October 7th was interpreted as a neuropathy affecting the L4-S1 bilaterally.

On October 25, 2010, Dr. Goldberg evaluated the petitioner pursuant to Section 12 and opined that the MRI was normal and the petitioner sustained a lumbar strain. The petitioner reported that soda fell on his right side injuring his right hip and leg.

On October 29, 2010, the petitioner saw Dr. Malek and reported that a case fell on his right side. The petitioner reported mid and low back pain with radiation down his right leg with tingling, numbness weakness down to his ankle. His impression was thoracolumbar musculoligamentous sprain and right lumbar radiculopathy. An MRI of the petitioner's right hip on November 3rd was unremarkable. Dr. Malek gave the petitioner a right L5-S1 transforaminal epidural steroid injection on November 19th. A lumbar discogram on December 10th noted concordant pain at L5-S1. A post discogram CT scan on December 10th revealed contrast at L3-4, L4-5 and L5-S1. The petitioner followed up with Dr. Malek on April 8, 2011, On February 14, 2011, Dr. Goldberg opined that the petitioner did not require any epidurals or a discogram and that he was at MMI and could work without restrictions.

A functional capacity evaluation on March 21, 2011, at Liberty Physical Therapy reported a light-duty capacity. The petitioner was released to light-duty work by Dr. Lambiasi on April 14, 2011, who noted that the petitioner ambulated with a cane. Photos of the petitioner on May 9, 2011, reveal him ambulating without crutches or a cane.

Dr. Goldberg testified on November 12, 2012, that the neuropathy shown on the EMG was essentially irrelevant, since if the spine was the source, it would have been bilateral radiculopathy which the petitioner did not report. He noted that the discogram

did not correlate with the MRI and the CT scan showed the dye was contained within the disc and was not a herniation by definition.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner through September 3, 2010, was reasonable and necessary. The medical care rendered the petitioner after September 3, 2010, was not reasonable or necessary and is denied. The petitioner did not report a back injury and only complained of and only treated for right hip and leg pain through September 3, 2010. The petitioner is not credible. The petitioner's request for benefits for his mid and low back is denied.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that his current condition of ill-being with his right hip and leg is causally related to the work injury. The petitioner failed to prove that his current condition of ill-being with his mid and low back is causally related to the work injury.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

Based upon the prior findings, the petitioner failed to prove that he is entitled to temporary total disability benefits after September 3, 2010. Dr. Lambiasi advised the petitioner to stop working on September 7, 2010, while he treated him for his unrelated back condition. While treating for his right hip and leg, the petitioner worked up to September 6, 2010. The petitioner's claim for temporary total disability benefits after September 3, 2010, is denied.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The respondent shall pay the petitioner the sum of $419.97/week for a further period of 25 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 5% loss of use of the man as a whole.

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

14IWCC0675

Cindy Flores,
Petitioner,
vs.

NO: 09WC 33162

Ultimate Exposure,
Respondent,

DECISION AND OPINION ON REVIEW

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

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

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: AUG 14 2014
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CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FLORES, CINDY
Employee/Petitioner

Case# **09WC033162**

14IWCC0675

ULTIMATE EXPOSURE
Employer/Respondent

On 4/8/2013, 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 0.10% 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:

1067 ANKIN LAW OFFICE LLC
JOSHUA RUDOLFI
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
THOMAS MALLERS
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

14IWCC0675

☐ 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

Cindy Flores,
Employee/Petitioner

v.

Ultimate Exposure,
Employer/Respondent

Case # **09** WC **33162**

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 **Chicago**, on **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 _____

14IWCC0675

FINDINGS

On **7/24/09**, 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 **$26,260.00**; the average weekly wage was **$505**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$5,969.58** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$5,969.58**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $336.67 per week for 28-6/7 weeks, commencing 7/25/09 through 10/18/09, from 10/30/09 through 12/20/09, from 5/14/10 through 6/7/10 and from 8/6/10 through 9/6/10, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 7/25/09 through 1/18/13, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $5,969.68 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $70,102.93, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $303.00 per week for 100 weeks, because the injuries sustained caused the 20% 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

4/8/13
Date

ICArbDec p 2

APR 8 - 2013

14IWCC0675

STATEMENT OF FACTS:

Petitioner, a 31 year old salon manager, testified that she had worked for Respondent for approximately four years. Her job duties included assisting between 60 and 125 clients per day, maintaining the facilities, compiling daily reports and schedules, coordinating payroll and cleaning the tanning beds on a daily basis. Petitioner testified that on July 24, 2009, between 6:00 pm and 7:00 pm, she was cleaning and wiping down a vertical tanning bed when she felt extreme pain in her lower back. She indicated that at the time of the incident she was using a rag and a spray bottle of sanitizer to wipe down the nearly six foot tall bed which required her to reach above her head and squat/stoop down to clean the bottom. Petitioner testified that she reported her injury and left to go home. She noted that upon getting in her car her back pain essentially immobilized her and she went to Resurrection Hospital. (PX7).

Petitioner testified that when her low back pain did not abate she went to Gottlieb Memorial Hospital on July 27, 2009. (PX2). An MRI of the lumbar spine was performed on August 19, 2009 revealed disc protrusions at the L3-L4 and L5-S1 levels with a disc bulge at L4-L5. (PX2). Petitioner underwent physical therapy at Gottlieb Memorial Hospital from August 20, 2009 through October 12, 2009. (PX2). Petitioner indicated that she remained off work during this time.

On September 15, 2009 Petitioner visited Dr. Martin Lanoff at the request of the Respondent for purposes of a §12 examination. (RX2). Dr. Lanoff opined that Petitioner sustained a lumbar strain injury which was causally related to the July 24, 2009 work incident, that she required three weeks of continued physical therapy and that she could return to work full duty. (RX2).

On October 2, 2009 Petitioner sought treatment with Dr. Zaki Anwar at Instant Care Medical Group. (PX3). Dr. Anwar recorded a history of a work accident on July 24, 2009 and noted that Petitioner was complaining of severe low back pain. (PX3). Dr. Anwar reviewed the MRI and diagnosed the Petitioner with disc herniations at L3-L4, L5-S1 and a disc bulge at L4-L5. (PX3). Dr. Anwar recommended a course of epidural steroid injections at the L3-L4 and L5-S1 levels which Petitioner received October 9, 2009, October 30, 2009 and November 10, 2009. (PX3). On October 16, 2009 Dr. Anwar continued Petitioner off work until October 19, 2009. (PX4).

Petitioner underwent an FCE on November 19, 2009. In addition, Petitioner underwent a course of work conditioning at Resurrection Health Care from November 23, 2009 through December 11, 2009. (PX3).

On December 18, 2009 Petitioner followed up with Dr. Anwar who noted 80-90% pain relief with the course of injections and work conditioning. (PX4). Dr. Anwar released the Petitioner to return to work full duty at that time. (PX4). Petitioner testified that she continued to have pain in her lower back.

On April 23, 2010 Petitioner returned to Dr. Anwar with complaints of continued pain in her lower back. (PX4). Due to Petitioner's failure to adequately respond to conservative measures, Dr. Anwar recommended a discogram. (PX4). Petitioner testified that she continued to work at that time.

On April 30, 2010 Petitioner underwent a discogram that indicated severe discogenic pain at L4-L5 and L5-S1. (PX4). The post-discogram CT scan revealed a 7 mm disc herniation at L5-S1 with an extruded nucleus pulposus and annular tear. (PX4). Petitioner returned to see Dr. Anwar on May 7, 2010, at which time a microdiskectomy was recommended. (PX4). On May 14, 2010 Dr. Anwar performed a microdiskectomy at L5-S1. (PX3, PX4). Petitioner was taken off work following the surgery. (PX4).

Petitioner followed up with Dr. Anwar on May 21, 2010 at which time she was continued off work. (PX4). On June 4, 2010 Petitioner again saw Dr. Anwar at which time it was noted that "[t]he patient is recovering pretty good three weeks after the lumbar microdiskectomy, and is ready to go back to work on 06/07/10. Patient has reached maximum medical improvement at this point, and will need to manage with medication as well as a home exercise program." (PX4). At the time of his examination on June 18, 2010 Dr. Anwar noted that Petitioner had responded very well to treatment, was doing a home exercise program and was "... ready to go back to work on a full-duty status at this point, but we also consider this patient to go for a work hardening and conditioning exercise with her work to get the maximum benefit." (PX4). On July 9, 2010 Petitioner followed up with Dr. Anwar and a course of work conditioning was recommended. (PX4). She noted that she underwent a course of work conditioning at ATI Physical Therapy from August 4, 2010 through September 5, 2010.

On July 21, 2010 Petitioner returned to Dr. Lanoff for a second §12 examination at which time the latter opined that Petitioner required no further medical care and could work in a full duty capacity. (RX4).

On August 6, 2010 Petitioner was seen by Dr. Anwar who recommended continued work hardening and that Ms. Flores stay off work until September 6, 2010. (PX3).

On August 17, 2010 Dr. Lanoff authored an addendum report that indicated that none of Petitioner's treatment was medically indicated. (RX5).

On September 3, 2010 Petitioner returned to Dr. Anwar who noted that Ms. Flores still had radiculopathy and recommended yoga. (PX3). Petitioner was returned to work in a light duty capacity.

Petitioner followed up with Dr. Anwar on October 2, 2010, October 15, 2010 and October 29, 2010 and continued to complain of pain in her lower back. (PX3). On November 19, 2010 Dr. Anwar recommended a course of chiropractic therapy which was performed by Dr. Michael Ponterelli of Windy City Wellness from December 1, 2010 to January 21, 2011. (PX6).

At the time of an office visit on February 25, 2011, Dr. Anwar opined that Petitioner was at maximum medical improvement with medication and released Ms. Flores to full duty work. (PX3). Petitioner returned to Dr. Anwar on April 1, 2011 complaining of continued low back pain. (PX3). Dr. Anwar recommended an MRI and continued Petitioner on full duty work. (PX3). An MRI of the lumbar spine performed on April 6, 2011 revealed a 3-4mm right-sided disc herniation at L5-S1. (PX4). On April 29, 2011 Dr. Anwar recommended a repeat microdiskectomy and referred Petitioner to his partner, Dr. Amit Mehta, for a second opinion. (PX3). On August 9, 2011 Petitioner visited Dr. Mehta who diagnosed failed back syndrome and recommended that Petitioner see a neurosurgeon. (PX3).

On August 16, 2011 Petitioner visited neurosurgeon Dr. Martin Herman at the Center for Brain and Spine Surgery. (PX5). Dr. Herman diagnosed Petitioner with a herniated disc at L5-S1 which he believed was causally related to the July 24, 2009 work injury. (PX5). Dr. Herman discussed a potential fusion surgery with the patient, but noted that Petitioner was disinclined to undergo such a procedure due to her young age. (PX5). Dr. Herman went on to opine that Petitioner was at maximum medical improvement and that her back condition is likely permanent and will require intermittent pain medication. (PX5).

On September 1, 2011 Petitioner saw Dr. Anwar who again recommended a repeat microdiskectomy. Petitioner testified that she does not wish to have a repeat microdiskectomy performed. She noted, however, that she continues to have pain for which she presently takes Tylenol. She further testified that prior to July 24, 2009 she had no complaints of low back pain and had received no treatment for any back condition.

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:

In order for an injury to be compensable under the Workers' Compensation Act, the injury must "arise out of" and "in the course of" the employment. (Ill. Rev. Stat. 1987, ch. 48, par. 138.2.). The phrase "in the course of" refers to the time, place and circumstances under which the accident occurred. Illinois Bell Telephone Co. v. Industrial Comm'n, 131 Ill. 2d 478, 483, 546 N.E.2d 603, 137 Ill. Dec. 658 (1989). The words "arising out of" refer to the origin or cause of the accident and presuppose a causal connection between the employment and the accidental injury. Illinois Bell Telephone Co., 131 Ill. 2d at 483. Both elements must be present at the time of the claimant's injury in order to justify compensation. Illinois Bell Telephone Co., 131 Ill. 2d at 483.

In the present case, there would appear to be no question that Petitioner was performing her job duties and thus was "in the course of" her employment at the time of the incident. The issue in dispute is whether the injury "arose out of" the incident in question.

An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury. *Nacoste Industries v. Industrial Commission*, 353 Ill.App.3d 1056, 1060, 820 N.E.2d 531, 534, 289 Ill.Dec. 755, 758 (Ill.App. 5 Dist. 2004). A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his or her duties. *Nacoste*, 820 N.E.2d at 534-535. Also, if the employee is exposed to a risk to a greater degree than the general public, the injury is similarly considered to have arisen out of his employment. *Komatsu Dresser Co. v. Industrial Commission*, 235 Ill.App.3d 779, ___, 601 N.E.2d 1339, 1344, 176 Ill.Dec. 641, 646 (Ill.App. 2 Dist. 1992) (court found that machinist's aggravation of pre-existing lower back condition following act of bending over to pick up part "arose out of" employment); see also *Kemp v Industrial Commission*, 264 Ill.App.3d 1108, 636 N.E.2d 1237, 201 Ill.Dec. 805 (court determined that meter reader was exposed to risk greater than general public when required to frequently bend and stoop to read air gauges approximately one foot off the ground on uneven construction sites); *Nacoste*, supra (court determined that injury occasioned when claimant stepped down six inches off machine platform "arose out of" her employment).

In the present case, Petitioner testified that she was cleaning a standing tanning booth, which she estimated was approximately 6' tall from top to bottom, when she felt excruciating pain in her lower back. She noted that she had begun her work day at about 1:00 pm on the date in question and that the incident occurred between 6:00 pm and 7:00 pm. In addition to the cleaning of tanning booths, Petitioner indicated that her job duties involved preparing daily reports, tracking numbers, doing scheduling, addressing payroll and taking care of clients. Along these lines, she estimated that she would see a minimum of 60 and up to 120 clients a day. Petitioner stated that in cleaning the tanning booths she would have to reach up and bend down. She also agreed with the recorded statement she provided the adjustor (RX1) in that she had discomfort in her lower back before she experienced the excruciating pain in her lower back, and that she did not feel said discomfort until she squatted down. When asked whether she cleaned 30 beds a day, or about 3 per hour, Ms. Flores indicated that it varies but that that sounded correct. Petitioner testified that she had no back injuries, or treatment for same, prior to the incident question.

Respondent argues that this testimony, along with the various histories, is consistent with the fact that Petitioner simply bent at the waist when she experienced the onset of her lower back symptoms, and that in doing so Ms. Flores was not exposed to a risk of injury greater than a member of the general public because of her employment. The Arbitrator disagrees. More to the point, the Arbitrator finds that while the act of bending

over at the waist is indeed not an activity that is unique to her employment, the fact that she would have to wipe down a 6 foot tall tanning booth from top to bottom approximately 30 times a day was.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner sustained accidental injuries arising out of and in the course of her employment on July 24, 2009.

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

Following the accident Petitioner complained of pain in her lower back. These pain complaints have been consistently documented in the Petitioner's medical records since her date of injury. Dr. Anwar, Dr. Mehta and Dr. Herman all have opined that Petitioner's current condition of ill-being is causally related to her work injury. Objective medical evidence in the form of MRIs performed on August 19, 2009 and April 6, 2011 and a provocative discography performed on April 30, 2010 substantiate Petitioner's pain complaints. Further, the operative report from the May 14, 2010 microdiskectomy demonstrates that extruded disc material was aspirated, which is entirely consistent with Petitioner's MRI reports and diagnosis. (PX3). Petitioner testified that she continues to have pain in her lower back and currently attempts to manage this pain with over the counter pain medication.

Respondent relies on the opinion of Dr. Lanoff who noted that there was no objective medical evidence to legitimize Petitioner's pain complaints. This is contradicted, however, by Petitioner's MRI scans, discography, and operative report. In addition, Dr. Lanoff notes in his July 21, 2010 report that Petitioner had 0/5 Waddell's signs, which would seem to argue against malingering. (RX4). Further, while Dr. Lanoff noted "degenerative changes" in the MRI's, the evidence shows that Petitioner had no prior history of back injury or treatment and was asymptomatic during the period leading up to the accident in question. Therefore, even if one were to say that Petitioner's back condition pre-existed the incident there is ample evidence to find that the accident aggravated and/or accelerated said condition.

Accordingly, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the credible evidence that her current condition of ill-being is causally related to the incident at work on July 24, 2009.

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 a result of the Petitioner's July 24, 2009 work related injury Petitioner sustained disc herniations at L3-L4 and L5-S1. Petitioner initially underwent a course of conservative medical treatment consisting physical therapy, pain medication, injections and work conditioning. When the pain did not abate, Dr. Anwar recommended discography and a microdiskectomy at L5-S1.

Respondent relies on a utilization review (UR) report dated June 28, 2010 to dispute the reasonableness and necessity of Petitioner's discography and microdiskectomy. (RX3). This UR report indicates that the principle reason for non-certification of medical treatment including the microdiskectomy and discography is that the Petitioner was "relatively pain free" and that she did not complain of radicular symptoms. (RX3). However, the medical records, in conjunction with Petitioner's credible testimony, shows that Ms. Flores continued to experience ongoing lower back complaints, including radicular symptoms, following the accident and that she

continued to seek treatment for same. Therefore, the Arbitrator finds the UR report findings to be unpersuasive and rules that Petitioner's medical treatment, including the discography and microdiskectomy, was reasonable and necessary under the circumstances.

The parties submitted into evidence an agreed stipulation outlining the amount of medical expenses that would be due and owing pursuant to the fee schedule in the event this matter was found compensable, with Respondent maintaining its objection as to liability as well as the reasonableness and necessity of said expenses. (Arb.Ex.#2). Based on this stipulation, the parties agreed that $70,102.93 would be due pursuant to the fee schedule for dates of services from October 9, 2009 through September 1, 2011. (Arb.Ex.#2).

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses totaling $70,102.93 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

The medical records show that Petitioner was taken off work July 25, 2009 and remained off work until being released by Dr. Anwar effective October 18, 2009. Respondent relies on the opinion of its §12 examining physician, Dr. Lanoff, to the effect that Petitioner was capable of full duty work effective September 15, 2009. However, the preponderance of the credible medical evidence shows that Petitioner was unable to work during this time.

Petitioner was subsequently taken off work on October 30, 2009 following her second epidural steroid injection with Dr. Anwar and was not returned to work until December 20, 2009. Respondent paid TTD benefits during that time.

Petitioner was next taken off work by Dr. Anwar on May 14, 2010 following the microdiskectomy and was returned to work on June 7, 2010.

Finally, Petitioner was again taken off work by Dr. Anwar on August 6, 2010 and returned to work on September 6, 2010.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner was temporarily totally disabled from July 25, 2009 through October 18, 2009, from October 30, 2009 through December 20, 2009, from May 14, 2010 through June 7, 2010 and August 6, 2010 through September 6, 2010, for a period of 28-6/7 weeks. The Arbitrator notes that Respondent is entitled to credit for TTD benefits paid in the amount of $5,969.58. (See Arb.Ex.#1).

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

Petitioner sustained herniated discs at L3-L4 and L4-L5 and a disc bulge at L4-L5. Petitioner underwent a microdiskectomy at L5-S1 on May 14, 2010. A subsequent MRI performed on April 6, 2011 revealed a 3-4mm disc herniation at L5-S1. Petitioner's physician, Dr. Anwar, opined that Petitioner was a candidate for a repeat microdiskectomy at that level while neurosurgeon Dr. Herman discussed possible fusion surgery at that level. However, Petitioner has refused further surgical intervention and therefore has reached maximum medical

improvement. Petitioner testified to on-going pain and continues to take over the counter pain medication as of the date of trial.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 20% 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

James Arwood,

Petitioner,

14IWCC0676

vs.

NO: 12WC 11421

State of Illinois - Department of Corrections,

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, prospective medical, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 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.

14IWCC0676

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: AUG 14 2014
o080614
CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

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

14IWCC0676

ARWOOD, JAMES
Employee/Petitioner

Case# **12WC011421**

SOI DEPT OF CORRECTIONS
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:

1097 SCHWEICKERT & GANASSIN
SCOTT GANASSIN
2101 MARQUETTE RD
PERU, IL 61354

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

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE C COPELAND
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

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)

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

14IWCC0676

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

James Arwood,
Employee/Petitioner

v.

State of Illinois Department of Corrections,
Employer/Respondent

Case # **12** WC **11421**

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 **Ottawa, Illinois**, 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 _____

FINDINGS

On the date of accident, **February 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.

14IWCC0676

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

In the year preceding the injury, Petitioner earned **$79,364.88**; the average weekly wage was **$1,526.25**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **1** dependent children.

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

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

Respondent is entitled to a credit of **$779.32** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $162.00 to Illinois Valley Orthopedics, $7,722.22 to Dr. Blair Rhode, $96.00 to Illinois Valley Community Hospital and $124.00 to Hospital Radiology, it should further repay the Petitioner's out of pocket expense of $15.00, as provided in Sections 8(a) and 8.2 of the Act.

Pursuant to Section 8(a) of the Act, Respondent shall provide the medical care recommended by Dr. Blair Rhode to include a left elbow/arm lateral epicondyle release and associated ancillary care.

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

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

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

Signature of Arbitrator

7/22/13
Date

ICArbDec19(b)

JUL 23 2013

FINDINGS OF FACT:

James Arwood, Petitioner in this matter, testified he has worked about 8 ½ years as a stationary fireman for Respondent, State of Illinois, Department of Corrections, at the Sheridan correctional facility. This job requires him to perform, among other things, boiler inspections. To perform this job, he is required to travel between buildings and inspect the heating system. On February 14, 2012, he was performing this task.

Petitioner provided that on this date, he was accompanied by an inmate assistant and because of this assistant, he was required to vary his travel pattern between buildings while performing his boiler maintenance and inspection activities.

On February 14, 2012, Petitioner and his inmate assistant were required to inspect the boilers located in the C-1 building. This structure is used to house inmates and some correctional center offices. The boiler system is located on the lower level. Petitioner testified the boiler area must be accessed through an exterior stairwell located at the north end of the building. These stairs consist of concrete and have a single rail located on one side of the descending stairs. Petitioner testified that as he approached these steps, he carried a clipboard in one hand and keys in the other. Mr. Arwood also maintained an eye on the inmate assistant he was assigned.

Petitioner testified that as he descended the stairway to the boiler room, the inmate assistant was following several feet behind. While a few steps from the bottom, this inmate asked a question of Petitioner. Mr. Arwood testified that as he turned toward the inmate the front of one of his feet struck a metal toe plate at the edge of the stair. This caused him to fall forward, miss the remaining stairs and strike the ground. Petitioner explained he was unable to stop or break his fall due to the clipboard and keys he carried. Mr. Arwood struck his right knee and head on the sidewall of the stairway as he fell. He then reports landing awkwardly on the ground injuring his right foot, left elbow and left ankle. Px 5. Mr. Arwood explained that after a few moments he was able to get up and continue his inspection of the C-1 building.

After this inspection, he reported his fall to the chief engineer, Jerry Daly. Mr. Arwood next completed an accident report and was sent to the health care unit at the prison. Rx 1. Petitioner testified that the nurse at this unit did little to reduce his pain and discomfort. As a result, he was sent to the Illinois Valley Community Hospital and seen in their Occupational Health Department. At this facility, Petitioner provided a history of falling down stairs at work and injuring his right foot, left elbow and left ankle. Px 5. A nurse practitioner, Debra Tostovarsnik, provided a restriction that required him to sit 90% of the day, use over the counter Ibuprofen for pain and apply ice every 2 hours for 20 minutes. Id. He could weight bear as tolerated and should elevate the right foot as needed. Id. A heel cushion was also prescribed. Id.

Petitioner testified he provided these work restrictions to Respondent and was then told no work was available within these restrictions. As such, Petitioner remained off work. He was off for 3 days of work and was originally paid by Respondent for this time. However, Respondent subsequently disputed the occurrence and demanded a return of the money. Respondent accomplished this by taking 3 days of pay out of Mr. Arwood's accumulated sick time. Petitioner testified he returned to work thereafter.

Petitioner returned to the Occupational Health Department on February 21, 2012. The note of that visit reflects Petitioner's multiple contusions were improving. Px 5. Petitioner was released to full duty. Id.

On his return to work, Mr. Arwood explained he had continuing problems with his right foot, especially the heal. Id. However, he indicated his more significant problem was his left arm as it occasionally locked in

place at the elbow. Id. Because Petitioner continued to experience these issues, he was referred to Dr. Peter Meier, an orthopedic surgeon at the Illinois Valley Community Hospital. Id.

Dr. Meier visited with Petitioner on March 12, 2012 and recorded the same history collected by others. Px 2, 4, 5 and Rx 1. This doctor explained Petitioner has continuing complaints of right foot and left elbow pain from his fall at the Sheridan Correctional Center. Id. Regarding these complaints, Dr. Meier noted pain in the plantar aspect of Petitioner's right foot was worse in the morning. Id. He found tenderness over the medial tuberosity of the os calcis of the right foot. Id. An exam of the left elbow revealed tenderness medially. Id. Dr. Meier wrote Petitioner suffered from right plantar fasciitis and a left elbow contusion. Id. He suggested heal cord stretching exercises, use of Ibuprofen or Naproxen and was told to return as needed. Id. Petitioner indicated he then tried to live with the injuries as best he could. However, because these problems continued, he felt it necessary to see his physician, Dr. Joel Leifheit on July 20, 2012.

Dr. Leifheit indicates Petitioner had left elbow pain and complaints that this joint would lock up. Px 3 & 4. As a result of Petitioner's continuing complaints, Dr. Leifheit referred Mr. Arwood to see Dr. Blair Rhode, an orthopedic surgeon. Id.

On August 2, 2012, Dr. Rhode met with Petitioner. Px 4. Dr. Rhode reported Petitioner was being seen for a work related injury sustained on February 14, 2012 when he fell down a set of stairs at the State prison. Id. Petitioner had left elbow complaints including pain and problems with use related to the accident. Id. Dr. Rhode wrote Mr. Arwood's right heel injury slowly improved after the accident but he continues to experience a locking and catching sensation in his left elbow. Id. After an examination, Dr. Rhode felt Petitioner's complaints were consistent with an intra-articular loose body. Id. As such, he recommended a MRI of the left elbow to assess this. Id. He further wrote Petitioner could maintain full duty work. Id.

The left elbow MRI prescribed by Dr. Rhode was performed on September 19, 2012. Id. This test indicated Mr. Arwood's left elbow area suffered from mild chondromalacia of the ulnar aspect of the superior surface of the radial head with subchondral fluid being present. Id. Elbow joint effusion was noted as well as common extenstor tendinosis with an intrasubstance partial tear along the insertion inferiorly. Id. Common flexer tendinosis and an intrasubstance tear was also found along with distal biceps tendinosis at the insertion into the bicipital tuberosity of the radius. Id.

Dr. Rhode next met with Petitioner on September 27, 2012. Id. At that visit, Mr. Arwood continued to experience significant left elbow pain as well as a catching sensation. Id. Dr. Rhode reviewed the MRI and wrote Petitioner demonstrates evidence of common extensor tendinopathy and a partial thickness tear. Id. Because the medial and lateral epicondyle demonstrated pain on palpation, Dr. Rhode injected the same with Kenolog and Lidocaine. Id. Petitioner reported this provided limited relief. After the injection, Petitioner was provided home stretching exercises and told to follow up again in 4 weeks. Id. Mr. Arwood visited with Dr. Rhode again on October 25, 2012. Id. The notes of this visit indicate Petitioner experienced continued pain and catching in the left elbow area. Id. As such, Dr. Rhode recommended a left lateral epicondyle release surgery. Id.

At his March 7, 2013 appointment, Dr. Rhode reexamined Petitioner's left arm and reported continued elbow pain. Id. He indicated Mr. Arwood's complaints of pain were increasing. Id. A cortisone injection was placed into the left elbow. Id. Petitioner indicated this provided limited relief. Surgery was again discussed at this appointment. Id. Mr. Arwood expressed his desire to have this surgery performed to relieve his pain and discomfort.

Since this accident, Petitioner has incurred $9,511.22 in medical expenses for the treatment of his injuries. Px 1. Of that amount, Petitioner's group insurance paid $779.32. Id. Insurance discounts of $612.68

have been taken. Id. Petitioner has also paid $15.00 out of his pocket towards his medical bills. Id. After taking into account the credits for payments made and Petitioner's out of pocket expense, there are unpaid bills of $8,104.22. Id.

With respect 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 as follows:

Mr. Arwood's position as a stationary fireman at the Sheridan Correctional Center required him to do maintenance on boilers and various piping throughout the facility. As part of that job, he also had an inmate assistant that he supervised. Mr. Arwood testified that when accompanied by an inmate assistant, you are to remain vigilant of their activities. On this date, Petitioner was traversing steps to the lower level of the C-1 building that provides inmate housing as well as some offices. While descending a set of outside steps, Petitioner's inmate assistant, who was behind him at the time, began speaking. Petitioner turned to the inmate and continued down the stairs. As he did this, Petitioner lost his footing and hit a toe plate at the end of one of the stairs with his shoe, missing this step and then falling down the next two stairs to the floor of the stairwell. Petitioner was unable to break his fall because of the keys and clipboard he was carrying.

This accident was then reported to Jerry Daly, the chief engineer, on the same day of the accident, February 14, 2012. Mr. Arwood next reported to the health unit at the prison. He did so and explained to the nurse how he was injured. Mr. Arwood indicates that after this explanation, he was told that there was little they could do for him there. As such, he was next required to see the Illinois Valley Community Hospital's Occupational Health Department. He reported there on February 15, 2012.

Petitioner has consistent histories from the Illinois Valley Community Hospital Occupational Health Department, Dr. Joel Leifheit, Dr. Peter Meier and Dr. Blair Rhode. They report Petitioner's condition of ill-being occurred as the result of a fall at the Sheridan Correctional facility. Initially, Petitioner's injuries included his right foot, left ankle and his left elbow. Over time, Petitioner's left ankle and right foot improved. However, the left elbow condition did not and continued to be a source of pain and discomfort including issues with it locking during use.

A September 19, 2012 MRI demonstrated Petitioner had mild chondromalacia of the ulnar aspect of the superior surface of the left radial head with an accumulation of subchondral fluid. Elbow effusion along with common extensor tendinosis and intrasubstance partial tearing was found. Distal biceps tendinosis in the left elbow was also noted.

After this MRI, Dr. Rhode confirmed Mr. Arwood requires surgery, including a left lateral epicondyle release and that this is related to Petitioner's work accident of February 14, 2012.

As Petitioner was involved in a work activity at the time of his fall, traversing steps to a location that required inspection and being distracted by his inmate assistant at the time of the occurrence, this Arbitrator finds that an accident did occur that arose out of Petitioner's employment by Respondent. The Arbitrator finds that the general public is not subjected to descending stairs while being cognizant of the whereabouts of an inmate. As such, Petitioner's act of descending stairs places him at a greater risk than that of the general public.

The medical records provide a consistent history that Petitioner's injuries are related to this fall. There is no contrary evidence. There has been no evidence indicating Petitioner had a pre-existing problem which required any care or treatment.

Following consideration of the testimony and evidence presented, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on February 14, 2012. The Arbitrator further finds that Petitioner's current condition of ill-being is causally related to his work injury.

With respect to (L.) What temporary benefits are due (TTD), the Arbitrator finds as follows:

In this case, evidence submitted show Petitioner was off work for a total of 3 days before he returned to his usual duties. The Act provide that if the period of temporary total incapacity for work last more than 3 working days, weekly compensation shall be paid beginning on the 4th day of temporary total incapacity and continuing as long as the total temporary incapacity lasts. As such, Petitioner failed to prove entitlement to any temporary total disability.

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; K. Is Petitioner entitled to any prospective medical care, the Arbitrator finds as follows:

Petitioner's care and treatment started the day of his accident. He reported to the health care facility at the Sheridan Correctional Center and found that there was little that could be done for him there. The next day, he was required by Respondent to report to the Illinois Valley Community Hospital Occupational Health Department. After multiple attempts to treat his condition, he was referred by that facility to see Dr. Peter Meier, an orthopedic surgeon. Like the Occupational Health Department, Dr. Meier also reported Petitioner fell at his place of employment and suffered injury.

At the Occupational Health Department, Mr. Arwood also spoke with Dr. Leifheit. He testified Dr. Leifheit provided a referral to Dr. Blair Rhode. Dr. Rhode met with Petitioner and provided the injuries were from his work injury of February 14, 2012. Initially, these injuries included multiple body parts, the right foot, left elbow and left ankle. After the passage of time and the treatment received, Petitioner's condition of ill-being has improved with his left elbow being his only significant source of pain. A MRI was performed on September 19, 2012 indicating the existence of chondromalacia with subchondral fluid accumulation, joint effusion and common extensor tendinosis with an intrasubstance partial tear. There was also reported distal biceps tendinosis in the same arm. Mr. Arwood's records reflect, as did his testimony, that he has continuing complaints of pain and discomfort in his left arm with a consistent catching sensation that prevents him from moving the elbow at various times of the day. To treat his injuries, Petitioner has obtained care with the Illinois Valley Community Hospital Occupational Health Department, Dr. Meier and Dr. Rhode.He has tried oral medications and undergone injections to the left arm and elbow. Petitioner testified injections have provided some relief but it has been incomplete. As a result, Mr. Arwood wants to undergo surgery as recommended by Dr. Rhode.

Following consideration of the testimony and evidence presented, the Arbitrator finds that the medical services that were provided to Petitioner were reasonable and necessary. Petitioner submitted payment for the reasonable and necessary medical services which are reflected in Px 1, a total $9,511.22 (Dr. Leifheit: $170.00, Illinois Valley Orthopedics/Dr. Meier: $162.00, Orland Park Orthopedic / Dr. Rhode: $7,722.22, Illinois Valley Community Hospital: $1,333.00, and Hospital Radiology: $124.00). Of this amount, Petitioner's insurance has paid $779.32. Respondent is entitled to a credit for this payment and shall hold Petitioner harmless from any subrogation claim or request for reimbursement by the group carrier. Insurance discounts of $612.68 have been received and Petitioner also paid $15.00 out of pocket. Id. There is $8,104.22 in medical expenses which remain unpaid (Illinois Valley Orthopedics/Dr. Meier: $162.00, Orland Park Orthopedic / Dr. Rhode: $7,722.22, Illinois Valley Community Hospital: $96.00, and Hospital Radiology: $124.00). Px 1. Respondent shall

reimburse Petitioner his out of pocket expense of $15.00 and further satisfy the outstanding medical expenses of $8,104.22 pursuant to the Illinois Worker's Compensation Fee Schedule.

Petitioner is further entitled to prospective medical care for his work related injury to his left elbow and arm. There is no evidence to the contrary which would indicate this treatment is anything other than reasonable and necessary. Respondent shall provide Petitioner with the care and treatment recommended by Dr. Blair Rhode that includes a left elbow epicondyle release and associated ancillary care.

With respect to (M.) Should penalties or fees be imposed upon Respondent, the Arbitrator finds as follows:

Following consideration of the testimony and evidence presented, this Arbitrator finds penalties are not appropriate under these circumstances. As such, none are awarded.

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

Terry Williams,

Petitioner,

vs.

City of Chicago,

Respondent.

14IWCC0677

NO: 10 WC 45478

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 31, 2014 is hereby affirmed and adopted.

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

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

14IWCC0677

The party commencing 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: AUG 14 2014
o8/6/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0677

WILLIAMS, TERRY
Employee/Petitioner

Case# **10WC045478**

CITY OF CHICAGO
Employer/Respondent

On 1/31/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4239 LAW OFFICES OF JOHN S ELIASIK
180 N LASALLE ST
SUITE 3700
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
JOHN D WHEELER
140 S DEARBORN 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

14IWCC0677

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Terry Williams
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **10** WC **45478**

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 **September 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 _____

14IWCC0677

FINDINGS

On **11/12/2010**, 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 **$69,246.84**; the average weekly wage was **$1,331.67**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$24,096.88** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$24,096.88**.

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

ORDER

As he finds Petitioner has failed to prove that he sustained an accident that arose out of and in the course of his employment by Respondent, the Arbitrator hereby denies compensation. 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.

Signature of Arbitrator

January 31, 2014
Date

JAN 31 2014

STATE OF ILLINOIS)
)
COUNTY OF COOK) 14IWCC0677

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Terry Williams,)
)
Petitioner,)
)
vs.) No. 10 WC 45478
)
)
City of Chicago,)
)
Respondent.)

STATEMENT OF FACTS

Petitioner's Testimony

Mr. Terry Williams, the Petitioner, testified he is employed by the City of Chicago. Specifically, he works in the Streets and Sanitation Department driving a garbage pick-up truck. The Petitioner testified that he has worked in this capacity for the City of Chicago for approximately 15 years.

His daily work activities include picking up garbage from various sites along his route and depositing the garbage at the dump site at the end of the day. The Petitioner testified that the dump site is located at 61st Street and State in the City of Chicago. The Petitioner testified that his work day began at 6:00 A.M. when he picked up his truck at the lot site, located at 52nd and Oakley. The Petitioner testified he drove a regular route ending at the dump site at 61st Street and State. Subsequently the Petitioner returned to the lot site at 52nd and Oakley to clock out for the day. The Petitioner testified that on a normal day he clocked out at approximately 2:30 P.M.

The Petitioner testified that he sustained an injury to his left knee on November 12, 2010. The Petitioner testified he was attempting to get back into the cab of his truck when he slipped. The Petitioner noted that he hit his left knee on the step leading into the cab of his truck. The Petitioner testified that he fell to the ground and into some mud. The Petitioner specifically noted that he was covered in black mud from his shoulders all the way down to his feet. The Petitioner noted that he yelled when he fell however no one came to his aid. The Petitioner specifically noted that no one saw him fall at the dump site on November 12, 2010.

The Petitioner noted that he felt pain in his knee and he returned to the lot site to clock out for the day. Upon arrival at the lot site, the Petitioner entered the trailer to clock out for the day. Petitioner testified that there were a number of other Street and Sanitation employees in the trailer at that time. The Petitioner specifically named individuals named: Mr. Lipsy, Mr. Spearman, Mr. Crump, Mr. Bennett and Mr. Parker.

The Petitioner noted that while inside the trailer Mr. Bennett insulted him because he was covered in mud and was emitting a foul odor. The Petitioner testified that his supervisor, Mr. Rubio, was in the trailer. Mr. Rubio asked the Petitioner if everything was "OK." The Petitioner testified that everything was "OK" and then he clocked out for the day.

The Petitioner testified that his left knee became increasingly painful on the following day, Saturday November 13th. Despite the pain the Petitioner testified that he did not seek any medical attention on November 13th. The Petitioner testified that he did not seek any medical attention on Sunday November 14th either.

The Petitioner testified that he returned to work on the morning of November 15th for his normal shift. The Petitioner noted that he worked a full shift from approximately 6:00 A.M. to 2:30 P.M. The Petitioner testified that on the evening of the 15th he presented to the University of Chicago Emergency Room.

Petitioner testified that at the Emergency room he reported pain in his left knee. According to the Records, the Petitioner indicated that he sustained a direct blow to his left knee approximately one week ago from standing height (RX2). The medical records also indicate that the Petitioner stated he injured his left knee due to tripping (RX2). Another notation indicates that the Petitioner sustained an injury to his left knee due to a slip and fall with sludge (RX2). At no point in the medical records from the University of Chicago does it indicate that the Petitioner sustained an injury to his left knee due to a work incident (RX2).

With respect to his medical treatment, the Petitioner noted that he underwent a number of tests, was placed off work and told to follow up with an orthopedic surgeon (RX2). The medical records indicate that the Petitioner sustained a left quadriceps tendon rupture and would likely require surgical intervention (RX2).

The Petitioner specifically testified that he did not work on Tuesday November 16th.

The Petitioner testified that he went to work the following morning, November 17th, for his regularly scheduled shift. The Petitioner testified that upon arrival he was told to present to Mercyworks for an examination of his left knee. The Mercyworks records dated November 17, 2010 indicate that the Petitioner sustained an injury to his left knee that morning at approximately 6:10 A.M. (RX4). The records specifically indicate that the Petitioner slipped on a rock causing him to injure his left knee on the steps of the truck (RX4). At no point in the Mercyworks medical records does it indicate that the Petitioner sought treatment at the University of Chicago on November 15th (RX4).

The Petitioner testified that he returned to work the following day to complete an incident report with Mr. Rubio. The Report indicates that the injury occurred at the lot site at 52nd and Oakley on the morning of November 17, 2010 (RX1). The Report indicates that on the morning of the 17th, the Petitioner slipped in the yard at the 52nd Street lot while going to get his truck (RX1). The Report indicates that the Petitioner called his supervisor and presented to MercyWorks that day (RX1).

With respect to the Petitioner's medical treatment, the Petitioner noted he choose to pursue treatment with Dr. Bush-Joseph. The Petitioner underwent quadriceps tendon repair surgery on

December 6, 2010 (RX4). The Petitioner tolerated the procedure well and there were no complications (RX4). Following surgery, the Petitioner testified he pursued a course of conservative recovery treatment. On May 23, 2011 Dr. Bush-Joseph cleared the Petitioner to return to work in a full duty capacity (RX4). The Petitioner testified that he since he has returned to work he has had no problems or issues with his left knee. The Petitioner noted he has continued to work in a full duty capacity and is able to complete all of his job duties.

The Petitioner testified that he previously filed an application for adjustment of claim for an injury he sustained in 2009. The Petitioner testified that he sustained an arm injury and the matter was resolved via settlement. The Petitioner noted that due to this prior experience he was generally familiar with workers' compensation. The Petitioner indicated that when he sustained his arm injury in 2009 he immediately reported it to his supervisor.

The Petitioner testified that his original application for adjustment of claim listed a date of accident of November 17, 2010 (RX5). Petitioner noted that he signed the application for adjustment of claim indicating that all of the information contained within was accurate. Petitioner testified that he signed the application for adjustment of claim on November 23, 2010 (RX5). Petitioner noted that the application for adjustment of claim was not amended until June 19, 2013, or 950 days after November 12, 2010.

Mr. Echols Testimony

Mr. Echols testified that as of November 12, 2010 he was employed by the City of Chicago within the Streets and Sanitation Department. Mr. Echols indicated that he was employed as a garbage truck driver and he is still employed in the same capacity today.

Mr. Echols testified that on November 12, 2010 he was at the dump site at 11:00 A.M. Mr. Echols indicated that he did not see the Petitioner fall. Mr. Echols noted that the Petitioner was standing near his vehicle. Mr. Echols specifically noted that the Petitioner had brown mud only on his left leg. Mr. Echols did not indicate that the Petitioner was covered in black mud from his shoulders down to his feet.

Mr. Crump Testimony

Mr. Crump testified that as of November 12, 2010 he was employed by the City of Chicago within the Streets and Sanitation Department. Mr. Crump indicated that he was employed as a garbage truck driver and he is still employed in the same capacity today.

Mr. Crump testified on November 12, 2010 while clocking out for the day when he encountered the Petitioner. Mr. Crump noted that the Petitioner had mud on him. Mr. Crump noted that other employees were "making fun" of the Petitioner because of the mud.

Mr. Lipsey Testimony

Mr. Lipsey testified that as of November 12, 2010 he was employed by the City of Chicago within the Streets and Sanitation Department. Mr. Lipsey indicated that he was employed as a garbage truck driver and he is still employed in the same capacity today.

Mr. Lipsey testified that on November 12, 2010 while clocking out for the day he encountered the Petitioner. Mr. Lipsey noted that the Petitioner had mud on him. Mr. Lipsey noted that other employees were "making fun" of the Petitioner because of the mud.

CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner failed to meet his burden by a preponderance of the evidence that an accident occurred that arose out of his employment with the Respondent on November 12, 2010.

The Arbitrator notes that the Petitioner was familiar with workplace accident procedures and workers' compensation. Petitioner testified that he sustained an arm injury in 2009. Petitioner testified that he reported the incident to his supervisor immediately and completed the necessary paperwork. Petitioner noted an application for adjustment of claim was filed and the parties reached a settlement. Therefore the Arbitrator finds that the Petitioner was familiar with standard workplace accident procedures at the time of the alleged accident on November 12, 2010 including but not limited to the reporting of accidents.

The Arbitrator finds that the Petitioner's treating medical records from the University of Chicago support the Respondent's position. The medical records indicate that the Petitioner presented to the University of Chicago Medical Center at 7:28 P.M. on November 15, 2010 (RX2). According to the medical records, the Petitioner gave multiple versions of when the accident occurred (RX2). The Petitioner initially noted that the accident occurred one week prior, on November 8, 2010 (RX2). Subsequently the Petitioner noted that the accident occurred the prior Friday (RX2). Therefore the Petitioner provided multiple accident dates and was unable to identify the specific date of the alleged accident.

Furthermore, according to the medical records from the University of Chicago, the Petitioner provided multiple explanations as to the mechanism of accident. The Petitioner provided the following explanations regarding the mechanism of accident: a direct blow to his left knee from standing height, an injury to the left knee due to tripping and a slip and fall with sludge (RX2). The Petitioner provided three different descriptions of the mechanism of accident according to the medical records from the University of Chicago and was unable to provide a consistent version of the accident date (RX2).

Although the Petitioner provided a variety of details regarding the various mechanisms of accident and dates of the accident, at no point did the Petitioner indicate that the injury occurred at work (RX2). The Petitioner testified that he told the University of Chicago medical staff that the injury occurred at work. Despite the Petitioner's testimony, this information is not contained anywhere within the medical records from the University of Chicago (RX2). The medical records contain notations from an intake nurse, a resident physician, an attending physician and an emergency nurse (RX2). None of the aforementioned medical personal noted that the injury occurred at work (RX2). The Petitioner asserts that he told the emergency room personnel that the injury occurred while at work however the medical records do not support this assertion (RX2). Pursuant to the medical records, the Petitioner provided an inconsistent record of how the alleged accident occurred and when the alleged accident occurred (RX2, RX4).

The Petitioner's medical records from MercyWorks raise additional inconsistencies with the Petitioner's testimony. The Petitioner's treating records from MercyWorks list a date of accident of November 17, 2010 (RX4). The Petitioner stated that at approximately 6:10 A.M. on November 17, 2010 at 52nd and Oakley he injured his left knee (RX4). Specifically, the Petitioner indicated that he struck his left knee on the step of a truck after tripping on a rock (RX4). This mechanism of accident is not consistent with the Petitioner's prior medical records from the University of Chicago nor his testimony (RX2). At no point did Petitioner mention slipping on a rock during his testimony. The Arbitrator notes this is the fourth version of the mechanism of accident that the Petitioner has provided within the medical records (RX2, RX4).

The medical records from MercyWorks also include the Petitioner's medical history with respect to his left knee (RX4). Pursuant to the medical records, the Petitioner specifically indicated that he sustained a left knee contusion in 2007 (RX4). When asked about this on cross examination, the Petitioner denied making such a statement. The Arbitrator notes that the Petitioner provided MercyWorks with a detailed medical history including a contusion he sustained three years ago, yet he failed to mention that he presented to the University of Chicago Medical center within the past 48 hours (RX4). Moreover, the Petitioner did not mention that he had been diagnosed at the University of Chicago with a probable left quadriceps tendon rupture, taken off work and referred to an orthopedic specialist (RX2, RX4).

The Arbitrator notes that the first report of injury indicates an accident date of November 17, 2010 (RX1). The Arbitrator notes that the Petitioner signed this document indicating that all of the information contained therein was correct (RX1). Pursuant to the report, the Petitioner indicated that on the morning of November 17, 2010 the Petitioner fell on his left knee while getting into his truck, called his supervisor and then presented to MercyWorks (RX1). The report does not indicate that the Petitioner injured his left knee on the step leading into his truck (RX1). Furthermore, the report indicates that the Petitioner called his supervisor (RX1). The Petitioner provided extensive details regarding the alleged incident during his direct examination; at no point did he indicate that he called his supervisor.

Furthermore, the report indicates that the incident occurred at the lot at 52nd and Oakley (RX1). The Petitioner provided extensive testimony indicating that the alleged injury occurred at the dump site at 61st and State. Question number 26 of the form asks whether or not the employee was hospitalized, the Petitioner indicated that he was not hospitalized (RX1). The medical records and

the Petitioner's own testimony clearly indicate that the Petitioner sought hospital treatment within the past 48 hours (RX2). Due to the numerous inconsistencies contained within the report, the Arbitrator does not find the Petitioner credible.

The Arbitrator notes that the original application for adjustment of claim is dated November 23, 2010 (RX5). The Arbitrator notes that the application lists a date of accident of November 17, 2010 (RX5). Petitioner confirmed in his testimony that he signed the original application for adjustment of claim certifying that all of the information contained therein was accurate. Moreover, the Arbitrator notes that the amended application for the adjustment of claim listing a date of accident of November 12, 2010 was filed on June 19, 2013. The Arbitrator notes that the Petitioner waited 950 days to formally assert the alleged date of accident. Furthermore, the Arbitrator notes that the Petitioner did not bring the alleged November 12, 2010 date of accident to the Respondent's attention until May of 2013.

The Arbitrator notes that pursuant to the Petitioner's testimony, he worked a full shift on Monday November 15, 2010 but then did not work on November 16th and returned to work on November 17th. Petitioner further provided testimony regarding his work hours. Petitioner noted that he always worked a normal eight hour shift from approximately 6:30 A.M. to 2:30 P.M. Petitioner noted that he did not work overtime at the time of the alleged incident. The Arbitrator notes that this testimony is not consistent with the Petitioner's wage statement.

Pursuant to the Petitioner's wage statement from the time of the alleged incident (RX3) the Petitioner worked a total of 16 hours during the pay period of November 16, 2010 through November 30, 2010 (RX3). Pursuant to the Petitioner's testimony, the Petitioner works eight hour days, therefore he worked for a total of two full days during this time period (RX3). The medical records indicate, and Petitioner confirmed during his testimony, that following the Petitioner's presentation to MercyWorks on November 17, 2010 he did not return to work until May of 2011. Therefore the Petitioner's first day off due to the alleged incident was November 18, 2010 (RX4, RX3).

Limiting the scope to the Petitioner's pay period of November 16, 2010 through November 30, 2010, it is clear that the Petitioner did not work from November 18, 2010 through November 30, 2010 (RX4, RX3). The medical records from MercyWorks and the Petitioner's wage statement confirm this information (RX4, RX3). This leaves only two days that the Petitioner could have worked, November 16th and November 17th. Pursuant to his testimony, the Petitioner presented to work on November 17, 2010 however the Petitioner indicated that he did not work on November 16, 2010. Therefore the Petitioner's testimony directly contradicts the information contained within his wage statement (RX3). Due to this inconsistency, the Arbitrator finds the Petitioner's testimony to be not credible.

The Arbitrator finds the testimony of Mr. Echols unreliable as there were clear factual inconsistencies when compared to the Petitioner's testimony. The Petitioner testified that the mud he was covered in was the color black. Conversely Mr. Echols testified that the mud the Petitioner was covered in was the color brown. The Petitioner testified that the mud covered his whole body from his shoulders down to his feet. Conversely Mr. Echols testimony indicated that the mud on the Petitioner was confined specifically to his left leg. Mr. Echols specifically noted that he did not see the Petitioner's alleged fall. Therefore the Arbitrator finds the testimony of Mr. Echols to be not credible.

Based upon all of the evidence as outlined in this decision, the Arbitrator finds the Petitioner not credible and that he failed to prove by a preponderance of the evidence that he sustained an accidental injury that arose out of and occurred in the course of her employment on November 12, 2010. Accordingly, the Petitioner's claim is hereby denied.

WITH RESPECT TO ISSUE (D), THE DATE OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's determination as to accident (issue "C"), the Arbitrator finds that the Petitioner did not sustain a work injury on November 12, 2010.

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 Arbitrator's determination as to accident (issue "C"), the Arbitrator finds that the Petitioner's current condition of ill-being is unrelated to an injury at work.

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

Based on the Arbitrator's determination as to accident (issue "C"), the Arbitrator finds that the Petitioner failed to prove his entitlement to permanent partial disability benefits. Accordingly, his claim for same is hereby denied.

Furthermore, based on the determination as to accident (issue "C"), the Arbitrator finds that the Respondent was not responsible for issuing any benefits to the Petitioner.

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

Rosemary Sanborn,

Petitioner,

14IWCC0678

vs.

NO: 12 WC 17554

State of Illinois/DHS,

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, penalties and fees, permanent disabililty, 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 October 11, 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.

14IWCC0678

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: AUG 14 2014
o8/6/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SANBORN, ROSEMARY
Employee/Petitioner

Case# **12WC017554**

14IWCC0678

STATE OF ILLINOIS
Employer/Respondent

On 10/11/2013, 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 0.06% 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:

0320 LANNON LANNON & BARR LTD
MICHAEL ROLENC
180 N LASALLE ST SUITE 3050
CHICAGO, IL 60601

5204 ASSISTANT ATTORNEY GENERAL
CHRISTOPHER FLETCHER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
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

OCT 11 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

14IWCC0678

☐ 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

Rosemary Sanborn
Employee/Petitioner

v.

State of Illinois
Employer/Respondent

Case # **12** WC **17554**

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 **September 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 **Hold harmless**

14IWCC0678

FINDINGS

On **4/17/2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned **$40,191.32**; the average weekly wage was **$772.91**.

On the date of accident, Petitioner was **67** years of age, ***single*** with **0** dependent children.

ORDER

Claim for compensation is denied. Petitioner failed to prove the injury occurred at work.

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

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

10/11/2013
Date

OCT 11 2013

14IWCC0678

FINDINGS OF FACT AND CONCLUSIONS OF LAW

On May 21, 2012, Petitioner filed an application for adjustment of claim, alleging that on April 17, 2012, she sustained accidental injuries to her left little toe when she tripped over some boxes. Petitioner had signed the application for adjustment of claim on May 15, 2012.

Petitioner, an office assistant on the date of accident, testified that when she was returning from a bathroom break, she tripped over a box of files and broke her toe on a metal part of a chair. The incident occurred in the room where Petitioner's workstation was located. Petitioner explained that there were boxes of files almost filling the entire room, as the staff were going through and organizing the files. Petitioner introduced into evidence photographs of the room, showing the boxes. Petitioner testified she took the photographs right after the accident.

Petitioner further testified that later in the day she reported the accident to her supervisor, Lily Hopkins. According to Petitioner, Ms. Hopkins did not give her an accident report form, stating that Petitioner had to request it from the Department of Central Management Services (CMS). Petitioner introduced into evidence an accident report dated May 15, 2012, stating that the accident occurred at 10:15 a.m. on April 17, 2012, and she reported the accident to Ms. Hopkins at 9:30 a.m. on April 19, 2012. The report further states the accident occurred in a conference room filled with boxes and describes the accident as follows: "Tripped over box, fell into chair leg stubbing toe." Petitioner admitted completing and signing the report. When questioned about the inconsistency between her testimony and the report regarding when she reported the accident to Ms. Hopkins, Petitioner testified that she did not recall the exact date. Petitioner further testified that she did not seek emergency treatment after the accident, and continued to work. On May 3, 2012, she began treating with her primary care physician, Dr. Ibrahim, for pain in her left foot.

The medical records from Dr. Ibrahim show that on May 3, 2012, Petitioner complained of pain and swelling in her left little toe after accidentally hitting her left foot "against hard structure." Petitioner alluded to difficulty working, in particular, "being on her feet, walking, stairs, standing," but did not report the injury occurred at work. Dr. Ibrahim ordered an X-ray and took Petitioner off work. The X-ray, performed May 4, 2012, showed acute fracture of the proximal phalanx of the left fifth toe and an old healed fracture of the fifth metatarsal bone. On May 15, 2012, Petitioner followed up with Dr. Ibrahim, complaining of pain in the left foot. Dr. Ibrahim recommended supportive care and pain management. He completed a CMS Initial Workers' Compensation Medical Report, stating that Petitioner reported stubbing her left little toe at work April 17, 2012. On May 30, 2012, Petitioner reported the pain was slowly subsiding. Dr. Ibrahim kept Petitioner off work. On June 13, 2012, Dr. Ibrahim declared Petitioner at maximum medical improvement and released her to return to work full duty.

On June 11, 2012, Respondent denied Petitioner's claim.

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:

The record indicates the injury occurred closer to May 3, 2012, than April 17, 2012. The Arbitrator notes that Petitioner continued to work after April 17, 2012, and did not seek treatment for her injury until May 3, 2012. An X-ray, performed May 4, 2012, showed acute, rather than healing fracture. The Arbitrator further notes that Dr. Ibrahim's clinical note from May 3, 2012, does not mention a work accident. On May 15, 2012, three things occurred: (1) Petitioner completed an accident report; (2) Petitioner had Dr. Ibrahim complete a CMS Initial Workers' Compensation Medical Report, stating she reported stubbing her left little toe at work; and (3) Petitioner consulted an attorney and completed an application for adjustment of claim.

The Arbitrator questions Petitioner's credibility and finds that she failed to prove by a preponderance of the evidence she broke her left little toe *at work* on or about April 17, 2012.

All other issues are 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jesus Gomez,

Petitioner,

14IWCC0679

vs.

NO. 10WC022455
(11WC048119)

Vanee Foods,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00.

14IWCC0679

The party commencing 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: AUG 14 2014
SM/sj
o-5/1/14
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GOMEZ, JESUS
Employee/Petitioner

Case# **10WC022455**

11WC048119

VANEE FOODS
Employer/Respondent

14IWCC0679

On 6/5/2013, 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 0.08% 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:

1922 SALK, STEVEN B & ASSOC LTD
ALEXANDRA BRODERICK
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

1454 THOMAS & ASSOCIATES
JOSEPH FITZPATRICK
300 S RIVERSIDE PLZ SUITE 2330
CHICAGO, IL 60606

2542 BRYCE DOWNEY & LENKOV
EVA INREM
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

14IWCC0679

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jesus Gomez
Employee/Petitioner

v.

Vanee Foods
Employer/Respondent

Case # **10** WC **22455**

Consolidated cases: **11 WC 48119**

An *Application for Adjustment 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 **May 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[x] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **6/8/2010**, Respondent Vanee Foods ***was*** operating under and subject to the provisions of the Act.

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

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 Vanee Foods.

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

In the year preceding the injury, Petitioner earned **$33,072.00**; the average weekly wage was **$636.00**.

On the date of accident, Petitioner was **26** years of age, ***single*** with **1** dependent child.

Petitioner ***has in part*** received reasonable and necessary medical services.

Respondent Vanee Foods ***has in part*** paid appropriate charges for reasonable and necessary medical services.

Respondent Vanee Foods shall be given a credit of **$3,402.64** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$3,402.64**.

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

ORDER

For the reasons set forth in the attached conclusions of law, the Arbitrator awards Petitioner the expenses associated with the treatment he underwent through August 2, 2010, other than the expenses associated with the EMG of July 9, 2010, with Respondent receiving credit for the medical expenses it paid. See pages 13-14 of the attached conclusions of law for a breakdown of the awarded expenses and credited payments. The Arbitrator declines to award expenses associated with the treatment Petitioner underwent after August 2, 2010.

Respondent Vanee Foods shall pay Petitioner temporary total disability benefits of $424.00 per week from June 10, 2010 through August 4, 2010, a period of 8 weeks, with Respondent Vanee Foods receiving credit for the $3,402.64 in benefits it paid prior to arbitration. Arb Exh 1.

Having found that Petitioner failed to establish causation as to his claimed current lumbar spine condition of ill-being, the Arbitrator awards no permanency benefits in this case.

The Arbitrator declines to award penalties and fees in this case.

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

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

6/4/13
Date

JUN - 5 2013

Jesus Gomez v. Vanee Foods, Inc.
10 WC 22455
Jesus Gomez v. Accurate Personnel
11 WC 48119

Procedural History

These consolidated cases involve claimed low back injuries. Accident is stipulated in 10 WC 22455 and disputed in 11 WC 48119. Petitioner previously filed a claim against Vanee Foods, Inc. numbered 09 WC 21660. That claim also involved the lower back. It was settled in 2012.

The case numbered 11 WC 48119 involves a borrowing-lending employment situation, with Petitioner having named only the loaning employer, Accurate Personnel, as a respondent. Petitioner opted to proceed on this basis. T. 10.

Arbitrator's Findings of Fact Relative to Both Cases

Dr. Engel, Petitioner's treating pain management physician, testified concerning the care he rendered in connection with both accidents. Dr. Engel is board certified in both anesthesiology and pain management. He has served as the director of pain management for Medicos Pain and Surgical Specialists since 2009. PX 22. For the most part, his testimony was consistent with his treatment records. Those records are summarized below.

Petitioner testified he began working for Vanee Foods, Inc. in approximately July of 2008. He worked as a general laborer, lifting boxes of meat and pushing heavy carts.

Petitioner testified he injured his lower back while working for Vanee Foods, Inc. on March 2, 2009. He was pushing a very heavy cart up a ramp when his left foot slipped. Records in PX 1 reflect that Petitioner was initially seen at Advanced Occupational Medicine Specialists and later chose to undergo care at Marque Medicos/Marque Pain & Surgical Specialists. MRIs of the thoracic and lumbar spine performed on April 10, 2009 showed no abnormalities. PX 2. Two EMGs, performed on April 29, 2009 and July 24, 2009, were negative. Px 2. Petitioner underwent two epidural steroid injections at L5-S1 (PX 3) as well as physical therapy and work conditioning. At the request of Vanee Foods, Petitioner saw Dr. Robertson for a Section 12 examination on May 18, 2009. Dr. Robertson noted no objective findings on examination. He found Petitioner to be capable of full duty and in need of four weeks of stretching exercises, performed twice weekly. He noted no pathology on the MRIs. He characterized the spinal X-rays as "not of diagnostic quality." He noted "significant symptom magnification." PX 6. On November 13, 2009, Dr. Chanduri of Medicos Pain & Surgical Specialists noted substantial improvement following work conditioning and released Petitioner to full duty. PX 3.

Petitioner testified he resumed full duty for Vanee Foods on November 14, 2009 and continued working as a general laborer without incident until his undisputed accident of June 8,

2010. T. 120. Arb Exh 1. On that date, sometime around his evening "lunch" break, Petitioner was transferring 25-pound boxes of raw chicken from a low pallet to a higher level when he injured his lower back. Petitioner testified he reported the accident to Rafael Gallegos and Beatrice Prancer [notice is not in dispute, Arb Exh 1.]

Petitioner retained counsel on June 10, 2010. [See Application filed in 10 WC 22455]. He returned to Marque Medicos that day and saw the same chiropractor, Dr. Perez, who had treated him after the March 2, 2009 injury. Dr. Perez's history reflects that Petitioner was repetitively lifting and carrying 30-pound boxes at work on June 8, 2010 when he began to experience lower back pain. Dr. Perez also noted that Petitioner had undergone a drug test at a company clinic earlier that same day, June 10, 2010.

Petitioner complained to Dr. Perez of pain in his lower back and legs, worse on the left. On examination, Dr. Perez noted positive straight leg raising bilaterally. He obtained lumbar spine X-rays, which showed no fractures or dislocations. He diagnosed a lumbar sprain/strain. He took Petitioner off work and prescribed physical therapy. PX 10.

Petitioner underwent an initial physical therapy evaluation at Marque Medicos on June 11, 2010, with the therapist noting that Petitioner reported having some minimal low back pain the day before the June 8, 2010 work accident.

On June 26, 2010, Petitioner underwent a lumbar spine MRI at Archer Open MRI Facility per Dr. Perez. The MRI demonstrated "minimal disc bulging and hypertrophy of ligamentum flavum and facet joints" at L4-L5, with the radiologist also noting "minimal bilateral neural foraminal stenosis" at that level.

Petitioner returned to Dr. Perez on June 29, 2010. On that date, Dr. Perez reviewed the MRI report. He described the MRI results as consistent with the reported mechanism of injury and complaints. He indicated that the MRI "reveals the complexity of the patient's lower back condition." He referred Petitioner to Dr. Engel for "medication management" and instructed Petitioner to stay off work and continue physical therapy. PX 10.

On July 1, 2010, Petitioner saw Dr. Engel of Medicos Pain & Surgical Specialists for a pain management consultation. In his history of that date, Dr. Engel noted that Petitioner had previously sustained a lumbar sprain/strain at work on March 2, 2009 and had resumed full duty on November 12, 2009 "with pain that was a 4/10 on the visual analog scale." Dr. Engel also noted that Petitioner began experiencing a gradual onset of "new" low back pain after handling boxes at work on June 8, 2010. He described the "root cause" of "these two pains" as "totally different." He noted that the lumbar spine MRI performed on April 10, 2009 was "read as unremarkable" while the MRI performed on June 26, 2010 showed "bilateral neural foramen stenosis at L4-5 secondary to disc bulging and hypertrophy of the ligamentum flavum and facet joints."

On examination, Dr. Engel noted a decreased range of lumbar spine motion, limited lumbar extension secondary to pain, 5/5 strength in both legs and negative straight leg raising bilaterally. T. 26.

Dr. Engel addressed causation as follows:

> "As the patient has a herniated disc on his new MRI that was not present on his previous MRI, his work-related accident of 6/8/10 is the direct cause of his current low back pain and radicular pain. Though I appreciate he had a previous muscle sprain and strain, this current injury is different as it is secondary to his herniated disc."

Dr. Engel prescribed Mobic, Omeprazole and Soma. He instructed Petitioner to stay off work and continue therapy. PX 11.

When Dr. Perez next saw Petitioner, on July 7, 2010, he noted that Petitioner was now complaining of "intense pain of his bilateral inguinal areas" as well as pain in his lower back and legs. He recommended an EMG "to rule out a lumbosacral radiculopathy." He instructed Petitioner to remain off work and continue therapy. PX 10.

On July 9, 2010, Petitioner underwent a lower extremity EMG. Dr. McCaffery, who is described as "board certified" in "chiropractic neurology," interpreted the EMG results as normal. PX 10.

On July 21, 2010, Petitioner underwent a CT scan of the pelvis at Dr. Perez's recommendation. The CT scan demonstrated an "atypical appearance of the left L5-S1 facet concerning for pars defect" and "no evidence of hernia." The interpreting radiologist, Dr. Lutz, suggested that Petitioner undergo oblique lumbar spine X-rays if he demonstrated lower back symptoms. PX 11.

Petitioner returned to Dr. Engel on July 29, 2010, with the doctor noting the results of the recent EMG and CT scan. He described the CT scan as revealing "L5-S1 facet joint syndrome." He noted that Petitioner complained not only of his lower back and legs but also of mid-back pain "going into the chest" with associated shortness of breath.

On examination, Dr. Engel noted a full range of motion with respect to flexion. He described backward extension as "with minimal deficit and mobility but it is [the] most painful maneuver." He described straight leg raising as negative bilaterally. At the hearing, he testified that, at this point, he "presumptively" diagnosed lumbar facet syndrome based on Petitioner's presentation. He testified that this syndrome can be either degenerative or acute. T. 32. He ordered a left L4, L5 and S1 medial branch block to explore this diagnosis. T. 30-31. After Petitioner saw Dr. Nandra on July 30, 2010, and obtained medical clearance, Dr. Engel performed the medial branch blocks on August 2, 2010. In his report, he noted he completed

the blocks at left L3, L4, L5 and S1 rather than the planned levels "since the patient had facet arthropathy at L3-4, L4-5 and L5-S1." PX 11.

At the next visit, on August 19, 2010, Dr. Engel noted that Petitioner obtained only three hours of pain relief following the blocks. He described this reaction as "appropriate as the injection was local anesthetic only." On examination, he noted a decreased lumbar spine range of motion, limited lumbar extension secondary to pain, 5/5 strength and negative straight leg raising bilaterally. He discussed "left L3, L4, L5 and S1 medial branch confirmatory blocks" with Petitioner. He discussed Petitioner's reaction as follows:

> "He understands that this injection is necessary prior to moving to radiofrequency ablation, which is the curative treatment. The patient wants to move right to the curative treatment, which would allow him to return to work faster. though I prefer confirmatory blocks, the patient was insisting upon moving to radiofrequency ablation."

He instructed Petitioner to remain off work and continue therapy and medication.

At the hearing, Dr. Engel testified that he recommended confirmatory blocks to Petitioner because the "false-positive rate for a diagnostic block is about 50 percent." He further explained:

> "When you add a confirmatory medial branch block, if the patient is pain free in the recovery room both times, you can be about 85 percent certain that the facet joint is the root cause of the patient's pain."

Dr. Engel described Petitioner as "refusing" to undergo the confirmatory blocks. T. 34-35.

Despite the lack of confirmation, Dr. Engel proceeded to perform the ablation procedure on August 30, 2010. Although Petitioner testified he noticed only a "bit" of improvement following this procedure, Dr. Engel described Petitioner's left-sided lower back pain as "essentially cured" on September 9, 2010. He noted that Petitioner complained primarily of right-sided lower back pain. On examination, he noted no abnormalities. He instructed Petitioner to start work conditioning. He released Petitioner to light duty with no lifting over 30 pounds. PX 11.

On September 27, 2010, Petitioner underwent an initial work conditioning evaluation at Elite Physical Therapy. The evaluating therapist, Luis Maldonado, P.T., noted a QVAS score of 63, "denoting a high perceived pain level," and an Oswestry score of 34%, "denoting a mild level of perceived disability." PX 12. Petitioner attended forty-five work conditioning sessions thereafter. On December 10, 2010, Maldonado noted that Petitioner was still complaining of

moderate lower back discomfort and was unable to tolerate frequent lifting/carrying of 80 pounds. PX 11-12.

At the request of Respondent Vanee Foods, Petitioner saw Dr. Ghanayem for a Section 12 examination on November 17, 2010. Dr. Ghanayem's report reflects that he is director of the division of spine surgery at Loyola University Medical Center. The report also reflects that Dr. Ghanayem reviewed "records and radiographs" in connection with his examination. With the exception of the June 2010 MRI scan, those records and radiographs are not otherwise described.

Dr. Ghanayem's report sets forth consistent accounts of the March 2, 2009 and June 8, 2010 work accidents. Dr. Ghanayem noted that Petitioner described himself as having improved but not fully recovered from the 2009 accident when the June 8, 2010 accident took place.

On examination, Dr. Ghanayem noted a normal gait and "an extreme amount of pain with light palpation" of the lumbar spine. He noted positive Waddell signs, 20 degrees of extension, 90 degrees of flexion, no neurological abnormalities and negative tension signs. He reviewed the June 2010 lumbar spine MRI scan and described it as "normal." He addressed causation and prognosis as follows:

> "My impression is that, based on the mechanism of injury, this gentleman may have sustained a back sprain. His symptoms of leg pain are not anatomic and do not correlate with his MRI scan. His back pain is in excess of what would be expected from the MRI scan as well. His diagnosis, based on the history, would be a back sprain. A brief course of physical therapy, on the order of three to four weeks' duration, would be medically appropriate. After that, he should have returned back to work at regular duty. He requires no further medical care. He is at MMI. There is no residual disability relative to this alleged June 9, 2010 muscular sprain."

Vanee RX 1.

On November 22, 2010, Dr. Engel noted that Petitioner was still complaining of 3/10 left-sided lower back pain. He noted no abnormalities on examination. He imposed a 50-pound lifting restriction and instructed Petitioner to continue work conditioning. PX 11.

On December 13, 2010, Dr. Engel noted that Petitioner reported improvement secondary to work conditioning but was still complaining of 3/10 left-sided lower back pain. He noted no abnormalities on examination. He imposed a permanent 75-pound lifting restriction and discharged Petitioner from care, noting he had nothing else to offer treatment-wise. He recommended a home exercise program and gym membership. PX 11.

Petitioner testified that Respondent Vanee Foods terminated him once he was released to restricted duty. On August 8, 2011, he began working for Respondent Accurate Personnel, a staffing agency. He was dealing with "extreme pain" in his leg and waist at this point. Accurate sent him to OSG, where he worked as a machine operator. His job required him to set up machines and lift boxes that weighed up to 50 pounds.

Petitioner testified that, while working at OSG on November 4, 2011, he was walking around a machine when he caught his right foot on a bolt. He almost hit the machine but was able to regain his balance. He was unable to recall exactly when this accident occurred. The following day, he began experiencing extreme pain in his low back, mid-back, legs and chest. Later he started experiencing neck pain as well. He reported the accident to Fatima and later to Carmella. [Notice is not in dispute, Arb Exh 2.] Accurate sent him to Alexian Brothers Medical Group in Bensenville. The initial note, dated November 7, 2011, reflects that Petitioner twice hyper-extended his left leg on November 4, 2011, when he walked around a machine at work, got his right foot stuck between a wall and a piece of metal and temporarily lost his balance. PX 23. The note also reflects that Petitioner complained of pain in his right foot, lower back, left groin and left thigh with radiation to the leg. The note contains no mention of the previous work accidents. A separate handwritten history reflects that Petitioner "tripped on a bolt and jerked body."

The examining physician, Dr. Sandoval, noted that Petitioner appeared to be in no distress and walked with a normal gait. On examination, the doctor noted a normal range of lumbar spine motion with mild tenderness at the level of the bilateral paravertebral muscles between L4 and L5, tenderness in the left groin, no hernia or masses, and an area of tenderness in the right foot with no bruises or contusion.

Dr. Sandoval diagnosed a lumbar sprain/strain, left groin strain, left thigh strain and right foot contusion. He prescribed Robaxin and Ibuprofen and imposed various work restrictions. PX 27. Petitioner testified that Respondent Accurate accommodated these restrictions.

Petitioner returned to Alexian Brothers the following day, November 8, 2011, and complained of pain in his right leg, chest, abdomen and throat. Petitioner indicated he felt "woozy" due to the medication prescribed the previous day. Petitioner underwent an EKG. The examining physician, Dr. Baksinski, diagnosed an adverse drug reaction and instructed Petitioner to stop taking the Robaxin and continue the Ibuprofen. Dr. Baksinski continued the previous work restrictions and instructed Petitioner to return on November 15, 2011 for a re-check. PX 23.

Petitioner also went to Marque Medicos on November 8, 2011. He saw Dr. Perez on that date and provided a history of the November 4, 2011 accident. The doctor's note reflects that Petitioner was walking quickly around a machine when he "suddenly tripped over a large bolt that was sticking out from the machine, causing him to lose his balance." The note also

reflects that Petitioner's body "twisted forcefully" as he started to fall but that Petitioner was able to regain his balance. The doctor noted complaints relative to the lower back, mid-back, left groin, left knee, legs and anterior chest. With respect to Petitioner's past history, the doctor noted:

> "The patient reports that he was physically well and that he was working without any difficulties prior to the work injury he sustained on 11/4/11. The patient reports that he has been employed for approximately three months at his current place of employment."

The doctor also noted a history of prior "episodes of lower back pain" that required treatment.

On examination, Dr. Perez noted significant tenderness to palpation over the T6 through T12 and the L1 through S1 spinal levels, as well as over the bilateral thoracic and lumbar paraspinal musculature. He also noted positive straight leg raising on the right at 40 degrees and muscle strength test results of 4/5.

Thoracic and lumbar spine X-rays showed no fractures or dislocations on preliminary reading.

Based on Petitioner's history, including the described mechanism of injury, Dr. Perez attributed Petitioner's current complaints to the November 4, 2011 accident. He prescribed physical therapy. He imposed work restrictions and referred Petitioner to Dr. Engel for medication management. PX 24.

Petitioner returned to Dr. Perez on November 11, 2011 and again complained of pain in his lower back, mid-back, legs, left groin and anterior chest. Petitioner indicated he had attempted to work with light duty restrictions but "felt worse." Petitioner reported having gone to an Emergency Room "due to the intense pain he was experiencing" and having received medication there. [No Emergency Room records are in evidence.] Dr. Perez noted that Petitioner appeared to be in obvious acute distress and was unable to stay in one position for even a short period. He took Petitioner off work and again referred him to Dr. Engel. PX 24.

Petitioner testified he presented Dr. Perez's "off work" slip to Carmella.

On November 15, 2011, Petitioner saw Dr. Engel of Medicos Pain & Surgical Specialists. Dr. Engel's note sets forth a consistent history of the November 4, 2011 work accident. The note also reflects that Petitioner previously injured his back on March 2, 2009 and June 9, 2010 and was discharged with a 75-pound lifting restriction after the June 9, 2010 accident.

Dr. Engel noted that Petitioner complained of unbearable, 10/10 pain in his mid-back, low back, legs, anterior chest and left groin. He noted that Petitioner was currently taking Hydrocodone and Ibuprofen. He reviewed the recent spinal X-rays, noting an apparent pars

defect at L5-S1. He indicated Petitioner might also have a spinous process fracture. He indicated that a radiologist would be reading the films.

On examination, Dr. Engel noted positive straight leg raising bilaterally at 45 degrees, 5/5 bilateral leg strength, full lumbar flexion, limited lumbar extension and pain to palpation of the bilateral lumbar paraspinous musculature. He diagnosed "low back pain syndrome" and "thoracic spine pain." He prescribed a lumbar spine MRI, commenting that the "current accident caused radiculopathy, which is likely secondary to disc disease." He asked Petitioner to stop taking Hydrocodone. He started Petitioner on Ultram and Ambien. He instructed Petitioner to stay off work and continue therapy. PX 24.

The MRI, performed on November 16, 2011, showed diffuse disc bulging at L3-4, L4-5 and L5-S1, with the radiologist also noting a "likely congenital" deformity involving the lamina bilaterally at L5-S1.

Petitioner underwent an initial physical therapy evaluation at Marque Medicos on November 18, 2011. The evaluating therapist, Norman Lambot, P.T., noted complaints of 7-8/10 pain in the low back and mid-back as well as numbness in both feet. He also noted that Petitioner "ambulates without obvious antalgia." PX 24.

Petitioner returned to Dr. Perez on November 21, 2011 and reported some improvement. The doctor noted that Petitioner was walking without any obvious antalgic gait. On examination, the doctor noted positive straight leg raising bilaterally and 5/5 strength. He reviewed the MRI. He instructed Petitioner to remain off work and continue therapy. PX 24.

On November 28, 2011, Dr. Engel compared the recent MRI with the previous MRI and opined that the "foraminal stenosis secondary to the contained disc herniation at L4-5 has gotten worse." He kept Petitioner off work and prescribed additional therapy and medication. PX 24.

On December 6, 2011, Dr. Perez noted that Petitioner did not appear to be in distress and was able to move with greater ease. He indicated that Petitioner's active range of motion had "clearly improved." He again noted positive straight leg raising bilaterally at 45 degrees. He described the MRI as "clinically significant" and correlative with Petitioner's complaints. He prescribed EMG/NCV testing "to further identify the radicular component of the patient's ongoing condition." He instructed Petitioner to stay off work, continue therapy and follow up with Dr. Engel. PX 24.

The EMG, performed on December 16, 2011, was negative. Dr. McCaffery performed this study. PX 24.

Dr. Perez continued to prescribe therapy and keep Petitioner off work following the negative EMG. PX 24.

On January 12, 2012, Dr. Engel noted some improvement in Petitioner's pain level but noted that Petitioner still complained of bilateral leg numbness as well as pain in his low back and mid-back. Straight leg raising was again positive bilaterally at 45 degrees. He instructed Petitioner to discontinue therapy and see Dr. Erickson, a neurosurgeon, for a consultation due to his "bilateral neural foraminal stenosis at L4-5." He released Petitioner to light duty with no lifting over 5 pounds and sit/stand as needed. PX 24.

Petitioner testified that, after he presented Dr. Engel's January 12, 2012 restrictions to Respondent Accurate, Carmella told him, "no work is available, I'll call you."

There is no indication that Petitioner ever saw Dr. Erickson.

On February 7, 2012, Petitioner began seeing Dr. Gireesan, an orthopedic surgeon. The doctor's note of that date sets forth a consistent account of the November 4, 2011 work accident. The note contains no mention of the previous work accidents but it does reflect that Petitioner previously underwent lumbar blocks and injections. The doctor indicated Petitioner was currently taking Tramadol.

Dr. Gireesan noted that Petitioner complained of pain in his feet, calves, knees, legs, lower back, neck and "all joints." Dr. Gireesan also noted that Petitioner complained of "pins and needles" in his extremities and difficulty sleeping.

Dr. Gireesan described Petitioner's gait as normal. Straight leg raising was negative bilaterally.

Dr. Gireesan assessed Petitioner as having an "unspecified disorder of muscle, ligament and fascia, with pain to the back and extremities." He started Petitioner on Trazadone and Cymbalta. PX 26.

At the request of Respondent Accurate Personnel, Petitioner saw Dr. Salehi for a Section 12 examination on May 10, 2012. Dr. Salehi's report of the same date reflects that he is a board certified neurosurgeon. Accurate RX 1.

Dr. Salehi's report sets forth a consistent account of the November 4, 2011 work accident. He noted that Petitioner complained primarily of low back pain but also complained of pain in his left groin, legs, knees, feet, neck and chest. He also noted that Petitioner reported taking Tramadol "when the pain is severe."

With respect to Petitioner's past medical history, Dr. Salehi noted that Petitioner "had one work injury with a different employer in 2009" and was still experiencing low back, groin and leg complaints as of the November 4, 2011 accident. Dr. Salehi also noted that Petitioner denied having pain in his neck and arms prior to the November 4, 2011 accident. He indicated Petitioner was released with restrictions in January of 2012 but not accepted back to work. He noted that Petitioner was currently working for himself, towing and selling vehicles.

Dr. Salehi indicated he reviewed numerous records, including the lumbar spine MRI reports of June 26, 2010 and November 16, 2011 and the EMG reports. He also reviewed the MRI films and lumbar spine X-rays. He interpreted the June 22, 2010 lumbar spine X-ray as showing slight spondylolisthesis at L5 and the November 9, 2011 lumbar spine X-ray as showing spina bifida occulta at L5 and "no obvious evidence of pars fracture."

On examination, Dr. Salehi noted a normal gait, tenderness to palpation at the mid-cervical region and lumbosacral junction, positive lying straight leg raising, negative sitting straight leg raising, no spasm, normal strength in all extremities, decreased sensation in the left leg in a non-dermatomal distribution and inconsistent behavorial responses (pain on simulation).

Dr. Salehi opined that the mechanism of injury described by Petitioner was "consistent with the diagnosis of lumbar strain." Based on this diagnosis, he viewed the first six weeks of treatment as medically appropriate, "including chiropractic treatment and physical therapy." He indicated there was "no good anatomic explanation for the diffuse complaints in the lower extremities, as there are no neural compressive lesions." He found no relationship between the November 4, 2011 accident and the neck/upper extremity complaints "as [Petitioner] had no such symptoms based on the records reviewed after the 11/4/11 work injury." He indicated Petitioner reached maximum medical improvement six weeks post-accident and "could have worked without restrictions at that time." He recommended that Petitioner perform home exercises, remain aerobically active and take over the counter analgesics as needed. Accurate RX 1.

Petitioner continued seeing Dr. Gireesan after the Section 12 examination. Dr. Gireesan started Petitioner on Ambien on July 24, 2012. On September 10, 2012, he refilled the Trazadone and Ambien and recommended that Petitioner engage in yoga and meditation. On October 19, 2012, he noted Petitioner was feeling better and doing stretches on his own. He started Petitioner on Lyrica and refilled the Trazadone and Ambien. At the next visit, on November 16, 2012, he prescribed Tramadol for pain and advised Petitioner to "take it sparingly." On January 17, 2013, he noted that Petitioner complained of pain in both shoulders and "all over the body." He also noted that Petitioner reported having undergone treatment at an unspecified Emergency Room the previous week. [No Emergency Room records are in evidence.] He described Petitioner's gait as normal and noted negative straight leg raising bilaterally. He refilled Petitioner's medications, including the Tramadol, but indicated he "advised [Petitioner] to refrain from taking Tramadol" and informed Petitioner that Tramadol is addictive. PX 26.

On March 26, 2013, Petitioner filed a Petition for Penalties and Attorney's Fees in both cases, alleging, inter alia, that Respondents did not rely on a qualified medical opinion or utilization review in denying benefits. PX 19, 33.

Petitioner testified he started his own business, buying and towing "junk" vehicles, at some point after January 2012.

Petitioner testified the 2011 work accident altered his life. He is unable to work for more than a couple of hours due to persistent pain in his back, neck and chest. When he gets up, he has to soak in a hot bath and do stretches to get going. He is a single father of two young children. The children are very active and he has difficulty taking care of them.

Under cross-examination by Respondent Vanee Foods, Petitioner testified he settled his March 2, 2009 back injury claim with Vanee. He netted about $7,000 from this settlement. He could not recall the percentage of loss involved in the settlement or the exact date on which the settlement was finalized. It may be that the settlement was finalized in May of 2012. The settlement contracts referenced only the '09 case. He settled the case based on his attorney's recommendation. He was aware that the other two cases remained pending.

Petitioner acknowledged signing the Application in 10 WC 22455 on June 10, 2010. He returned to Marque Medicos following the June 2010 accident because the treatment he received at Marque Medicos after the '09 accident was "pretty good." Marque Medicos offered him transportation on a few occasions. He recalled using this transportation a few times to go from his home to the surgicenter for blocks and injections. He lived in Chicago at that time. The surgicenter was also in Chicago. T. 155-156. He is currently not working. He never incorporated his business, which was called "JG Towing," but he did pay taxes. His brother and friends helped him with this business. T. 156-157. When there was heavy labor involved, he got help. The business was not high volume. On some days, he towed only one vehicle. Towing did not require heavy labor. He had a flatbed tow truck and only had to operate levers. He did towing from about January of 2012 until September 2012, when his tow truck "went down." After that, he continued buying vehicles for scrap for a while. He last bought a scrap vehicle about two to three months before the hearing. He worked for a florist on Kedzie for a couple of days before being fired over a daycare-related issue. After that, he briefly worked as a forklift operator through an agency called "Staff Right." At times, he had to operate the forklift in reverse. This caused his neck and back to ache. He took Tramadol at work, "zoned out," dropped two pallets and got fired. He has not filed any new claims. He did not file any claims before the '09 claim. He is looking for work and would accept a job if it were offered to him. His right wrist is in a cast because he sustained a fracture at home the Friday before the hearing.

Under cross-examination by Respondent Accurate Personnel, Petitioner testified the November 4, 2011 accident took place at OSG Tap & Die. T. 173. He was near the end of a 90-day probationary period when this accident occurred. He was "led to believe" he would have been offered a full-time job at OSG had he completed this period. The work he did at OSG was light and he could sit or stand as needed. T. 177. He worked on Saturday, November 5, 2011 and did not report the accident until November 7, 2011. He did not continue care at Alexian Brothers because the female doctor he saw at the second visit did not seem to believe him and wanted him to sign something. T. 179. He did not see Dr. Erickson per Dr. Engel's referral

because he did not want to undergo any additional procedures. T. 180. He has seen Dr. Gireesan on and off since his first injury in 2009. He applied for unemployment twice and was denied twice. He participated in a telephonic hearing in January of 2012. He believes he was denied benefits because he was honest during this hearing. He was honest and truthful with Dr. Salehi but the doctor was not honest and truthful in his report. T. 183. At Dr. Gireesan's recommendation, he uses exercise machines and does core work and stretches. He is currently taking Tramadol, Trazadone and Ambien. T. 185-186. In January of 2013, Dr. Gireesan told him to avoid the Tramadol if possible but he needs to take this at times due to extreme pain. He is scheduled to return to Dr. Gireesan in two days. He no longer takes Lyrica because he cannot afford to pay for this medication. T. 185-186.

On redirect, Petitioner testified he picked up his checks from Respondent Accurate Personnel during the time he worked at ODG. T. 187-189.

Under re-cross, Petitioner testified he represented himself in his claim for unemployment benefits. It was because he was honest and truthful while he was representing himself that he was denied benefits. T. 190. Because he is represented in his workers' compensation claims, he feels "protected."

On further redirect, Petitioner testified he was honest and truthful throughout the hearing. T. 190-192.

No witnesses testified on behalf of either Respondent.

Jesus Gomez v. Vanee Foods, Inc.
10 WC 22455
(consolidated with 11 WC 48119 – see separate Decision]

Arbitrator's Credibility Assessment

Petitioner was articulate but very subdued. He was essentially without affect during much of the hearing. His complaints of severe, debilitating pain are at odds with Dr. Ghanayem's findings and some of his treatment records.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between his undisputed work accident and his claimed current lumbar spine condition of ill-being?

The Arbitrator finds that Petitioner failed to establish a causal relationship between the undisputed work accident of June 8, 2010 and his claimed current lumbar spine condition of ill-being.

In the Arbitrator's view, the undisputed work accident of June 8, 2010 resulted in a lumbar strain which fully resolved. While there was a suggestion of facet arthropathy on the pelvic CT scan of July 21, 2010, and while the Arbitrator finds it reasonable for Dr. Engel to have performed diagnostic medial branch blocks on August 2, 2010, in light of the CT results and Petitioner's presentation at that time [see further discussion below], the Arbitrator finds that Petitioner failed to establish causation as to the care he underwent after August 2, 2010 and as to the 75-pound lifting restriction Dr. Engel ultimately imposed on December 13, 2010. Dr. Ghanayem noted positive Waddell signs and symptom magnification on November 17, 2010. RX 1 Vanee Foods. Dr. Engel noted absolutely no abnormal examination findings on either November 22, 2010 or December 13, 2010. PX 11. The Arbitrator further notes that, when Petitioner saw Dr. Perez on November 8, 2011, following his November 4, 2011 accident, he reported that he was "doing well" and able to perform all of his required work duties prior to that accident.

Is Petitioner entitled to medical expenses?

Based in part on the foregoing causation analysis, the Arbitrator awards the expenses associated with the care Petitioner underwent through August 2, 2010 other than the expenses associated with the EMG of July 9, 2010. The record contains no specific evidence as to the training or qualifications of Dr. McCaffery, the "chiropractic neurologist" who performed this EMG. Even if such evidence existed, there is no indication that Dr. McCaffery examined Petitioner to confirm Dr. Perez's findings prior to performing the EMG. PX 10.

Specifically, the Arbitrator awards the following, with Respondent Vanee Foods

receiving credit for the reflected payments:

Marque Medicos (PX 13)

Physical Therapy – Homer Saclayan, P.T.	
6/11/10	$ 165.04 (paid)
6/29/10	$ 67.47 (paid)
7/20/10	$ 67.47
Physical Therapy – Fernando Perez, D.C.	
6/11/10 – 7/29/10	$7,799.34 ($5,208.54 paid)
Physical Therapy – Gattas, P.T.	
7/23/10	$ 269.88
Chiropractic – Fernando Perez, D.C.	
6/10/10 – 7/26/10	$ 729.67 ($576.05 paid)

Medicos Pain & Surgical (PX 16)

7/1/10, office visit with Dr. Engel	$ 204.48 (paid)
7/29/10, office visit with Stacy Pond, P.A.	$ 100.68
7/30/10, Dr. Nandra examination	$ 694.21
8/2/10, Dr. Engel's fee – medial branch blocks	$2,453.28
8/2/10, facility fee – medial branch blocks	$5,884.22

Metro Anesthesia Consultants (PX 17)

8/2/10, anesthesia – medial branch blocks	$2,020.00

Specialized Radiology Consultants

6/22/10, lumbar spine X-rays	$ 55.00 ($53.97 paid, RX 2)

Archer Open MRI (PX 15)

6/26/10, lumbar spine MRI	$1,601.57
7/21/10, pelvic CT scan	$1,112.68

The Arbitrator declines to award Petitioner expenses associated with the treatment, including the radiofrequency ablation and work conditioning, he underwent following August 2, 2010. Dr. Engel's records reflect that he felt it necessary to proceed with confirmatory blocks after the initial diagnostic blocks and before performing radiofrequency ablation but that he did not perform any confirmatory blocks in this case because Petitioner "insisted" on moving directly to the potentially curative ablation. At the hearing, Dr. Engel acknowledged that diagnostic medial branch blocks have a "high," or 50%, "false-positive" rate and that this is why

confirmatory blocks are needed. He did not explain why he, a trained professional, would skip the confirmatory blocks and proceed with a potentially useless procedure costing over $20,000 (see PX 16 for a breakdown of Dr. Engel's fee and the facility fee from 8/30/10) based solely on a patient's "insistence." T. 35. While Dr. Engel testified that the ablation resulted in "dramatic improvement" (T. 41), Petitioner testified that the ablation provided only a "bit" of relief. Based on Petitioner's lack of response to the ablation, the Arbitrator finds it likely that Petitioner did not in fact have facet arthropathy or facet joint syndrome.

In addressing Petitioner's claim for medical expenses, the Arbitrator has given consideration to the opinions voiced by Dr. Ghanayem. Dr. Ghanayem viewed the accident as causing a lumbar strain that required a brief course of therapy. Dr. Ghanayem specifically referenced the MRI, which he read as negative, but he did not mention either the pelvic CT scan or Dr. Engel's records documenting painful lumbar extension. Had Dr. Ghanayem opined that there was no reason for Dr. Engel to suspect facet joint syndrome, the Arbitrator might have viewed Petitioner's claim for medical expenses differently.

In summary, the Arbitrator finds it reasonable for Dr. Engel to have recommended and performed a diagnostic procedure for suspected facet joint syndrome, based on his initial examination findings and the pelvic CT scan results. The Arbitrator finds that Petitioner failed to prove the reasonableness and necessity of the care that followed the diagnostic procedure.

Is Petitioner entitled to temporary total disability benefits? Is Petitioner entitled to temporary partial disability benefits?

Based on the foregoing analysis and Respondent's binding stipulation (Arb Exh 1), the Arbitrator finds that Petitioner was temporarily totally disabled from June 10, 2010 through August 4, 2010 (the 8-week period Respondent stipulated to), with Respondent receiving credit for the $3,402.64 in temporary total disability benefits it paid prior to arbitration. The stipulated average weekly wage of $636.00 gives rise to a temporary total disability rate of $424.00. Eight weeks multiplied by $424.00 equals $3,392.00. There was thus a slight overpayment of $10.64.

Is Petitioner entitled to permanency?

Having found that Petitioner failed to establish a causal relationship between the undisputed work accident of June 8, 2010 and his claimed current lumbar spine condition of ill-being, the Arbitrator declines to award permanent partial disability benefits in this case.

Is Respondent liable for penalties and fees?

Although the Arbitrator has found that it was reasonable for Dr. Engel to proceed with diagnostic medial branch blocks on August 2, 2010, the Arbitrator otherwise finds persuasive Dr. Ghanayem's opinion that the June 8, 2010 work accident resulted in a relatively minor

lumbar spine strain that required only a few weeks of conservative care. The print-out establishes that Respondent paid about $6,000 in medical expenses relating to the care Petitioner underwent between June 10 and July 29, 2010. The Arbitrator declines to award penalties and fees in this case.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jesus Gomez,

Petitioner,

14IWCC0680

vs.

NO. 11WC048119
(10WC22455)

Accurate Personnel, LLC

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, permanent disability, medical expenses, notice, penalties, 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 June 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $17,500.00.

141WCC0680

The party commencing 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: AUG 14 2014
SJM/sj
o-5/1/14
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

GOMEZ, JESUS
Employee/Petitioner

Case# **11WC048119**
10WC022455

ACCURATE PERSONEL LLC
Employer/Respondent

14IWCC0680

On 6/19/2013, 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 0.07% 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:

1922 SALK, STEVEN B & ASSOC LTD
ALEXANDRA BRODERICK
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

2542 BRYCE DOWNEY & LENKOV LLC
EVA INREM
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

14IWCC0680

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

JESUS GOMEZ
Employee/Petitioner

v.

ACCURATE PERSONNEL, LLC
Employer/Respondent

Case # **11** WC **48119**

Consolidated cases: **10WC22455**

An *Application for Adjustment 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 **MAY 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 **November 4, 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 lumbar spine condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$6,241.25**; the average weekly wage was **$416.08**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **2** dependent children.

Petitioner ***has in part*** received reasonable and necessary medical services.

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

Respondent shall be given a credit of **$n/a** for TTD, **$n/a** for TPD, **$n/a** for maintenance, and $ 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

PETITIONER SUSTAINED AN ACCIDENT ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT ON NOVEMBER 4, 2011. PETITIONER ESTABLISHED A CAUSAL CONNECTION BETWEEN THIS ACCIDENT AND HIS CURRENT LUMBAR SPINE CONDITION OF ILL-BEING.

FOR THE REASONS SET FORTH IN THE ATTACHED CONCLUSIONS OF LAW, RESPONDENT SHALL PAY TEMPORARY TOTAL DISABILITY BENEFITS FROM NOVEMBER 11, 2011 THROUGH DECEMBER 22, 2011, A PERIOD OF 6 WEEKS, AT THE RATE OF $286.00 PER WEEK.

FOR THE REASONS SET FORTH IN THE ATTACHED CONCLUSIONS OF LAW (SEE P. 14), RESPONDENT SHALL PAY REASONABLE AND NECESSARY MEDICAL EXPENSES, PURSUANT TO THE MEDICAL FEE SCHEDULE, AS FOLLOWS:

1. **ALEXIAN BROTHERS – PX 27 ($420.77)**
2. **MARQUE MEDICOS – PX 28 ($4,348.42)**
3. **ARCHER OPEN MRI – PX 29 ($1,132.43)**
4. **MEDICOS PAIN AND SURGICAL SPECIALISTS – PX 30 ($334.99)**
5. **INDUSTRIAL PHARMACY – PX 31 ($1,245.88)**

RESPONDENT SHALL PAY PETITIONER PERMANENT PARTIAL DISABILITY BENEFITS OF $286 /WEEK FOR 20 WEEKS, BECAUSE THE INJURIES SUSTAINED RESULTED IN PERMANENCY EQUIVALENT TO 4% LOSS OF THE PERSON AS A WHOLE, AS PROVIDED IN SECTION 8(D)2 OF THE ACT.

RESPONDENT IS LIABLE FOR SECTION 19(L) PENALTIES IN THE STATUTORY MAXIMUM AMOUNT OF $10,000. THE ARBITRATOR DECLINES TO AWARD SECTION 19(K) PENALTIES OR FEES.

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

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

June 18, 2013
Date

JUN 19 2013

Jesus Gomez v. Vanee Foods, Inc.
10 WC 22455
Jesus Gomez v. Accurate Personnel
11 WC 48119

Procedural History

These consolidated cases involve claimed low back injuries. Accident is stipulated in 10 WC 22455 and disputed in 11 WC 48119. Petitioner previously filed a claim against Vanee Foods, Inc. numbered 09 WC 21660. That claim also involved the lower back. It was settled in 2012.

The case numbered 11 WC 48119 involves a borrowing-lending employment situation, with Petitioner having named only the loaning employer, Accurate Personnel, as a respondent. Petitioner opted to proceed on this basis. T. 10.

Arbitrator's Findings of Fact Relative to Both Cases

Dr. Engel, Petitioner's treating pain management physician, testified concerning the care he rendered in connection with both accidents. Dr. Engel is board certified in both anesthesiology and pain management. He has served as the director of pain management for Medicos Pain and Surgical Specialists since 2009. PX 22. For the most part, his testimony was consistent with his treatment records. Those records are summarized below.

Petitioner testified he began working for Vanee Foods, Inc. in approximately July of 2008. He worked as a general laborer, lifting boxes of meat and pushing heavy carts.

Petitioner testified he injured his lower back while working for Vanee Foods, Inc. on March 2, 2009. He was pushing a very heavy cart up a ramp when his left foot slipped. Records in PX 1 reflect that Petitioner was initially seen at Advanced Occupational Medicine Specialists and later chose to undergo care at Marque Medicos/Marque Pain & Surgical Specialists. MRIs of the thoracic and lumbar spine performed on April 10, 2009 showed no abnormalities. PX 2. Two EMGs, performed on April 29, 2009 and July 24, 2009, were negative. Px 2. Petitioner underwent two epidural steroid injections at L5-S1 (PX 3) as well as physical therapy and work conditioning. At the request of Vanee Foods, Petitioner saw Dr. Robertson for a Section 12 examination on May 18, 2009. Dr. Robertson noted no objective findings on examination. He found Petitioner to be capable of full duty and in need of four weeks of stretching exercises, performed twice weekly. He noted no pathology on the MRIs. He characterized the spinal X-rays as "not of diagnostic quality." He noted "significant symptom magnification." PX 6. On November 13, 2009, Dr. Chanduri of Medicos Pain & Surgical Specialists noted substantial improvement following work conditioning and released Petitioner to full duty. PX 3.

Petitioner testified he resumed full duty for Vanee Foods on November 14, 2009 and continued working as a general laborer without incident until his undisputed accident of June 8,

2010. T. 120. Arb Exh 1. On that date, sometime around his evening "lunch" break, Petitioner was transferring 25-pound boxes of raw chicken from a low pallet to a higher level when he injured his lower back. Petitioner testified he reported the accident to Rafael Gallegos and Beatrice Prancer [notice is not in dispute, Arb Exh 1.]

Petitioner retained counsel on June 10, 2010. [See Application filed in 10 WC 22455]. He returned to Marque Medicos that day and saw the same chiropractor, Dr. Perez, who had treated him after the March 2, 2009 injury. Dr. Perez's history reflects that Petitioner was repetitively lifting and carrying 30-pound boxes at work on June 8, 2010 when he began to experience lower back pain. Dr. Perez also noted that Petitioner had undergone a drug test at a company clinic earlier that same day, June 10, 2010.

Petitioner complained to Dr. Perez of pain in his lower back and legs, worse on the left. On examination, Dr. Perez noted positive straight leg raising bilaterally. He obtained lumbar spine X-rays, which showed no fractures or dislocations. He diagnosed a lumbar sprain/strain. He took Petitioner off work and prescribed physical therapy. PX 10.

Petitioner underwent an initial physical therapy evaluation at Marque Medicos on June 11, 2010, with the therapist noting that Petitioner reported having some minimal low back pain the day before the June 8, 2010 work accident.

On June 26, 2010, Petitioner underwent a lumbar spine MRI at Archer Open MRI Facility per Dr. Perez. The MRI demonstrated "minimal disc bulging and hypertrophy of ligamentum flavum and facet joints" at L4-L5, with the radiologist also noting "minimal bilateral neural foraminal stenosis" at that level.

Petitioner returned to Dr. Perez on June 29, 2010. On that date, Dr. Perez reviewed the MRI report. He described the MRI results as consistent with the reported mechanism of injury and complaints. He indicated that the MRI "reveals the complexity of the patient's lower back condition." He referred Petitioner to Dr. Engel for "medication management" and instructed Petitioner to stay off work and continue physical therapy. PX 10.

On July 1, 2010, Petitioner saw Dr. Engel of Medicos Pain & Surgical Specialists for a pain management consultation. In his history of that date, Dr. Engel noted that Petitioner had previously sustained a lumbar sprain/strain at work on March 2, 2009 and had resumed full duty on November 12, 2009 "with pain that was a 4/10 on the visual analog scale." Dr. Engel also noted that Petitioner began experiencing a gradual onset of "new" low back pain after handling boxes at work on June 8, 2010. He described the "root cause" of "these two pains" as "totally different." He noted that the lumbar spine MRI performed on April 10, 2009 was "read as unremarkable" while the MRI performed on June 26, 2010 showed "bilateral neural foramen stenosis at L4-5 secondary to disc bulging and hypertrophy of the ligamentum flavum and facet joints."

On examination, Dr. Engel noted a decreased range of lumbar spine motion, limited lumbar extension secondary to pain, 5/5 strength in both legs and negative straight leg raising bilaterally. T. 26.

Dr. Engel addressed causation as follows:

> "As the patient has a herniated disc on his new MRI that was not present on his previous MRI, his work-related accident of 6/8/10 is the direct cause of his current low back pain and radicular pain. Though I appreciate he had a previous muscle sprain and strain, this current injury is different as it is secondary to his herniated disc."

Dr. Engel prescribed Mobic, Omeprazole and Soma. He instructed Petitioner to stay off work and continue therapy. PX 11.

When Dr. Perez next saw Petitioner, on July 7, 2010, he noted that Petitioner was now complaining of "intense pain of his bilateral inguinal areas" as well as pain in his lower back and legs. He recommended an EMG "to rule out a lumbosacral radiculopathy." He instructed Petitioner to remain off work and continue therapy. PX 10.

On July 9, 2010, Petitioner underwent a lower extremity EMG. Dr. McCaffery, who is described as "board certified" in "chiropractic neurology," interpreted the EMG results as normal. PX 10.

On July 21, 2010, Petitioner underwent a CT scan of the pelvis at Dr. Perez's recommendation. The CT scan demonstrated an "atypical appearance of the left L5-S1 facet concerning for pars defect" and "no evidence of hernia." The interpreting radiologist, Dr. Lutz, suggested that Petitioner undergo oblique lumbar spine X-rays if he demonstrated lower back symptoms. PX 11.

Petitioner returned to Dr. Engel on July 29, 2010, with the doctor noting the results of the recent EMG and CT scan. He described the CT scan as revealing "L5-S1 facet joint syndrome." He noted that Petitioner complained not only of his lower back and legs but also of mid-back pain "going into the chest" with associated shortness of breath.

On examination, Dr. Engel noted a full range of motion with respect to flexion. He described backward extension as "with minimal deficit and mobility but it is [the] most painful maneuver." He described straight leg raising as negative bilaterally. At the hearing, he testified that, at this point, he "presumptively" diagnosed lumbar facet syndrome based on Petitioner's presentation. He testified that this syndrome can be either degenerative or acute. T. 32. He ordered a left L4, L5 and S1 medial branch block to explore this diagnosis. T. 30-31. After Petitioner saw Dr. Nandra on July 30, 2010, and obtained medical clearance, Dr. Engel performed the medial branch blocks on August 2, 2010. In his report, he noted he completed

the blocks at left L3, L4, L5 and S1 rather than the planned levels "since the patient had facet arthropathy at L3-4, L4-5 and L5-S1." PX 11.

At the next visit, on August 19, 2010, Dr. Engel noted that Petitioner obtained only three hours of pain relief following the blocks. He described this reaction as "appropriate as the injection was local anesthetic only." On examination, he noted a decreased lumbar spine range of motion, limited lumbar extension secondary to pain, 5/5 strength and negative straight leg raising bilaterally. He discussed "left L3, L4, L5 and S1 medial branch confirmatory blocks" with Petitioner. He discussed Petitioner's reaction as follows:

> "He understands that this injection is necessary prior to moving to radiofrequency ablation, which is the curative treatment. The patient wants to move right to the curative treatment, which would allow him to return to work faster. though I prefer confirmatory blocks, the patient was insisting upon moving to radiofrequency ablation."

He instructed Petitioner to remain off work and continue therapy and medication.

At the hearing, Dr. Engel testified that he recommended confirmatory blocks to Petitioner because the "false-positive rate for a diagnostic block is about 50 percent." He further explained:

> "When you add a confirmatory medial branch block, if the patient is pain free in the recovery room both times, you can be about 85 percent certain that the facet joint is the root cause of the patient's pain."

Dr. Engel described Petitioner as "refusing" to undergo the confirmatory blocks. T. 34-35.

Despite the lack of confirmation, Dr. Engel proceeded to perform the ablation procedure on August 30, 2010. Although Petitioner testified he noticed only a "bit" of improvement following this procedure, Dr. Engel described Petitioner's left-sided lower back pain as "essentially cured" on September 9, 2010. He noted that Petitioner complained primarily of right-sided lower back pain. On examination, he noted no abnormalities. He instructed Petitioner to start work conditioning. He released Petitioner to light duty with no lifting over 30 pounds. PX 11.

On September 27, 2010, Petitioner underwent an initial work conditioning evaluation at Elite Physical Therapy. The evaluating therapist, Luis Maldonado, P.T., noted a QVAS score of 63, "denoting a high perceived pain level," and an Oswestry score of 34%, "denoting a mild level of perceived disability." PX 12. Petitioner attended forty-five work conditioning sessions thereafter. On December 10, 2010, Maldonado noted that Petitioner was still complaining of

moderate lower back discomfort and was unable to tolerate frequent lifting/carrying of 80 pounds. PX 11-12.

At the request of Respondent Vanee Foods, Petitioner saw Dr. Ghanayem for a Section 12 examination on November 17, 2010. Dr. Ghanayem's report reflects that he is director of the division of spine surgery at Loyola University Medical Center. The report also reflects that Dr. Ghanayem reviewed "records and radiographs" in connection with his examination. With the exception of the June 2010 MRI scan, those records and radiographs are not otherwise described.

Dr. Ghanayem's report sets forth consistent accounts of the March 2, 2009 and June 8, 2010 work accidents. Dr. Ghanayem noted that Petitioner described himself as having improved but not fully recovered from the 2009 accident when the June 8, 2010 accident took place.

On examination, Dr. Ghanayem noted a normal gait and "an extreme amount of pain with light palpation" of the lumbar spine. He noted positive Waddell signs, 20 degrees of extension, 90 degrees of flexion, no neurological abnormalities and negative tension signs. He reviewed the June 2010 lumbar spine MRI scan and described it as "normal." He addressed causation and prognosis as follows:

> "My impression is that, based on the mechanism of injury, this gentleman may have sustained a back sprain. His symptoms of leg pain are not anatomic and do not correlate with his MRI scan. His back pain is in excess of what would be expected from the MRI scan as well. His diagnosis, based on the history, would be a back sprain. A brief course of physical therapy, on the order of three to four weeks' duration, would be medically appropriate. After that, he should have returned back to work at regular duty. He requires no further medical care. He is at MMI. There is no residual disability relative to this alleged June 9, 2010 muscular sprain."

Vanee RX 1.

On November 22, 2010, Dr. Engel noted that Petitioner was still complaining of 3/10 left-sided lower back pain. He noted no abnormalities on examination. He imposed a 50-pound lifting restriction and instructed Petitioner to continue work conditioning. PX 11.

On December 13, 2010, Dr. Engel noted that Petitioner reported improvement secondary to work conditioning but was still complaining of 3/10 left-sided lower back pain. He noted no abnormalities on examination. He imposed a permanent 75-pound lifting restriction and discharged Petitioner from care, noting he had nothing else to offer treatment-wise. He recommended a home exercise program and gym membership. PX 11.

Petitioner testified that Respondent Vanee Foods terminated him once he was released to restricted duty. On August 8, 2011, he began working for Respondent Accurate Personnel, a staffing agency. He was dealing with "extreme pain" in his leg and waist at this point. Accurate sent him to OSG, where he worked as a machine operator. His job required him to set up machines and lift boxes that weighed up to 50 pounds.

Petitioner testified that, while working at OSG on November 4, 2011, he was walking around a machine when he caught his right foot on a bolt. He almost hit the machine but was able to regain his balance. He was unable to recall exactly when this accident occurred. The following day, he began experiencing extreme pain in his low back, mid-back, legs and chest. Later he started experiencing neck pain as well. He reported the accident to Fatima and later to Carmella. [Notice is not in dispute, Arb Exh 2.] Accurate sent him to Alexian Brothers Medical Group in Bensenville. The initial note, dated November 7, 2011, reflects that Petitioner twice hyper-extended his left leg on November 4, 2011, when he walked around a machine at work, got his right foot stuck between a wall and a piece of metal and temporarily lost his balance. PX 23. The note also reflects that Petitioner complained of pain in his right foot, lower back, left groin and left thigh with radiation to the leg. The note contains no mention of the previous work accidents. A separate handwritten history reflects that Petitioner "tripped on a bolt and jerked body."

The examining physician, Dr. Sandoval, noted that Petitioner appeared to be in no distress and walked with a normal gait. On examination, the doctor noted a normal range of lumbar spine motion with mild tenderness at the level of the bilateral paravertebral muscles between L4 and L5, tenderness in the left groin, no hernia or masses, and an area of tenderness in the right foot with no bruises or contusion.

Dr. Sandoval diagnosed a lumbar sprain/strain, left groin strain, left thigh strain and right foot contusion. He prescribed Robaxin and Ibuprofen and imposed various work restrictions. PX 27. Petitioner testified that Respondent Accurate accommodated these restrictions.

Petitioner returned to Alexian Brothers the following day, November 8, 2011, and complained of pain in his right leg, chest, abdomen and throat. Petitioner indicated he felt "woozy" due to the medication prescribed the previous day. Petitioner underwent an EKG. The examining physician, Dr. Baksinski, diagnosed an adverse drug reaction and instructed Petitioner to stop taking the Robaxin and continue the Ibuprofen. Dr. Baksinski continued the previous work restrictions and instructed Petitioner to return on November 15, 2011 for a re-check. PX 23.

Petitioner also went to Marque Medicos on November 8, 2011. He saw Dr. Perez on that date and provided a history of the November 4, 2011 accident. The doctor's note reflects that Petitioner was walking quickly around a machine when he "suddenly tripped over a large bolt that was sticking out from the machine, causing him to lose his balance." The note also

reflects that Petitioner's body "twisted forcefully" as he started to fall but that Petitioner was able to regain his balance. The doctor noted complaints relative to the lower back, mid-back, left groin, left knee, legs and anterior chest. With respect to Petitioner's past history, the doctor noted:

> "The patient reports that he was physically well and that he was working without any difficulties prior to the work injury he sustained on 11/4/11. The patient reports that he has been employed for approximately three months at his current place of employment."

The doctor also noted a history of prior "episodes of lower back pain" that required treatment.

On examination, Dr. Perez noted significant tenderness to palpation over the T6 through T12 and the L1 through S1 spinal levels, as well as over the bilateral thoracic and lumbar paraspinal musculature. He also noted positive straight leg raising on the right at 40 degrees and muscle strength test results of 4/5.

Thoracic and lumbar spine X-rays showed no fractures or dislocations on preliminary reading.

Based on Petitioner's history, including the described mechanism of injury, Dr. Perez attributed Petitioner's current complaints to the November 4, 2011 accident. He prescribed physical therapy. He imposed work restrictions and referred Petitioner to Dr. Engel for medication management. PX 24.

Petitioner returned to Dr. Perez on November 11, 2011 and again complained of pain in his lower back, mid-back, legs, left groin and anterior chest. Petitioner indicated he had attempted to work with light duty restrictions but "felt worse." Petitioner reported having gone to an Emergency Room "due to the intense pain he was experiencing" and having received medication there. [No Emergency Room records are in evidence.] Dr. Perez noted that Petitioner appeared to be in obvious acute distress and was unable to stay in one position for even a short period. He took Petitioner off work and again referred him to Dr. Engel. PX 24.

Petitioner testified he presented Dr. Perez's "off work" slip to Carmella.

On November 15, 2011, Petitioner saw Dr. Engel of Medicos Pain & Surgical Specialists. Dr. Engel's note sets forth a consistent history of the November 4, 2011 work accident. The note also reflects that Petitioner previously injured his back on March 2, 2009 and June 9, 2010 and was discharged with a 75-pound lifting restriction after the June 9, 2010 accident.

Dr. Engel noted that Petitioner complained of unbearable, 10/10 pain in his mid-back, low back, legs, anterior chest and left groin. He noted that Petitioner was currently taking Hydrocodone and Ibuprofen. He reviewed the recent spinal X-rays, noting an apparent pars

defect at L5-S1. He indicated Petitioner might also have a spinous process fracture. He indicated that a radiologist would be reading the films.

On examination, Dr. Engel noted positive straight leg raising bilaterally at 45 degrees, 5/5 bilateral leg strength, full lumbar flexion, limited lumbar extension and pain to palpation of the bilateral lumbar paraspinous musculature. He diagnosed "low back pain syndrome" and "thoracic spine pain." He prescribed a lumbar spine MRI, commenting that the "current accident caused radiculopathy, which is likely secondary to disc disease." He asked Petitioner to stop taking Hydrocodone. He started Petitioner on Ultram and Ambien. He instructed Petitioner to stay off work and continue therapy. PX 24.

The MRI, performed on November 16, 2011, showed diffuse disc bulging at L3-4, L4-5 and L5-S1, with the radiologist also noting a "likely congenital" deformity involving the lamina bilaterally at L5-S1.

Petitioner underwent an initial physical therapy evaluation at Marque Medicos on November 18, 2011. The evaluating therapist, Norman Lambot, P.T., noted complaints of 7-8/10 pain in the low back and mid-back as well as numbness in both feet. He also noted that Petitioner "ambulates without obvious antalgia." PX 24.

Petitioner returned to Dr. Perez on November 21, 2011 and reported some improvement. The doctor noted that Petitioner was walking without any obvious antalgic gait. On examination, the doctor noted positive straight leg raising bilaterally and 5/5 strength. He reviewed the MRI. He instructed Petitioner to remain off work and continue therapy. PX 24.

On November 28, 2011, Dr. Engel compared the recent MRI with the previous MRI and opined that the "foraminal stenosis secondary to the contained disc herniation at L4-5 has gotten worse." He kept Petitioner off work and prescribed additional therapy and medication. PX 24.

On December 6, 2011, Dr. Perez noted that Petitioner did not appear to be in distress and was able to move with greater ease. He indicated that Petitioner's active range of motion had "clearly improved." He again noted positive straight leg raising bilaterally at 45 degrees. He described the MRI as "clinically significant" and correlative with Petitioner's complaints. He prescribed EMG/NCV testing "to further identify the radicular component of the patient's ongoing condition." He instructed Petitioner to stay off work, continue therapy and follow up with Dr. Engel. PX 24.

The EMG, performed on December 16, 2011, was negative. Dr. McCaffery performed this study. PX 24.

Dr. Perez continued to prescribe therapy and keep Petitioner off work following the negative EMG. PX 24.

On January 12, 2012, Dr. Engel noted some improvement in Petitioner's pain level but noted that Petitioner still complained of bilateral leg numbness as well as pain in his low back and mid-back. Straight leg raising was again positive bilaterally at 45 degrees. He instructed Petitioner to discontinue therapy and see Dr. Erickson, a neurosurgeon, for a consultation due to his "bilateral neural foraminal stenosis at L4-5." He released Petitioner to light duty with no lifting over 5 pounds and sit/stand as needed. PX 24.

Petitioner testified that, after he presented Dr. Engel's January 12, 2012 restrictions to Respondent Accurate, Carmella told him, "no work is available, I'll call you."

There is no indication that Petitioner ever saw Dr. Erickson.

On February 7, 2012, Petitioner began seeing Dr. Gireesan, an orthopedic surgeon. The doctor's note of that date sets forth a consistent account of the November 4, 2011 work accident. The note contains no mention of the previous work accidents but it does reflect that Petitioner previously underwent lumbar blocks and injections. The doctor indicated Petitioner was currently taking Tramadol.

Dr. Gireesan noted that Petitioner complained of pain in his feet, calves, knees, legs, lower back, neck and "all joints." Dr. Gireesan also noted that Petitioner complained of "pins and needles" in his extremities and difficulty sleeping.

Dr. Gireesan described Petitioner's gait as normal. Straight leg raising was negative bilaterally.

Dr. Gireesan assessed Petitioner as having an "unspecified disorder of muscle, ligament and fascia, with pain to the back and extremities." He started Petitioner on Trazadone and Cymbalta. PX 26.

At the request of Respondent Accurate Personnel, Petitioner saw Dr. Salehi for a Section 12 examination on May 10, 2012. Dr. Salehi's report of the same date reflects that he is a board certified neurosurgeon. Accurate RX 1.

Dr. Salehi's report sets forth a consistent account of the November 4, 2011 work accident. He noted that Petitioner complained primarily of low back pain but also complained of pain in his left groin, legs, knees, feet, neck and chest. He also noted that Petitioner reported taking Tramadol "when the pain is severe."

With respect to Petitioner's past medical history, Dr. Salehi noted that Petitioner "had one work injury with a different employer in 2009" and was still experiencing low back, groin and leg complaints as of the November 4, 2011 accident. Dr. Salehi also noted that Petitioner denied having pain in his neck and arms prior to the November 4, 2011 accident. He indicated Petitioner was released with restrictions in January of 2012 but not accepted back to work. He noted that Petitioner was currently working for himself, towing and selling vehicles.

Dr. Salehi indicated he reviewed numerous records, including the lumbar spine MRI reports of June 26, 2010 and November 16, 2011 and the EMG reports. He also reviewed the MRI films and lumbar spine X-rays. He interpreted the June 22, 2010 lumbar spine X-ray as showing slight spondylolisthesis at L5 and the November 9, 2011 lumbar spine X-ray as showing spina bifida occulta at L5 and "no obvious evidence of pars fracture."

On examination, Dr. Salehi noted a normal gait, tenderness to palpation at the mid-cervical region and lumbosacral junction, positive lying straight leg raising, negative sitting straight leg raising, no spasm, normal strength in all extremities, decreased sensation in the left leg in a non-dermatomal distribution and inconsistent behavorial responses (pain on simulation).

Dr. Salehi opined that the mechanism of injury described by Petitioner was "consistent with the diagnosis of lumbar strain." Based on this diagnosis, he viewed the first six weeks of treatment as medically appropriate, "including chiropractic treatment and physical therapy." He indicated there was "no good anatomic explanation for the diffuse complaints in the lower extremities, as there are no neural compressive lesions." He found no relationship between the November 4, 2011 accident and the neck/upper extremity complaints "as [Petitioner] had no such symptoms based on the records reviewed after the 11/4/11 work injury." He indicated Petitioner reached maximum medical improvement six weeks post-accident and "could have worked without restrictions at that time." He recommended that Petitioner perform home exercises, remain aerobically active and take over the counter analgesics as needed. Accurate RX 1.

Petitioner continued seeing Dr. Gireesan after the Section 12 examination. Dr. Gireesan started Petitioner on Ambien on July 24, 2012. On September 10, 2012, he refilled the Trazadone and Ambien and recommended that Petitioner engage in yoga and meditation. On October 19, 2012, he noted Petitioner was feeling better and doing stretches on his own. He started Petitioner on Lyrica and refilled the Trazadone and Ambien. At the next visit, on November 16, 2012, he prescribed Tramadol for pain and advised Petitioner to "take it sparingly." On January 17, 2013, he noted that Petitioner complained of pain in both shoulders and "all over the body." He also noted that Petitioner reported having undergone treatment at an unspecified Emergency Room the previous week. [No Emergency Room records are in evidence.] He described Petitioner's gait as normal and noted negative straight leg raising bilaterally. He refilled Petitioner's medications, including the Tramadol, but indicated he "advised [Petitioner] to refrain from taking Tramadol" and informed Petitioner that Tramadol is addictive. PX 26.

On March 26, 2013, Petitioner filed a Petition for Penalties and Attorney's Fees in both cases, alleging, inter alia, that Respondents did not rely on a qualified medical opinion or utilization review in denying benefits. PX 19, 33.

Petitioner testified he started his own business, buying and towing "junk" vehicles, at some point after January 2012.

Petitioner testified the 2011 work accident altered his life. He is unable to work for more than a couple of hours due to persistent pain in his back, neck and chest. When he gets up, he has to soak in a hot bath and do stretches to get going. He is a single father of two young children. The children are very active and he has difficulty taking care of them.

Under cross-examination by Respondent Vanee Foods, Petitioner testified he settled his March 2, 2009 back injury claim with Vanee. He netted about $7,000 from this settlement. He could not recall the percentage of loss involved in the settlement or the exact date on which the settlement was finalized. It may be that the settlement was finalized in May of 2012. The settlement contracts referenced only the '09 case. He settled the case based on his attorney's recommendation. He was aware that the other two cases remained pending.

Petitioner acknowledged signing the Application in 10 WC 22455 on June 10, 2010. He returned to Marque Medicos following the June 2010 accident because the treatment he received at Marque Medicos after the '09 accident was "pretty good." Marque Medicos offered him transportation on a few occasions. He recalled using this transportation a few times to go from his home to the surgicenter for blocks and injections. He lived in Chicago at that time. The surgicenter was also in Chicago. T. 155-156. He is currently not working. He never incorporated his business, which was called "JG Towing," but he did pay taxes. His brother and friends helped him with this business. T. 156-157. When there was heavy labor involved, he got help. The business was not high volume. On some days, he towed only one vehicle. Towing did not require heavy labor. He had a flatbed tow truck and only had to operate levers. He did towing from about January of 2012 until September 2012, when his tow truck "went down." After that, he continued buying vehicles for scrap for a while. He last bought a scrap vehicle about two to three months before the hearing. He worked for a florist on Kedzie for a couple of days before being fired over a daycare-related issue. After that, he briefly worked as a forklift operator through an agency called "Staff Right." At times, he had to operate the forklift in reverse. This caused his neck and back to ache. He took Tramadol at work, "zoned out," dropped two pallets and got fired. He has not filed any new claims. He did not file any claims before the '09 claim. He is looking for work and would accept a job if it were offered to him. His right wrist is in a cast because he sustained a fracture at home the Friday before the hearing.

Under cross-examination by Respondent Accurate Personnel, Petitioner testified the November 4, 2011 accident took place at OSG Tap & Die. T. 173. He was near the end of a 90-day probationary period when this accident occurred. He was "led to believe" he would have been offered a full-time job at OSG had he completed this period. The work he did at OSG was light and he could sit or stand as needed. T. 177. He worked on Saturday, November 5, 2011 and did not report the accident until November 7, 2011. He did not continue care at Alexian Brothers because the female doctor he saw at the second visit did not seem to believe him and wanted him to sign something. T. 179. He did not see Dr. Erickson per Dr. Engel's referral

because he did not want to undergo any additional procedures. T. 180. He has seen Dr. Gireesan on and off since his first injury in 2009. He applied for unemployment twice and was denied twice. He participated in a telephonic hearing in January of 2012. He believes he was denied benefits because he was honest during this hearing. He was honest and truthful with Dr. Salehi but the doctor was not honest and truthful in his report. T. 183. At Dr. Gireesan's recommendation, he uses exercise machines and does core work and stretches. He is currently taking Tramadol, Trazadone and Ambien. T. 185-186. In January of 2013, Dr. Gireesan told him to avoid the Tramadol if possible but he needs to take this at times due to extreme pain. He is scheduled to return to Dr. Gireesan in two days. He no longer takes Lyrica because he cannot afford to pay for this medication. T. 185-186.

On redirect, Petitioner testified he picked up his checks from Respondent Accurate Personnel during the time he worked at ODG. T. 187-189.

Under re-cross, Petitioner testified he represented himself in his claim for unemployment benefits. It was because he was honest and truthful while he was representing himself that he was denied benefits. T. 190. Because he is represented in his workers' compensation claims, he feels "protected."

On further redirect, Petitioner testified he was honest and truthful throughout the hearing. T. 190-192.

No witnesses testified on behalf of either Respondent.

Jesus Gomez v. Accurate Personnel
11 WC 48119

Arbitrator's Credibility Assessment

Petitioner was articulate but very subdued. He was essentially without affect during much of his testimony. His complaints of intense, debilitating pain are at odds with Dr. Salehi's findings and some of his treatment records.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident on November 4, 2011 arising out of and in the course of his employment?

The Arbitrator finds that Petitioner sustained a compensable work accident on November 4, 2011. In so finding, the Arbitrator cites Petitioner's detailed and uncontradicted testimony concerning the mechanism of this accident and the consistent histories set forth in the treatment records.

Did Petitioner establish a causal connection between the accident of November 4, 2011 and his current lumbar spine condition of ill-being?

The Arbitrator finds that Petitioner established causation as to a current lumbar strain condition of ill-being. The Arbitrator finds that Petitioner failed to establish causation as to the 5-pound lifting restriction imposed by Dr. Engel in January of 2012 and the neck, foot, knee and other complaints Petitioner voiced at various times. In finding that Petitioner failed to prove causation as to the 5-pound lifting restriction, the Arbitrator notes that Dr. Gireesan, who treated Petitioner after January of 2012, did not diagnose a specific condition and never imposed any restrictions.

Is Petitioner entitled to medical expenses?

Petitioner seeks an award of $10,005.69 in fee schedule and prescription charges associated with the treatment he underwent at or with Alexian Brothers, Marque Medicos, Medicos Pain & Surgical Specialists, Archer MRI, Industrial Pharmacy and Dr. Gireesan (PX 27-32).

Respondent's Section 12 examiner, Dr. Salehi, opined that the November 4, 2011 accident resulted in a lumbar strain. Based on this diagnosis, Dr. Salehi viewed the first six weeks of treatment, "including chiropractic treatment and physical therapy," as medically appropriate. RX 1 Accurate Personnel.

The Arbitrator finds Dr. Salehi's opinions concerning diagnosis and treatment to be

more persuasive than those voiced by Dr. Engel. In so finding, the Arbitrator notes that, although Dr. Engel recommended a surgical consultation when he last saw Petitioner, the surgeon who saw Petitioner after that date, i.e., Dr. Gireesan, was unable to reach a specific diagnosis and opted to treat Petitioner conservatively.

The Arbitrator awards Petitioner the following:

Alexian Brothers Medical Group (PX 27)		
11/7/11 – 11/8/11	$	420.77
Marque Medicos (PX 28)		
11/8/11 – 1/10/12, physical therapy	$	3,691.58
11/8/11 – 12/27/11, chiropractic (Dr. Perez)	$	656.84
Archer Open MRI (PX 29)		
11/16/11, lumbar spine MRI	$	1,132.43
Medicos Pain & Surgical Specialists (Dr. Engel) (PX 30)		
11/15/11 – 1/12/12	$	334.99
Industrial Pharmacy (PX 31)		
11/15/11 – 1/12/12	$	1,245.88

The Arbitrator recognizes that some of the foregoing medical expenses stem from treatment rendered slightly beyond the six-week "window" contemplated by Dr. Salehi. Consistent with the decision issued in the companion claim, the Arbitrator declines to award the Marque Medicos fee schedule expenses of $1,903.70 associated with the EMG performed by Dr. McCaffery on December 16, 2011. Dr. McCaffery is a chiropractor, not a medical doctor. Petitioner presented no persuasive evidence showing that Dr. McCaffery is sufficiently qualified to interpret EMG studies. Nor does it appear that Dr. McCaffery examined Petitioner prior to performing the EMG. PX 24. The Arbitrator also declines to award the $619.50 in fee schedule expenses associated with the treatment rendered by Dr. Gireesan between July 24, 2012 and January 17, 2013. This treatment took place well beyond the six-week window contemplated by Dr. Salehi.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims temporary total disability benefits from November 11, 2011 through March 7, 2012. Arb Exh 2. The Arbitrator awards temporary total disability benefits from November 11, 2011 through December 22, 2011, a period of six weeks, in reliance on the opinions expressed by Dr. Salehi. The Arbitrator finds persuasive Dr. Salehi's conclusion that Petitioner would have been capable of resuming full duty within approximately six weeks of the accident. RX 1 Accurate Personnel.

Is Petitioner entitled to permanency?

Having found that Petitioner established causation as to a current lumbar strain condition of ill-being, the Arbitrator finds that Petitioner established permanency equivalent to 4% loss of use of the person as a whole under Section 8(d)2, or 20 weeks of benefits.

Is Respondent Accurate Personnel liable for penalties and fees?

Respondent disputed accident in this case but did not call any witness to refute Petitioner's testimony concerning the mechanism of injury. The mechanism of injury that Petitioner described is set forth in the treatment records, including the initial records from Alexian Brothers, Respondent's selected provider. Dr. Sandoval of Alexian Brothers diagnosed a lumbar strain, as did Respondent's examiner, Dr. Salehi. Dr. Salehi noted some inconsistencies on examination but nevertheless opined that it was appropriate for Petitioner to stay off work for six weeks and undergo six weeks of treatment. Despite the opinions voiced by Drs. Sandoval and Salehi, Respondent paid no benefits in this case.

Respondent does not argue that it acted in good faith in disputing accident and declining to pay six weeks of medical expenses and temporary total disability. Instead, Respondent maintains it should not be held liable for penalties or fees because Petitioner failed to make a specific demand for payment. While it is true that, in this case, Petitioner did not offer into evidence any letters or other communications demanding payment of specific medical bills or claimed periods of temporary total disability, Petitioner did offer various unpaid medical bills, two of which specifically reference Respondent's workers' compensation carrier, Dallas National/Coventry. PX 27, 31. The first of these is the bill relating to treatment rendered by Alexian Brothers, a provider of Respondent's selection. PX 27. Respondent offered no evidence explaining why it failed to pay its own selected provider. The bill from Alexian Brothers stems from treatment rendered on November 7 and 8, 2011, approximately eighteen months prior to the hearing.

On this record, the Arbitrator finds it appropriate to award penalties pursuant to Section 19(l). Such penalties are in the nature of a non-discretionary late fee. McMahan v. Industrial Commission, 183 Ill.2d 499 (1998). The Arbitrator awards Section 19(l) penalties at the rate of $30.00 per day and in the maximum statutory amount of $10,000.00, based on the lengthy delay in payment of the Alexian Brothers bill.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCHENRY)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Smith Jr.,

Petitioner,

vs.

14IWCC0681

NO: 03 WC 27555

Mid American Heating & Air Conditioning, Inc.,

Respondent,

DECISION AND OPINION ON REMAND

This matter is before the Commission on Circuit Court Judge Thomas A. Meyer reversal and remand of the Commission's decision which was issued on December 19, 2011. In that reversal and remand, the Judge affirmed the decision of the Commission in regards to the Petitioner's lack of credibility. In his decision, the Judge noted that the Commission addressed the inconsistencies in the Petitioner's claims and the contradictions between his testimony and the records of his various physicians. Per the Judge, "The Commission made specific note of the inconsistencies between Petitioner's testimony and his medical records and cited specific examples from the records of Dr. Kroll, Dr. Lorenz and Dr. Goldflies in the Decision." The Judge specifically stated that the "Commission had a basis on which to determine that the Petitioner's credibility was lacking."

The Judge went on to find that the Commission had determined that Petitioner's condition of ill-being on the date of the Arbitrator's hearing was not causally connected to the accident which occurred on February 3, 2003. However, the Judge found that there was no

medical evidence contained in the record that indicated the chronic condition had resolved or returned to its pre-accident state and remanded this case back to the Commission for a finding in that regard.

This matter was originally tried under Section 19(b) of the Act. The Section states that the Arbitrator "may find the disabling condition is temporary and has not yet reached a permanent condition and may order payment of compensation up to the date of the hearing, which award shall be reviewable and enforceable as the same manner as other awards, and in no instance be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, but shall be conclusive as to all other questions except the nature and extent of said disability."

In this particular instance the Commission found that Petitioner is not entitled to any further temporary total disability after September 22, 2003. Petitioner has the right to go back to the Arbitrator and try to prove that he is entitled to temporary total disability after the date of the Arbitration hearing or to prove that he has sustained permanent disability as a result of the February 3, 2003 accident.

The Commission assumes that the Circuit Court Judge remanded this back to the Commission to make a determination of whether Petitioner is entitled to further temporary disability since the hearing date or to determine when and if Petitioner is entitled to any permanent disability as a result of this injury. The Commission stated in its original decision that "as provided in Section 19(b) of the Act, the 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."

The Commission found that as of September 22, 2003, based on Petitioner's lack of credibility, the medical records of the various treating physicians, the Petitioner's lack of cooperation with those physicians, and the emergency Room Doctor's findings on that date, the Petitioner was not entitled to further temporary disability and medical treatment thereafter up until the date of the hearing before the Arbitrator. The Commission believes the Circuit Judge had no objection to that finding. The Commission did not find that Petitioner's condition had fully resolved and if so when that resolution occurred. That is an issue that had yet to be decided and the Petitioner and the Respondent have the right under Section 19(b) to offer evidence for or against it before the Arbitrator. Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Therefore the Commission, per the Remand of the Circuit Court Judge, 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).

14IWCC0681

The Judge also remanded this matter back to the Commission "to complete its analysis of the impact of its decision regarding Section 19(d)." Section 19 (d) of the Act provides that "If any employee shall persist in insanitary or injurious practices which tend to either imperil or retard his recovery, OR shall refuse to submit to such medical, surgical, or hospital treatment as is reasonably essential to promote his recovery, the Commission may, in its discretion, reduce or suspend the compensation of any injured employee."

Nowhere in the Commission is decision Section 19(d) cited. The Commission took the Petitioner's lack of credibility, the various inconsistent medical records of treating physicians, as well as his failure to fully comply with the treatment that they prescribed, to come to the conclusion that Petitioner failed to meet his burden of proof regarding causal connection and further temporary total disability. However, even if it was mentioned, that Section of the Act allows the Commission, in its discretion, to use the Petitioner's failure to comply with the reasonable treatment as one of the basis for denying benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that this case is remanded 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).

DATED: AUG 15 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
O: 6/18/14
049

STATE OF ILLINOIS)
) SS.
COUNTY 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

Elias Urena,

Petitioner,

14IWCC0682

vs.

NO: 01 WC 50469

Eagle Concrete Contractors,

Respondent,

DECISION AND OPINION ON REVIEW UNDER §19(h) AND 8(a)

Petition for hearing under Section 19(h) and 8(a) having been filed by the Petitioner and due notice having been given; this cause came on for hearing before Commissioner Charles J. DeVriendt on August 13, 2012, and February 4, 2013, in Chicago, Illinois. The Commission having jurisdiction over the persons and subject matter and being advised in the premises finds:

The Commission finds that Respondent is not liable for penalties under Section 19(k) or (l). Wanda Perlinski, who is the workers compensation manager of Cincinnati Insurance, testified that all reasonable and necessary bills that were submitted had been paid. The medical bills that had been presented at the August 13, 2012 hearing and allegedly unpaid were not submitted to her prior to that date. (Review Transcript Pg. 15)

After receiving the bills she contacted Sherman Hospital on October 16, 2012 and found that they had a zero balance. The Garcia Medical Center's bill was reviewed in regard to the fee schedule and a $735.00 check was issued. The Neopath's bill was denied in 2009 by Corvel and upon resubmission was still denied. The bill from Westbrook was confirmed as a zero balance by Pam who indicated that bill was paid by Medicare. The bill from Retina Institute had an outstanding balance of $14.82 which she paid. The outstanding medical bills of Dr. Mack were first seen by her after August 13, 2012, and were paid pursuant to the fee schedule. (Review Transcript Pgs. 16-22)

The Commission finds that the unpaid Neopath's bill should be denied because the bill was for a non-covered procedure per state regulations. The coding on that bill was ICD-9 diagnosis 365.10 which is a non-covered procedure for unspecified open angle glaucoma. (Review Transcript Pg. 42)

The prescription bills that Petitioner claimed Ms. Perlinski would not pay were not tendered to her prior to August 13, 2012. They have been paid since she received them. (Review Transcript Pgs. 22-24)

Therefore, the Commission denies the Petitioner's claim for Section 19(k) and (l) penalties on the alleged unpaid medical bills and prescriptions.

The Commission also finds that Petitioner has proven a loss of use to the right eye to the extent of 75%.

Since the Arbitration hearing in March 22, 2006, the Petitioner has had a right corneal transplant performed by Dr. Mack in January 14, 2010. Following that surgery he continued to treat with Dr. Mack and on April 12, 2010, Petitioner indicated that his eyes felt good but felt that he had a vision decrease since the surgery. Dr. Mack however found a large improvement in Petitioner's visual acuity with a gas perm contact lens. He found the Petitioner had 20/70 acuity with that lens. (Petitioner Exhibit 12 Pgs. 9-13)

On March 11, 2011 Dr. Mack performed a cryopreserved amniotic membrane procedure. The amniotic membrane is a donated tissue and is useful in reducing inflammation and is used in high risk cornea transplants. Shortly after the surgery, Petitioner questioned whether the graft was failing. Petitioner had a number of diagnostic studies which were all normal. (Petitioner Exhibit 12 Pgs. 16-18)

Dr. Mack, who had been treating the Petitioner for his right eye injury since 2002, testified that his vision is similar to what it was at that time, but it is certainly not a stable situation today. (Petitioner Exhibit 12 Pgs. 3-6) He further testified that there are objective findings today that correlate with a decrease in visual acuity. (Petitioner Exhibit 12 Pgs. 20-22)

The Commission finds Dr. Mack testimony to be credible and therefore finds the Petitioner's loss of use of the right eye is now at 75%.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $534.16 per week for an additional period of period of 37.5 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 75% of the right eye. Petitioner received 50% of the right eye in the original arbitration hearing.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is not responsible to pay for any alleged penalties or fees pursuant to Section 19(k) and 19(l) for

unpaid medical bills.

14IWCC0682

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,100.00. 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: AUG 15 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
O: 6/18/14
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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSHUA LOWE,

Petitioner,

vs.

NO: 12 WC 21668

14IWCC0683

ILLINOIS DEPARTMENT OF TRANSPORTATION,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability (TTD), causal connection, maintenance, vocational rehabilitation and penalties, 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 finds that the Petitioner is entitled to Section 19(k) penalties totaling $5,557.75. The penalty represents fifty percent of $11,155.49 which represents fifty percent loss of use of the left index finger pursuant to Section 8(e) of the Act.

Pursuant to Section 19(k) of the Act:

> In case where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act

equal to 50% of the amount payable at the time of such award.

According to Section 8(e)8 of the Act:

> The loss of the first or distal phalanx of the thumb or of any finger or toe shall be considered to be equal to the loss of one-half of such thumb, finger or toe and the compensation payable shall be one-half of the amount above specified. The loss of more than one phalanx shall be considered as the loss of the entire thumb, finger or toe.

Mr. Lowe sustained an undisputed work accident to his left index finger on February 3, 2011. He presented to OSF emergency room immediately following the accident where it was noted Petitioner sustained a crush injury to the left index finger. Dr. Chad Tattini performed a complete transsection of the left index finger flexor digitorum profundus and both slips of the flexor digitorum superficialis. There was a partial laceration of the left index finger ulnar digital nerve. Dr. Tattini repaired zone 2 of the left index finger FDT and FDS tendons and he repaired the left index finger ulnar digital nerve. Dr. Tattini noted that the finger could result in an amputation either immediate or in a delayed fashion. PX.1.

A Summary of Disability was completed by IDOT on February 9, 2011. Mr. Lowe's average weekly wage was calculated as $864.77 and his TTD rate was $576.51. RX.2.

By Respondent's exhibit 3, the Respondent began paying TTD benefits on February 16, 2011. The TTD covered the period of February 8, 2011 through February 15, 2011.

On February 16, 2011, Dr. Tattini performed a left index finger amputation. Dr. Tattini noted that the crushing mechanism had since caused irreversible tissue ischemia to the left index finger that was now necrotic and non-viable. According to the pathology surgical report, 6.1 cm in length of the left index finger was amputated. There was enough bone stump left for a pinching mechanism. PX.1.

On March 1, 2011, the Respondent paid TTD benefits for the period of February 3, 2011 through February 7, 2011 and from February 16, 2011 through February 28, 2011. RX.3. The Respondent paid the February 2, 2011 hospital bills on March 29, 2011 and the February 16, 2011 hospital bills on April 26, 2011. *Id.*

Petitioner received payment from the State in the amount of $11,155.49 on June 29, 2012 representing 50% loss of use of the index finger. PX.8. Lowe received payment of $11,155.49 on October 5, 2012 representing the additional 50% loss of use of the index finger. *Id.*

By the holding of the Appellate Court in *Lester v. Industrial Commission,* 256 Ill.App.3d 520, if the employer delays paying compensation, the employer has the burden of showing that it had a reasonable belief that the delay was justified. The court stated that the legislature intended that individuals who receive amputations should be immediately compensated when no dispute exists as to whether the injury arose out of and in the course of his employment.

The Workers' Compensation Panel further explained Lester in *Greene Welding & Hardware v. Illinois Workers' Compensation Commission*, 396 Ill.App.3d 754, the court rejected any implication that a grace period existed in paying statutory benefits under Section 8(e) of the Act. The court held that the Act established a bright-line test for payment of such benefits.

The Court held that where there is no dispute regarding whether a claimant's amputation injuries arose out of and in the course of employment, statutory benefits for amputation are to be paid no later than the time at which the employer reasonably knows of the extent of the amputation and is capable of calculating the appropriate AWW.

In the matter at bar, the Request for Hearing form indicated that the Respondent stipulated to accident and causal connection. The Respondent completed a Summary of Disability on February 9, 2011 calculating Petitioner's AWW and TTD rate. Respondent began paying TTD benefits on February 16, 2011. On March 29, 2011, Respondent paid the February 2, 2011 bill and on April 26, 2011 they paid the February 16, 2011 medical bills. Despite the payment of TTD benefits, and medical bills, not contesting accident or causal connection, and calculating the appropriate AWW, Respondent offered no explanation, in its one sentence brief, as to why Petitioner was not paid PPD until June 29, 2012, almost 17 months after the accident.

On cross-examination, the Respondent elicited testimony from Mr. Lowe that established that no legitimate defense existed for the non-payment of amputation benefits to Petitioner by Respondent under Section 8(e) of the Act. The Respondent's cross-examination of the Petitioner confirmed that there may have been confusion as to the extent of the left finger amputation. However, the Respondent noted in its questioning that the confusion was on the part of the State, not the Petitioner. T.18. Respondent offered no evidence that it ever attempted to clarify its "confusion."

The Respondent averred that it did not pay the 50% amputation PPD until after Petitioner retained an attorney. *Id.* The Respondent offered no reasonable justification for the delay in payment of the benefits. A quick review of the surgery report would have cleared up any confusion that may have existed.

Applying the standards set forth in *Lester* and *Greene*, the Commission finds that the Respondent is without a reasonable justification for its delay in the payment of 8(e) benefits in the amount of 50% loss of the right index finger, to the Petitioner. Accordingly, the Petitioner is entitled to Section 19(k) penalties totaling $5,557.75. The Commission declines to award penalties on the second installment of the award as the evidence does not clearly demonstrate that Respondent was aware that Petitioner sustained a 100% loss of the finger by amputation. The Commission affirms the remainder of the Arbitrator's award.

The Commission further notes that the Respondent made a one sentence filing with the Commission which states, in its entirety, "The Appellee respectfully requests the Commission to affirm and adopt the Decision of Arbitrator Stephen Mathis, which was filed on 12/20/2013."

In regards to Respondent's one sentence filing in this matter, the Commission feels brief effort was made to advise the presiding panel of the correctness of the Arbitrator's Decision.

14IWCC0683

The Commission, however, is still charged with the statutory duty to review the record in its entirety and discern the correctness of the arbitrator's decision. The assistance and active participation of both party's counsel is presumed to be an integral part of this process. The Commission has taken great pains to review the record below, and protect both Petitioner's and Respondent's interests.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 20, 2013, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $36,838.19 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.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner shall be awarded TTD benefits from this accident date of February 3, 2011 until August 2, 2012 for a total of $45,051.57. Respondent shall be given a credit of $45,051.57 for TTD already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to the Petitioner additional compensation of $5,557.75 as provided in Section 19(k) 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: AUG 15 2014

Michael J. Brennan

MJB/tdm
O: 7/28/14
052

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LOWE, JOSHUA
Employee/Petitioner

Case# **12WC021668**

14IWCC0683

ILLINOIS DEPT OF TRANSPORTATION
Employer/Respondent

On 12/20/2013, 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 0.09% 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:

4707 LAW OFFICE OF CHRIS DOSCOTCH
CASEY MATLOCK
2708 N KNOXVILLE AVE
PEORIA, IL 61604

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

5116 ASSISTANT ATTORNEY GENERAL
GABRIEL CASEY
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1430 CMS BUREAU OF RISK MGMT
WORKERS COMPENSATION MANAGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

DEC 20 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0683

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

Joshua Lowe
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # 12 WC 21668

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 **Stephen Mathis**, Arbitrator of the Commission, in the city of **Peoria**, on **September 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 _____

FINDINGS

On **8/17/2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**44,968.00**; the average weekly wage was $**864.77**.

On the date of accident, Petitioner was **26** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**45,051.57** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

Respondent is entitled to a credit of $**36,838.19** under Section 8(j) of the Act.

ORDER

Respondent shall be given a credit of $36,838.19 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Petitioner shall be awarded TTD benefits from his accident date of 2/3/11 until 8/2/2012 for a total of $45,051.57. Respondent shall be given a credit of $45,051.57 for TTD already paid.

No penalties or attorney's fee are awarded to Petitioner.

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

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

S J Mathis
Signature of Arbitrator

12-13-13
Date

DEC 20 2013

STATEMENT OF FACTS

The facts of this claim are undisputed. Petitioner was employed by the Illinois Department of Transportation as a seasonal snow plow driver during the winter months. On 2/3/11, Petitioner suffered an injury to his left index finger. After being seen in the emergency room, Petitioner was referred to Dr. Tattini, a plastic surgeon, who performed surgery to repair the finger on the same day. This surgery was eventually found to be unsuccessful and the finger was then amputated on 2/16/11.

Petitioner underwent 25 of 27 scheduled work conditioning physical therapy sessions as recommended by Dr. Tattini. (Rx. 1). On 8/2/12, Petitioner was discharged successfully from the program having met all of his goals other than returning to work, which was due to the fact that Petitioner's employment was seasonal and the winter work season had not yet begun. *Ibid.* The discharge mentions 3 times that Petitioner feels he is able and ready to return to work. *Ibid.* Specifically, Petitioner was recorded to be able to lift 80 pounds floor to waist, 50 pounds from waist to overhead and lift and carry 100 pounds. *Ibid.* On 8/22/12, Dr. Tattini released Petitioner to return to work with no restrictions. (Rx. 4).

Until June of 2012, Petitioner was unrepresented by council in regards to his worker's compensation claim. He had never asked for nor been paid any amount of permanent benefit for his finger amputation. Upon being retained, Petitioner's attorney Casey Matlock requested that Petitioner's PPD be paid according to statutory amputation amounts. Respondent then issued Petitioner payment for 50% loss of use of his finger on 6/26/12. (Rx. 3). Apparently there was some confusion as to where Petitioner's finger was amputated. Attorney Matlock contacted Respondent again to clarify at what level the amputation occurred and for payment for the rest of the finger. Respondent then agreed and paid the remaining 50% loss of use of the finger on 10/5/12. (Rx. 3).

Petitioner received a letter recalling him to work for the winter of 2012, beginning on 10/16/12, and returned his acceptance of the recall on 8/28/12. (Rx. 6). On his acceptance, Petitioner indicated that he was able to work as soon as possible. *Ibid.* Lugene Joines testified on behalf of Respondent. She indicated that Petitioner and Respondent were bound by an employment contract between CMS, IDOT and the Teamsters for the winter "snowbird" position and hiring for it. (Rx. 5). This contract required that snowbirds who have sustained an illness or injury that required them to miss work or a recall would be returned to work or recalled the next season upon proper medical release and completion of the proper form, a CMS 95. (Rx. 5, p. 4, para. f).

Ms. Joines testified that she repeatedly attempted to have Petitioner return the completed CMS 95 form. She first called him on 8/31/12 to request the form and a copy of Petitioner's CDL license. This was followed up by a letter sent to Petitioner on 9/4/12 requesting the completed CMS 95 form and included a copy of the

form and a description of Petitioner's job requirements. (Rx. 7). Dr. Tattini's office then returned the CMS 95 form to Respondent via fax on 9/26/12. (Rx. 8). Upon inspection of the form, it was not completed and did not indicate Petitioner's physical impairment, box 6, or the extent of his disability, box 7, but instead simply stated "see prior evaluation." (Rx. 7, p. 3). Ms. Joines then contacted Petitioner by phone on the 28th and informed him that Respondent needed a properly completed CMS 95 indicating no restrictions in order to recall him to work in October.

On 10/3/12, Ms. Joines spoke with Attorney Matlock concerning what was needed and then sent him a fax containing the same CMS 95 form and description of the snowbird position. (Rx. 9). Ms. Joines then left messages on Petitioner's phone on 10/19, 10/22, 10/23 and 10/24 until Petitioner returned her calls on 10/24 and indicated that his attorney would contact her concerning the required forms. On 11/16/12, a month after the 10/16/12 recall date, Dr. Tattini's office refaxed the same CMS 95 form to Respondent with the additional information that his extent of disability was "pending FCE 11/16/12." (Rx. 10). Ms. Joines testified that the CMS 95 form had to be completed by a doctor who had treated Petitioner for his finger injury, but that it did not have to be completed specifically by Dr. Tattini.

Petitioner had an FCE that was performed on 10/23/12. (Px. 4). The results indicated deficits in 6 of 8 categories for upper body strength and capabilities, such as lifting and carrying. (Px. 4, p. 3). Dr. Tattini's office did not return any further CMS 95 forms as they adopted the FCE results and did not believe that Petitioner could return to his position as a snowbird.

CONCLUSIONS OF LAW

K. What temporary benefits are in dispute?

The Arbitrator finds that Petitioner is entitled to TTD benefits beginning on the date of his injury, 2/3/11, until his rehabilitation completed and he attained maximum medical improvement, 8/2/12. There is no question that Petitioner was seriously injured and required multiple surgeries and rehabilitation for his left index finger. Petitioner completed his rehabilitation on 8/2/12 and was successful discharged from therapy at that time. Also on that date, Petitioner felt willing and able to return to his previous position as a snowbird, as indicated by the release. Petitioner's willingness and ability to return to work is corroborated by his completion of the recall letter on 8/28/12 indicating that he was willing and able to return to work as soon as possible. Dr. Tattini also appeared to agree with Petitioner's rehabilitation and ability in August of 2012 as he released Petitioner to return to work with no restrictions on 8/22/12.

It appears that the only thing that kept Petitioner from returning to work successfully was Dr. Tattini's inability or unwillingness to complete the CMS 95 form that he was provided. Respondent and Petitioner were

bound by the Teamster contract which required both a CMS 95 form with no restrictions indicated and a successful physical completed to return to work. Dr. Tattini released Petitioner to work full duty but did not echo that lack of restrictions on the CMS 95 form, where all he had to do was check a few boxes properly. Ms. Joines indicated that Petitioner could have sought out another doctor to treat with and complete the CMS 95 form. Petitioner did not do so. He continued to treat with Dr. Tattini who would not appropriately complete the form, despite having released Petitioner with no restrictions. The Arbitrator will not extend Petitioner's TTD benefits or require extensive maintenance benefits in a situation where Petitioner could have easily returned to work by either compelling his doctor to properly complete a form consistently with his previous full return to work release or by seeking another doctor who was willing to properly complete said form. Petitioner's testimony and all records indicate that Petitioner was willing and able to return to work as a snowbird in August of 2012.

Concerning the FCE, the Arbitrator finds that this record lists conclusions of Petitioner's ability without actually showing any results of Petitioner's testing. There is no explanation why Petitioner would have been able to lift and carry more weight and be able fulfill his job requirements in August and then not be able to do so in October. Petitioner indicated that he agreed with the August testing as he was willing and able to return to work as well as his continued attempts to get Dr. Tattini to properly execute the CMS 95 form. The Arbitrator finds the August testing results to be accurate and does not find the October results to be consistent with those results, or explainable as to the difference, and therefore, finds them skewed and inaccurate.

M. Should penalties or fees be imposed upon Respondent?

The Arbitrator finds that Respondent's behavior was proper in regards to their payment of PPD for Petitioner's left index finger amputation. Petitioner believes that Respondent should have paid for 100% loss of use of his left index finger immediately after his amputation surgery. At the hearing, the evidence established that Petitioner was injured and an attempt to save his finger was initiated. After this failed, almost two weeks later, Petitioner had his amputation surgery on 2/16/11. Petitioner was off work being paid TTD during this time. Petitioner then underwent physical therapy and other treatment until August of 2012.

At no time before he retained council in June of 2012 did Petitioner request any payment of PPD benefits for his finger. When the request for payment was made by Attorney Matlock, it was promptly paid within a month's time. There was a misunderstanding concerning where on the finger Petitioner's amputation was which required Attorney Matlock to request further PPD benefits, which was then promptly paid by Respondent. There was no evidence presented that Respondent willfully, maliciously or vexatiously withheld Petitioner's statutory finger amputation PPD.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

☐ 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

CHARLES NEEDHAM,

Petitioner,

14IWCC0684

vs.

NO: 10 WC 44263

CITY OF PEORIA,

Respondent.

DECISION AND OPINION ON REVIEW

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

Based upon a review of the record as a whole, the Commission modifies the Arbitrator's award of permanent partial disability benefits, from 15% loss of use of the right arm and 15% loss of use of the left arm, to 10% loss of use of the right arm and 10% loss of use of the left arm. In so doing, the Commission relies on Petitioner's testimony that his bilateral arm condition had greatly improved following his surgeries and that his residual complaints were of a little tingling in his fingers and some tightness around his incisions, that Petitioner returned to work full duty on January 10, 2013 following his November 2012 bilateral elbow surgeries, that Petitioner was placed at maximum medical improvement at the time of his full duty release to return to work, and that Petitioner subsequently sought no additional medical treatment for his work injuries.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,067.20 per week for a period of 6-1/7 weeks, from November 6, 2012 through December 19, 2012, that being the period of temporary total incapacity for work under §8(b) of the Act.

14IWCC0684

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 50.6 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of 10% of the use of the right arm, and the loss of 10% of the use of the left arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $23,262.22 for medical expenses 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.

The Respondent is exempt from bonding requirement for removal of this cause to the Circuit Court based upon Section 19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 15 2014
KWL/kmt
07/28/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NEEDHAM, CHARLES
Employee/Petitioner

Case# **10WC044263**

14IWCC0684

CITY OF PEORIA
Employer/Respondent

On 10/15/2013, 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 0.06% 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:

1337 KNELL & KELLY LLC
STEPHEN P KELLY ESQ
504 FAYETTE ST
PEORIA, IL 61603

0980 HASSELBERG GREBE SNODGRASS ET AL
MICHAEL P ROUSH
124 S W ADAMS ST SUITE 360
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA

14IWCC0684

☐ 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

Charles Needham
Employee/Petitioner

v.

City of Peoria
Employer/Respondent

Case # **10** WC **44263**

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 **Stephen Mathis**, Arbitrator of the Commission, in the city of **Peoria**, on **July 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. ☒ 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 _____

14IWCC0684

FINDINGS

On **10/30/09**, 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 **$83,200.00**; the average weekly wage was **$1,600.00**.

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.

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

ORDER

- **The Petitioner did give proper notice to the Respondent of an accident.**
- **The Petitioner established that he sustained an accident that arose out of and in the course of his employment with the Respondent on October 30, 2009.**
- **The Petitioner's condition of ill being is causally related to the work accident described occurring on October 30, 2009.**
- **Respondent shall pay Petitioner temporary total disability benefits of $1,067.20/week for 6-1/7 weeks, commencing 11/6/12 through 12/19/12, as provided in Section 8(b) of the Act.**
- **Respondent shall pay reasonable and necessary medical services of $23,262.22, as provided in Section 8(a) of the Act.**
- **Respondent shall pay Petitioner permanent partial disability benefits of $669.64/week for 37.95 weeks, because the injuries sustained caused the 15% loss of the right arm, as provided in Section 8(e) of the Act.**
- **Respondent shall pay Petitioner permanent partial disability benefits of $669.64/week for 37.95 weeks, because the injuries sustained caused the 15% loss of the left arm, as provided in Section 8(e) of the Act.**

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

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

S J Mathis
Signature of Arbitrator

10-2-2013
Date

OCT 15 2013

ICArbDec p. 2

14IWCC0684

WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT?

The Petitioner claims a work-related injury occurring on or about October 30, 2009. The Petitioner's claim is that he sustained bilateral cubital tunnel as a result of his regular work activities for the Respondent. The Petitioner further maintains that the bilateral cubital tunnel syndrome arose out of and in the course of his employment.

The Petitioner testified that he provided notice of the alleged work accident to the employer on December 10, 2009. A review of Respondent's Exhibit 9 reveals the Form 45 prepared by the Petitioner on December 10, 2009, advising the Respondent of an alleged work injury in October 2009.

The Petitioner's testimony was un-rebutted. Therefore, the Arbitrator finds that the Petitioner provided proper notice pursuant to the Illinois Workers' Compensation Act of an alleged accident occurring on or about October 30, 2009, in the statutory allotted time under the Act.

DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT? IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

TESTIMONY OF PETITIONER

The Petitioner testified that he began his employment with the Respondent in 1987. The Petitioner's employment began as a patrol officer. The Petitioner was employed with the Respondent since 1987 as a police officer performing patrolman duties.

The Petitioner testified that during his employment with the Respondent since 1987, he took on collateral tasks. Such tasks included being on the SWAT team. The Petitioner testified he would perform SWAT team activity up until the year 2005.

The Petitioner testified as to his duties as a patrol officer for the Respondent in June 2009 leading up to October 30, 2009. The Petitioner testified that his duties for the Respondent would require him to be in a squad car for days over a seven hour period.

The Petitioner testified that his duties from June 2009 to October 2009 required him to work on a computer in his squad car. The Petitioner testified this required him to use his right and left arms in an awkward position. The Petitioner testified that this caused his arms to be in an unusual position while performing typing activity on the computer for both the right and left elbow.

The Petitioner identified that he was also required to fill out reports, and that this was done usually in his squad car. The Petitioner testified that when filling out those reports, he would have his arms and elbows in awkward positions. The Petitioner testified that this would cause stress on his right and elbows while performing these activities. The Petitioner also identified that he would be required to work with an alley light in this car. This required him to place his right arm against the seat and flick off and on the light in looking at different houses.

The Petitioner further testified while working as a city police officer from June 2009 to October 2009, he would rest his elbows on hard surfaces throughout his shift. The Petitioner testified that during his employment as a patrol officer for the City of Peoria, he would rest his left arm on the door. The Petitioner further testified as it relates to his right arm, he would rest his arm on the center console while performing his police activities. The Petitioner testified that on a daily basis while performing his normal job activities for the Respondent he would rest his elbows on hard surfaces.

The Petitioner testified that he was not a good typist. The Petitioner testified that he would perform typing activities on a daily basis in an awkward position. The Petitioner was required to prepare reports and tickets while performing normal police activities for the Respondent.

The Petitioner testified that he started noticing numbness and tingling in his little fingers and pain in both of his elbows dating back to 2007. The Petitioner testified that initially in 2007 the pain and numbness in his fingers and elbows were not significant.

The Petitioner testified that in June of 2009 leading to October 2009, his numbness and tingling and pain in his elbows progressively got worse. The Petitioner testified that his problems with his right and left elbows became so bad in October 2009 that he sought medical treatment. The Petitioner testified that his family doctor, Dr. Hickok, referred him to an orthopedic specialist, Dr. Garst, on October 30, 2009.

The Petitioner testified that he chose the accident date of October 30, 2009, because this is the date that he was referred to the orthopedic specialist. Additionally, the Petitioner testified that Dr. Garst reported to him that he was suffering from a work-related condition.

The Arbitrator notes a review of Dr. Garst's records indicates on October 3, 2009, that the Petitioner was suffering from a work-related condition. Dr. Garst indicates this work-related condition was due to the Petitioner's work activity for the Respondent as a police officer. (Dr. Garst's records, Petitioner's Exhibit 2)

A review of Dr. Garst's records indicate that Dr. Garst did indeed indicate on the intake form that the Petitioner's condition of ill being was related to his work activities for the Respondent. Dr. Garst noted the Petitioner was referred by his family doctor, Dr. Hickok. Dr. Garst noted the Petitioner's complaints began with typing. Dr. Garst provided treatment of the Petitioner on October 30, 2009. (Petitioner's Exhibit 2)

The Petitioner testified that the Respondent had him examined by their company doctor, Dr. Moody. The first examination took place on December 10, 2009. The Arbitrator notes that Dr. Moody's records indicate on December 10, 2009, the Petitioner was seen and associated his problems with his right and left elbows with his computer work for the Respondent. The Arbitrator finds it significant that Dr. Moody placed restrictions on the Petitioner from performing computer work and writing reports.

The Petitioner underwent an EMG/NCV study on April 9, 2010. This was performed by Dr. Russo. The EMG/NCV study performed by Dr. Russo on April 9, 2010, revealed the Petitioner had been suffering from bilateral cubital tunnel syndrome of both right and left sides. (Petitioner's Exhibit 3)

The Petitioner testified he last saw Dr. Garst on June 11, 2010. The Petitioner indicated that although Dr. Garst had indicated he was at maximum medical improvement, the Petitioner still was having problems with his right and left elbows. The Petitioner testified that he attempted to continue to work as a police officer for the Respondent after seeing Dr. Garst on June 11, 2010. The Petitioner testified that his pain and numbness and tingling never went away in both arms.

The Petitioner testified that he saw Dr. Hickok, his family doctor. The Petitioner testified that Dr. Hickok referred the Petitioner to a second orthopedic surgeon, that being Dr. James Williams. The Petitioner testified he first saw Dr. James Williams on October 14, 2010.

The Petitioner testified that Dr. Williams provided conservative care for him on October 14, 2010.

The Petitioner testified that he worked for the City of Peoria as a police officer from October 14, 2010, until April 9, 2012. He testified that he continued to do his police work activities. He testified that his problems and complaints of numbness and tingling and pain in the

right and left elbows never went away. The Petitioner testified that he decided to be re-examined by Dr. James Williams.

The Petitioner testified on April 9, 2012, he saw Dr. Williams for a second time. The Petitioner testified at that time he had a discussion with Dr. Williams regarding his work activities for the Respondent. The Petitioner testified that this is first time that he became aware that resting his elbows on the car surface could be an aggravating or contributing factor to his condition of ill being of bilateral cubital tunnel syndrome. The Petitioner testified Dr. Williams informed him that resting his elbows could be a factor to his condition of ill being.

TESTIMONY OF TAMMY COWAN

The Respondent called Case Manager, Tammy Cowan. Ms. Cowan testified that she did a job analysis in May of Petitioner's squad car. Ms. Cowan admitted that there were mistakes made in her report. Ms. Cowan testified that information she received from the Respondent may not have been true as it relates to the Petitioner's true work activities.

Ms. Cowan testified that she was aware of the theory of "trucker's elbow". Ms. Cowan testified that the Petitioner was required to be in a squad car for over a seven hour period on certain days. Ms. Cowan testified that the Petitioner would be required to rest his elbows on hard surfaces in the squad car throughout the day.

TESTIMONY OF DR. JAMES WILLIAMS

Dr. James Williams testified in this case. Dr. Williams is a board certified orthopedic surgeon who is a treating physician in the Peoria area. Dr. Williams testified that 99 percent of his practice is dedicated to treating individuals as opposed to performing independent medical examinations.

Dr. Williams testified that his education was that of doing his residency in the Indianapolis Hand Center and obtaining his board certification in the orthopedic field.

Dr. Williams testified that he has a specialty in orthopedics in treating conditions of the hands. Dr. Williams testified that he does treat individuals who suffer from conditions such as that of the Petitioner in this case. Dr. Williams testified that he has treated conditions of ill being such as suffered by the Petitioner as a treating physician.

Dr. Williams testified that he saw the Petitioner on October 14, 2010. Dr. Williams testified Petitioner is a Peoria police officer who works for the City of Peoria and that the Petitioner had previously treated with Dr. Jeff Garst for complaints of right wrist and elbow pain, as well as numbness and tingling in ring and middle fingers, worse on right than left. He had Tinel's at both elbows and probable cubital tunnel. Nerve study was performed which showed left greater than right cubital tunnel syndrome, mild to moderate in degree. Petitioner treated with therapy and when Dr. Garst saw Petitioner in June of 2010 Petitioner was improved. Dr. Garst did not feel there was any urgency for surgery. Dr. Williams testified that the Petitioner has been learning to compensate for his computer in the car. Petitioner's work as a Peoria police officer involves a lot of hands-on work as well as typing in the car as he is driving and that is what has aggravated and brought on his condition. Petitioner has no other previous injury. Petitioner has no history of diabetes, high blood pressure or any type of inflammatory arthropathy. Dr. Williams testified Petitioner is not overweight and is obviously not female, so Petitioner has no other reasons for having this problem.

Dr. Williams testified that based upon his examination of the Petitioner and Petitioner's history and nerve conduction velocity study, Petitioner does have cubital tunnel syndrome. Dr. Williams testified it is his opinion that these problems Petitioner currently has are related to his job.

Dr. Williams testified he saw the Petitioner on April 9, 2012. Petitioner has been with the Peoria Police Department for 25 years, 17 years on the SWAT team. Dr. Williams testified

that as a sniper, Petitioner would lay down with his elbows bent holding a rifle which would obviously involve his elbows being flexed and pressure being placed on the elbows. That would give Petitioner like almost a spider-web-type feeling along the ulnar aspect of his hand which is obviously cubital tunnel. Since Petitioner has been in a car and driving and computers have been added to the police cars, Petitioner's arm is obviously resting, his right arm which seems worse than the left, his elbow being flexed with pressure being placed on his right elbow which gives him that same feeling of numbness and tingling in his ring and small fingers. Dr. Williams testified that at this point that seems to be an aggravating factor.

Dr. Williams testified that he performed a physical examination of Petitioner. Petitioner still has numbness and tingling in ring and small fingers, right worse than left. Petitioner does have positive Tinel's at both cubital tunnels. Nerve study done in April of 2010 does demonstrate mild to moderate cubital tunnel. Dr. Williams testified that Petitioner's job has been at least an aggravating factor in this development and Petitioner's eventual possible need for treatment. Dr. Williams testified that, without question, and based upon a reasonable degree of medical and surgical certainty, that Petitioner's problem has at least been aggravated by his work for the Peoria Police Department.

Dr. Williams testified that he again saw the Petitioner on October 4, 2012. Dr. Williams noted a history of Petitioner consistent with that given previously. Petitioner indicates he rests his right elbow on the printer on the arm rest as the computer is docked right in front of it. This puts pressure on Petitioner's right elbow while he is driving which results in numbness and tingling in ring and small fingers on right side. This has definitely seemed to be something that has been aggravating to the Petitioner's condition. Dr. Williams testified that Petitioner does get some numbness and tingling at night also while sleeping which seems to be somewhat sporadic. It comes much more consistently when at work. Petitioner indicates it appears to be at work

when his elbow is bent and when he is driving with his elbow resting on the console where the printer is.

Dr. Williams testified that he performed a physical examination of Petitioner. Petitioner does have some discomfort in right shoulder with rotation, almost like a SLAP-type lesion with a positive O'Brien sign. Dr. Williams testified that at this point, his impression is that Petitioner could have some type of SLAP pathology within the right shoulder. Dr. Williams testified that it is not related to Petitioner's cubital tunnel type findings.

Dr. Williams testified it is his opinion that the Petitioner does have cubital tunnel syndrome both on the right and left with the right being more symptomatic than the left. Dr. Williams testified that he feels the Petitioner's work for the Peoria Police Department which he has done for 25 years was at least an aggravating or contributing factor to his condition of ill-being and the eventual surgery he may need and the medical treatment he has had so far.. Dr. Williams further testified that Petitioner does not smoke, which is a risk factor.
Dr. Williams testified that it has been well shown that pressure over the ulnar nerve, as well as prolonged elbow flexion, does result in increased tension within the ulnar nerve, as well as increased pressure on the nerve, which does result in eventual development of cubital tunnel syndrome and can be at least an aggravating or contributing factor to that problem.

Dr. Williams is of the opinion that the Petitioner's condition of bilateral cubital tunnel syndrome is directly related to his work as a police officer. Dr. Williams testified that this is due to the Petitioner resting his arms on the console and the door. Dr. Williams indicated that there are multiple medical literatures to support this position that this is a work-related condition.
Dr. Williams noted that Dr. Russo's EMG/NCV report in April of 2010 does contain a history of the Petitioner resting his arm on the console and support Petitioner's contention in this case.

TESTIMONY OF DR. DAVID FLETCHER

The Petitioner had the medical records examined by Dr. David Fletcher. Dr. Fletcher is board certified in occupational medicine and practices in the Champaign, Illinois area. Dr. Fletcher has worked on numerous cases involving truck drivers and police officers. Dr. Fletcher has represented many municipalities as relates to injured workers. Dr. Fletcher is very familiar with a police squad car and the ergonomics of the same.

Dr. Fletcher performed a record review at the request of Attorney Steve Kelly.

Dr. Fletcher reviewed the following records:

- May 5, 2011 IME Report from Dr. Peter E. Hoepfner
- Dr. Williams Treating records Midwest Orthopaedic Center
- Dr. Garst records (Great Plains Orthopaedics)
- Deposition Transcript of Dr. Williams 10/31/12
- OSF St. Francis Medical Center Records – Dr. Moody
- MMI of Illinois, Inc. Job Analysis
- Form 45
- Application for Adjustment of Claim

Dr. Fletcher testified that he noted the Petitioner sought treatment from the chiropractor on or about October 16, 2009. Dr. Fletcher noted that the Petitioner may have called the chiropractor on October 9, 2009. After looking at the Application for Adjustment of Claim, Dr. Fletcher testified that the date of accident is consistent with the records that he had. Dr. Fletcher testified that October 9, 2009, is a consistent date with the records reviewed in this case.

Dr. Fletcher was asked to assume that the Petitioner was going to testify that on October 9, 2009, he called the chiropractor's office for an appointment. The appointment was set with the chiropractor's office for October 16, 2009. Dr. Fletcher was asked to assume the Petitioner's complaints got to the point where he needed medical care for his elbows on that date. Dr. Fletcher testified that this was an appropriate accident date for this case.

Dr. Fletcher noted that the chiropractor records of October 16, 2009, indicate that the Petitioner had problems with both elbows. Dr. Fletcher noted that the chiropractor referred the Petitioner to Dr. Garst.

Dr. Fletcher testified he reviewed the records of Dr. Garst. Dr. Fletcher noted that Dr. Garst held the opinion that the Petitioner's condition of ill being of bilateral cubital tunnel syndrome was related to his work activities as a police officer. This was noted in Dr. Garst's records.

Dr. Fletcher testified he reviewed the records of Dr. Garst extensively. Dr. Fletcher testified the diagnosis was bilateral cubital tunnel syndrome. Dr. Fletcher agreed with Dr. Garst's treatment recommendation. Dr. Fletcher agreed with Dr. Garst that this was a work-related condition.

Dr. Fletcher testified that after reviewing Dr. Garst's records he felt this was a work-related condition and the condition of ill-being of the Petitioner was directly related to the work activities as a police officer for the City of Peoria.

Dr. Fletcher testified regarding the EMG/NCV study performed by Dr. Russo. The EMG/NCV study was dated April 9, 2010. Dr. Fletcher noted that the EMG/NCV study confirmed that the Petitioner had bilateral cubital tunnel syndrome.

Dr. Fletcher testified that the Petitioner came under the care of Dr. James Williams. Dr. Fletcher testified he reviewed the complete records of Dr. James Williams. Dr. Fletcher was of the opinion that Dr. Williams' diagnosis of bilateral cubital tunnel was proper. Dr. Fletcher agreed with Dr. Williams that this was a work-related condition.

Dr. Fletcher reviewed the deposition testimony of Dr. Williams. Dr. Fletcher agreed with Dr. Williams' opinion that the Petitioner's condition of ill-being was related not only to the awkward positioning of his arms in the squad car but also the extensive pressure placed upon the

elbows while in the squad car. Dr. Fletcher testified that the opinions of Dr. Williams that this is a work-related condition were consistent with Dr. Fletcher's opinions in this case.

Dr. Fletcher testified he reviewed the job analysis study generated by the City of Peoria, the Respondent in this case. Dr. Fletcher testified this job analysis was not sufficient. Dr. Fletcher testified there was no study done of the positioning of the Petitioner's elbows in the car and also extrinsic pressure in the car.

Dr. Fletcher testified he was very familiar with a police squad car. Dr. Fletcher testified that he has been in police squad cars. Dr. Fletcher testified that it is his opinion that the Petitioner's squad car for the City of Peoria contributed to his bilateral cubital tunnel syndrome.

Dr. Fletcher testified that he did review the records of Dr. Moody. Dr. Fletcher agreed with Dr. Moody that if Officer Needham placed his elbows on the armrests and the door for an extended period of time that this could be a contributing factor to his bilateral cubital tunnel syndrome.

Dr. Fletcher reviewed the medical records of Dr. Hoepfner. Dr. Fletcher disagreed with Dr. Hoepfner that there is no such theory as extrinsic pressure causing cubital tunnel. Dr. Fletcher cited the British Journal hand article in addition to Greens Book of Hand article in refuting this position of no extrinsic pressure contributing to cubital tunnel syndrome.

Dr. Fletcher addressed the issue of Petitioner's weightlifting. Dr. Fletcher felt that the Petitioner's weightlifting could have been a contributing factor to the cubital tunnel but did not sever the causation of the Petitioner's work activity as a police officer contributing with the diagnosis of bilateral tunnel syndrome.

Dr. Fletcher testified that the treatment rendered by Dr. James Williams was reasonable and necessary. Dr. Fletcher testified that the treatment by Dr. Williams in the form of surgery to

both the right and left elbows was directly causally related to the Petitioner's work activity with the City of Peoria.

Dr. Fletcher testified that the time off that the Petitioner was required to take off as a result of the surgery was directly related to the work injury.

TESTIMONY OF DR. MOODY

Dr. Moody testified. Dr. Moody is the company physician for the City of Peoria. Dr. Moody saw the Petitioner on one occasion. Dr. Moody is a board certified occupational physician.

Dr. Moody saw the Petitioner on December 10, 2009. Dr. Moody testified that the Petitioner provided a history of having tightness of the ulnar aspect of his forearms for about two years. The Petitioner also reported a tingling sensation around his wrists and tingling in the right ring finger. The Petitioner informed Dr. Moody that he relates this to computer use at work and the Petitioner indicated he is not a proficient typist.

The Petitioner informed Dr. Moody on December 10, 2009, that Dr. Garst had provided him with injections. The assessment was the Petitioner had medial epicondylitis and suspected cubital tunnel in both right and left elbows.

Dr. Moody testified that he did place restrictions on the Petitioner. The restrictions let the Petitioner do less computer work and do handwriting. Dr. Moody testified these restrictions were placed on Petitioner to ease the complaints the Petitioner had while doing his work.

Dr. Moody testified that when the Petitioner came in he gave a date of injury of October 2009. Dr. Moody does not dispute that it was in October of 2009 when the Petitioner had complaints that required him to seek medical care.

Dr. Moody testified on direct examination that he was provided additional information in this case. Dr. Moody testified he saw a job analysis performed on behalf of the City of Peoria.

Dr. Moody testified he addressed a causal connection letter to the City of Peoria. This was entered as Deposition Exhibit No. 3.

Dr. Moody testified on cross examination that he only saw the Petitioner once. Dr. Moody further testified that he cannot identify how much the Petitioner performed weightlifting activity outside the City of Peoria. Dr. Moody could not give an opinion as to whether or not the weightlifting activity had an effect on the Petitioner's condition of ill-being.

Dr. Moody testified that he did review an EMG/NCV study done by Dr. Russo. This was marked as Deposition Exhibit No. 6. Dr. Russo's report of April 9, 2010, confirmed that the Petitioner had bilateral cubital tunnel syndrome.

Dr. Moody testified it was his understanding that the Petitioner came under the care of Dr. Williams. Dr. Williams performed surgery on the Petitioner's elbows. Dr. Moody testified he did see the Petitioner in late 2012 releasing the Petitioner back to work full duty.

Dr. Moody testified that he did see the records of Dr. Garst. Dr. Moody testified he was aware that Dr. Garst was of the opinion that the Petitioner's work activities exacerbated his condition of ill-being. Dr. Garst's records were offered into evidence as Deposition Exhibit No. 7.

Dr. Moody has no criticisms of Dr. Garst as a physician.

Dr. Moody also noted that Dr. Williams testified in this case. Dr. Moody confirmed that Dr. Williams felt this was a work-related situation.

Dr. Moody did testify that there was a theory in the medical society of extrinsic pressure/compression of the cubital. Dr. Moody was aware of the British Journal of Hand Surgery. Dr. Moody testified this Journal established that truck drivers who rest an elbow on the window sill could develop a compressive ulnar nerve entrapment. Dr. Moody testified that if any other physician testified that such a theory did not exist, that physician would be wrong.

Dr. Moody testified that the Petitioner was a traveling employee. The Petitioner's basic work station was a squad car. Dr. Moody confirmed that the job analysis study performed on behalf of the City of Peoria indicates that the Petitioner is required to be in the car 67-100 percent of the shift. Dr. Moody testified that if the Petitioner did rest his elbows for an extended period of time on the window sill that the left cubital tunnel syndrome could be aggravated by that activity. Dr. Moody testified that if the Petitioner rested his right elbow on the armrest while working on the computer, that could aggravate the Petitioner's symptoms of cubital tunnel syndrome.

Dr. Moody confirmed that the Petitioner is not overweight. This was not a risk factor to the Petitioner developing cubital tunnel syndrome. The Petitioner was also not a smoker and this would not have been a risk factor for the Petitioner developing cubital tunnel syndrome.

Dr. Moody did review the job description at length. Dr. Moody did identify that the job description was defective. The job description is defective in that it showed the police officer never being required to lift over 25 pounds. Dr. Moody disagreed with that assessment. Additionally, Dr. Moody disagreed with the job analysis study indicating that a police officer would not be required to carry over 50 pounds.

Dr. Moody did testify that awkward positioning could aggravate cubital tunnel syndrome. Dr. Moody testified that he felt that if the Petitioner worked the computer with the non-dominant arm in an awkward position, this could have aggravated his cubital tunnel syndrome.

TESTIMONY OF DR. HOEPFNER

The Respondent had the medical records review by Dr. Hoepfner. Dr. Hoepfner did a record review on behalf of the City of Peoria. Dr. Hoepfner did not examine the Petitioner. Dr. Hoepfner did not take a history from the Petitioner.

Dr. Hoepfner testified that he did not believe the Petitioner's work activities as a police officer caused or contributed to his bilateral cubital tunnel syndrome. Dr. Hoepfner did not believe in the extrinsic compression of the cubital tunnel theory.

Dr. Hoepfner had no criticisms of Dr. Garst and Dr. Williams regarding their abilities as physicians. Dr. Hoepfner agreed with these physicians' diagnoses. Dr. Hoepfner agreed with their recommendations and treatment in this case.

ARBITRATOR'S FINDINGS

The Arbitrator finds, based off the evidence, that the Petitioner has proven by a preponderance of the evidence that he sustained a work injury while working for the Respondent on October 30, 2009. The Arbitrator further finds that the Petitioner has met his burden by a preponderance of the evidence that his condition of ill being was causally related to his work activities with the Respondent on October 30, 2009.

Therefore, the Arbitrator finds that the Petitioner did indeed sustain a work-related accident while working for the Respondent on October 30, 2009. The Arbitrator further finds that the Petitioner's condition of ill being of bilateral cubital tunnel syndrome is related to his work activities for the Respondent of October 30, 2009.

IS THE PETITIONER ENTITLED TO TEMPORARY TOTAL DISABILITY BENEFITS?

In light of the finding that the Petitioner did indeed sustain an accident that arose out of and in the course of his employment and his condition of ill being is causally related to the work activities for the Respondent, the Arbitrator hereby awards temporary total disability benefits to the Petitioner. The Arbitrator finds that the Petitioner is entitled to temporary total disability from November 6, 2012, to December 19, 2012. This is the time period that the Petitioner was off work as a result of the surgeries performed by his treating physician, Dr. James Williams.

WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY?

In light of the finding that the Petitioner did indeed sustain an accident that arose out of and in the course of his employment and his condition of ill being is causally related to the work activities for the Respondent, the Arbitrator hereby awards medical benefits to the Petitioner. The Arbitrator finds that the Petitioner is entitled to receive the following. The Arbitrator awards the Petitioner the following:

1. Midwest Orthopaedic Center - $5,965.10
2. Great Plains Orthopaedics - $1,190.00
3. JSK Chiropractic - $1,859.12
4. Occ Health – Randolph - $355.00
5. Center for Health, 11/6/12 - $2,770.00
6. Center for Health, 11/27/12 - $2,770.00
7. Dr. Christopher McCar - $824.00
8. Dr. Dennis Bathke - $721.00
9. Dr. James Williams, 4/9/12 - $108.00
10. Dr. James Williams, 10/4/12 - $108.00
11. Dr. James Williams, 11/6/12 - $2,417.00
12. Dr. James Williams, 11/27/12 - $2,417.00
13. OSF St. Francis, 12/20/12 - $942.00
14. OSF St. Francis, 1/9/13 - $816.00

Total Medical Bills: $23,262.22

The Respondent will pay directly to the Petitioner the lump sum for the medical.

That the Respondent will get full credit for the monies paid pursuant to Section 8(j) of the Illinois Workers' Compensation Act.

WHAT IS THE NATURE AND EXTENT OF THE INJURY?

In light of the finding that the Petitioner did indeed sustain an accident that arose out of and in the course of his employment and his condition of ill being is causally related to the work activities for the Respondent, the Arbitrator hereby awards medical benefits to the Petitioner.

The Petitioner did undergo two surgical procedures. Both surgical procedures were that of ulnar carpal tunnel releases.

At the time of the trial, the Petitioner testified he still notices achiness and weakness in both elbows. The Petitioner testified that he still notices problems with his elbows at the time of trial.

Based on the foregoing, the Arbitrator finds the Petitioner is entitled to 15 percent loss of use of the right arm and 15 percent loss of use of the left arm.

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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tim Perry,
Petitioner,

14IWCC0685

vs.

NO: 11 WC 05088, 11 WC 11984
11 WC 11985, 11 WC 11986

Excel Corporation ,
Pella Window Corporation,
Respondents.

DECISION AND OPINION ON REVIEW

This cause comes before the Commission on Petitioner's Petition for Review of the Arbitrator's Denial of his Motion to Consolidate, filed on October 2, 2013 for claims 11 WC 5088, 11 WC 11984, 11 WC 11985, and 11WC 11986. The parties were represented by counsel and appeared before Arbitrator Lindsay on September 4, 2013 regarding Petitioner's Motion to Consolidate the above referenced claims. No record was made of the September 4, 2013 hearing, and Arbitrator Lindsay issued an Order denying Petitioner's Motion to Consolidate. Petitioner now requests the Commission to consider the issue of "Improper Denial of Motion to Consolidate."

The Commission notes claim 11 WC 5088 and claim 11 WC 11986 are currently venued in Quincy while claim 11 WC 11984 and claim 11 WC 11985 are currently venued in Peoria. The Applications for Adjustment of Claim state, in pertinent part, as follows:

1. 11 WC 5088 – Date of accident: 5/27/2008, Respondent Excel Corp, Part of body affected: "Back and body";

2. 11 WC 11984 – Date of accident: 9/19/2008, Respondent Pella Window Corp, Part of body affected: "back and body",

3. 11 WC 11985 –Date of accident: 2/20/2011, Respondent Pella Window Corp, Part of body affected: "back and body",

4. 11 WC 11986 – Date of accident: 2/20/2011, Respondent Excel Corp, Part of body affected: "Back and body".

Petitioner filed a transcript of hearing that took place on October 5, 2011 before Arbitrator White in support of his Petition for Review. On that date, Petitioner argued a Motion to Consolidate claims 11 WC 5088, 11 WC 11984, 11 WC 11985 and 11 WC 11986. Both Respondents objected to consolidation at that time and argued there were no medical records in evidence and no evidence that the claims, involving different Respondents with different dates of injury, even had the same body part at issue. Arbitrator White denied the Petitioner's Motion to Consolidate. At that time, the Arbitrator noted that the issue could be revisited at a later date should the Petitioner obtain additional evidence in support of his Motion.

Petitioner argued that after Arbitrator White's denial of his Motion to Consolidate in 2011, he obtained medical records and then proceeded at hearing on a new Motion to Consolidate on September 4, 2013 before Arbitrator Lindsay. Petitioner argued the medical records obtained since the 2011 Motion hearing show treatment to the low back for all four claims. No record was made on September 4, 2013 and Arbitrator Lindsay denied Petitioner's Motion to Consolidate without further reasoning.

Petitioner filed a Petition for Review requesting the Commission to consider the issue of "Improper Denial of Motion to Consolidate" on October 2, 2013. On or about January 27, 2014, Petitioner's counsel, Tom Lichten, filed a brief in support of his Petition for Review of the Arbitrator's denial of Petitioner's Motion to Consolidate. In his brief, the Petitioner took issue with the September 4, 2013 Order of Arbitrator Lindsay denying the Petitioner's Motion to Consolidate the four above mentioned claims. Petitioner argued the Arbitrator erred in denying Petitioner's Motion to Consolidate because all four claims are for injury to the low back.

Petitioner further argued that the Arbitrator erred on September 4, 2013 in denying his Motion to Consolidate because such a ruling is in direct violation of Illinois Workers' Compensation Rule 7030.10(d). Petitioner argued that Arbitrator Lindsay was required under that rule to grant Petitioner's Motion to Consolidate all four claims on the Quincy docket. Rule 7030.10(d), titled "Arbitrator Assignments", states as follows:

> In the event a Petitioner has an Application for Adjustment of Claim pending and files one or more Applications for Adjustment of Claim against the same Respondent, or against different Respondents alleging accidental injuries to the same part of the body subsequent cases shall on motion of any party be assigned to the case filed first. If a case is dismissed or otherwise closed and the Petitioner files an Application for Adjustment of Claim relating to the same accident, the case will be assigned to the Arbitrator assigned to the first case filed involving that accident…All disputes involving reassignment shall be heard by the Chairman or a Commissioner designated by the Chairman.

Petitioner appears to allege that his Motion to Consolidate should have been granted by Arbitrator Lindsay because an assignment of Arbitrator is equivalent to a consolidation of claims. However, Rule 7030.10(d) applies to assignment of an arbitrator, not consolidation of claims. In *Mark Davis v. Emery Forwarding*, 05 IWCC 0170, the Petitioner appealed the Arbitrator's final Decision and also appealed the Arbitrator's denial of his Motion to Consolidate claims. The Commission stated in *Davis* that it is unquestionable that under Rule 7030.10(d), upon request of a party in the case, the second Application for Adjustment should have been assigned to the Arbitrator to whom the first case was assigned. Once the subsequent cases are assigned to the same Arbitrator as the one assigned to the first case, the requirement under the rule has been satisfied. Rule 7030.10(d) simply provides for a determination of which Arbitrator would resolve such motions when multiple cases involving the same parties or parts of the body are filed.

14IWCC0685

Once the assignment is completed, it is within the Arbitrator's province and discretion to determine whether the two cases should be consolidated for hearing and/or decision. *Id.*

Respondent Pella Window Corporation argues that the Arbitrator's September 4, 2013 Order denying the Motion to Consolidate the four claims is interlocutory and therefore not ripe for appeal at this time. The Commission agrees. If Petitioner chooses to appeal the Order, he should do so as part of an appeal of the Arbitration decision(s) on the merits. *See Lundgren v. Carpet Interiors*, 07 IWCC 1404, *Borreson v. USF Holland*, 05 IWCC 0595, and *Beyer v. Henry Pratt Co*, 98 IWCC 67545. In *Lundgren v. Carpet Interiors*, the Commission noted that Section 16 of the Act states that permitting piecemeal litigation and review within the Commission is contrary to the Act's intention to provide simple and summary processes and procedures, prompt administrative handling of claims, and reduction of expenses to claimants. In *University of Illinois Hospital v. Workers' Compensation Comm'n*, the Commission stated a decision is final if it disposes of the litigation on the merits and leaves no matters pending and disputed. 2012 Il App (1st) 113130WC. An exception to this rule is carved out in *Thomas v. Illinois Industrial Commission*, for Section 19(b) decisions. 78 Ill. 2d 327 (1980).

The Commission finds it lacks jurisdiction to render a decision in this matter as the October 5, 2011 and September 4, 2013 Orders are interlocutory and not appealable at this time.

Further, the Commission notes that even if it had jurisdiction to render a decision, there was no Record made of the September 4, 2013 Motion hearing and no evidence, including the motion itself, is in evidence. The Commission notes that its files for each of the referenced claims contain an Attorney Representation Agreement and an Application for Adjustment of Claim. No further party filings are contained in the Commission files. With regard to the Record of Hearing on October 5, 2011, no exhibits were entered into evidence, including any medical records or the Petitioner's Motion to Consolidate. With regard to the September 4, 2013 hearing on Petitioner's Motion to Consolidate, the hearing was not on the record and no documents were entered into evidence. As such, the Commission lacks any evidence to substantiate Petitioner's argument that the four referenced claims relate to the same body part and should be consolidated.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Review of his Motion to Consolidate claims 11 WC 05088, 11 WC 11984, 11 WC 11985 and 11 WC 11986 is dismissed for lack of jurisdiction under the Act.

DATED: AUG 15 2014

Daniel R. Donohoo

Charles J. DeVriendt

Mario Basurto

o-06/25/14
drd/adc
68

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

Brennan Gambrel,
Petitioner,

14IWCC0686

vs. NO: 11 WC 43490

Illinois Tool Works,
Respondent.

DECISION AND OPINION ON REMAND
FROM THE CIRCUIT COURT

This matter comes before the Commission on remand from the Circuit Court of Illinois, Cook County, directing the Commission to reconsider its denial of Petitioner's claim and instructing the Commission to address the evidence that the Court found corroborated Petitioner's testimony regarding his alleged work accident. The Circuit Court found that the Commission should reconsider its Decision, which affirmed and adopted Arbitrator Dollison's denial of Petitioner's claim. After reconsidering all of the evidence, including Petitioner's uncorroborated testimony that he informed two supervisors and gave a recorded statement regarding his alleged accident, and being advised of the facts and law, the Commission again finds that Petitioner failed to prove that an accident arising out of and in the course of Petitioner's employment with Respondent occurred on July 26, 2011.

Petitioner, a setup technician, alleged that he suffered a work accident on July 26, 2011, while working light duty due to a July 13, 2010 crush injury to his foot. The 2010 claim was consolidated for trial with the instant case and was denied by the Arbitrator in a separate opinion at 10 WC 037511. No appeal was taken from that denial.

At Arbitration, Petitioner testified that he developed low back pain on July 26, 2011, while removing parts from the assembly line and placing them in totes. In August of 2011, he treated with Dr. Gaurang Zala with WellGroup Health Partners for his ongoing back pain and radiculopathy and received medications and a referral to orthopedist Dr. William Payne. Petitioner presented to Dr. Payne on September 13, 2011. The doctor noted Petitioner's history of a crush injury on July 13, 2010, and Petitioner complained of ongoing back pain. Neither Dr. Zala nor Dr. Payne mentions an accident date of July 26, 2011 or describes any work-related exacerbation of Petitioner's ongoing lumbar complaints.

14IWCC0686

Rehabilitation specialist, Dr. DeRubertis, evaluated Petitioner on September 23, 2011, and Petitioner again described his July 13, 2010 injury. Dr. DeRubertis's notes contain no mention of a July 26, 2011 work accident. Dr. DeRubertis administered two lumbar ESIs and referred Petitioner to pain management specialist, Dr. Rajive Adlaka.

Dr. Adlaka performed a discogram on January 25, 2012, which showed no reproduction of pain at L3-4, L4-5 or L5-S1. A CT scan showed mild bilateral foraminal narrowing and mild central canal stenosis at L4-5, and a February 2, 2012 EMG showed right S1 radiculopathy and mild underlying peripheral neuropathy.

On February 9, 2012, Dr. Payne diagnosed SI joint pain and referred Petitioner to Dr. Adlaka for SI joint injections. Dr. Adlaka reached the same diagnosis on March 7, 2012 and administered ESIs on April 4, 2012 and May 2, 2012. At the time of arbitration, Petitioner remained off work and testified he suffered low back pain, could not feel his left toes, and had difficulty sitting.

Arbitrator Dollison concluded that Petitioner failed to prove he suffered a work accident on July 26, 2011 and denied all benefits, relying upon the absence of any mention of that alleged accident in any treating physician's office notes. The Arbitrator found that Petitioner had presented no evidence to corroborate his claim of work accident. Petitioner filed a timely appeal to the Commission, which summarily affirmed and adopted the Arbitrator's Decision.

Petitioner appealed to the Circuit Court, which noted that the Commission had failed to acknowledge that Petitioner testified that he advised his supervisors of his accident on the date of accident and provided a recorded statement to Respondent's human resources department the following day. The Court remanded the case to the Commission with instructions to consider this evidence as corroborating Petitioner's claim of accident arising out of and in the course of his employment on July 26, 2011. The Court reasoned that the two supervisors who were the recipients of Petitioner's verbal notice and the alleged recorded statement were within Respondent's control. The Court maintained that Respondent's failure to produce these witnesses and statement at arbitration created a presumption that the evidence, if produced, would be adverse or unfavorable to Respondent and that this evidence corroborated Petitioner's claim of accident on July 26, 2011.

The Commission acknowledges that the presumption that evidence within the control of one party is unfavorable may arise under some circumstances when that party fails to offer the evidence at hearing. However, in this case, the two supervisors and the recorded statement were available to Petitioner, who had the ability to subpoena the supervisors to attend the hearing and to subpoena Respondent to provide the recorded statement. There is no indication in the record that Petitioner attempted to obtain the testimony of the two supervisors or the alleged statement. Respondent did not refuse to present this evidence; it simply chose not to present the testimony of Petitioner's supervisors or the purported recorded statement as part of its defense.

The Circuit Court cites *Reo Movers, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 216, 589 N.E.2d 704, 168 Ill. Dec. 304 (1st Dist. 1992) in support of its instruction to the Commission to consider Respondent's failure to produce the supervisors as witnesses or the recorded statement as evidence as creating a presumption that those witnesses and the alleged statement would support Petitioner's claim of accident and be unfavorable to Respondent. In *Reo Movers*, Petitioner sought to obtain a copy of a contract that was in possession of both Respondents. Petitioner subpoenaed the document from Reo, and Reo's representative refused to produce the contract, explaining that he was still searching for it. The Court found Respondent's explanation "sketchy at best," and concluded that a presumption arose in that case from Respondent's failure to produce the document.

However, the Appellate Court in *Reo Movers* recognized that this presumption does not arise where there is a reasonable excuse for the failure to produce the evidence or where the evidence is equally available to the other side. In the present case, Petitioner's supervisors were subject to subpoena by Petitioner, as well as by Respondent, and Petitioner could have required Respondent to produce the alleged recorded statement prior to hearing by utilizing the Commission's subpoena power. This evidence was available to both parties, so no presumption arises against Respondent in this case.

In *Chidichimo v. Industrial Comm'n*, 278 Ill. App. 3d 369, 662 N.E.2d 611, 214 Ill. Dec. 1045 (1st Dist. 1996), the Appellate Court distinguished between civil and Workers' Compensation cases.

> In civil cases, statutory discovery rules and the supreme court rules apply, including Rule 219 (134 Ill. 2d R. 219), which provides sanctions for discovery violations. However, workers' compensation cases are governed by the Act and do not allow for pretrial discovery.

278 Ill. App. 3d at 375. In *Chidichimo*, Petitioner subpoenaed time sheets and production records from Respondent. Respondent voluntarily provided the requested materials for two of the three subpoenas issued by Petitioner, but returned the third subpoena, noting that the Workers' Compensation Act does not provide for pre-trial discovery. Petitioner did not take the necessary steps to enforce the subpoena for over four years. During that time, Respondent destroyed the requested records pursuant to its standard practice of purging old records. The Court found that there was no evidence that the destruction of the records was in bad faith. It recognized the difference between the situation in the case before it and those in which failure to disclose documents can itself be evidence. The Court found that, where there is a deliberate destruction of evidence or failure to comply with discovery rules, the presumption that the evidence is unfavorable to the party in possession may arise, but in *Chidichimo*, the employer failed to comply with the subpoena simply because it was not required to do so and no presumption arose.

Moreover, once an employer produces direct evidence on the disputed issue, the presumption vanishes. Even if there were a presumption that arose from Respondent's failure to produce the supervisors' testimony or the alleged recorded statement itself, that presumption would have been outweighed by the total absence of any mention of a July 26, 2011 work accident in Petitioner's contemporaneous medical records and of his attribution of his complaints

14IWCC0686

to his July 13, 2010 work accident. See, for example, Dr. Payne's September 13, 2011 office note (PX6).

The Circuit Court correctly noted that the Arbitrator completely ignored Petitioner's testimony that he reported his accident to two supervisors on the date it occurred and provided a recorded statement to Respondent's human resources director on the following day when he concluded that there was absolutely no evidence that corroborated Petitioner's claim of work accident. Petitioner's testimony is some evidence to corroborate his 2011 claim, but the question for the Commission remains whether Petitioner's testimony is credible. Petitioner's testimony, standing alone, is insufficient proof that an accident occurred, especially when considered in conjunction with the absence of any mention of a 2011 accident in his contemporaneous medical records. Petitioner did not offer the testimony of either supervisor and failed to introduce his alleged recorded statement, although he might have obtained this evidence by subpoena. Contrary to Petitioner's argument, Respondent did not have an affirmative duty to introduce all evidence in support of Petitioner's claim. The Commission finds Petitioner's testimony not credible.

For the foregoing reasons, and after reconsidering all of the evidence and relevant law, the Commission re-affirms its prior Decision, affirming and adopting the Arbitrator's Decision, finding that Petitioner failed to prove that he suffered an accident arising out of and in the course of his employment with Respondent on July 26, 2011. All benefits are denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 1, 2012 is hereby affirmed and adopted.

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

Bond for 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: AUG 15 2014

drd/dak
o-07/02/14
68

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

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

Vahe Torian,

Petitioner,

14IWCC0687

vs.

NO. 10 WC01806

International Test & Balance

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant to an order of remand from the Circuit Court of Cook County. In accordance with the order of the Circuit Court entered November 20, 2013. The Commission considers the issue of payment of temporary total disability benefits from June 21, 2011through February 27, 2012 regarding award of temporary total disability payments for the period from June 2, 2011 through February 27, 2012 based upon the Circuit Court Order.

Respondent is ordered to pay temporary total disability for the period from June 21, 2011 through February 27, 2012. Additionally, the Circuit Court of Cook County remands the instant case to the Commission for clarification of its order denying without prejudice the award of vocational rehabilitation on the basis that it was "premature". Finally, the Circuit Court in affirming the Commission's award of penalties remands the award for determination as to whether the calculation of the penalties was in compliance with the Illinois Workers' Compensation Act. The Circuit Court affirms all other findings of the Commission.

The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or permanent disability, if

any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E. 2d 1322, 35 Ill.Dec. 794 (1980).

Petitioner was a 40 year old sheet metal balancer who was married with 5 dependent children. The Petitioner fell on October 14, 2008 when a ladder he was standing on slipped and he fell to the floor. The parties stipulated to the employment relationship, notice and an average weekly wage of $1,525.20. It was further stipulated that the Respondent paid $27,652.99 in temporary disability payments. The Arbitrator found causal connection between the accident and Petitioner's condition of ill-being based upon the testimony of the Petitioner; the clinical notes of Petitioner's treating physician Drs. Brayton (a neurosurgeon), Dr. Lu (a pain specialist), an initial cervical MRI and the opinions expressed by Respondent's Section 12 examiner Dr. Nixon based upon his first report.

Petitioner presented to AIM Clinic following the accident on October 14, 2008 seeking treatment for an injury to his finger, right forearm, wrist and significantly, pain in his neck and shoulder which he rated as a 6/10 and characterized as sharp, stabbing and radiating. He was discharged to return to work with restrictions; i.e. avoid use of right arm and work to tolerance with restrictions. Petitioner testified that he was off work from October 15th through the 17th and returned to regular duty on October 20, 2008. As part of his discharge instructions from AIM Clinic Petitioner was given a script for Tylenol 3 and a restriction from using his right arm. The Arbitrator found that the medication and the restriction rendered Petitioner temporarily totally disabled from October 15th through October 17th, 2009. From the time Petitioner returned to work on October 20, 2009 he remained on regular duty until June 27, 2009.

In the months that transpired from his injury until June 27, 2009 the Petitioner experienced intermittent neck pain and diminishing strength in his right arm. Although he is right dominant he increasingly relied on his left hand to perform his work.

On June 27, 2009 Petitioner complained to Dr. Paul Stromberg M.D., his internist, of experiencing a "flash" of pain from his neck and right arm 3 weeks prior that produced a persistent tingling on the back of his right arm and numbness in his right hand and left palm. Petitioner expressed that "he now feels weak" and unable to do his job. Dr. Stromberg recommended a cervical MRI along with possible neurosurgical consultation.

An MRI was performed on July 6, 2009 which revealed multiple abnormalities in the cervical spine, most significantly; large extrusions at C3-C4 and C4-C5 and moderately severe C4-C5 central spinal stenosis and cord compression. Dr. Stromberg referred Petitioner to a neurosurgeon, Dr. John Brayton M.D. for further evaluation.

On July 17, 2009 the Petitioner was examined by Dr. Brayton. The doctor discussed surgery; noted the Petitioner wanted to try injections and therapy and took the Petitioner off work .An epidural injection was subsequently administered by Dr.Lu, a pain specialist.

Respondent's Section 12 examine, Dr. Nixon saw Petitioner on August 26, 2009. He concurred with Dr.Brayton that the Petitioner could not return to his regular job but felt he could

do sedentary work. Dr. Nixon also agreed with Dr. Brayton's surgical recommendation. On October 5, 2009 Dr. Brayton performed a cervical fusion on Petitioner at Delnor Hospital.

On December 24, 2009 Respondent terminated payment of temporary total disability payments. The Arbitrator found that the Respondent lacked an objectively reasonable basis for the discontinuation of temporary total disability benefits citing to *Continental Distributing Co. v Industrial Commission, 98 Ill 2d 407,415-6 (1983).*

Petitioner remained off work on a medical restriction placed by Dr. Brayton until April 22, 2010. He was then released to return to light duty following a valid functional work evaluation .Respondent first offered light work to Petitioner on May 24, 2010. Based upon the foregoing the Arbitrator found that the Petitioner was temporarily totally disabled from July 16, 2009 through May 23rd, 2010, a period of 44 3/7 weeks.

Petitioner did light duty work from May 24, 2010 through June 22, 2010. Petitioner worked a total of only 41.25 hours. The small number of hours was attributable to several factors, among them, limited work assignments offered by Respondent.

Petitioner telephoned Dr. Brayton on June 3,2010 informing him that he was experiencing neck and right arm symptoms due to "needing to look down frequently" at work. Dr. Brayton's office records reflect that the doctor informed Petitioner via his office staff that he recommended vocational re-training.

On June 15,2010 Dr. Brayton gave Petitioner a script placing him under additional work restrictions i.e. no repetitive neck flexion/extension, no overhead lifting or reaching, no lifting over 20 lbs., no sitting for more than 30 minutes without position change, and no repetitive arm movements.

The Petitioner testified that he gave these restrictions to the Respondent and that Respondent did not provide work that fit the restrictions. The Arbitrator found that the Respondent made an effort to provide work within Dr. Brayton's restrictions but there was too little work available for Petitioner to do. The Petitioner testified that, as of June 22,2010, it was his understanding that the Respondent had no work that would comply with Dr. Brayton's restrictions. He stopped working and applied for unemployment benefits.

At hearing the Petitioner testified that he relocated his family to California in July 2010 for financial reasons but did not join them until August 2011. Dr. Brayton has an office note from April 2010 that refers to Petitioner having moved to California.

There is a lack of clarity concerning whether Petitioner was in Illinois or California between June 2010 and May 2011. On October 12, 2010 Petitioner telephoned Dr. Brayton's office. The note states that Petitioner was in town "from California" in order to meet with his attorney. The Arbitrator was troubled by the Petitioner's vague testimony concerning his activities from the time he left Respondent's employ concerning both his whereabouts and also

his job search efforts which lacked documentation until May and June 2011 and questioned Petitioner's credibility regarding those issues

On July 22, 2010 Petitioner's counsel sent a letter to Respondent's counsel requesting reinstatement of temporary total disability/maintenance benefits and vocational rehabilitation, based upon his understanding that the Respondent was unable to accommodate the most recent work restrictions. He indicated that he would retain his own expert in the event the Respondent declined to initiate vocational rehabilitation.

At the time of the Petitioner's call to Dr. Brayton on October 12th, 2010 he reported continuation of the symptoms reported in June i.e. neck pain with flexion and a constant warm tingling feeling. Petitioner had an MRI of the cervical spine performed on October 15, 2010 which reported the finding of a syrinx in the cord at C6 that appeared more prominent in size than on the prior MRI dated January 27, 2010. Dr. Brayton wrote a letter to Dr. Stromberg on November 5, 2010 recommending the need for an EMG and nerve conduction velocity studies to characterize the degree of radiculopathy and rule out concurrent peripheral entrapment neuropathy. He goes on to state that they may need to pursue permanent disability given Petitioner's intolerance to even modified duty in a sedentary setting. The Petitioner testified that the electrodiagnostic testing recommended by Dr. Brayton was not performed due to his lack of funds and refusal of workers' compensation to pay for the testing.

The Arbitrator declined to award temporary total disability benefits from June 23, 2010 through May 1, 2011 citing the lack of evidence that Petitioner engaged in a job search for light duty work compatible with the restrictions placed by Dr. Brayton was conducted prior to May 2, 2011 combined with the lack of explanation concerning Petitioner's whereabouts (Illinois vs. California) during this period.

On June 21, 2011, eight months after Petitioner's last examination Dr. Brayton ordered Petitioner "off work" in a telephone communication that was relayed to Petitioner via office staff. The record does not indicate that the Petitioner was seen by Dr. Brayton that day or indicate the basis for the decision that the Petitioner was no longer capable of light duty. Based on the foregoing the Arbitrator denied temporary total disability benefits from June 21, 2011 to the time of hearing on February 27, 2012.

In addition to reversing the Commission's decision denying the payment of temporary partial disability payments from June 21, 2011 through February 27, 2012 the Circuit Court further remanded this matter for clarification of the Commission's finding that vocational rehabilitation was premature.

The Commission has considered and recognizes that the FCE performed on March 19, 2010 by Ron Larkins states that the Petitioner "does not demonstrate a strong rehabilitation potential through either PT or work conditioning due to the high stability of client's symptoms and other objective findings...". Dr. Brayton in his report to Dr. Stromberg on April 22,2010 which followed his own examination states the opinion that further work conditioning is not appropriate and would not allow Petitioner to resume his prior work activities that require sustained overhead neck extension and sustained repetitive overhead lifting. In June 2010, Dr.

Brayton placed further significant restrictions on Petitioner's work activities. Eventually, Petitioner stopped working and applied for unemployment. In November 2010, Dr. Brayton did not order the Petitioner "off work". Even following an MRI in October and an order in November that Petitioner undergo further EMG/NV Dr. Brayton did not order the Petitioner "off work".

The evidence presented at hearing supports the Respondent's assertion that the restrictions placed were accommodated in that the Petitioner was provided with a number of work surfaces to use including an adjustable drafting table which would permit the Petitioner to do his work without having to look down. Additionally, there was no production quota or deadline imposed that would prohibit Petitioner from taking necessary breaks. The Arbitrator found that accommodations were made by Respondent.

The evidence presented further supports that although the Petitioner was capable of performing light duty work there is no evidence that Petitioner made a search for light duty work either in California or Illinois until May 2011.

On July 22, 2010 Petitioner's counsel sent a letter to Respondent's counsel requesting reinstatement of temporary total disability/maintenance benefits and vocational rehabilitation , based upon his understanding that the Respondent was unable to accommodate the most recent work restrictions. He indicated that he would retain his own expert in the event the Respondent declined to initiate vocational rehabilitation.

As stated previously Dr. Brayton prescribed EMG/NV testing on November 5,2010 but notably did not take the Petitioner off work pending the completion of that testing. Petitioner did not go to see Dr. Brayton for any treatment or assessment subsequent to October 5, 2010 .

Approximately eight months later on June 21, 2011 Petitioner telephoned Dr. Brayton's office. He was not examined by Dr. Brayton on that date. Petitioner's call was returned by a member of the office staff. The office records indicate that the following was conveyed to the Petitioner "...per JB –pt should not return to work.WC is denying all further testing. Advised pt to get legal help."

This exchange via the office staff offers no basis for Dr. Brayton now taking the Petitioner off work. It contains no information that the Petitioner reported any symptoms. It does not describe the clinical condition of the Petitioner. It states no rationale for the change in Petitioner's work status. This note gives neither the Arbitrator nor the Commission any evidence that would be useful in determining that the Petitioner was in need of vocational rehabilitation. It contains no information about any functional limitations the Petitioner was experiencing due to his injury at that point in time.

The lack of current medical information in conjunction with Petitioner's failure to engage in any documented job search from June 23, 2010 to May 1, 2011 leaves the functional status of the Petitioner uncertain. There is not sufficient evidence in the record to permit the Commission to make a finding that the Petitioner was unable to perform or find employment within Dr.

14IWCC0687

Brayton's work restrictions of June 2010 . Therefore, the Petitioner's request for vocational rehabilitation was appropriately denied as premature.

The Commission's ordered the Respondent to authorize and pay for prospective medical care in the form of a return visit to Dr. Brayton for purposes of clarifying Petitioner's work status as well as previously prescribed EMG/NV testing should Dr. Brayton determine that such testing is required. After completion of the prospective medical care ordered by the Commission the Petitioner may, if appropriate, renew his request for vocational rehabilitation and the matter will be considered by the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the denial of temporary total disability payments from June 21, 2011 through February 27, 2012 is reversed pursuant to the November 20,2013 order of the Circuit Court of Cook County. THE COMMISSION finds no basis in the record or the law for altering its decision regarding the denial of temporary total disability payments for the period from June 21, 2011 through February 27, 2012 however awarded based upon the Circuit Court order.

IT IS FURTHER ORDERED BY THE COMMISSION that the finding that the Arbitrator and the Commission that the award of vocational rehabilitation is premature is clarified for the reasons previously stated in this decision and the COMMISSION finds no basis in the record or the law for altering its decision .

IT IS FURTHER ORDERED BY THE COMMISSION that the calculations of penalties is in compliance with the Illinois Workers' Compensation Act.

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

Bond for the removal of this cause to the Circuit Court by the Respondent is hereby fixed at the sum of $55,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: AUG 15 2014
SJM/msb
o-05/01/2014
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

Michael Lever,

Petitioner,

vs.

NO: 13 WC 000387

Gilead Sciences,

14IWCC0688

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 treatment 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 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).

On April 24, 2012 Petitioner, a 46-year-old travelling sales representative, was involved in a traffic collision while working for Respondent. Petitioner testified that he stopped his vehicle behind three other cars at a red light. When the traffic light turned green, the car directly behind Petitioner accelerated into the rear end of Petitioner's vehicle, but the force of impact did not cause Petitioner to strike the car in front of him. Petitioner was restrained in a seatbelt and did not strike his head. Petitioner testified that he immediately called his supervisor, the police, and his insurance company. No emergency medical services attended the scene and Petitioner did not go to the hospital. Petitioner offered photographs of his car bumper purportedly taken subsequent to the accident. Although we note Petitioner's testimony that the rear bumper was pushed up under the car, but in the photographs the bumper appears only slightly askew and no other significant damage is visible.

The record shows that Petitioner had a pre-existing low back condition for which he underwent chiropractic treatment and injections. On April 20, 2009, Petitioner saw his primary care physician, Dr. Schueler. Petitioner reported pulling his back several days earlier and that he had been in chiropractic treatment with Dr. Novak. On May 27, 2009 a lumbar MRI showed bulging discs at levels L4-5 and L5-S1. Petitioner purportedly underwent injections by Dr. Randle in the fall of 2009. He continued to complain to Dr. Schueler that he had low back pain with shooting pains down his right and left sides. Petitioner underwent a repeat lumbar MRI on January 10, 2010. The report indicated disc bulging and degenerative changes at levels L3-4, L4-5 and L5-S1 and an annular tear at L4-5. The radiologist noted that in comparison to the prior study the changes at L4-5 and L5-S1 were slightly advanced.

There is no further evidence of back treatment until December 1, 2011 when Petitioner was seen by Dr. Tate at Crane Clinic Sport Medicine. Petitioner complained of severe lumbar pain with radiation into the left buttock and thigh. His long history of back pain was noted, and also that he had some relief with prior injections and chiropractic treatment. On December 21, 2011 Petitioner returned to Dr. Tate for injections of platelet-rich plasma into his bilateral sacroiliac joints, iliolumbar ligament and the L5/S1 facet joints. Dr. Tate repeated the injections on March 15, 2011. On April 10, 2012 Petitioner saw Dr. Schueler for unrelated reasons but reported that he had not recently been taking his Flexeril and he felt increasing tightness in his back.

Although Petitioner did not go to the hospital after the April 24, 2012 accident, he did return to his chiropractor, Dr. Novak. At Dr. Novak's office Petitioner completed a "Work Injury Information" form and an "Auto Accident History" from and reported that he was rear-ended at 10:00 a.m. and injured his low back and neck. He indicated that his head and body were facing forward at the time of impact and he denied any injury or bruise from the seatbelt. His complaints were of continuous moderate to severe bilateral lumbar pain, bilateral buttock pain, left anterior thigh pain and intermittent moderate left-sided neck stiffness. Petitioner indicated that he takes Skelaxin at night for pain. Petitioner also returned to Dr. Novak the following day and on April 26, 2012. Petitioner reported the same symptoms of left-sided neck pain, bilateral lumbar pain and left leg pain, and also reported bilateral mid-thoracic pain. Petitioner testified that he took a few days off of work following the accident but then returned to work on April 28, 2012 because he had an obligation to give a presentation.

There are no further treatment records until July 17, 2012 and Petitioner continued to work during this time. On July 17, 2012, Petitioner returned to Dr. Novak and was released from care; maximum medical improvement with respect to the motor vehicle accident was noted. Petitioner continued to report some right-sided neck pain and bilateral buttock and lumbar pain, but the pain chart does not indicate any lower extremity symptoms.

Petitioner offered the deposition testimony of Ms. Kenehan, prior regional director for Respondent. Ms. Kenehan retired in March of 2013 and testified via deposition on July 10, 2013. Ms. Kenehan supervised Petitioner between February of 2011 and October of 2012 when Petitioner went on medical leave. She has known Petitioner professionally since 1998. As

Petitioner's supervisor, she rode along with Petitioner on sales calls every four to six weeks and conduct quarterly staff meetings. She testified that Petitioner was a top performer in the company and that she was not aware that Petitioner had any physical problems between February 2011 and April 24, 2012. She testified that Petitioner called her after the motor vehicle accident. Ms. Kenehan testified that she tried but was unsuccessful in finding a replacement for Petitioner for the April 28, 2012 conference. The first time she saw Petitioner after the accident was in May of 2012. She testified that she noticed he was "struggling" and he told her that he had back pain. She observed him wincing with movements such as reaching for his seatbelt. She believed that Petitioner "wasn't the same. He wasn't functioning." She testified that she had to help him lift samples out of his car, that he needed to stand during meetings, and that every activity took him longer to perform. She believed Petitioner's condition was impacting his performance and the company. Ms. Kenehan testified that she advised Petitioner to seek another medical opinion when he did not appear to be improving. In August of 2012 Petitioner and Ms. Kenehan went to a meeting in San Francisco. Ms. Kenehan recalled that Petitioner did not attend the group dinners and had to stand up during the meetings. She testified that she encouraged Petitioner to take time off of work because he was reporting to her that he was in pain and he did not feel like he could do his job anymore.

On cross-examination, Ms. Kenehan testified that she spoke to her own supervisor, Mr. Graef, about Petitioner's situation although she confirmed that she never put anything in writing. Ms. Kenehan testified that she was not responsible for reporting workers' compensation claims.

Petitioner returned to Dr. Schueler on September 27, 2012 with complaints of persistent low back pain; the motor vehicle accident was not mentioned in Petitioner's history. Dr. Schueler ordered a bone scan and a repeat MRI. Petitioner's bone scan was normal and the October 12, 2012 lumbar MRI indicated disc bulges at levels L1-L2, L2-L3, L3-L4, L4-L5 and L5-S1, an annular tear at L4-L5, and a small left central extrusion at L5-S1. On October 23, 2012, Petitioner was examined by Dr. Kennedy, a neurosurgeon, on referral from Dr. Schueler. Petitioner gave a history of back pain since his thirties that worsened over the previous three years. Dr. Kennedy noted "about three weeks ago as he turned he had very severe pain the lower lumbar area and was bedridden for about two days." The April 24, 2012 accident was not mentioned in Petitioner's history. Dr. Kennedy recommended a discogram for further evaluation and indicated that an anterior lumbar fusion may be an option. Dr. Kennedy excused Petitioner from all work. At the hearing, Petitioner claimed to be entitled to temporary total disability benefits from October 29, 2012 through the date of hearing.

On October 29, 2012, a lumbar discogram and CT indicated disc bulges from L2-3 through L5-S1 with annular tears noted at L4-5 and L5-S1 and a protrusion at L2-L3 in contact with the existing left nerve root. On November 11, 2012 Petitioner returned to Dr. Kennedy's office and surgery was recommended and discussed. On December 27, 2013 Dr. Kennedy continued to keep Petitioner off of work and noted that authorization for surgery was being sought. On January 4, 2013 Dr. Kennedy noted that authorization had been denied. Petitioner then reported an "additional history" of having sustained a motor vehicle accident in April of 2012, causing him to have "different pain" thereafter. He claimed that during the time period

prior to the accident he was "pain free." Dr. Kennedy opined that the need for surgery was therefore related to the accident. On January 7, 2013 Petitioner filed an Application for Adjustment of Claim. In February and March of 2012, Petitioner underwent a series of lumbar epidural steroid injections recommended by Dr. Kennedy and Dr. Kennedy continued to excuse Petitioner from all work.

On March 29, 2013 Petitioner was examined by Dr. Mirkin, an orthopedic surgeon, at the request of Respondent. Petitioner denied any history of left leg pain prior to the accident. Dr. Mirkin noted that Petitioner walked with an exaggerated antalgic gait. Dr. Mirkin opined that Petitioner had degenerative disc disease with left lumbar radiculopathy that pre-existed the accident of April 24, 2012. He believed that surgery was a reasonable treatment option but that the need for surgery was not related to the accident. Dr. Mirkin saw no medical reason that Petitioner could not work if he desired to do so and noted that Petitioner did work for many months following the accident.

On April 3, 2013 Dr. Kennedy examined Petitioner and noted that the course of lumbar epidural steroid injections did not provide relief. Dr. Kennedy reiterated his surgical recommendation and restriction against all work. Dr. Kennedy testified via deposition on May 29, 2013. Dr. Kennedy reviewed Petitioner's prior records in addition to reviewing his own file in anticipation of the deposition. Dr. Kennedy believed that the disc bulging present in the October 11, 2012 MRI had clearly progressed since the May 27, 2009 and January 10, 2011 studies. Dr. Kennedy testified that he excused Petitioner from work as of October 23, 2012 because Petitioner's job duties of driving and getting into and out of his car aggravated Petitioner's symptoms. Dr. Kennedy agreed that Petitioner did not report a work-related accident or motor vehicle accident during his initial consultations. After the request for surgery was denied, Dr. Kennedy recalled that Petitioner "discussed with me in more specific detail the onset of the symptoms." Petitioner gave Dr. Kennedy a more complete history of prior treatment and the motor vehicle accident in April of 2012. Petitioner explained that his pain was "much worse than any other prior experience that he had had. And also, it was in a different pattern. It was predominately lower lumbar area not sacroiliac joint pain" and that he also had much more severe left leg pain. Petitioner explained that he had been functioning and able to work and engage in normal activities up until the time of the car accident and thereafter he was not. While he noted that Petitioner did have complaints documented by Dr. Schueler two weeks prior to the accident, he did not believe that Petitioner's pre-accident symptoms compared to what he experienced following the accident. Dr. Kennedy opined that to a reasonable degree of medical certainty Petitioner's pre-existing back condition was worsened by the accident and now required surgery.

On cross-examination, Dr. Kennedy agreed that Petitioner was 46-years-old with a history of low back pain since his thirties. Dr. Kennedy agreed that during the initial consultation he asked Petitioner about the onset of his low back complaints; Petitioner described a long history of back pain and a recent incident that left him in such severe pain that he was bedridden for two days. Dr. Kennedy agreed that the only MRI film he personally reviewed was the October 11, 2012 MRI; he only reviewed the reports of the previous studies. Dr. Kennedy agreed

that prior records do indicate that Petitioner had complaints of pain going down both legs, including a November 6, 2009 complaint of left-sided back pain going all the way down into Petitioner's Achilles tendon. He agreed that the records show that Petitioner had been taking Flexeril prior to the accident and had been prescribed Relafen, Skelaxin, Vioxx and Vicodin during his treatment history. He agreed that Dr. Schueler's note from September 27, 2012 also did not mention the motor vehicle accident. Dr. Kennedy agreed that Petitioner was apparently working until October 23, 2012. Although Dr. Kennedy testified that his surgical recommendation was "yet to be determined" before he learned of the April 24, 2012 accident, the records contradict Dr. Kennedy's testimony and they show that in fact Dr. Kennedy's surgical recommendation and request for authorization preceded his knowledge of the motor vehicle accident.

On June 14, 2013 Dr. Mirkin testified via deposition. Dr. Mirkin testified that he found it significant that Petitioner had been prescribed pain medications and muscle relaxers for many years. He also believed that Petitioner's claim of no prior left leg pain was blatantly contradicted by the records. He testified that his opinion was that Petitioner had degenerative disc disease but no evidence that it had been worsened by the motor vehicle accident or that surgery would be causally related to the accident. Dr. Mirkin also found it significant that Petitioner did not even attribute his complaints to the accident when he resumed treatment in the fall of 2012, only after authorization for the requested surgery was denied by Petitioner's group health insurance. On cross examination, Dr. Mirkin agreed that Petitioner did not give him specific details of the motor vehicle accident; he agreed that the details could be relevant. Dr. Mirkin confirmed that Petitioner denied left-sided radicular symptoms pre-existing the accident. Dr. Mirkin testified that he wrote down exactly what Petitioner reported to him. Dr. Mirkin agreed that the records show that although Petitioner was released from care on July 17, 2012 by Dr. Novak, Petitioner was not completely pain-free at that time. Dr. Mirkin agreed that the records do not indicate that any surgical recommendations had been made during Petitioner's treatment history prior to the accident. He agreed that degenerative conditions can be aggravated by trauma, although he testified that the symptoms of degenerative conditions may increase with any activity. Dr. Mirkin reviewed the October 11, 2012 MRI and while he agreed with the radiologist's interpretation of L4-5 disc bulging and an annular tear, he opined that the findings appeared similar to the previous films. He testified that the software, machines and techniques can all make a difference in the results but that nevertheless the MRI films appeared substantially similar in showing degenerative disc disease, annular lesions and bulging discs. Dr. Mirkin disagreed that the accident was related to the need for back surgery because Petitioner already had all of the pathology prior to the accident. Dr. Mirkin does not disagree with Dr. Kennedy's surgical recommendation but he opined that "if you do a fusion on him at L5-S1, very likely, five years later, he's going to need more at L4-5, and may need some in his neck. He's got a systemic condition of degenerative spine disease."

After examining the entire record on review, we find that Petitioner sustained a temporary aggravation of his preexisting condition due to the motor vehicle accident on April 24, 2012, but we conclude that the aggravation resolved by July 17, 2012 when Petitioner was released by Dr. Novak. We find that Petitioner's complaints in the fall of 2012 when he sought

treatment with Dr. Kennedy are unrelated to the accident. Petitioner's pre-existing condition is significant for recurrent aggravations overlying progressive degenerative disk disease. Following the accident, Petitioner demonstrated improvement of his acute symptoms with a few sessions of chiropractic treatment; he was able to return to work after several days and continued working until October of 2012. We note that Dr. Kennedy was given no history of the accident until after his surgical recommendation was made and Petitioner's group health insurance denied authorization.

We note Dr. Kennedy's testimony that although Petitioner made no mention of the accident until after the surgery was denied he still maintained his opinion that Petitioner's condition was causally related to the accident. Based on Petitioner's subjective statements, he believed that Petitioner's chronic pain changed after the accident in that it became more severe, involved more radiation into the legs and also worsened to the point of necessitating surgery. We do not find the causal connection opinion of Dr. Kennedy based on Petitioner's subjective history to be supported by the credible record.

After considering all of the evidence, we find that Petitioner reached maximum medical improvement from any injuries sustained as a result of the April 24, 2012 accident by July 17, 2012 and that he failed to prove that he sustained any permanent partial disability as a result of the accident. Therefore, we modify the decision of the Arbitrator and vacate the Arbitrator's award of temporary total disability benefits, prospective medical treatment and any medical expenses incurred by Petitioner after July 17, 2012.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay the necessary and related medical expenses under §8(a) of the Act through July 17, 2012.

The party commencing 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: AUG 18 2014
RWW/plv
o-6/24/14
46

Ruth W. White

Daniel D. Donohoo

Charles J. DeVriendt

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

LEVER, MICHAEL L
Employee/Petitioner

Case# **13WC000387**

GILEAD SCIENCES
Employer/Respondent

14IWCC0688

On 9/11/2013, 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 0.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5174 EDMONDS LAW OFFICE
J ROBERT EDMONDS
1012 PLUMMER DR SUITE 201
EDWARDSVILLE, IL 62025

1872 SPIEGEL & CAHILL PC
PATRICK J JESSE
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

14IWCC0688

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)

Michael L. Lever
Employee/Petitioner

v.

Gilead Sciences
Employer/Respondent

Case # 13 WC 00387

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 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. ☒ 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 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 $150.020.00; the average weekly wage was $2,885.00.

On the date of accident, Petitioner was 46 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 $53,070.85 for other benefits (non-occupational disability benefits), for a total credit of $53,070.85.

Respondent is entitled to a credit of $7,019.19 under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 3, 18, 20, 22, 24, 25 and 26, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of $7,019.19 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. Kennedy, including, but not limited to, back surgery.

Respondent shall pay Petitioner temporary total disability benefits of $1,288.96 per week for 34 4/7 weeks commencing October 29, 2012, through July 18, 2013, as provided in Section 8(b) of the Act.

Petitioner's petition for Sections 19(k) and (l) penalties and Section 16 attorneys' fees is denied.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

September 6, 2013
Date

SEP 11 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 24, 2012. According to the Application, Petitioner sustained injuries to the back, neck and body as a whole as a result of a rear-end auto accident. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. Respondent stipulated that Petitioner sustained a work-related accident; however, Respondent disputed liability on the basis of causal relationship.

Petitioner began working for Respondent, a pharmaceutical company, in July, 2010, and was employed as a sales representative. Virtually all of Petitioner's customers were cardiologists and his sales territory included St. Louis, the Metro-East and as far south as Cape Girardeau. Petitioner's typical workday was 8 AM to 5 PM and involved a significant amount of travel. Petitioner estimated that he spent approximately 80% of his time at work driving.

On April 24, 2012, Petitioner was driving his automobile in St. Louis and had just taken an exit off of I-64. He was at the stoplight at the intersection of Skinker and Clayton Road when he was rear-ended by another vehicle. Petitioner testified that he sustained an immediate onset of severe low back pain with radiating pain into the left leg to the foot as well as some neck pain.

Prior to April 24, 2012, Petitioner had low back problems which required medical treatment; however, Petitioner testified that his prior back problems did not significantly impact his ability to work and that no prior surgical recommendation had ever been made to him. The fact that Petitioner had these prior low back problems is the primary basis for Respondent's disputing causal relationship.

Petitioner testified that prior to April 24, 2012, he had low back problems for approximately 10 years. He described the symptoms as being tightness in the back with some involvement of the left buttock and leg. Petitioner's counsel tendered into evidence medical records regarding medical treatment received by Petitioner prior to April 24, 2012.

On April 20, 2009, Petitioner was seen by Dr. Dean Schueler, his family physician, and Petitioner informed him that he had back symptoms and had been seen by a chiropractor, Dr. Novak. Dr. Schueler examined Petitioner, made a diagnosis of lumbar degenerative disc disease and prescribed some medications. On May 27, 2009, an MRI was performed at Dr. Schueler's direction which revealed bulging discs at L4-L5 and L5-S1.

Dr. Schueler saw Petitioner on November 10, 2009, and Petitioner complained of low back pain shooting down the right side. Dr. Schueler's record of that date stated that the pain was previously on the left side but that Petitioner had injections from Dr. Randle which helped and that he had been seen by Dr. Novak but that did not help. No records of Dr. Randle were tendered into evidence at trial nor were any pre-accident records of Dr. Novak tendered at trial.

Petitioner was seen by Dr. Schueler on March 10, 2010, but this visit was not in regard to any low back symptoms. Dr. Schueler ordered another MRI scan which was performed on January

10, 2010, and it revealed disc bulging and degenerative changes at L3-L4, L4-L5 and L5-S1. An annular tear was also noted at L4-L5. The radiologist noted that, in comparison to the prior MRI, the findings at L4-L5 and L5-S1 were slightly greater. (Petitioner's Exhibit 8). The next time Petitioner saw Dr. Schueler was April 10, 2012, (two weeks prior to the accident) for a rash on his left leg, lesions on his elbows, to obtain a topical medication for his face and back pain. In regard to back pain, the records stated that Petitioner ceased the use of Flexeril a few weeks ago due to "HA" and the back was getting tight. In regard to examination findings, the record only stated that the musculoskeletal examination was positive for back pain (Petitioner's Exhibit 5).

Petitioner was seen at Crane Clinic Sport Medicine by Dr. Kristin Tate on December 1, 2011. At that time, Petitioner complained of severe lumbar spine pain with radiation into the left buttock and thigh. Petitioner informed Dr. Tate that he had obtained some relief with injections and chiropractic treatment. Dr. Tate noted that Petitioner had low back pain for many years and opined that he had sacroilitis and a strain but that the MRI suggested an L4-L5 annular tear.

On December 21, 2011, Dr. Tate performed injections of platelet rich plasma on both sides of his low back. Petitioner obtained some relief of his low back symptoms and underwent a second set of injections on March 15, 2012. Petitioner testified that immediately prior to the accident of April 24, 2012, that he felt good and was able to work without restrictions.

Following the accident, Petitioner sought treatment from Dr. Richard Novak, a chiropractor (who had previously treated him for low back problems). Dr. Novak saw Petitioner on the same day of the accident and his records of April 24 through April 26, 2012, were received into evidence at trial. The history of the auto accident was noted in those records and Petitioner completed a pain chart which indicated he had low back pain with burning of both hips, more on the left than right. The intensity of the pain was indicated as approximating "unbearable" and that Petitioner had no pain at all earlier in the week (Petitioner's Exhibit 6).

Petitioner testified that Dr. Novak authorized him to return to work on April 28, 2012, but that this was at his specific request. Prior to the accident Petitioner was scheduled to give a presentation to a group of cardiologists/customers which happened to be his best customers. Petitioner was able to give the presentation and he continued to work; however, he testified that he made a number of modifications in the manner in which he performed his work duties, specifically, no climbing of stairs, exercising greater caution when exiting his vehicle, etc. In mid-July, 2012, Dr. Novak released Petitioner from care and he continued to work but stated he was in constant pain. Petitioner had no medical treatment from July 17, 2012, to September 27, 2012.

On September 27, 2012, Petitioner was seen by Dr. Schueler, at which time Petitioner complained of low back pain. Dr. Schueler ordered a bone scan and another MRI which were performed on October 3, and October 11, 2012, respectively. The bone scan was normal and the MRI revealed disc bulges at L1-L2, L2-L3, L3-L4, L4-L5 and L5-S1. The annular tear at L4-L5 was noted as well as a small left central extrusion at L5-S1. Dr. Schueler referred Petitioner to Dr. David Kennedy, a neurosurgeon.

Dr. Kennedy evaluated Petitioner on October 25, 2012. In his record of that date, the history was that Petitioner began to have low back pain in his 30's which had worsened in the last three years. There was no reference to the auto accident of April 24, 2012. Petitioner informed Dr. Kennedy of having epidural steroid injections and platelet rich plasma injections prior to being seen by him. Petitioner also informed Dr. Kennedy that three weeks prior to his initial visit that he experienced very severe back pain and was bedridden for two days. Dr. Kennedy reviewed the MRI of October 11, 2012, and noted that it revealed an annular tear and very large disc bulge at L4-L5. Dr. Kennedy recommended Petitioner have a discogram and noted the potential need for an anterior lumbar fusion. He authorized Petitioner to be off work and Petitioner ceased working shortly thereafter (Petitioner's Exhibit 2).

A discogram and CT scan were performed on October 29, 2012, and disc bulges were noted from L2-L3 through L5-S1 with annular tears noted at L4-L5 and L5-S1 and a protrusion at L2-L3 in contact with the exiting left nerve root (Petitioner's Exhibit 21). Dr. Kennedy saw Petitioner on January 4, 2013, and, at that time, Petitioner advised him of having sustained the motor vehicle accident in April, 2012 (Dr. Kennedy's record does erroneously use the date of April 12, 2012). Dr. Kennedy examined Petitioner and opined that Petitioner's pain and current need for treatment was related to the accident of April, 2012. Petitioner has continued to see Dr. Kennedy and has received some epidural injections; however, he wants to proceed with the surgery recommended by Dr. Kennedy. Dr. Kennedy has continued to authorize Petitioner to remain off work.

At the direction of the Respondent, Petitioner was examined by Dr. R. Peter Mirkin, an orthopedic surgeon, on March 29, 2013. Dr. Mirkin reviewed a letter from Respondent's counsel as well as medical records provided to him and examined the Petitioner. Dr. Mirkin opined that Petitioner had degenerative disc disease with left side lumbar radiculopathy the pre-existed the motor vehicle accident of April 24, 2012. He opined that surgery was an option; however, he did not attribute the need for same to the accident (Respondent's Exhibit 1).

Dr. Kennedy was deposed on May 29, 2013, and his deposition testimony was received into evidence at trial. Dr. Kennedy's testimony was consistent with his medical records and he reaffirmed his opinion that there was a causal relationship between the accident, Petitioner's low back condition and the need for surgery. While Dr. Kennedy agreed that Petitioner had low back symptoms that pre-dated the accident, he noted that Petitioner's post-accident symptoms were much worse than they had been previously, the pain was more in the lumbar area than before and the left leg symptoms were much more intense. Further, Dr. Kennedy noted that the post-accident bulging as noted in the MRI was clearly worse than what was indicated in the pre-accident MRIs. Dr. Kennedy opined that the motor vehicle accident of April 24, 2012, caused an aggravation of Petitioner's pre-existing condition, that Petitioner is not MMI and that fusion surgery is indicated (Petitioner's Exhibit 15).

Dr. Mirkin was deposed on June 14, 2013, and his deposition testimony was received into evidence at trial. Dr. Mirkin's testimony was consistent with his medical report and he reaffirmed his opinion that there was not a causal relationship between the accident and Petitioner's current back condition. While Dr. Mirkin agreed that surgery may be appropriate, he opined that the need for it is because of Petitioner's pre-existing degenerative disc disease. On cross-examination, Dr. Mirkin agreed that the post-accident MRI of October 11, 2012, revealed

pathology at L5-S1 that was not seen on the MRI of January 10, 2011. Further, Dr. Mirkin agreed that the type of degenerative condition Petitioner had in the low back could be aggravated by trauma (Respondent's Exhibit 2).

Deann Kenehan, Petitioner's prior supervisor, was deposed on July 10, 2013, and her deposition testimony was received into evidence at trial. Kenehan was not available to testify live at the hearing. Kenehan testified that Petitioner had been previously scheduled to give a presentation to a group of cardiologists/customers on April 28, 2012. She testified that Petitioner was the lead person for this presentation and that, in spite of her efforts to find someone, no one else was available to give the presentation in his place. Kenehan did have occasion to observe Petitioner in May and June, 2012, and observed that he had some difficulty while driving, moving around the office, etc.

Petitioner's wife also testified at the trial and confirmed that Petitioner had low back pain prior to the accident but that when he did, he usually recovered rather quickly. Since the accident, she has observed Petitioner having difficulties with mobility and he is not able to perform household chores the way he was able to do prior to the accident.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the accident of April 24, 2012.

In support of this conclusion the Arbitrator notes the following:

While there is no question that Petitioner had pre-existing back symptoms, Petitioner testified they did not significantly affect his ability to work and that no prior surgical recommendation had ever been made to him. Petitioner testified that there was a significant worsening of his symptoms following the accident. The Arbitrator finds this testimony be credible and consistent with the medical evidence.

The Arbitrator finds the opinion of Petitioner's treating doctor, Dr. Kennedy, to be more persuasive than that of Respondent's Section 12 examiner, Dr. Mirkin. Dr. Kennedy noted the increase in symptoms following the accident and also observed the differences in the pre-and post-MRI studies. In spite of his opinion to the contrary, Dr. Mirkin agreed that Petitioner's pre-existing condition could be aggravated by trauma.

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

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

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 3, 18, 20, 22, 24, 25 and 26, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of $7,019.19 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 including, but not limited to, the back surgery recommended by Dr. Kennedy.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 34 4/7 weeks commencing October 29, 2012, through July 18, 2013.

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

The Arbitrator concludes that Petitioner is not entitled to Sections 19(k) and (l) penalties or Section 16 attorneys' fees.

In support of this conclusion the Arbitrator notes the following:

Respondent's denial of benefits was not vexatious nor was it in bad faith.

William R. Gallagher, Arbitrator

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

Ottis E. Claude, Jr.,

Petitioner,

vs.

NO: 08 WC 3817

14IWCC0689

USF Holland,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 31, 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.

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

DATED:
TJT:yl AUG 18 2014
o 8/11/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CAUDLE, OTTIS JR
Employee/Petitioner

Case# **08WC003817**

USF HOLLAND
Employer/Respondent

14IWCC0689

On 5/31/2013, 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:

2427 KANOSKI BRESNEY
ALLEN MUELLER
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

2904 HENNESSY & ROACH PC
CRAIG COLBROOK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

14IWCC0689

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

Ottis Caudle Jr.
Employee/Petitioner

v.

USF Holland
Employer/Respondent

Case # **08 WC 003817**

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 **May 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 **12/22/2007**, 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.

Petitioner's current condition of ill-being ***is not*** causally related to his employment with Respondent.

ORDER

No benefits 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.

D. Ryan McCarthy
Signature of Arbitrator

May 27, 2013
Date

ICArbDec p. 2

MAY 31 2013

FINDINGS OF FACT

The Petitioner was hired by the Respondent on Nov. 26, 2007 as a dock worker at its trucking facility in Atlanta, Illinois. At that time he was 32 years old and had been a member of the Teamsters Union since June of the same year.

His job primarily required him to work on a large loading dock with 28 individual dock doors which trucks would use to load and unload their product. PX 13 represents an accurate depiction of the Petitioner's work area.

His typical work day began with him spending some time cleaning the dock itself, which he did by sweeping with a broom, stacking up empty pallets and emptying the garbage. The Petitioner said that this took one to two hours each day, while Jody White, the terminal manager, testified that cleaning took two to three hours. The rest of the day, the Petitioner primarily drove a fork lift truck moving products. The truck was a standard fork lift weighing roughly 7500 pounds with standard hard rubber tires and no suspension. He operated the truck from a seated position, moving the products by using tines or forks to lift pallets.

He is alleging a repetitive trauma injury occurred to his lower back during the twelve days he drove for the Respondent as a result of bouncing or jostling while driving his truck.

The main dock consisted of a large smooth surface which did not cause any vibration. The Petitioner testified that much of his day was spent driving on the large dock, moving products near the dock doors where they would later be loaded onto semis. He referred to the large dock as a staging area. Once the trucks arrived for loading, he would access them by driving his truck across metal dock plates maintained by the Respondent. There were 27 docking areas for semis, and the Petitioner loaded on all of them on a daily basis. While he initially testified that the weight of the fork lift and the nature of the metal plates caused him to bounce to some degree as he went over them, he later admitted that there was very little, if any, bounce as he used these 27 docking areas. The Petitioner testified that he would load and unload 50 to 60 trailers per day.

The 28th dock was in fact a permanent trailer which had been added to the main dock as a storage area. In order to access this trailer, the Petitioner had to drive across a dock plate which he said sloped down anywhere from 3 to 5 inches. Ms. White disagreed, stating that there was no decline between the dock and permanent trailer, and that she never saw a decline over 1 to 1.5 inches between any of the 28 dock doors and trailers during the seven years she worked as terminal manager. The Petitioner testified that he would dive in and out of the storage trailer 20 to 30 times per shift. Later he said that the number was 30 to 40 times. He said that driving into the area was not bad as far as bouncing on his truck. However, he said that coming out of the storage area was a problem. He said that the ramp or plate would cause him to bounce and that a couple of times each shift his forks or tines would hit the plate causing his truck to be jarred or actually stop. He acknowledged on cross-examination that this only occurred while he was coming off the 28th dock.

The evidence showed that his first day of actual driving for the Respondent was on Nov. 27, 2013 and that he drove a total of twelve days. His work day normally lasted over 11 hours.

Prior to working for the Respondent, the Petitioner testified that he had no known problems with his lower back, and no evidence was offered to contradict his testimony. Prior to starting work, he passed an extensive pre-employment physical aimed at determining whether he could perform form the job.

The Petitioner testified that he began to notice soreness and stiffness in his lower back after about a week or two of work. He did not report his problem to anyone at work, and he said it increased in severity to the point where it was hard to move by his last day of work on Dec. 14, 2007.

On Dec. 22, 2007, the Petitioner went for treatment at the emergency room at the Memorial Medical Center. He testified that his pain had gradually increased and was beginning to radiate down into his left leg. The hospital records contain a different history. (PX 9) They indicate that the Petitioner reported an abrupt onset of back and leg pain of one days duration. They contain no reference to the problems which the Petitioner described at work and no reference to an earlier onset with a gradual increase in symptoms. They do list as risk factors heavy lifting and repetitive stress. A physical examination revealed a positive straight leg raising test on the left, and the diagnosis was a lumbar disc herniation with radiculopathy. The Petitioner then saw his family physician with similar findings on Jan. 10, 2008. An MRI was then performed showing a large left disc herniation causing significant compromise of the left S1 nerve root and mild canal stenosis. The Petitioner was then referred to a surgeon.

petitioner saw Dr. Per Freitag on January 31, 2008. Petitioner's Exhibit 3, page 30. Dr. Freitag diagnosed a herniated disc and prescribed cortisone shots. Dr. Freitag's records also noted nothing regarding any trauma at work, and Dr. Freitag did not opine on causation at this point On March 27, 2008, Dr. Freitag's records reflect that Petitioner reported he was doing well, with only minor discomfort in his left calf. Petitioner's Exhibit 3, page 28. He wanted to return to work. Petitioner testified that he had continued pain at that time, but asked Dr. Freitag to clear him to return to work so he could start a new job. Dr. Freitag found that Petitioner was at MMI and needed no work restrictions. Petitioner's Exhibit 3, page 28. Petitioner testified that his new job required him to drive a forklift over rocks and mud. Petitioner testified that this activity did not make him symptomatic. Petitioner testified that this job lasted approximately 11 months. He testified that his back pain continued throughout that time.

On August 19, 2008, Dr. David Fletcher performed an independent medical examination on Petitioner. Dr. Fletcher's report noted that Petitioner reported no pain, just some slight soreness. Dr. Fletcher's report also noted that Petitioner did not mention a specific work injury. Dr. Fletcher confirmed Petitioner's diagnosis of a resolved herniated disc, and confirmed that Petitioner was at MMI. However, he opined that Petitioner's condition was not causally connected to his employment.

Petitioner returned to Dr. Freitag on March 26, 2009, approximately one year after being released at MMI. Petitioner's Exhibit 3, page 26. Petitioner testified his subsequent employment ended approximately in March, 2009. Transcript page 42. Petitioner reported continued pain. According to Dr. Freitag's records, Petitioner reported that his symptoms were worse when he played baseball. Petitioner's Exhibit 3, page 24. However, Petitioner testified that he only coached baseball, and that coaching did not make his condition symptomatic.

Dr. Freitag eventually recommended surgery, and this was performed on January 13, 2010. Petitioner's Exhibit 10. After surgery, Dr. Freitag was deposed on June 22, 2009. In that deposition, Dr. Freitag was asked to assume, hypothetically, that the Petitioner worked 12 hours a day, four days a week, and that the dock plates over which he drove gave under the weight of the forklift, causing drivers to bump and jostle on the forklift. Dr. Freitag was further asked to assume that one dock plate in particular was not functioning properly such that the forklift would actually drop about two inches when it went over the dock plate. Dr. Freitag was asked that if experiencing this bumping and jostling over the course of three to four weeks could be a causative factor in Petitioner's condition. Dr. Freitag responded that it could have been. He said that as the Petitioner was seated when driving the forklift, the axial load from bouncing up and down could cause or aggravate the condition. He also said that when the Petitioner would bump the dock plate, it could aggravate the condition. This was the first time Dr. Freitag commented on causation. In that deposition, Dr. Freitag admitted that he had no first-hand knowledge of Respondent's facility. Petitioner's Exhibit 1.

Following surgery, Petitioner reported improvement in his back pain to Dr. Freitag. However, he testified that he had continued pain in his left leg. Nonetheless, on July 15, 2010, Petitioner reported to Dr. Freitag that he was doing well. As such, Dr. Freitag found that Petitioner was at MMI, and released him to return to full duty work. Petitioner's Exhibit 4, page 20.

Petitioner testified that the pain in his left leg continued, but he did not seek further treatment until April 4, 2011. Petitioner's Exhibit 5. Following further diagnostic testing, Dr. Freitag recommended a lumbar hemilaminectomy. This was performed on September 28, 2011. Following the surgery, Petitioner reported improvement in his back and leg pain. Petitioner's Exhibit 5. He testified that presently his pain remains improved, though he does have some minor lingering symptoms.

On February 25, 2013, Dr. Fletcher drafted a supplemental report in which he reviewed further medical records, a job description, and Dr. Freitag's causation opinion. Respondent's Exhibit 3. Dr. Fletcher confirmed that Petitioner's condition was not causally connected to Petitioner's employment. He noted that Petitioner only worked for Respondent for one month. Thus, he was not exposed to enough cumulative trauma to cause his condition. Dr. Freitag also noted the one-year treatment gap beginning in March 2008, which coincided with Petitioner's supplemental employment.

CONCLUSIONS OF LAW

In a repetitive trauma, the issues of accident and causation are intertwined. Petitioner must prove that repetitive activity at work caused or contributed to an injury, in this case the lower back. The Petitioner must prove and identify a work activity and prove it is causally related to his injury. Here, he argues that a chain of events analysis satisfies his burden of proof. In fact, there is no evidence of pre-existing problems prior to November 26, 2007 when he began to work for the Respondent. There is evidence as of December 22, 2007 that he had a lower back injury, likely a herniated disc. However the law requires more. The Petitioner must prove a repetitive trauma at work. The Arbitrator believes that he has failed to prove such a trauma.

The evidence shows that the Petitioner drove a fork lift truck for the Respondent from between five and eight hours a shift, depending on whose testimony you believe. Either way, the evidence shows very little activity which could be considered traumatic to his lower back. Much of his shift was spent driving on a flat, smooth dock. There was no testimony that such an activity caused any vibration or bouncing to his lower back. Fifty to sixty times a shift he drove over dock plates to access semis which had come to the facility for loading. The Petitioner testified that there was very little, if any, bouncing as he performed that activity. The only thing he did which could have produced back trauma was when he drove up and out of the permanent trailers used for storage. He only made twenty to thirty trips into those trailers per shift, and noticed only a momentary bouncing as he exited the trailer except when his forks would strike the plate or surface, which did result in his being jarred. The Petitioner testified this occurred on about two of every ten trips, meaning that it happened four to six times a shift. He also said that when this happened, he did not notice any pain or other symptoms to his lower back.

Ms. White, the terminal manager, disputed the existence of a height difference between the main dock and storage dock. It was her job to monitor the dock plates, a job which she performed on a daily basis, and she had driven a fork lift.

The Petitioner has a slight advantage over Ms. White regarding credibility on this issue, as he actually moved forklifts full of product. However, proof of this activity when accessing the storage trailers does not come close to proving the repetitive activity which he claims to have encountered throughout each work shift.

The Petitioner bears the burden of proving the repetitive activity. His own testimony eliminates repetitive activity when he cleaned the work area, drove on the main dock or drove on and off of the dock plate when accessing a trailer. Perhaps if he offered a co-worker or someone else familiar with the job to corroborate his testimony, it would be more persuasive. Also, despite his claim that his pain started and progressed at work, he reported it to no one. Similarly, the first records of treatment at the ER contain no history consistent with an injury at work.

This lack of evidence of trauma also diminishes the weight to be given to the testimony of Dr. Freitag. Dr. Freitag was given no history from the Petitioner concerning his work activities when he began treatment. Also, the hypothetical question given to the doctor to elicit opinions on causation was flawed. The Petitioner did not work on a fork lift twelve hours a day and, as the above cited evidence points out, the truck did not bump around a lot causing him to be jostled. Dr. Freitag testified that bouncing up and down could cause an axial load on the lumbar discs, leading to a herniation. The evidence simply did not show much, if any, bouncing.

The Petitioner must prove he had an accident at work. It is not the Respondent's duty to prove one did not occur. For the reasons stated above, the Arbitrator finds that the Petitioner failed to prove an accident arising out of his employment, and the claim is therefore 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

Joshua W. Seago,

Petitioner,

vs.

NO: 09 WC 45767
14IWCC0690

Benoist Brothers Supply Company,

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, medical expenses, prospective 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 December 16, 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: AUG 18 2014
TJT:yl
o 8/11/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

SEAGO, JOSHUA W
Employee/Petitioner

Case# **09WC045767**

BENOIST BROTHERS SUPPLY CO
Employer/Respondent

14IWCC0690

On 12/16/2013, 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:

2046 BERG & ROBESON PC
STEVE W BERG
1217 S 6TH ST PO BOX 2485
SPRINGFIELD, IL 62705

0725 HANSEN & ENRIGHT
ANDREW J KOVACS
701 MARKET ST SUITE 200
ST LOUIS, MO 63101-1862

14IWCC0690

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Joshua W. Seago
Employee/Petitioner

v.

Benoist Brothers Supply Co.
Employer/Respondent

Case # 09 WC 45767

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **October 16, 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, **3/26/08**, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$22,248.72**; the average weekly wage was **$427.86**.

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

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

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

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

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

ORDER

Petitioner failed to prove his current condition of ill-being in his back is causally connected to the March 26, 2008 accident. No benefits are 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, or other benefits, 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

December 12, 2013
Date

ICArbDec19(b)

DEC 16 2013

Joshua W. Seago v. Benoist Brothers Supply Co.
09 WC 45767 (19(b))

The Arbitrator finds:

Petitioner, who had worked for Respondent for approximately 5 years, suffered an undisputed accident at work on March 26, 2008. Petitioner was initially examined at Springfield Clinic/Prompt Care by Dr. Steven Lewis. The history indicates Petitioner was unloading a truck when he lifted two forty pound boxes and loaded them onto a dolly. Thereafter he was handed a box which weighed about 120 lbs. and while twisting to place it on the dolly he felt a spot in his back pop along with extreme pain. Petitioner presented with right-sided low back pain and, while he complained of some pain down towards his right buttock, he denied any pain, numbness or tingling going down the side of his leg.

Petitioner had lumbar x-rays taken which revealed disc space narrowing at L5-S1 and the radiologist suggested that an MRI might be helpful if there was clinical concern for a disc herniation. The radiologist's report included a history of lower back pain and radiating pain down the right leg since a lifting injury. (PX 2)

Dr. Lewis recommended that Petitioner remain off work for three days and then have a work limitation of no lifting or pushing or pulling more than 10 pounds and no repetitive bending of his back and recommended physical therapy for Petitioner. (PX 2 and see PT evaluation and treatment form pg. 4 of PX 2) Petitioner was advised that if any numbness or tingling in his legs worsened he should follow up immediately. (PX 2)

Petitioner next saw his primary care physician, Dr. Glen Weisgerber, on April 2, 2008, where the history of the lifting injury was recorded in Dr. Weisgerber's notes. Petitioner's ongoing pain complaints were noted and there is a reference to "burning, radicular pain right leg." Treatment in the form of therapy, exercises, medication, and light duty restrictions were noted. (PX 3)

Petitioner presented for physical therapy at Springfield Clinic beginning on April 4, 2008. Petitioner reported that he was handling a 120 lb. case on March 24th (PX 5, p. 2) when he twisted and moved the case and felt immediate pain in his low back accompanied by a pulling sensation, a loud pop and a burning sensation. Thereafter, he felt like he was walking "sideways." Petitioner reported missing five days of work and that he was currently working on a light duty basis. Petitioner described pain on the right side of his low back which was constant and accompanied by an occasional burning sensation.

Petitioner also reported that the pain had previously radiated into the anterior right thigh but had since centralized to the left side of his lumbar spine. Petitioner denied any prior low back problems. The plan was for Petitioner to attend therapy twice a week for four weeks. (PX 5)

Petitioner returned for therapy on April 9, 2008 at which time he reported he had not taken any pain medication the night before at bedtime as he had forgotten to do so; however, he also noted he really didn't need it. Petitioner was independent in his home exercises and finding he did not need to ice his back as frequently as before. (PX 5)

Mr. Seago then saw Dr. Weisgerber again on April 9, 2008, reporting that he was still quite sore and in severe pain. Dr. Weisgerber took Petitioner off work "for medical reasons" followed by a light duty release and return to regular duty on April 21, 2008. (PX 3)

Petitioner attended physical therapy on April 11, 2008 and it was noted he tolerated his exercises "well." (PX 5)

At his April 16, 2008 physical therapy visit, Petitioner reported he would be advancing to full duty on Monday. Petitioner also reported occasional pain when getting up too quickly from a stool and the ability to go up and down steps without a gait problem if he didn't think about it. He did note some increased pain with increased activity. (PX 5) Petitioner returned to therapy two days later stating he felt worse that day as he had "overdone things" trimming a tree on the ground with a chainsaw. Absent that, Petitioner felt 75% better with only the occasional sharp pain. Petitioner was advised to contact Dr. Lewis if he had any questions about returning to work. (PX 5)

Petitioner then returned to physical therapy on April 23, 2008, reporting he had been taken off light duty and was doing better. He rated his current pain as a "2/10." He also reported no problems mowing on the 22nd and was walking without any problems. (PX 5)

Petitioner again reported for therapy two days later. He was given exercises and a cold pack and reported some pain after application of the ice but that after a couple of "press ups" and walking around, it went away. (PX 5)

Petitioner next went to physical therapy on May 2, 2008. He reported no pain with flexion, no pain whatsoever that day, and the ability to perform full duty work without any problems. He himself was quoted as stating he felt like he was doing great and was

having no problems going up and down stairs. Petitioner's goals had been met and he was discharged from therapy. (PX 5) According to the May 5, 2008 therapy discharge summary, Petitioner was reporting no pain at all and working full duty. Back strength was reportedly excellent and Petitioner was happy with his progress. Petitioner's goals had been met to 100%. (PX 5)

Petitioner saw Dr. Weisgerber on July 2 and July 14, 2008 for migraine headaches and sinusitis-type complaints. No mention of Petitioner's back was made. (PX 3)

Petitioner again saw Dr. Weisgerber on September 23, 2008 for pharyngitis and an upper respiratory infection. No back complaints were noted. (PX 3)

Petitioner continued working for Respondent during this time.

Approximately eleven months after last seeing Dr. Weisgerber, Petitioner returned to see him on October 30, 2009 reporting acute and chronic low back pain with some radicular pain into his right leg. Another notation sates that Petitioner's leg pain was running down both legs. On October 30, 2009 Dr. Weisgerber gave Petitioner a script for an MRI noting Petitioner had a work injury with low back pain. (PX 3)

Petitioner underwent a lumbar spine MRI at Springfield Clinic on November 13, 2009. The impression was a small broad-based central disc protrusion at L5-S1 but no significant spinal canal or neural foraminal stenosis. (PX 3)

After Petitioner underwent the lumbar MRI, Dr. Weisgerber referred Petitioner to Dr. Joseph Williams, at the Orthopedic Center of Illinois. The initial visit was on December 16, 2009. Dr. Williams' history of the accident is consistent with the accident description provided by Petitioner. According to the history Petitioner experienced significant back pain at the time of the accident. (PX 6) As part of the visit, Petitioner completed a pain drawing indicating he was experiencing symptoms in his low back and radiating down his left leg. He marked a "pins and needles" sensation in both feet but no right leg radiating pain. Petitioner described constant pain that flared up with lying down, sitting, and standing. When examined by the doctor, Petitioner's current complaints included low back pain and left lower extremity pain. He reported taking the occasional Advil for pain and was noted to be working although activity worsened his pain. Petitioner also reported left lower extremity pain at night when lying down. Dr. Williams' assessment was chronic low back pain, left lower extremity pain (possibly radiculopathy) and a L5-S1 disc protrusion. On examination, Petitioner showed no significant weakness in his lower extremities or tension signs. Dr. Williams reviewed the

MRI report which showed a small broad-based dis protrusion at L5-S1 but wanted to see the actual film. Therapy was recommended and Petitioner was given a script for Naproxen. No work restrictions were given. Petitioner was asked to return in four weeks and to bring the MRI film. (PX 6)

Petitioner was re-evaluated by Dr. Williams on January 19, 2010 reporting therapy had not yet been approved. Petitioner's complaints remained unchanged. Dr. Williams again requested therapy and a prescription for Ibuprofen was given. Dr. Williams still wanted to see the actual MRI film. (PX 6)

Petitioner returned to the doctor on February 23, 2010 having "recently undergone another MRI."[1] Petitioner still had not been approved for physical therapy. According to the office note, Petitioner's "new" MRI suggested discogenic back pain secondary to L5-S1 and an annular tear. Therapy was warranted along with non-steroidal anti-inflammatory medication. (PX 6)

Petitioner presented to Dr. Weisgerber in March of 2010 regarding another accident he had sustained with Respondent which involved an eye injury stemming from an explosion a year earlier. (PX 3)

Petitioner returned to Dr. Williams on April 13, 2010, with no change in his complaints or treatment. Therapy still had not been approved. (PX 6)

Petitioner resigned from his job with Respondent on July 28, 2010 citing "consistent pain" from three injuries. (PX 16)

Physical therapy was approved on August 20, 2010. (PX 6) Petitioner underwent a course of therapy at Premiere Physical Therapy from August 23, 2010 through October 4, 2010. (PX 7)

Petitioner returned to see Dr. Williams in October of 2010 after going through a course of physical therapy. Petitioner's complaints included significant low back pain which had been "quite bad" in the previous week. Petitioner also described some pain going down his left leg but it was minimal compared to the pain in his low back. Petitioner was instructed that his next step was a left epidural injection. Dr. Williams was not in favor of any surgery and suggested weight loss would also help with management of his symptoms. (PX 6)

[1] There is no MRI report for this time period in the record.

Petitioner underwent the injection but reported no improvement when re-examined by Dr. Williams on December 7, 2010. According to a Health History Questionnaire, Petitioner was working for "New Wave" at this time. Petitioner also reported having trouble sleeping and "wanting something done for his symptoms." A repeat MRI was ordered. (PX 6)

Petitioner underwent a lumbar spine MRI on December 13, 2010. In the section marked "Indications," it states, "Fall, continued pain."[2] It revealed a focal disc herniation on the left at L5-S1 causing significant foraminal compression. (PX 6)

Petitioner met with Dr. Williams on January 10, 2011 and they reviewed the MRI which the doctor's notes state as showing significant degenerative changes at L5-S1 and lateral recess stenosis and foraminal stenosis as a result of the left-sided disc protrusion. Dr. Williams felt Petitioner's complaints were consistent with the MRI findings. The doctor also noted that Petitioner's left wrist was splinted due to recent surgery with Dr. Greatting. Dr. Williams explained to Petitioner that he felt Petitioner was too young to undergo the surgery of choice, a fusion, and further cautioned Petitioner against doing anything surgically until he had recovered from his wrist/hand surgery. (PX 6)

As instructed, Petitioner returned to see Dr. Williams in February. Petitioner was off work at the time as he was recovering from surgery for a left metacarpal fracture. Petitioner reported ongoing back pain complaints but he wasn't taking any medication except for Aleve. Dr. Williams stood by his earlier recommendation to avoid surgery in light of his age and obesity. Dr. Williams also suggested a three level discogram to help determine if the L5-S1 disc was the source of Petitioner's problems and to help determine if Petitioner was a surgical candidate. (PX 6)

The request for a discogram was denied in March of 2011. (PX 9)

In late April of 2011 Petitioner again returned to Dr. Williams with ongoing complaints of chronic low back pain and difficulties with activities of daily living. Petitioner reported he was currently unemployed having been laid off from his job after his hand surgery was performed. He had lost ten pounds. On exam, straight leg raise testing was negative bilaterally and sensation to light touch was grossly intact. Dr. Williams remained steadfast in his treatment recommendations with the only modification being

[2] The Technologist's Information Form states, "Petitioner fell while lifting heavy box 3-4 years."

a consultation with Dr, Watson. The importance of weight loss was also discussed. (PX 6)

As requested, Dr. John Watson examined Petitioner on May 10, 2011. Petitioner reported his original work injury and ongoing complaints of aching, burning, stabbing, and tingling type pain which has been worse in recent months. He mostly noted back pain as Dr. Watson reviewed the MRI film and report. He felt there was neural foraminal narrowing at L5-S1 secondary to lateral protrusion and moderate degenerative disc disease at L5-S1 and L3-4. He did not see any evidence of a disc herniation. Petitioner walked with a non-antalgic gait. His pain was noted to go down the left leg in an L5 pattern. He displayed tenderness throughout his lumbar paraspinal region both in the superficial region and myofascial region. He had good lumbar range of motion, flexion, and extension. Petitioner displayed more pain with extension, than flexion. Dr. Watson's diagnosis was multilevel lumbar degenerative disc disease and a lumbar disc protrusion with a left lower extremity radiculopathy. Dr. Watson noted, "It is unclear whether the patient has had such significant pain for the past several years; I would have expected the left L5 TFESI to give him some relief." Dr. Watson recommended electrodiagnostic testing and then a return visit. (PX 6)

According to a June 11, 2011 office note of Dr. Weisgerber, Petitioner presented that day requesting another MRI on his back as well as a second opinion. He also reported having gone to the emergency room. (PX 3)

Petitioner returned to Dr. Watson on June 24, 2011. He had lost twenty pounds. Petitioner also noted left leg pain and a "funny" feeling in his three middle toes. Occasionally, Petitioner notes right anterior thigh pain. "He is requesting something for his lawyer in regard to restrictions. He reports his worker's compensation has ran out." On examination Petitioner displayed good strength in his lower extremities bilaterally. His calves were soft and non-tender. Sensation was intact. His gait was at baseline. Petitioner's diagnoses were modified to include mild to moderate lumbar spinal stenosis. Dr. Watson encouraged weight loss and a forty pound weight limit restriction along with no repetitive bending. He was to return in three months. (PX 6)

Petitioner presented to the Memorial Medical Center Emergency Room on August 29, 2011 due to back pain, reporting he had an old injury in 2008 and constant pain complaints radiating down his right leg. His prior injury had involved left leg complaints. Petitioner reported he had been working out and sat down to reach for a bottle and his back began to hurt. (PX 11)

Petitioner returned to see Dr. Watson on September 12, 2011. Petitioner reported an "acute exacerbation" of his symptoms two weeks ago on Monday when he had just finished walking and went to grab a bottle of water and experienced significant low back pain which necessitated a trip to the emergency room. Petitioner was using a prednisone Dosepak, hydrocodone and cyclobenzaprine. The EMG had been denied by workers' compensation. Overall, Petitioner appeared to be improving but his pain was noted to be somewhat disabling still. The EMG and discogram were again recommended along with weight reduction. (PX 6)

Petitioner underwent electrodiagnostic testing for his lower extremities on October 12, 2011. Dr. Watson found no electrodiagnostic evidence of an acute or subacute bilateral lower extremity lumbosacral radiculopathy. He did find mild polyphasia with one CRD in the left peroneus longus, which could represent a chronic left L5 radiculopathy, but the rest of Petitioner's muscles were within normal limits. (PX 8)

Petitioner underwent a functional capacity evaluation (FCE) on November 1, 2011. Petitioner demonstrated subjective tolerances between light and medium physical demand level which appeared to be below the required demand for his job in HVAC supplies. Petitioner's efforts were believed to be accurate reflections of his abilities although there was some self-limiting behavior due to fear of throwing his back out. At the time of the FCE, Petitioner reported he had resigned with Respondent and had taken a job in sales. He had since been released from the sales position but had the option to return if he could do so within one year (January of 2012). (PX 10)

When Petitioner returned to see Dr. Watson on November 8, 2011 he reported chronic pain down his left leg and significant difficulty with activities of daily living. Petitioner remained unemployed and had undergone two surgeries with Dr. Greatting. He was struggling with weight reduction. A lengthy discussion was held with Dr. Watson expressing uncertainty as to whether surgery would alleviate all of Petitioner's symptoms. Various surgeries were discussed with the understanding each one might not resolve all of his pain complaints. Petitioner wanted a second opinion and noted his attorney had attempted to get a second opinion with Dr. Payne but that was refused. Dr. Watson noted, "He is determined to seek a surgical solution." (PX 6)

Petitioner was next seen by Dr. Weisgerber on November 9, 2011 reporting that he had seen Dr. Williams who did not recommend any surgery at the present time. Petitioner wanted a second opinion. The doctor noted Petitioner was complaining of bilateral leg pain but no foot drop. Petitioner was advised to work on weight loss, exercises, and diet. Dr. Weisgerber put Petitioner on Vicodin and Aleve. Petitioner then returned to the

doctor on December 7, 2011 and reported he was still waiting on a second opinion from Dr. MacGregor. Epidural injections were discussed. Otherwise, Petitioner's treatment plan remained unchanged. (PX 3)

On December 14, 2011 Dr. Weisgerber gave Petitioner a note stating Petitioner "was to be off work due to medical reasons, low back pain 12/7/11 and unable to perform work of any kind until released." (PX 3)

Petitioner was furnished medical management services with Genex, a medical case management company, commencing January 20, 2012. The assigned nurse attended Petitioner's visit with Dr. MacGregor and monitored care and treatment through the reporting period. (PX 19) In her initial report she noted Petitioner was complaining of constant left leg pain and intermittent right leg pain. (PX 18)

Petitioner next presented to Dr. MacGregor on January 23, 2012. Petitioner recounted his accident noting he initially had left leg pain but now reporting bilateral leg pain. They reviewed Petitioner's December 13, 2010 MRI. The doctor agreed with the radiologist's report. Dr. MacGregor recommended hydrotherapy, another MRI without contrast, and weight loss. (PX 12)

A new MRI was performed on February 2, 2012. That study revealed the disc at L5-S1, as well as, a disc at the next adjacent level at L4-L5. Dr. MacGregor recommended water therapy for Petitioner. Dr. MacGregor is also recommending surgery for Petitioner but wants Mr. Seago's weight to be under 300 pounds. (PX 12 & PX 18)

At the request of Respondent, Petitioner underwent an examination with Dr. Steven Delheimer on April 9, 2012. A written report followed. Petitioner's history of the accident was consistent with other summaries. At the time of the examination Petitioner reported mid and low back pain along with bilateral leg pain radiating down his legs to his feet. Petitioner reported that his leg pain was worse than his back pain and that the pain in both areas was constant and increased with any type of repetitive movement or with prolonged sitting and standing, especially in the low back area. On a scale of 1 – 10, Petitioner rated his pain at "8." Petitioner also reported stiffness and soreness in his mid back region and bilateral hip and thigh pain, left worse than the right. According to Petitioner, the pain started in his left leg and then began in his right leg. He reported being told not to return to work. Petitioner denied the ability to walk long distances or perform any type of significant activity. Petitioner's medical history also included a left hand injury for which Petitioner had undergone surgery on January 4, 2011. Petitioner had not worked since then.

Petitioner also reported the rare use of Vicodin. Dr. Delheimer summarized Petitioner's medical care and treatment as found in the medical records that he had been provided. He noted Petitioner had gone to the emergency room on August 29, 2011 after bending over to pick up a water bottle and feeling a pull in his back and acute right leg pain. Dr. Delheimer reviewed an MRI dated December 13, 2010 and another one dated February 2, 2012. He reviewed the November 13, 2009 lumbar spine MRI report. Petitioner again presented to Dr. Weisgerber on May 7, 2012. Petitioner was treating with Dr. MacGregor for his back and Dr. Greatting for a left wrist injury. (PX 3)

On physical examination Dr. Delheimer found Petitioner able to change position fluidly without any outward sign of distress. No paraspinal spasm was present. His straight leg raise was negative bilaterally. Deep tendon reflexes were normal. Strength and gait were normal and Petitioner could walk on his toes and heels without difficulty. Dr. Delheimer concluded Petitioner suffered, at most, a soft tissue injury involving his lumbar area. He did not believe Petitioner suffered any type of aggravation of his minor degenerative disc disease nor did he see any evidence of a herniated disc or a permanent aggravation of an underlying condition. He felt Petitioner had "long since" reached maximum medical improvement and he required no further care for the effects of his injury. Petitioner's current pain complaints lacked any objective findings, consistent with his underlying degenerative disc disease to some degree. The changes seen on his MRI were felt to be of no clinical significance and certainly required no surgery. Treatment through May 2, 2008 would be related to the injury. Petitioner needed no restrictions. In sum, Petitioner sustained a lumbar strain which had resolved by May 2, 2008. His ongoing complaints lack any objective findings. (Exhibit B to RX A)

No further case management services were provided after April 11, 2012. (PX 19)

Dr. Margaret MacGregor was deposed on September 5, 2012. (PX 18) Dr. MacGregor, a board certified neurosurgeon, testified that a causal connection existed between Petitioner's current condition of ill-being and his incident of March, 2008. According to Dr. MacGregor, Petitioner has displayed no Waddell signs. She reviewed the December 13, 2010 MRI and felt it showed mild degenerative changes at multiple levels abut at L5-S1 there was a significant left foraminal compromise due to a focal disc herniation on the left. At the time Petitioner first appeared before Dr. MacGregor he related having left leg pain with the original injury and that would be consistent with the MRI. She then requested an updated MRI which was done in 2012 and revealed some progression of the intervertebral disc degeneration at L4-5 as well as a central disc protrusion at L4-5 and one at L5-S1. At L5-S1 it was a diffuse disc bulge, slightly

greater to the left, but with a superimposed small focal left disc protrusion – all of which would be consistent with the 2010 MRI.

Prior to her deposition Dr. MacGregor had last seen Petitioner on July 30, 2012. He was still attempting to lose weight as she had recommended and she still felt he needed aqua therapy. His current diagnosis is herniated discs at L5-S1 and L4-5. She remains hesitant to recommend fusion surgery due to Petitioner's young age. She did not believe he could probably go back to full duty status but she would probably get a functional capacity evaluation before making any final determination. At the current time Petitioner was still being worked up. When asked whether or not Petitioner's herniated disc could or might have been caused by his March of 2008 injury, Dr. MacGregor stated, "I would say first, I've seen Mr. Seago a number of years after that accident. And it would depend upon the care and treatment that he received up until that time." (PX 18, p. 22) Dr. MacGregor went on to testify that if Petitioner had received care and treatment on a "relatively continuous basis" since the time of the injury and for the same or similar complaints, then the disc is related to the accident. (PX 18, p. 23)

On cross-examination Dr. MacGregor admitted she had never seen any medical records pertaining to Petitioner's care and treatment before he came to her. She also acknowledged that Petitioner is the one who told her, essentially, that his problems stemmed from his 2008 accident. (PX 18, pp. 24-25)

In a letter dated September 6, 2012 from Petitioner's attorney, Dr. Weisgerber was asked to confirm that Petitioner did continue to complain of back pain when the doctor saw him between May of 2008 and November of 2009. In response, Dr. Weisgerber wrote, "I have been continualy [sic] following up on Mr. Seago back pain last visit to date 06/07/2012. As you are aware that his back pain stems from a workmans comp. claim that I initialy [sic] treated him for on 06/07/2008. (PX 4)

Dr. Delheimer's deposition was taken on January 21, 2013. (RX A) Dr. Delheimer is board certified but doesn't need to go through recertification as he "grandfathered" in. Twenty-five percent of his practice focuses on independent medical examinations of which approximately eighty percent is done for the defense side of litigation. The doctor testified consistent with his earlier report. Dr. Delheimer testified that Petitioner reached maximum medical improvement for his lumbar strain on April 21, 2008 because that was when he was released to full duty. (RX A)

On cross-examination he acknowledged that at the time he felt Petitioner was at maximum medical improvement (April 21, 2008) Petitioner was still undergoing active physical therapy. He did not believe he had seen Dr. MacGregor's office notes and records or the functional capacity evaluation. He further acknowledged that he felt Petitioner could return back to work but he didn't really have any understanding of Petitioner's job duties for Respondent. Dr.Delheimer also acknowledged that he didn't review the actual March 26, 2008 x-ray but he did note the radiologist stated that there was some mild narrowing of the L5-S1 disc space which can indicate some disc pathology at that particular inner space. He further acknowledged that the radiologist raised a flag at that time that an MRI might be needed. Regarding the EMG study, Dr. Delheimer also agreed that polyphasia can be something associated with a chronic L5 radiculopathy. Dr. Delheimer also indicated that he did not think Petitioner had a herniated disc and while the radiologist may have indicated differently in December of 2010 that might because the term "herniation" is used loose and fast. He also disagreed with Dr. MacGregor's diagnosis of same as well as Dr. Breihan's (a utilization reviewer issuing a report in March of 2011). He also acknowledged that people can have high pain thresholds and still not overtly show symptoms. Finally, Dr. Delheimer testified that while Petitioner reported ongoing symptoms the doctor did not see anything on the MRI which suggested an aggravation had occurred. When asked what he might need to see to determine there had been an aggravation, the doctor testified, "A herniated disc." On redirect examination Dr. Delheimer testified that if there had been a herniation in March of 2008 he would have expected Petitioner to undergo treatment on a regular basis regardless of how stoic he might be. When asked to comment on the annular tear, Dr. Delheimer testified, "I have no – annular tears occur, you know. And whether they're pain-producing, I don't know..... So I don't disagree with him on that." (RX A)

Petitioner last saw Dr. Weisgerber on September 27, 2013 for his back. Petitioner's pain was described as persistent. A Medrol Dosepak was added. (PX 3)

At the arbitration hearing, Petitioner testified that he didn't have any knowledge of Dr. Weisgerber's full duty release issued in April of 2008. Petitioner further testified that he was had not improved by April 21, 2008.

Petitioner testified he was discharged from physical therapy as of May 5, 2008; however, he was still experiencing symptoms in his low back and lower extremity.

Petitioner testified he continued to work for Respondent, although his testimony indicated that he was not performing his full work activities because he was under the impression that he still had some light duty restrictions. Petitioner also testified that he

continued to have problems in his low back and lower extremities and it worsened to the point that Dr. Weisgerber finally sent him for an MRI of his low back. This occurred on October 30, 2009.

Petitioner also testified that he saw Dr. Weisgerber between the end of his physical therapy on May 5, 2008 and the date Dr. Weisgerber ordered the MRI of his low back, October 30, 2009. Petitioner testified that he continued to mention his ongoing low back complaints to Dr. Weisgerber during that time despite the fact no complaints to that effect are found in the doctor's records.

Petitioner testified he was seen at Memorial Medical Center emergency room on August 29, 2011 for back pain. Petitioner described at trial that he was sitting at the time and had merely reached his right arm across to a table on his left side to pick up a bottle of water. Petitioner testified that once the immediate pain from that activity resolved, he was back to the same condition that he was in prior to that activity.

Petitioner testified that prior to his injury of March 26, 2008, he was not experiencing any problems with his low back or lower extremities, nor had he had any low back injuries. Petitioner also credibly testified that he had no new injuries between the date of his injury and his first MRI in September, 2009. He further testified that he has had no new injuries through the date of Arbitration.

The Arbitrator concludes:

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

Petitioner failed to meet his burden of proving that his current condition of ill-being in his low back is causally related to the March 26, 2008 accident. Petitioner relies upon the testimony and opinions of Dr. MacGregor in order to establish causal connection. Dr. MacGregor acknowledged that she did not see any of Petitioner's prior treatment records and that she solely relied upon Petitioner's representation to her that his problems stemmed from his work accident. However, Petitioner was given a full duty release after a short course of physical therapy and returned to work thereafter with a significant gap in treatment. While Petitioner testified that he did not believe he had been given a full duty release in the spring of 2008 that is not what is shown by the physical therapy records. Those records indicate Petitioner knew he was being released to return to full duty work and that he did so and, when discharged, was having no problems. Petitioner also testified that he told Dr. Weisgerber about ongoing back

complaints in July of 2008 when he was examined for other problems. However, Dr. Weisgerber did not document any back problems. Furthermore, the "report" the doctor provided to Petitioner's attorney does not clearly corroborate Petitioner's testimony nor was the doctor deposed.

As the foregoing illustrates, Petitioner was not a credible witness. His testimony concerning his ongoing pain complaints (and the reporting of same to his doctor) and his belief that he wasn't given a full duty release in April of 2008 were not corroborated by other records or evidence. Additionally, Petitioner's history concerning his leg complaints is inconsistent. Dr. MacGregor believed Petitioner initially experienced left leg complaints after his accident; however, that is not the case. First, there is a question as to whether he experienced any leg complaints immediately after the accident as he denied same at the time of his first visit with Dr. Lewis. However, even if he is given the benefit of the doubt concerning the possibility of some complaints, the records clearly indicate he was complaining of right leg pain, not left leg pain. Finally, there is the fact he was discharged from physical therapy in early May of 2008 with no leg complaints whatsoever. The medical records fail to suggest any left leg radiating pain complaints prior to October 30, 2009, a date that comes on the heels of an eleven month gap in treatment following a full duty release. There was no evidence of a herniated disc prior to November of 2009. While one might argue that the 2008 lumbar spine x-ray report stated an MRI might be appropriate, same would only be true if there was clinical suspicion for a herniated disc. There was none. Hence, no MRI was ordered in 2008.

Petitioner suffered a lumbar strain which resolved by May 5, 2008, at which time he was discharged from physical therapy and was working full duty.

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

Petitioner's exhibit number 1 consists of medical bills Petitioner claims are associated with his care and treatment for his injury of March 26, 2008. None of the bills are for services incurred prior to May 5, 2008. Petitioner's claim for medical bills is denied.

K. Is Petitioner entitled to any prospective medical care?

Based upon the Arbitrator's causation determination, prospective medical care is denied.

L. What temporary benefits are in dispute? TTD

As a result of his accident of March 26, 2008, Petitioner was initially taken off work for 3 days following the visit with Dr. Steven Lewis on March 26, 2008 and thereafter placed on light duty restrictions. (PX 2) Respondent is not liable for this period as it was only three days.

****

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

James C. Wilson,

Petitioner,

vs.

NO: 13WC 21760

Alton Machine Works,

14IWCC0691

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, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Arbitrator's Decision, decreasing Petitioner's permanent partial disability award from 5% to 2 ½% loss of use of the left hand, as provided in Section 8(e) of the Act. All else is affirmed and adopted.

The Commission views the evidence differently than the Arbitrator regarding the permanency of his injuries.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $427.50 per week for a period of 5.125 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 2 1/2% loss of use of the left hand.

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

14IWCC0691

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 $2,200.00. 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: AUG 2 0 2014
o072314
CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILSON, JAMES C
Employee/Petitioner

Case# **13WC021760**

ALTON MACHINE WORKS
Employer/Respondent

14IWCC0691

On 11/26/2013, 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:

JOSEPH E HOEFERT
ATTORNEY AT LAW
1600 WASHINGTON AVE
ALTON, IL 62002

0560 WIEDNER & McAULIFFE LTD
MARY SABATINO
ONE 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

14IWCC0691

James C. Wilson
Employee/Petitioner

v.

Alton Machine Works
Employer/Respondent

Case # 13 WC 21760

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 October 29, 2013. By stipulation, the parties agree:

On the date of accident, March 14, 2013, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $8,550.00, and the average weekly wage was $712.50.

At the time of injury, Petitioner was 40 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 $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.

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 $427.50 per week for a period of 10.25 weeks because the injury sustained caused the 5% loss of use of the left hand, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from March 14, 2013, through October 29, 2013, 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.

William R. Gallagher, Arbitrator

November 19, 2013
Date

NOV 26 2013

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 March 14, 2013, and that Petitioner sustained an injury to his left hand while working with a hammer drill. There was no dispute regarding accident and the only disputed issue at trial was the nature and extent of disability.

Petitioner testified that he worked for Respondent as a machine operator and that while working with a hammer drill, he began to experience numbness in the palm of his left hand just below the ring and little fingers as well as numbness in the ring and little fingers themselves. On March 14, 2013, Petitioner sought treatment at Midwest Occupational Medicine where he was seen by Dr. Scott McLain. Petitioner informed Dr. McLain that he experienced symptoms while using a hammer drill on concrete. Dr. McLain examined Petitioner and diagnosed him with left hand/wrist palmar neuritis. He prescribed a wrist support and recommended Petitioner use ice/heat and take over-the-counter medications.

Petitioner was seen again at Midwest Occupational Medicine on March 18, March 21, and April 4, 2013, and his left hand condition was slowly improving. When seen on March 21, 2013, Dr. McLain prescribed a course of physical therapy and continued work restrictions of no use of the left hand. When seen on April 4, 2013, Petitioner reported a 30% improvement in the numbness symptoms and that he had been using a TENS unit.

Petitioner returned to Midwest Occupational Medicine on April 22, 2013, when he was seen by Dr. George Dirkers for both a left fifth metatarsal fracture and his left hand. At that time, Petitioner advised that he was having no problems with his left hand and that he was doing fine.

At trial, Petitioner testified that the treatment he received helped his symptoms; however, he stated that his hand and fingers still get numb especially when he performs overhead activities or bends his elbow. These symptoms have also caused Petitioner to experience some sleep disruption.

Conclusions of Law

The Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 5% loss of use of the left hand.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner nor Respondent tendered into evidence an AMA impairment rating report.

Petitioner worked as a machine operator and his job required him to have active use of both of his upper extremities.

Petitioner was 40 years old at the time of the manifestation.

There was no evidence the injury will have any effect on Petitioner's future earning capacity.

Petitioner's medical records established that he was diagnosed with left hand palmar neuritis. Petitioner's complaints are consistent with that diagnosis and corroborated by the medical treatment records.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
)SS
COUNTY OF MADISON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jamie Hatten,
Petitioner,

vs.

Wal-Mart Associates,
Respondent,

No. 10WC 13227
14IWCC0692

ORDER

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

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission Decision dated August 20, 2014, is hereby recalled pursuant to Section 19(f) of the Act. The parties should return their original decisions to Commissioner Charles J. DeVriendt.

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

Charles J. DeVriendt

DATED: SEP 0 5 2014

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

Jamie Hatten,

Petitioner,

vs.

10 WC 13227
NO: 14 IWCC0692

Wal-Mart Associates,

Respondent,

CORRECTED 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, temporary total disability and permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission finds that Petitioner has a loss of use to the extent of 15% to the person as a whole under Section 8(d)(2). The commission views the evidence presented by the Petitioner in regard to permanency differently than that of the Arbitrator.

All else is affirmed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $245.33 per week for a period of 75 weeks, as provided in §8(d) (2) of the Act, for the reason that the injuries sustained caused the loss of use to the extent of 15% of a person as a whole

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,400.00. 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: SEP 0 5 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
O: 6/13/14
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HATTEN, JAMIE
Employee/Petitioner

Case# **10WC013227**

14IWCC0692

WAL-MART ASSOCIATES
Employer/Respondent

On 6/13/2013, 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 0.08% 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:

1239 KOLKER LAW OFFICES
JASON R CARAWAY
9423 W MAIN ST
BELLEVILLE, IL 62223

2593 GANAN & SHAPIRO PC
AMANDA WATSON
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

14IWCC0692

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

Jamie Hatten
Employee/Petitioner

v.

Wal-Mart Associates
Employer/Respondent

Case # 10 WC 13227

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 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 _____

FINDINGS

On September 22, 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, in part, causally related to the accident.

In the year preceding the injury, Petitioner earned $12,155.95; the average weekly wage was $264.26.

On the date of accident, Petitioner was 37 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $6,834.19 for TTD, $0.00 for TPD, $0.00 for maintenance, and $12,000.00 for other benefits (advance payment of permanent partial disability), for a total credit of $18,834.19.

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

ORDER

Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibit 6 excluding any bills for medical services provided subsequent to May 9, 2011, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability of $245.33 per week for 27 6/7 weeks commencing October 27, 2010, through May 9, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability of $245.33 per week for 125 weeks because the injuries sustained cause the 25% loss of use of the body as a whole as provided in Section 8(d)2 of the Act.

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

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

William R. Gallagher, Arbitrator

June 6, 2013
Date

JUN 13 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 September 22, 2009. According to the Application, Petitioner sustained an injury to the back/MAW as a result of lifting. This case was previously tried on October 26, 2010, before Arbitrator Andrew Nalefski on a 19(b) petition filed on behalf of the Petitioner. The disputed issues in the prior trial were Petitioner's entitlement to temporary total disability benefits for 12 4/7 weeks, from July 31, 2010, through October 26, 2010; Section 16 attorneys' fees and 19(l) penalties; and some bills for chiropractic treatment. Arbitrator Nalefski awarded the disputed temporary total disability benefits, Section 16 attorneys' fees and 19(l) penalties, but denied the chiropractic bills. Respondent filed a review of the Arbitrator's decision and, on review, the Illinois Workers' Compensation Commission modified the Decision of Arbitrator Nalefski, affirming the award of temporary total disability benefits, affirming the denial of chiropractic bills, slightly increasing the 19(l) penalties but vacating the award of Section 16 attorneys' fees. Respondent appealed the Decision of the Commission to the Circuit Court of Madison County which affirmed the Commission's decision on March 20, 2012. Copies of the record of proceedings on arbitration and all of the aforementioned decisions were received into evidence at trial.

It was stipulated that Petitioner sustained an injury to her low back arising out of and in the course of her employment for Respondent on September 22, 2009. Subsequent to the accident, Petitioner was treated by Dr. Morris, a chiropractor, and Dr. Matthew Gornet, an orthopedic surgeon. Petitioner was able to return to work on a part-time and restricted basis for Respondent and worked from May 6, 2010, through July 30, 2010, in that capacity. When Petitioner was seen by Dr. Gornet on July 15, 2010, Petitioner made a statement in which she threatened to get a gun and make use of it on anyone affiliated with Respondent who had become a problem for her. On July 30, 2010, Petitioner's employment was terminated by Respondent because of the aforementioned threatening statements made by her.

Subsequent to the termination of Petitioner's employment by Respondent on July 30, 2010, Respondent refused to voluntarily pay any temporary total disability benefits and this was the primary reason the case was tried on October 26, 2010. At that time, Petitioner was still receiving medical treatment and no one had opined that she was at MMI. The Decisions of Arbitrator Nalefski, the Illinois Workers' Compensation Commission and the Circuit Court all cited the case of Interstate Scaffolding v. Illinois Workers' Compensation Commission, 923 N.E.2d 266 (Ill. 2010), as authority for awarding Petitioner temporary total disability benefits.

Subsequent to the decision of the Circuit Court, Respondent paid the award and made a further payment of temporary total disability benefits of 27 6/7 weeks, for the period of October 27, 2010, through May 9, 2011. When the case was tried on April 18, 2013, Petitioner sought an award for an odd-lot permanent total disability and medical bills. Respondent disputed liability on the basis of causal relationship stating that it ceased as of May 9, 2011. The basis of Respondent's position in regard to causal relationship was Petitioner's alleged noncompliance with medical treatment, in particular, the fact that Petitioner was noncompliant with a weight loss program that had been prescribed for her as a pre-requisite to having back surgery performed.

Subsequent to the trial of October 26, 2010, Petitioner continued to treat with Dr. Gornet. During the time Dr. Gornet had previously treated Petitioner, she had an MRI performed and Dr. Gornet opined that she had disc pathology at L4-L5 and that back surgery was indicated. Dr. Gornet had not determined precisely what type of surgery he contemplated performing (discectomy, fusion, disc replacement, etc.); however, Dr. Gornet declined to perform any type of back surgery on Petitioner because of her obesity.

When Petitioner was seen by Dr. Gornet on November 22, 2010, Dr. Gornet's medical record of that date noted that her weight was 294 pounds and that when he had previously seen her around the end of September, 2010, he informed her that she had six months to lose weight but she had not done so. Petitioner's prior weight was 292 pounds which Dr. Gornet characterized as being essentially no change. In an effort to assist Petitioner with the weight issue, Dr. Gornet had previously referred Petitioner to Dr. Hani Soudah, an internist, who initially saw Petitioner on September 16, 2010. In Dr. Soudah's record of October 15, 2010, it was noted that Petitioner's weight was 291 pounds and was not adhering to the treatment plan. When Dr. Soudah saw Petitioner on November 9, 2010, Petitioner's weight was 286.20 pounds; however, when Dr. Soudah saw Petitioner on November 22, 2010, Petitioner's weight was 290.20 pounds and Dr. Soudah specifically noted that Petitioner was "Non compliant with our obesity unit management plan." On January 6, 2011, Petitioner's weight was 290 pounds. On January 24, 2011, Petitioner's weight was 289.60 pounds, and Dr. Soudah again noted issues regarding Petitioner's compliance. When seen by Dr. Soudah on February 7 and February 28, 2011, Petitioner's weight was 290.60 and 291 pounds, respectively. Again, Dr. Soudah noted that Petitioner was noncompliant. Further, he specifically stated he was not in favor of any surgical treatment for obesity.

When Petitioner was seen by Dr. Gornet on January 24, 2011, her weight was 292 pounds and Dr. Gornet noted that he had been contacted by Dr. Soudah's office and informed of Petitioner's noncompliance with their treatment. Dr. Gornet's record of that date stated "I believe that she is noncompliant with treatment. I believe she continues to perceive that she is a 'victim' in all of this and has done nothing to improve her overall condition on her own and has taken little to no personal responsibility with trying to assist in management of her problem." Dr. Gornet also noted that if Petitioner had not lost significant weight by the time of his next visit that he would place her at MMI. When Petitioner inquired about gastric bypass surgery, Dr. Gornet opined that it was not indicated for someone who has "...clearly demonstrated noncompliance."

Dr. Gornet saw Petitioner on March 28, 2011, and her weight was 304 pounds. He noted that there was nothing to be done in the way of surgery but ordered that a functional capacity evaluation (FCE) be performed. An FCE was performed on April 8, 2011, and when Dr. Gornet saw Petitioner on May 9, 2011, he reviewed its findings. Dr. Gornet opined that Petitioner was at MMI and imposed permanent restrictions of no lifting over 25 pounds and no repetitive bending. He also gave Petitioner a prescription for a TENS unit.

Petitioner was subsequently seen in the ER of St. Anthony's Health Center on June 28, 2011, for back and leg pain. Petitioner was also seen in the ER of Alton Memorial Hospital on December 24, 2011, for low back pain.

Petitioner testified that her education is limited and that she has neither a high school diploma nor a GED. Petitioner stated she is also dyslexic and was diagnosed when this with this condition when she was in grade school. She testified that she has a difficult time reading and comprehending things. Prior to working for Respondent, Petitioner worked as a pizza delivery person and she was able to do this by memorizing where streets were located. Petitioner also worked for her father in a vending machine business called "Jamie's Video Darts" in which she would resupply vending machines at various locations. When her father died in 2001, Petitioner operated this business on her own for period of time.

Petitioner testified that following Dr. Gornet's opining that she was at MMI that she conducted a job search. The logs of this job search were tendered into evidence at trial. Portions of Petitioner's job search log appeared to be in chronological date order; however, this was not a consistent pattern. It is very difficult to determine the extent of job searches actually completed by Petitioner during 2011. An example of this is on page 5 of the job search log which has an entry of April 26, 2012, and the one immediately after it is dated July 13, 2011. The last entry on page 13 is May 5, 2012; however, all of the entries on page 14 are dated June 14, 2011, and the first entry on page 15 is July 1, 2012. Further, many these entries are duplicates or indicate that the contact with the prospective employer was on-line. For a substantial portion of the entries, it is not clear whether Petitioner had direct contact with the prospective employer or whether it was limited to on-line contact only.

At the direction of her attorney, Petitioner was evaluated by Delores Gonzalez, a vocational expert, on January 18, 2013. Gonzalez reviewed Petitioner's medical records, interviewed Petitioner, obtained a vocational history from her and administered a number of tests to her. In regard to the employment history, Gonzalez's report stated that Petitioner began working for Jamie's Video Darts in 1982 (when she would have been 11 years old) and continued to work there until 2009. There are two separate time periods indicated, 1982 to 2001 and 2001 to 2009 but the job description and duties for each of are identical. Gonzalez also reviewed Petitioner's job search logs and described the search activities in respect to 2011 as being "...minimal at best." However, she also stated that it was necessary to take into consideration Petitioner's education and limited job experience and opined that Petitioner would only be able to work at an unskilled level of work and that given her lack of a GED that there was a significant hindrance in her ability to find work. There was no statement from Gonzalez that there was not a reasonably stable job market for Petitioner or that Petitioner was incapable of returning to work in the current job market.

Respondent obtained a vocational evaluation from JoAnn Richter-Hill on March 4, 2013. At that time, Richter-Hill reviewed the report of Gonzales and Petitioner's job search logs. Richter-Hill subsequently met with the Petitioner on March 14, 2013. She prepared two reports dated March 4, 2013, one of which was in regard to her review of Gonzalez's evaluation and the other was a labor market survey. She also prepared a report dated March 14, 2013, regarding her meeting with the Petitioner. All three of these reports were received into evidence at trial and Richter-Hill also testified at trial.

In her review of Petitioner's job logs, Richter-Hill acknowledged that there were significant number of employer contacts; however, she noted that a lot of them were with the same

employer and that a significant number of the jobs that were listed by Petitioner were not consistent with her work restrictions. She ultimately opined that this was not a good faith effort on the part of the Petitioner to secure employment. Richter-Hill opined that Petitioner was employable and that there was a reasonably stable labor market given Petitioner's age, employment background, work skills and educational level. In respect to Petitioner's work background, Richter-Hill's report of March 4, 2013, stated that Petitioner had approximately 27 years (while she testified at trial that it was 30 years) of owning, operating and managing a company, Jamie's Video Darts. At the time this case was tried, Petitioner was 42 years of age

The assistant manager of Respondent's Wood River store, Tonya Curtis, testified at trial and she stated that Respondent can and does provide work to individuals who have work/activity restrictions including those caused by work-related injuries. She testified that if Petitioner's employment had not been terminated in July, 2010, Petitioner could still be working for Respondent at that time.

Conclusions of Law

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

The Arbitrator concludes that, as a result of the accident of September 22, 2009, Petitioner sustained a low back injury that caused disc pathology at the L4-L5 level; however, because Petitioner was noncompliant with weight loss treatment that was essential to promote her recovery, she reached a point of maximum medical improvement as of May 9, 2011.

In support of this conclusion the Arbitrator notes the following:

The Arbitrator takes judicial notice of Section 19(d) of the Act which provides in pertinent part: "If any employee shall persist in insanitary or injurious practices which tend to either imperil or retard his recovery or shall refuse to submit to such medical, surgical, or hospital treatment as is reasonably essential to promote his recovery, the Commission may, in its discretion, reduce or suspend the compensation of any such injured employee."

In this case, Petitioner's noncompliance with the medical treatment is documented in the medical treatment records. Dr. Gornet recommended that Petitioner undergo back surgery but was unwilling to proceed with it until Petitioner lost weight. Dr. Gornet referred Petitioner to Dr. Soudah, who prescribed a weight loss program. Both Dr. Gornet and Dr. Soudah stated in their medical reports that Petitioner was noncompliant.

The Arbitrator finds that Petitioner was noncompliant and that this was an injurious practice that imperiled or retarded her recovery as provided by Section 19(d) of the Act.

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 through May 9, 2011, was reasonable and necessary and that Respondent is liable for payment of the medical bills associated therewith.

Respondent shall pay reasonable and necessary medical expenses as identified in Petitioner's Exhibit 6 excluding any bills for medical services provided subsequent to May 9, 2011, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

As stated herein, Petitioner was found to be at MMI as of May 9, 2011, and Respondent is not liable for medical bills incurred thereafter.

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

The Arbitrator concludes that Petitioner is entitled to payment of temporary total disability benefits of 27 6/7 weeks commencing October 27, 2010, through May 9, 2011.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 25% loss of use of the body as a whole.

In support of this conclusion the Arbitrator notes the following:

Petitioner sought an order for an odd-lot permanent total disability on the basis that, when considering all factors, Petitioner is not employable in a reasonably stable labor market. The Arbitrator finds that Petitioner has not met the burden of proof.

Petitioner's noncompliance with medical care is relevant to this determination. Dr. Gornet would not proceed with surgery because of Petitioner's noncompliance with treatment in regard to weight loss and opined that she was at MMI and imposed permanent work/activity restrictions. It is not possible to determine with any certainty what Petitioner's recovery and disability would have been had she been compliant.

The Arbitrator notes that Petitioner's vocational rehabilitation expert, Delores Gonzalez, did not specifically state that there was no stable labor market for Petitioner but that Petitioner's lack of a GED was a significant hindrance. Respondent's vocational rehabilitation expert, JoAnn Richter-Hill, opined that Petitioner was employable. The Arbitrator notes that the opinion of Respondent's expert, Richter-Hill, was based upon an erroneous assumption that Petitioner had "operated" her own business for 27 to 30 years. The Arbitrator notes that according to the work history recorded by Gonzalez, Petitioner did begin "working" in the vending business in 1982 when she would have been 11 years of age and that she did, in fact, operate the business for approximately eight years, from 2001 to 2009.

Tonya Curtis, Respondent's Assistant Manager's unrebutted testimony was that Respondent can and does provide work to individuals that have work/activity restrictions and that if Petitioner had not been terminated in July, 2010, she could have still been employed by Respondent.

Accordingly, based on the preceding, the Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 25% loss of use of the body as a whole.

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Randel L. Britton,

Petitioner,

vs.

NO: 12 WC 22208

14IWCC0693

Secretary of State,

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, temporary total disability and permanent disability and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

The Commission finds that Petitioner sustained injuries arising out of the scope and in the course of his employment on May 23, 2012, and that his condition of ill-being was causally connected to that accident. The Commission further finds that Petitioner is entitled to temporary total disability from November 2, 2012, through December 6, 2012, at a rate of $454.66. In addition thereto, the Commission also finds that Petitioner is entitled to 47 weeks of compensation at a rate of $409.15 because the injuries sustained caused the loss of use of the right hand to the extent of 7.5% and loss of use to the right arm to the extent of 12.5%.

Petitioner testified that his job for the Respondent was to process drivers' licenses and abstracts. He enters the information he receives from the public through telephone calls, email requests and faxes. He testified that 80-85% of his day is devoted to data entry. He handles up to 400 abstracts a day. Petitioner uses a computer and is typing on a constant basis. When he types the abstracts he is mostly typing numbers using the number key pad on the right side of his keyboard. (Transcript Pgs. 15-18)

Petitioner began to develop pain in both wrists but predominantly on the right. He also had pain in the right elbow. He reported the accident to the people at work and saw Dr. Trudeau who eventually referred him to Dr. Neumeister. (Transcript Pgs. 23-24)

14IWCC0693

Respondent stipulated that they received notice of the alleged injury within the time limits stated in the Act.

Dr. Neumeister performed surgery on October 31, 2012. This surgery consisted of a right cubital and carpal tunnel release. (Petitioner Exhibit 1)

Doctor Neumeister testified at deposition on May 20, 2013 that if Petitioner was doing data entry and heavy use of the keyboard, that could aggravate his right carpal tunnel and right cubital tunnel. He testified that if the symptoms of carpal tunnel and cubital tunnel came on while doing those activities, then those activities aggravated his condition. He would consider those activities as being repetitive. (Petitioner Exhibit 2 Pgs.20-25)

The Commission finds the testimony of the Petitioner to be credible. The Commission also finds the testimony of Dr. Neumeister credible and adopts his opinions as they pertain to causal connection.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $454.66 per week for a period of 5 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 $409.15 per week for a period of 47 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use to the right hand to the extent of 7.5% and the loss of use of the right arm to the extent of 12.5%

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses as they pertain to Petitioner's treatment of his injuries under §8(a) of the Act and 8-2.

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

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

DATED: AUG 2 0 2014

Charles J. DeVriendt

Daniel R. Donohoo

HSF
O: 6/24/14
049

DISSENT

The well-reasoned decision of Arbitrator Lindsay is supported by the facts and the law. The Commission should affirm her decision in its entirety. With respect, I dissent.

Ruth W. White

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRITTON, RANDEL L
Employee/Petitioner

Case# **12WC022208**

SECRETARY OF STATE
Employer/Respondent

14IWCC0693

On 9/11/2013, 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 0.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1590 SGRO HANRAHAN DARR & BLUE
ELLEN C BRUCE
1119 S 6TH ST
SPRINGFIELD, IL 62703

0499 DEPT OF CENTRAL MGMT SERVICES
WORKMENS COMP RISK MGMT
801 S SEVENTH ST 6 MAIN
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0514 ASSISTANT ATTORNEY GENERAL
GLISSON, RICHARD C
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

SEP 11 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0693

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

RANDEL L. BRITTON
Employee/Petitioner

v.

SECRETARY OF STATE
Employer/Respondent

Case # **12** WC **022208**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **July 16, 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 23, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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 **$35,459.84**; the average weekly wage was **$681.92**.

On the date of accident, Petitioner was **42** years of age, ***married*** with **2** dependent children.

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

Respondent ***has*** 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** in other benefits for which credit may be allowed under Section 8(j) of the Act.

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

ORDER

Petitioner failed to prove he sustained an accident that arose out of his employment or that his conditions of ill-being in his hands and right elbow are causally connected to his employment for Respondent. 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

September 9, 2013
Date

SEP 11 2013

Petitioner alleges injuries to his wrists/hands and right arm/elbow which he attributes to repetitive trauma with a manifestation date of May 23, 2012. (PX 1)

The Arbitrator finds:

Petitioner's Job History

Petitioner began working for Respondent on December 15, 2006 as an "Intermittent Operations Associate." Petitioner worked 5.5 hours per day. He held that position until April 1, 2010 when he was promoted to an "Operations Associate." With the promotion came an increase in work hours (7.5 hours/day). As of October 1, 2010, Petitioner was an "Operations Associate" with a position number of "K6605-56-10-00-1." Petitioner was transferred to another position (but still as an "Operations Associate") on March 16, 2012 (position number "K6605-64-10-20-1"). (RX 3)

According to a May 21, 2009 Position Description for "K6605-56-10-00-1" an "Operations Associate" receives, analyzes, and responds to complex telephone inquiries from various sources and performs research and verification of vehicle title and/or registration information using various computer system programs. This requires computer work, mailing, and the ability to lift and carry up to 25 pounds and exercise independent judgment. The position's essential functions include the ability to sit for periods of long duration with occasional walking, occasional bending/twisting at the neck, frequent reaching forward, frequent typing, manual finger dexterity, the ability to lift and carry up to 25 lbs, vision, hearing, and the ability to verbally communicate. The job was also noted to require frequent (34% - 66%) manual dexterity and finger dexterity, frequent (34% - 66%) non-stop typing, and occasional hand/grip strength. (RX 5)

According to an April 20, 2010 Position Description for "K6605-64-10-20-1" this position involved many of the same tasks as the previous position, as well as processing of microfilm documents and abstracts of driving records pertaining to automated reports, faxes and e-mails from administrative hearings and reviews and evaluation of Illinois driving records to certify the validity of Illinois drivers licenses and driving permits for court purposes. The position also involved review and mailing of driving records to other states notifying them of DUI convictions. The position requires the ability to lift/carry up to ten lbs. The essential functions of the job include occasional hand/grip strength with frequent typing and continuous finger dexterity. Non-stop typing was described as "frequent." (RX 4)

At the time of arbitration Petitioner testified he was an "Operations Associate" for Respondent, having held that position since approximately 2008. Petitioner testified that he worked at the Driver's Services building located on Dirksen Parkway in Springfield. Petitioner

testified that an "Operations Associate" processes information for drivers license abstracts. On a typical day, Petitioner handles mail, phone calls, faxes, and inputs information into a computer. Petitioner explained that his day generally involves sorting requests received via mail or fax by names and drivers license numbers. He then enters those into the data base. Thereafter, he puts the requests together and rubber bands them in sets of 100 and distributes them to the proper department. Petitioner estimated he handles 300 to 400 abstracts per day and described the pace of work as "constant."

Petitioner also testified that he has phone duty one full day and one half day but he still uses the computer to bring up callers' license information and insert pertinent information from the caller. Most of the information he enters is numerical and so the majority of his time is spent using the number keypad. According to Petitioner the phone calls come in one after another.

Petitioner testified regarding his work station explaining that his computer is to his left at an angle but the keyboard is centered. A telephone and stapler is located by his computer. A basket for incoming faxes is also located by the computer. Petitioner testified that he does not have a gel pad for his keyboard. A mouse is located to the right of the keyboard and situated on a mouse pad. Petitioner's keyboard does not come out from the desk. Petitioner's wrists are often sitting on his desk with his wrists flexed. Petitioner uses his left hand to enter letters. Petitioner did not believe he had ever undergone an ergonomic evaluation. His desk area has remained the same since he moved there.

Petitioner generally works from 8:00 to 4:30 with a one hour lunch period and two fifteen minute breaks. Petitioner estimated that 80 to 85 percent of his work day is spent on data entry.

Petitioner was shown RX 4 and 5, the position descriptions for the last two jobs he held. Petitioner testified that they were fairly accurate although he estimated the amount of time he spent in research and verification (item 2 of job duties) in the "2010" position at 40%, not 30%. With respect to RX 5 (his current position) he felt the duties listed in paragraph 1 should be 60-70%, not 35%.

Summary of the Medical Records

Petitioner presented to Dr. Edward Trudeau on May 23, 2012, and underwent an EMG/NCS. Dr. Trudeau diagnosed Petitioner with bilateral carpal tunnel syndrome and right cubital tunnel syndrome. According to Dr. Trudeau's report, Petitioner was referred to him by Dr. Moinuddin. As part of the referral, Dr. Moinuddin provided Dr. Trudeau with detailed notes[1]. Dr. Trudeau also referenced an "extremely thorough questionnaire" which "he" was kind enough to fill out and which contained "all of the elements of consultation." (PX 4)

Dr. Trudeau noted that Petitioner is right-handed and that Petitioner was complaining of pain and paresthesias diffusely in the upper extremities both proximally and distally with

[1] These are not a part of the record.

numbness throughout the entire hand on either side but with worse symptoms on the right side. Petitioner also related discomfort in his wrists and elbows and a "pinching type" feeling in his neck. Reference was made to a pain drawing which indicated discomfort in Petitioner's wrists and neck region. However, Petitioner was primarily noting the gradual onset over the previous year of pain and paresthesias in both upper extremities in the course of his work duties as an operations associate for Respondent. Petitioner's right wrist was sore, Petitioner's finger tips on his left hand were numb and he thought it was difficult to lift any sort of heavy object. Petitioner also reported that when he used the computer for any length of time and throughout the day his symptoms worsened. Dr. Trudeau further noted that Petitioner did not believe there was any other injury or illness that would have caused this; rather, he felt it was connected to his work duties. Dr. Trudeau mentioned that Dr. Moinuddin suspected Petitioner might have carpal tunnel syndrome. Dr. Trudeau found electroneurophysiologic evidence of bilateral median neuropathies and ulnar neuropathy at the right elbow. (PX 4)

Dr. Trudeau authored a letter on May 29, 2012 to Petitioner's attorney stating that Petitioner would be "touching base" with Respondent for a "work related" condition and "since the date of the electrodiagnostic identification of his condition was 5-23-12, [he] believed that would likely be the most appropriate date of injury." (PX 4)

Petitioner signed his Application for Adjustment of Claim on June 20, 2012. (PX 1)

Petitioner presented to Dr. Neumeister for a surgical consultation on June 27, 2012. Petitioner was initially seen by Dr. Derby; however, Dr. Neumeister also examined Petitioner and discussed the case with Dr. Derby, the resident. According to the notes, Petitioner was right hand dominant, a non-smoker, and 46 years old. Petitioner reported having had a spinal cord injury in the lumbar region secondary to a car accident in 1985. Petitioner had progressed from wheelchair to walker to cane which he used in his right hand regularly. Petitioner reported symptoms of soreness and numbness in his right hand more so than his left and more soreness in his right elbow. Petitioner stated that the tips of all of his fingers were numb, notably on the right side and that this had been going on for greater than a year, and that the symptoms were waking him up at night. Petitioner had reportedly tried Ibuprofen and splinting without alleviation of his symptoms. Dr. Neumeister noted that Petitioner worked for Respondent. (PX 2)

On physical examination Petitioner exhibited a positive nerve compression of the median nerve at the right wrist as well as a positive Tinel's sign. Petitioner's right elbow also displayed a positive Tinel's sign. Petitioner's left hand was fairly unremarkable when performing all the tests aside from notable provocative nerve compression of the median nerve. Dr. Derby believed Petitioner had evidence of bilateral carpal tunnel syndrome, symptomatically worse on the right than the left. Noting "conservative therapy had failed," he recommended surgery. Petitioner was also noted to have evidence of right cubital tunnel syndrome. (PX 2)

Respondent had Petitioner examined by Dr. Anthony Sudekum at the Missouri Hand Center on September 10, 2012 after which the doctor prepared a lengthy report in which he set forth his examination findings, opinions, and philosophy on repetitive trauma. As part of the examination Dr. Sudekum reviewed Dr. Trudeau's report of May 23, 2012. He did not review

any of Dr. Neumeister's records. Dr. Sudekum further noted that Petitioner had been in a motor vehicle accident at the age of 16 which rendered him paralyzed from the waist down for approximately four years after which he was able to gradually recover partial lower extremity function resulting in the need for bilateral ankle-foot orthoses for bilateral foot drop and a cane for assistance in ambulation. Petitioner reportedly used the cane with his right hand. Petitioner was noted to walk with significant gait abnormality due to his lumbar spine injury and partial paralysis and used the cane when walking.

Dr. Sudekum's physical examination revealed full range of motion of Petitioner's elbows, forearms, wrists, thumbs and fingers with normal sensation throughout both hands albeit mild tenderness with palpation in the region of the right medial epicondyle and tenderness over the left thumb index webspace over the adductor muscle. Petitioner also had tenderness of the left shoulder in the rotator cuff/supraspinatus region with internal rotation and abduction of the shoulder. Petitioner's Tinel's and Phalen's signs were negative at his wrists bilaterally. Tinel's testing on Petitioner's right elbow was positive but the Phalen's was negative. On the left elbow, Phalen's was positive but Tinel's was negative. Dr. Sudekum noted generalized weakness in Petitioner's bilateral upper extremities. Nerve conduction studies were normal for motor and sensory latencies but mildly abnormal for amplitudes and F-wave.

Petitioner and Dr. Sudekum discussed Petitioner's job with Respondent. Petitioner explained his computer duties and paperwork responsibilities. Dr. Sudekum noted:

> [Petitioenr] indicates the he has worked for the State of Illinois, Driver's License Bureau for approximately six years, since December 18, 2006. Since April of 2012 he has held the position of "Operations Associate" and in this position he works from 8 AM until 4:30 PM, five days a week performing a desk/clerical job that involves computer work, telephone work, and other clerical tasks involved in the acquisition and transfer of information pertaining to driver's licenses for the State of Illinois, Driver Services Bureau. He states that his duties include looking up driver's licenses, birthdays, names, person information and anything related to driving, driving abstracts and/or violations. In addition to working on the computer, this job also involves management of paperwork and paper files, including date stamping, stapling, removing staples, copying, faxing, and talking on the phone. He spends approximately 30% at this time, 1-1/2 days per week, as a "Public Inquiry Operator" where his job involves talking on the phone, talking and answering questions from citizens about driver's license procedures, information, etc. He states that when doing this job he does some computer work as needed.
>
> Between October 2010 and April 2012, he held the position of "Public Inquiry Operator" full-time, where his job involved

answering phones at the Driver's License Bureau all day taking questions and providing information to the Public regarding driver's license procedures and information.

Between December 2006 and October 2010 he worked as an "Operations Assistant" at the Winchester Warehouse where his job involved clerical tasks and light manual activity including data entry, filing, copying, faxing and handling the license plates. (RX #1, Exb. #2, p. 6).

In addition to the above, Dr. Sudekum reviewed written position descriptions and physical requirements for the following positions held or performed by Petitioner during his six-year tenure at the Driver's License Bureau:

- Job title; Internal Operations Assistant; Department; Vehicle Services: Section; License Plate Operations: Division; Winchester Distribution
- Job title; Intermittent Operations Asst.: Department; Vehicle Services: Section; Administration: Division; Winchester Distribution
- Job title; Operations Asst.: Department; Vehicle Services: Section; Vanity Plates/Validation: Division; Special Plates: Unit; Validation Sticker Control

Dr. Sudekum was of the opinion Petitioner has some significant left shoulder pain that might suggest a rotator cuff tendinitis or some pathology of the cervical spine. He also thought Petitioner possibly had some bilateral medial epicondylitis/tendinosis and/or possible peripheral neuropathy. He recommended diagnostic studies of Petitioner's cervical spine and left shoulder along with elbow MRIs. A repeat nerve conduction study might be appropriate to further evaluate peripheral neuropathies. He also felt it might be appropriate to have Petitioner's primary care physician evaluate him for any potential metabolic/systemic causes. Dr. Sudekum recommended occupational therapy, an elbow paid, and nonsteroidal medications for petitioner's left upper extremity. He did not recommend anything for Petitioner's right elbow and did not believe Petitioner had any evidence of bilateral carpal tunnel syndrome. He further noted significant differences in Petitioner's history, exam, and nerve conduction study findings when comparing his evaluation with the earlier one of Dr. Trudeau and specifically noted Petitioner's only complaint on the day of his examination was left hand numbness as Petitioner denied any right hand numbness but mentioned some soreness in his right elbow. Petitioner also reported his symptoms that day were worse on the left than the right side. Dr. Sudekum did not recommend any surgery for Petitioner's hands/wrists. He was further of the opinion that Petitioner's upper extremity complaints and symptoms were not caused or aggravated by his employment activities for Respondent. (RX 1, Dep. Ex. 2)

Dr. Sudekum stated: "I have reviewed extensive position descriptions and job analysis information pertaining to the manual activities that [Petitioner] wouldn't perform in his job at the Driver's License Bureau. Based on my review of this information as well as my discussion of [Petitioner's] job duties with him today, it is my opinion, with a reasonable degree of medical certainty, that his upper extremity complaints and symptoms including possible left ulnar

neuropathy/cubital tunnel syndrome was not caused or aggravated by his employment activities for the State of Illinois, Driver's License Bureau where he has worked for the past six years." (RX 1, Dep. Ex. 2)

On October 31, 2012, Dr. Neumeister performed a right carpal tunnel and cubital tunnel release on Petitioner (PX 2). On November 12, 2012, Petitioner reported his numbness and tingling had resolved. Petitioner was instructed in scar massage. On the next visit on December 3, 2012, Dr. Neumeister noted Petitioner was doing well with some minor tenderness but good sensation to each hand (PX 2). At that time, Dr. Neumeister released Petitioner to follow up on an as-needed basis. (PX 2)

Petitioner returned to work for Respondent on December 7, 2012.

Deposition Testimony – Causal Connection

The depositions of Petitioner's treating physician, Dr. Neumeister, and Respondent's examining physician, Dr. Sudekum, were taken.

Dr. Sudekum is board certified in both plastic and reconstructive surgery as well as surgery of the upper extremity. Prior to the deposition Dr. Sudekum was provided with Dr. Neumeister's medical note. Dr. Sudekum disagreed with Dr. Derby's comment that conservative therapy had been attempted as he had seen no evidence of same. Dr. Sudekum testified in accord with his earlier report and reiterated his opinion that Petitioner's work activities for Respondent did not cause or aggravate Petitioner's upper extremity symptoms or conditions explaining that Petitioner had been paralyzed from the waist down and ambulated with significant difficulty and has some significant lumbar spine problems which could be affecting his spine further. Dr. Sudekum also failed to find evidence of carpal tunnel syndrome although he acknowledged some mild ulnar abnormalities. (RX 1)

Dr. Neumeister's deposition was taken on May 20, 2013. Dr. Neumeister is board certified in plastic surgery with an added qualification in hand surgery. (PX 3)

Dr. Neumeister was asked about his understanding of Petitioner's profession. The following exchange occurred:

Q. Did you discuss [Petitioner's] profession in the course of your treatment?
A. I actually don't have anything written down to note that. (PX #3, pp. 20-21)

Respondent's counsel also addressed this during cross-examination with the following exchange taking place:

Q. And we talked about his job duties, but you also testified that you didn't specifically have any conversations with him about what work he was performing at the Secretary of State; is that correct?

A. Correct. I have no recollection of that, nothing in the notes.
Q. And your note on the first date - - or the note of 6-27-2012 says he works at the Secretary of State, but that particular note does not indicate what duties he peforms for the Secretary of State; is that correct?
A. That is correct.
Q. You don't know what job duties, other than what Ms. Bruce conveyed to you today, what he was doing for the Secretary of State; is that correct?
A. That is correct. (PX #3, pp. 25-26)

During direct examination Dr. Neumeister opined the use of the cane could aggravate Petitioner's symptoms since "You are putting a lot of pressure right there. You're loading the wrist, if you will; loading where we put pressure on it. And it's right at the site - - I would imagine, if I'm holding a cane, it's right over where the carpal tunnel would be. So essentially, when you use the cane, you bend your wrist up or extend it, and then you put pressure down. And in that position, you could actually stretch the nerve and also put pressure on top of the ligament which is pushing on the nerve." (PX #3, pp. 16-17).

Dr. Neumeister was also asked some questions about Petitioner's medical history. Respondent's counsel and Dr. Neumeister then had the following exchange during cross-examination:

Q. And you mentioned that you did operate on the right side, both for the carpal and the cubital. And you indicated that the gentleman came in and he used a cane. He was post - - had a significant automobile accident, I think, when he was 16, was wounded, in a wheelchair and he progressed. So do you know how many years he had been using a cane?
A. I don't. It does indicate he progressed from the wheelchair to a walker to the case. And actually to clarify the point, I don't recall if he was using the cane as he walked in to the clinic that day either.
Q. And I saw some record about 200 plus pounds. So when you talk about the use of the cane being a potential contributing factor to the development of the carpal tunnel syndrome, a lot of it's because he's putting his weight on there every step he takes, and he's got his wrist in a position that could cause some issues with that median nerve; is that a fair statement?
A. I would think so, yes.
Q. And, in fact, he indicated that he used the cane on the right side; is that correct?
A. Correct.
Q. And that's the side that you ultimately operated on?
A. Correct (PX #3, pp. 27-28).

Additional Testimony from Petitioner

At the arbitration hearing Petitioner testified that he continues to work for Respondent in his capacity as an "Operations Associate." Petitioner testified that approximately 80-85 percent

of his day involves data entry and that when he isn't performing data entry he is arranging documents he reviews via mail or facsimile.

Petitioner acknowledged that he was involved in a car accident at the age of 15 which required him to use a wheelchair and cane thereafter. Petitioner testified he was able to transition to the use of a cane in his mid-20's and that he uses it for balance. As he is right-handed, he primarily uses the cane with his right hand; however, he occasionally uses his left hand. Petitioner denied ever experiencing any pain in his wrist or elbow with use of the cane. Petitioner uses the cane for balance in crowds or when walking long distances.

Petitioner testified that no one ever evaluated his work station after he reported trouble with his wrists and that he continued working for Respondent until his surgery.

Petitioner testified that he has received no TTD benefits for his time off from work.

Petitioner testified that the examination with Dr. Sudekum was "uncomfortable," as Dr. Sudekum spent the first few minutes of the examination talking about the state of workers' compensation in Illinois. Petitioner testified that the appointment became very uncomfortable and seemed one-sided after Dr. Sudekum's criticism of worker's compensation. Dr. Sudekum then spent an additional amount of time attempting to debunk Petitioner's previous doctors. Petitioner testified that it was as if Dr. Sudekum had made a decision about Petitioner's condition even before administering the proper tests. Petitioner also testified that he made clear during the examination that it was his right wrist and elbow that were experiencing the most pain. Petitioner further testified that the doctor's assistant performed a "shock test." According to Petitioner, the doctor also "pitched" to him how he would perform the left-sided surgery.

Petitioner testified that since the surgery he has experienced ongoing problems with his right elbow when grasping large objections and that his right arm goes numb when he is sleeping. Petitioner will get up to get the circulation going. Petitioner believed he had more problems grasping with his right hand that his left one. Petitioner was very pleased with the surgery on his right side.

Petitioner testified that he has been, and remains, avid about physical fitness and that he is now less able to lift weights and exercise with his right arm and both hands. He testified that he has been a member of FitClub since its opening, and prior to his injury he performed weight training and cardio exercises on a regular basis. He testified that after his injury he could no longer lift weights, and has focused on cardio exercises. Petitioner further testified that his grip strength is diminished as he could previously bench press 275 lbs. and is now limited to 100 lbs.

Petitioner denied experiencing any of his pre-surgery symptoms with use of a cane. He reported his accident to his supervisors, Donna Moon and Steve Jenkins, on May 24 or 25, 2012 because he "guessed" that it was his job duties causing his problems. Petitioner denied any problems before going to work for Respondent. Finally, Petitioner explained that any decision to have surgery on his left upper extremity is being postponed until he sees just how his right side does.

The Arbitrator concludes:

1. Accident and Causal Connection. Petitioner failed to prove he sustained an accident on May 23, 2012 arising out of and in the course of his employment with Respondent nor did he prove that his current conditions of ill-being in his hands and wrists and right elbow are causally related to his May 23, 2012 accident and his work duties for Respondent.

   Based upon the evidence in the record, Petitioner's bilateral arm conditions manifested themselves on May 23, 2012. It is on/about that date that Petitioner was seen by Dr. Trudeau and told by the doctor that he had evidence of bilateral carpal tunnel syndrome and that (based upon the doctor's report) it was probably work-related. Having determined that, the Arbitrator nevertheless concludes that a compensable accident has not been established. While May 23, 2012 may be a viable manifestation date, Petitioner has failed to prove his condition in his upper extremities arose out of or is causally connected to his job duties for Respondent. In so concluding the Arbitrator notes Petitioner's speculation as to the cause of his symptoms (he testified he "guessed" it was work-related), the absence of information from various doctors which might have shed light on the issue (Dr. Moinuddin and the pain drawing, questionnaire, and referral information to Dr. Trudeau), and the fact Petitioner did not discuss his job duties with Dr. Neumeister at any time and, in fact, presented to the doctor with a history suggesting his use of a cane with his right hand might be the source of his problem.

   On the issues of arising out of and causation, the Arbitrator concludes that the "opinions" of Dr. Trudeau, as stated in his report, are unpersuasive and somewhat biased. It is not clear why Dr. Trudeau forwarded a copy of his report to Petitioner's attorney (something which occurred before Petitioner even signed his Application for Adjustment of Claim) but the tone of the letter suggests the doctor is more advocate than consultant. Furthermore, without the accompanying information from Dr. Moinuddin (as referenced in Dr. Trudeau's report) it is not possible to know what information Dr. Trudeau was provided with prior to evaluating Petitioner, a factor which could impact any weight to be given the report. While Petitioner testified that eighty percent of his job duties were typing intensive, that he lacked a gel pad for his keyboard, and that he typed with his wrists at an angle and noticed symptoms in his extremities while typing none of that information was ever provided to, or discussed with, Dr. Neumeister. As with a specific trauma case, Petitioner's testimony regarding it must be corroborated with other evidence in the record. In this instance, Petitioner's testimony wasn't corroborated by Dr. Neumeister's records. While Dr. Trudeau's records suggest Petitioner may have discussed his job duties with the doctor, the circumstances surrounding the examination and incomplete records from that exam cast a cloud upon the records.

Finally, the Arbitrator notes the testimony of Dr. Neumeister. Dr. Neumeister candidly testified that use of a cane could aggravate carpal and cubital tunnel syndromes (although it would be harder for him to understand the latter) and that he had nothing to confirm that he and Petitioner ever discussed Petitioner's profession. He testified, "The only other thing that we discussed was the use of the cane." (PX 3, p. 21) While Dr. Neumeister also testified that he believed Petitioner's job duties of "data entry and heavy use of a keyboard" could have aggravated Petitioner's carpal tunnel and cubital tunnel syndromes, he had no recollection of any conversations with Petitioner about his work for Respondent, did not know what duties Petitioner's job involved, did not know what positions Petitioner had held over the years, and had no documentation of Petitioner ever representing to him that he had increased symptoms or pain while working. Dr. Neumeister further acknowledged that once the condition develops, many activities, including work, home, and the use of the cane, could cause symptoms. In comparison, Dr. Sudekum was provided with various job descriptions and discussed Petitioner's job with him in great detail. While Petitioner may have been uncomfortable with the doctor's manner and forma,t the doctor, nevertheless, rendered an opinion based upon more relevant information that that possessed by Dr. Neumeister.

Petitioner's claim for compensation is denied. No benefits are awarded. All other issues are moot.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ashley Eddards,

Petitioner,

vs. NO: 11 WC 3373

Heritage Manor-Streator,

14IWCC0694

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 and permanent disability and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

The Commission finds that Petitioner has failed to prove that she sustained injuries arising out of and in the course of her employment with the Respondent.

The Petitioner testified that on November 21, 2010 she was a certified nursing assistant for the Respondent. She worked the 10pm to 6 am shift and started working for Respondent the first week in November. On that date she was turning a heavy patient weighing between 300 to 350 pounds. She testified that as she pushed the patient she felt some resistance from the patient and did not feel any pain but heard a pop in her shoulder. Her shoulder began to hurt her through the night. (Transcript Pgs. 11-17)

Petitioner went home but when she awoke her right shoulder was in severe pain. (Transcript Pgs. 17-21)

Petitioner first sought medical care with Dr. Tiemann on November 23, 2010. According to his records (Respondent Exhibit 6) she gives a date of accident of November 22, 2010 but

gives no specific episode but indicates she does do lifting and rolling of multiple patients. When she saw Dr. Tiemann on that date she presented with shoulder pain for 1 day and indicated it started after working the night before. She once again indicated that there was no particular injury noted per the Doctor's records. (Respondent Exhibit 7)

Petitioner saw Dr. Tiemann again on December 16, 2010, complaining of pain in her right shoulder. The Doctor's notes indicate "c/o trauma/injury: no specific injury but started after working." (Respondent Exhibit 7)

Glenda Erschen was director of nurses for the Respondent. She testified that Petitioner reported the alleged accident to her November 23, 2010. Petitioner informed her that "last night my right shoulder started hurting. Petitioner indicated that she did not work last night so she did not know if she hurt it the night before or if she slept on it wrong. Ms. Erschen urged the Petitioner to come in and speak with her and at 9:30 pm on November 23, 2010 she came into the nurses' office and said "I woke up this morning and still had pain in my right shoulder and I cannot turn my head all the way to the right." She asked the Petitioner if she remembered any particular tasks that she performed that caused her pain and Petitioner's response was "No. But I turn people all the time and that's what could have happened." Petitioner indicated to her that she first had pain in the shoulder on November 22, 2010 at 9 pm. Petitioner did not work for Respondent after November 22, 2010 at 6:22 am. (Transcript Pgs. 64-67)

When Petitioner reported the alleged accident she made no mention of a specific incident nor did she mention the rolling of a 350 pound patient. (Transcript Pg. 68)

To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. *Baggett v. Industrial Comm'n*, 201 Ill. 2d 187, 266 Ill. Dec. 836, 775 N.E.2d 908 (2002); *Paganelis v. Industrial Comm'n*, 132 Ill. 2d 468, 480, 139 Ill. Dec. 477, 548 N.E.2d 1033 (1989); *Horath v. Industrial Comm'n*, 96 Ill. 2d 349, 356, 70 Ill. Dec. 741, 449 N.E.2d 1345 (1983); *Jones v. Industrial Comm'n*, 93 Ill. 2d 524, 526, 67 Ill. Dec. 829, 445 N.E.2d 309 (1983); *Rogers v. Industrial Comm'n*, 83 Ill. 2d 221, 223, 46 Ill. Dec. 691, 414 N.E.2d 744 (1980). "In the course of employment" refers to the time, place and circumstances surrounding the injury. *Lee v. Industrial Comm'n*, 167 Ill. 2d 77, 81, 212 Ill. Dec. 250, 656 N.E.2d 1084 (1995); *Scheffler Greenhouses, Inc. v. Industrial Comm'n*, 66 Ill. 2d 361, 366, 5 Ill. Dec. 854, 362 N.E.2d 325 (1977).

The Commission finds that the Petitioner's testimony regarding the accident is not credible. On cross examination Petitioner insisted that she told Dr. Tiemann on November 23, 2010 that she was moving the 350 pound patient and felt a pop in her shoulder. She also did not recall telling the Doctor that there was no specific injury or that she also had neck pain. (Transcript Pgs. 47-48) These statements were rebutted by Dr. Tiemann's records. (Respondent Exhibit 6 & 7) The Petitioner's testimony is also inconsistent with that of Glenda Erschen whom the Commission finds credible.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision filed on October 9, 2013 is hereby reversed and a finding be made that Petitioner failed to prove

14IWCC0694

that she sustained an injury arising out of the scope and in the course of her employment.

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: AUG 2 0 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
O: 6/25/14
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

EDDARDS, ASHLEY
Employee/Petitioner

Case# **11WC003373**

HERITAGE MANOR-STREATOR
Employer/Respondent

14IWCC0694

On 10/9/2013, 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 0.06% 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:

0652 EMMANUEL F GUYON
5 E BRIDGE ST
STREATOR, IL 61364

2912 HANSON & DONAHUE LLC
PETER DONAHUE
900 WARREN AVE SUITE 3
DOWNERS GROVE, IL 60515

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

14IWCC0694

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
CORRECTED

Ashley Eddards
Employee/Petitioner

v.

Heritage Manor - Streator
Employer/Respondent

Case # **11** WC **3373**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Geneva, Illinois**, 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 **Number of dependents**

FINDINGS

On **11-21-10**, 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 $**NA**; the average weekly wage was $**400.00**.

On the date of accident, Petitioner was **29** years of age, ***married*** with **2** 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

Respondent shall pay Petitioner temporary total disability benefits of $286.00/week for 6 weeks, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $286.00/week for 63.25 weeks, because the injuries sustained caused the permanent partial disability of said Petitioner to the extent of 12.65%, as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical services of $5,163.20, as provided in Section 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator

10/7/13
Date

ICArbDec p 2

OCT 9 - 2013

FINDINGS OF FACT

Petitioner testified that on November 21, 2010, she worked as a C.N.A. at Heritage Manor for 11 days, since November 10, 2010. Petitioner testified that on November 21, 2010 she suffered an injury to her right shoulder while moving a resident who weighed 300 to 355 pounds. Petitioner recalled that the resident was resistive and pushed against the wall to resist when she tried to move her. Petitioner testified feeling a pop in her shoulder and didn't think anything of it. Petitioner testified that she completed the shift, went home and then went to sleep.

Petitioner testified that after awakening in early afternoon, she noticed increased pain in her shoulder. Petitioner contacted her primary care physician, Dr. Jennifer Tieman, Parkside Medical Center, Streator, Illinois. Petitioner testified that she did not work on November 22, 2010. She reported the problem to Heritage on the morning of November 23, 2010. Petitioner indicated she reported directly to the Director of Nursing, Glenda Erschen.

Respondent submitted what was marked as Respondent Exhibit No. 2, that being the Employee Report of Incident, filled out and signed by Petitioner on November 23, 2010. Petitioner recorded that she was injured on November 22, 2010 at 9 p.m. In this form, Petitioner indicated her shoulder started hurting at home. She stated that her injury was caused either by turning residents on the night of November 21, 2010 or she could have slept on her shoulder wrong. Petitioner also indicated that she was repositioning a resident in bed.

Petitioner presented to Dr. Jennifer Tieman on November 23, 2010 with a history of "...shoulder pain for 1 day right, anterior, started after working the night before, no particular injury noted..." Dr. Tieman assessed likely muscle strain. Medication and off work for two days was prescribed. Petitioner was instructed to return on a prn basis. The doctor also indicated, "not certain if work related or unrelated." (RX 7)

Petitioner testified that she returned to work that night, November 23, 2010 and was placed on light duty. Petitioner continued to work for Respondent until she was terminated on December 1, 2010 for "no call, no show."

On December 16, 2010, Petitioner returned to Dr. Tieman complaining of increased shoulder pain, worse with lifting arm. The doctor noted there was no specific injury but did start after working. The doctor ordered x-rays and a MRI of the right shoulder. (RX 7)The MRI was performed on December 21, 2010 demonstrating tendinopathy or a partial thickness tear of the distal supraspinatus tendon. (PX 2)

At the referral of Dr. Tieman, Petitioner reported to Dr. Upendra Sinha on December 29, 2010. At that time Petitioner provided that she had been experiencing right shoulder pain for at least one month. The doctor noted that Petitioner claimed that she was lifting a patient and developed pain. Dr. Sinha reviewed the MRI indicating same showed partial tear of the supraspinatus tendon. The doctor diagnosed impingement syndrome, administered a cortisone injection, prescribed medication and physical therapy. (PX 1)

Petitioner returned to Dr. Sinha on January 11, 2011 with continued complaints of pain. The doctor administered a second cortisone injection and continued physical therapy. On January 25, 2011, Dr. Sinha recommended surgical intervention. (PX 1)

On February 15, 2011, Petitioner underwent open anterior acromioplasty, right shoulder. The postoperative diagnosis was impingement syndrome, right shoulder. (PX 1)

Post-operative care was uneventful. Dr. Sinha discharged her on March 29, 2011. Petitioner returned to the doctor on July 13, 2011. The doctor noted she had almost full range of motion with only night pain. Petitioner was again discharged. (PX 1)

Petitioner testified that she had no prior injury to her right shoulder. She stated that currently she cannot raise her right arm above shoulder level. Petitioner testified she is reluctant to lift any objects over 20 lbs., because she is fearful she will re-injure the shoulder. Petitioner is now employed at Casey's General Store as a cashier, which involves almost no lifting. Petitioner stated she does experience pain at the present time, especially at night.

Ms. Glenda Erschen testified on behalf of Respondent in this matter. Ms Erchen is the Director of Nursing at Heritage Manor. She testified there are 130 beds/residents at Heritage Manor. The CNA staff totals as follows: Day shift (6:00 am to 2:00 pm) has 14 CNA's, with 6 assistants; afternoon shift (2:00 pm to 10:00 pm), has 10 CNA's; night shift (10:00 pm to 6:00 am) has 6 CNA's. There are six wings to the nursing home, and six CNA's on duty during the night shift. During the night shift the CNA's are required to 'turn' the residents between 2:30 and 3:30 am. The turning operation consists of "rolling" the patient about 90° in the bed, not picking them up physically, but simply turning the resident in the bed itself. Ms. Erchen indicated two employees are required to 'roll' a resident if the weight is over a certain upper limit. Petitioner testified she asked for assistance to perform the operation on the heavier residents, but was told she had to perform the operation without assistance from another staff member.

Ms. Erschen testified that on November 23, 2010 at 9 a.m., Petitioner called her and stated that the night before her right shoulder started hurting and that she did not know if it happened at work or at home. She asked Petitioner to come in and make a formal report of accident. Ms. Erschen went on to testify that at 9:30 a.m. on November 23, 2010 Petitioner came in and made a formal report of a claim. She provided that Petitioner told her that she woke up with pain in her right shoulder and could not turn her head all the way to the right. When asked if there was any particular activity that she was doing at work that might have caused her injury, Petitioner replied no but that she turns people all the time. She also indicated Petitioner did not give a specific history of moving a resident who weighed 300 to 350 pounds and feeling a pop and pain in her shoulder while doing this.

In support of the Arbitrator's findings regarding (C) <u>Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?</u>, the Arbitrator finds as follows:

Petitioner testified that on November 21, 2010 she suffered an injury to her right shoulder while moving a resident who weighed 300 to 355 pounds. Petitioner recalled that the resident was resistive and pushed against the wall to resist when she tried to move her. Petitioner testified feeling a pop in her shoulder. She did not think anything of it, completed the shift, went home and went to sleep. After awakening in early afternoon, she noticed increased pain in her shoulder. Petitioner contacted her primary care physician, Dr. Jennifer Tieman.

On November 23, 2010, Petitioner completed an Employee Report of Incident. In this form, Petitioner indicated her shoulder started hurting at home. She stated that her injury was caused either by turning residents

on the night of November 21, 2010 or she could have slept on her shoulder wrong. Petitioner also indicated that she was repositioning a resident in bed.

Petitioner presented to Dr. Jennifer Tieman on November 23, 2010 with a history of "...shoulder pain for 1 day right, anterior, started after working the night before, no particular injury noted..." Dr. Tieman assessed likely muscle strain. Petitioner returned to the doctor on December 16, 2010. Dr. Tieman noted there was no specific injury but did start after working.

At the referral of Dr. Tieman, Petitioner reported to Dr. Upendra Sinha on December 29, 2010. Petitioner provided that she had been experiencing right shoulder pain for at least one month. The doctor noted that Petitioner claimed that she was lifting a patient and developed pain. The doctor diagnosed impingement syndrome.

Petitioner's testimony is consistent with the medical records provided and the Employee Report of Incident. Treating records show "...shoulder pain for 1 day right, anterior, started after working the night before...no specific injury but did start after working..." and "...she was lifting a patient and developed pain." The Employee Report of Incident provide that although her shoulder started hurting at home, her injury was caused either by turning residents on the night of November 21, 2010 or she could have slept on her shoulder wrong. Petitioner provided that she was repositioning a resident in bed. The Arbitrator notes that Petitioner testified that when her shoulder "popped" she didn't think anything of it. She continued to work, went home and went to sleep. After awakening later that afternoon, she noticed increased pain. The sequence is plausible and not incredible.

Based on the above, the Arbitrator finds that Petitioner sustained an accidental injury that arose out of and in the course of her employment with Respondent on November 21, 2010.

In support of the Arbitrator's findings regarding (F) <u>Is Petitioner's current condition of ill-being causally related to the injury</u>, the Arbitrator finds as follows:

It is well established that proof of a prior state of health and a change following and continuing after an injury that necessitates off work and medical care may establish that a claimant's impaired condition was due to the injury. <u>Navistar Intern. Transp. Corp. v Industrial Comm'n.</u> 734 N.E. 2d 900 (1st Dist. 2000)

In this case, Petitioner's unrebutted testimony demonstrates that she had no prior injury or complaints with respect to her right shoulder prior to the accident of November 21, 2010. On November 21, 2010 she suffered an injury to her right shoulder while moving a resident who weighed 300 to 355 pounds. While performing the maneuver, she felt a pop in her right shoulder.

Petitioner sought treatment with Dr. Jennifer Tieman who ordered a MRI which demonstrated a tendinopathy or a partial thickness tear of the distal supraspinatus tendon. Thereafter, Petitioner was referred to Dr. Upendra Sinha who ultimately performed an open anterior acromioplasty, right shoulder. The postoperative diagnosis was impingement syndrome, right shoulder.

Based upon the above, the Arbitrator finds that a causal relationship exists between her right shoulder condition of ill-being and the accident sustained on November 21, 2010.

In support of the Arbitrator's findings regarding (J) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Petitioner had a State of Illinois Medical Card at the time of receiving medical treatment by Dr. Tieman, Dr. Sinha, the surgery at St. Mary's Hospital, and physical therapy. All medical expenses have been paid by the State of Illinois Department of Health and Family Services. The total medical expenses were $34,177.75. (PX 5) The State of Illinois has asserted a lien against the Worker's Compensation case of Petitioner in the amount of $5,163.20. The State of Illinois has offered to compromise the lien for the sum of $2,500.00. (RX 8)

Based on the above, the Arbitrator finds the medical services provided were reasonable and necessary. The Arbitrator further finds that Respondent is responsible for the lien amount asserted in the amount of $5,163.20.

In support of the Arbitrator's findings regarding (K) What temporary benefits are in dispute? TTD, the Arbitrator finds as follows:

Petitioner seeks temporary total disability benefits from January 28, 2011 through March 28, 2011. On January 25, 2011, Dr. Sinha recommended surgical intervention. On February 15, 2011, Petitioner underwent open anterior acromioplasty, right shoulder. The postoperative diagnosis was impingement syndrome, right shoulder. Post-operative care was uneventful. Dr. Sinha discharged her on March 29, 2011.

Based on the above, the Arbitrator finds that Petitioner was temporarily totally disabled for the period of February 15, 2011 through March 29, 2011, a period of 6 weeks

In support of the Arbitrator's findings regarding (L) What is the nature and extent of the injury, the Arbitrator finds as follows:

Petitioner underwent open anterior acromioplasty, right shoulder. The postoperative diagnosis was impingement syndrome, right shoulder. She was ultimately discharged from care on March 29, 2011. Petitioner last saw a doctor on July 13, 2011. The doctor noted she had almost full range of motion with only night pain. P

Petitioner testified she currently she cannot raise her right arm above shoulder level. Petitioner testified she is reluctant to lift any objects over 20 lbs., because she is fearful she will re-injure the shoulder. Petitioner is now employed at Casey's General Store as a cashier, which involves almost no lifting. Petitioner stated she does experience pain at the present time, especially at night.

Based on the above, the Arbitrator finds Petitioner is permanently disabled to the extent of 12.65% under Section 8(d)2 of the Act.

In support of the Arbitrator's findings regarding (O) Other: The number of Petitioner's dependents at the time of accident, the Arbitrator finds as follows:

Petitioner claimed three dependents at time of trial. However, Petitioner provided no testimony or evidence regarding the number of dependents which she had at the time of trial. It is Petitioner's burden to prove every element of her case. The only evidence made was by Respondent in the Employee Incident Report and Form 45 that at the time of the accident Petitioner had two dependents. Based on this evidence, the

Arbitrator finds that at the time of the accident Pet itioner had two dependents pursuant to the Illinois Workers' Compensation Act.

14IWCC0694

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

Javier Mendoza.
Petitioner.
vs.

NO: 12WC 2372

Chicago American Manufacturing, LLC.,
Respondent,

14IWCC0695

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, 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 February 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: AUG 2 0 2014
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TJT/jrc
051

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MENDOZA, JAVIER
Employee/Petitioner

Case# **12WC002372**

10WC021488

CHICAGO AMERICAN MANUFACTURING LLC
Employer/Respondent

14IWCC0695

On 2/7/2013, 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 0.11% 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:

1922 SALK & ASSOCIATES
ALEXANDER BRODERICK
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

0532 HOLECEK & ASSOCIATES
FRED NORMAN
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

14IWCC0695

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

JAVIER MENDOZA
Employee/Petitioner

v.

CHICAGO AMERICAN MANUFACTURING, LLC
Employer/Respondent

Case # **12** WC **02372**

Consolidated cases: **10 WC 21488**

An *Application for Adjustment 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 **12/27/2012**. 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. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

14IWCC0695

FINDINGS

On **1/9/2012**, 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 **$19,032.00**; the average weekly wage was **$366.00**.

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.

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

ORDER

Respondent shall pay Petitioner reasonable and necessary medical expenses of $184.47 pursuant to Sections 8(a) and 8.2 of the Act. PX 22-24.

Petitioner failed to establish permanent partial disability stemming from the accident of January 9, 2012. The Arbitrator awards no permanency benefits in this claim.

The Arbitrator awards no penalties or fees in this claim.

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

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

2/7/13
Date

FEB - 7 2013

Javier Mendoza v. Chicago American Manufacturing
10 WC 21488 and 12 WC 2372

14IWCC0695

Arbitrator's Findings of Fact Relative to Both Cases

The parties agree that Petitioner was injured while working for Respondent on May 21, 2010 (10 WC 21488) and January 9, 2012 (12 WC 2372). The disputed issues in both cases are medical, permanency and penalties/fees. Arb Exh 1, 3. In the first case, Petitioner claims unpaid fee schedule charges totaling $74,894.77. In the second case, he claims unpaid fee schedule charges totaling $184.47. Arb Exh 3. In the first case, Respondent does not dispute the reasonableness or necessity of Petitioner's shoulder surgeries but takes issue with some of the charges. In both cases, Respondent takes issue with the method by which Petitioner's providers arrived at the claimed fee schedule amounts. T. 6.

Petitioner testified through a Spanish-speaking interpreter. He was born on April 12, 1966. He grew up in Mexico. He stopped attending school after the first year of high school. T. 15-16.

Petitioner testified he began working for Respondent on January 11, 2009. His job title was machine operator but he performed a variety of tasks, such as packing and assembly. He routinely lifted items weighing between 30 and 60 pounds. T. 17.

Petitioner testified his health was fine prior to May 21, 2010. He denied injuring either shoulder prior to that date. T. 17-18. On that date, he fell from a height of about four feet while using a control to operate an overhead crane. He fell to his left side, striking his arms and the bridge of his nose in the process. He extended his right arm as he fell so as to release the control, which was in his right hand. T. 20. Afterward, his supervisor took him to the Emergency Room at MacNeal Hospital. It was early in the morning on May 22, 2010 when they arrived at the hospital. T. 21.

Petitioner testified he complained to hospital personnel of pain in his nose and both shoulders. The Emergency Room records set forth a consistent account of Petitioner's fall. The records reflect complaints relative to the nose, left shoulder and left leg. The Emergency Room physician repaired a 1 centimeter nose laceration. On left shoulder examination, she noted a limited range of motion. Left shoulder X-rays revealed degenerative changes. The physician prescribed ointment and Motrin and released Petitioner from care, with instructions to avoid using his left arm at work "until cleared by follow-up physician." PX 1.

Petitioner testified he presented the work restriction to Juan Arias and Arturo Sosa at Respondent and was not accommodated. T. 23-24.

On May 24, 2010, Petitioner saw Dr. Laluya, an osteopath, at Excel Occupational Health Clinic. Petitioner testified that Arturo Sosa of Respondent referred him to this clinic. T. 24. Dr. Laluya wrote to Juan Arias of Respondent the same day. His letter sets forth a detailed account

of Petitioner's work accident. He noted complaints of nose pain and "left greater than right shoulder pain." He indicated that Petitioner denied any previous shoulder injuries.

On examination of Petitioner's nose, Dr. Laluya noted a small laceration with three intact sutures. On examination of Petitioner's left shoulder, he noted ecchymosis over the triceps, somewhat diffuse pain over the deltoid, triceps and anterior shoulder, no obvious instability and a significantly limited active range of motion. On examination of the right shoulder, he noted no ecchymosis or swelling and active abduction and forward flexion to 45 degrees. He indicated Petitioner was able to keep his right arm overhead, once the arm was positioned there. X-rays of the nasal bone and right shoulder showed no obvious fractures.

Dr. Laluya applied a sling to Petitioner's left arm. He instructed Petitioner to ice both shoulders. He placed Petitioner on restricted duty.

Petitioner also went to Marque Medicos on May 24, 2010. He testified he sought care at this facility because he wanted a second opinion. T. 25. He saw Dr. James, a chiropractor, and provided her with a history of his May 21, 2010 work accident and subsequent treatment. He complained of bilateral shoulder pain, left worse than right, and some low back discomfort. He described his nose pain as very mild. He denied any previous accidents and surgeries. He indicated he was taking Motrin for pain, as previously prescribed.

On examination, Dr. James noted several stitches on the bridge of Petitioner's nose, bruising on the left posterior arm, limited active flexion in the lumbar spine and markedly decreased motion of both shoulders. Supraspinatus testing was "greater on the left than the right."

Dr. James prescribed bilateral shoulder MRIs to rule out rotator cuff tears. She recommended orthopedic and pain management consultations. She also recommended therapy three times weekly for four weeks, with the therapy to include "lumbar spine manipulation. She took Petitioner off work and noted he would require pain medication once the Motrin prescription expired.

On May 27, 2010, Petitioner underwent an initial therapy evaluation at Marque Medicos. Homer Saclayan, P.T., the evaluating therapist, noted complaints relative to both shoulders and the lower back. Petitioner described his low back pain as very minimal. Saclayan noted that Petitioner had his left arm in a sling. He also noted a healing hematoma in the left posterior arm. He indicated Petitioner was unable to perform the "empty can sign" on the left due to extreme pain.

Petitioner underwent the recommended bilateral shoulder MRI scans at Archer Open MRI on June 2, 2010. T. 25. The left shoulder MRI revealed an effusion and a "complete tear of the infraspinatus tendon with near complete tearing of the supraspinatus tendon." The radiologist described both tendons as "retracted to at or near the level of the glenohumeral articulation." He could not rule out an underlying SLAP tear. The right shoulder MRI revealed

"extensive, near complete tears of the infraspinatus and supraspinatus tendons" and an effusion with "fluid extending into the subacromial/subdeltoid bursa." PX 3B.

Petitioner returned to Excel on May 26, 2010 and indicated he was still using the sling and having difficulty lifting both arms. He also indicated that no light duty was available. The examining physician, whose signature is not legible, noted "extensive ecchymoses" on the left shoulder. Speed, Neer/Hawkins and O'Brien testing was positive on examination of the left shoulder. Neer/Hawkins and O'Brien testing was positive on examination of the right shoulder. The physician diagnosed a healing nasal laceration and bilateral shoulder contusions. He suspected rotator cuff injuries. He took Petitioner off work and instructed him to continue to wear the sling and apply ice. He indicated that Petitioner might require MRI scanning and therapy. PX 2.

Petitioner went back to Excel on June 1, 2010 and indicated that ice was not helping. He reported being able to lift his left arm due to pain. He described having a "little more movement" in his right arm. The examining physician, whose signature is not legible, noted ecchymosis to the left triceps area as well as a hematoma on palpation. Neer testing was positive on the left and negative on the right. The physician continued to keep Petitioner off work. He directed Petitioner to continue wearing the sling and applying ice. He prescribed therapy and indicated Petitioner might require a left shoulder arthrogram if therapy did not help. PX 2.

On June 8, 2010, Dr. Laluya sent Petitioner a letter informing he was being discharged from care by Excel since he had opted to see doctors of his own choice. PX 2.

On June 10, 2010, Petitioner saw Dr. Engel of Medicos Pain & Surgical Specialists. Petitioner testified that Dr. James referred him to Dr. Engel. T. 26. The doctor's history reflects that Petitioner fell about four feet from a tow truck while holding onto a control, extending his right arm as he fell and landing on his left side and shoulder. Petitioner complained of bilateral arm pain, rated 6/10, and left-sided back pain, rated 1/10.

On examination, Dr. Engel noted a decreased range of motion in both shoulders, 5/5-upper body strength secondary to pain and a full range of lumbar spine motion.

Dr. Engel prescribed Mobic, Omeprazole and Soma. He instructed Petitioner to continue therapy and remain off work until he could see Dr. Nam, an orthopedic surgeon. He offered Petitioner "roundtrip ground, non-emergency and non-ambulance based transportation" to facilitate treatment. PX

Petitioner first saw Dr. Nam on June 14, 2010. Petitioner testified that Drs. James and Engel referred him to Dr. Nam. T. 26. Petitioner provided Dr. Nam with a history of his work accident and denied any pre-accident shoulder problems.

On examination of Petitioner's shoulders, Dr. Nam noted an extremely painful range of motion, positive impingement, drop arm and O'Brien signs and rotator cuff strength testing of 4-/5 with pain.

Dr. Nam interpreted the MRIs as showing very large retractive rotator cuff tears in both shoulders. He also noted the presence of fluid, "suggesting acute injury," and evidence of a labral tear in the left shoulder. Based on Petitioner's history and examination, along with the MRIs, he found a causal relationship between the work accident and the bilateral rotator cuff tears. He found it "reasonable and necessary" to proceed with surgery but also discussed non-operative measures. He noted that Petitioner opted for surgery and expressed a desire to have his left shoulder addressed first. He instructed Petitioner to remain off work.

Petitioner returned to Dr. Nam on July 26 and August 30, 2010. The doctor's examination findings were unchanged. He indicated he was awaiting surgical authorization.

At Respondent's request, Petitioner saw Dr. Bush-Joseph for a Section 12 examination on August 17, 2010. Petitioner testified he provided Dr. Bush-Joseph with various treatment records and gave the doctor a history of his work accident. T. 45. Petitioner was aware that Dr. Bush-Joseph agreed as to the need for bilateral shoulder surgery. T. 46.

Dr. Bush-Joseph issued a Section 12 examination report to Travelers Insurance on August 17, 2010. RX 1. The report reflects that Dr. Bush-Joseph is a professor in the department of orthopedic surgery at Rush University Medical Center.

Dr. Bush-Joseph noted that Petitioner is right-handed. He also noted that Petitioner's nephew served as an interpreter throughout the examination.

Dr. Bush-Joseph's report sets forth a detailed account of the work accident of May 21, 2010 and subsequent treatment. The doctor noted that Petitioner denied having any problem with either of his shoulders prior to that accident.

On examination of Petitioner's left shoulder, Dr. Bush-Joseph noted active forward elevation of "only 95 degrees," active abduction of 45 degrees, marked weakness with both of these maneuvers and tenderness over the glenohumeral joint and over the greater tuberosity region. On examination of the right shoulder, Dr. Bush-Joseph noted forward elevation of 170 degrees, abduction of 150 degrees and abduction/external rotation of 90 degrees.

Dr. Bush-Joseph reviewed the MRI scans and diagnosed "bilateral acute rotator cuff tears." He found "no evidence of a pre-existing medical condition that would explain the severe weakness or profound physical examination findings." He indicated that the treatment records "seem to support and, indeed, [are] consistent with a history of the accident and subsequent injury." He attributed the rotator cuff tears to the work accident and stated that right shoulder surgery was "clearly indicated" due to the accident. He further stated that left shoulder surgery was "appropriate and indicated" and "should be performed on an immediate

basis to provide a greater chance of eventual full recovery." He projected that recovery from left-sided surgery would take five to seven months due to the severity of the left shoulder injury. He projected that recovery from right-sided surgery would take three to five months.

Dr. Bush-Joseph opined that the chiropractic care rendered to date had been "ineffective" and was "unlikely to provide any future benefit."

Dr. Bush-Joseph found Petitioner capable of only sedentary desk duty. He reiterated that further treatment should not be delayed.

Dr. Bush-Joseph indicated that Petitioner had a "50% probability" of needing permanent lifting restrictions of below shoulder use of the left arm. He also indicated that a lifting restriction of 45-50 pounds was "possible."

Dr. Bush-Joseph described Petitioner's prognosis with respect to his right shoulder as "good to excellent." With respect to the left shoulder, however, he indicated that the prognosis was "somewhat guarded." RX 1.

On August 31, 2010, A. Kohn signed a Medicos Pain & Surgical Specialists form authorizing the prescribed left shoulder surgery. PX 5.

On September 16, 2010, Petitioner underwent surgery consisting of a left shoulder arthroscopic rotator cuff repair, subacromial decompression, labral debridement and synovectomy. PX 3-4.

Petitioner returned to Dr. Nam on September 27, 2010. The doctor noted no signs of infection. He instructed Petitioner to remain off work and begin passive range of motion therapy.

Petitioner saw Dr. James again on October 15, 2010 and reported some improvement in his left shoulder. He was still experiencing right shoulder pain. Dr. James recommended that Petitioner advance his home exercises and follow up with Dr. Nam.

Petitioner saw Dr. Engel again on November 4 and December 2, 2010 and complained of bilateral shoulder pain. The doctor refilled Petitioner's Mobic, Omeprazole, Soma and Ultram. He again offered Petitioner transportation services and instructed him to follow up with Dr. Nam.

At his next two visits to Dr. Nam, on November 22 and December 20, 2010, Petitioner reported some improvement secondary to therapy. Dr. Nam prescribed additional therapy, to be performed three times weekly. He continued to keep Petitioner off work.

On November 23, 2010, Dr. James noted that Petitioner's pain level was the same but that he had a greater range of left shoulder motion. She recommended that Petitioner follow up with Dr. Nam.

At a December 30, 2010 re-evaluation, therapist Norman Lambot, P.T. (hereafter "Lambot") noted that Petitioner was still complaining of 5/10 pain in both shoulders but that he had made "great gains" with respect to range of motion.

On January 24, 2011, Petitioner told Dr. Nam his left shoulder was improving but he was still experiencing pain in his right shoulder. On right shoulder examination, Dr. Nam noted some pain along the acromioclavicular joint, some pain with cross-chest adduction, a positive impingement sign and 4/5 rotator cuff strength with pain. Dr. Nam recommended right shoulder surgery and instructed Petitioner to continue therapy and remain off work.

On January 25, 2011, A. Kohn, R.N. signed an Ambulatory Surgical Care Facility form authorizing the prescribed right shoulder surgery. PX 5.

On February 1, 2011, Dr. Nam performed a right shoulder arthroscopic repair of a "massive" and retracted rotator cuff tear, a subacromial decompression, extensive debridement of labral and proximal biceps tendon tears, a "mini-Mumford," or distal clavicle co-planing, and a synovectomy. PX 3-4.

Petitioner returned to Lambot on February 10, 2011 and complained of 2-3/10 left shoulder pain and 6-7/10 right shoulder pain. Lambot did not perform any right shoulder testing due to the recent surgery.

On March 7, 2011, Dr. Nam described Petitioner's left shoulder as "doing fine" and the right shoulder as "improving." On left shoulder examination, he noted an essentially full range of motion. On right shoulder examination, he noted some limitation in forward flexion, abduction and rotation and strength of 5-/5. He kept Petitioner off work and prescribed additional therapy.

Petitioner continued undergoing therapy thereafter. On March 31, 2011, Dr. Engel noted improvement and discontinued the Ultram. He refilled the Mobic, Omeprazole and Soma. On April 18, 2011, Dr. Nam prescribed additional therapy only for the right shoulder and released Petitioner to desk work with no use of the right arm and lifting restrictions relative to the left arm.

Petitioner testified he presented Dr. Nam's restrictions to Respondent but was not accommodated. T. 32-33.

At Respondent's request, Petitioner saw Dr. Bush-Joseph for purposes of a Section 12 re-examination on June 7, 2011. T. 48-49. Petitioner testified that Dr. Bush-Joseph obtained shoulder X-rays on this date. T. 49. Petitioner also testified that Dr. Bush-Joseph did not tell

him he no longer needed formal therapy. T. 50. According to Petitioner, Dr. Bush-Joseph expressed no criticism of the care he was receiving. T. 51.

Dr. Bush-Joseph addressed his June 7, 2011 re-examination report to Kim Ahern, R.N. of Medical Consultant Network. The doctor noted that Petitioner had undergone bilateral shoulder surgery by Dr. Nam since his original examination. He also noted that Petitioner reported good improvement with respect to his left shoulder but had "residual symptoms on the right side."

On re-examination of Petitioner's left shoulder, Dr. Bush-Joseph noted forward elevation to 175 degrees, abduction to 165 degrees and external rotation to 90 degrees. He also noted mild subacromial crepitation but normal strength. On re-examination of Petitioner's right shoulder, Dr. Bush-Joseph noted "mild residual atrophy," "significant residual subacromial clicking," forward elevation to 170 degrees, abduction to 140 degrees and external rotation to 85 degrees. He also noted 5-/5 strength to forward elevation and abduction and "diminished biceps tone on the right side."

Dr. Bush-Joseph obtained bilateral shoulder X-rays. He indicated that the "glenohumeral contours, or Shenton's line, on the left shoulder has been properly re-established and shows significant improvement from the presurgical radiographs." He saw "no evidence of arthritic wear of the glenohumeral joints."

Dr. Bush-Joseph indicated that Petitioner obtained a "good result" from his left rotator cuff repair. He saw no need for further left shoulder treatment, despite Petitioner's "mild residual functional weakness." He found no need for restrictions relative to the left arm. He indicated it was "safe to continue with a home exercise program alone."

Dr. Bush-Joseph described Petitioner's more recent right shoulder surgery as a "massive arthroscopic repair of a massive rotator cuff tear with distal clavicle excision." He indicated there was "indeed a need for two more months of formal physical therapy to achieve functional strength and use of the right arm and shoulder, specifically for overhead labor and reaching." He found Petitioner capable of restricted duty, with no lifting over 50 pounds below waist level and no lifting over 25 pounds from waist to chest level with the right arm and shoulder. He anticipated that Petitioner would be able to resume full duty with respect to his right arm on August 1, 2011.

Dr. Bush-Joseph further commented:

> "I do believe that a work conditioning or work hardening program is indicated at this time given the fact that he has a near normal active and passive range of motion. I see no benefit from further pain center medical management. The patient is clearly in an orthopedic recovery condition and his care should indeed be supervised by his treating orthopedic

surgeon. Despite the severity of his initial injury, the patient has shown significant functional improvement and can be expected to achieve a full–duty recovery of both the right and left arms."

RX 2.

On June 17, 2011, Dr. Bush-Joseph issued an addendum in response to an inquiry from Kim Ahern, R.N. as to his specific opinion concerning further right shoulder treatment. Dr. Bush-Joseph responded as follows: "I believe that eight more weeks of formal physical therapy, three times per week, is indicated to achieve a functional level of strength and mobility and endurance of the right shoulder." RX 3.

Petitioner returned to Dr. Nam on June 27, 2011 and reported occasional painful cracking in both shoulders. On bilateral shoulder examination, the doctor noted forward flexion of 155, external rotation of 40 and internal rotation to T9. Impingement testing was negative bilaterally. The doctor prescribed work conditioning and again released Petitioner to desk work with no overhead lifting and no lifting over five pounds.

On June 29, 2011, Dr. Engel provided Petitioner with a two-month supply of Mobic and Soma, noting that Petitioner was not scheduled to begin work conditioning for eight days.

On July 8, 2011, Petitioner underwent a work conditioning evaluation at Elite Physical Therapy. T. 51. Petitioner provided a history of his work accident and surgeries to the evaluator, Jeff Goode, PT, and indicated he had not returned to work since the accident. Goode described Petitioner's bilateral shoulder range of motion as within normal limits. He noted some strength deficits. He characterized Petitioner as an excellent candidate for work conditioning. PX 6. On July 22, 2011, Luis Maldonado, P.T. noted that Petitioner had made "great progress" in the work conditioning program and exhibited increased tolerance for above-shoulder reaching, lifting and pushing/pulling. While Petitioner was still exhibiting some "functional and stability deficits with shoulder/overhead lifting" as of July 29, 2011, Maldonado indicated Petitioner "has met all of his return to work goals."

On August 1, 2011, Petitioner returned to Dr. Nam and complained of some occasional "cracking" in his shoulders. Dr. Nam discontinued the work conditioning, released Petitioner to full duty on a trial basis and instructed Petitioner to return in one month. He indicated he would consider a functional capacity evaluation if Petitioner experienced difficulty with resuming his regular duties.

Dr. Nam addressed Dr. Bush-Joseph's opinions as follows: "In general, I do agree with Dr. Bush-Joseph's findings. However, I am not 100% positive that [Petitioner] will be able to return to work without problems, which is why we are going to do a trial return to work full duty." PX 3B.

Petitioner testified he resumed working as a machine operator for Respondent.

Petitioner saw Dr. Engel for the last time on August 25, 2011. Dr. Engel noted that Petitioner had resumed working and that work caused Petitioner "a little bit of left shoulder pain." On examination, Dr. Engel noted a full range of motion in both shoulders. He discharged Petitioner from care, noting that Petitioner no longer required prescription medication.

On August 29, 2011, Dr. Nam released Petitioner to full duty and discharged him from care. PX 4-5. T. 34.

Petitioner testified that the prescribed therapy helped him and that he noticed improvement after his shoulder surgeries. T. 34. After each surgery, he used an "icing machine" prescribed by Dr. Nam. Using this machine relieved his shoulder pain. T. 34-35.

The parties agree that Petitioner sustained a second work accident on January 9, 2012. Petitioner testified that a machine struck his chest and ribs that day. He reported the accident to Victor, his boss, and sought care at Excel Occupational Health Clinic on January 11, 2012. T. 36.

Records from Excel (PX 20) reflect that Petitioner saw Dr. Strong on January 11, 2012. The doctor noted that Petitioner had been struck by a moving machine part two days earlier. Petitioner complained of pain in his rib area. On examination, Dr. Strong noted some ecchymosis on the anterior chest, tenderness over the posterior 10th, 11th and 12th ribs and no difficulty breathing. Dr. Strong diagnosed contusions. He released Petitioner to full duty and recommended that Petitioner apply ice to the affected areas and return in two days. PX 20.

Petitioner returned to Excel on January 13, 2012 and reported no improvement. Dr. Pillar imposed work restrictions and prescribed Ibuprofen. PX 20. Petitioner testified he presented the restrictions to "Edgar" at work but was not accommodated. T. 37.

Petitioner also went to Marque Medicos on January 13, 2012. He testified he returned to this facility because he found the earlier treatment helpful. T. 37. He saw Dr. Gattas, a chiropractor, and provided a history of his January 9, 2012 work accident. He also reported that he was working without difficulty prior to the accident. Dr. Gattas noted some chest ecchymosis and tenderness on examination. He obtained rib X-rays, which were negative on preliminary reading. In a subsequent report, Dr. Aikenhead, a chiropractic radiologist, noted a "questionable appearance of the ninth rib on the right." Dr. Gattas took Petitioner off work on January 13, 2012 and prescribed therapy. Petitioner underwent an initial therapy evaluation at Marque Medicos on January 19, 2012. Petitioner attended several therapy sessions thereafter. Dr. Gattas released Petitioner to restricted duty on January 19, 2012. On February 3, 2012, Dr. Gattas released Petitioner to full duty as of the following day. PX 21.

As of the hearing, Petitioner was still working for Respondent. T. 38. He continues to experience shoulder pain. His left clavicle bone "jumps up." He does not experience this

problem with his right clavicle. T. 39. He does not sleep the way he did before the accident. He is unable to lift his two granddaughters. His "bones snap a lot." T. 40.

Under cross-examination, Petitioner had no recollection of undergoing treatment at Ambulatory Surgical Care Facility. Aside from MacNeal and Excel, he only underwent treatment at Marque Medicos. T. 44. It was after shoulder surgery was recommended that he saw Dr. Bush-Joseph at the request of the insurance company. T. 44. After he underwent the shoulder surgeries, Dr. Bush-Joseph re-examined him. T. 48. He discussed his surgical outcome with Dr. Bush-Joseph. The doctor told him the outcome was "the best [the doctors] could have done." T. 49-50. After he returned to work, following a course of work conditioning, Respondent rotated him to a different job that involved machine set-up rather than machine operation. The set-up job was not as difficult. He still continued to operate machines, however. T. 52.

On redirect, Petitioner reiterated that Dr. James of Marque Medicos referred him to Dr. Engel. Dr. Engel works for Medicos Pain & Surgical Specialists. T. 54. Dr. Engel referred him to Dr. Nam, who performed the shoulder surgeries. Dr. Nam performed one of these surgeries at a facility in Aurora called Ambulatory Surgical Care. T. 56.

Petitioner called Shahnaz Ali. Ali testified she is director of revenue generation at Premier Billing Solutions. Premier performs coding, billing and collections for Marque Medicos, Ambulatory Surgical Center and Medicos Pain & Surgical Specialists. T. 58-59.

Ali testified she has a bachelor's degree in telecommunications management. She obtained certification in coding through the American Academy of Professional Coders. She has attended courses and webinars concerning coding and billing. T. 59.

Ali testified she is familiar with the fee schedule that pertains to Illinois workers' compensation claims. She routinely prepares fee schedule certifications in the course of her employment by Premier. A fee schedule certification is a "customized document" that informs a carrier and/or attorney of the type of procedure or service performed, the applicable CPT code, the fee schedule amount due for that code, applicable payments and/or adjustments, and any remaining "UCR" or fee schedule balance. A "UCR" balance is the "usual, customary and reasonable" charge." T. 60. It is different from the fee schedule charge. T. 60-61.

Ali testified she prepares a fee schedule certification by using a customized software program. This program pulls in fee schedule charges from the Commission's website and matches those charges against the coded services. A payable charge is determined by the year and the applicable "Geo zip."

Ali testified she prepared and signed PX 7, Petitioner's fee schedule and "UCR" bill from Marque Medicos for services rendered in connection with his shoulder injuries. The "UCR" charges, before payment, totaled $91,095.00. The "UCR" balance is $919.67 and the fee schedule balance is $559.05. T. 64.

Ali testified she prepared and signed PX 8, Petitioner's fee schedule and "UCR" bill from Medicos Pain & Surgical Specialists. The "UCR" charges totaled $83,754.60 and the fee schedule balance, calculated after payments were made, totals $29.856.58. Ali testified she obtained the codes in PX 8 from the doctors who treated Petitioner. T. 65-66.

Ali testified she prepared and signed PX 10, Petitioner's fee schedule and "UCR" bill from Ambulatory Surgical Care Facility. The "UCR" charges totaled $90,905.11 and the fee schedule balance, calculated after payments were made, totals $38,554.20.

Ali testified her job at Premier also involves overseeing surgical authorization. In order to obtain authorization for a proposed surgery, a physician typically submits a surgery scheduling form to Premier. Premier then submits all the documentation supporting the physician's request to the carrier, along with a pre-authorization form to be completed by the adjuster. T. 67-68. Ali identified PX 16 and 17 as the forms she faxed to the adjuster while seeking pre-authorization of Petitioner's two shoulder surgeries. She received both forms back from the adjuster. T. 68-69.

Under cross-examination, Ali testified she did not receive a subpoena in connection with her testimony. She appeared at the request of Petitioner's attorney. During the year before the hearing, she testified at the Commission four or five times. T. 71-72. She is the top employee in her department at Premier. She has worked for Premier since March of 2010. T. 72. She has worked in the field of billing and coding since 2005. T. 73. In her capacity as director of revenue generation at Premier, she does not report to the Illinois Department of Public Health. T. 74. Once a surgery has taken place, she uses the operative report to determine the applicable CPT [current procedural terminology] codes for billing purposes. T. 74. Premier is a subsidiary of Marque Medicos. Other entities in the Marque Medicos network include Ambulatory Surgical Care and Medicos Pain & Surgical Specialists. T. 76. These entitles perform services at multiple locations but it would not be possible for "double billing" to occur because "each specific charge, depending on [the location where treatment is rendered] is billed in its own separate section of the software." T. 77. PX 8 reflects a facility fee schedule charge of $57,789.34. PX 10 reflects a facility fee schedule charge of $69,012.17 for the surgery that took place at Ambulatory Surgical Care Facility. T. 79. The two charges do not represent "double billing" because they are charges for surgeries performed at two different facilities. T. 79. Some of the facilities in the Marque Medicos network are in close proximity to one another. T. 82. The difference between a "UCR" charge and the ultimate fee schedule charge is written off as a fee schedule adjustment. T. 84. Respondent provided payment for Petitioner's shoulder surgeries. T. 85.

On redirect, Ali clarified that the charges set forth in PX 8 stem from services provided on September 16, 2010 while the charges in PX 10 stem from services provided on February 1, 2011. T. 86.

Under re-cross, Ali testified that it is not possible to assign multiple CPT codes to one service because coding is based strictly on the operative reports that the surgeons provide. T. 87.

In response to questions posed by the Arbitrator, Ali testified that "facility fees" include the surgical procedure itself plus any supplies or implants used during that procedure. Coding is based on the procedures designated in the operative report. Only the surgeon describes those procedures. T. 88-89.

In addition to the exhibits previously summarized, Petitioner offered into evidence itemized bills and fee schedule summaries from Marque Medicos Kedzie (Dr. James, Dr. Gattas and Norman Lambot, P.T.) [PX 7], Medicos Pain & Surgical Specialists (Dr. Engel, Dr. Ravinderpal, facility fees and transportation expenses) [PX 8], Metro Anesthesia Consultants (anesthesia administered on February 1, 2011) [PX 9], Ambulatory Surgical Care Facility, LLC (surgery performed on February 1, 2011) [PX 10}, Gray Medical (various charges in February and March of 2011) [PX 11], Chicago Orthopedics & Sports Medicine (Dr. Nam, 6/14/10 through 8/1/11) [PX 12], Excel Occupational Health Clinic (alcohol and drug screening performed 1/11/12) [PX 22], Marque Medicos Kedzie (Dr. Gattas, Norman Lambot, P.T. and record copy charges) [PX 23], Specialized Radiology Consultants (rib X-rays, 1/19/12) [PX 24]. Respondent objected to these exhibits solely on the basis of liability. T. 94, 96.

Petitioner also offered into evidence various documents relating to his claim for penalties and fees. These documents include an Amended Petition for Penalties and Fees filed on December 4, 2012, about three weeks prior to the hearing. In this pleading, Petitioner alleged, inter alia, that Respondent pre-authorized yet failed to pay for his two shoulder surgeries. PX 13. The documents also include letters sent to Petitioner's counsel to Respondent's counsel on November 16, 2011, May 17, 2012 and December 3, 2012. Petitioner's counsel transmitted outstanding bills totaling $175,681.50 with the first letter (PX 14), outstanding bills totaling $115,517.80 with the second letter (PX 15) and outstanding bills totaling $74,894.77 [the amount claimed at trial in 10 WC 21488] and records with the third letter (PX 18). The Arbitrator granted Respondent leave to respond to Petitioner's claim for penalties and fees in its proposed decision.

Respondent did not call any witnesses. In addition to Dr. Bush-Joseph's reports and addendum (RX 1-3), previously discussed, Respondent offered into evidence a print-out of medical payments it made prior to trial. Those payments including several medical case management charges. T. 114-115. RX 4. The Arbitrator admitted RX 4 into evidence over Petitioner's objection as to the inclusion of the case management charges, with the understanding that the attorneys would address this issue in their proposed decisions. T. 114-115. In its proposed decision, Respondent asserted that it paid a total of $182,092.72 in treatment-related expenses prior to trial.

14IWCC0695

Arbitrator's Credibility Assessment

Petitioner testified in a forthright manner. The Arbitrator found him credible.

Is Petitioner entitled to reasonable and necessary medical expenses in 12 WC 2372?

Petitioner claims outstanding medical expenses totaling $184.47 in his second case, 12 WC 2372. That total includes $43.00 in charges stemming from alcohol and drug testing performed at Excel Occupational Health Clinic on January 11, 2012 (the date of Petitioner's second accident) (PX 22), $92.10 in charges stemming from treatment provided by Marque Medicos, Petitioner's selected provider (PX 23), and $49.37 in charges stemming from rib X-rays performed by Specialized Radiology on January 13, 2012 (PX 24). Respondent's payment print-out (RX 4) does not reflect any payments toward these charges. Respondent objected to PX 22, 23 and 24 only on the basis of liability. T. 96.

The Arbitrator awards Petitioner the outstanding medical expenses totaling $184.47, subject to the fee schedule. Petitioner initially sought treatment at Excel, a facility of Respondent's selection. Excel conducted alcohol and drug testing on the day Petitioner was injured. Physicians at Excel diagnosed rib contusions, dispensed Ibuprofen and instructed Petitioner to apply ice to his chest. There is no indication that the doctors at Excel ordered chest or rib X-rays. PX 20. Petitioner then decided to return to Marque Medicos, where he had earlier undergone treatment for his shoulder injuries. In the Arbitrator's view, it was eminently reasonable for Dr. Gattas of Marque Medicos to order bilateral rib X-rays on January 13, 2012, given the mechanism of injury Petitioner described. PX 21. Petitioner met his burden of proving the reasonableness and necessity of the treatment rendered by Marque Medicos and Specialized Radiology.

Is Petitioner entitled to permanency in 12 WC 2372?

The Arbitrator declines to award permanent partial disability in 12 WC 2372. The records from Marque Medicos reflect that the undisputed accident of January 11, 2012 resulted in chest and rib contusions which resolved by February 4, 2012, when Dr. Gattas released Petitioner to full duty. PX 21. Petitioner did not testify to any ongoing complaints specific to his chest or ribs. There is no basis for awarding permanency in this case.

Is Respondent liable for penalties and fees in 12 WC 2372?

Petitioner seeks Section 19(k) penalties and fees, along with the maximum Section 19(l) penalty of $10,000.00, on the aforementioned unpaid medical expenses of $184.47.

The Arbitrator declines to award penalties and fees in this case. The unpaid charges at issue are nominal.

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

JAVIER MENDOZA,

Petitioner,

vs. NO: 10 WC 21488

CHICAGO AMERICAN MANUFACTURING, LLC., **14IWCC0696**

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, penalties and 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 vacates the Arbitrator's award of penalties and attorney fees pursuant to §§ 19(k), 19(l) and 16 of the Act, which were awarded by the Arbitrator in reference to case number 10 WC 21488. No penalties and fees were awarded by the Arbitrator in case number 12 WC 2372.

With regard to 19(k) penalties and 16 attorney fees, the Arbitrator declined to award same on any unpaid benefits other than a $4,780.52 medical bill from Gray Medical. It should be noted that said bill was entered into evidence as Petitioner's Exhibit 11. While a witness testified with regard to the medical bills in this case relative to Premier Billing Solutions, no such testimony was presented with regard to the bills of Gray Medical. As a result, there was no specific testimony as to the medical charges and available reductions pursuant to the medical fee schedule as contained in Section 8.2 of the Act.

In reviewing the bills themselves in Petitioner's Exhibit 11, the Commission notes that

the only evidence presented was in the form of an invoice, as opposed to HCFAs. As such, while there are medical codes noted on the bills, there is no description of the charges whatsoever. The Petitioner testified that Dr. Nam prescribed an "icing machine" for his shoulders. The Commission was unable to locate such a prescription in the records of Dr. Nam that were admitted into evidence.

A review of Respondent's Exhibit 4, which is a printout of the medical expenses paid by Respondent related to this claim, indicates total payments to Gray Medical of $10,120.71 between April and July of 2011. The invoice of Gray Medical only acknowledges $9,170.71 in payments. Thus, there is a discrepancy as to the amount that was actually paid.

The Arbitrator indicates that the Gray Medical bills were the only awarded charges that remained wholly unpaid as of the hearing. Both Petitioner's Exhibit 11 and Respondent's Exhibit 4 make clear that these charges were not wholly unpaid, but rather that significant payments had been made by Respondent. Given the lack of proof that the devices that Gray Medical charged for were actually prescribed, as well as the discrepancy in what was paid by Respondent, the Commission finds that the Respondent did not act unreasonably or vexatiously in any amounts Gray Medical asserts are unpaid. As such, penalties and attorney fees do not lie, and the award of same by the Arbitrator is vacated.

The Arbitrator's award of §19(l) penalties, based on delay of payment, notes that Petitioner requested payment of numerous bills well prior to the time of trial, including the bill of Gray Medical. As the Commission finds that the Respondent had a reasonable dispute with regard to the unpaid bills in this case, any delay in payment was with good and just cause pursuant to §19(l). As such, the award of 19(l) penalties is also vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award of penalties and attorney fees pursuant to §§19(k), 19(l) and 16 of the Act are hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $309.33 per week for a period of 112.5 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the loss of 10% of the person as a whole with regard to the left shoulder and 12.5% of the person as a whole with regard to the right shoulder.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $73,501.50 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.

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.

14IWCC0696

DATED:
TJT: pvc
o 7/24/14
51

AUG 2 0 2014

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MENDOZA, JAVIER
Employee/Petitioner

Case# **10WC021488**

12WC002372

CHICAGO AMERICAN MANUFACTURING LLC
Employer/Respondent

14IWCC0696

On 2/7/2013, 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 0.11% 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:

1922 SALK & ASSOCIATES
ALEXANDER BRODERICK
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

0532 HOLECEK & ASSOCIATES
FRED NORMAN
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

14IWCC0696

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

JAVIER MENDOZA
Employee/Petitioner

v.

CHICAGO AMERICAN MANUFACTURING, LLC
Employer/Respondent

Case # **10** WC **21488**

Consolidated cases: **12 WC 02372**

An *Application for Adjustment 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 **12/27/2012**. 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 **5/21/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$19,032.00**; the average weekly wage was **$366.00**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **2** dependent children.

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $73,501.50, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits at the applicable minimum permanency rate of $309.33 per week for 112.5 weeks, because the injuries sustained caused 10% loss of the person as a whole in regards to the left shoulder (50 weeks) and 12.5% loss of the person as a whole in regards to the right shoulder (62.5 weeks), as provided in Section 8(d)2 of the Act. Will County Forest Preserve District v. IWCC, 2012 Ill.App. LEXIS 109 (3rd Dist. 2012).

Respondent shall pay to Petitioner Section 19(k) penalties in the amount of $2,390.26, Section 16 attorney fees in the amount of $956.10 and Section 19(l) penalties in the statutory maximum amount of $10,000.00.

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

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

2/7/13
Date

FEB - 7 2013

Javier Mendoza v. Chicago American Manufacturing
10 WC 21488 and 12 WC 2372

14IWCC0696

Arbitrator's Findings of Fact Relative to Both Cases

The parties agree that Petitioner was injured while working for Respondent on May 21, 2010 (10 WC 21488) and January 9, 2012 (12 WC 2372). The disputed issues in both cases are medical, permanency and penalties/fees. Arb Exh 1, 3. In the first case, Petitioner claims unpaid fee schedule charges totaling $74,894.77. In the second case, he claims unpaid fee schedule charges totaling $184.47. Arb Exh 3. In the first case, Respondent does not dispute the reasonableness or necessity of Petitioner's shoulder surgeries but takes issue with some of the charges. In both cases, Respondent takes issue with the method by which Petitioner's providers arrived at the claimed fee schedule amounts. T. 6.

Petitioner testified through a Spanish-speaking interpreter. He was born on April 12, 1966. He grew up in Mexico. He stopped attending school after the first year of high school. T. 15-16.

Petitioner testified he began working for Respondent on January 11, 2009. His job title was machine operator but he performed a variety of tasks, such as packing and assembly. He routinely lifted items weighing between 30 and 60 pounds. T. 17.

Petitioner testified his health was fine prior to May 21, 2010. He denied injuring either shoulder prior to that date. T. 17-18. On that date, he fell from a height of about four feet while using a control to operate an overhead crane. He fell to his left side, striking his arms and the bridge of his nose in the process. He extended his right arm as he fell so as to release the control, which was in his right hand. T. 20. Afterward, his supervisor took him to the Emergency Room at MacNeal Hospital. It was early in the morning on May 22, 2010 when they arrived at the hospital. T. 21.

Petitioner testified he complained to hospital personnel of pain in his nose and both shoulders. The Emergency Room records set forth a consistent account of Petitioner's fall. The records reflect complaints relative to the nose, left shoulder and left leg. The Emergency Room physician repaired a 1 centimeter nose laceration. On left shoulder examination, she noted a limited range of motion. Left shoulder X-rays revealed degenerative changes. The physician prescribed ointment and Motrin and released Petitioner from care, with instructions to avoid using his left arm at work "until cleared by follow-up physician." PX 1.

Petitioner testified he presented the work restriction to Juan Arias and Arturo Sosa at Respondent and was not accommodated. T. 23-24.

On May 24, 2010, Petitioner saw Dr. Laluya, an osteopath, at Excel Occupational Health Clinic. Petitioner testified that Arturo Sosa of Respondent referred him to this clinic. T. 24. Dr. Laluya wrote to Juan Arias of Respondent the same day. His letter sets forth a detailed account

of Petitioner's work accident. He noted complaints of nose pain and "left greater than right shoulder pain." He indicated that Petitioner denied any previous shoulder injuries.

On examination of Petitioner's nose, Dr. Laluya noted a small laceration with three intact sutures. On examination of Petitioner's left shoulder, he noted ecchymosis over the triceps, somewhat diffuse pain over the deltoid, triceps and anterior shoulder, no obvious instability and a significantly limited active range of motion. On examination of the right shoulder, he noted no ecchymosis or swelling and active abduction and forward flexion to 45 degrees. He indicated Petitioner was able to keep his right arm overhead, once the arm was positioned there. X-rays of the nasal bone and right shoulder showed no obvious fractures.

Dr. Laluya applied a sling to Petitioner's left arm. He instructed Petitioner to ice both shoulders. He placed Petitioner on restricted duty.

Petitioner also went to Marque Medicos on May 24, 2010. He testified he sought care at this facility because he wanted a second opinion. T. 25. He saw Dr. James, a chiropractor, and provided her with a history of his May 21, 2010 work accident and subsequent treatment. He complained of bilateral shoulder pain, left worse than right, and some low back discomfort. He described his nose pain as very mild. He denied any previous accidents and surgeries. He indicated he was taking Motrin for pain, as previously prescribed.

On examination, Dr. James noted several stitches on the bridge of Petitioner's nose, bruising on the left posterior arm, limited active flexion in the lumbar spine and markedly decreased motion of both shoulders. Supraspinatus testing was "greater on the left than the right."

Dr. James prescribed bilateral shoulder MRIs to rule out rotator cuff tears. She recommended orthopedic and pain management consultations. She also recommended therapy three times weekly for four weeks, with the therapy to include "lumbar spine manipulation. She took Petitioner off work and noted he would require pain medication once the Motrin prescription expired.

On May 27, 2010, Petitioner underwent an initial therapy evaluation at Marque Medicos. Homer Saclayan, P.T., the evaluating therapist, noted complaints relative to both shoulders and the lower back. Petitioner described his low back pain as very minimal. Saclayan noted that Petitioner had his left arm in a sling. He also noted a healing hematoma in the left posterior arm. He indicated Petitioner was unable to perform the "empty can sign" on the left due to extreme pain.

Petitioner underwent the recommended bilateral shoulder MRI scans at Archer Open MRI on June 2, 2010. T. 25. The left shoulder MRI revealed an effusion and a "complete tear of the infraspinatus tendon with near complete tearing of the supraspinatus tendon." The radiologist described both tendons as "retracted to at or near the level of the glenohumeral articulation." He could not rule out an underlying SLAP tear. The right shoulder MRI revealed

"extensive, near complete tears of the infraspinatus and supraspinatus tendons" and an effusion with "fluid extending into the subacromial/subdeltoid bursa." PX 3B.

Petitioner returned to Excel on May 26, 2010 and indicated he was still using the sling and having difficulty lifting both arms. He also indicated that no light duty was available. The examining physician, whose signature is not legible, noted "extensive ecchymoses" on the left shoulder. Speed, Neer/Hawkins and O'Brien testing was positive on examination of the left shoulder. Neer/Hawkins and O'Brien testing was positive on examination of the right shoulder. The physician diagnosed a healing nasal laceration and bilateral shoulder contusions. He suspected rotator cuff injuries. He took Petitioner off work and instructed him to continue to wear the sling and apply ice. He indicated that Petitioner might require MRI scanning and therapy. PX 2.

Petitioner went back to Excel on June 1, 2010 and indicated that ice was not helping. He reported being able to lift his left arm due to pain. He described having a "little more movement" in his right arm. The examining physician, whose signature is not legible, noted ecchymosis to the left triceps area as well as a hematoma on palpation. Neer testing was positive on the left and negative on the right. The physician continued to keep Petitioner off work. He directed Petitioner to continue wearing the sling and applying ice. He prescribed therapy and indicated Petitioner might require a left shoulder arthrogram if therapy did not help. PX 2.

On June 8, 2010, Dr. Laluya sent Petitioner a letter informing he was being discharged from care by Excel since he had opted to see doctors of his own choice. PX 2.

On June 10, 2010, Petitioner saw Dr. Engel of Medicos Pain & Surgical Specialists. Petitioner testified that Dr. James referred him to Dr. Engel. T. 26. The doctor's history reflects that Petitioner fell about four feet from a tow truck while holding onto a control, extending his right arm as he fell and landing on his left side and shoulder. Petitioner complained of bilateral arm pain, rated 6/10, and left-sided back pain, rated 1/10.

On examination, Dr. Engel noted a decreased range of motion in both shoulders, 5/5-upper body strength secondary to pain and a full range of lumbar spine motion.

Dr. Engel prescribed Mobic, Omeprazole and Soma. He instructed Petitioner to continue therapy and remain off work until he could see Dr. Nam, an orthopedic surgeon. He offered Petitioner "roundtrip ground, non-emergency and non-ambulance based transportation" to facilitate treatment. PX

Petitioner first saw Dr. Nam on June 14, 2010. Petitioner testified that Drs. James and Engel referred him to Dr. Nam. T. 26. Petitioner provided Dr. Nam with a history of his work accident and denied any pre-accident shoulder problems.

On examination of Petitioner's shoulders, Dr. Nam noted an extremely painful range of motion, positive impingement, drop arm and O'Brien signs and rotator cuff strength testing of 4-/5 with pain.

Dr. Nam interpreted the MRIs as showing very large retractive rotator cuff tears in both shoulders. He also noted the presence of fluid, "suggesting acute injury," and evidence of a labral tear in the left shoulder. Based on Petitioner's history and examination, along with the MRIs, he found a causal relationship between the work accident and the bilateral rotator cuff tears. He found it "reasonable and necessary" to proceed with surgery but also discussed non-operative measures. He noted that Petitioner opted for surgery and expressed a desire to have his left shoulder addressed first. He instructed Petitioner to remain off work.

Petitioner returned to Dr. Nam on July 26 and August 30, 2010. The doctor's examination findings were unchanged. He indicated he was awaiting surgical authorization.

At Respondent's request, Petitioner saw Dr. Bush-Joseph for a Section 12 examination on August 17, 2010. Petitioner testified he provided Dr. Bush-Joseph with various treatment records and gave the doctor a history of his work accident. T. 45. Petitioner was aware that Dr. Bush-Joseph agreed as to the need for bilateral shoulder surgery. T. 46.

Dr. Bush-Joseph issued a Section 12 examination report to Travelers Insurance on August 17, 2010. RX 1. The report reflects that Dr. Bush-Joseph is a professor in the department of orthopedic surgery at Rush University Medical Center.

Dr. Bush-Joseph noted that Petitioner is right-handed. He also noted that Petitioner's nephew served as an interpreter throughout the examination.

Dr. Bush-Joseph's report sets forth a detailed account of the work accident of May 21, 2010 and subsequent treatment. The doctor noted that Petitioner denied having any problem with either of his shoulders prior to that accident.

On examination of Petitioner's left shoulder, Dr. Bush-Joseph noted active forward elevation of "only 95 degrees," active abduction of 45 degrees, marked weakness with both of these maneuvers and tenderness over the glenohumeral joint and over the greater tuberosity region. On examination of the right shoulder, Dr. Bush-Joseph noted forward elevation of 170 degrees, abduction of 150 degrees and abduction/external rotation of 90 degrees.

Dr. Bush-Joseph reviewed the MRI scans and diagnosed "bilateral acute rotator cuff tears." He found "no evidence of a pre-existing medical condition that would explain the severe weakness or profound physical examination findings." He indicated that the treatment records "seem to support and, indeed, [are] consistent with a history of the accident and subsequent injury." He attributed the rotator cuff tears to the work accident and stated that right shoulder surgery was "clearly indicated" due to the accident. He further stated that left shoulder surgery was "appropriate and indicated" and "should be performed on an immediate

basis to provide a greater chance of eventual full recovery." He projected that recovery from left-sided surgery would take five to seven months due to the severity of the left shoulder injury. He projected that recovery from right-sided surgery would take three to five months.

Dr. Bush-Joseph opined that the chiropractic care rendered to date had been "ineffective" and was "unlikely to provide any future benefit."

Dr. Bush-Joseph found Petitioner capable of only sedentary desk duty. He reiterated that further treatment should not be delayed.

Dr. Bush-Joseph indicated that Petitioner had a "50% probability" of needing permanent lifting restrictions of below shoulder use of the left arm. He also indicated that a lifting restriction of 45-50 pounds was "possible."

Dr. Bush-Joseph described Petitioner's prognosis with respect to his right shoulder as "good to excellent." With respect to the left shoulder, however, he indicated that the prognosis was "somewhat guarded." RX 1.

On August 31, 2010, A. Kohn signed a Medicos Pain & Surgical Specialists form authorizing the prescribed left shoulder surgery. PX 5.

On September 16, 2010, Petitioner underwent surgery consisting of a left shoulder arthroscopic rotator cuff repair, subacromial decompression, labral debridement and synovectomy. PX 3-4.

Petitioner returned to Dr. Nam on September 27, 2010. The doctor noted no signs of infection. He instructed Petitioner to remain off work and begin passive range of motion therapy.

Petitioner saw Dr. James again on October 15, 2010 and reported some improvement in his left shoulder. He was still experiencing right shoulder pain. Dr. James recommended that Petitioner advance his home exercises and follow up with Dr. Nam.

Petitioner saw Dr. Engel again on November 4 and December 2, 2010 and complained of bilateral shoulder pain. The doctor refilled Petitioner's Mobic, Omeprazole, Soma and Ultram. He again offered Petitioner transportation services and instructed him to follow up with Dr. Nam.

At his next two visits to Dr. Nam, on November 22 and December 20, 2010, Petitioner reported some improvement secondary to therapy. Dr. Nam prescribed additional therapy, to be performed three times weekly. He continued to keep Petitioner off work.

On November 23, 2010, Dr. James noted that Petitioner's pain level was the same but that he had a greater range of left shoulder motion. She recommended that Petitioner follow up with Dr. Nam.

At a December 30, 2010 re-evaluation, therapist Norman Lambot, P.T. (hereafter "Lambot") noted that Petitioner was still complaining of 5/10 pain in both shoulders but that he had made "great gains" with respect to range of motion.

On January 24, 2011, Petitioner told Dr. Nam his left shoulder was improving but he was still experiencing pain in his right shoulder. On right shoulder examination, Dr. Nam noted some pain along the acromioclavicular joint, some pain with cross-chest adduction, a positive impingement sign and 4/5 rotator cuff strength with pain. Dr. Nam recommended right shoulder surgery and instructed Petitioner to continue therapy and remain off work.

On January 25, 2011, A. Kohn, R.N. signed an Ambulatory Surgical Care Facility form authorizing the prescribed right shoulder surgery. PX 5.

On February 1, 2011, Dr. Nam performed a right shoulder arthroscopic repair of a "massive" and retracted rotator cuff tear, a subacromial decompression, extensive debridement of labral and proximal biceps tendon tears, a "mini-Mumford," or distal clavicle co-planing, and a synovectomy. PX 3-4.

Petitioner returned to Lambot on February 10, 2011 and complained of 2-3/10 left shoulder pain and 6-7/10 right shoulder pain. Lambot did not perform any right shoulder testing due to the recent surgery.

On March 7, 2011, Dr. Nam described Petitioner's left shoulder as "doing fine" and the right shoulder as "improving." On left shoulder examination, he noted an essentially full range of motion. On right shoulder examination, he noted some limitation in forward flexion, abduction and rotation and strength of 5-/5. He kept Petitioner off work and prescribed additional therapy.

Petitioner continued undergoing therapy thereafter. On March 31, 2011, Dr. Engel noted improvement and discontinued the Ultram. He refilled the Mobic, Omeprazole and Soma. On April 18, 2011, Dr. Nam prescribed additional therapy only for the right shoulder and released Petitioner to desk work with no use of the right arm and lifting restrictions relative to the left arm.

Petitioner testified he presented Dr. Nam's restrictions to Respondent but was not accommodated. T. 32-33.

At Respondent's request, Petitioner saw Dr. Bush-Joseph for purposes of a Section 12 re-examination on June 7, 2011. T. 48-49. Petitioner testified that Dr. Bush-Joseph obtained shoulder X-rays on this date. T. 49. Petitioner also testified that Dr. Bush-Joseph did not tell

him he no longer needed formal therapy. T. 50. According to Petitioner, Dr. Bush-Joseph expressed no criticism of the care he was receiving. T. 51.

Dr. Bush-Joseph addressed his June 7, 2011 re-examination report to Kim Ahern, R.N. of Medical Consultant Network. The doctor noted that Petitioner had undergone bilateral shoulder surgery by Dr. Nam since his original examination. He also noted that Petitioner reported good improvement with respect to his left shoulder but had "residual symptoms on the right side."

On re-examination of Petitioner's left shoulder, Dr. Bush-Joseph noted forward elevation to 175 degrees, abduction to 165 degrees and external rotation to 90 degrees. He also noted mild subacromial crepitation but normal strength. On re-examination of Petitioner's right shoulder, Dr. Bush-Joseph noted "mild residual atrophy," "significant residual subacromial clicking," forward elevation to 170 degrees, abduction to 140 degrees and external rotation to 85 degrees. He also noted 5-/5 strength to forward elevation and abduction and "diminished biceps tone on the right side."

Dr. Bush-Joseph obtained bilateral shoulder X-rays. He indicated that the "glenohumeral contours, or Shenton's line, on the left shoulder has been properly re-established and shows significant improvement from the presurgical radiographs." He saw "no evidence of arthritic wear of the glenohumeral joints."

Dr. Bush-Joseph indicated that Petitioner obtained a "good result" from his left rotator cuff repair. He saw no need for further left shoulder treatment, despite Petitioner's "mild residual functional weakness." He found no need for restrictions relative to the left arm. He indicated it was "safe to continue with a home exercise program alone."

Dr. Bush-Joseph described Petitioner's more recent right shoulder surgery as a "massive arthroscopic repair of a massive rotator cuff tear with distal clavicle excision." He indicated there was "indeed a need for two more months of formal physical therapy to achieve functional strength and use of the right arm and shoulder, specifically for overhead labor and reaching." He found Petitioner capable of restricted duty, with no lifting over 50 pounds below waist level and no lifting over 25 pounds from waist to chest level with the right arm and shoulder. He anticipated that Petitioner would be able to resume full duty with respect to his right arm on August 1, 2011.

Dr. Bush-Joseph further commented:

> "I do believe that a work conditioning or work hardening program is indicated at this time given the fact that he has a near normal active and passive range of motion. I see no benefit from further pain center medical management. The patient is clearly in an orthopedic recovery condition and his care should indeed be supervised by his treating orthopedic

> surgeon. Despite the severity of his initial injury, the patient has shown significant functional improvement and can be expected to achieve a full–duty recovery of both the right and left arms."

RX 2.

On June 17, 2011, Dr. Bush-Joseph issued an addendum in response to an inquiry from Kim Ahern, R.N. as to his specific opinion concerning further right shoulder treatment. Dr. Bush-Joseph responded as follows: "I believe that eight more weeks of formal physical therapy, three times per week, is indicated to achieve a functional level of strength and mobility and endurance of the right shoulder." RX 3.

Petitioner returned to Dr. Nam on June 27, 2011 and reported occasional painful cracking in both shoulders. On bilateral shoulder examination, the doctor noted forward flexion of 155, external rotation of 40 and internal rotation to T9. Impingement testing was negative bilaterally. The doctor prescribed work conditioning and again released Petitioner to desk work with no overhead lifting and no lifting over five pounds.

On June 29, 2011, Dr. Engel provided Petitioner with a two-month supply of Mobic and Soma, noting that Petitioner was not scheduled to begin work conditioning for eight days.

On July 8, 2011, Petitioner underwent a work conditioning evaluation at Elite Physical Therapy. T. 51. Petitioner provided a history of his work accident and surgeries to the evaluator, Jeff Goode, PT, and indicated he had not returned to work since the accident. Goode described Petitioner's bilateral shoulder range of motion as within normal limits. He noted some strength deficits. He characterized Petitioner as an excellent candidate for work conditioning. PX 6. On July 22, 2011, Luis Maldonado, P.T. noted that Petitioner had made "great progress" in the work conditioning program and exhibited increased tolerance for above-shoulder reaching, lifting and pushing/pulling. While Petitioner was still exhibiting some "functional and stability deficits with shoulder/overhead lifting" as of July 29, 2011, Maldonado indicated Petitioner "has met all of his return to work goals."

On August 1, 2011, Petitioner returned to Dr. Nam and complained of some occasional "cracking" in his shoulders. Dr. Nam discontinued the work conditioning, released Petitioner to full duty on a trial basis and instructed Petitioner to return in one month. He indicated he would consider a functional capacity evaluation if Petitioner experienced difficulty with resuming his regular duties.

Dr. Nam addressed Dr. Bush-Joseph's opinions as follows: "In general, I do agree with Dr. Bush-Joseph's findings. However, I am not 100% positive that [Petitioner] will be able to return to work without problems, which is why we are going to do a trial return to work full duty." PX 3B.

Petitioner testified he resumed working as a machine operator for Respondent.

Petitioner saw Dr. Engel for the last time on August 25, 2011. Dr. Engel noted that Petitioner had resumed working and that work caused Petitioner "a little bit of left shoulder pain." On examination, Dr. Engel noted a full range of motion in both shoulders. He discharged Petitioner from care, noting that Petitioner no longer required prescription medication.

On August 29, 2011, Dr. Nam released Petitioner to full duty and discharged him from care. PX 4-5. T. 34.

Petitioner testified that the prescribed therapy helped him and that he noticed improvement after his shoulder surgeries. T. 34. After each surgery, he used an "icing machine" prescribed by Dr. Nam. Using this machine relieved his shoulder pain. T. 34-35.

The parties agree that Petitioner sustained a second work accident on January 9, 2012. Petitioner testified that a machine struck his chest and ribs that day. He reported the accident to Victor, his boss, and sought care at Excel Occupational Health Clinic on January 11, 2012. T. 36.

Records from Excel (PX 20) reflect that Petitioner saw Dr. Strong on January 11, 2012. The doctor noted that Petitioner had been struck by a moving machine part two days earlier. Petitioner complained of pain in his rib area. On examination, Dr. Strong noted some ecchymosis on the anterior chest, tenderness over the posterior 10^{th}, 11^{th} and 12^{th} ribs and no difficulty breathing. Dr. Strong diagnosed contusions. He released Petitioner to full duty and recommended that Petitioner apply ice to the affected areas and return in two days. PX 20.

Petitioner returned to Excel on January 13, 2012 and reported no improvement. Dr. Pillar imposed work restrictions and prescribed Ibuprofen. PX 20. Petitioner testified he presented the restrictions to "Edgar" at work but was not accommodated. T. 37.

Petitioner also went to Marque Medicos on January 13, 2012. He testified he returned to this facility because he found the earlier treatment helpful. T. 37. He saw Dr. Gattas, a chiropractor, and provided a history of his January 9, 2012 work accident. He also reported that he was working without difficulty prior to the accident. Dr. Gattas noted some chest ecchymosis and tenderness on examination. He obtained rib X-rays, which were negative on preliminary reading. In a subsequent report, Dr. Aikenhead, a chiropractic radiologist, noted a "questionable appearance of the ninth rib on the right." Dr. Gattas took Petitioner off work on January 13, 2012 and prescribed therapy. Petitioner underwent an initial therapy evaluation at Marque Medicos on January 19, 2012. Petitioner attended several therapy sessions thereafter. Dr. Gattas released Petitioner to restricted duty on January 19, 2012. On February 3, 2012, Dr. Gattas released Petitioner to full duty as of the following day. PX 21.

As of the hearing, Petitioner was still working for Respondent. T. 38. He continues to experience shoulder pain. His left clavicle bone "jumps up." He does not experience this

problem with his right clavicle. T. 39. He does not sleep the way he did before the accident. He is unable to lift his two granddaughters. His "bones snap a lot." T. 40.

Under cross-examination, Petitioner had no recollection of undergoing treatment at Ambulatory Surgical Care Facility. Aside from MacNeal and Excel, he only underwent treatment at Marque Medicos. T. 44. It was after shoulder surgery was recommended that he saw Dr. Bush-Joseph at the request of the insurance company. T. 44. After he underwent the shoulder surgeries, Dr. Bush-Joseph re-examined him. T. 48. He discussed his surgical outcome with Dr. Bush-Joseph. The doctor told him the outcome was "the best [the doctors] could have done." T. 49-50. After he returned to work, following a course of work conditioning, Respondent rotated him to a different job that involved machine set-up rather than machine operation. The set-up job was not as difficult. He still continued to operate machines, however. T. 52.

On redirect, Petitioner reiterated that Dr. James of Marque Medicos referred him to Dr. Engel. Dr. Engel works for Medicos Pain & Surgical Specialists. T. 54. Dr. Engel referred him to Dr. Nam, who performed the shoulder surgeries. Dr. Nam performed one of these surgeries at a facility in Aurora called Ambulatory Surgical Care. T. 56.

Petitioner called Shahnaz Ali. Ali testified she is director of revenue generation at Premier Billing Solutions. Premier performs coding, billing and collections for Marque Medicos, Ambulatory Surgical Center and Medicos Pain & Surgical Specialists. T. 58-59.

Ali testified she has a bachelor's degree in telecommunications management. She obtained certification in coding through the American Academy of Professional Coders. She has attended courses and webinars concerning coding and billing. T. 59.

Ali testified she is familiar with the fee schedule that pertains to Illinois workers' compensation claims. She routinely prepares fee schedule certifications in the course of her employment by Premier. A fee schedule certification is a "customized document" that informs a carrier and/or attorney of the type of procedure or service performed, the applicable CPT code, the fee schedule amount due for that code, applicable payments and/or adjustments, and any remaining "UCR" or fee schedule balance. A "UCR" balance is the "usual, customary and reasonable" charge." T. 60. It is different from the fee schedule charge. T. 60-61.

Ali testified she prepares a fee schedule certification by using a customized software program. This program pulls in fee schedule charges from the Commission's website and matches those charges against the coded services. A payable charge is determined by the year and the applicable "Geo zip."

Ali testified she prepared and signed PX 7, Petitioner's fee schedule and "UCR" bill from Marque Medicos for services rendered in connection with his shoulder injuries. The "UCR" charges, before payment, totaled $91,095.00. The "UCR" balance is $919.67 and the fee schedule balance is $559.05. T. 64.

Ali testified she prepared and signed PX 8, Petitioner's fee schedule and "UCR" bill from Medicos Pain & Surgical Specialists. The "UCR" charges totaled $83,754.60 and the fee schedule balance, calculated after payments were made, totals $29.856.58. Ali testified she obtained the codes in PX 8 from the doctors who treated Petitioner. T. 65-66.

Ali testified she prepared and signed PX 10, Petitioner's fee schedule and "UCR" bill from Ambulatory Surgical Care Facility. The "UCR" charges totaled $90,905.11 and the fee schedule balance, calculated after payments were made, totals $38,554.20.

Ali testified her job at Premier also involves overseeing surgical authorization. In order to obtain authorization for a proposed surgery, a physician typically submits a surgery scheduling form to Premier. Premier then submits all the documentation supporting the physician's request to the carrier, along with a pre-authorization form to be completed by the adjuster. T. 67-68. Ali identified PX 16 and 17 as the forms she faxed to the adjuster while seeking pre-authorization of Petitioner's two shoulder surgeries. She received both forms back from the adjuster. T. 68-69.

Under cross-examination, Ali testified she did not receive a subpoena in connection with her testimony. She appeared at the request of Petitioner's attorney. During the year before the hearing, she testified at the Commission four or five times. T. 71-72. She is the top employee in her department at Premier. She has worked for Premier since March of 2010. T. 72. She has worked in the field of billing and coding since 2005. T. 73. In her capacity as director of revenue generation at Premier, she does not report to the Illinois Department of Public Health. T. 74. Once a surgery has taken place, she uses the operative report to determine the applicable CPT [current procedural terminology] codes for billing purposes. T. 74. Premier is a subsidiary of Marque Medicos. Other entities in the Marque Medicos network include Ambulatory Surgical Care and Medicos Pain & Surgical Specialists. T. 76. These entitles perform services at multiple locations but it would not be possible for "double billing" to occur because "each specific charge, depending on [the location where treatment is rendered] is billed in its own separate section of the software." T. 77. PX 8 reflects a facility fee schedule charge of $57,789.34. PX 10 reflects a facility fee schedule charge of $69,012.17 for the surgery that took place at Ambulatory Surgical Care Facility. T. 79. The two charges do not represent "double billing" because they are charges for surgeries performed at two different facilities. T. 79. Some of the facilities in the Marque Medicos network are in close proximity to one another. T. 82. The difference between a "UCR" charge and the ultimate fee schedule charge is written off as a fee schedule adjustment. T. 84. Respondent provided payment for Petitioner's shoulder surgeries. T. 85.

On redirect, Ali clarified that the charges set forth in PX 8 stem from services provided on September 16, 2010 while the charges in PX 10 stem from services provided on February 1, 2011. T. 86.

Under re-cross, Ali testified that it is not possible to assign multiple CPT codes to one service because coding is based strictly on the operative reports that the surgeons provide. T. 87.

In response to questions posed by the Arbitrator, Ali testified that "facility fees" include the surgical procedure itself plus any supplies or implants used during that procedure. Coding is based on the procedures designated in the operative report. Only the surgeon describes those procedures. T. 88-89.

In addition to the exhibits previously summarized, Petitioner offered into evidence itemized bills and fee schedule summaries from Marque Medicos Kedzie (Dr. James, Dr. Gattas and Norman Lambot, P.T.) [PX 7], Medicos Pain & Surgical Specialists (Dr. Engel, Dr. Ravinderpal, facility fees and transportation expenses) [PX 8], Metro Anesthesia Consultants (anesthesia administered on February 1, 2011) [PX 9], Ambulatory Surgical Care Facility, LLC (surgery performed on February 1, 2011) [PX 10}, Gray Medical (various charges in February and March of 2011) [PX 11], Chicago Orthopedics & Sports Medicine (Dr. Nam, 6/14/10 through 8/1/11) [PX 12], Excel Occupational Health Clinic (alcohol and drug screening performed 1/11/12) [PX 22], Marque Medicos Kedzie (Dr. Gattas, Norman Lambot, P.T. and record copy charges) [PX 23], Specialized Radiology Consultants (rib X-rays, 1/19/12) [PX 24]. Respondent objected to these exhibits solely on the basis of liability. T. 94, 96.

Petitioner also offered into evidence various documents relating to his claim for penalties and fees. These documents include an Amended Petition for Penalties and Fees filed on December 4, 2012, about three weeks prior to the hearing. In this pleading, Petitioner alleged, inter alia, that Respondent pre-authorized yet failed to pay for his two shoulder surgeries. PX 13. The documents also include letters sent to Petitioner's counsel to Respondent's counsel on November 16, 2011, May 17, 2012 and December 3, 2012. Petitioner's counsel transmitted outstanding bills totaling $175,681.50 with the first letter (PX 14), outstanding bills totaling $115,517.80 with the second letter (PX 15) and outstanding bills totaling $74,894.77 [the amount claimed at trial in 10 WC 21488] and records with the third letter (PX 18). The Arbitrator granted Respondent leave to respond to Petitioner's claim for penalties and fees in its proposed decision.

Respondent did not call any witnesses. In addition to Dr. Bush-Joseph's reports and addendum (RX 1-3), previously discussed, Respondent offered into evidence a print-out of medical payments it made prior to trial. Those payments including several medical case management charges. T. 114-115. RX 4. The Arbitrator admitted RX 4 into evidence over Petitioner's objection as to the inclusion of the case management charges, with the understanding that the attorneys would address this issue in their proposed decisions. T. 114-115. In its proposed decision, Respondent asserted that it paid a total of $182,092.72 in treatment-related expenses prior to trial.

Javier Mendoza v. Chicago American Manufacturing, LLC
10 WC 21488 and 12 WC 2372 (consolidated)

Arbitrator's Credibility Assessment

Petitioner testified in a forthright manner. The Arbitrator found him credible.

Is Petitioner entitled to outstanding medical expenses in 10 WC 21488?

Petitioner claims a total of $74,894.77 in outstanding fee schedule charges in his first claim, 10 WC 21488. This total includes charges from six providers.

Petitioner claims $559.05 in outstanding fee schedule charges from Marque Medicos. According to PX 7, this amount includes $396.10 in physical therapy charges and $162.95 in chiropractic charges. A close examination of PX 7 reveals, however, that all of the outstanding charges stem from treatment rendered by Dr. James, a chiropractor. That treatment extended through June 24, 2011. None of the charges stem from the therapy provided by Homer Saclayan, P.T. or Norman Lambot, P.T. In his initial report, dated August 17, 2010, Respondent's Section 12 examiner, Dr. Bush-Joseph described the chiropractic care rendered to date as ineffective and "unlikely to provide any future benefit." RX 1. Dr. James offered no explanation as to why it was appropriate for a chiropractor to render or oversee care in this case, given that Petitioner had bilateral rotator cuff tears rather than spinal injuries. Dr. Nam, Petitioner's treating orthopedic surgeon, prescribed physical therapy and work conditioning, not chiropractic intervention.

In reliance on Dr. Bush-Joseph, the Arbitrator declines to award Petitioner the outstanding fee schedule charges of $559.05 from Marque Medicos.

Petitioner claims $29,856.58 in outstanding fee schedule charges from Medicos Pain & Surgical Specialists. Based on PX 8, this amount includes $148.88 for treatment provided by Dr. Engel on May 26, 2011 and $29,707.70 in facility fees stemming from the left shoulder surgery performed September 16, 2010. The Arbitrator declines to award Dr. Engel's charges. Dr. Engel provided pain management services to Petitioner during a period when Petitioner was seeing Dr. Nam for his bilateral rotator cuff tears. Dr. Nam never prescribed pain management. Dr. James prescribed it. It is completely unclear why Petitioner would require concurrent treatment from Drs. James, Engel and Nam. In the absence of reports or testimony explaining why Dr. Nam, a board certified orthopedic surgeon, could not have addressed Petitioner's need for pain medication, there is no evidentiary basis for an award of Dr. Engel's outstanding charges. The Arbitrator awards the facility fee schedule charges of $29,707.70. Ali testified that "facility fees" are based solely on codes provided by a surgeon – in this case, Dr. Nam. Respondent's examiner, Dr. Bush-Joseph, agreed that Petitioner required the surgeries that Dr. Nam performed. Respondent authorized the surgeries. Dr. Bush-Joseph expressed no criticism of Dr. Nam's care. In fact, he specifically opined that Petitioner obtained a "good result" from

the left shoulder surgery. RX 2. While the "facility fees" seem high from a layperson's perspective, the operative report reflects that Dr. Nam performed four procedures on September 15, 2010: rotator cuff repair, subacromial decompression, debridement and synovectomy.

Petitioner claims $459.08 in outstanding fee schedule charges from Metro Anesthesia Consultants. Based on PX 9, these charges stem from anesthesia administered during the right shoulder surgery of February 1, 2011. Respondent pre-authorized this surgery and Respondent's examiner found the surgery to be reasonable and necessary. The Arbitrator awards Petitioner the outstanding charges of $459.08 from Metro Anesthesia.

Petitioner claims $38,554.20 in outstanding fee schedule charges from Ambulatory Surgical Care Facility. Based on PX 10, this amount represents facility fees stemming from the right shoulder surgery performed on February 1, 2011. The Arbitrator awards these facility fees, based on the same analysis she applied to the facility fees stemming from the left shoulder surgery.

Petitioner claims $5,314.89 in outstanding fee schedule charges from Gray Medical, the purveyor of the ice machine Petitioner used following his shoulder surgeries. Dr. Nam prescribed this machine and Petitioner testified he found the machine to be beneficial. It is unclear to the Arbitrator how Petitioner arrived at the figure of $5,314.89 since the itemized bill in PX 11 reflects a balance of $4,780.52 after insurance payments of $9,170.71 and adjustments of $2,858.77. The Arbitrator awards Petitioner outstanding fee schedule charges of $4,780.52 from Gray Medical.

Finally, Petitioner claims $150.97 in outstanding charges from Chicago Orthopaedics. Petitioner alleges these charges stem from Petitioner's August 1, 2011 visit to Dr. Nam. RX 4 and the Chicago Orthopaedics bill, however, reflect that Dr. Nam charged $152.00 per visit for the June 27, 2011 and August 1, 2011 visits and that Respondent's carrier made post-adjustment payments of $123.80 on August 31, 2011 and October 10, 2011.toward these visits. The bill shows a balance of $152.00 but it is not clear what this balance represents. On this record, the Arbitrator declines Petitioner's request for an award of $150.97.

In summary, the Arbitrator awards Petitioner $73,501.50 in outstanding fee schedule charges.

Is Petitioner entitled to permanent partial disability benefits in 10 WC 21488?

In the first case, 10 WC 21488, Petitioner sustained significant injuries to both of his shoulders, with both injuries requiring surgery. Respondent's examiner, Dr. Bush-Joseph, originally viewed the injury to the left shoulder as the more serious of the two. RX 1. Later, however, he described Petitioner as having made a good recovery from the left shoulder

surgery, noting only mild residual weakness. RX 2. With respect to the right shoulder, Dr. Bush-Joseph described Petitioner as undergoing a "massive" arthroscopic repair of a "massive" rotator cuff tear, as well as a distal clavicle excision. RX 2.

On August 1, 2011, Petitioner's surgeon, Dr. Nam, noted improvement but some occasional "cracking" in the shoulders and 5-/5 rotator cuff strength bilaterally. He released Petitioner to full duty on a trial basis. Four weeks later, he found Petitioner capable of full duty with no additional trial period required.

Petitioner credibly testified to ongoing problems with both shoulders. Petitioner indicated that his left clavicle is unusually elevated. He demonstrated this to the Arbitrator. He has difficulty sleeping and cannot lift his granddaughters. He testified his bones "snap a lot." T. 39-40.

Based on the treatment records, Dr. Bush-Joseph's reports and Petitioner's credible testimony, and noting that Petitioner is right-handed (RX 1), the Arbitrator awards Petitioner permanency in 10 WC 21488 equivalent to 22.5% loss of use of the person as a whole under Section 8(d)2, or 112.5 weeks of compensation at the applicable minimum rate of $309.33 per week. This award includes 62.5 weeks of compensation, representing 12.5% loss of use of the person, for Petitioner's right shoulder injury and 50 weeks of compensation, representing 10% loss of use of the person, for Petitioner's left shoulder injury. The Arbitrator awards permanency under Section 8(d)2 rather than 8(e) pursuant to Will County Forest Preserve District v. IWCC, 2012 Ill.App. LEXIS 109 (3rd Dist. 2012).

Is Respondent liable for penalties and fees?

Petitioner seeks penalties under Sections 19(k) and (l) and attorney fees under Section 16 on the claimed fee schedule charges discussed above. Petitioner filed an Amended Petition for Penalties and Attorney Fees on December 4, 2012 noting, inter alia, that Respondent pre-authorized the two shoulder surgeries "yet failed to pay for" those surgeries. PX 13. At the hearing, Respondent responded to this pleading by offering a print-out showing it had paid $182,092.72 in treatment-related expenses to date. Respondent's counsel also asked the Arbitrator to note that the outstanding balances claimed by Petitioner's counsel steadily declined between November 2011 and the hearing. Whereas Petitioner's counsel originally claimed a balance of $175,681.50 on November 16, 2011, she claimed a much lower amount, $74,894.77, at the hearing.

In the instant case, there is no disagreement between the parties as to the reasonableness and necessity of Petitioner's two shoulder surgeries. At the hearing, however, there was clearly a disagreement as to whether all the charges stemming from those surgeries were reasonable and whether the outstanding fee schedule charges were accurately calculated. Petitioner relied on Shahnaz Ali to explain the basis for the fee schedule charges. Respondent's counsel crossed Ali on the subject of "double billing," with Ali testifying that the division of

facilities, as well as her software and methodology, enabled her to avoid making this mistake.

The Arbitrator, having considered Ali's testimony and reviewed Petitioner's various demands for payment along with RX 4, awards Section 19(k) penalties and Section 16 attorney fees only on the awarded fee schedule charges of $4,780.52 from Gray Medical. Petitioner's counsel requested that Respondent pay these surgery-related charges as early as November 16, 2011, more than a year prior to trial. PX 15. These charges were the only awarded charges that remained wholly unpaid as of the trial. The Arbitrator awards Petitioner Section 19(k) penalties in the amount of $2,390.26, representing 50% of $4,780.52, and Section 16 attorney fees in the amount of $956.10, representing 20% of $4,780.52. In the Arbitrator's view, Respondent failed to meet its burden of proving that it acted in an objectively reasonable manner in failing to pay these charges.

The Arbitrator also awards Petitioner $10,000.00 in Section 19(l) penalties, representing the statutory maximum calculated at $30.00 per day. The Arbitrator awards the statutory maximum because Petitioner requested payment of numerous bills, including the bill from Gray Medical, on November 16, 2011, more than 365 days before the trial. Such penalties are not tied in with particular conduct. Rather, they are in the nature of a late fee. McMahan v. Industrial Commission, 183 Ill.2d 499, 515 (1998).

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHNNY GROVES,

Petitioner,

vs. NO: 12 WC 010226

CARGILL MEAT SOLUTIONS,

14IWCC0697

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue(s) of the nature and extent of 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.

Based on a review of the entire record in evidence, the Commission finds that the Petitioner's permanency award should be increased to 22.5% of the man as a whole under §8(d)(2) of the Act, for the reasons set forth below.

Initially, the Commission notes that pursuant to Will County Forest Preserve District vs. Illinois Workers' Compensation Commission, 970 N.E.2d 16, 361 Ill.Dec. 16 (2012), injuries to the shoulder are to be awarded permanent partial disability compensation pursuant to §8(d)(2) of the Act. Thus, the Arbitrator properly awarded permanency benefits in this case as a percentage of the man as a whole.

Following the July 12, 2011 accident, the Petitioner underwent an initial surgery with Dr. Romanelli on January 12, 2012. The diagnosis was massive acute on chronic supraspinatus and infraspinatus tears, and the surgery involved subacromial decompression and AC joint resection, with limited rotator cuff debridement. The spinatus tears were too retracted with scarred tissue

that was too poor to repair. Dr. Romanelli stated in his report (in Petitioner's Exhibit 6) that: "This was too longstanding with an acute on chronic process to be able to repair it".

Petitioner continued to have problems, particularly with overhead activities, and he underwent therapy and injections. Dr. Romanelli severely restricted the Petitioner's activities, noting the only thing that would ultimately help Petitioner was a shoulder replacement, but that he believed the Petitioner should wait until he was at least 60 years old.

Petitioner underwent a Section 12 examination with Dr. Paletta on August 15, 2012. Noting there were other possible procedures that would involve even greater subsequent limitations, he recommended the shoulder replacement, but noted that Petitioner would still be limited in overhead activities after the surgery. He agreed with Dr. Romanelli that there had been an "acute on chronic tear" (Petitioner's Exhibit 13).

Due to significant ongoing problems, Petitioner underwent the right reverse shoulder replacement on December 3, 2012. Dr. Romanelli indicated an excellent outcome, and on June 12, 2013 released Petitioner to unrestricted work, recommending a six month follow up.

The Petitioner testified that in this case he worked as a general operator in Respondent's meat processing facility, and had been required to use a type of gun to remove lard from carcasses. He testified he initially returned to work following shoulder replacement surgery as a "toe notcher". As this job also involved the repetitive use of a "gun", he continued to have pain. He was able to bid into a position in blood rendering, which he testified did not involve as much physical labor, had no constant repetition and minimal work above shoulder level, which appears to be the main activity that causes him ongoing problems.

The Petitioner was able to obtain a job in Respondent's facility that requires less repetitive work activity and physical work, and while he currently has no specific work restrictions, the Commission believes the evidence indicates that were the Petitioner again forced to seek employment for some reason, his ability to work at jobs involving overhead and/or repetitive right arm work would be limited.

The evidence shows the Petitioner consistently showed a willingness to try his best to get back to work. He initially treated with Midwest Occupational Health, the company clinic, and was referred from that facility to Dr. Romanelli, his surgeon. He continued to seek treatment in this chain of referral and never went outside of it to seek an opinion on his own. Based on the Commission's experience with injuries like this, it is entirely possible that had Petitioner done so, some form of permanent restrictions could have been recommended. In fact, the Respondent's Section 12 examining physician, Dr. Paletta, stated in his August 15, 2012 report that the claimant would remain limited in overhead activities following shoulder replacement. While it is true that no physician has placed work restrictions for the Petitioner, it is clear to the Commission that the Petitioner has credible ongoing complaints regarding overhead work.

It appears that the Petitioner had some level of preexisting internal derangement in the right shoulder, but the evidence indicates he had been able to work in jobs for Respondent involving both repetitive and overhead use of the right arm without problems. Petitioner testified

he had no right shoulder problems prior to the accident date, and Dr. Romanelli reported on November 16, 2011 that Petitioner indicated he had no pain or discomfort in the shoulder before the accident despite using the larding gun at work for many years.

Given the multiple surgeries and ongoing complaints, the need for an early shoulder replacement surgery, as well as the potential problems the Petitioner could face if forced back into a job involving overhead work, the Commission finds that the Petitioner sustained the permanent loss of 22.5% of the man as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $439.15 per week for a period of 112.5 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the loss of 22.5% of the man as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent has or shall reasonable and necessary medical expenses pursuant to §§8(a) and 8.2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $49,500.00. 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: AUG 2 0 2014
TJT: pvc
o 7/29/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GROVES, JOHNNY
Employee/Petitioner

Case# **12WC010226**

CARGILL MEAT SOLUTIONS
Employer/Respondent

14IWCC0697

On 2/10/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2934 BOSHARDY LAW OFFICE PC
ANDREW RICCI
1610 S 6TH ST
SPRINGFIELD, IL 62703

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
JASON H PAYNE
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

14IWCC0697

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

JOHNNY GROVES,
Employee/Petitioner

v.

CARGILL MEAT SOLUTIONS,
Employer/Respondent

Case # 12 WC 10226

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 **Maureen H. Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **1/17/14**. By stipulation, the parties agree:

On the date of accident, **7/12/11**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**38,059.87**, and the average weekly wage was $**731.92**.

At the time of injury, Petitioner was **53** years of age, ***married*** with **no** dependent children.

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

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**.

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

ORDER

Respondent shall pay Petitioner the sum of **$439.15**/week for a further period of **62.5** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **petitioner a 12.5% of use of his person as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **7/12/11** through **1/17/14**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent has or shall pay reasonable and necessary medical bills pursuant to Sections 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator

1/18/14
Date

ICArbDecN&E p.2

FEB 10 2014

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 53 year old general operator, sustained an accidental injury to his right shoulder that arose out of an in the course of his employment by respondent on 7/12/11. Petitioner was employed by respondent for 24-25 years.

On 7/12/11 petitioner was running the leaf lard guns, overhead trolley, and counterbalance, which in combination weighed approximately 40 pounds. Petitioner stated that this broke loose and fell down approximately 4 feet striking him in his right shoulder and his right hand. He reported that the brunt of the force was to his right shoulder. He noticed immediate pain. Petitioner reported the incident to his supervisor. Petitioner denied any problems with his right arm before this accident.

As a result of this injury petitioner treated with Drs. Gordon, Romanelli and Brower. On 7/13/11 petitioner underwent an x-ray to his right hand that revealed abnormal density in the palmar aspect of the wrist at the level of the carpal metacarpal joints as seen on the lateral view. This was identified as a nonspecific finding. A fracture could not be excluded. On 7/14/11 Dr. Gordon diagnosed right shoulder and right wrist pain. An x-ray of the right shoulder revealed no acute abnormality. An x-ray of the right hand revealed triangular ossification projecting between the proximal and second metacarpals, probably representing an accessory ossicle. Dr. Gordon ordered a CT scan of the right wrist and hand. He released petitioner to light duty work.

Following the CT scan of the right wrist and hand petitioner followed up with Dr. Romanelli. Dr. Romanelli did not believe that petitioner had a fracture but did put him in a wrist brace. Petitioner stated that his right wrist was improving, although he still noticed some mild pain in his right wrist and some swelling in his right hand. On 7/20/11 Dr. Romanelli's impression was a contusion of the right wrist. On 7/22/11 petitioner was still complaining of right shoulder pain and difficulty raising his right shoulder to the front and side due to pain. Dr. Gordon performed a right shoulder subacromial corticosteroid injection.

Petitioner continued to follow up with Dr. Gordon. He continued to complain of right shoulder pain. Dr. Gordon prescribed a course of physical therapy and continued petitioner on light duty work. On 10/25/11 petitioner reported to Dr. Gordon that he was doing well and was essentially symptom-free until he tried to push a box at work recently and experienced increased pain in his right shoulder. Dr. Gordon recommended an MRI of the right shoulder.

On 11/2/11 petitioner underwent an MRI of the right shoulder that showed complete full thickness tears of the supraspinatus, appearing chronic, and a tear of the infraspinatus, which may be subacute, and also tendinopathy and partial thickness tear of the subscapularis and tendinopathy of the long head of the biceps

tendon. Also noted was retraction with the muscle atrophy of the supraspinatus and infraspinatus. Dr. Gordon referred petitioner to Dr. Romanelli for orthopedic treatment.

On 1/12/12 petitioner underwent surgical intervention by Dr. Romanelli. The postoperative diagnosis was massive acute on chronic care of the supraspinatus and infraspinatus, right shoulder. The procedure included a diagnostic right shoulder arthroscopy with subacromial decompression and AC joint resection with limited debridement of the rotator cuff with inability to repair the cuff tissue. Petitioner followed-up postoperatively with Dr. Romanelli

On 2/15/12 Dr. Romanelli noted that petitioner was able to abduct to 20 to 25° and flex to approximately 20°. Dr. Romanelli did not think that petitioner would be able to really perform a job function where he had to do any lifting and that he would not be able to lift more than 1 to 2 pounds with his right upper extremity. He was also of the opinion that petitioner should continue working on strengthening his right shoulder. Dr. Romanelli did not see petitioner being able to do any overhead activities. Petitioner continued to work light duty for respondent.

On 3/5/12 petitioner was re-examined by Dr. Gordon. His impression was right acute on chronic full thickness rotator cuff tear, unrepairable. Dr. Gordon recommended that petitioner continue physical therapy three times a week for the next four weeks. He continued him on light duty.

Petitioner followed up with Dr. Romanelli on 4/13/12. At that time he was provided a corticosteroid injection. Petitioner stated that it helped to some extent for about a day or two, but then the pain returned. Petitioner continued to report loss of range of motion at his right shoulder. Petitioner continued in physical therapy and on light duty. On 5/11/12 Dr. Romanelli returned petitioner to work with restrictions of no overhead activities with his right arm, and no lifting greater than 3 to 5 pounds with the right arm. Dr. Romanelli was of the opinion that these restrictions would be permanent until further notice.

On 6/22/12 Dr. Romanelli performed another cortisone injection. At that time petitioner was having pain and discomfort at night. He stated that he was not able to do his job. On 8/22/12 petitioner returned to Dr. Romanelli with ongoing complaints of pain and discomfort in his right shoulder. Dr. Romanelli continued petitioner's work restrictions. He was of the opinion that one day petitioner would probably need a reverse shoulder replacement. On 10/24/12 Dr. Romanelli recommended the surgery be performed.

On 12/3/12 petitioner underwent a right reverse shoulder replacement. Petitioner followed-up postoperatively with Dr. Romanelli. On 12/18/12 Dr. Romanelli released petitioner to work, with no use of the right arm. Petitioner continued treating with Dr. Romanelli and undergoing a course of physical therapy.

On 2/20/13 petitioner followed up with Dr. Romanelli. He stated he was doing very well and having a lot less pain and discomfort. Dr. Romanelli was of the opinion petitioner should continue working with no lifting above shoulder height, and no pushing or pulling over 5 to 10 pounds.

On 4/12/13 Dr. Romanelli released petitioner to full duty work. On 6/12/13 petitioner last followed up with Dr. Romanelli. He reported no pain, and was not taking any narcotic pain medications. His range of motion was improving. Dr. Romanelli advised petitioner to continue working on strengthening of his right shoulder. Petitioner demonstrated full range of motion of the shoulder and excellent strength. Dr. Romanelli dischargd petitioner from his care. He told him to follow-up in six months.

Currently petitioner complains of weakness in the right shoulder after raising it about 4 to 5 times. He testified that after doing this he is unable to lift his right arm overhead without assistance of his left arm. Petitioner also described difficulty reaching behind him to get his billfold out of the back pocket of his pants. Petitioner stated that while sitting for too long he has to move his arm into different positions. Once in awhile while sleeping at night he might have a problem with his right shoulder. Petitioner also talked about increased pain when it is cold out. Any constant repetition of the right arm hurts. After working a long day his arm hurts worse in the evening. Petitioner's unable to do multiple repetitions of the same thing without experiencing pain at his right shoulder. Petitioner stated that his biggest problem was reaching overhead. Any chores that he performs that require overhead lifting causes him some pain.

Petitioner stated that he is still working full duty, however, he is in a new position that does not require constant repetition of the right shoulder. He stated that he mostly does paperwork. Petitioner stated that the job he is performing is one he bid on, and not one he was forced into due to the injury.

As a result of his injury petitioner underwent 2 surgeries. On 1/12/12 petitioner underwent a diagnostic right shoulder arthroscopy, with subacromial decompression and AC joint resection with limited debridement of the rotator cuff with inability to repair the cuff tissue. When petitioner did not improve despite additional conservative treatment that included injections, petitioner underwent a second surgery. On 12/3/12 petitioner underwent a right reverse shoulder replacement. On 4/12/13 petitioner was returned to full duty work. When petitioner last followed up with Dr. Romanelli on 6/12/13 he reported no pain and was not taking any narcotic pain medications. Dr. Romanelli noted that petitioner's range of motion was improving, and advised petitioner to continue working on strengthening of his right shoulder.

At trial, petitioner had some subjective complaints. He testified that after lifting his right arm overhead 4 or 5 times he had difficulty lifting it again without assistance of the left arm. He also described difficulty

reaching behind to reach his billfold in his back pocket. Petitioner reported some night symptoms, and pain after working all day long. Petitioner's biggest complaint was pain with overhead lifting.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner sustained 12.5% loss of use of his person as a whole pursuant to Section 8(d) 2 of the Act as a result of the injury he sustained on 7/12/11.

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

Kenneth Billington,

Petitioner,

vs. NO: 12 WC 36727

Illinois Department of Corrections, **14IWCC0698**

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 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 20, 2013 is hereby affirmed and adopted.

No bond or summons for State of Illinois cases.

DATED: AUG 20 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:6/26/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BILLINGTON, KENNETH
Employee/Petitioner

Case# **12WC036727**

14IWCC0698

ILLINOIS DEPT OF CORRECTIONS
Employer/Respondent

On 8/20/2013, 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 0.07% 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:

2028 RIDGE & DOWNES LLC
MICHAEL K BRANDOW
415 N E JEFFERSON AVE
PEORIA, IL 61603

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

5116 ASSISTANT ATTORNEY GENERAL
GABRIEL CASEY
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

AUG 20 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0698

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

KENNETH BILLINGTON
Employee/Petitioner

v.

ILLINOIS DEPARTMENT OF CORRECTIONS,
Employer/Respondent

Case # 12 WC 36727

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 **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. ☒ 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 26, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$71,916.00**; the average weekly wage was **$1,383.00**.

On the date of alleged accident, Petitioner was **53** years of age, ***married*** with **no** dependent children under 18.

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

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

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

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

ORDER

Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment by Respondent on **August 26, 2008.**

Petitioner further failed to prove that the condition of ill-being complained of is causally related to any work activities performed on behalf of Respondent.

All claims for compensation 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

August 14, 2013
Date

AUG 20 2013

14IWCC0698

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 testified he works for Respondent as a dietary supervisor. Petitioner assists inmates in preparing food for the next day. After the food is made, it is chill blasted and stored overnight. Petitioner on August 26, 2012 was working the third shift, or from 9:00 pm to 5:00 am.

Petitioner testified that on August 26, 2012, he sustained a spider bite on his left third finger. This occurred when he entered the storage room for cooking supplies and reached into a box for some vegetables. He then saw the spider on his left hand and shook it off. Later that evening, the spot turned red. It remained red the next afternoon and there was a boil.

On August 28, 2012, he sought treatment with Dr. Krock, his family physician, who referred him to Dr. Gawda. Dr. Gawda on August 31, 2012 excised the boil, took multiple samples and cultured them, and then diagnosed and treated Petitioner for MRSA.

Petitioner testified he never saw anyone perform pest control during the third shift, but when he previously worked the first shift, he would see people spraying for bugs in the late morning to early afternoon. Respondent introduced contracts indicating that it received regular pest control services from 2010 to the present. (Rx1)

In addition, Petitioner testified he was also bitten or stung on his right hand on November 16, 2012, and under his left armpit in early April, 2013, both resulting in a MRSA infection. Petitioner testified the November 16, 2012 insect bite occurred at home in his garage. Records from The Graham Hospital in evidence reveal treatment for right upper extremity pain and swelling. Petitioner gave a history of a burning sting to his hand 3 days ago in his garage, and complained of redness, swelling and drainage.

Records of Dr. Krock reflect on August 28, 2012 a history of he thought he had a spider bite at work. A note of Dr. Gada dated August 31, 2012 indicates a history of starting 4 days ago. Unsure of etiology. Started at work. A nurse's note reflects a history of "He felt something crawling on his hand and shook it off. Later he popped a blister on his hand and within 24 hours began experiencing redness." (Px1)

On August 27, 2012, Petitioner filled out an accident report where he stated he was getting supplies from dry good storage room and something bit or stung his left hand. Petitioner testified the storage room had poor lighting and e did not see the color of the bug that bit him, he was sure it was a spiderand he knew that because he saw eight legs.

Petitioner testified he does not experience pain, swelling, loss of motion or other disability to his left hand. Petitioner showed the Arbitrator a 1-1/2 inch scar on the side of his third left hand finger that resulted from the debridement.

The question is whether an insect bite as alleged here arose out of and in the course of Petitioner's employment. Is this a risk common to the public at large or is it a neutral risk? Or is this a risk peculiar to his employment?

Petitioner has been diagnosed with MRSA, once for an alleged bite that occurred at his garage at home, and one that he claims occurred on August 26, 2012 at work. Petitioner did not offer evidence that his work made him more likely to be bitten by an insect, and did prove that he was bitten while not working, and suffered the same symptoms.

Based upon the above, the Arbitrator finds that the alleged insect bite of August 26, 2012 did not constitute a risk distinctly associated with his job, but represented a neutral risk as found in *Illinois Institute of Technology Research Institute v. Industrial Commission*, 314 Ill. App. 3d 149 (1st Dist. 2007). It would further appear that this risk was no greater than that of the general public under these circumstances.

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 by Respondent on August 26, 2012.

Based further upon the above, the Arbitrator finds that the condition of ill-being complained of is not causally related to any work activities performed on behalf of 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?

See findings of this Arbitrator in "C," and "F" above.

Based upon said findings, all claims made by Petitioner for medical charges or expenses in this matter are hereby denied.

K. What temporary benefits are in dispute?

See findings of this Arbitrator in "C," and "F" above.

Based upon said findings, all claims made by Petitioner for temporary total disability benefits in this matter are hereby denied.

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

See findings of this Arbitrator in "C," and "F" above.

Based upon said findings, all claim made by Petitioner for permanent partial disability benefits in this matter are hereby 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

Jody K. Graff,

Petitioner,

vs.

NO: 12 WC 11837

14IWCC0699

Family Hospice,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of accident 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 30, 2013 is hereby affirmed and adopted.

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

DATED: AUG 20 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:6/25/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRAFF, JODY K
Employee/Petitioner

Case# **12WC011837**

14IWCC0699

FAMILY HOSPICE
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:

0744 STRELLIS & FIELD CHTD
DENNIS M FIELD
115 E MILL ST
WATERLOO, IL 62298

1454 THOMAS & ASSOCIATES
ROBERT A HOFFMAN
300 S RIVERSIDE PLZ SUITE 2330
CHICAGO, IL 60606

14IWCC0699

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

Jody K. Graff
Employee/Petitioner

v.

Family Hospice
Employer/Respondent

Case # 12 WC 11837

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 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 _____

14IWCC0699

FINDINGS

On February 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 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 $54,357.68; the average weekly wage was $1,045.34.

On the date of accident, Petitioner was 44 years of age, single with 1 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $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 26, 2013
Date

AUG 30 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 February 28, 2012. According to the Application, Petitioner was walking to a vehicle and twisted her ankle causing an injury to her left ankle. Respondent denied liability on the basis that, although Petitioner did sustain an accidental injury, it did not occur under circumstances arising out of and in the course of her employment for Respondent.

Petitioner is an RN and she was employed by Respondent as an RN/Case Manager. Respondent provides health care services for terminally ill patients. Petitioner's job duties required her to be "on call" for various periods of time when she was at her residence. One of the occasions that Petitioner was required to be "on call" was between 5:00 PM on February 27, 2012, and 8:30 AM on February 28, 2012. The procedure that is utilized when a patient believes that he/she needs the services of an RN, is that the call is made to an answering service who then calls whatever RN is on duty. The RN then calls the patient to determine what needs to be done, if it is an emergency, if a house call needs to be made, etc.

At approximately 3:30 AM on February 28, 2012, Petitioner received a telephone call from the answering service and then she called the patient. At that time, Petitioner spoke to the patient's daughter and determined that it was an emergency situation for which she would have to make a house call. Petitioner proceeded to put her uniform on, grabbed her bag and started to walk to the front door of her residence. While Petitioner was walking to her front door, she realized she left her clipboard (which contained necessary and vital information) on her kitchen table. Petitioner then turned around to go back to the kitchen and, when she did so, she rolled her left ankle and heard an extremely loud "pop."

Petitioner testified that the floor she fell on was carpeted, that there were no foreign substances on the floor and she did not trip on anything. Petitioner was simply walking toward the front door of her residence, realized that she had left the clipboard on her kitchen table, turned around and twisted her left ankle.

Following the accident, Petitioner was unable to bear any weight on her ankle. She initially called another nurse and made arrangements to have the patient cared for. Petitioner's daughter then took her to the ER of St. Anthony's Medical Center. X-rays taken there revealed that Petitioner had sustained a non-displaced fracture of the lateral malleolus.

Petitioner was subsequently treated by Dr. Dale Doerr, an orthopedic surgeon, who initially saw Petitioner on February 29, 2012. Dr. Doerr confirmed the diagnosis of a fracture of the lateral malleolus and he applied a short leg cast. Dr. Doerr authorized Petitioner to return to work for a sit down job only on March 5, 2012.

Petitioner testified that she was able to return to work on April 7, 2012, and work two to three days per week until Dr. Doerr released her to return to work without restrictions on June 4, 2012.

At trial Petitioner testified that her ankle lacks a full range of motion, her balance has been adversely affected and, because of the pain, she has to apply heat and ice to her ankle on a daily basis. She has not been seen by Dr. Doerr or any other medical providers since the time she was released to return to work without restrictions. When Petitioner did return to work without restrictions she was able to do so and has been able to perform all of her required job duties.

Conclusions of Law

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

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of her employment for Respondent.

In support of this conclusion the Arbitrator notes the following:

The Arbitrator finds that Petitioner failed to prove that she was subject to any greater risk than that to which the general public is exposed. The Arbitrator further finds the case of Caterpillar Tractor Company v. Industrial Commission, 541 N.E.2d 665 (Ill. 1989), to be controlling. In the Caterpillar case, compensation benefits were denied to an employee who stepped off of a curb onto a slight incline and sustained an ankle injury. The Court denied compensation benefits in that case because the employee did not prove that he was subject to any risks greater than that to which the general public is exposed to with the Court noting that curbs and the risks inherent in traversing them are something that are confronted by all members of the public. Caterpillar at 669.

In the instant case, the Petitioner was at her residence and she was simply in the process of walking to her front door when she realized she had left that clipboard on the kitchen table and, when she turned, she twisted her left ankle. The floor that Petitioner was on was carpeted, there were no foreign substances on it and Petitioner did not trip over anything.

In regard to disputed issues (J), (K) and (L) the Arbitrator makes no conclusions of law because these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issue (C).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF 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

Lakeesa L. Dillard,

Petitioner,

vs.

NO: 10 WC 24860

Grand Prairie Transit Co.,

Respondent,

14IWCC0700

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 16, 2013 is hereby affirmed and adopted.

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

DATED: AUG 20 2014

MB/mam
o:6/25/14
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DILLARD, LAKEESHA L
Employee/Petitioner

Case# **10WC024860**

14IWCC0700

GRAND PRAIRIE TRANSIT CO
Employer/Respondent

On 10/16/2013, 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 0.15% 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:

2687 KROCKEY CERNUGEL COWGILL ET AL
THOMAS COWGILL
3180 THEODORE ST SUITE 102
JOLIET, IL 60435

0208 GALLIANNI DOELL & COZZI LTD
ROBERT J COZZI
20 N CLARK ST SUITE 1800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

14IWCC0700

☐ 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

Lakeesa L. Dillard
Employee/Petitioner

v.

Grand Prairie Transit Co.
Employer/Respondent

Case # **10** WC **24860**

Consolidated cases: ----

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **New Lenox, Illinois**, 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

FINDINGS

14IWCC0700

On **February 7, 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 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 **$19,765.80**; the average weekly wage was **$399.44.**

On the date of accident, Petitioner was **35** years of age, ***single*** with **2** dependent children.

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

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

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

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

ORDER

Having found that Petitioner failed to prove that she sustained an accident that arose out of and in the course her employment with Respondent on February 7, 2010; or that her present condition of ill-being was causally related to the alleged repetitive trauma at work, Petitioner's claim for compensation is hereby denied.

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

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

Signature of Arbitrator

10/15/13
Date

ICArbDec p. 2

OCT 16 2013

STATEMENT OF FACTS:

Petitioner was employed by Respondent as a school bus driver. She was assigned to a bus that transported handicapped students including those that were confined to wheelchairs. She typically had three students in wheelchairs and ten who were not on any given day. The students who were confined to wheelchairs gained access to the bus by means of a lift. Petitioner was required to secure the wheelchairs to the floor of the bus. She was required to climb up and descend 6 – 8 bus steps, 8 – 12 times during the day.

Petitioner had previously injured her left knee. She received physical therapy and resumed her normal job duties. In early 2010, Petitioner developed swelling and popping in her left knee. She noticed pain while going up and down the stairs of the bus. She went to her primary care physician, Dr. Sikand, on January 22, 2010 and complained of knee pain and a popping sensation "when walking." She was sent for an MRI which was performed on February 7, 2010 and showed a "chronic tear of the anterior cruciate ligament." Petitioner was sent to an orthopedic physician. (Pet. Ex. 1)

Petitioner was first seen at the office of orthopedic surgeon, Dr. Pulluru, on February 23, 2010. She provided a history of injuring her knee four years earlier and having difficulty ever since. Petitioner underwent surgery on her left knee on March 24, 2010 consisting of arthroscopic anterior cruciate ligament reconstruction and partial medial menisectomy. (Pet. Ex. 2) She underwent post-operative physical therapy and returned to full duty work on April 7, 2010. At the present time, she still notices pain and swelling in her left knee. She continues to be employed as a bus driver but for a different transit company.

Dr. Jeffrey E. Coe testified that he is a board-certified specialist in occupational medicine. (Pet. Ex. 6, page 4) He examined Petitioner on August 30, 2011. In addition to performing a physical examination, he also reviewed the medical records and took a history. (Pet. Ex. 6, page 5)

Petitioner provided a history of climbing 6 – 8 steps of the bus, 8 – 12 times per day. He conducted a physical examination and made the following findings: normal gait; tenderness over the medial tibial plateau; positive patellar grind test; full range of motion; no instability; full strength; mild atrophy of the left thigh. (Pet. Ex. 6, pages 19-24)

Dr. Coe diagnosed status post-left knee surgery with ACL reconstruction, partial medial menisectomy. (Pet. Ex. 6, page 24) He opined that Petitioner's work activities were a factor that aggravated her pre-existing, post-traumatic and degenerative changes in the left knee leading to the surgery performed by Dr. Pulluru in March of 2010. (Pet. Ex. 6, page 25)

On cross-examination, he stated he was not an orthopedic surgeon and never performed the type of surgery that Petitioner underwent. (Pet. Ex. 6, page 28) Petitioner told him that she had never injured her left knee in the past and that the only knee problem she ever experienced was with her right knee. The doctor however noted that all the medical documentation showed she had a past left knee problem. (Pet. Ex. 6, page 31) The doctor provided that ACL injuries are often caused by hyper-extending or twisting the knee. (Pet. Ex. 6, page 32) He stated that the only activities that she described to him that could affect her knees were climbing up and down the stairs. (Pet. Ex. 6, page 34) He also stated that Petitioner could have completely torn her ACL several years earlier or she could have partially torn her ACL or she may have suffered the medial meniscal tear initially or later on.

Dr. David J. Raab testified that he is a board-certified orthopedic surgeon for the past twenty-two years. (Resp. Ex. 1, page 22) His practice deals primarily with knee and shoulder surgery with the majority of his work with the knee. (Resp. Ex. 1, page 6) He performed an examination of Petitioner on February 10, 2012. He reviewed medical records for treatment in 2006 through the date of the examination. The physical examination revealed the following findings: full range of motion; no effusion; trace positive Lachman tests; negative pivot shift; no medial or lateral joint line tenderness; patellar femoral crepitus; full range of motion. (Resp. Ex. 1, pages 8, 9) He felt her prognosis was excellent. (Resp. Ex. 1, page 9)

In his opinion, the type of injury that she underwent the surgery for, a torn ACL and a torn meniscus, would not be the type of injury resulting from repetitive activities such as going up and down stairs. Her height would not be a factor. (Pet. Ex. 13) Dr. Raab testified that repetitive trauma is not the etiology for an anterior cruciate ligament tear. (Resp. Ex. 1, page 16) he stated that repetitively going up and down the stairs would not cause a medial meniscal tear either nor is it the mechanism of injury for an unstable anterior cruciate deficient knee. (Resp. Ex. 1, page 17) The doctor also stated that doing up and down the stairs of a bus is not the mechanism to injure her meniscus or injure her anterior cruciate ligament. (Resp. Ex. 1, page 19)

With respect to issues (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent" and (F) "Is the petitioner's current condition of ill-being causally related to the injury?" the Arbitrator concludes the following:

Petitioner alleges a repetitive trauma injury. The repetitive activities that she alleges to have caused her left knee injury consist of walking up and down 6 – 8 stairs of her bus 8 – 12 times per day. In order to establish that a repetitive trauma injury has occurred, the claimant must prove that her activities were indeed repetitive. The Arbitrator finds that the alleged activities were not sufficiently repetitive over the course of an 8 hour day to constitute a repetitive trauma injury. Furthermore, the activities that Petitioner performed were not strenuous.

Petitioner's treating orthopedic surgeon, Dr. Pulluru, did not offer an opinion as to causation. Petitioner retained an independent medical examiner, Dr. Jeffrey Coe, who opined that Petitioner's activities consisting of walking up and down her bus stairs several times per day either caused or aggravated her left knee leading to a torn ACL and medial meniscus. Conversely, Respondent offered the opinion of Dr. David Raab who opined that the alleged work activities did not cause or aggravate the condition leading to the surgery.

The Arbitrator finds the opinions of Dr. Raab more persuasive than those of Dr. Coe for the following reasons. First, Dr. Raab is an orthopedist whose practice consists primarily of performing knee surgeries. Dr. Coe, on the other hand, has no expertise in orthopedics and has never performed knee surgery. Secondly, Dr. Raab opined that the activity alleged consisting of walking up and down stairs does not produce an injury to the anterior cruciate ligament or medial meniscus. Dr. Coe conceded that the usual way in which such injuries occur is a hyper-extension or twisting of the knee. There was no indication either through Petitioner's testimony or the medical records that Petitioner hyper-extended or twisted her knee in walking up and down the bus stairs. Thirdly, Dr. Coe conceded that he could not say when she had torn her ACL and she could have torn it several years earlier. In fact, a tearing of the ACL was consistent with the original history given to Dr. Pulluru that she had injured her knee in 2006 and had experienced increasing problems with it ever since.

Based on all the above, the Arbitrator finds that Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment or that her present condition of ill-being was

causally related to the alleged repetitive trauma at work. Her claim for compensation, therefore, is denied. All remaining issues are rendered 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

Steve Bildilli,

Petitioner,

vs.

NO: 11 WC 08549

14IWCC0701

State of Illinois-Department of Corrections,

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 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.

No bond or summons for State of Illinois cases.

DATED: AUG 20 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:6/25/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BILDILLI, STEVEN
Employee/Petitioner

Case# **11WC008549**

14IWCC0701

SOI-DEPT OF CORRECTIONS
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:

1937 TUGGLE SCHIRO & LICHTENBERGER
NICHOLAS SCHIRO
510 N VERMILION ST
DANVILLE, IL 61832

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

4993 ASSISTANT ATTORNEY GENERAL
CHRISTINA J SMITH
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

JUL 23 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

7.

14IWCC0701

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

STEVE BILDILLI
Employee/Petitioner

v.

STATE OF ILLINOIS-DEPARTMENT OF CORRECTIONS
Employer/Respondent

Case # **11** WC **08549**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Urbana**, on **June 20, 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 _____

14IWCC0701

FINDINGS

On **09/22/10**, 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 **$55,698.00**; the average weekly wage was **$1,071.11**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his left and right hand and wrist due to repetitive work activities that arose out of and in the course of his employment with Respondent 0 and he has failed to prove by a preponderance of the credible evidence that his current condition of ill-being as it relates to his left and right hand and wrist is causally related to any alleged injury on September 22, 2010. 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.

D. Ltr McCarthy
Signature of Arbitrator

July 20, 2013
Date

JUL 23 2013

Findings of Fact

Petitioner Steve Bildilli is employed with Respondent State of Illinois-Department of Corrections at the Danville Correctional Center in Danville, IL. Petitioner has been working at the Danville Correctional Center for approximately 28 years. Petitioner's current position is as a Correctional Food Supervisor II. Petitioner began this position in April 2010. (TX, P. 13).

Prior to April 2010, Petitioner had been in the position of Correctional Officer where his job duties were to maintain security and the health and safety of the inmates and staff. Petitioner testified that his job duties in this position required him to open all the doors for every cell twice a day when counting inmates, open a closet with cleaning supplies, and open the main door to the wing. Petitioner testified that the keys used were regular keys such as house keys. (TX, p. 14). He never had to use Folger keys. (TX 39) The door and entryways included several heavy doors at the entry but the inmate cell doors were lighter. Petitioner testified that he had to turn a key to open the door approximately 400 times a shift when working on a post that had two wings and approximately 200 times a shift when working on a shift with only one wing. (TX p. 15). Petitioner testified that he was assigned to work a two-wing shift only 10% of the time. (TX p. 16).

Petitioner testified that some of the doors were not easy to open and close, particularly the entry doors on the front of the wing which were older doors and often required the use of two hands to open them because they stuck a little bit. (TX, p. 16). Petitioner testified that he had to walk down both sides of the wings and then up stairs to count both sides of the wings upstairs. Petitioner testified that he worked seven and a half hours a day and was on his feet 80 percent of the time while at work and was turning keys to open and close doors approximately 15-20% of the time. (TX, p. 17). Petitioner testified that his job involved very little paperwork. Petitioner testified that he worked 5 days a week and then whenever he could get overtime. Petitioner testified that as a correctional officer, he would work overtime two or three times a month. (TX p. 18).

In April 2010, when Petitioner switched jobs to being a Corrections Food Supervisor, Petitioner testified that his job duties of opening doors and turning keys increased between 10 and 15%. (TX p. 19). Petitioner testified that he had to not only unlock the door but had to turn the key again to lock them. Petitioner testified that between opening and closing doors and locks and padlocks on an average day he would turn keys 350 to 375. (TX p. 20). Petitioner testified that he worked on average a day a week of overtime and that a typical workweek with no overtime was 37 ½ hours. (TX p. 20).

Petitioner testified that while working as a Correctional Officer three years ago, he began to notice aches and pain in hands and he took Aleve. When he went over to dietary in 2010, his hands starting hurting a lot more. (TX, p. 21). Petitioner testified that his hands started getting numb in the middle of the night and that would wake him up. He noticed that his grip strength was decreased when opening jars. (TX, p. 21).

Petitioner made an appointment with Dr. Berkes at the Carle Clinic. Petitioner testified that he never treated for hand numbness or carpal tunnel symptoms before. Petitioner had a prior right elbow injury, bilateral shoulder injuries and neck injuries that he treated for at Carla Clinic. On September 9, 2010, Petitioner had his first appointment with Dr. Berkes for his carpal tunnel symptoms. (TX, p. 22, PX 1). Petitioner's doctor recommended Petitioner wear a splint at night and ordered a nerve conduction study. (TX p. 23, PX 1).

On September 22, 2010, Petitioner underwent a nerve conduction study which revealed very mild bilateral carpal tunnel syndrome. (PX 1, p. 19-20). On September 23, 2010, Petitioner asked his doctor if the condition of his hands could be work related and according to Petitioner he was advised that it could be.

Petitioner testified that he reported his numbness to his supervisor, Marcia Keys around September 27, 2010. Petitioner testified that he was advised to go to health care and to fill out the workers' compensation

paperwork which he did. (TX p. 25-26). Petitioner testified that he an amputation injury to his right hand in 1981 and a boxing injury in high school. Other than that, Petitioner testified he had never had any other injuries or any numbness, tingling or pain in his hands like he experienced in 2010. (TX p. 27).

On February 3, 2011, Petitioner underwent bilateral carpal tunnel releases. Petitioner was off work from February 3, 2011 to February 21, 2011 and used 5 service connected days for his time off. Petitioner agreed that he would only be owed one week of TTD if the arbitrator found in his favor. Petitioner returned to work full duty on February 21, 2011. Petitioner has not suffered any other accidents since returning to work. Petitioner testified that surgery helped him immensely and that he does not take any medication for his hands. Petitioner has returned to his same job and has no problems performing his job. He stated that his right and left hands were "a whole lot better. I can sleep at night. I don't wake up with my hands numb." Petitioner testified that he noticed his grip strength was not what it used to be but a lot better than before the surgery. (TX p. 28-29).

Petitioner owns a small farming operation and has some hogs for his grandchildren. Petitioner sold the goats that he previously had. Petitioner stated that he does not perform any hand intensive work as a part of his farming operation. Petitioner stated that he did not discuss his job duties in detail with Dr. Fakhouri, Respondent's IME doctor. Petitioner stated that he provided the date of September 16, 2010 for his injury when he originally called in to Caresys because he thought that was the date he saw Dr. Berkes. (TX p. 33).

On cross examination, Petitioner testified that he first started experienced symptoms of numbness and tingling late in 2009. Petitioner testified that he worked on the wing but that he did not notice the numbness and tingling while he was working. Petitioner testified that it really bothered him when he was trying to sleep and that it kept him awake at night. Petitioner did not notice it while performing his job duties except that he noticed his grip strength was worse. (TX p. 35).

Petitioner testified that prior to April 2010 he was working as a wing officer. Petitioner could not state how long he had been a wing officer but stated that he has held various different jobs from being on the wings, being a control officer, being a commissary officer, a segregation officer, a yard officer, and a tower officer. (TX, p. 36). Petitioner stated that he has probably been a wing officer for two to five years prior to April 2010 when he transferred to dietary but that even as a wing officer, his assignment was always on a daily basis. Petitioner testified that on any given day, he could be on the wing or in the tower or a control officer or filling in for someone on vacation relief. Petitioner testified that the control position did not require any opening any doors because it is done with a touch screen. Petitioner testified that the other jobs that he could be assigned to on a daily basis—control, commissary, supervisor, tower, movement officer—did not require him to use his key and open doors the 200-400 times that he testified he would have to as a wing officer. (TX, p. 38).

Petitioner testified that he did not ever use the Folger Adams keys but always used regular size keys. Petitioner testified that, for the most part, only the entry doors were heavy and occasionally an inmate's cell door might be tough to open or jammed or an inmate would block his door. Petitioner testified that approximately 50 of the 400 times that he had to use his key to open a door, it was a heavy door. (TX, p. 38-39). Petitioner testified that he always used his right hand to turn the key and his left hand to open the doors unless the door was jammed and then he would use both hands. (TX p. 41). Petitioner testified that one count a day was an ID count which required him to actually use the key and physically open the cell doors. (TX p. 42). Petitioner testified that it took about a second to turn the key and a half a second to open the door. (TX p. 41).

Petitioner testified that he never experienced symptoms of numbness and tingling while working as a wing officer. (TX p. 43).

On November 26, 2009, Petitioner testified that his prior testimony in a hearing on a prior claim was correct and that his job duties required him to be on his feet for seven and three quarters hour per day and the

had to go up and down the stairs for the majority of his day. Petitioner again agreed with his prior testimony that as of November 26, 2009, he was on relief post where he was in the yard half the day and in the tower half the day. Petitioner testified that he could have been on that post for 90 days because there is a 90 day rotation. (TX p. 44-45). Petitioner testified that he did not have to do any repetitive activities while in the yard and did not have to do any repetitive hand movements while in the tower. (TX p. 46).

Petitioner testified that when he was moved to the position of food supervisor, that post aggravated his carpal tunnel symptoms. Petitioner stated that his job was to keep the inmates that are coming in for lunch out of the kitchen area and keep the inmates working in the kitchen area away from the dining room. Petitioner testified that there was a north side chow hall and a south side chow hall and there is a brick wall with a door on the south side and a door on the north side that needs to be kept secure. There is a chuckhole where the door remains unlocked but sometimes there are bread racks or things that can't fit through the chuckhole and so he would have to open those doors. (TX p. 47). Petitioner testified that there were also padlocks on the refrigeration and freezer units. Petitioner testified that all keys in this area are regular size and that there are two heavy doors on the north and south side that are heavy and that he would have to open those doors 20 to 25 times a shift. Petitioner testified that his job did not require him to move any large objects. (TX p. 48-50).

Petitioner testified that since he returned to work after his surgeries, he has not had to return to his doctor for any residual symptoms related to his carpal tunnel. Petitioner never had to ask his supervisor for any modifications to his job duties and was able to perform all the material duties of his job.

Petitioner's supervisor, Marcia Keys testified that she has been the Food Service Manager for the Danville Correctional Center for 19 years and that she supervises 15 positions—two of which are currently vacant. Steve Bildilli is one of the individuals that Ms. Keys supervises. (TX p. 55). Ms. Keys oversees the entire dietary department and is responsible for ordering all the supplies, equipment, food, and everything needed to run the department. She does the scheduling for her staff, conducts overtime offerings, evaluations, approves time off and delegates all orders that need to be followed to run the department. (TX p. 56).

Mr. Bildilli's position is as a correctional Food Service Supervisor II. As of September 2010, Petitioner's position would have been as a Food Service Supervisor I. Ms. Keys testified there is no material difference in the duties of the two positions. Mr. Bildilli is responsible for supervision of food preparation, maintaining sanitation, and custodial duties. He instructs the inmates on the things that they need to do and corrects them and handles any discipline of the inmates. Mr. Bildilli would use his keys to provide an inmate access to supplies and let them in and out of rooms to retrieve items as they are preparing food, or conduct an inventory. He would also use the key for the office door that he passes through. The keys are normal size house keys, not Folger Adams keys.

Ms. Keys testified that there are various assignments that a food supervisor may have. One assignment is called production and that means they are responsible for supervising the meal preparation and cooking. In that position, on a typical shift, a food supervisor may have to go into the 10 coolers rooms to retrieve supplies or let the inmates in and out of that room. There are 10 or 12 rooms on average that he might need to go into at least one time and there are other doors that would open throughout the shift to let inmates in or out or let himself in or out. The majority of Mr. Bildilli's shift, he would be supervising the inmates and the inmates do all of the actual food preparation. Some of the doors required that you turn the key to unlock them and turn the key to lock them but some of them lock on their own. The doors are not heavier than normal doors.

Ms. Key's office is located approximately 150 to 200 feet from where Mr. Bidilli does his job. Ms. Keys does walk around the dietary area at times during the shifts. Ms. Keys previously held the same position as Mr. Bildilli and is familiar with the job duties and activities that Mr. Bidilli is responsible for. On a given shift Ms. Keys testified that Mr. Bildilli would open and close the doors somewhere between 10 and 20 times and that he

might have to open the areas that are padlocked between five and seven times. Petitioner did not ever complain to Ms. Keys prior to making his claim that his job duties were bothering his hands. After returning to work from his surgery, Petitioner has not reported any problems performing his job duties. He was on light duty immediately after the surgery and since returning to full duty has not requested any modifications or taken any additional time off related to the surgery. Ms. Keys testified that the job description attached as Respondent's Exhibit 5 was accurate.

On cross examination, Ms. Keys stated that the job description does not discuss the use of the hand and that based on that it might not be complete and accurate. Ms. Keys stated that she has been working at the department since 1986 and began and a Correctional Officer for 15 months and then went into food service as a Food Service Supervisor I until 1990 and then was promoted to Food Service Supervisor III until 1994 and then was promoted to food service manager and has been in that position ever since. (TX, p. 69-72).

Ms. Keys did not think that the job was hand intensive in any way. Ms. Keys cannot see Mr. Bidilli the entire time he is doing his job. Mr. Bildilli starts work at 3:00 p.m. and Ms. Keys overlaps with her shift for three hours. (TX. p. 72-73). Ms. Keys based her testimony on the estimate of the number of time Mr. Bildilli performed certain activities by walking herself through his job duties and what she did while in that position. Ms. Keys testified that she considered Petitioner to be a good worker but that she did not consider him to be honest and forthright. She did not recall writing him up for anything. (TX p. 74-76).

Ms. Keys stated that she had the opinion that he was not honest and forthright because there have been incidences where she has known something to not be the truth and that Mr. Bildilli always has an ulterior motive or does things for personal gain. Ms. Keys recalled Mr. Bildilli telling her how much his hands were worth if he had surgery. Ms. Keys stated that she did not think he had good character and that Mr. Bildilli was very self-serving. Ms. Keys stated that she did not trust the Petitioner. (TX, p. 77-78).

Ms. Keys stated that percentages on the job description included opening and closing the doors to access the food in the various categories of assisting and estimating the food production, and receiving the food containers. (TX. p. 78). Ms. Keys stated that opening and closing doors time-wise, is not that much of the job. It takes a second or two second to open and closed a door and once they are done with food production, they sit around and hang out. (TX. 79-80).

Ms. Keys has been in this position for 19 years and has supervised all of the individuals in Mr. Bildilli's position during that entire time. Ms. Keys is aware of the material job duties and understands what these individuals are doing while they are at work. (TX. p. 81).

Petitioner's treating doctor, Dr. James Sobeski was deposed on September 22, 2011. Dr. Sobeski testified that he treated Petitioner in April, 2007 for a shoulder injury.

Dr. Sobeski testified that his understanding of Petitioner's job duties were that he was a guard essentially and opened doors. (PX 5, p. 8). Petitioner first treated with his office for symptoms of carpal tunnel syndrome on September 9, 2010. (PX 5, p. 9) At that time Petitioner presented with complaints of numbness and tingling in both hands and felt that his hands were weak at times and get pain in his forearms. These symptoms wake him up at night. He also complained of some triggering of his right index finger. (PX 5, p 10). Petitioner was sent for an EMG which showed very mild bilateral carpal tunnel syndrome. Petitioner treated with splits for nighttime use and on October 21, 2010 Petitioner returned and opted for surgery. (PX 5, p. 11). The carpal tunnel release surgery on both hands was performed on February 3, 2011. Dr. Sobeski's office saw Petitioner just once after the surgery on February 17, 2011 for the removal of the stitches and released him from care. (PX 5, p. 11-12).

Dr. Sobeski testified that Petitioner did not have any other medical conditions that could cause carpal tunnel syndrome. Dr. Sobeski testified that he believed Petitioner's job duties caused or contributed to the development of carpal tunnel syndrome. (PX 5, p. 12-13). The basis of his opinion was his understanding of the job which he understood required, "heavy gripping" and "the fact that he told us that these symptoms occurred, were aggravated by the job itself." (PX 5, p. 13). Dr. Sobeski testified that the care and treatment was reasonable.

Dr. Sobeksi testified on cross examination that the only time that he would have actually seen the Petitioner was on the date of surgery. (PX 5, p. 15). Dr. Sobeski testified that he never actually spoke to the Petitioner about his job duties and its never noted anywhere in the medical records a discussion regarding his work duties. (PX 5, p. 15). Dr. Sobeski stated that he himself had previously working in a prison and based his testimony on that. He stated that he knew what Petitioner did stating, "***they have big heavy keys that have to turn, large locks and then pull open heavy doors. And I think those sorts of activities of heavy gripping and moving large objects could certainly cause or aggravate carpal tunnel syndrome.***" (PX 5, p. 15-16). Dr. Sobeski stated that if Petitioner did not actually perform these duties, then work would not be a cause. (PX 5, p. 16).

Dr. Sobeski never worked at the Danville Correctional Center. Dr. Sobeski was not aware of how often Petitioner performed any of his job duties and could not give an estimate of how long an individual would have to perform job duties for them to cause carpal tunnel syndrome. Dr. Sobeski stated that the more time per day he performs those activities, the more likely it would cause carpal tunnel. (PX 5, p. 17). Dr. Sobeski agreed that obesity, and age can be risk factors. Dr. Sobeski could not point to any notes in the medical records that Petitioner complaint of having problems with his hand or wrist while performing his job duties. (PX5 p. 22).

Dr. Sobeksi stated that his understanding of his work activities as of September 2010 were that Petitioner was using ***big heavy keys and opening and closing big, heavy doors on a repetitive basis***. (PX 5, p. 22). Dr. Sobeski stated that the first he heard of Petitioner's job in the dietary department was the day of the deposition. (PX 5, p. 27).

Respondent sent Petitioner for Independent Medical Examination by Respondent to Dr. Anton J. Fakouri. Dr. Fakouri saw Petitioner on April 5, 2012 and authored a report on the same day. (RX 1). Dr. Fakouri performed a physical examination of the Petitioner, took a history from Petitioner and reviewed his medical records. Based upon that, Dr. Fakouri concluded that Petitioner did suffer from bilateral carpal tunnel syndrome and that as of April 5, 2012, he had a complete resolution. (RX 2, p. 7-9). Dr. Fakouri also discussed with Petitioner his job duties and reviewed the Petitioner's job descriptions as a corrections officer and as a food supervisor. Dr. Fakouri concluded that Petitioner's job duties did not cause, contribute to, aggravate or accelerate his carpal tunnel syndrome. (RX 2, p. 9-10). He based his conclusion on the fact that his ***job duties did not require any forceful gripping, or operating vibratory tools, such as a jackhammer. Dr. Fakouri provided the opinion that closing doors and doing the activities Petitioner described to him is not related to the development of carpal tunnel.*** (RX 2, p. 10).

Dr. Fakouri stated that the jobs that are described in the literature that are associated with carpal tunnel syndrome are repetitive forceful activities and after discussing Petitioner's job duties with him, he did not believe that any of the activities described predispose someone to carpal tunnel. (RX 2, p. 17-18). Dr. Fakouri testified that he did not believe that opening doors predisposes someone to the development of carpal tunnel syndrome and he did not know of any literature that would support that. (RX 2, p. 19-20). Dr. Fakouri understood that the doors at the prison were metal doors and prison cell doors but did not know the type of keys Petitioner used but after discussing Petitioner's work duties with him, did not believe any of the activities of turning keys or turning doors were related. (RX 2, p. 20).

Dr. Fakouri testified that the Petitioner did not tell him about any forceful grasping activities and that what the Petitioner described to him does not correlate with the literature or his experience of causation of carpal tunnel syndrome. (RX 2, p. 23-24).

I. CONCLUSIONS OF LAW

ISSUE C: DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT? *AND* ISSUE F: IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner is alleging an accidental injury to his left and right hands and wrists due to repetitive work activities that arose out of and in the course of his employment with Respondent and manifested itself on September 22, 2010

Petitioner testified that prior to April 2010 when he was assigned to the post of a wing officer as a Correctional Officer he would have to use his key to lock and unlock doors on average 200 times a shift. For 10% of the time when he was a wing officer assigned to a two wing unit, Petitioner would have to use his key to lock and unlock doors 400 times a shift. Petitioner stated that he had probably been a wing officer for two to five years prior to April 2010 when he transferred to dietary but that even as a wing officer, his assignment was always on a daily basis. Petitioner testified that on a given day, he could be on the wing or in the tower or a control officer or filling in for someone on vacation relief. Petitioner testified that the control position did not require any opening any doors because it is done with a touch screen. Petitioner testified that the other jobs that he could be assigned to on a daily basis—control, commissary, supervisor, tower, movement officer—did not require him to use his key and open doors the 400 times that he testified he would have to as a wing officer. (TX, p. 38).

Petitioner testified that he did not ever use the Folger Adams keys but always used regular size keys. Petitioner testified that, for the most part, only the entry doors were heavy and occasionally an inmate's cell door might be tough to open or jammed or an inmate would block his door. Petitioner testified that 50 of the times that he had to use his key to open a door, it was a heavy door. (TX, p. 38-39). Petitioner also testified that at various times, he would be on vacation relief assignments which were on a 90 day rotation and he could be posted in the yard or the tower. Petitioner testified that he did not have to do any repetitive activities while in the yard and did not have to do any repetitive hand movements while in the tower. (TX p. 44-46).

Petitioner testified that as a Food Services Supervisor, he was required to only unlock the doors but had to turn the key to lock them. Petitioner testified that between opening and closing doors and locks and padlocks on an average day he would turn keys 350 to 375 on average a day. (TX p. 20). Petitioner estimated that in this post, 20-25 times would be on heavy or hard to open doors. Petitioner testified that he was not required to move heavy objects.

Respondent's witness, Marcia Keys was Petitioner's supervisor during the time frame that Petitioner testified he notice an increase in his symptoms that he associated with his work activities. Ms. Keys was the Food Service Manager for the Danville Correctional Center and held that position for 19 years. Prior to being promoted to the position of manager, Ms. Keyes has worked in the post held by Mr. Bidilli and had supervised all individuals in that post for the past 19 years. Ms. Keys was familiar with the job duties and requirements and with the activities performed during each shift. While Ms. Keys did not personally view Mr. Bidilli during the entire time that he was working, she was familiar with the job requirements and with what Mr. Bildilli was supposed to be doing on a given shift.

Ms. Keys testified that while Petitioner did have to open various doors throughout his shift, she would put this number at a much lower number between 10 to 20 time opening doors to the various rooms and 5-7 times opening padlocks. Ms. Keys testified that none of the doors are heavier than normal doors. She explained that the job required supervising the inmates while they prepared the meals and allowing them access to the various locked refrigerators and freezers and pantries where food was stored. Petitioner's primary responsible was to monitor and supervise the inmates. Ms. Keys did not see the job as hand intensive.

Both Petitioner and his supervisor agree that Petitioner never used heavy keys or Folder Adams keys. Both Petitioner and his supervisor agree that it takes about a second to turn a key and open a door. Obviously there is a large discrepancy in the *number* of key turns estimated by Petitioner and his supervisor. ***Even taking Petitioner's estimate for the time he was a Food Service Supervisor of 350-375 times a shift would amount to between 5.8 and 6.2 minutes a shift.***

Petitioner's doctor, Dr. James Sobeski, had not spoken to the patient about his job duties and did not have any notes in his medical records indicating that Petitioner advised him that his job duties aggravated his carpal tunnel symptoms. In fact, Dr. Sobeksi saw Petitioner for treatment only on the day of surgery. Dr. Sobeski testified more than once in his deposition that his understanding of Petitioner's job duties were that he was a guard essentially and opened doors. (PX 5, p. 8). Dr. Sobeski stated that he understood Petitioner's job duties and explained that "***they have big heavy keys that have to turn large locks and then pull open heavy doors. And I think those sorts of activities of heavy gripping and moving large objects could certainly cause or aggravate carpal tunnel syndrome.***" (PX 5, p. 15-16). Dr. Sobeski stated that if Petitioner did not actually perform these duties, then work would not be a cause. (PX 5, p. 16).

Dr. Sobeski never worked at the Danville Correctional Center. Dr. Sobeski was not aware of how often Petitioner performed any of his job duties. Dr. Sobeski stated that the more time per day he performs those activities, the more likely it would cause carpal tunnel. (PX 5, p. 17). Dr. Sobeksi testified on cross examination that the only time that he would have actually seen the Petitioner was on the date of surgery. (PX 5, p. 15). Dr. Sobeski testified that he never actually spoke to the Petitioner and its never noted anywhere in the medical records a discussion regarding his work duties. (PX 5, p. 15).

In addition, Petitioner's doctor based his opinion on the assumption that Petitioner's entire job was using heavy keys and opening heavy doors and moving heavy objects. ***It is undisputed that Petitioner did not use heavy keys.*** Petitioner testified that only a small percentage of the number of doors he had to open were heavy doors. Further, Petitioner's doctor did not have any information regarding the job that Petitioner alleges primarily caused his symptoms, that of a Food Services Supervisor, stating on the date of his deposition that it was the first time he ever heard that Petitioner worked in that position. Therefore the testimony of Petitioner's doctor is not compelling as he did not have an accurate understanding of Petitioner's job duties.

Dr. Fakouri concluded that Petitioner's job duties did not cause, contribute to, aggravate or accelerate his carpal tunnel syndrome. (RX 2, p. 9-10). He based his conclusion on the fact that his ***job duties did not require any forceful gripping, or operating vibratory tools, such as a jackhammer. Dr. Fakouri provided the opinion that closing doors and doing the activities Petitioner described to him is not related to the development of carpal tunnel.*** (RX 2, p. 10).

The Arbitrator considers the fact that Dr. Sobeski had an incorrect understanding of the petitioner's job duties in rendering his opinion on causation to be most important in consideration of the issue. The Petitioner has the burden of proof, and failed to meet his burden in this instance.

The Arbitrator finds that Petitioner failed to prove by a preponderance of the credible evidence that he sustained an accidental injury his hands and wrists due to repetitive work duties. Petitioner's supervisor testified that the number of times Petitioner would need to be using his key was well under 50 times a shift and that there are very few heavy doors in dietary. However, even accepting Petitioner's estimate of his job duties and using his own numbers, these duties are clearly not repetitive in nature as he would be performing the alleged repetitive tasks for a total of ***between 5.8 and 6.2 minutes*** in a 7 1/2 hour shift. The Arbitrator does not find Petitioner's testimony credible that these tasks were repetitive or constituted a major portion of his job duties. While he was required to use his keys to unlock and lock doors, this was incidental to his primary job of supervising the inmates and did not rise to a level where it was repetitious in nature. If that were the case, Petitioner would not be in a position to adequately supervisor inmates who were involved the task of preparing food with knives and heavy pots and other metal objects. In addition, Petitioner's supervisor estimated the number of times Petitioner would use his keys to lock and unlock doors as significantly lower than the Petitioner. Even if we accept that this number might be greater on given shifts, it still would not rise to the level of being repetitive in nature.

Taking into account Petitioner's job duties before April 2010 as a Corrections Officer is also not compelling as Petitioner testified that this job was even less hand intensive by 10-15% and that in addition to being a wing officer, he was working in a variety of different posts including control, yard duty, commissary, segregation, tower, movement officer, none of which required repetitive hand movements.

In addition, Petitioner never testified that he experienced symptoms while at work or that he noticed while working that turning the keys aggravated his hands. Petitioner testified that after he started working as a Food Supervisor in April 2010, his hands started getting numb in the middle of the night and that it would wake him up and that he noticed his grip strength was decreased when opening jars—something that he did not testify he did at work. (TX, p. 21). Petitioner testified that when he worked as a Corrections Officer in late 2009, he did not notice any numbness or tingling while he was working but that it bothered him while he was trying to sleep and that it kept him awake at night. (TX, p. 35).

Arbitrator finds that Petitioner's job duties with Respondent did not cause or aggravate his bilateral carpal tunnel syndrome and that his current condition of ill-being was not caused by her work duties.

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

Randy Peebles,
Petitioner,

vs.

NO: 12 WC 18029

14IWCC0702

Summit Stainless Steel,
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 causation, medical expenses, temporary total disability, permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission finds that the last page of the Arbitrator's decision appears to be an internal note and the Commission strikes the same from the decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on November 4, 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.

14IWCC0702

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $16,700.00. 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: AUG 2 0 2014

MB/jm

O: 8/7/14

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PEEBLES, RANDY
Employee/Petitioner

Case# **12WC018029**

14IWCC0702

SUMMIT STAINLESS STEEL
Employer/Respondent

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.

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:

1137 LAW OFFICES OF NEIL KAUFFMAN
1944 W CHICAGO AVE
CHICAGO, IL 60622

1739 STONE & JOHNSON CHARTERED
PATRICK DUFFY
200 E RANDOLPH ST 24TH FL
CHICAGO, IL 60601

14IWCC0702

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

RANDY PEEBLES
Employee/Petitioner

v.

SUMMIT STAINLESS STEEL
Employer/Respondent

Case # **12** WC **018029**

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 **Wheaton**, on **October 7, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0702

FINDINGS

On the date of accident, **May 7, 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 condition of ill-being through 7/15/12 ***is*** causally related to the accident. SEE DECISION

In the year preceding the injury, Petitioner earned **$31,096**; the average weekly wage was **$598**.

On the date of accident, Petitioner was **34** years of age, ***married*** with **4** 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 **$806.56** 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 $398.66 per week for a period of 21-2/7 weeks as Petitioner was temporarily and totally disabled commencing 5/12/12 through 10/7/12 pursuant to Section 8(b) of the Act. Respondent shall receive credit for amounts paid.

Medical benefits

Respondent shall pay to Petitioner the reasonable and necessary medical expenses incurred prior to 7/15/12 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

Permanent Partial Disability

Respondent shall pay Petitioner permanent partial disability benefits of $358.80/week for 25 weeks because the injuries sustained caused the loss of 5% MAN AS A WHOLE 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.

Carolyn Doherty
Signature of Arbitrator

10/1/13
Date

NOV - 4 2013

FINDINGS OF FACT

At trial, the parties stipulated that the 34 year old Petitioner sustained a work related accident on 5/7/12. ARB EX 1. Accident and notice are not at issue. ARB EX 1. Petitioner testified that he worked for Respondent in shipping and receiving filling orders. His job duties required him to lift various weights up to 100 pounds. Petitioner worked 8 am to 5 pm. On 5/7/12, Petitioner was at work filling orders. He testified that he drove a forklift to pick up a new order around 2:30 pm. Petitioner testified that to fill the order he had to lift ½ inch bars of steel. Petitioner credibly testified that he was lifting between 70 to 75 pounds of steel material out of the pan to place on a scale for weighing. While lifting the material he felt his left shoulder and lower back pop. Petitioner testified that he screamed in pain and then tried to walk off the pain. Petitioner reported the injury to his back and shoulder.

Petitioner testified that he drove himself to Central DuPage hospital on 5/7/12. The Central DuPage records indicate that Petitioner reported an injury to his left shoulder and low back and that he felt a pop in his left shoulder and low back while lifting material at work. X-rays of the left shoulder were negative. Petitioner was told to use ice and Motrin for pain. He was returned to work on light duty for 2 days. PX 2. Petitioner did not return to work the next day. Rather, Petitioner testified that his pain was worse and that he had a bulge on the left side of his neck between his neck and left shoulder so he went to the ER at St. James Hospital as it was closer to his home. On 5/8/12 at St James, Petitioner again reported the accident and the pain in his left shoulder and low back after lifting at work. The shoulder pain was reported as shooting down his left arm. PX 3. He was diagnosed with a musculoskeletal injury to his left shoulder. He was given Motrin and Flexeril and told to follow up with his primary care doctor. PX 3.

Petitioner returned to Central DuPage Hospital on 5/9/12 complaining of continued left shoulder and low back pain with some pain into the right hip area. PX 2. Petitioner was diagnosed with neck and back sprain and left shoulder sprain. Cervical spine x-rays taken on 5/9/12 were negative. Lumbar spine x-rays taken on 5/9/12 were also negative. He was told to discontinue the prescribed pain medication referenced as Vicodin and Ibuprofen and was taken off work until he could see a primary care doctor. PX 2. Petitioner returned to Central DuPage on 5/16/12 for follow up when he was again continued off work pending evaluation. PX 2.

Petitioner chose to seek care at Affiliated Health Care and his first visit was on 5/17/12. Petitioner received chiropractic care from Dr. Sistino 3 to 4 times per week to low back, left shoulder and neck. Petitioner testified that the treatment helped temporarily but the pain would return after a few hours.

Petitioner also saw Dr. Osman, per the referral of Affiliated, for a neurology consult on 5/23/12. Dr. Osman noted Petitioner's neck pain travel with vague paresthesia and feeling of weakness to the left shoulder, scapula and proximal upper arm. The low back pain radiates with paresthesia and feeling of weakness to the right buttock and thigh. Spasm, tenderness and limited range of motion was noted on exam to the lumbar and cervical region worse in the left cervical and right lumbar areas. Petitioner was diagnosed with lumbar and cervical radiculopathy and spasm and cervical sprain and strain. Petitioner was to continue his current management with physical and chiropractic therapies and medication. If he was not improved in 2 to 3 weeks an EMG was to be considered. Based on the continued symptoms, an EMG and nerve conduction study was performed of the left upper and right lower extremities and the

cervical and lumbar paraspinal muscles bilaterally on 6/6/12. The impression was right L4-5-S1 radiculopathy and left C5-C6 radiculopathy.

In his 6/8/12 report, Dr. Sistino diagnosed Petitioner with a cervical and thoracic sprain/strain, left lower cervical radiculopathy, left shoulder sprain strain with "attendant dysfunction of the left rotator cuff components", impingement of the left shoulder and a thoracolumbarsacral strain/sprain. PX 4. He indicated that Petitioner continued under his care at that time for continued symptoms.

On 6/14/12, Petitioner was sent for a cervical MRI for his continued cervical complaints that referred into his left shoulder. The MRI was interpreted by Dr. Kuritza to show a subligamentous posterior bulge/protrusion measuring approximately 2-3 mm noted to slightly elevate the posterior longitudinal ligament and indent the thecal sac. The bulge appears broad-based and no significant spinal stenosis or significant neuroforaminal narrowing was noted. PX 4. Petitioner continued his care regimen at Affiliated. PX 4.

Petitioner attended a Section 12 exam with Dr. Weber at Respondent's request on 6/18/12. Dr. Weber is at Rush Midwest Orthopedics. RX 1. Petitioner reported cervical, left shoulder and lumbar pain. Dr. Weber's exam of the cervical spine showed no consistent limitations of range of motion, negative Spurling's and global weakness on the left side which is not consistent with any dermatomal pattern. She opined that "there is no ongoing active diagnosis in regards to his cervical spine and based upon his reported initial injury I do not believe that a cervical injury occurred at the time of the incident." With regard to the left shoulder, Dr. Weber noted "his examination today revealed inconsistent findings. He has had full range of motion of the shoulder. He had no evidence of impingement. Although he reported during testing weakness, this was inconsistent. He described a pop during lifting. I find no evidence of any bicipital abnormality. He had negative impingement. He had no scapular dyskinesia, no shoulder hike to suggest any ongoing pathology. His exam was unremarkable with the exception of some subjective weakness, which was global through the entire left upper extremity. It is my opinion that he may have sustained a mild strain to the shoulder but in my opinion that has resolved. Finally, with regard to the low back, Dr. Weber noted "his examination revealed normal range of motion and a normal neurological examination. He had no specific paraspinal muscle tenderness. He describes lifting 15 pounds at the time of the injury which seems to be a low level to result in his subjective complaints. [On cross exam, Petitioner denied telling Dr. Weber he was lifting 15 pounds but rather that he was lifting 70 to 75 pounds when injured] Additionally, him injuring both left shoulder and back at the same time is somewhat suspect with such a low level weight. He may have sustained a mild lumbar strain, but in my opinion no other injuries took place and presently I do not believe that that is an active diagnosis."

Dr. Weber concluded that Petitioner did not need any further treatment, he was at MMI and that he could return to work without restrictions. She further opined that Petitioner's exam revealed symptom magnification and that his subjective symptoms were not objectively founded. In her opinion, his present complaints are not related to the alleged work accident of 5/7/12. RX 1.

On 7/17/12, Dr. Sistino wrote a final report indicating that Petitioner was improved and feeling better and "In our opinion, the patient has reached maximum medical improvement under his treatment plan at this office and under our supervision. Patient continues to experience cervical symptomatology that at times interferes with his activities of daily living and occupational responsibilities. These symptoms have become less frequent and have subsided to a tolerable level in the recent weeks." Dr. Sistino concluded

that Petitioner was totally incapacitated from 5/17/12 through 7/15/12 while under his care. Dr. Sistino returned Petitioner to his regular duty work as of 7/16/12 and was given instructions for home care of his symptoms. PX 4.

Petitioner testified that he last saw Dr. Sistino in July 2012 for treatment. Petitioner further testified that Dr. Sistino told him on 7/15/12 that he still needed "PT" on his back and shoulder but that Petitioner asked Dr. Sistino to release him so that he could go back to work. Petitioner testified that he has not had any treatment for his neck, shoulder or back since that date. If he has pain in those areas he stretches or performs home exercises. Petitioner testified that he has no plans for additional appointments or additional medical care.

Petitioner testified that he returned to work on 7/16/12 but that Respondent "did not have a job" for him. Petitioner further testified that he took his release to return to full duty work dated 7/16/12 to Respondent and was told his position was filled. The Arbitrator notes that Petitioner was off work prior to 7/16/12 during the period when his job was "filled." The Arbitrator further notes that on cross exam, Petitioner denied that several weeks before the accident he gave notice that he was going to quit to work closer to home. Petitioner requests TTD through 10/7/12 when he found another job as a groundman/switcher with H&M International Transportation. Petitioner testified that he worked with H&M through 1/4/13 when he was terminated for job performance failure during the 90 day probationary period. PX 8. Petitioner testified that he was unable to climb ladders on freight trains or lift as required due to pain in his left shoulder and low back. Petitioner was told that he could not work fast enough or keep the required job pace. Petitioner testified that he began receiving unemployment benefits in February 2013.

The parties have received notice from the Illinois Department of Healthcare & Family Services that the Respondent was obligated to withhold child support payments from Petitioner's paychecks. RX 2.

Petitioner testified that he does not have a high school diploma or a GED. All of his jobs have involved physical labor. Petitioner testified to having significant and varied experience in the trades. He testified that he has difficulty performing the type of job he did for Respondent in that he has pain and popping in his shoulder or low back when he tries to lift.

Petitioner testified that he did not have problems with his neck, left shoulder or low back before this accident. He testified that he is unable to sleep on his left shoulder or back and has daily pain in his neck, left shoulder and back. When he feels pain he does his home stretching exercises. Petitioner testified that he has 4 children under the age of 14 and that he is unable to play sports or be as active with his children due to shoulder and low back pain. He has difficulties with activities of daily living. He no longer plays sports. Petitioner testified that he has back pain if he stands too long, has pain with overhead lifting and still uses a brace for his back 3 to 4 times per week. Petitioner testified that he takes Tylenol for pain.

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?

The Arbitrator notes that the parties stipulated to the issues of accident and proper notice. ARB EX 1. Based on the credible testimony of Petitioner as buttressed by his treating medical records, the Arbitrator finds that Petitioner's cervical, left shoulder and lumbar conditions through his MMI date of 7/15/12 are causally related to the work accident of 5/7/12. In so finding, the Arbitrator notes that Petitioner did not have problems with these areas, including the cervical area, prior to the stipulated accident of 5/7/12 and that his treatment for all conditions was immediate and consistent thereafter through 7/15/12. The Arbitrator further notes that Petitioner's complaints to the left arm, neck and low back are reflected in the records from Central DuPage Hospital two days after the accident on 5/9/12 and that Petitioner was sent for cervical x-rays as well as shoulder and lumbar x-rays. Petitioner was diagnosed on 5/9/12 with neck and back sprain and left shoulder sprain. The Arbitrator finds that these medical records, and those that follow, sufficiently buttress Petitioner's complaints to all areas following the accident and support a finding of causal connection for all areas.

The Arbitrator further notes that Petitioner's neck, left shoulder and low back conditions have been described by all physicians, treating and examining, to be strain/sprains. This diagnosis continued after the 6/14/12 cervical MRI and his treatment regimen did not change. Petitioner's treating physician, Dr. Sistino, returned Petitioner to full duty unrestricted work as of 7/16/12. Petitioner's testimony that he requested this return to work despite Dr. Sistino's belief he still needed treatment is not supported in Dr. Sistino's written discharge report. Rather, in the report, Dr. Sistino clearly states, "In our opinion, the patient has reached maximum medical improvement under his treatment plan at this office and under our supervision. Patient continues to experience cervical symptomatology that at times interferes with his activities of daily living and occupational responsibilities. These symptoms have become less frequent and have subsided to a tolerable level in the recent weeks." Accordingly, Dr. Sistino returned Petitioner to full duty. Petitioner has not sought or received any additional medical care for his conditions since 7/15/12.

Based on Petitioner's release at MMI and his full duty work release as of 7/16/12, the Arbitrator finds causal connection for Petitioner's neck, left shoulder and lumbar conditions through his last visit with Dr. Sistino on 7/15/12.

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

Respondent's dispute with regard to medical expenses was based on liability. Based on the Arbitrator's findings on the issue of causal connection through 7/15/12, the Arbitrator further finds Respondent is to pay Petitioner the reasonable and necessary medical expenses incurred in connection with his causally related conditions through 7/15/12 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any. ARB EX 1.

(K) What TTD is owed Petitioner?

Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that Petitioner was temporarily and totally disabled for a period of 21-2/7 weeks commencing 5/12/12 through 10/7/12 pursuant to Section 8(b) of the Act. In so finding, the Arbitrator notes that Petitioner's off work status was noted in the records of Central DuPage Hospital and the records of Affiliated. Dr. Sistino noted that Petitioner was totally incapacitated from 5/17/12 through 7/15/12 while under his care. Specifically, the Arbitrator further finds that Petitioner was completely off work when his job was "filled"

by Respondent and that when Petitioner returned with a full duty release on 7/16/12, no job was offered at that time or anytime thereafter. Accordingly, the award of TTD extends through the date of 10/7/12 when Petitioner found another job with a new employer. Respondent shall receive credit for amounts paid. ARB EX 1.

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

In considering permanent disability in this matter, the Arbitrator shall base the determination on the following factors pursuant to Section 8.1b(b) of the Act: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. 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 are explained below. The Arbitrator initially notes that in this matter no reported level of impairment pursuant to Section 8.1b(a) was provided. The remaining enumerated factors were considered as follows and include consideration of the Section 12 physician, Dr. Weber.

The Arbitrator finds that the Petitioner was 34 years of age at the time of the accident. As stated above, the medical records reflect that Petitioner sustained essentially strains and sprains to his neck, left shoulder and low back for which he received conservative treatment followed by a release to full duty work. The Arbitrator notes Petitioner's continued complaints of pain in his neck, left shoulder and low back and that these pain complaints interfere with Petitioner's activities of daily living including his family interaction, ability to play sports and his ability to sleep. The Arbitrator further notes that Petitioner has not sought or received any additional care since his last visit to Dr. Sistino on 7/15/12.

With regard to Petitioner's occupation and his future earning capacity, the Arbitrator notes Petitioner's testimony that he has pain with overhead activities and lifting and that he feels he is unable to perform the type of physical labor and lifting as he was performing prior to the accident. However, the medical records and particularly Dr. Sistino's discharge report do not support Petitioner's claimed inability to lift or work at a job similar to his job with Respondent. The Arbitrator notes Petitioner's assertion that his future earnings capacity has diminished as evidenced by his inability to perform and keep his job with a subsequent employer due to the lingering symptoms in his shoulder and neck. However, the Arbitrator finds this argument unsupported by the record as a whole and too speculative on which to base a finding of impaired earning capacity based on the strain injuries received in the accident of 5/7/12.

Based on the foregoing and on the record as a whole, the Arbitrator finds Petitioner sustained 5% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act.

TTD - Rx 1 report of dr weber check this date and determine proper cut off of ttd and liability - cut off on 5/29 – ime not unitl 6/18 – ttd through date of full duty return or past that through 10 when he got another job???

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Loretta Kite,

Petitioner.

vs.

NO: 11 WC 10508
11 WC 10509

Wal-Mart,

14IWCC0703

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, extent of temporary total disability, medical expenses, prospective medical care and calculation of credit and being advised of the facts and law, modifies the Decisions of the Arbitrator as stated below and otherwise affirms and adopts the Decisions of the Arbitrator, which are attached hereto and made a part hereof. The Commission further remands these cases to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322 (1980).

The Commission modifies the Decisions of the Arbitrator finding that Petitioner was temporarily totally disabled from March 6, 2011 through May 14, 2011 (10 weeks) and from July 21, 2011 through July 15, 2012 (51-3/7 weeks) and from February 7, 2013 through June 7, 2013 (17-2/7 weeks), a total period of 78-5/7 weeks. On March 5, 2011, Petitioner went to the ER at Memorial Hospital. On March 6, 2011, the ER discharged Petitioner, noting she would be able to return to work at full duty in 3 days. Petitioner was not authorized off work by Dr. Hong

on March 8, 2011. However, in a Worker's Compensation Request for Medical Care form dated by Petitioner on March 9, 2011, Dr. Hong indicated that he authorized her off work. On March 14, 2011, Dr. Hong authorized Petitioner off work. On March 21, 2011, Dr. Lupardus had Petitioner remain off work until released by chiropractor Dr. Eavenson. On March 31, 2011, Dr. Gornet authorized Petitioner off work through May 15, 2011. On April 7, 2011, Dr. Eavenson authorized Petitioner off work through May 15, 201. On July 18, 2011, Dr. Lupardus noted that Petitioner returned to work on May 15, 2011 with restrictions. Dr. Gornet released Petitioner to return to work light duty with restrictions on May 23, 2011. Therefore, Petitioner was temporarily totally disabled from March 6, 2011 through May 14, 2011 (Dr. Lupardus' July 18, 2011 note that Petitioner had returned to work on May 15, 2011).

Petitioner then went to Memorial Hospital on July 18, 2011 and ER Dr. Mecker noted Petitioner was discharged that day and that she should be able to return to work on July 20, 2011. Petitioner saw Dr. Gornet on July 21, 2011 and he authorized her off work. Therefore, temporary total disability began again on July 21, 2011, when Petitioner was authorized off work by Dr. Gornet. ER personnel did not authorize Petitioner off work. On January 9, 2012, Dr. Gornet noted that Petitioner's work status remained unchanged on light duty, but she was not working as there was no light duty available, thus temporary total disability continued. Dr. Gornet released Petitioner to return to work full duty on July 16, 2012. Therefore, Petitioner was temporarily totally disabled from July 21, 2011 through July 15, 2012 (Dr. Gornet records).

Petitioner testified she worked full duty from July 16, 2012 to February 7, 2013. On February 7, 2013, Dr. Gornet authorized Petitioner off work through June 7, 2013. Therefore, temporary total disability began again on February 7, 2013. Petitioner testified that she has not worked since February 7, 2013. Petitioner was not authorized off work after June 7, 2013. Therefore, Petitioner was temporarily totally disabled from February 7, 2013 through June 7, 2013 (Dr. Gornet records). The Commission affirms all else. The Commission notes that Px1 shows medical expenses of $28,386.00 and Rx4 shows payments of $19,091.67 made to the medical providers by Respondent, excluding fees for medical management, a §12 evaluation and mileage to that evaluation.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 78-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $28,386.00 for medical expenses under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act and subject to credit of $19,091.67 for payments made to the medical providers by Respondent.

14IWCC0703

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes that Respondent paid $4,373.28 in TTD benefits.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit in the amount of $2,209.57 under §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize in writing and pay for the treatment recommended by Dr. Gornet including, but not limited to, disc replacement surgery, pursuant to the Medical Fee Schedule.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $22,700.00. 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: AUG 20 2014
MB/maw
o05/29/14
43

Mario Basurto

Stephen J. Mathis

David L. Gore

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

KITE, LORETTA
Employee/Petitioner

Case# **11WC010508**
11WC010509
11WC010510

WAL-MART
Employer/Respondent

14IWCC0703

On 12/6/2013, 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 0.10% 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:

EVANS & BLASI LLC
PETER BLASI
1512 JOHNSON RD
GRANITE CITY, IL 62040

2593 GANAN & SHAPIRO PC
AMANDA WATSON
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

14IWCC0703

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)

Loretta Kite
Employee/Petitioner

v.

Wal-Mart
Employer/Respondent

Case # 11 WC 10508

Consolidated cases:
11 WC 10509 & 11 WC 10510

An *Application for Adjustment 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 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 dates of accident, February 9, 2011 (11 WC 10508), February 24, 2011 (11 WC 10509), and March 5, 2011 (11 WC 10510), Respondent was operating under and subject to the provisions of the Act.

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

On February 9, 2011(11 WC 10508) and February 24, 2011 (11 WC 10509), Petitioner did sustain accidents that arose out of and in the course of employment. On March 5, 2011 (11 WC 10510), Petitioner did not sustain an accident (repetitive trauma) 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 accidents of February 9, 2011 (11 WC 10508), and February 24, 2011 (11 WC 10509). Petitioner's current condition of ill-being is not causally related to the accident (repetitive trauma) of March 5, 2011 (11 WC 10510).

In the year preceding the injury, Petitioner earned $18,131.79; the average weekly wage was $348.69.

On the date of accident, Petitioner was 40 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 $4,373.28 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $4,373.28.

Respondent is entitled to a credit of $2,209.57 under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation in 11 WC 10510 is denied.

Respondent shall pay for 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 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, disc replacement surgery.

Respondent shall pay Petitioner temporary total disability benefits of $253.00 per week for 100 1/7 weeks commencing March 6, 2011, through May 26, 2011, July 19, 2011 through July 16, 2012, and February 7, 2013, through October 29, 2013, 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 2, 2013
Date

ICArbDec19(b)

DEC 6 - 2013

Findings of Fact

Petitioner filed three Applications for Adjustment of Claim which alleged she sustained accidental injuries arising out of and in the course of her employment for Respondent. In case 11 WC 10508, Petitioner alleged that she sustained a work-related accident on February 9, 2011, when some boxes fell on her injuring her neck and upper extremities. In case 11 WC 10509, Petitioner alleged that she sustained a work-related accident on February 24, 2011, while lifting a bucket of doughnut icing which caused her to sustain injuries to her neck and upper extremities. In case 11 WC 10510, Petitioner alleged a repetitive trauma injury to her neck and upper extremities as a result of stocking shelves and alleged the manifestation date of March 5, 2011.

Respondent admitted that Petitioner sustained work-related accidents on February 9, and February 24, 2011; however, Respondent denied that Petitioner sustained a repetitive trauma injury on March 5, 2011. Further, Respondent disputed liability in regard to the accidents of February 9, and February 24, 2011, on the basis of causal relationship. These cases were tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills, temporary total disability benefits and prospective medical treatment.

Petitioner worked for Respondent as a sales associate in the bakery department and her job duties required her to stock shelves, remove product from pallets, push/pull carts, etc. Petitioner worked the 5 AM to 2 PM shift five days a week.

On February 9, 2011, Petitioner was unloading boxes of cookies from a cart and several boxes fell, striking Petitioner in the head and neck. Each of these boxes weighed approximately 10 pounds. Petitioner reported the accident to her supervisor but did not seek any medical treatment at that time because she thought that the pain and stiffness in her neck that she was experiencing would resolve on its own.

On February 24, 2011, Petitioner was in the process of lifting a five gallon bucket of doughnut icing that weighed approximately 20 pounds when she felt a sharp pain in her neck that caused a tingling/numb sensation down her arms. Petitioner testified that this was not like the symptoms she previously experienced; however, she did not seek any immediate medical treatment as she again believed that the symptoms would resolve on their own. Petitioner reported this accident to her supervisor and continued to work her regular work duties; however, Petitioner testified that the pain increased over the next several days.

Petitioner testified that on March 5, 2011, while she was in the process of stocking shelves that she experienced an onset of increased pain/numbness in the neck going down the left arm. At that same time, Petitioner experienced numbness in her face and she thought she was having either a heart attack or stroke. This was not reported as a work injury but Petitioner did seek medical attention shortly thereafter.

Petitioner went to the ER of Memorial Hospital in Belleville. According to the ER records, Petitioner had left arm pain with numbness down the left arm for the preceding four to five days. Multiple diagnostic tests were performed and it was determined that Petitioner had not sustained a heart attack. The ER record also noted that Petitioner's complaints seem to be

"musculoskeletal" and "radicular," and Petitioner was given some anti-inflammatory medications and directed to follow-up with her primary doctor.

Petitioner was seen by Dr. Jim Hong, her family physician, on March 8, 2011. According to Dr. Hong's record of that date, Petitioner had left arm radiculopathy after lifting for two weeks. The record also contained a form completed and signed by Petitioner on March 9, 2011, in which she indicated a date of accident of February 24, 2011, which indicated she injured her left arm while lifting a bucket of icing. Dr. Hong authorized Petitioner to be off work, prescribed some medications and ordered physical therapy.

Petitioner was seen again by Dr. Hong on March 14, 2011, and his record of that date stated that Petitioner's pain symptoms began after lifting objects at work on February 9, 2011. Dr. Hong authorized Petitioner to remain off work, continued medications with physical therapy and ordered a CT scan of the cervical spine. A CT scan was performed on March 16, 2011, which revealed mild degenerative changes and a disc bulge at C3-C4. Petitioner had physical therapy at Ace Physical Therapy on March 16, and March 18, 2011. Those records specifically referenced the work accidents of February 9, and February 24, 2011, as the incidents that precipitated the neck and left arm symptoms.

On March 21, 2011, Petitioner began treating with Multi-Care Specialist and she was treated by Dr. Rodney Lupardus and Dr. Mark Eavenson, a chiropractor. Dr. Lupardus initially evaluated Petitioner on March 21, 2011, and his record of that date contained the history of the work-related accidents of February 9, and February 24, 2011. Petitioner also stated that on March 5, 2011, the pain/numbness in the left arm worsened while she was at work and that she went to the ER. Dr. Lupardus referred Petitioner to Dr. Eavenson for chiropractic treatment and physical therapy. Dr. Eavenson also saw Petitioner on March 21, 2011, and Petitioner provided him with a history of the onset of her neck and left arm symptoms that was consistent with the history she had provided to Dr. Lupardus.

Dr. Eavenson opined Petitioner had a possible cervical disc protrusion with left upper extremity radiculitis. He ordered an MRI scan. The MRI scan was performed on March 22, 2011, which revealed a disc bulge at C3-C4 with neuroforaminal stenosis with near abutment of both exiting C4 nerve roots. Dr. Eavenson treated Petitioner with chiropractic care and physical therapy which provided Petitioner with some relief. Dr. Eavenson subsequently referred Petitioner to Dr. Matthew Gornet, an orthopedic surgeon.

Dr. Gornet initially evaluated Petitioner on March 31, 2011. At that time, Petitioner informed Dr. Gornet of the work-related accidents of February 9, and February 24, 2011, and that she presently had constant pain especially with lifting, arm activity and turning to the left. Dr. Gornet reviewed the MRIs scan and opined that it revealed a bilobular disc protrusion at C3-C4. He opined that Petitioner's symptoms were related to her work-related injuries, although the injury of February 24th, seemed to be the more significant of the two. He authorized Petitioner to be off work and recommended additional conservative treatment with Dr. Eavenson.

In April, 2011, Petitioner received additional physical therapy and chiropractic treatment at Multi-Care Specialist, and was seen again by Dr. Gornet on May 23, 2011. At that time,

Petitioner still had significant symptoms so Dr. Gornet referred Petitioner to Dr. Kaylea Boutwell for some injections. Dr. Gornet opined Petitioner could return to work with restrictions of no lifting over 10 pounds, no repetitive bending/lifting, alternating between standing and sitting, no overhead work, no pushing/pulling and limited hours.

Dr. Boutwell saw Petitioner on June 1, June 15, and June 17, 2011, and gave her epidural injections to the cervical spine on those occasions. Petitioner was seen again by Dr. Gornet on June 20, 2011, and he noted that she had been working light duty but still has significant neck and shoulder pain. Dr. Gornet saw Petitioner on July 21, 2011, and Petitioner's complaints had worsened. At that time, Dr. Gornet recommended that Petitioner undergo disc replacement surgery at C3-C4 and authorized Petitioner to be off work.

At the direction of the Respondent, on June 27, 2011, Dr. Colin Poon. Dr. Poon, a radiologist, reviewed the MRI scan of March 21, 2011, and opined that it revealed a right central disc bulge at C3-C4 with stenosis at the right lateral recess.

At the direction of the Respondent, Petitioner was examined by Dr. Daniel Kitchens, a neurosurgeon, on August 23, 2011. In connection with his examination of Petitioner, Dr. Kitchens reviewed Petitioner's medical treatment records. Petitioner informed Dr. Kitchens of having sustained the work-related accidents on February 9, and February 24, 2011, and the onset of pain occurring on March 5, 2011. Petitioner still had complaints of neck pain with discomfort in the left shoulder and numbness of the left hands/fingers. Petitioner also complained of minimal discomfort in the right shoulder and numbness in her right hand. Dr. Kitchens opined that Petitioner did not have symptoms of cervical radiculopathy and that the accident of February 9, 2011, did not aggravate or exacerbate her degenerative spine condition. This was based on Dr. Kitchens' observation that Petitioner did not have an acute worsening of symptoms until one month post-accident when she first sought medical treatment. He further stated that the initial medical records did not describe a work injury of significant force being applied to her neck. He opined Petitioner could return to work without restrictions and that further medical treatment, including disc replacement surgery, was not indicated.

Dr. Gornet saw Petitioner on September 16, 2011, and, at that time, reviewed Dr. Kitchens' report. In regard to Dr. Kitchens' opinion that the accident of February 9, 2011, did not cause or exacerbate her degenerative spine condition, Dr. Gornet stated that this opinion was "... irrelevant and means nothing." Dr. Gornet agreed that the accident did not cause or exacerbate the degenerative condition; however, he stated that Petitioner has disc pathology at C3-C4 consisting of a central disc herniation with bilobular appearance and that this is the cause of her symptomatology. He reaffirmed his opinion that this condition was work-related, noting the failure of conservative treatment and he restated his treatment recommendation for disc replacement surgery. (Petitioner's Exhibit 6).

Dr. Gornet was deposed on December 19, 2011, and his deposition testimony was received into evidence at trial. Dr. Gornet's testimony was consistent with his medical records and he again opined that Petitioner's current condition was related to her work-related accidents but that the accident of February 24, 2011, was the more significant. He specifically stated that Petitioner's lifting of the bucket of icing could have caused the disc injury, especially to a disc that may have

been compromised a few weeks prior. Dr. Gornet again stated his disagreement with Dr. Kitchens' opinion and noted that it was inconsistent with her medical history.

Petitioner was seen again by Dr. Gornet on January 9, 2012, and her condition was unchanged. He reaffirmed his treatment recommendation for disc replacement surgery at C3-C4 and authorized Petitioner to work light duty but noted that none was available for her. Petitioner continued treatment with Dr. Lupardus and Dr. Gornet in February and April, 2012, and her condition remained essentially the same.

When Dr. Gornet saw Petitioner on July 9, 2012, Petitioner's condition was essentially the same and she had not been able to return to work because of the lack of availability of light duty work. Dr. Gornet noted Petitioner's concern about the possibility of losing her job and recommended that she attempt return to work at full duty. At trial, Petitioner testified that she returned to work for Respondent on full duty on July 16, 2012.

Dr. Gornet saw Petitioner again on October 8, 2012, and her condition was essentially the same. Dr. Gornet again renewed his recommendation for disc replacement surgery. Dr. Gornet saw Petitioner on February 7, 2013, and, at that time, Petitioner informed him that she had continued to work but that her symptoms were getting progressively worse, with neck pain, headaches and pain into both shoulders, upper back and arms. Dr. Gornet reaffirmed his opinion as to causality and authorized Petitioner to be off work.

Petitioner testified that she has not worked since February 9, 2013, and that she continues to have the neck pain and pain down both arms which continues to worsen. She wants to proceed with the surgery that has been recommended by Dr. Gornet. Petitioner denied any prior injuries to either the neck or upper extremities.

At the request of Petitioner's counsel, on April 11, 2013, Dr. Larry Reed, a radiologist, read the MRI of March 22, 2011, and opined that it revealed a disc herniation at C3-C4 extending into the neural foramina bilaterally but more on the right side.

Apparently at the request of Respondent's counsel, Dr. Kitchens prepared a supplemental report dated September 26, 2013, in which he opined that the accident of February 24, 2011, did not cause or exacerbate Petitioner's degenerative spine condition.

Conclusions of Law

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

Pursuant to the stipulations of the parties, the Arbitrator concludes that Petitioner sustained accidental injuries that arose out of and in the course of her employment for Respondent on February 9, and February 24, 2011.

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injury, with a manifestation date of March 5, 2011, arising out of and in the course of her employment for Respondent.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that she sustained work-related injuries on February 9, and February 24, 2011, and that she experienced a gradual worsening of symptoms thereafter, in particular, after the accident of February 24, 2011.

On March 5, 2011, while stocking shelves at work, Petitioner testified that she experienced an onset of increased pain/numbness. There was no accident reported on that date and there was no evidence of March 5, 2011, being the manifestation date of a repetitive trauma injury.

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

The Arbitrator concludes that Petitioner's current state of ill-being is causally related to the accidents of February 9, and February 24, 2011.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained work-related injuries to her neck and upper extremities on February 9, and February 24, 2011. Further, Petitioner's testimony that she had no prior injuries to those areas of the anatomy was unrebutted.

The Arbitrator finds the opinion of Petitioner's primary treating physician, Dr. Gornet, to be more persuasive than that of Respondent's Section 12 examiner, Dr. Kitchens, in regard to the issue of causality. Dr. Gornet has examined the Petitioner on multiple occasions and he reviewed the MRI scan opining that it revealed disc pathology at C3-C4. In both his medical records and deposition testimony, Dr. Gornet opined that Petitioner's condition was related to the accidents of February 9 and February 24, 2011, although the accident of February 24, 2011, seemed to be the more significant of the two.

Dr. Kitchens initially opined that Petitioner's degenerative spine condition was not related to the accident of February 9, 2011, and, and a supplemental report prepared a later date, made the same conclusion in regard to the accident of February 24, 2011. As Dr. Gornet noted, whether Petitioner's degenerative spine condition was either caused or exacerbated by the accident(s) is not the critical issue in this case. The critical issue is whether there is a causal relationship between the disc pathology at C3-C4 and the accidents of February, 2011. While Dr. Kitchens has opined that there is no relationship, he does not provide any explanation as to the basis for Petitioner's continued symptomatology.

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 the medical bills associated therewith.

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 $2,209.57 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 including, but not limited to, the disc replacement surgery recommended by Dr. Gornet.

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

The Arbitrator concludes Petitioner is entitled to payment of temporary total disability benefits for 100 1/7 weeks, commencing March 6, 2011, through May 26, 2011, July 19, 2011 through July 16, 2012, and February 7, 2013, through October 29, 2013.

William R. Gallagher, Arbitrator

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

14IWCC0703

KITE, LORETTA
Employee/Petitioner

Case# **11WC010509**

11WC010508
11WC010510

WAL-MART
Employer/Respondent

On 12/6/2013, 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 0.10% 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:

EVANS & BLASI LLC
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1512 JOHNSON RD
GRANITE CITY, IL 62040

2593 GANAN & SHAPIRO PC
AMANDA WATSON
411 HAMILTON BLVD SUITE 1006
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14IWCC0703

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)

Loretta Kite
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Consolidated cases:
11 WC 10508 & 11 WC 10510

An *Application for Adjustment 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 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 dates of accident, February 9, 2011 (11 WC 10508), February 24, 2011 (11 WC 10509), and March 5, 2011 (11 WC 10510), Respondent was operating under and subject to the provisions of the Act.

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

On February 9, 2011(11 WC 10508) and February 24, 2011 (11 WC 10509), Petitioner did sustain accidents that arose out of and in the course of employment. On March 5, 2011 (11 WC 10510), Petitioner did not sustain an accident (repetitive trauma) 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 accidents of February 9, 2011 (11 WC 10508), and February 24, 2011 (11 WC 10509). Petitioner's current condition of ill-being is not causally related to the accident (repetitive trauma) of March 5, 2011 (11 WC 10510).

In the year preceding the injury, Petitioner earned $18,131.79; the average weekly wage was $348.69.

On the date of accident, Petitioner was 40 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 $4,373.28 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $4,373.28.

Respondent is entitled to a credit of $2,209.57 under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation in 11 WC 10510 is denied.

Respondent shall pay for 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 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, disc replacement surgery.

Respondent shall pay Petitioner temporary total disability benefits of $253.00 per week for 100 1/7 weeks commencing March 6, 2011, through May 26, 2011, July 19, 2011 through July 16, 2012, and February 7, 2013, through October 29, 2013, 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 2, 2013
Date

ICArbDec19(b)

DEC 6 - 2013

Findings of Fact

Petitioner filed three Applications for Adjustment of Claim which alleged she sustained accidental injuries arising out of and in the course of her employment for Respondent. In case 11 WC 10508, Petitioner alleged that she sustained a work-related accident on February 9, 2011, when some boxes fell on her injuring her neck and upper extremities. In case 11 WC 10509, Petitioner alleged that she sustained a work-related accident on February 24, 2011, while lifting a bucket of doughnut icing which caused her to sustain injuries to her neck and upper extremities. In case 11 WC 10510, Petitioner alleged a repetitive trauma injury to her neck and upper extremities as a result of stocking shelves and alleged the manifestation date of March 5, 2011.

Respondent admitted that Petitioner sustained work-related accidents on February 9, and February 24, 2011; however, Respondent denied that Petitioner sustained a repetitive trauma injury on March 5, 2011. Further, Respondent disputed liability in regard to the accidents of February 9, and February 24, 2011, on the basis of causal relationship. These cases were tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills, temporary total disability benefits and prospective medical treatment.

Petitioner worked for Respondent as a sales associate in the bakery department and her job duties required her to stock shelves, remove product from pallets, push/pull carts, etc. Petitioner worked the 5 AM to 2 PM shift five days a week.

On February 9, 2011, Petitioner was unloading boxes of cookies from a cart and several boxes fell, striking Petitioner in the head and neck. Each of these boxes weighed approximately 10 pounds. Petitioner reported the accident to her supervisor but did not seek any medical treatment at that time because she thought that the pain and stiffness in her neck that she was experiencing would resolve on its own.

On February 24, 2011, Petitioner was in the process of lifting a five gallon bucket of doughnut icing that weighed approximately 20 pounds when she felt a sharp pain in her neck that caused a tingling/numb sensation down her arms. Petitioner testified that this was not like the symptoms she previously experienced; however, she did not seek any immediate medical treatment as she again believed that the symptoms would resolve on their own. Petitioner reported this accident to her supervisor and continued to work her regular work duties; however, Petitioner testified that the pain increased over the next several days.

Petitioner testified that on March 5, 2011, while she was in the process of stocking shelves that she experienced an onset of increased pain/numbness in the neck going down the left arm. At that same time, Petitioner experienced numbness in her face and she thought she was having either a heart attack or stroke. This was not reported as a work injury but Petitioner did seek medical attention shortly thereafter.

Petitioner went to the ER of Memorial Hospital in Belleville. According to the ER records, Petitioner had left arm pain with numbness down the left arm for the preceding four to five days. Multiple diagnostic tests were performed and it was determined that Petitioner had not sustained a heart attack. The ER record also noted that Petitioner's complaints seem to be

"musculoskeletal" and "radicular," and Petitioner was given some anti-inflammatory medications and directed to follow-up with her primary doctor.

Petitioner was seen by Dr. Jim Hong, her family physician, on March 8, 2011. According to Dr. Hong's record of that date, Petitioner had left arm radiculopathy after lifting for two weeks. The record also contained a form completed and signed by Petitioner on March 9, 2011, in which she indicated a date of accident of February 24, 2011, which indicated she injured her left arm while lifting a bucket of icing. Dr. Hong authorized Petitioner to be off work, prescribed some medications and ordered physical therapy.

Petitioner was seen again by Dr. Hong on March 14, 2011, and his record of that date stated that Petitioner's pain symptoms began after lifting objects at work on February 9, 2011. Dr. Hong authorized Petitioner to remain off work, continued medications with physical therapy and ordered a CT scan of the cervical spine. A CT scan was performed on March 16, 2011, which revealed mild degenerative changes and a disc bulge at C3-C4. Petitioner had physical therapy at Ace Physical Therapy on March 16, and March 18, 2011. Those records specifically referenced the work accidents of February 9, and February 24, 2011, as the incidents that precipitated the neck and left arm symptoms.

On March 21, 2011, Petitioner began treating with Multi-Care Specialist and she was treated by Dr. Rodney Lupardus and Dr. Mark Eavenson, a chiropractor. Dr. Lupardus initially evaluated Petitioner on March 21, 2011, and his record of that date contained the history of the work-related accidents of February 9, and February 24, 2011. Petitioner also stated that on March 5, 2011, the pain/numbness in the left arm worsened while she was at work and that she went to the ER. Dr. Lupardus referred Petitioner to Dr. Eavenson for chiropractic treatment and physical therapy. Dr. Eavenson also saw Petitioner on March 21, 2011, and Petitioner provided him with a history of the onset of her neck and left arm symptoms that was consistent with the history she had provided to Dr. Lupardus.

Dr. Eavenson opined Petitioner had a possible cervical disc protrusion with left upper extremity radiculitis. He ordered an MRI scan. The MRI scan was performed on March 22, 2011, which revealed a disc bulge at C3-C4 with neuroforaminal stenosis with near abutment of both exiting C4 nerve roots. Dr. Eavenson treated Petitioner with chiropractic care and physical therapy which provided Petitioner with some relief. Dr. Eavenson subsequently referred Petitioner to Dr. Matthew Gornet, an orthopedic surgeon.

Dr. Gornet initially evaluated Petitioner on March 31, 2011. At that time, Petitioner informed Dr. Gornet of the work-related accidents of February 9, and February 24, 2011, and that she presently had constant pain especially with lifting, arm activity and turning to the left. Dr. Gornet reviewed the MRIs scan and opined that it revealed a bilobular disc protrusion at C3-C4. He opined that Petitioner's symptoms were related to her work-related injuries, although the injury of February 24th, seemed to be the more significant of the two. He authorized Petitioner to be off work and recommended additional conservative treatment with Dr. Eavenson.

In April, 2011, Petitioner received additional physical therapy and chiropractic treatment at Multi-Care Specialist, and was seen again by Dr. Gornet on May 23, 2011. At that time,

Petitioner still had significant symptoms so Dr. Gornet referred Petitioner to Dr. Kaylea Boutwell for some injections. Dr. Gornet opined Petitioner could return to work with restrictions of no lifting over 10 pounds, no repetitive bending/lifting, alternating between standing and sitting, no overhead work, no pushing/pulling and limited hours.

Dr. Boutwell saw Petitioner on June 1, June 15, and June 17, 2011, and gave her epidural injections to the cervical spine on those occasions. Petitioner was seen again by Dr. Gornet on June 20, 2011, and he noted that she had been working light duty but still has significant neck and shoulder pain. Dr. Gornet saw Petitioner on July 21, 2011, and Petitioner's complaints had worsened. At that time, Dr. Gornet recommended that Petitioner undergo disc replacement surgery at C3-C4 and authorized Petitioner to be off work.

At the direction of the Respondent, on June 27, 2011, Dr. Colin Poon. Dr. Poon, a radiologist, reviewed the MRI scan of March 21, 2011, and opined that it revealed a right central disc bulge at C3-C4 with stenosis at the right lateral recess.

At the direction of the Respondent, Petitioner was examined by Dr. Daniel Kitchens, a neurosurgeon, on August 23, 2011. In connection with his examination of Petitioner, Dr. Kitchens reviewed Petitioner's medical treatment records. Petitioner informed Dr. Kitchens of having sustained the work-related accidents on February 9, and February 24, 2011, and the onset of pain occurring on March 5, 2011. Petitioner still had complaints of neck pain with discomfort in the left shoulder and numbness of the left hands/fingers. Petitioner also complained of minimal discomfort in the right shoulder and numbness in her right hand. Dr. Kitchens opined that Petitioner did not have symptoms of cervical radiculopathy and that the accident of February 9, 2011, did not aggravate or exacerbate her degenerative spine condition. This was based on Dr. Kitchens' observation that Petitioner did not have an acute worsening of symptoms until one month post-accident when she first sought medical treatment. He further stated that the initial medical records did not describe a work injury of significant force being applied to her neck. He opined Petitioner could return to work without restrictions and that further medical treatment, including disc replacement surgery, was not indicated.

Dr. Gornet saw Petitioner on September 16, 2011, and, at that time, reviewed Dr. Kitchens' report. In regard to Dr. Kitchens' opinion that the accident of February 9, 2011, did not cause or exacerbate her degenerative spine condition, Dr. Gornet stated that this opinion was "... irrelevant and means nothing." Dr. Gornet agreed that the accident did not cause or exacerbate the degenerative condition; however, he stated that Petitioner has disc pathology at C3-C4 consisting of a central disc herniation with bilobular appearance and that this is the cause of her symptomatology. He reaffirmed his opinion that this condition was work-related, noting the failure of conservative treatment and he restated his treatment recommendation for disc replacement surgery. (Petitioner's Exhibit 6).

Dr. Gornet was deposed on December 19, 2011, and his deposition testimony was received into evidence at trial. Dr. Gornet's testimony was consistent with his medical records and he again opined that Petitioner's current condition was related to her work-related accidents but that the accident of February 24, 2011, was the more significant. He specifically stated that Petitioner's lifting of the bucket of icing could have caused the disc injury, especially to a disc that may have

been compromised a few weeks prior. Dr. Gornet again stated his disagreement with Dr. Kitchens' opinion and noted that it was inconsistent with her medical history.

Petitioner was seen again by Dr. Gornet on January 9, 2012, and her condition was unchanged. He reaffirmed his treatment recommendation for disc replacement surgery at C3-C4 and authorized Petitioner to work light duty but noted that none was available for her. Petitioner continued treatment with Dr. Lupardus and Dr. Gornet in February and April, 2012, and her condition remained essentially the same.

When Dr. Gornet saw Petitioner on July 9, 2012, Petitioner's condition was essentially the same and she had not been able to return to work because of the lack of availability of light duty work. Dr. Gornet noted Petitioner's concern about the possibility of losing her job and recommended that she attempt return to work at full duty. At trial, Petitioner testified that she returned to work for Respondent on full duty on July 16, 2012.

Dr. Gornet saw Petitioner again on October 8, 2012, and her condition was essentially the same. Dr. Gornet again renewed his recommendation for disc replacement surgery. Dr. Gornet saw Petitioner on February 7, 2013, and, at that time, Petitioner informed him that she had continued to work but that her symptoms were getting progressively worse, with neck pain, headaches and pain into both shoulders, upper back and arms. Dr. Gornet reaffirmed his opinion as to causality and authorized Petitioner to be off work.

Petitioner testified that she has not worked since February 9, 2013, and that she continues to have the neck pain and pain down both arms which continues to worsen. She wants to proceed with the surgery that has been recommended by Dr. Gornet. Petitioner denied any prior injuries to either the neck or upper extremities.

At the request of Petitioner's counsel, on April 11, 2013, Dr. Larry Reed, a radiologist, read the MRI of March 22, 2011, and opined that it revealed a disc herniation at C3-C4 extending into the neural foramina bilaterally but more on the right side.

Apparently at the request of Respondent's counsel, Dr. Kitchens prepared a supplemental report dated September 26, 2013, in which he opined that the accident of February 24, 2011, did not cause or exacerbate Petitioner's degenerative spine condition.

Conclusions of Law

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

Pursuant to the stipulations of the parties, the Arbitrator concludes that Petitioner sustained accidental injuries that arose out of and in the course of her employment for Respondent on February 9, and February 24, 2011.

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injury, with a manifestation date of March 5, 2011, arising out of and in the course of her employment for Respondent.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that she sustained work-related injuries on February 9, and February 24, 2011, and that she experienced a gradual worsening of symptoms thereafter, in particular, after the accident of February 24, 2011.

On March 5, 2011, while stocking shelves at work, Petitioner testified that she experienced an onset of increased pain/numbness. There was no accident reported on that date and there was no evidence of March 5, 2011, being the manifestation date of a repetitive trauma injury.

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

The Arbitrator concludes that Petitioner's current state of ill-being is causally related to the accidents of February 9, and February 24, 2011.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained work-related injuries to her neck and upper extremities on February 9, and February 24, 2011. Further, Petitioner's testimony that she had no prior injuries to those areas of the anatomy was unrebutted.

The Arbitrator finds the opinion of Petitioner's primary treating physician, Dr. Gornet, to be more persuasive than that of Respondent's Section 12 examiner, Dr. Kitchens, in regard to the issue of causality. Dr. Gornet has examined the Petitioner on multiple occasions and he reviewed the MRI scan opining that it revealed disc pathology at C3-C4. In both his medical records and deposition testimony, Dr. Gornet opined that Petitioner's condition was related to the accidents of February 9 and February 24, 2011, although the accident of February 24, 2011, seemed to be the more significant of the two.

Dr. Kitchens initially opined that Petitioner's degenerative spine condition was not related to the accident of February 9, 2011, and, and a supplemental report prepared a later date, made the same conclusion in regard to the accident of February 24, 2011. As Dr. Gornet noted, whether Petitioner's degenerative spine condition was either caused or exacerbated by the accident(s) is not the critical issue in this case. The critical issue is whether there is a causal relationship between the disc pathology at C3-C4 and the accidents of February, 2011. While Dr. Kitchens has opined that there is no relationship, he does not provide any explanation as to the basis for Petitioner's continued symptomatology.

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 the medical bills associated therewith.

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 $2,209.57 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 including, but not limited to, the disc replacement surgery recommended by Dr. Gornet.

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

The Arbitrator concludes Petitioner is entitled to payment of temporary total disability benefits for 100 1/7 weeks, commencing March 6, 2011, through May 26, 2011, July 19, 2011 through July 16, 2012, and February 7, 2013, through October 29, 2013.

William R. Gallagher, Arbitrator

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

Scott Buxton,
Petitioner,

vs.

Caterpillar Inc.,
Respondent,

NO: 11 WC 41682

14IWCC0704

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, the satutory interpretation of §8.1(b), causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,800.00. 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: AUG 20 2014

MB/mam
o:6/26/14
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUXTON, SCOTT
Employee/Petitioner

Case# **11WC041682**

14IWCC0704

CATERPILLAR INC
Employer/Respondent

On 8/7/2013, 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
JON WALKER
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2994 CATERPILLAR INC
MARK FLANNERY
100 N E ADAMS
PEORIA, IL 61629-4340

14IWCC0704

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

SCOTT BUXTON
Employee/Petitioner

v.

CATERPILLAR, INC.
Employer/Respondent

Case # 11 WC 41682

An *Application for Adjustment 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 **Springfield**, on **June 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

FINDINGS

On **October 19, 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 **$35,994.00**; the average weekly wage was **$782.48**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **3** 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 **$2,608.33** for TTD, **$327.29** for TPD, **$0** for maintenance, and **$288.04** for other benefits, for a total credit of **$3,223.66**.

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

ORDER

Respondent shall pay Petitioner the sum of $469.49/week for a further period of 19 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the 25% loss of use of the left thumb.

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

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

07/26/2013
Date

AUG 7 - 2013

14IWCC0704

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

SCOTT BUXTON
Employee/Petitioner

v. Case # 11 WC 41682

CATERPILLAR, INC.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated to an accident of October 19, 2011, when Petitioner, Scott Buxton, a 45-year old welder, sustained injuries to his left thumb when it was caught between a lifting device and a case while working for Respondent, Caterpillar, Inc. (Arbitrator's Exhibit (AX) 1). Petitioner testified that as a welder with Respondent, he uses welding guns, grinders and chippers. He must use both hands for the welding gun and the grinder, using his right hand for triggering and the left hand for steadying the devices. Petitioner testified he spends approximately 50% of his workday with a torch in hand welding, and between 15-20% of the day performing grinding duties.

On October 20, 2011, Petitioner presented to Dr. Jeffery Smith. He noted Petitioner injured his left thumb when it was smashed between a lifting device and a case. Dr. Smith noted a very unstable fracture and planned to perform surgery later that day. Dr. Jeffery Smith also completed paperwork noting that the injury was related to Petitioner's employment with Respondent and that the left thumb fracture was due to the crush injury. (Petitioner's Exhibit (PX) 2).

On October 20, 2011, Petitioner underwent surgery with Dr. Smith. The procedure performed consisted of a repair of the proximal phalanx with 3 millimeter mini screw fixation. Dr. Smith gave a post-operative diagnosis of a highly unstable proximal phalanx fracture. Dr. Smith's operative report notes, "I attempted to place a microscrew in this across the fracture, but it was not nearly stable enough, so this was removed and a 3 mm mini screw was then placed across the fracture site. This provided excellent stability and reduced the fracture anatomically in both AP and lateral views..." (PX 2).

On November 8, 2011, Petitioner returned Dr. Smith. Dr. Smith reviewed radiographs and noted, "complete dorsal displacement of the fracture in relationship to the shaft. In AP view, it seems pretty well aligned, but in a lateral view it is definitely shifted dorsally." Dr. Smith noted that Petitioner would need to undergo deep hardware removal that would likely be followed by a repeat internal fixation to get the fracture united in anatomic position. (PX 2).

On November 11, 2011, Petitioner underwent a second thumb surgery. Dr. Smith's operative diagnosis was that of failed hardware, left thumb proximal phalanx fracture. Dr. Smith performed a revision intramedullary fixation of the left thumb proximal phalanx fracture. (PX 2).

On November 29, 2011, Petitioner returned to Dr. Smith. Dr. Smith noted that Petitioner was 5 ½ weeks out from his original open reduction internal fixation and 2 to 2 ½ weeks out from the secondary surgery. Dr. Smith noted recommended a bone stimulator to accelerate healing of the fracture. (PX 2).

On January 19, 2012, Petitioner was again evaluated by Dr. Smith. The doctor noted that Petitioner was 13 weeks out from open reduction internal fixation. Dr. Smith noted stiffness in the IP joint and recommended therapy. (PX 2). On February 21, 2012, Petitioner returned to Dr. Smith. Dr. Smith noted, "Our plan will be to see him in 4 weeks for repeat radiographic and clinical examination with the anticipation of deep hardware removal shortly thereafter if radiographs show significant bone callus formation at the fracture site." (PX 2).

On May 4, 2012, Petitioner underwent a third surgery with Dr. Smith. Dr. Smith gave a post-operative diagnosis of left thumb, proximal phalanx - retained deep hardware. Dr. Smith performed a deep hardware removal with two incisions and two K wires. (PX 2).

On May 17, 2012, Petitioner again presented to Dr. Smith. The doctor noted, "On physical examination today, he is doing really well. The alignment of the thumb is good. He has no pain. His motion is a little better, but still not 100%. He might not ever have 100%, but I think he will continue to improve." (PX 2). On September 11, 2012, Petitioner last saw Dr. Smith. Dr. Smith noted, "On examination today, he has pretty good motion. He lacks about 40%-50% of flexion of the IP joint of the thumb. He has good MP motion." He released Petitioner from his care on this date. (PX 2).

Petitioner returned to work as a welder with Respondent following his three thumb surgeries and resulting medical treatment. When performing his welding duties upon his initial return to work, Petitioner would wear a splint over his thumb. He could weld with this splint on, but performing his grinding work would become difficult while wearing it. Petitioner would therefore trade grinding duties for welding duties with other employees, whereby Petitioner would perform both his and others' welding duties, while those workers would perform his grinding duties. Petitioner also clarified that a note in Dr. Smith's records indicating that Petitioner could weld with one hand was inaccurate, as welding without his left hand to steady the gun would not produce a very accurate weld.

At Respondent's request, Dr. Rajesh Ethiraj prepared an AMA Impairment Rating Assessment. Dr. Ethiraj gave Petitioner an impairment rating of 6% of a digit (2% of a hand or 2% of upper extremity). (RX 3, Dep. Exh. 4). Petitioner's "QuickDASH" report (disabilities of the arm, shoulder and hand) score was 40, with severe difficulty opening a tight or new jar and with recreational activities which take some force through the arm, shoulder, or hand. (RX 3, Dep. Exh. 5).

Petitioner testified that he has stiffness and loss of range of motion in his thumb, noting that it does not bend as it did prior to the surgery. He further noted pain and aches in addition to sensitivity to cold. Petitioner described altering his job technique. With regard to welding, Petitioner is not as fast and must take several breaks each day to rest his thumb. He must also take breaks with welding because his left hand will tire with the weight of the welding gun. With regard to grinding, Petitioner testified it is harder to hold the grinder and that his thumb tires more easily than before the accident. Petitioner also testified about his hobby of pheasant and rabbit hunting, and noted that since the accident, he could not hold his shotgun properly and therefore had to change his technique in holding the firearm.

CONCLUSIONS OF LAW

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

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the incident and injury of October 19, 2011. The Arbitrator notes that Petitioner described catching his left thumb between a lifting device and the case. A consistent description is noted throughout the medical records. The Arbitrator relies on the opinion of the treating surgeon, Dr. Jeffery Smith, who found a causal connection between the incident and Petitioner's left thumb injury and surgeries. No opinion was offered to rebut causation. The Arbitrator further notes that Petitioner was a credible witness at trial, and gave open, direct and forthcoming testimony during both direct and cross-examination. Great weight is placed on Petitioner's credibility when assessing his testimony concerning his work duties and related symptoms.

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

Pursuant to Section 8.1b of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq.* (hereafter 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.
>
> 820 ILCS 305/8.1b.

With regard to Section 8.1b(b)(i) of the Act (reported level of impairment per the AMA Guides), the Arbitrator notes that Dr. Ethiraj found AMA Guides Sixth Edition impairment at 6% impairment of a digit. (RX 3, Dep. Exh. 4). The Arbitrator notes that Dr. Ethiraj made his impairment rating using the methodology of "diagnosis based impairment," as opposed to "range of motion impairment." (RX 3, p.

21). Range of motion impairment was measured as an alternative method, however this lent a lower impairment figure per Dr. Ethiraj. (RX 3, pp. 22-24). In reviewing Dr. Ethiraj's impairment report, the Arbitrator notes no reference to the loss of range of motion under the "Physical Examination Grade Modifier." (RX 3, Dep. Exh. 4). The treating surgeon, Dr. Jeffery Smith, noted that Petitioner lacks about 40% to 50% of flexion of the IP joint of the thumb. (PX 2). At his deposition, Dr. Ethiraj testified to 30% to 35% loss of range of motion. (RX 3, p. 33). However, in the report section titled "Physical Examination," there is no reference to either 40-50% or 30-35% loss of range of motion, but simply "mild Range of Motion decrease." When asked if there was anywhere in the AMA Guides that defined Petitioner's loss of range of motion range as "mild" or whether said assessment was his own interpretation, Dr. Ethiraj replied that it was his interpretation. (RX 3, p. 57). While Petitioner's treating physician did not testify as to what level Petitioner's loss of range of motion would be as a result of the accident (*e.g.*, mild, moderate, or significant), the Arbitrator questions how such a loss of range of motion that Petitioner has experienced would constitute only "mild" loss, given the evidence in the record. Impairment and permanent partial disability (PPD) as defined by the AMA Guides Sixth Edition are not the same, and this was in fact noted by Dr. Ethiraj during his deposition. (RX 3, pp. 28, 63-64). The Arbitrator makes note of this distinction when assessing the weight given to the AMA impairment rating at issue and in determining the permanency award. Taking into account all the aforementioned facts, the Arbitrator gives some weight to Dr. Ethiraj's AMA impairment rating when determining the permanency award.

With regard to Section 8.1b(b)(ii) of the Act (Petitioner's occupation), Petitioner's occupation is that of a welder, a fairly labor-intensive job. *See Williams v. Flexible Staffing, Inc.*, 13 IWCC 557 (May 29, 2013).[1] Petitioner testified he spends 50% of his workday with a torch in hand welding, and 15-20% grinding. The Arbitrator notes that Petitioner must use his left hand, and therefore his left thumb, when performing both the welding and grinding duties. The Arbitrator concludes that Petitioner's permanent partial disability will be larger based on this regard than an individual who performs lighter work, and great weight is placed on this factor when determining the permanency award.

With regard to Section 8.1b(b)(iii) of the Act (Petitioner's age at the time of injury), Petitioner was 45 years old at the time of his injury. (See AX 1; AX 2, noting a birth date of February 2, 1966). The Arbitrator considers Petitioner to be a somewhat younger individual and concludes that Petitioner's PPD will be more extensive than that of an older individual because he will have to live and work with the permanent partial disability longer. *See Williams*, cited *supra*. Ample weight is placed on this factor when determining the permanency award.

With regard to Section 8.1b(b)(iv) of the Act (Petitioner's future earning capacity), the Arbitrator notes that Petitioner returned to his same position as before the accident. While Petitioner testified as to some difficulty with his position and needing to take longer breaks while performing his duties as a result of the injury at issue, there is no evidence that Petitioner's future earning capacity is diminished. The Arbitrator places some weight on this factor when determining the permanency award.

With regard to Section 8.1b(b)(v) of the Act (evidence of disability corroborated by Petitioner's treating medical records), the Arbitrator notes the objective, measured evidence of loss of range of motion of the left thumb as a result of the proximal phalanx fracture suffered by Petitioner on the date of accident.

[1] In *Williams v. Flexible Staffing, Inc.*, the Commission took judicial notice when discussing Section 8.1b(b)(ii) of the Act in that the occupation of a welder was considered medium-to-heavy work, and concluded that the petitioner's permanent partial disability in this regard would be higher than an individual who performed lighter-duty work.

Petitioner's first surgery involved phalanx repair with screw fixation. Due to failed hardware, Petitioner underwent a second surgery consisting of hardware revision. The third surgery Petitioner underwent involved deep hardware removal with two incisions and two K wires. Dr. Smith, the treating surgeon who performed all three of Petitioner's surgical operations, found that Petitioner lacks about 40%-50% of flexion of the IP joint of the thumb. Dr. Smith also noted that Petitioner might not ever have 100% range of motion in his left thumb, but that he should continue to improve. (PX 2). At trial, Petitioner credibly testified he has stiffness and loss of range of motion and that his thumb is sensitive to cold temperatures. Petitioner described having difficulty using a shotgun while participating in his hunting activities, in particular while applying pressure to the stock of the gun. The Arbitrator notes these complaints are credible and consistent with Petitioner's injury and three surgeries, as well as the 40%-50% loss of range of motion noted by Dr. Smith. It is also noted that Dr. Ethiraj did not note any inconsistencies or unreliable responses to the QuickDASH report. (RX 3, Dep. Exh. 4). Great weight is afforded this factor when determining the permanency award.

The Arbitrator notes that the determination of PPD is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant, as noted above. Therefore, applying Section 8.1b of the Act, Petitioner has sustained accidental injuries that caused the 25% loss of use of the left thumb. The Arbitrator finds that Respondent shall pay Petitioner the sum of $469.49 per week for a further period of 19 weeks, as provided under 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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott Moran,
Petitioner,

vs.

NO: 10 WC 20287

14IWCC0705

Village of Homewood,
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, causation, medical expenses, temporary total disability, permanent disability, rulings on exhibits and credit for PEDA payments 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 strikes the following sentence from the Arbitrator's decision: "The Arbitrator also notes that the cases are employment specific and, in the context of firefighters and police officers, establish a trend to deny recovery for post-traumatic stress disorder to first responders".

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

14IWCC0705

The party commencing 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: AUG 2 0 2014

MB/jm

O: 8/7/14

43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORAN, SCOTT P
Employee/Petitioner

Case# **10WC020287**

14IWCC0705

VILLAGE OF HOMEWOOD
Employer/Respondent

On 12/17/2013, 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 0.09% 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:

0728 LAW OFFICES OF THOMAS W DUDA
3125 N WILKE RD
SUITE A
ARLINGTON HTS, IL 60004

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
DANIEL W ARKIN
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 (§(e)18)
☒ None of the above

14IWCC0705

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Scott P. Moran
Employee/Petitioner

Case # 10 WC 20287

v.

Village of Homewood
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 Lynette Thompson-Smith, Arbitrator of the Commission, in the city of Chicago, on January 7, 2013 and September 30, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other Admissibility of Petitioner's Exhibits 10-12, which were accepted as rejected exhibits.

14IWCC0705

FINDINGS

On March 30, 2010, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did not sustain an accidental injury 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 $88,752.04; the average weekly wage was $1,706.77.

On the date of accident, Petitioner was 42 years of age, married, with 2 children under 18.

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 $7,477.30 for TTD, $N/A for TPD, $N/A for maintenance, and $N/A for other benefits, for a total credit of $7,477.30.

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

ORDER

The Petitioner has not proven, by a preponderance of the evidence, that he sustained accidental injuries, which arose out of and in the course of his employment with the respondent on March 30, 2010. Therefore, no benefits are awarded, pursuant to the Act.

Respondent shall be given a credit of $7,477.30 for temporary, total disability benefits paid to Petitioner.

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

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest 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.

14IWCC0705

Findings of Fact

The disputed issues in this matter are: 1) accident; 2) notice; 3) causal connection; 4) the admissibility of Petitioner's exhibits 10-12; and 5) the nature and extent of the injuries. *See,* AX1.

Scott Moran, (the "petitioner") was hired by the Village of Homewood, (the "respondent") as a firefighter/paramedic, on February 22, 1991. Prior to working for the respondent, he worked as a paid, on call firefighter for the Villages of Justice and Willow Springs, where he also served as Assistant Chief. The petitioner testified that he has responded to fires and vehicle accidents, which involved both injuries and deaths, between 1986 and 1993.

The petitioner also testified that he was promoted to the position of Lieutenant for the Village of Homewood, in May of 2006. This involved working in both a supervisory as well as a "hands on" capacity, depending upon the severity of each call.

It is undisputed that the petitioner was in charge of a crew that responded to a house fire on March 30, 2010. As the incident commander, Petitioner took charge of the fire by directing the firefighters where to go and what to do at the scene. Petitioner testified that he was about to put on gear to help fight the fire when firefighter Brian Cary said to him "we got this lieu". Petitioner told firefighters Kieta and Carey to enter and attempt to extinguish the fire and support firefighters from Hazel Crest, who were already in the building. Petitioner testified that all of his activities occurred outside of the house and that he did not go into the house or onto the roof. He also was not involved in any rescue activities i.e., pulling anyone out of the fire or assisting with any type of emergency medical services, at the scene.

It is undisputed that a fellow firefighter, Brian Carey, died in this fire and that another firefighter, Karra Kopas, sustained serious burns. When Carey was pulled from the building, he was wearing neither mask nor helmet. Petitioner testified that he escalated an alarm and sent out a mayday signal, which secured an ambulance from a mutual aid department. Resuscitation and first aid efforts were performed by a Flossmoor firefighter by the name of Urbanetti, before Carey was transported to the hospital.

The petitioner remained in charge of the fire scene until Chief Kasper assumed responsibility. After the fire was out, the petitioner and the other firefighters were taken to the training room for a debriefing and counseling by support staff and clergy. The firefighters from the other towns were also taken to the training room for a debriefing. A Critical Incident Stress Debriefing ("CISD") team was brought in that evening to assist all persons regarding the loss of a co-worker. For approximately two (2) weeks after the incident, the Homewood Fire Department referred all of its calls to neighboring fire departments and took no calls. Petitioner and all of the other firefighters, who had experienced the death of firefighter Carey, were ordered, by Deputy Chief Johnson, to present to Dr. Timothy McManus; a psychologist, who treated them on an individual basis.

Dr. McManus testified that four (4) to five (5) firefighters were referred to him by Deputy Chief Johnson, for psychological care and that Lieutenant Moran suffered from post-traumatic stress disorder, as a result of the incidents of March 30, 2010. Dr. McManus further testified that petitioner felt responsible for what happened to both firefighters and that the doctor had originally diagnosed the petitioner as having acute stress disorder. As Petitioner worked through his problems, Dr. McManus stated that upon his return to work, the petitioner was showing good control over his anxiety. The petitioner also presented to Dr. Marc Slutsky, who concurred with Dr. McManus' findings. *See*, PX 13 pgs. 11-29; PX14 pgs. 13, 20; & PX3.

The petitioner testified that he did not sustain any physical injuries as a result of the fire on March 30, 2010; and that this case is a claim for psychological injuries. The petitioner testified that he contacted Dr. Mark Slutsky at the request of his attorney; which is documented by an e-mail dated April 23, 2010. The petitioner also testified that he began seeing Dr. Slutsky on May 5, 2010, while he was also seeking treatment with Dr. McManus, with whom he first treated on April 23, 2010. *See,* PX9.

The petitioner testified that his treatment with Dr. McManus consisted of talking about the effects of the fire as well as his difficulty sleeping; and the fact that he was having flashbacks of the fire. The petitioner also testified that Dr. McManus released him to return to work on June 14, 2010; and that he continued to follow up with Dr. McManus through December 21, 2010.

Dr. McManus' notes from his final session with the petitioner, on December 21, 2010, provided a diagnosis of post-traumatic stress disorder, which had improved. In his evidence deposition on May 16, 2013, Dr. McManus testified at that the petitioner was not experiencing symptoms when he was seen in December of 2010. He also testified that the petitioner returned to see him on January 11, 2011 and told him that he had again begun to experience some symptoms that were related to the fire. Dr. McManus advised the petitioner to return to see him if he had any further problems. At the time of Dr. McManus' evidence deposition on May 16, 2013, the petitioner had not returned to see him.

After being released to return to work on June 14, 2010, the petitioner responded to numerous house fires and a hotel fire. The petitioner testified that he had responded to approximately twenty-nine (29) fires, and that he performed all of his job duties at these fires. He also testified that he did not make any complaints about his job duties or about having any problems performing his job to any of his supervisory personnel, including Deputy Chief Johnson and Chief Grabowski. Additionally, the petitioner testified that he has been able to perform all of his jobs duties associated with the position of a lieutenant for the Homewood Fire Department, subsequent to returning to work.

The Arbitrator recognizes that the petitioner had adverse emotional reactions stemming from the circumstances of the March 30, 2010 fire; which resulted in the death of a fellow firefighter and burns to another firefighter. However, the Arbitrator also notes that the petitioner did not sustain a physical injury or receive any treatment, other than psychological treatment, subsequent to the fire.

14IWCC0705

Conclusions of Law

The Arbitrator initially notes that cases involving psychological problems, in the absence of a direct physical injury, are generally found not to be compensable. However, exceptions to this position do exist and were addressed by the Supreme Court in *Pathfinder Co. v. Industrial Commission*, 62 Ill.2d 556, 343 N.E.2d 913 (1976). The Court, for the first time, permitted recovery for a psychological disability when the claimant sustained no physical injury. In *Pathfinder,* the claimant suffered a severe, immediate, emotional trauma after she extracted the severed hand of a co-worker from a punch press that amputated the coworker's hand at the wrist. She immediately fainted at the sight of the severed hand and was taken to the hospital. The Court stated that it "must conclude that an employee who, like the claimant here, suffers a sudden, severe emotional shock traceable to a definite time, place and cause which causes psychological injury or harm has suffered an accident within the meaning of the Act, though no physical trauma or injury was sustained." Since *Pathfinder,* courts have adhered to the requirement of a shocking event resulting in a immediate reaction, in order for a petitioner to recover for solely psychological injuries.

In line with *Pathfinder,* the court in *Chicago Bd. of Educ. v. Industrial Comm'n.,*169 Ill.App. 3d 459, 523 N.E.2d 912 (1st Dist. 1988) rejected the contention that mental disorders are compensable as occupational diseases when the disorder was caused by general, work-related emotional pressures, common to the employment relationship. *Id.,* at 523 N.E.2d at 917. By way of dicta, the *Chicago Bd. of Educ.* court stated that employment conditions, causing a physical disorder, need not be the sole or major cause of the disability but only a contributing cause. However, the requirements are more stringent when the employment conditions are alleged to have caused a mental disorder. The worker must prove that the employment conditions, when compared with non-employment conditions, were the major contributory cause of the mental disorder. *Id.*, at 523 N.E.2d at 918. The mental disorder must have arisen from situations of greater dimensions that that which all similarly situated employees must face.

In the case of *Perry v. City of Peoria*, 1 IIC 791, 2001 Ill. Wrk. Comp. LEXIS 804, that petitioner and several other firefighters went into a house fire with petitioner leading the way, holding an uncharged fire hose. While in the attic, there was a "flashover," which petitioner testified was the sudden explosive ignition of fire within the residence. Petitioner further testified that he had never been involved in or seen a flashover before. As a result of the flashover, petitioner and several other firefighters were trapped on the upper floors of the residence, and had no water to protect themselves as the hose had been burned through. They eventually escaped by climbing out windows. At his next scheduled shift, during a debriefing, the fire chief stated that he thought his firefighters had died.
That Petitioner began experiencing nightmares, nervousness and difficulty sleeping over the next two days and was diagnosed with PTSD. The arbitrator, in that matter, found the case compensable, holding that recovery for non-traumatically induced mental disease is limited to those who can establish that: (1) the mental disorder arose in a situation of greater dimensions that the day to day

emotional strain and tension which all employees must experience; (2) the conditions existed in reality, from an objective standpoint; and (3) the employment conditions when compared with the non-employment conditions, were the "major contributory cause" of the mental disorder; citing *Chicago Bd. of Educ.*, supra. The court also cited *Pathfinder*, stating that an employee who suffers a sudden, severe emotional shock, traceable to definite time and place and to a readily perceivable cause, which produced immediate psychological disability, can recover under the act even though no physical trauma was sustained.

The Arbitrator also notes that the claimant in *Perry* received psychiatric treatment for more than two years on a regular basis and continued to follow up with his psychiatrist on a regular basis up to and including the time of trial. Petitioner also continued to take various psychotropic prescription medications, including Ativan, Zoloft, Alprazolam, Xanax, Klonopin and Prozac. He also testified that he takes extra medication on the days he works in order to control his anxiety. The petitioner in the present case received treatment for symptoms and complaints. However, he testified that he has not seen Dr. McManus or any other doctor relative to this matter since January 11, 2011 and that he has no appointments scheduled for a follow up visit.

In the cases of *Ushman v. City of Springfield*, 08 IWCC 0234, *Runion v. Industrial Comm'n.*, 245 Ill.App.3d 470, 615 N.E.2d 8 (5th Dist. 1993) and *City of Springfield v. Industrial Comm'n.*, 214 Ill.App.3d 301, 573 N.E.2d 836 (1991), similar facts and holdings distinguish these cases from the instant case.

In *Ushman,* the claimant was a police officer who pursued an armed murder suspect. He fired shots at the suspect, and the suspect later died due to a self-inflicted gunshot wound. The claimant was under the mistaken impression he had shot and killed the suspect. The Commission confirmed the arbitrator's decision, holding that because the claimant felt normal for a period of less than two (2) weeks and the event was not an uncommon event for a police officer, he could not be compensated under the Act.

In *Runion,* the Appellate court denied benefits, holding that the employee had not shown that any "on the job" pressures were extraordinary to his employment. The court held that on the job stress itself is not a disease. Besides being extraordinary, the conditions producing the disability must have existed in reality from an objective standpoint; and the conditions must have been the major contributory cause of the mental disorder. The claimant in *Runion* was a lathe operator and his job conditions and production schedule were compared with those of every other employee, which again suggests that the proper interpretation and evaluation is to compare the petitioner in the present case with other firefighters, rather than with the general public.

In *City of Springfield*, the claimant, a fire inspector, claimed his workload, politics, interpretation of rules and discrimination led to stress related mental disease. Court held that because conditions

claimant referred to were not unique to claimant's employment or to claimant himself, claimant did not satisfy the test that would allow court to find he suffered an occupational disease.

In *General Motors Parts Division v. Industrial Comm'n.*, 167 Ill.App.3d 678, 522 N.E.2d 1260 (1st Dist. 1988), the Appellate Court reversed the Circuit Court and Commission, denying compensation and adhering strictly to *Pathfinder* in holding that a "sudden, severe emotional shock which results in immediately apparent psychic injury and is precipitated by an uncommon event of significantly greater proportion or dimension than that to which the employee would otherwise be subjected in the normal course of employment" is required for compensability. The Appellate Court stated that *Pathfinder* does not permit recovery for every non-traumatic psychic injury from which an employee suffers, merely because the employee can identify some stressful work related episode which contributes in part to the employee's depression or anxiety. Anxiety, emotional stress or depression, which develops over time in the normal course of an employment relationship does not constitute a compensable injury under *Pathfinder*. "Compensation for non-traumatic psychic injury cannot be dependent solely upon the peculiar vicissitudes of the individual employee as he relates to his general work environment." *See also, Turrentine v. Springfield Park Dist.*, 99 IIC 0847, 97 IWCC 61559, where the claimant was employed as police officer and was denied compensation stemming from his claim that a stabbing, at a domestic abuse call, was a shocking event.

Comparing the facts and holdings in the cases cited above with the instant case, the Arbitrator specifically notes that the petitioner did not sustain a physical injury on March 30, 2010 or any time thereafter. He was also not inside of the house, did not witness the actual death of his co-worker or the burns sustained by his other co-worker; and was not involved in the rescue efforts of either of them. The Arbitrator also notes that cases are employment specific and, in the context of firefighters and police officers, establish a trend to deny recovery for post-traumatic stress disorder to first responders.

The Petitioner relies on Illinois Appellate Court case *Diaz v. Illinois Workers' Compensation Comm'n*, 2013 Ill.App.2d, 12024, WC, 989 N.E.2d 233 (2d Dist. 2013) and *Kieta v. Village of Homewood*, 12 IWCC 1263 (2012), to support his claim for workers' compensation benefits. The Arbitrator finds that the subject case is distinguished from these cases. In *Diaz* the employee, a police officer, sought worker's compensation for post-traumatic stress disorder caused by a work-related accident. An individual pulled and pointed a gun at the officer and he did not realize, at the time, that the gun was a toy. Until the individual was restrained, approximately forty (40) officers considered the perpetrator to be armed and dangerous. Three (3) days after this incident, the officer suffered a panic attack and was subsequently diagnosed with post-traumatic stress disorder. The Commission found that the officer had failed to prove that he had sustained a compensable accident and the trial court affirmed this decision. On appeal, the Court found that the Commission had held the employee to a unique standard of severe emotional shock not otherwise applicable to employees in other lines of

work. This employee had suffered a sudden, severe emotional shock that resulted in his development of post-traumatic stress disorder.

In *Kieta,* this petitioner, a firefighter, was at the scene of the subject fire with the subject petitioner and actually went into the burning building on Petitioner's directive. This firefighter crawled into the house, as there was zero visibility. While attempting to douse the fire with a 2 ½-inch hose, steam and smoke hit his facemask and he asked a co-worker, i.e., Carey, to take the hose, while he adjusted his equipment. He transferred the hose to him. There was a sudden order to get out of the house however, before they could evacuate, a flash over occurred, which severely burned Kopas and subsequently killed Carey. This petitioner testified that he felt guilty and responsible for Carey and Kopas because he was the one who was supposed to be on the flash line and he had transferred that duty to others, who suffered severe and fatal injuries. This petitioner also saw Dr. McManus approximately two weeks after the fire, where he complained of nightmares, constantly seeing the fire, not wanting to talk about the fire; and increased alcohol intake. In addition, there was an investigation of this petitioner, regarding his behavior at the fire; and he feared termination as a result of the investigation. These facts support a conclusion that the petitioner in *Kieta* suffered a sudden, severe, emotional shock. The Arbitrator does not find similar facts in the subject case.

The Arbitrator finds that the petitioner has not proven, by a preponderance of the evidence, that he sustained accidental injuries, which arose out of and in the course of his employment with the respondent on March 30, 2010. Accordingly, all claims for compensation are denied. As the Arbitrator has found that the petitioner has not proven an accident, the remaining issues are moot and will not be addressed.

14IWCC0705

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
10WC20287
SIGNATURE PAGE

L Thompson Smith
Signature of Arbitrator

December 17, 2013
Date of Decision

DEC 17 2013

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

Helen Doran,

Petitioner,

vs.

William Wrigley Jr. Company,

Respondent,

14IWCC0706

NO: 09WC 9121

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, occupational disease, medical expenses, temporary total disability and permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 30, 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.

14IWCC0706

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

DATED: AUG 2 1 2014

o081814
MJB/bm
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DORAN, HELEN
Employee/Petitioner

Case# 09WC009121

14IWCC0706

WILLIAM WRIGLEY JR COMPANY
Employer/Respondent

On 10/30/2013, 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 0.08% 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:

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

1109 GAROFALO SCHREIBER HART ET AL
JAMES R CLUNE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

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

Helen Doran
Employee/Petitioner

v.

William Wrigley, Jr. Company
Employer/Respondent

Case # **09** WC **09121**

Consolidated cases: ____

14IWCC0706

An *Application for Adjustment 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 **9/16/2013**. 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. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ____

FINDINGS

On **10/14/2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$52,520.00**; the average weekly wage was **$1,010.00**.

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

Respondent shall be given a credit of $ for TTD, $ for TPD, $ for maintenance, and **$32,735.40** for other benefits, for a total credit of **$32,735.40**.

Respondent is entitled to a credit of **$26,281.50 (group medical)** under Section 8(j) of the Act.

ORDER

No benefits are awarded. See attached Decision.

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

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

Signature of Arbitrator

10/28/13
Date

ICArbDec p. 2

OCT 30 2013

FINDINGS OF FACT 14IWCC0706

Petitioner, a 50 year old executive administrative assistant for Respondent, began working for Respondent in 1989. Petitioner worked for Respondent through 10/14/10. She is presently not working. Petitioner testified that her job duties required her to work as an executive assistant for high level management personnel. Petitioner testified that she was scheduled to work 6.75 hours per day 5 days per week. However, she testified that her job duties required her to be on call evenings and weekends. Petitioner testified that she was given a cell phone and a lap top so she could be reached 24 hours per day 7 days per week.

Petitioner testified that during her tenure with Respondent she worked for 5 managers and 2 vice presidents and that at some point in 2008 and into 2009 she supported 40 to 50 people including chemists and lab technician. Included in her "support" duties, Petitioner ordered supplies, prepared travel vouchers, made travel arrangements, completed international travel paper work and extensive typing. The physical activities involved to accomplish these tasks included handwriting of travel plans detailed computer data entry of ingredient orders. Petitioner testified that she used her hands to type and on an average work day she spent 90% of her day typing at work and at home. Petitioner testified that in 2002 her role changed and her workload increased due to corporate changes in management. Petitioner testified that during her employment tenure she had to take work home in order to complete the work calendars for high level executives by entering the work schedules into Outlook and answering emails. Petitioner testified that she received 40 to 100 emails per day. Petitioner testified that she could not complete these tasks during the day at work because she was busy with other daily work load tasks of ordering and mailing which required data entry and computer work.

Petitioner testified that in 2002 she noticed pain in both hands. She testified that her desk at one of her assigned offices was not ergonomically correct. Petitioner testified that she carried her computer to work and that she noticed that her hands would become stiff, tired and swollen. Petitioner testified that as time progressed she started to drop things like bottles of water and trays of coffee. Petitioner continued to notice these problems into 2003.

Petitioner testified that she fell at work injuring her back, right hip and right rotator cuff in 2004. Petitioner was off work until May 2005. Petitioner's claim from those injuries was resolved. Petitioner did not injure her arms or hands in the 2004 accident.

Lauren Lackey testified via deposition. RX 3. The Petitioner worked as Ms. Lackey's administrative assistant between approximately 2004 and 2009. RX 3, p. 4-5. Ms. Lackey no longer works for Respondent. While employed by Respondent, her title was Director of North American Gum and Candy business for research and development. RX 3, p. 6. Ms. Lackey testified that Petitioner did "basic typing, basically did my calendar, my travel, my expense report, filing some." RX 3, p. 6. She testified that Petitioner typed on a computer keyboard to perform these tasks. Petitioner did not answer Ms. Lackey's phone. Ms. Lackey also testified that Petitioner simultaneously worked for 2 to 3 other people who worked with Ms. Lackey. Petitioner performed the same duties for those individuals. RX 3, p. 7.

Petitioner sat right outside Ms. Lackey's office so the witness was able to observe Petitioner at work. She did not observe anything unusual about the way Petitioner typed. Specifically, she did not see Petitioner's hands unusually flexed and she did not witness Petitioner using extreme force or aggression while typing. RX 3, p. 7. She further testified that Petitioner did not type every minute of every work day. She observed Petitioner away from the keyboard at times retrieving and distributing mail and socializing. Petitioner never advised Ms. Lackey that she had too much work or that she was unable to keep up with the assigned work. RX 3, p. 8. Ms. Lackey described Petitioner's job as sedentary. RX 3, p. 9. Ms. Lackey further testified that Petitioner was never criticized in performance reviews. RX 3, p. 11. Ms. Lackey testified that she did not watch Petitioner at her computer for 8 hours per day and does not know specifically how much time Petitioner spent sitting at the keyboard typing in information for Ms. Lackey and the 2 to 3 other executives. RX 3, p. 15. Ms. Lackey testified that she was in the office 80% of the time and that she observed Petitioner approximately 60% of that time.

At trial, Petitioner testified that she disagreed with portions of Ms. Lackey's testimony. Specifically, Petitioner noted that Ms. Lackey did not mention adequate details of Petitioner's duties nor did she mention that Petitioner worked from home via lap top and cell phone or that she was on call 24 hours per day 7 days per week. Petitioner testified that she only saw Ms. Lackey in the office 2 days per week and for only one to two hours per day on those 2 days. Petitioner testified that she was given outstanding performance reviews.

In October 2008, Petitioner performed the job duties described above. Petitioner testified that in October 2008 she was waking at night due to bilateral arm numbness. Petitioner saw her primary care doctor who sent Petitioner to Dr. Durudogan on 10/14/08. Dr. Durudogan is a board certified D.O. Petitioner was right hand dominant. On her first visit, Petitioner complained of pain down her left arm for 1-1/2 months in duration. Petitioner advised she thought her condition was work related and she described doing repetitive clerical work without lifting. Dr. Durudogan examined Petitioner's left hand, wrist, and elbow and diagnosed left lateral epdicondylitis and carpal tunnel syndrome.

Dr. Durudogan performed injections to the left wrist and elbow and as of her 11/11/08 visit Petitioner was told to continue night splinting, vitamin B6 and to have an ergonomic work space assessment. Petitioner testified that she asked for the assessment at work but the results were not presented at trial. As of 11/11/08, Petitioner was placed under restrictions of no repetitive activity with her left arm and rest every 15 mins per hour. On exam, he noted a positive Phalen's. Left wrist pain complaints continued at the exam of 12/08 with positive Phalen's and mildly positive Tinel's. Petitioner also had tenderness in the left elbow about the upper lateral epicondyle. Dr. Durudogan noted that Petitioner's 10/16/08 EMG was negative for carpal tunnel but was a partial report. The 12/2/08 EMG was positive for left carpal tunnel and ulnar nerve injury related to the elbow typically seen in cubital tunnel syndrome. He also determined the EMG indicated right carpal tunnel. PX 1. In January 2009, an EMG dated 1/9/09 performed by Dr. Atluri was negative for left carpal or cubital tunnel. PX 2.

On 2/3/09, Dr. Durudogan continued the work restrictions and recommended a left carpal tunnel release. The left carpal tunnel release was eventually performed on 10/7/09. Petitioner also underwent right carpal tunnel release surgery thereafter on 2/3/10. An EMG of the left median

and ulnar nerves performed on 3/9/10 showed no electrodiagnostic evidence for any peripheral nerve compromise to account for Petitioner's numbness of her left 4th and 5th fingers. PX 3. A left ulnar nerve decompression surgery was performed on 5/5/10.

At the post surgical visit of 1/7/11, Dr. Durudogan noted Petitioner did well with surgery and had no complaints of numbness or tingling down her arms. The carpal tunnel surgeries resolved the numbness and tingling in her right and left hands and the left ulnar surgery resolved some residual numbness and tingling in her left 4th and 5th fingers. Her complaints at the visit of 1/7/11 related to her left shoulder. Petitioner stated at trial that she is not claiming any left shoulder problems in connection with the instant matter. T. 39. Dr. Durudogan opined that Petitioner's bilateral carpal tunnel, left cubital tunnel and epicondylitis are "most likely work-related" based on the history provided. PX 7, pp. 21-22. He did not consider any ergonomic measurements in his opinion. PX 7, p. 23. Also, he testified that his type written notes on his visits with Petitioner do not contain a description of Petitioner's work activities. PX 7, p. 25,33. Dr. Durudogan testified that the first opinion he gave as to a causal relationship between Petitioner's conditions and her work in writing was in his 1/8/10 report when requested by Petitioner's counsel. PX 7, p. 32. Dr. Durudogan also testified that in combination, Petitioner's age of 50, her post menopausal age range and her weight could result in her carpal tunnel independent of her work activities. PX 7, p. 28. Dr. Durudogan testified that other than Petitioner's history to him that she thought her condition was work related he had no scientific basis to conclude that Petitioner's activities at work caused her left sided and right sided problems. PX 7, p. 38. He indicated his opinion that Petitioner's reported work duties could aggravate or accelerate her conditions, even if caused by other independent factors, based on the fact that Petitioner reported no other potentially aggravating activities. PX 7, p. 39.

Petitioner testified that she gave Dr. Durudogan a job description which she prepared. PX 9. However, Dr. Durudogan testified that he never received or reviewed a job description for Petitioner. PX 7. Petitioner testified that she could not call if she provided a written or an oral description of her job duties.

Petitioner's first Section 12 exam was on 12/22/08 performed by Dr. Atluri. Petitioner reported pain, numbness and tingling in the left upper extremity and a gradual onset of numbness and tingling in both hands and fingers over a period of several months. Petitioner noted that she first reported her symptoms in October 2008 at a check up with her physician. RX 1. Exam revealed a positive Tinel's over the cubital tunnel on the left, negative on the right. Dr. Atluri noted that "based upon the history as related to me by the patient, her physical findings, x-rays and medical records available for my review, Ms. Doran appears to have multiple conditions affecting her left upper extremity." He noted the possibility of bilateral carpal tunnel. He diagnosed likely left elbow lateral epicondylitis. Dr. Atluri recommended EMG studies and additional treatment dependent on those results. Petitioner described her work activities to Dr. Atluri who noted, "There is no description of significant forceful gripping and/or heavy lifting with the arms in an awkward position on a routine basis. Based upon the patient's description of her work activities, the numbness and tingling as well as her left upper extremity pain would not be considered related to her work activities." He opined Petitioner was capable of working without restrictions. RX 1.

Petitioner underwent a second Section 12 exam with Dr. Atluri on 8/2/10 after all three of her surgeries were performed. Dr. Atluri noted Petitioner's improved symptoms in her right and left hands as well as in her left 4th and 5th fingers. Petitioner continued to complain of limited left hand strength, soreness in her left biceps, and mild pain in her right thumb. Petitioner denied any persistent numbness or tingling. Dr. Atluri noted that based upon Petitioner's history and the positive response to her three surgeries, he now determined that "...although the patient's electrodiagnostic studies did not reveal carpal tunnel syndrome, her response to the surgical intervention indicates that she did, indeed, have bilateral carpal tunnel syndrome. Her improvement after her left elbow surgery indicates that she did have some type of ulnar neuritis (cubital tunnel syndrome)." RX 2.

Dr. Atluri goes on to state, "My opinions have not changed regarding the etiology of these conditions. There is no relationship between her upper extremity problems and her usual work activities. Her work as an administrative assistant does not involve forceful gripping, heavy lifting, pushing and pulling on a frequent basis with her upper extremities." RX 2.

The Arbitrator notes that Dr. Atluri indicates that he reviewed a workstation evaluation report dated 12/2/08. However, he makes no further comment regarding the report or its results and no such report is included with Dr. Atluri's report or anywhere else in the record.

Following her left hand surgery, Petitioner was off work from 10/7/09 through 11/8/09 while attending physical therapy. Petitioner was off work following her right hand surgery on 2/4/10 through 10/13/10 during which time she attended physical therapy and underwent a left ulnar nerve decompression followed by physical therapy for the left elbow. As of 10/12/10 Dr. Durudogan released Petitioner to return to work following her treatment for the left and right upper extremities.

Petitioner testified that she did not return to work for Respondent at that time because she received a termination letter from Respondent on 7/24/10.

Currently, Petitioner testified that she is not able to type or write as she did before her conditions. Petitioner is unable to carry heavy objects or open or grasp items as she did before her conditions. Petitioner testified that she has difficulty holding a pen and her handwriting is sloppy. She complains of right thumb pain and is no longer able to do crafts or garden. She drops cups and plates and no longer uses a computer. If she does type, she uses one index finger and does not use the left hand at all to avoid the ulnar pain. Home cleaning activities cause pain such as vacuuming and she does not carry laundry loads. Petitioner has not returned to work. She has been unsuccessful and has had no response to her applications for secretarial work.

CONCLUSIONS OF LAW

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

C. Did Petitioner sustain accidental injuries arising out of and in the course of her employment on October 14, 2008? F. Is Petitioner's current condition of ill-being causally related to the injury of October 14, 2008?

The Arbitrator initially notes that based upon the medical evidence and testimony presented, Petitioner did in fact sustain bilateral carpal tunnel and left cubital tunnel conditions for which she received appropriate treatment followed by a successful recovery. However, based upon the record in its entirety, the Arbitrator finds Petitioner has not proven by a preponderance of the credible evidence that she sustained accidental injuries arising out of and in the course of her employment. In so finding, the Arbitrator further finds that Petitioner's conditions of ill-being are not causally related to her employment activities for Respondent.

Petitioner maintains, and the Arbitrator takes note, that she was performing a great deal of work in supporting a number of executives. The Arbitrator further notes that the keyboarding and data entry work was performed both in the office and at home. However, the Arbitrator also notes that the described worked was not forceful, did not involve impact, did not involve vibration, and, at best, may have involved poor hand positioning. The Arbitrator also takes note that there is no evidence in the record describing Petitioner's workstation ergonomics. Other than Petitioner's own report and conclusion that her conditions resulted from her work duties, there is no evidence, medical or otherwise, to support that conclusion.

The Arbitrator further notes that there is no reliable or independent basis for Dr. Durudogan's causal opinion. His causal opinion is admittedly based solely on the job description purportedly provided to him by Petitioner and on Petitioner's own opinion of causal relationship. However, upon close examination of the record, the record is not clear on when or if Petitioner's work activities were provided to him as none of the visit notes include comment on Petitioner's work activities. Furthermore, Petitioner did not reliably testify when or if she provided PX 9 to Dr. Durudogan or whether she provided a verbal work description. Dr. Durudogan conceded that he did not recall the "specifics" of Petitioner's work activities and that he did not "...know what she did on a specific daily basis" and that "it's just purely by her history." PX 7, p. 25,32. Further, Dr. Durudogan testified that his first causal opinion was provided 2 years after treatment began only after he was asked for that written opinion by Petitioner's counsel in requesting a narrative report. The Arbitrator further notes that Dr. Durudogan did not review any ergonomic workstation reports when rendering an opinion. Dr. Durudogan further conceded that other than Petitioner's history to him that she thought her condition was work related he had no scientific basis to conclude that Petitioner's activities at work caused her left sided and right sided problems. PX 7, p. 38. As such, the Arbitrator places greater weight on the opinion of the hand surgeon, Dr. Atluri, and the scientific studies supporting his opinions.

The Arbitrator finds that under the facts and evidence specific to the instant matter, the weight of the credible evidence is in favor of Respondent. Based on the Arbitrator's findings on the issues of accident and causal connection, all remaining issues are moot. No benefits are awarded.

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marcy M. Faber,

Petitioner,

vs.

NO: 08 WC 22105

14IWCC0707

State of Illinois/Mendota,

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 reasonableness and necessity of medical expenses and nature and extent of permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Arbitrator's Decision finding that chiropractic treatment by Dr. Barrett was no longer reasonable or necessary after June 27, 2008, the date of the §12 evaluation by Dr. Nicholson. The Commission notes that Petitioner received chiropractic treatment 164 times with Dr. Barrett from January 28, 2008 through October 2, 2009. She had treated 53 times between January 28, 2008 and June 25, 2008. Dr. Barrett opined his chiropractic treatment was reasonable and necessary and testified that on numerous occasions Petitioner informed him that his treatment was the only thing that gave her some relief. Dr. Barret basically testified that Petitioner's condition waxed and waned. Petitioner testified that Dr. Barrett's chiropractic treatments were the only thing that gave her some relief. On June 27, 2008, Dr. Nicholson opined that further chiropractic care was not medically necessary or appropriate. In his December 18, 2012 MCMC Utilization Review, chiropractor Dr. Bowman

14IWCC0707

opined that six chiropractic treatments beginning January 28, 2008 can be considered appropriate, but anything after would not be appropriate as there was no documented improvement in Petitioner's condition. The Commission finds the opinions of Dr. Nicholson and Dr. Bowman more persuasive than those of Dr. Barrett. The Commission awards Dr. Barrett's medical bills from January 28, 2008 through June 25, 2008 (Px1), which total $5,003.00, under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act. Respondent is to receive credit of $3,794.49 for payments made to Dr. Barrett (Rx6).

The Commission affirms all else. The Commission notes that the parties agreed that Petitioner was temporarily totally disabled from December 27, 2007 through February 3, 2010, 109-3/7 weeks, and that Respondent is entitled to credit of $41,542.10 for TTD benefits paid. TTD and credit for same was not at issue on Review.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $5,003.00 for medical expenses under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act and subject to credit of $3,794.49 for payments made to the medical provider by Respondent.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $342.25 per week for a period of 67.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 13.5%.

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

DATED: AUG 2 1 2014
MB/maw
o05/28/14
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FABER, MARCY M
Employee/Petitioner

Case# **08WC022105**

14IWCC0707

STATE OF ILLINOIS/MENDOTA
Employer/Respondent

On 2/5/2013, 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 0.11% 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:

0190 LAW OFFICES OF PETER F FERRACUTI
THOMAS M STROW
110 E MAIN ST
OTTAWA, IL 61350

5048 ASSISTANT ATTORNEY GENERAL
MEGAN JANICKI
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

0499 DEPT OF CENTRAL MGMT SERVICES
MGR WORKMENS COMP RISK MGMT
801 S SEVENTH ST
8 MAIN
SPRINGFIELD, IL 62794-9208

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

FEB 5 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0707

-STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Marcy M. Faber
Employee/Petitioner

v.

State of Illinois/Mendota
Employer/Respondent

Case # **08** WC **22105**

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 **Robert Falcioni**, Arbitrator of the Commission, in the city of **Ottawa**, on **December 27, 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 **December 11, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,661.68**; the average weekly wage was **$570.42**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$41,542.10** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$41,542.10**.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $342.25/week for 67.5 weeks, because the injuries sustained caused the 13.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary unpaid medical services of $22,802.10, as provided in Sections 8(a) and 8.2 of the Act and as set forth more fully on the attached Memorandum of Decision. Respondent shall receive credit for any payments already made but not yet reflected on Petitioner's medical bills exhibit offered at hearing.

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

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

Nhell E Mc

Signature of Arbitrator

January 28, 2013

Date

FEB - 5 2013

MARCY M. FABER V. STATE OF ILLINOIS/MENDOTA: 08 WC 22105

I. STATEMENT OF FACTS

Petitioner Marcy Faber testified that she worked as a public service representative for the Secretary of State, Department of Motor Vehicles, in Mendota.

She testified that on December 11, 2007, she fell on ice in the parking lot, and jammed up her left shoulder and neck. Petitioner is right-hand dominant. Accident, notice, and causation are not disputed by Respondent.

Petitioner went to the emergency room at Mendota Community Hospital the next day on December 12, 2007. (PX7 at 5). X-rays were taken, revealing no fracture. (PX7 at 17). She was diagnosed with a left shoulder strain and referred to her family physician. (PX7 at 10). She was given work restrictions of no lifting greater than 5 pounds told she must wear a sling. (PX7 at 13).

Petitioner saw Dr. Raymond Meyer at Rezin Orthopedics on December 19, 2007. (PX3 at 11). He diagnosed her with a left shoulder strain (AC joint sprain, rotator cuff contusion). He also recommended a sling for one week and no work. She returned on December 26, 2007, continuing to have pain. (PX3 at 10). X-rays of her left clavicle were taken, which revealed no gross fracture or dislocation. Dr Meyer's plan was to start her in physical therapy. She was kept off work at this time. (PX3 at 27). Petitioner returned on January 9, 2008, stating her pain is aggravated with physical therapy. (PX3 at 8). At that time, an MRI was ordered and Petitioner's physical therapy was discontinued. She was kept off work on that date. (PX3 at 25).

The MRI of Petitioner's left shoulder was done on January 20, 2008, and it revealed no obvious acute abnormality. (PX6 at 44, PX3 at 19).

Dr. Jeff Barrett, a chiropractor, testified via evidence deposition on December 12, 2012. (PX14). Petitioner first saw Dr. Barrett on January 28, 2008, after knowing of Dr. Barrett through friends. (PX11 at 3). Petitioner gave a history of coming in from the parking lot, slipping on the ice, falling to the left, and catching herself on her left hand with her arm straight out. (PX14 at 6-7). Petitioner complained of palpable pain both in the left shoulder and down the arm and the left scapular area. Dr. Barrett found that Petitioner had a positive Kemp's test bilaterally and that she had winging of the scapula. He also found that Petitioner's reflex at the C5 area was absent. She also had severe rhomboid myospasm, left greater than right. There was visible swelling of the left AC joint. Dr. Barrett thought there was a possible labral tear in the shoulder or damage to the long thoracic nerve. Dr. Barrett did some physical therapy to the left shoulder and worked on the thoracic spine. He explained that interferential therapy helps reduce the swelling in the AC joint and bring new blood into the area to increase the healing time. (PX14 at 11). Dr. Barrett explained interferential therapy as a procedure using an electrical stimulus that sends in the same charge at different angles, which will break up adhesions. (PX14 at 42). Dr. Barrett referred her to Dr. Paul Perona, an orthopedic surgeon. He also placed Petitioner on light duty – no tearing of forms, pushing, pulling, or typing.

Petitioner next saw Dr. Barrett on January 30, 2008. Dr. Barrett did interferential therapy of the shoulder area and the left scapular area working on the thoracic spine. He also took her off work at that time. (PX14 at 13).

Petitioner had 164 visits with Dr. Barrett before her surgery from January 28, 2008 through October 2, 2009. (PX11). Petitioner testified that the chiropractic treatment was the only thing truly helping her manage her symptoms during this time. This is confirmed by Petitioner's statements made to Dr. Barrett and recorded in his treatment notes.

On February 18, 2008, Petitioner had an MRI of her left shoulder, which revealed possible adhesive capsulitis and areas of tendinosis. (PX6 at 29). Her x-rays on that date revealed thoracic spondylosis with dextroscoliosis. (PX6 at 31).

Petitioner saw Dr. Paul Perona on February 19, 2008. She was referred to physical therapy. (PX9 at 33).

Petitioner was evaluated for physical therapy on February 28, 2008. (PX9 at 33). The notes indicate that she did experience increased burning following physical therapy treatment as well as later on that date per phone call. (PX9 at 34). Petitioner testified that she completed three therapy sessions.

Petitioner went to the ER at Illinois Valley Community Hospital on March 2, 2008. (PX13 at 8). She was diagnosed with a shoulder strain. (PX13 at 11).

On March 14, 2008, Petitioner had a CT scan of her chest. No abnormality associated with her left shoulder pain was identified by the scan. (PX9 at 24). On March 15, 2008, Petitioner went to the ER at St. Margaret's hospital, complaining that the pain in her shoulder had worsened by the dye injection for CT of her chest that she had the previous day. (PX9 at 13). She received injections of decadron and lidocaine into the scapular area for pain. (PX9 at 15).

Petitioner had an MRI of her cervical spine on March 24, 2008. (PX6 at 23). It revealed no significant disc bulge, disc protrusion, spinal or neuroforaminal stenosis.

On March 31, 2008, an EMG was performed by Dr. Angela Benavides, and at that time it was felt that there was a long thoracic nerve neuropathy. (PX12 at 2).

Petitioner was referred to Dr. Guido Marra of Loyola University Medical Center and first met with him on May 27, 2008. (PX5 at 25). At that time, he recommended a repeat EMG in 2 months as there was evidence of some partial recruitment of her serratus anterior. She was given work restrictions of no repetitive use of the left arm. (PX5 at 32).

Petitioner had another EMG done on June 16, 2008, which showed improvement of the long thoracic nerve. (PX12 at 5).

Petitioner returned to Dr. Marra on June 24, 2008. (PX5 at 21). He reviewed the results of her EMG which showed incremental improvement in the long thoracic nerve. On examination, she continued to demonstrate signs of winging and poor recruitment of the serratus anterior muscle. His plan was to have another EMG done in 3 months and see her back after that.

On June 24, 2008, Petitioner was also officially discharged from physical therapy. The records indicate that at the time of her last visit she continued to have burning involving the left scapular region along with anterior and posterior left shoulder. She noted that any activity involving her left arm causes increased pain. (PX9 at 39).

Dr. Barrett testified that he treated Petitioner 48 times from January 31, 2008 through June 27, 2008. (PX14 at 14). He further testified that the purpose of those visits were to alleviate some of the pain and get her back to a normal functioning status. (PX14 at 14). Dr. Barrett explained that with a long thoracic injury, chiropractic involvement has shown wonderful progression. (PX14 at 15). Dr. Barrett explained that when doing therapy to improve neurological conditions, which is what Petitioner has, it can take years. (PX14 at 17). Dr. Barrett testified to performing examinations of Petitioner's range of motion in the cervical area on January 28, 2008, February 11, 2008, and March 3, 2008. (PX14 at 50).

Dr. Barrett explained that during his treatment prior to Petitioner's surgery, he was trying to treat the cervical area, trying to strengthen the muscle and trying to prep that area, if in case surgery was needed, that muscle was working properly and would be in a functional position where it would be stronger. He also was working to alleviate Petitioner's pain. (PX14 at 23). Dr. Barrett testified that Dr. Perona had suggested treatment for the cervical brachial area and Dr. Koehn thought Petitioner needed testing and treatment on the brachial plexus area, which was the area he was working on improving and making Petitioner stronger for the surgery. (PX14 at 25).

On June 27, 2008, Petitioner was evaluated for an Independent Medical Evaluation by Dr. Gregory Nicholson. (RX1). In his report, Dr. Nicholson explains that Petitioner has been through therapy and continued to have pain that she localizes over the scapula itself, a burning pain in the superior and anterior aspect of the shoulder. His diagnosis was periscapular pain secondary to a long thoracic nerve neuropathy. In response to the question is the diagnosis causally related to the fall of 12/11/07, Dr. Nicholson wrote, "Yes, she had a fall onto her arm and rib cage. She had immediate pain and burning in the rib cage and periscapular area." He indicated that the recommended treatment was physical therapy. He indicated that further chiropractic treatment was not medically necessary or appropriate. He indicated that she could return to light duty work where she is sitting at a desk and most things are at desk height. He wrote that she should not be standing for long periods of time and doing reaching away from her body grasping or lifting. He specifically indicated that she had not reached MMI at this time. (RX1).

Dr. Barrett testified that he did not agree with Dr. Nicholson's opinion as of June 27, 2008 that further chiropractic care was not medically necessary or appropriate. (PX14 at 18). He explained that he was not sure Dr. Nicholson had the full story because he suggested that Petitioner should be having physical therapy, but explained that he was performing physical

therapy on Petitioner. (PX14 at 18-19). Dr. Barrett further explained that there were at least three different surgical opinions from different doctors, Dr. Schlenker wanting to do a rib resection, another surgeon wanting to do a scalenectomy, and Dr. Nicholson wanting to do a pectoralis major transfer. (PX14 at 20). Petitioner clearly testified that the only relief she received during this period was from the treatments offered by Dr. Barrett and that nothing the pain doctors did relieved her pain, even temporarily. (PX14 at 42).

Petitioner also testified that Dr. Barrett's treatment helped and that he was the only one who knew how to treat her. He knew it was a thoracic injury right away. His treatments allowed her to function. She testified that she continued to see Dr. Barrett after the IME because she still had pain, and the treatments helped her to function, gave her strength and better mobility.

Petitioner had another EMG done on September 8, 2008, and at that time the left long thoracic motor nerve showed normal latency and slightly reduced amplitude. (PX12 at 6).

Petitioner returned to Dr. Marra on September 30, 2008. (PX5 at 17). She continued to complain of significant parascapular pain. Dr. Marra reviewed the results of her EMG, which documented recovery of her long thoracic nerve. He indicated that he did not feel that split type transfer was recommended, and referred her to Dr. Ken Candido for pain management.

Petitioner saw Dr. Candido on November 3, 2008. (PX16).

Petitioner returned to Dr. Marra on November 11, 2008. (PX5 at 12). Her examination revealed mild scapular winging and reasonable parascapular control. Dr. Marra indicated he did not feel she was a candidate for pec transfer at this time, and referred her to Dr. Scott Simon at Mayo Clinic for a second opinion. This referral was never approved by Respondent.

Petitioner saw Dr. James Schlenker on November 25, 2008. (PX10 at 7). He wrote down a detailed history of Petitioner's prior treatment, including that she had been told she had a rotator cuff tear and later told by another doctor that she had an ACL strain. He indicated that she stopped physical therapy due to the burning sensation and pain. He indicated that the pain interrupts her ADL's (hair, laundry, can't drive, drops items). He indicated she takes Motrin daily with little relief. He indicated her left arm was "very heavy, feels dead – going numb on neck, hard to hold." (PX10 at 7). He also indicated she was tender over her brachial plexus area. Dr. Schlenker indicated she has long thoracic neuropathy and recommended a left first rib resection. (PX10 at 8). On January 13, 2009, the surgery was cancelled per Dr. Schlenker, as it was not approved by workers' compensation. (PX10 at 9). Dr. Schlenker referred Petitioner to Dr. Ron Kloc. (PX10).

Petitioner saw Dr. Richard Keen on February 5, 2009 and again on March 19, 2009. (PX15).

On March 20, 2009, Dr. Keen wrote that Petitioner continues to experience debilitating symptoms of left neck, shoulder, and arm pain, with weakness consistent with a direct injury to her left arm, brachial plexus and branch nerves, including the long thoracic nerve and thoracic outlet syndrome. He indicated that it was not clear whether either rib resection or a scalenectomy

would necessarily relieve all of her symptoms. He stated that he had hesitation proceeding with thoracic outlet release at the time, but believed she would need to have it done at a future date. He believed she was unable to work as of that date. (PX15).

Petitioner saw Dr. Ronald Kloc of Illinois Valley Community Hospital on April 7, 2009. (PX13 at 38). He ruled out thoracic outlet syndrome. (PX13 at 39). His plan was to improve her pain with injections of the scalene muscles. He diagnosed her with pain syndrome for bracial flexus. (PX13 at 41).

Petitioner returned to Dr. Keen on April 16, 2009. (PX15).

Petitioner had an MRI of her cervical spine on May 15, 2009. (PX6 at 16). It indicated minimal disc bulging at C3-C4 through C5-C6 and no significant change from the previous exam.

Petitioner returned to Dr. Keen on May 28, 2009. (PX15).

On June 10, 2009, Petitioner was evaluated for a second IME by Dr. Nicholson. (RX2). At this time, Petitioner still complained of constant burning pain in the medial border of the scapular area, the posterior aspect of the shoulder, over the top of the clavicle, down the arm, and occasionally into the hand. Dr. Nicholson diagnosed her with dysfunction of the serratus anterior, secondary to a long thoracic nerve palsy, despite that her EMG results had normalized over time. He indicated that she still had a significant weakness of the serratus anterior and had winging of the scapula. He recommended a sternal head pectoralis major transfer to address the long thoracic nerve palsy. He indicated that Petitioner may have other problems, but such problems could not be addressed until you eliminate the primary injury, which was a long thoracic nerve palsy with the subsequent winging scapula. He indicated he would not first do a rib resection at this point because those symptoms may be secondary to the scapular dysrhythm. He indicated that Petitioner was very debilitated by the pain and her poor function and was not able to do full duty work. He indicated that the most she could do is sit at a desk for about two to three hours and then she has significant pain in and around the scapula and down the arm. He indicated that she was not at MMI on this date, and was still having significant problems accompanied by clinical evidence of scapulothoracic dysrhythm, winging scapula syndrome, and serratus dysfunction. (RX2).

Petitioner returned to Dr. Keen on July 16, 2009. (PX15). He indicated she "needs surgery; wants scalenectomy."

Petitioner saw Dr. Nicholson for treatment on September 9, 2009. (RX3). At that time, he recommended a sternal head pectoralis major transfer with an allograft tendon to substitute for the absent action of the serratus anterior to provide better scapular mechanics and take the poor mechanics away from the left side. He also recommended an arthroscopy of the left shoulder to ensure that they were not missing any intra-articular pathology. He indicated that an arthroscopic suprascapular nerve decompression at the suprascapular notch may indeed relieve many of the symptoms Petitioner was experiencing at that time. (RX3).

Petitioner had a left shoulder arthroscopy as well as a left pectoralis major transfer for scapula winging on October 5, 2009, performed by Dr. Nicholson. (PX17).

She followed up with Dr. Nicholson after the surgery on October 14, 2009. (PX2 at 15). She saw him again on November 4, 2009, and he indicated that post-surgery there was no winging of the scapula. (PX2 at 13).

Petitioner began physical therapy following surgery on November 10, 2009, at City Center Physical Therapy in Peru. She completed 34 sessions and was discharged on March 19, 2010. (PX2 at 49).

Her next appointment with Dr. Nicholson was on December 16, 2009, where he indicated her only complaint was of trapezial tightness. (PX2 at 12). On the next visit on January 27, 2010, he indicated she was having some upper trapezius and neck issues, but thought it was an accommodation issue. He returned her to work on this date. (PX2 at 11).

Petitioner saw Dr. Nicholson again on April 14, 2010. (PX2 at 10). Dr. Nicholson indicated that Petitioner still had some pain over the lateral aspect of the latissimus. He indicated that "she may always have some muscle irritation in that area," but he did not place her on any restrictions. He released her at MMI on that date. (PX2 at 10).

Petitioner testified that even when Dr. Nicholson released her she still had pain in the scapular, trapezial, and neck area. She testified that she had none of these symptoms prior to the accident on December 11, 2007.

Petitioner returned to Dr. Nicholson on June 23, 2010, complaining of increasing pain in the upper trapezius and down the spine between the medial border of the scapula and her vertebral column. (PX2 at 18). He wrote, "I do not doubt that she has pain but as a shoulder surgeon I do not have a solution for her at this time." He instructed her to follow up with pain management, a physiatrist well-versed in fibromyalgia and soft tissue issues, or a rheumatologist. (PX2 at 18).

On May 2, 2011, Dr. Benavides gave Petitioner injections of Kenalog and Lidocaine for her left shoulder and neck pain. (PX12 at 1).

On May 3, 2011, Petitioner had an MRI of her cervical spine. (PX6 at 10). It indicated minimal disc bulging at C3-C4 through C6-C7 with minimal flattening of the anterior thecal, no cord or nerve root encroachment demonstrated, and no significant change from the prior MRI.

Petitioner testified that she returned to Dr. Barrett after her surgery at Dr. Nicholson's direction.

Dr. Barrett testified that he treated Marcy through May 16, 2011, which included 5 visits in 2011 after her surgery. (PX14 at 22). He testified that he attempted to refer her back to Dr. Nicholson, but he would not see her. (PX14 at 26). Marcy was still complaining of pain in the long thoracic area after the surgery. Dr. Barrett was treating her to relieve the pain and was

doing interferential therapy to relieve the swelling. (PX14 at 35). Petitioner testified she would have returned to Dr. Nicholson if he had been willing to see her.

Dr. Barrett testified that he spoke with Carla, the state comptroller, who authorized further treatment in 2011. (PX14 at 31). He never got a denial from the state that his treatment was not authorized. (PX14 at 32).

Dr. Barrett testified that the fall would be directly related to the shoulder injury or it could be a neurological deficit due to the damage of the long thoracic nerve because of the fall. (PX14 at 12). Dr. Barrett stated that he believe Marcy's condition all correlates directly to her injury on December 11, 2007. (PX14 at 35).

Dr. Barrett testified that he has witnessed Marcy exercising after the surgery, and the left arm does not perform like it should because there has been a transfer of a muscle. (PX14 at 23). Dr. Barrett testified that he believes Marcy should be under permanent restrictions, including no heavy lifting and no overhead, but admitted he never placed her on official restrictions. (PX14 at 29-30). Dr. Barrett also testified that he believes Marcy needs more treatment. (PX14 at 34).

Petitioner testified that her condition never returned to the status before the accident on December 11, 2007. Petitioner testified she is limited in some activities. She cannot do anything overhead, she cannot sweep, cannot stand at hair salon. Petitioner testified that she continues to have symptoms, including a burning pain in her back and neck. It hurts to sleep, and she cannot sit for long periods.

Petitioner testified that she has not returned to 100%. She stated that she has not gotten further medical treatment because the workers' compensation system makes it too difficult. She testified that she would have liked to go to the Mayo Clinic, but it was not approved.

Respondent offered at trial a Utilization Review, prepared by MCMC, a company located in Massachusetts. (RX4). The author of the report, Davis Bowman, DC – who is licensed in California, New Jersey and Texas – attempted to contact Dr. Barrett but did not establish any communication prior to issuing the report. Dr. Bowman opined only 6 chiropractic visits were medically necessary.

Respondent also offered printouts of its TTD and medical payments. (RX5, RX6).

II. CONCLUSIONS OF LAW

J. In support of the Arbitrator's Decision as to WHAT AMOUNT SHOULD BE AWARDED FOR REASONABLE AND NECESSARY MEDICAL SERVICES, the Arbitrator finds the following:

Petitioner's Exhibit #1 is a compilation of itemized medical expenses related to Ms. Faber's medical care following her December 11, 2007 accident. (PX1).

Specifically regarding the chiropractic care that is in dispute, Petitioner testified that treatment with Dr. Barrett was the only thing that gave her relief. She testified that she continued to see Dr. Barrett after the IME because she still had pain, and the treatments helped her to function, gave her strength and better mobility. Dr. Barrett also offered extensive testimony explaining why his treatment was reasonable and necessary to treat Petitioner's condition. The Arbitrator notes that the Utilization Review chiropractor, Dr. Bowman, did not communicate with Dr. Barrett to ask why the treatment was necessary. Rather, Dr. Bowman simply stated that 6 visits were appropriate. The Arbitrator also notes that Dr. Nicholson apparently did not dispute the need for chiropractic care up through his initial IME, but only continuing care.

The Arbitrator finds Dr. Barrett's and Petitioner's testimony to be credible and persuasive relating to Petitioner's need for chiropractic care. The Arbitrator further notes that Dr. Barrett testified his treatment in 2011 was specifically authorized by Respondent and that they raised no objection at the time.

Based upon the Arbitrator's finding that Dr. Barrett's chiropractic care is related to the work injury, the Arbitrator awards these expenses for Petitioner's related medical treatment.

Thus, the Arbitrator finds that Petitioner shall be entitled to total medical expenses of $119,139.37 minus adjustments made by the workers' compensation carrier of $43,724.74 with Respondent to receive Section 8(j) credit for payments and adjustments of $32,602.66, leaving an amount due to Petitioner of $22,802.10 for her remaining reasonable, related, and necessary medical expenses subject to the limitations of the medical fee schedule of Section 8.2 of the Act and per the Request for Hearing form (ARBX1). Respondent shall receive credit for any payments already made but not yet reflected on Petitioner's medical bills exhibit offered at hearing.

L. <u>In support of the Arbitrator's Decision as to THE NATURE AND EXTENT OF THE INJURY, the Arbitrator finds the following:</u>

Petitioner testified that her condition never returned to the status before the accident on December 11, 2007. Petitioner testified she is limited in some activities. She cannot do anything overhead, she cannot sweep, cannot stand at hair salon. Petitioner testified that she continues to have symptoms, including a burning pain in her back and neck. It hurts to sleep, and she cannot sit for long periods. She stated that she has not gotten further medical treatment because the workers' compensation system makes it too difficult. The record reflects additional care was recommended for Petitioner, but was not pursued either because it was not authorized by Respondent or Dr. Nicholson refused to see Petitioner for a return visit.

Dr. Barrett testified that he has witnessed Petitioner exercising after the surgery, and the left arm does not perform like it should because there has been a transfer of a muscle. (PX14 at 23). Dr. Barrett testified that he believes Marcy should be under permanent restrictions, including no heavy lifting and no overhead. (PX14 at 29-30). Dr. Barrett also testified that he believes Petitioner needs more treatment. (PX14 at 34).

Based upon the greater weight of the evidence, Petitioner's continuing symptoms and pain, and Petitioner's permanent restrictions, the Arbitrator finds that Petitioner is entitled to an award of 13.5%loss of the person as a whole pursuant to Section 8(d)(2) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas M. Finnigan,

Petitioner,

vs.

NO: 13 WC 28653

14IWCC0708

Sharlen Electric Company,

Respondent.

DECISION AND OPINION ON REVIEW

Petitioner and Respondent appeal the Decision of Arbitrator Kelmanson in a §19(b) proceeding finding that as a result of accidental injuries arising out of and in the course of his employment on August 8, 2013, Petitioner is entitled to necessary medical expenses under the medical fee schedule, Respondent is entitled to credit of $239.36 and $161.64 paid towards the medical bills, that Petitioner failed to prove entitlement to TTD and TPD benefits, that Petitioner is entitled to prospective medical care of lumbar steroid injections recommended by Dr. Montella and that penalties and attorneys' fees were not warranted. The issues on Review are whether Petitioner sustained accidental injuries arising out of and in the course of his employment and whether a causal relationship exists between those injuries and Petitioner's current condition of ill-being and if so, the amount of reasonable and necessary medical expenses, the extent of temporary total disability, the extent of temporary partial disability and whether Petitioner is entitled to prospective medical care, penalties and attorneys' fees. The Commission, after reviewing the entire record, modifies the Decision of the Arbitrator finding that Petitioner sustained accidental injuries arising out of and in the course of his employment, that a causal relationship exists between those injuries and Petitioner's current condition of ill-being, that Petitioner was entitled to temporarily partial disability benefits on August 14, 2013 of $172.00, on August 16, 2013 of $143.32, on August 19, 2013 of $157.66 and on August 22, 2013 of $200.66, that Petitioner was temporarily totally disabled from August 23, 2013 through

14IWCC0708

November 12, 2013, a period of 11-5/7 weeks, that Petitioner is entitled to $2,502.55 for reasonable and necessary medical expenses, that Respondent is entitled to credit of $239.36 and $161.64 for payment of medical expenses, that Respondent is entitled to credit of $7,125.60 for compensation paid, that Petitioner is entitled to prospective medical care of lumbar steroid injections recommended by Dr. Montella and that penalties and attorneys' fees were not warranted for the reasons set forth below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, maintenance or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322 (1980).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 49 year old journeyman electrician, testified that is a member of IBEW Local 134. He has been a union electrician for 28 years (Tr 9-10). Petitioner had been working for Respondent for 2 to 3 months before August 8, 2013 (Tr 10). At that time, he was working at a construction site on Clark and Polk, on the second floor deck of a 6-story condominium building that was under construction (Tr 10-11). There were 10 condo units per floor. He had worked other projects like this in the past (Tr 11). Petitioner was in charge of putting the down openings in the deck for the hallway lighting, which consisted of regular lighting and emergency lighting. He had to pipe in from box-to-box so that when concrete was poured, nothing was missed. The wood would be pulled off so the lights could be put in a finished product for that floor (Tr 11-12). Petitioner explained that the carpenters lay down a deck, a floor of plywood. On top of that plywood, other trades such as electricians and plumbers put in their openings that are going to be used after the wood is stripped away. When the cement is poured and cured, the openings are inside the cement (Tr 12-13). Rebar is laid on top of the plywood, a mesh to strengthen the concrete (Tr 13). The rebar consists of 1-inch rods that are 30 feet long and crisscross each other to form a web. The rebar is laid down in sheets over the top of the wood. The rebar is probably about 12 to 14 inches deep above the wood. Petitioner walks on top of the rebar to get from box to box and slides his pipes underneath and ties them together (Tr 13). The pipes and boxes he was installing were underneath the rebar and on top of the wood floor; they are flat on top of the wood floor so that will be the ceiling of the floor below (Tr 14).

On August 8, 2013, there was nothing above him and he was on the next deck (Tr 14). After lunch that day, there was rain and all the other trades had pulled off the site. The crew Petitioner was on had to stay because the cement was being delivered the following morning and all the pipes had to be in (Tr 14-15). Pipes had to be connected box-to-box before the cement came (Tr 15). At approximately 2:15 p.m., as Petitioner went from one box to the next box, which was approximately 20 to 25 feet away down the hallway, he was walking across the rebar. He was carrying a Sawzall, a battery operated reciprocating saw used for cutting pipe and weighing 15 to 20 pounds, in his left hand (Tr 15-16). In his right hand, he was carrying a

5-gallon bucket with hand tools (Tr 16). As Petitioner walked from one box to the next box, his right foot slipped off the rebar and went through one of the rebar webs, maybe a foot deep. He went to catch himself and twisted (Tr 16-17). He tried to catch himself with the bucket and pushed down on the bucket and twisted. He did not fall (Tr 18). He had caught the bottom of the bucket with the top of the rebar (Tr 18). The only thing that went down inside the rebar web was his right foot (Tr 18-19). The weight of his body went with the bucket (Tr 19). When this happened, Petitioner noticed a burning sensation in the top of his buttocks, the bottom of his back, in his left leg and in his right leg from the knees up (Tr 19). He stopped to gather himself and told Craig, the journeyman in charge, what had happened (Tr 20). On this job, Craig was not the foreman, but he was a go-to guy for Respondent (Tr 21). He told Craig that he had tweaked his back (Tr 21). After that, Petitioner was in pain for the rest of the afternoon and moved a lot slower than he normally did (Tr 22). He was not able to stand up straight. Craig covered for him the rest of the day, which was only another 45 minutes (Tr 22). He was asked to work overtime, but he could not perform the work (Tr 22). He felt sore when he got home and took a couple Vicodins. Petitioner had been prescribed Vicodin before this date by Dr. Montella, who he had seen for his left shoulder and neck. He also laid on a heating pad (Tr 23).

The next day, Friday, August 9, 2013, Petitioner arrived at work at his regular time (Tr 24). He worked alongside of Craig, working in the other tower cutting off stubs, the pipes that stick out once the cement is poured. This was easier work than he was doing the day before (Tr 24). He was able to sit and cut stubs, but he was miserable and very sore (Tr 24). The pain was predominantly in his lower back and right leg (Tr 25). Petitioner took two Vicodins in the morning. He worked on Saturday, August 10, 2013. The cement on the deck he had worked on was hard and he cut down the stubs and spray painted them so no one would trip on them, an easy day as well (Tr 25). While working that day he was very sore. Petitioner told Craig he was going to have to tell Respondent that he hurt himself because he was not getting any better and was getting worse (Tr 26). He took two Vicodins when he got up that morning (Tr 26). On Sunday, August 11, 2013, Petitioner was scheduled off work. He felt worse. Every day it had gotten worse, progressively worse up until the present. The pain in his back, legs and feet was constant and did not go away (Tr 26).

Petitioner reported for work on Monday, August 12, 2013, at 6 or 6:30 a.m. and read the newspaper (Tr 27). When he was driving to work, Petitioner felt miserable. He was going to let the general foreman know that he got hurt at work. That morning, Petitioner saw Bob Strandberg, the general foreman, and reported the August 8, 2013 accident to him (Tr 28). Mr. Strandberg told Petitioner he should fire him right then. Petitioner explained to him that was why he did not tell him the day it happened (Tr 28). Petitioner stated that it was a hostile job site (Tr 28). He then went and talked to the union steward Mr. Quik (Tr 28). He then saw Mr. Quik go into the trailer where Mr. Strandberg was and saw him come out of the trailer (Tr 30-31). Mr. Strandberg then came out of the trailer and came to Petitioner and told him that he had to go to Immediate Care and that he would fill out the accident report (Tr 32). Petitioner then went to Physicians Immediate Care at 811 S. State Street in Chicago (Tr 32). This was the first time Petitioner sought treatment for his accidental injuries (Tr 33).

At Physicians Immediate Care on August 12, 2013, Petitioner was examined by a doctor and x-rays were taken. He was prescribed medications and given work restrictions (Tr 33). After being given the restrictions, Petitioner spoke with Bridget McCann, who worked in Respondent's office. Ms. McCann instructed Petitioner on what he would be doing for light duty (Tr 34). He was offered light duty work at that time (Tr 34). On Tuesday, August 13, 2013, Petitioner called Ms. McCann at 6:30 a.m. and told her he was too sore to drive to work and could not even get out of his house. He explained to her that the doctor's examination the day before left him in more pain than he was when he came to him (Tr 35). Ms. McCann called Petitioner in the afternoon and they agreed he would start light duty on Wednesday morning (Tr 36). On Wednesday morning, August 14, 2013, Petitioner drove an hour from his home to Respondent's shop and reported to work at 7:00 a.m. He was assigned to count light fixtures on a blueprint, which was located on the 3rd floor of the building and he had to walk 3 flights of stairs. He felt miserable as he walked up the stairs and had a great deal of pain in both sides of his butt and in his right leg and from his right ankle all the way up the back of his leg was burning (Tr 36-37). He had to lean across a table to count all the fixtures on the blueprint (Tr 37). He was unable to do this and felt very sore. The more he tried to stand or sit to compromise one way or the other, he could not do either due to his pain (Tr 37-38). Petitioner took a 15 minute break and then went to Ms. McCann and told her he could not continue and needed to leave (Tr 38). He then went home, leaving at 9:00 a.m. (Tr 38).

On Thursday, August 15, 2013, Petitioner was sore. He came in and discussed the way he felt with Charlie, the purchasing agent (Tr 39). He then went to the Physicians Immediate Care doctor for his scheduled appointment (Tr 40-41). The doctor continued the light duty work restrictions, continued prescribed medications and gave him a back brace (Tr 42). Petitioner reported for work on Friday, August 16, 2013, and cleaned the dock for Charlie, sweeping as best as he could. He wore the back brace (Tr 42). After 2 hours, his right leg was burning so badly that he could not even stand up. At his 9:00 a.m. break, Petitioner went across the street and sat in his van until his leg settled down. He then went back across the street and told Charlie he could not do it and was going home. He went home and took two Vicodins and laid on a heating pad the rest of the day (Tr 43).

On Monday, August 19, 2013, Petitioner went to Midwest Sports Medicine to see Dr. Montella (Tr 44). Dr. Montella was not available, so Petitioner saw his physician assistant, who examined and x-rayed him and recommended a lumbar MRI (Tr 44). Petitioner returned to work on August 20, 2013 and was assigned to fabricate boxes for the job site. He did this for 2 hours, then let Charlie know he could not do any more and went home (Tr 45). On August 22, 2013, Petitioner returned to Physicians Immediate Care Center in Chicago and his light duty work restrictions were continued (Tr 46). On August 23, 2013, Petitioner saw Dr. Montella at Midwest Sports Medicine & Orthopaedics (Tr 46). Dr. Montella examined him, recommended physican therapy and authorized him off work (Tr 47). Petitioner has been off work ever since that day (Tr 48).

On August 28, 2013, Petitioner underwent a lumbar MRI at MRI River North (Tr 48). Petitioner was seen at Physicians Immediate Care Center on August 29, 2013, but he refused to go through the same examination he had been through 3 prior times because all he did was aggravate the symptoms (Tr 48). After those examinations, he could not leave the office for 15 or 20 minutes until his back settled down enough to where he could walk out (Tr 48-49). Petitioner stated that the day after those examinations he had problems getting out of bed and standing up erect, everything was aggravated and it intensified the pain to the point where he could not leave the house and he would from the bed to the couch (Tr 49).

On August 27, 2013, Petitioner started physical therapy at Athletico. Dr. Montello had prescribed physical therapy (Tr 50). Petitioner stated that he attended the prescribed weeks from Dr. Montello and the physical therapist recommended he go back to Dr. Montello because the therapy was only aggravating the situation (Tr 50). On September 11, 2013, Petitioner saw Dr. Montello, who continued him off work and recommended he see Dr. Friedman for possible orthotics for his feet (Tr 51). Petitioner did see Dr. Freidman, but did not want to get the orthotics until he figured out what was causing his back pain (Tr 51). Petitioner saw Dr. Montella on October 9, 2013, who changed his medication from 7.5 milligams Vicodin to 10 milligrams Norco (Tr 51). Petitioner currently takes Norco (Tr 52). The Norco helped the morning of this hearing, but being present all day he was miserable (Tr 52). Dr. Montella kept him off work (Tr 52).

At Respondent's request, Petitioner saw Dr. Zelby on August 11, 2013 (Tr 52). He last saw Dr. Montella on October 30, 2013 (Tr 52). Dr. Montella continued him off work and continued Norco. Dr. Montella also suggested epidural steroid injections to his back, which he wants to undergo (Tr 53). Petitioner currently noticed he does not do much activity. He gets up and goes from the bedroom to the front room and lays on the couch (Tr 53). First thing in the morning, it takes him quite a while to stand up. He has a problem standing fully erect because his pain feels as if he is being pushed forward and it takes a good 5 minutes to gather himself and then he goes and has coffee in his front room (Tr 54). His wife makes and brings him coffee. He is right handed. If he picks up any weight, he gets a shooting pain across his low back (Tr 55). He takes baby steps because he has tenderness in his feet and his leg and back are sore (Tr 55). His pain is not going away and he has been living with it for months (Tr 55). He takes stairs one at a time. Going up and down stairs is a lot of effort and it is a lot of pain and he has to lean against the wall or railing (Tr 56). His wife does not work. This has affected their relationship a great deal. Respondent denied benefits and the bills are backing up. He is not able to do much around the house for his wife and this creates a lot of stress. His daughter does not get the attention she used to get. He does not have patience and is irritable (Tr 57). He has not received any TTD benefits (Tr 57). Petitioner acknowledged he did receive an advance from Respondent (Tr 58). Not having benefits has affected him. He borrows money from everyone and he has maxed out his credit cards. He is constantly worried that something is going to be turned off (Tr 58). Petitioner bought a house 6 months ago and he put everything he had down on it and got a good deal, but he cannot make his mortgage payments currently without borrowing from someone (Tr 58-59). Petitioner had no back injuries before August 8, 2013

and had none after (Tr 59). Over a 2 week period of time that he was working light duty, the first week he worked 12 hours and the following week he worked 3 hours (Tr 59-60). On August 14th he worked 2 hours. On August 16th he worked 3 hours. On August 19th he worked 2.5 hours. On August 22nd he worked 1 hour (Tr 60). Petitioner stated that Bridget McCann assured him he would still make his 40 hour work week (Tr 61). He did not receive TPD benefits (Tr 61). The parties agreed that Respondent paid $7,125.60 as a compensation advance, an advance payment on all disputed issues (Tr 63-64). The advance was paid on October 28, 2013 (Tr 65). Petitioner has filed a penalties petition. Respondent has filed a response to the penalties petition.

2. On cross-examination, Petitioner testified that for 6 month to a year prior to August 8, 2013, Dr. Montella had prescribed medications of Vicodin – Hydrocodone with a dosage of 4 to 5 per day as needed (Tr 71-72). He would get a refill every month (Tr 72). At that time, Dr. Montella was treating him for neck and shoulder pain, which probably starting in 2012 (Tr 72). Dr. Montella had put Petitioner on pain management and he would see him every 3 months (Tr 73). Petitioner testified to the following: "Q. And had you injured your shoulder and neck? A. You know, I think I had – It was work related. I think I had pulled or strained myself initially when I went to see him. He had no findings when he had done his x-rays." There is no present workers' compensation claim for his neck (Tr 74). Petitioner had worked for Respondent for several weeks before his back injury (Tr 74). Prior to working for Respondent, Petitioner worked for BP in Indiana for 14 months. He had left BP, then 2 to 3 weeks passed and then he had picked up the call for Respondent (Tr 75). Petitioner was treating for his neck and shoulder while working for BP (Tr 75).

Petitioner's injury occurred on Thursday, August 8, 2013, and was not reported to Respondent until the following Monday, August 12, 2013 (Tr 75). Craig was a co-worker and a journeyman in charge. He was not sure if Craig was a foreman or not. Craig was performing foreman tasks and not working with tools and was in charge of the blueprint of the work they were performing and crossing off the work as it was being completed (Tr 75-77). When Petitioner went to work on Monday, August 12, 2013, he knew he was going to report to someone what had happened and written documentation would be prepared. Craig was not the person who would have been filling out that paperwork (Tr 77). Petitioner did not think Craig witnessed what happened (Tr 78). Petitioner acknowledged there is a rule at Respondent that injuries should be reported immediately, but stated it was a hostile work site (Tr 78). To his knowledge, his employment has never been terminated by Respondent (Tr 78).

The first physician Petitioner saw after the incident was at Physicians Immediate Care (Tr 78). Respondent sent him to Physicians Immediate Care (Tr 78-79). He was released to light duty by the doctor at Physicians Immediate Care (Tr 79). None of the light duty work he performed involved jumping or running, but did involve prolonged bending over (Tr 79). Leaning over the table reading blueprints involved bending over from the time he got there to the time he left, approximately 2 hours (Tr 79). His definition of prolonged is 2 hours (Tr 80). None of the light duty work involved twisting, prolonged ladder climbing, lifting over his shoulder

more than 25 pounds or pushing or pulling more than 50 pounds (Tr 80). He first was seen at Physicians Immediate Care on August 12, 2013 (Tr 81). The table where the blueprints were was higher than desk height and the work could have been done standing up (Tr 81). The table was 8 to 10 feet long and 4 feet wide and the blueprints were on the table. To read the blueprints, Petitioner had to slide them closer to him and lean over (Tr 82). He was given Prednisone and Flexeril, a muscle relaxer, on August 22, 2013 and those medications made him worse (Tr 83). Petitioner refused to be examined on August 29, 2013 (Tr 83). He saw Dr. Montella's physician's assistant on August 19, 2013 after work and he was in a great deal of pain (Tr 83). August 19, 2013 was the day Petitioner was knocking out knockouts in the octagon electrical boxes (Tr 84). After he made the holes, he screwed in the little connectors (Tr 84). He did this on top of a gang box (Tr 84). Petitioner identified a photograph of an octagon 8B box for ceiling fixtures (Tr 85). Those are the ceiling boxes he used for lighting the hallway (Tr 85). The boxes in the walls are square (Tr 86). The box in the photograph is a little bigger than the box he would have worked with (Tr 86). He used a hammer with a point on it to knock out the knockouts and then twist it off with pliers (Tr 87). He would then screw fittings into the knockout holes (Tr 87). He did this while standing and sitting (Tr 88). At the hearing, after sitting for two hours, Petitioner was in a great deal of pain, his feet were on fire and his leg was burning (Tr 88). He was dropped off at the hearing (Tr 89). He occasionally drives a minivan. His wife occasionally works (Tr 89). Petitioner was not wearing the back brace at the hearing (Tr 89-90). The epidural steroid injections prescribed by Dr. Montella had been scheduled to begin on November 18, 2013 (Tr 90).

Petitioner acknowledged he missed quite a few physical therapy sessions with Athletico (Tr 90). He chose not to attend approximately 8 physical therapy sessions due to pain (Tr 90). Petitioner has not exercised since September 19, 2013 and he hurt when pushing a trash can up a driveway at home (Tr 91-92). He currently takes Norco, not Vicodin (Tr 93). He has been instructed not to take Vicodin (Tr 93). Petitioner has not treated for his neck and shoulder since his back injury (Tr 93). Petitioner had numerous workers' compensation claims over the years, but none involved his back except this one (Tr 94). The only current recommended treatment is epidural steroid injections (Tr 94). If he does not respond well to the epidural steroid injections, his doctor wants another lumbar MRI (Tr 94).

3. On re-direct examination, Petitioner testified he did not feel well while working on those ceiling junction boxes (Tr 94-95). He completed a half dozen boxes and the fingers of his right hand felt burning sensation and numbness in the back of his arm from his wrist to his shoulder (Tr 95). There is no difference between a foreman and journeyman in charge (Tr 95). Craig gave him instructions as to how to complete the tasks on August 8, 2013 (Tr 95-96). Petitioner waited until the following Monday to make a formal written report because he did not want to lose his job (Tr 97). Someone had been fired the week before August 8, 2013 (Tr 98-99). The union had put a hall-appointed steward on the job site because they were treating Petitioner unfairly and there were threats all the time (Tr 99). Petitioner stated that he knew he would lose his job if he had reported he injured himself (Tr 106). He was dropped off by his brother-in-law at the hearing site at 8:00 a.m., his lawyer arrived at 9:00 a.m. and it was 3:25 p.m. at that time

(Tr 106-107). He currently felt tired, sore, in pain and miserable and that is why he kept changing positions (Tr 107).

On re-cross examination, Petitioner testified that he is not willing to try the light duty work that was available to him before (Tr 108). He cannot drive an hour from his home to that job site and try and perform a job for an hour or two and then drive back home and only be paid for the time he is physically there and not be compensated for the entire day (Tr 109). For one week Petitioner was paid for 11 hours and for another week he was paid for 3 hours and Respondent forgot to pay him the rest of the money (Tr 109). One of the reasons for his not showing up for restricted duty work that was being offered is not because he did not like the way he was paid or was paid late. He could not go to work due to his pain. An hour driving to work aggravated his back to the point where he was already sore. Regardless of the task, he could not perform it for longer than 2 hours (Tr 110-111). On re-direct examination, Petitioner testified that Dr. Montella currently has him authorized off work (Tr 111).

4. According to Physicians Immediate Care medical records, Px1, Petitioner was seen by Dr. Lava on August 12, 2013 and complained of low back pain. The following history was noted: "Happened on Thursday. Pt was walking on top of re-bar and was uneven. Pt slipped and felt a pinch in his back." Petitioner reported constant moderate sharp back pain since August 8, 2013 with radiation of pain into his bilateral buttocks, but not beyond. He reported no similar problems in the past. Further history was noted: "Patient slipped off a beam 4 days ago on 8/8/13 and felt a pop in his back at the time." Petitioner reported his pain was worse, especially when getting up in the morning with pain to the buttocks, left greater than right. Petitioner also complained of muscle pain over his low back. His current medications were hydrocodone-acetaminophen 7.5 mg-750 mg Tab. On examination, Dr. Lava found altered gait and posture, variable posture noted comparing entrance into clinic and during examination when Petitioner was slightly hunched over and moving more slowly than noted in the waiting room. Dr. Lava found diffuse tenderness of thoracic, lumbar and sacral muscles with no spasm, diffuse tenderness of thoracic, lumbar and sacrum spine, positive Waddell signs, back pain with axial loading, skin hypertensive to light pinch over wide area negative, pain bilaterally when rotating shoulders and pelvis in tandem, inconsistently reproducible report of pain to a stimulus bilaterally and reduced lumbar range of motion. X-rays were taken and showed joint spaces well maintained, no fractures or dislocations. Dr. Lava diagnosed lumbosacral joint/ligament sprain. Dr. Lava gave restrictions to avoid jumping and running, avoid prolonged bending over, prolonged twisting, prolonged ladder climbing, no over the shoulder lifting greater than 25 pounds, no lifting from waist to shoulder greater than 25 pounds, no lifting below the waist greater than 25 pounds and no pulling/pushing greater than 50 pounds.

On August 15, 2013, Petitioner reported to Dr. Lava that his back pain was getting worse in the LS region on the right. He also reported pain in his neck, left back and right thigh which he described as numbness. Pain was worse with prolonged sitting, but also occured with prolonged standing. Dr. Lava noted that Petitioner refused straight leg raises because he said it made his pain worse for an entire day on the last examination. His examination findings were

the same. Dr. Lava diagnosed lumbosacral joint/ligament sprain and low back pain/lumbago. Dr. Lava prescribed Prednisone and Flexeril. Dr. Lava gave restrictions to avoid prolonged sitting, prolonged bending over, prolonged ladder climbing, no lifting below waist greater than 25 pounds and no pulling/pushing greater than 25 pounds.

5. The medical records of Midwest Sports Medicine & Orthopaedics, Px2, indicate Petitioner was seen by Kody Lewis, PA-C, on August 19, 2013 and reported a chief complaint of radiating back pain. Petitioner reported his symptoms had been present for 2½ weeks and constant. His right side pain was severe with rating of 9/10. The following history was noted: "The onset of his symptoms was sudden and related to a work injury. He is an electrician and while carrying heavy buckets at work, lost his balance and sustained a twisting injury." Petitioner reported his symptoms improve with rest and medications. Additional symptoms include radiation of pain on the involved side down his right leg and sleep disturbances. Petitioner reported that the other day while driving, he experienced burning and numbness into his right leg that lasted almost 20 minutes. He also has some pain going around into his lower right chest and stated that it hurt to take a deep breath. He has no difficulty breathing. Petitioner's treatment with Physicians Immediate Care was noted and Petitioner reported that the back brace given by the clinic caused him more pain than relief and he discontinued using it. On examination, Kody Lewis found marked muscle spasm in the right lumbar spinal muscles, tenderness along the lumbar spine and the spinal muscles into his buttocks, decreased range of motion in all directions and Petitioner was unable to raise his legs/bend his knees to his chest. X-rays were taken and showed no lumbar spine deformity or fractures. Kody Lewis diagnosed right low back pain. Petitioner was to continue Prednisone and Flexeril. It was noted that Petitioner also takes Vicodin for his neck pain, so no other pain killers were prescribed. Kody Lewis ordered a lumbar MRI and prescribed physical therapy 2-3 times a week for 4-6 weeks.

6. Petitioner saw Dr. Lava on August 22, 2013 and complained of muscle pain. He reported being worse after taking Prednisone and Flexeril. Petitioner complained of burning to his right foot and ankle that radiated up to his right thigh and buttocks. He was worse after activity. Petitioner also complained of pain under his right ribs and numbness to both hands. He was sent by work for re-evaluation. On examination, Dr. Lava found positive straight leg raises and the same Waddell signs. Dr. Lava diagnosed lumbosacral joint/ligament sprain. Dr. Lava's differential diagnoses were spine pathology, herniated disc and back strain. Dr. Lava ordered a lumbar MRI. Dr. Lava gave restrictions to avoid prolonged kneeling, prolonged squatting, prolonged bending over, prolonged twisting, prolonged jumping, prolonged running, prolonged ladder climbing, no lifting below the waist greater than 25 pounds and no pulling/pushing greater than 25 pounds. (Px1).

7. On August 23, 2013, Petitioner saw Dr. Montella and reported his symptoms had worsened since the last visit. His low back pain was getting progressively worse. Petitioner also complained of experiencing increased numbness and tingling, primarily in his right hand and palm, which has never happened before. The numbness and tingling also increases in both hands while driving for prolonged periods. In his legs, sometimes the pain can begin from his feet and

radiate upwards also accompanied by numbness and tingling. Lumbar pain was worse on the right side, but he had radiating pain into his left buttocks. He was also having some pain in his right lower ribs which increased with sitting for prolonged periods, such as when driving, which caused him difficulty breathing. On examination, Dr. Montella found normal alignment, mild paraspinal muscle tenderness with associated spasm, decreased range of motion in all planes, tenderness with terminal motion, positive straight leg raises, positive contralateral straight leg raises and no Waddell signs. Dr. Montella's impression was work related lumbar disc herniation. Dr. Montella ordered a lumbar MRI. He prescribed physical therapy 2-3 times a week for 4-6 weeks. Dr. Montella authorized Petitioner off work. (Px2).

8. Petitioner underwent a lumbar MRI on August 28, 2013. The radiologist found normal lumbar alignment and curvature. The vertebral body heights were maintained. There was degenerative loss of disc signal between L2 and L5, but with maintained disc height. At L2-3, there was disc bulging towards the inferior aspects of both neural foramen and a left inferior foraminal disc protrusion and there was mild left foraminal stenosis. At L3-4, there was a mild posterior disc bulging and a left foraminal disc protrusion and mild left foraminal narrowing. At L4-5, there was mild posterior disc bulging, a right foraminal annular fissure was seen and there was mild bilateral foraminal stenosis without significant central canal stenosis. At L5-S1, there was no focal disc herniation, central canal or foraminal stenosis. The radiologist's impression was overall a mild degree of degenerative changes in the lumbar spine were seen, with disc bulges and disc protrusions resulting in mild bilateral foraminal stenosis at L4-5 and mild left foraminal stenosis at L2-3 and L3-4. (Px1).

9. Petitioner saw Dr. Lava on August 29, 2013 and reported being worse and with cramping pain to his left buttocks. Petitioner also reported having numbness to his right foot, which he had not described before. He reported he has had burning from his right foot to his thigh. Both feet hurt upon awakening each morning, which he had also not described before. Dr. Lava noted, "Pt now is refusing examination because he says that when he lifts his legs during exam, the pain lasts for days." Petitioner also declined a longer course of Prednisone. Dr. Lava reviewed the August 28, 2013 lumbar MRI, which showed overall mild degree of degenerative changes in the lumbar spine with disc bulges and disc protrusions resulting in mild bilateral foraminal stenosis at L4-5 and mild left foraminal stenosis at L2-3 and L3-4. His prescribed medications were Prednisone, Flexeril and hydrocodone-acetaminophen. Dr. Lava noted that Petitioner's mood was angry and he was very dissatisfied with his care to date. Petitioner reported that his pain was excruciating. Dr. Lava noted Petitioner was pacing around the room without any visible discomfort. Dr. Lava noted he had discussed Petitioner's case with Dr. Koehler and both doctors concurred that his last examination findings and MRI were inconsistent with his complaints and that there was a significant degree of overdramatization of his injury. Dr. Lava noted, "The patient wants to see a specialist which I do not feel is warranted." Dr. Lava discharged Petitioner from his care. Dr. Lava noted that Petitioner's complaints were compatible with his history, physical examination and MRI results. Dr. Lava gave restrictions to avoid jumping and running, avoid prolonged bending over, prolonged twisting, prolonged ladder climbing, no lifting below waist greater than 25 pounds and no pulling or pushing greater than 25 pounds. (Px1).

10. According to the records of Athletico, Px3, Petitioner was seen for an initial physical therapy evaluation on August 27, 2013 and he began physical therapy that day. He did not show up the next day. He did not show up on August 29, 2013, but called and informed that the workers' compensation insurance adjuster told him that physical therapy would not be covered. Petitioner informed that he was meeting with a lawyer that day and would call back. On September 3, 2013, Petitioner cancelled due to insurance issues. He did not show up on September 9, 2013, but called and stated he forgot about his appointment, which was rescheduled. On September 11, 2013, the physical therapist issued a report which noted that Petitioner had attended only 2 sessions. The therapist noted that Petitioner reported he was walking up a ramp the day before and had a severe increase in low back pain to the point of nausea and had to sit down for 20 minutes. He reported his low back and gluteal pain had been increased since then. Petitioner refused to perform exercises and informed he was seeing his doctor.

11. Petitioner saw Dr. Montella on September 11, 2013 and reported ongoing low back pain which was unchanged. Dr. Montella opined, "Because of this recent work injury to his lower back, it has also aggravated his neck and right shoulder pain; and also the back of his right arm between his elbow and shoulder. He will feel numbness and tingling in that area also and into his right hand and fingers, which is something that only recently began occurring. He still feels the numbness and tingling into his right leg and foot. He is having increased pain today since had visit with PT earlier." On examination, Dr. Montella found negative straight leg raises and crossed raises, paraspinal muscle tenderness bilaterally with associated spasm, decreased range of motion in all planes, tenderness with terminal motion and no Waddell signs. Dr. Montella reviewed lumbar MRI. It was Dr. Montella's impression that Petitioner had a lumbar disc herniation. He continued prescribed medications and physical therapy. Dr. Montella referred Petitioner to Dr. Friedman, a foot and ankle specialist, for orthotics to minimize stress placed across the lumbar spine and lower extremities. He also prescribed Medrol Dose Pack. (Px2).

12. On September 13, 2013, Petitioner reported to the physical therapist that his doctor gave him steroid pills, which helped decrease his low back pain. Petitioner also reported his pain was worse after physical therapy. On September 17, 2013, Petitioner cancelled the session due to other obligations and it was rescheduled. On September 18, 2013, Petitioner cancelled due to weather and traffic. On September 19, 2013, the physical therapist issued a report which noted that Petitioner had attended 4 sessions. Petitioner reported his low back pain was feeling better this morning, but after he tried to push a trash can back up his driveway, his pain increased almost to the point it was right after he was initially injured. The therapist noted that Petitioner was too irritable to tolerate more than minimal activity in physical therapy. The therapist noted that Petitioner reported extreme lumbar pain to minimal pressure with palpation to his lumbar spine when lying on his side. On September 21, 2013, Petitioner reported increased hip pain, increased pressure in his low back when standing for very long and increased pain when driving to this session.

On September 23, 2013, Petitioner reported feeling slightly better, that he had been sitting in a massage chair for hours over the weekend and his low back felt much less tender. No exercises were attempted this day. The therapist sent a message to Dr. Montella inquiring about aquatic therapy. On September 25, 2013, Petitioner cancelled due to being stuck downtown. On September 27, 2013, the physical therapist issued a report which noted that Petitioner had attended 7 sessions. Petitioner reported being no different, that he continued to have increased pain in his low back, his groin and down his legs to his feet, right lower extremity worse than the left. In the September 30, 2013 report, the physical therapist noted Petitioner had attended 8 sessions and reported his right leg pain had improved slightly, but his low back pain was the same. He reported some pain and numbness and tingling in his left foot and shin which began when he awoke this morning. He was less tender than before. Petitioner cancelled on October 2, 2013 due to family issue. In a report issued October 4, 2009, the physical therapist noted Petitioner had attended 9 sessions and reported increased pain in his left foot and into his groin. Petitioner also reported increased low back pain after performing exercises and then he was unable to tolerate lying in a prone position.

In a letter to PA-C Kody Lewis dated October 7, 2013, the physical therapist noted Petitioner had attended 10 sessions and that since he began physical therapy, he has reported minimal improvement. The therapist noted Petitioner continued to complain of a burning pain in the middle of his low back as well as radicular symptoms down into his right groin and posterior thigh and recently, increased burning pain in his left foot. Petitioner also complained of upper back pain around his right lower ribs laterally. Petitioner reported that getting into and out of his car has been very painful and that due to his low back pain, he has difficulty sitting, standing, sleeping, getting in and out of bed, walking, going up and down stairs and getting into and out of his truck. (Px3).

13. Petitioner saw Dr. Montella on October 9, 2013 and reported no significant changes and he was having problems with Walgreen's pharmacy. On examination, Dr. Montella found negative straight leg raises and the rest was the same. Dr. Montella noted that Petitioner was currently under a "Zero Tolerance Policy". Dr. Montella noted, "According to the Prescription Monitoring website, he has been dispensed #364 pills of the Vicodin ES 7.5/750mg or 7.5/300mg since 9/5/13." Dr. Montella noted that Petitioner was aware that if there are any similar issues with this in the future, he would no longer prescribe him medication. Dr. Montella noted that Petitioner is on a long term narcotic usage for pain management. Dr. Montella prescribed Norco and ordered another lumbar MRI. Petitioner was to remain off work.

On October 30, 2013, Petitioner saw Dr. Montella and complained of severe low back, right hip, leg, foot and toes pain with numbness and tingling. Petitioner reported he was unable to function due to severe pain. On examination, Dr. Montella found mild palpable tenderness, paraspinal muscle tenderness on the right, limited lumbar flexion and extension and loss of spinal rhythm, hips had a painless symmetric range of motion and straight leg raises were negative. Dr. Montella's impression was work related disc herniation. Dr. Montella prescribed epidural steroid injections. Petitioner was to follow-up in 1 month and remain off work. (Px2).

14. At Respondent's request, Petitioner saw Dr. Zelby on October 11, 2013 for a §12 evaluation. In his report of that date, Rx1, Dr. Zelby noted that August 8, 2013 accident and Petitioner's treatment. Petitioner complained of constant pain across his low back into the right gluteal region and occasionally into the right groin and he gets intermittent tingling in the right foreleg and foot. Petitioner reported he felt his symptoms were exacerbated with sitting or standing and he gets little relief with heat or when lying down. Petitioner reported no prior episodes of these or similar type of symptoms. His prescribed medications were noted. Dr. Zelby noted Petitioner's occupation and Petitioner described it as light physical labor. Dr. Zelby noted that after his injury, Petitioner tried light duty work for short periods over a couple weeks, but has not worked since approximately August 20, 2013. Petitioner rated his pain at 8/10, but Dr. Zelby noted Petitioner rested and moved with no pain behaviors during the examination.

On examination, Dr. Zelby found tenderness to palpation of the lower lumbar and right upper gluteal regions, even with non-physiologic light touch. Forward flexion was to 60°, hyperextension less than 5°, right lateral bend and left lateral bend were to 10°. Lying straight leg raises on the right were positive in the back only and were negative on the left. Sitting straight leg raises were negative on the right and left. Gait was intermittently antalgic and favoring the right leg when so. There were no paraspinal muscle spasm. Sensation to pinprick was diminished in the entire right lower extremity. Dr. Zelby noted there were non-organic and inconsistent behavioral responses such as pain on superficial light touch, pain on simulation, diminished pain on distraction and non-anatomic sensory changes. Dr. Zelby noted the MRI report results and recited the medical records.

Dr. Zelby noted that Problem #1 was lumbosacral spondylosis. He noted that Petitioner's examination this day was remarkable for an essentially normal neurologic examination and a report of an MRI that is described as showing mild degenerative changes with no more than mild foraminal stenosis at several levels. Dr. Zelby noted that Petitioner had no radicular symptoms and no radicular findings on examination. Dr. Zelby noted, "He does have 4/5 Waddell signs, with fairly dramatic symptom amplification. In the context of describing findings on his MRI, this raises a question as to whether his symptoms are related to his symptom amplification or any actual infirmity in the lumbar spine. This also raises a question as to the cause of relationship between his ongoing subjective complaints and his report August 8, 2013 work injury. Mr. Finnegan is reported severity of symptoms and their reported persistence seems inconsistent with the objective medical evidence." Dr. Zelby opined Petitioner was easily qualified to work in at least a light-medium physical demand level, lifting at least 30 pounds occasionally and 10-15 pounds frequently. Dr. Zelby noted that a determination regarding the need for additional treatment and assessment of maximum medical improvement could better be made with a review of the MRI films and any additional MRI scans Petitioner may have had.

15. Medical bills were admitted into evidence as Px4, Px5 and Px6. A Penalties Petition was admitted into evidence as Px9 and a Response to the Penalties Petition was admitted as Rx5. A photograph of an octagon electrical conduit box was admitted into evidence as Rx3. A Motion to Strike §19(b) Petition was admitted into evidence as Rx4 and the Commission denies same

finding that proper evidence was submitted with Petitioner's §19(b) Request for Hearing.

The parties stipulated that R should be given credit for medical bill payments of $161.64 and $239.36 (Tr 7). The parties also stipulated that Petitioner worked the following hours and was paid for: on August 12, 2013, 8 hours; on August 14, 2013, 2 hours; August 16, 2013, 3 hours; August 19, 2013, 2.5 hours; August 22, 2013, 1 hour. (Tr 123-124).

Based on the record as a whole, the Commission modifies the Decision of the Arbitrator finding that Petitioner sustained accidental injuries arising out of and in the course of his employment, that a causal relationship exists between those injuries and Petitioner's current condition of ill-being, that Petitioner was entitled to temporarily partial disability benefits on August 14, 2013 of $172.00, on August 16, 2013 of $143.32, on August 19, 2013 of $157.66 and on August 22, 2013 of $200.66, that Petitioner was temporarily totally disabled from August 23, 2013 through November 12, 2013, a period of 11-5/7 weeks, that Petitioner is entitled to $2,502.55 for reasonable and necessary medical expenses, that Respondent is entitled to credit of $239.36 and $161.64 for payment of medical expenses, that Respondent is entitled to credit of $7,125.60 for compensation paid, that Petitioner is entitled to prospective medical care of lumbar steroid injections recommended by Dr. Montella and that penalties and attorneys' fees were not warranted.

The Commission finds that the Arbitrator erred in making findings based on the proposed decisions of the parties. Proposed decisions are not evidence and the Arbitrator should not have relied on them.

The Commission affirms the Arbitrator's finding that Petitioner sustained accidental injuries arising out of and in the course of his employment on August 8, 2013, based on Petitioner's testimony and the medical records, which corroborate Petitioner's testimony regarding accident. The Commission finds that a causal relationship exists between those injuries and Petitioner's current condition of ill-being, based on the chain of events and treating Dr. Montella's opinions as stated in his medical records. §12 Dr. Zelby did not definitively opine that no causal connection exists.

Regarding temporary partial disability, the Commission notes that Petitioner did not submit any pay stubs into evidence. Average weekly wage was $1,720.00. Petitioner worked 40 hours a week at full duty. $1,720.00 ÷ 40 hours = $43.00 per hour. $43.00 per hour X 8 hours a day = $344.00 a day. The parties stipulated that Petitioner worked the following hours:
-August 14, 2013: 2 hours (2 hours X $43.00 per hour = $86.00. $344.00 - $86.00 = $258.00 X 2/3rds = $172.00). For August 14, 2013, Petitioner is owed TPD benefits of $172.00.
-August 16, 2013: 3 hours (3 hours X $43.00 per hour = $129.00. $344.00 - $129.00 = $215.00 X 2/3rds = $143.32. For August 16, 2013, Petitioner is owed TPD benefits of $143.32.
-August 19, 2013: 2.5 hours (2.5 hours X $43.00 per hour = $107.50. $344.00 - $107.50 = $236.50 X 2/3rds = $157.66. For August 19, 2013, Petitioner is owed TPD benefits of $157.66.

-August 22, 2013: 1 hour (1 hour X $43.00 per hour = $43.00. $344.00 - $43.00 = $301.00 X 2/3rds = $200.66. For August 22, 2013, Petitioner is owed TPD benefits of $200.66.
The total amount of the above is $673.64 ($172.00 + $143.32 + $157.66 + $200.66).

Regarding temporary total disability, the Commission notes that Dr. Montella authorized Petitioner off work on August 23, 2013. Dr. Montella continued Petitioner off work through November 12, 2013, the date of the arbitration hearing. Therefore, the Commission finds Petitioner was temporarily totally disabled from August 23, 2013 through November 12, 2013, a period of 11-5/7 weeks and awards $1,146.66 per week for that period.

The Commission notes the following medical expenses: Physicians Immediate Care: $924.32 balance per fee schedule; Midwest Sports Medicine & Orthopaedics: $399.47 balance per fee schedule; Athletico: $1,178.76 balance per fee schedule. The total of these medical expenses is $2,502.55 and the Commission awards this amount. The Commission gives credit to Respondent for $239.36 and $161.64, based on the parties'stipulation. The Commission gives Respondent a general credit for $7,125.60 for compensation paid as per the parties' stipulation. The Commission finds Petitioner is entitled to prospective medical care of lumbar steroid injections recommended by Dr. Montella and orders Respondent to authorize and pay for same. The Commission affirms the Arbitrator's finding of no penalties or attorneys' fees were warranted under these circumstances. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,146.66 per week for a period of 11-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $673.64 for the period of temporary partial incapacity for work under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $2,502.55 for medical expenses under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act and subject to credit of $239.36 and $161.64 for payments made to the medical providers by Respondent.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes that Respondent paid $7,125.60 for compensation to Petitioner.

14IWCC0708

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize in writing and pay for the treatment of lumbar steroid injections recommended by Dr. Montella, pursuant to the Medical Fee Schedule.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $9,200.00. 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: AUG 2 1 2014
MB/maw
o06/05/14
43

Mario Basurto

Stephen J. Mathis

David L. Gore

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

Billie Cooper,
Petitioner,

vs.

NO: **01WC 7129**

Consolidated cases: 01WC 7130, 02WC 52556, 04WC 23916, 04WC 23917, 04WC 48472, 05WC 52366, 05WC 54352, & 07WC 46355

City of Chicago,

Respondent,

14IWCC0709

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 10, 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: AUG 21 2014
O081814
MJB/bm
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0709

COOPER, BILLIE
Employee/Petitioner

CITY OF CHICAGO
Employer/Respondent

Case# 01WC007129

01WC007130
02WC052556
04WC023916
04WC023917
04WC048472
05WC052366
05WC054352
07WC046355

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:

0230 FITZ & TALLON LLC
PATRICK A TALLON
5338 MAIN ST
DOWNERS GROVE, IL 60517

0766 HENNESSY & ROACH PC
ERICA LEVIN
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

14IWCC0709

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

Billie Cooper
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 01 WC 07129

Consolidated cases: 01 WC 07130, 02 WC 52556, 04 WC 23916, 04 WC 23917, 04 WC 48472, 05 WC 52366, 05 WC 54352, & 07 WC 46355

An *Application for Adjustment 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 **11/2/12 and 2/28/13**. 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 **November 10, 2000**, Respondent *was* 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 failed to establish a causal connection between the undisputed work accident of November 10, 2000 and any claimed current right toe, foot or ankle condition of ill-being.

In the year preceding the injury, Petitioner earned **$41,539.68**; the average weekly wage was **$798.84**.

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

Petitioner failed to establish any compensable lost time.

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**.

ORDER

FOR THE REASONS SET FORTH IN THE ATTACHED CONCLUSIONS OF LAW, THE ARBITRATOR FINDS THAT THE UNDISPUTED WORK ACCIDENT OF NOVEMBER 10, 2000 RESULTED IN STRAINS OF THE RIGHT BIG TOE, FOOT AND LEG THAT REQUIRED ONE VISIT TO MERCYWORKS ON NOVEMBER 13, 2000. PETITIONER FAILED TO ESTABLISH CAUSATION AS TO ANY CURRENT CLAIMED RIGHT TOE OR FOOT CONDITION OF ILL-BEING. PETITIONER ALSO FAILED TO ESTABLISH ANY COMPENSABLE LOST TIME AND PERMANENCY. THE ARBITRATOR FINDS THAT THE TREATMENT RENDERED BY MERCYWORKS ON NOVEMBER 13, 2000 WAS RELATED TO THE WORK ACCIDENT AND WAS REASONABLE AND NECESSARY. THE ARBITRATOR AWARDS NO MEDICAL EXPENSES IN CONNECTION WITH THIS TREATMENT BECAUSE THE MERCYWORKS BILL OF NOVEMBER 13, 2000 SHOWS A $0 BALANCE. PX 1. RESPONDENT SHALL BE GIVEN A CREDIT FOR MEDICAL BENEFITS THAT HAVE BEEN PAID AND RESPONDENT SHALL HOLD PETITIONER HARMLESS AGAINST ANY CLAIMS BY ANY PROVIDERS OF THE SERVICES FOR WHICH RESPONDENT IS RECEIVING THIS CREDIT, AS PROVIDED IN SECTION 8(J) OF THE ACT.

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

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

Molly C Mason
Signature of Arbitrator

4/10/13
Date

APR 10 2013

14IWCC0709

Billie Cooper v. City of Chicago
01 WC 7129 (consolid. with 01 WC 7130, 02 WC 52556, 04 WC 23916-7, 04 WC 48472, 05 WC 54352, 05 WC 52366 and 07 WC 46355)

Arbitrator's Findings of Fact Relative to 01 WC 7129 (D/A 11/10/00)

Petitioner testified she began working for Respondent on April 17, 1998. T. 11/2/12 at 27.

Petitioner's accident of November 10, 2000 is not in dispute. Arb Exh 1. Petitioner denied experiencing any foot or ankle injuries prior to that date. T. 11/2/12 at 84. On that date, Petitioner was working as a laborer assigned to a garbage truck. Her duties involved lifting heavy items, dumping garbage carts and cleaning alleys. T. 11/2/12 at 27-28. She testified she was spotting a truck in a quarry when she stepped into soft ground and twisted her right foot and ankle. T. 11/2/12 at 28-29.

Petitioner testified she notified Respondent of the accident (RX 2) and went to MercyWorks Occupational Medical Center at Respondent's direction. T. 11/2/12 at 29. The records from MercyWorks reflect that Petitioner provided a history of the accident to Dr. Marino on November 13, 2000 and complained of "pain in the middle side of the right ankle, first toe and right calf." Dr. Marino also noted that Petitioner had undergone a left knee arthroscopy in March of 2000 and bilateral bunion surgery in 1984.

On examination of Petitioner's right foot and ankle, Dr. Marino noted tenderness in the big toe in the MP and PIP joint areas, scarring from the previous bunion surgery, minimal tenderness in the medial malleolar area and a full range of ankle motion. Right foot and ankle X-rays showed an "old fracture or dislocation of the distal fifth metatarsal" and small spurs at the insertion of the Achilles tendon but no evidence of acute fracture or dislocation. PX 2, p. 6.

Dr. Marino diagnosed strains of the right big toe, foot and leg. He prescribed Ibuprofen and ice packs. He instructed Petitioner to take the rest of the day off, resume full duty the following day and return to MercyWorks on November 16, 2000. PX 2, pp. 4-5.

A subsequent MercyWorks note, dated December 5, 2000, reflects that the case was closed due to non-compliance. PX 2, p. 5.

Petitioner testified she resumed her regular duties following her visit to MercyWorks. Petitioner also testified, that at some point thereafter, she had difficulty wearing required footware, i.e., steel-toed boots, at work due to bilateral foot problems. T. 11/2/12 at 97.

Arbitrator's Conclusions of Law

Did Petitioner establish causal connection?

The Arbitrator finds that Petitioner failed to establish a causal connection between her undisputed accident of November 10, 2000 and any claimed current right toe, foot or ankle condition of ill-being. The MercyWorks records reflect that Dr. Marino diagnosed strains on November 13, 2000 and released Petitioner to full duty as of November 14, 2000. Petitioner failed to return to MercyWorks on November 16, 2000, as instructed. Petitioner testified to post-accident bilateral foot problems but did not offer any evidence linking those problems to the November 10, 2000 accident.

Is Petitioner entitled to temporary total disability benefits?

Following the November 10, 2000 accident, Petitioner saw Dr. Marino at MercyWorks on November 13, 2000, with the doctor instructing her to stay off work the rest of that day and resume full duty the following day. Petitioner testified she resumed full duty as directed.

Petitioner failed to establish any compensable lost time. The Arbitrator awards no temporary total disability benefits in this case.

Is Petitioner entitled to reasonable and necessary medical expenses?

As a result of the undisputed accident of November 10, 2000, Petitioner underwent treatment at MercyWorks on November 13, 2000. Petitioner claims the medical expenses relating to this treatment but PX 1 shows a $0 balance in connection with the services provided by MercyWorks on November 13, 2000. There are no outstanding expenses to award.

Is Petitioner entitled to permanent partial disability benefits?

Having found that Petitioner failed to establish causation as to any claimed right big toe or right foot and ankle condition of ill-being, the Arbitrator awards no permanency benefits in this case.

STATE OF ILLINOIS) BEFORE THE ILLINOIS WORKERS' COMPENSATION
) SS COMMISSION
COUNTY OF COOK)

Michael Roche,

Petitioner,

vs. NO. 08WC41977
14IWCC0710

Martin Petersen Company,

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 Corrected Decision and Opinion on Review dated September 12, 2014, has been filed by Respondent herein. In its Corrected Decision and Opinion on Review dated September 12, 2014, the Commission addressed the parties' respective previous Petitions under Section 19(f) of the Act. Turning to Respondent's present Petition, the Commission is of the opinion that it should be granted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision and Opinion on Review dated September 12, 2014 is hereby vacated and recalled pursuant to Section 19(f) for clerical error contained therein.

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

DATED: OCT 24 2014
SM/sj
44

Stephen J. Mathis

08WC41977
14IWCC0710

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

Michael Roche,

Petitioner,

vs.

NO 08 WC 41977
14IWCC0710

Martin Petersen Company,

Respondent.

SECOND CORRECTED DECISION AND OPINION ON REVIEW

Timely petition for review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, benefit rates, temporary disability, maintenance and permanent disability/wage differential 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 consistent with our decision.

Petitioner filed an application for benefits on September 23, 2008, which alleges that on June 23, 2008, he sustained an injury to his right knee at the jobsite. The evidence at trial showed that at the time of the accident Petitioner was nearing the end of his five year apprenticeship as a union plumber, with the expectation that he would become a journeyman union plumber in September of 2008. The parties stipulated that Petitioner's earnings during the year preceding the injury were $27,235.98 and his average weekly wage was $866.60. As a result of the injury, Petitioner underwent arthroscopic chondroplasties with microfractures of the lateral femoral condyle and chrondroplasty of the medial femoral condyle. On October 28, 2010, Dr. Trotter declared Petitioner at maximum medical improvement and permanently restricted Petitioner to medium-heavy work, "but he cannot do the full work place activities of a plumber, which involves bending and stooping, essentially without limit." Dr. Trotter opined Petitioner could only

occasionally bend or stoop and could stand or walk for no longer than 45 minutes at a time and no more than 4 hours a day. As a result of these restrictions Petitioner has not returned to his apprenticeship.

Petitioner conducted a job search and intermittently worked as a telemarketer, in the spring of 2011 and early spring of 2012. On or about April 30, 2012, Petitioner began working as an assistant technician for H-O-H Technologies performing preventative maintenance on commercial water treatment systems. At the time of the arbitration hearing, Petitioner was earning $16.25 an hour, corresponding to an average weekly wage of $650.00. Thus, Petitioner's current average weekly wage is $216.60 less than it was at the time of the accident. Furthermore, had Petitioner successfully completed his apprenticeship, he would be earning $45.00 an hour, corresponding to an average weekly wage of $1,800.00.

The Arbitrator awarded retroactive wage differential benefits based on the difference between what Petitioner would be earning as a journeyman union plumber and what he was earning as a telemarketer and then as an assistant maintenance technician before his most recent raise. Further, the Arbitrator awarded prospective wage differential benefits based on the difference between what Petitioner would be earning as a journeyman union plumber and what he was earning as an assistant maintenance technician at the time of the arbitration hearing.

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

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

We find that the Arbitrator erred in basing the wage differential on the average weekly wage of a journeyman union plumber, rather than the average weekly wage of apprentice union plumber. We note that a correct calculation of the wage differential yields significantly lower weekly sums. As we are not certain whether Petitioner would rather elect a loss of trade award pursuant to section 8(d)2 of the Act, we remand the matter to the Arbitrator for a determination of permanent disability award consistent with our decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the corrected decision of the Arbitrator filed July 22, 2013 is modified as stated herein and otherwise

affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $577.33 per week for a period of 108 1/7ths weeks, from 10/02/2008 through 10/28/2010, 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 $577.33 per week for a period of 69 6/7ths weeks, from 10/29/10 through 2/29/12, that being the period of maintenance benefits under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the medical bills in evidence pursuant to §§8(a) and 8.2 of the Act.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that the matter is remanded to the Arbitrator for a determination of permanent disability award consistent with our decision, which is interlocutory and not immediately appealable.

DATED:
SM/msb OCT 2 4 2014
o-7/10/2014
44

Stephen Mathis

David L. Gore

Mario Basurto

14IWCC0710

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

ROCHE, MICHAEL
Employee/Petitioner

Case# 08WC041977

MARTIN PETERSEN CO INC
Employer/Respondent

On 7/22/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4788 HETHERINGTON KARPEL BOBBER ET A
PETER BOBBER
161 N CLARK ST SUITE 2080
CHICAGO, IL 60601

0560 WIEDNER & MCAULIFFE LTD
MARGARET McGARRY
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

14IWCC0710

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

MICHAEL ROCHE
Employee/Petitioner

v.

MARTIN PETERSON CO., INC.
Employer/Respondent

Case # 08 WC 41977

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 **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Chicago**, 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. ☒ What temporary benefits are in dispute?
☒ 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 **07/23/2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$27,235.98**; the average weekly wage was **$866.60**.

On the date of accident, Petitioner was **39** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$45,393.07** for TTD, **$0.00** for TPD, **$29,959.43** for maintenance, and **$0.00** for other benefits, for a total credit of **$75,352.50**.

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

ORDER

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.
Respondent shall pay Petitioner temporary total disability benefits of $577.33/week for 108-1/7ths weeks, commencing **10/2/2008** through **10/28/2010**, as provided in Section 8(b) of the Act. Respondent shall receive credit for amounts paid.
Respondent shall pay Petitioner maintenance benefits of $577.73/week for 69-6/7ths weeks, commencing **10/29/10** through **2/29/2012**, as provided in Section 8(a) of the Act. Respondent shall receive credit for amounts paid.

Respondent shall pay Petitioner permanent partial disability benefits as provided in Section 8(d)(1) of the Act as follows:

a. $966.72 per week from March 1, 2012 through April 29, 2012 totaling 8 4/7ths weeks;
b. $815.46 per week from April 30, 2012 through December 31, 2012 totaling 35 1/7th weeks; and
c. $766.67 per week from January 1, 2013 through June 11, 2013, the arbitration hearing date, totaling 23-1/7ths weeks and ongoing for the duration of petitioner's disability.

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

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

7/18/13
Date

JUL 22 2013

FINDINGS OF FACT

At the time of his July 23, 2008 work accident, petitioner was 39 years old with two children and he resides in Palatine with his wife. Petitioner completed eleventh grade but never obtained a diploma. Petitioner obtained a GED in 1989. Petitioner also underwent a five year apprenticeship program with Local 130 of Chicago Journeyman Plumbers Union. He was set to become a journeyman plumber two months after his work accident in September, 2008.

Petitioner suffered a right knee injury at work in 1999 which resulted in his medial collateral ligament being surgically repaired. Subsequent to that injury and related medical treatment, petitioner was returned to work full duty with no restrictions. He had no subsequent treatment or lost time from work with regard to his right knee from 2000 through his July 23, 2008 work accident. In order to be accepted into the plumber's apprenticeship program, petitioner had to undergo a physical which he passed.

In December 2007, petitioner commenced employment with respondent. His job title was apprentice plumber and his job duties included installing commercial plumbing at Lutheran General Hospital in Park Ridge, which mostly involved installation of cast iron pipe overhead and vertically. The parties stipulated to a work related accident on July 23, 2008. ARB EX 1. On that date, Petitioner was carrying a ten foot length of cast iron pipe weighing sixty to eighty pounds from the floor on which materials were being stored to a different floor where work was being performed. While walking in the corridor, he attempted to kick a piece of sheet metal out of his way with his right foot. While doing so, his right foot slipped causing him to twist his right knee, lose his balance and fall landing on his right knee while bended. Immediately following the occurrence, he noted pain inside the right knee cap. He attempted to continue working and noticed pain and throbbing about the knee as he did so.

The following day, July 24, 2008, petitioner was directed by respondent to obtain medical treatment at the Advocate Occupational Health Clinic. (P.Ex.1). There, he was diagnosed with a right knee strain, and the doctor ordered rest, ice, wrapping and medication. He was also restricted to light duty work. Thereafter, for several days, his employer provided light duty office work in Kenosha, Wisconsin.

On July 29, 2008, petitioner noted that his knee seemed improved and he was released to return to work. (P.Ex.1). As he attempted to get to work the following day, he noticed significant discomfort and pain about his knee and he could not work. He attempted to make an appointment in August of 2008 with Dr. Dicillo, but was unable to do so due to a lack of authorization from the workers' compensation insurance company. Then, petitioner remained off work and utilized his personal insurance to make an appointment with orthopedic surgeon Dr. Trotter. On October 2, 2008, Dr. Trotter took petitioner off work, ordered him a brace, medication, injections, physical therapy, and an MRI. (P.Ex.2).

The MRI took place on October 9, 2008 and revealed a rupture of the anterior cruciate ligament with knee joint effusion and a contusion of the posterior aspect of the lateral femoral condyle away from the articular surface and chondral degeneration and mild subchondral marrow reactive changes in the tibial femoral joint especially in the medical compartment. (P.Ex.3). Petitioner continued with conservative treatment for his knee through early 2009. Dr. Trotter fitted Petitioner for a knee brace which he received in November 2008. Petitioner testified that he remained active and that he walked without the knee brace. Petitioner continued with physical therapy and a home exercise program but advised the therapist that the exercises increased his knee soreness so he stopped the PT program. Petitioner testified that he was not wearing the knee brace at home and when active. Petitioner testified that his knee buckled at home but not at physical therapy.

Respondent had video surveillance conducted of petitioner on four occasions between January 19, 2009 through February 7, 2009. RX 3. The Arbitrator viewed the video in its entirety. The Arbitrator notes the video depicts petitioner entering and exiting a car on several occasions over the course of 4 different days. He is seen entering and exiting the car without apparent difficulty and is also seen walking at a quick pace and without pain behavior on several occasions. He is not wearing a knee brace. On 2/7/09, Petitioner is seen at a water park with his children. (R.Ex.3). At times in the water park he is seen slightly limping and favoring his right leg. He is specifically seen limping after sliding down a water slide and then on occasion walking with a slightly altered gait while in the water park. Petitioner does not appear in pain while at the water park. RX 3.

On April 7, 2009, Dr. Trotter performed surgery to the right knee at St. Alexius Medical Center consisting of arthroscopic chondroplasty with microfractures, lateral femoral condyloplasty of the medial femoral condyle as well as GPS autologous platelet constructor injection. (P.Ex.5). Post-operatively, petitioner noted that his right knee felt more stable and that the buckling stopped. However, he still had significant pain in the knee and became depressed as a result of his lack of improvement. PX 2. He then underwent further physical therapy. Petitioner admitted to spotty compliance with PT as reflected in the ATI records. Dr. Trotter's records in May 2009 note that Petitioner had to miss some therapy due to "some personal issues going on with his family" and that he was feeling depressed. PX 2. On June 18, 2009, Dr. Trotter noted that Petitioner was feeling "markedly better" and that he had less knee pain. Dr. Trotter noted that he would "like to see how he does returning to work in several days" but that "due to the nature of his work place related injury, he will have an indication for more treatments including medication, injections and surgery." Dr. Trotter stated that Petitioner was not at MMI and that he would "like to see how he does" Petitioner was to follow up in 6 to 8 weeks. PX 2. On July 23, 2009, Petitioner returned to Dr. Trotter with recurrent right knee pain and effusion. Dr. Trotter prescribed Supartz injections and took Petitioner off work again. Petitioner continued to treat with Dr. Trotter in 2009 and receive his injections in October and November 2009. PX 2, PX 4.

On July 31, 2009, Petitioner attended a Section 12 exam with Dr. Zoellick. Dr. Zoellick agreed that Petitioner's symptoms were related to the accident, that Petitioner's treatment had been

reasonable and that he was not yet at MMI. He agreed with the recommendation of additional injections. He further agreed with the work restrictions imposed including no repetitive bending or squatting and lifting up to 30 pounds. RX 1.

After the third injection in November 2009, Petitioner was arrested for possession of drugs. He was released from jail in November 2009 and returned to Dr. Trotter in December 2009. On 12/31/09, Dr. Trotter noted, "Although he does have achy discomfort, I think he is, perhaps, doing better than he would have had he not had the Visco supplementation. ... I will see him in follow up on an as needed based basis [sic] on how he is doing. Two days per week, full duty is appropriate for starters. We will see how he tolerates this. I would like to see him in follow up in about a two month period. If for some reason his employer will not take him back, then I would recommend two weeks of work conditioning four hours per day." PX 2.

Petitioner began work conditioning on 1/6/10 at 5 days per week 4 hours per day for 2 weeks. He was discharged on 1/19/10 for failure to attend.

On 2/2/10, Petitioner returned to Dr. Trotter and continued to complain of right knee problems which Dr. Trotter determined stemmed from posttraumatic degenerative joint disease that occurred from the injury and from the period of time in which his cartilage was rubbing together prior to surgery. He felt that the twisting trauma loading injury to the knee directly traumatized the cartilage and that he had resulting ongoing pain and recurrent swelling in his right knee. Dr. Trotter noted that Petitioner could work light duty but that no such duty was offered. He noted Petitioner could not return to work as a plumber and that he was too young for knee replacement surgery. Therefore, Dr. Trotter recommended vocational retraining. PX 2.

On April 5, 2010 respondent had petitioner evaluated again by Dr. Zoellick. Dr. Zoellick continued to agree that Petitioners' symptoms were related to the accident of July 23, 2008 and that his treatment up to that time was reasonable and necessary. He further determined that Petitioner had reached MMI and recommended a trial of regular work without restrictions. Dr. Zoellick further stated that if Petitioner was unable to perform his regular work Petitioner should obtain an FCE "with validity to determine whether or not he would need any permanent work restrictions." RX 1. Respondent's nurse case manager then arranged for petitioner to undergo a FCE at WCS on April 19, 2010. The FCE revealed petitioner's ability to perform at the very heavy physical demand level but the therapist was unable to make recommendations regarding restrictions due to "inconsistencies" present during the evaluation indicating less that maximum effort from Petitioner. RX 1, p. 41.

On July 29, 2010, Dr. Trotter ordered an "independent and nonbiased" FCE to determine a reasonable assessment of Petitioner's condition as he did not feel the prior FCE was valid. PX 2.

Petitioner testified that he spent August 2010 in jail on possession of illegal drug charges from July 2010. RX 2. Petitioner testified that he has been sober since September 2010 and is a member of a recovery program.

The FCE ordered by Dr. Trotter was performed on September 8, 2010 at ATI. (See P.Ex.2). That FCE found petitioner able to function at a medium physical demand level capable of occasionally lifting 62 pounds with frequent lifting of 36 pounds. (P.Ex.6) That testing also was found to be a valid representation of petitioner's present physical capabilities. Thereafter, on October 28, 2010 Dr. Trotter, agreeing with the ATI FCE restrictions, released petitioner from care with permanent restrictions which he opined prevented petitioner from returning to work as a plumber. (P.Ex.2, P.Ex.7p.10).

Following the FCE and release, no offer was made by Respondent to accommodate the permanent restrictions or to provide vocational rehabilitation assistance. At the request of his counsel, petitioner underwent a vocational assessment performed by independent vocational rehabilitation counselor Edward Rascati on October 4, 2010. Mr. Rascati concluded petitioner could likely be placed in retail or customer service positions paying $9.00 to $12.00 per hour and that reeducation would not immediately increase his earning potential. (P.Ex.9).

Thereafter, petitioner commenced his self-directed job search which included performing in person contacts at businesses in his area; performing online research; filling out applications; making telephone inquiries; networking with friends and relatives; and stopping in local establishments to see if work was available. These establishments included Menards, Home Depot, Lowe's, various gas stations, Aldi, factories and restaurants. Petitioner testified to the self-directed job search efforts but did not keep track of his job search efforts in any formal way.

In early 2011, petitioner attempted a commission-based cologne sales job. Petitioner was briefly employed in this position as he determined he was not suited for a sales position. Petitioner next accepted a job selling Kirby vacuum cleaners. However, he had limited success with that job as well because his sales were not at a significant margin. Petitioner earned $125 during that period but lost money having spent $350 in gas.

On June 14, 2011, Petitioner was sentenced in connection with a 2010 drug possession charge to two years of probation, with the first year including home confinement with electronic monitoring. (R.Ex.2) Petitioner could seek a modification of that confinement in order to attend work or a job interview. Petitioner testified that while in house he continued to look for work daily on the computer. He looked for jobs he could do from home. Again, no job logs were kept documenting these efforts but Petitioner testified that he contacted Mr. Rascati by phone and advised that he was using the computer at home to find a job. Petitioner testified that in February 2012, he commenced work with G Incomes an internet-based earnings company affiliated with Amazon. Unfortunately, that venture was not successful and petitioner had no return on his investments that exceeded $450.00.

On March 1, 2012 through April 29, 2012, petitioner obtained employment performing telemarketing for a company named Outsource Marketing. That job paid him $10.00 per hour and he worked for twenty to twenty-eight hours per week selling various banking services and setting up appointments for individuals with various Canadian banks.

Ultimately, on April 30, 2012 petitioner started his present job as an assistant technician with H-O-H Water Technologies. After an interview with H-O-H, petitioner petitioned and was granted early release from his home confinement effective April 14, 2012. His job duties at H-O-H included performing preventative maintenance on commercial water treatment systems. Initially, he was paid a salary of $30,000.00 annually which equates to $14.42 per hour for a forty hour work week. Thereafter, effective January 1, 2013, his pay was increased to $16.25 an hour, equating to an annual salary of approximately $33,779.20.

Petitioner has obtained no other job offers and vocational counselor Rascati opined that the H-O-H Water Technology job is suitable for petitioner. He also opined that petitioner should be commended for finding such a well-paying job given his restrictions and limited transferable skills. (P.Ex.11). Petitioner testified that he continues to work as an assistant technician for H-O-H Water Technologies. Physically he is able to handle the demands of the job and he has performed it successfully for over one year. Petitioner's present employment is distinct from his job at Martin Peterson in that his present job requires no extended or extensive kneeling, no carrying of heavy materials down stairs or up or down ladders and no significant repetitive work. His physical job duties include lifting 50 pounds occasionally. Petitioner testified that had he continued working as a plumber, he would have been a journeyman plumber effective September of 2008 and his present earnings would have been $45.00 per hour. His union's website confirms this hourly rate. (P.Ex.14)

Presently, petitioner notices pain in his right knee daily. He elevates the knee and also treats it with ice, Ibuprofen and he takes fish oil and glucosamine to help his knee joint. In terms of his work activities, he is not able to work as a plumber because of the weights he would be required to lift as well as excessive walking, carrying, twisting, and kneeling for extended times. Presently, petitioner modifies his activities and avoids twisting his right knee, walks as short as distance possible. In terms of home activities, petitioner testified that as a result of his knee injury, he quit playing softball which he did three times a week prior to his accident. He significantly limits the duration and intensity in which he plays with his children in activities such as basketball, flag football, or Frisbee. Any activity he does engage in, he can no longer move as well as he used to and he limits the duration and intensity in which he performs the activities so as to minimize the pain about his knee.

Edward Rascati testified in his capacity as a professional rehabilitation consultant. PX 12. Based on Petitioner's treatment records from Dr. Trotter and the results/restrictions of the September 2010 FCE, he opined that Petitioner could not return to work as a plumber. He determined that Petitioner had many transferable skills and that a job search in the areas of retail and customer service was appropriate. PX 12, p. 9. As of August 24, 2011, Petitioner's job search had continued at retail stores. Thereafter, he was aware Petitioner was under house arrest and that his job search continued on line at home and that Petitioner could obtain leave to attend an interview. PX 12, p. 14. His last conversation with Petitioner was in June 2012 at which time Petitioner advised he was working at HOH. He understood this job to be within Petitioner's physical restrictions and that Petitioner was earning $30,000 per year. PX 12, p. 16. Mr. Rascati opined that Petitioner's current job with HOH constitutes suitable employment. Finally, he

opined that Petitioner's job search was reasonable and appropriate. PX 12, p. 18. On cross, Mr. Rascati verified that he never received any job logs from Petitioner verifying a job search at home. PX 12, pp. 29-33.

CONCLUSIONS OF LAW

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

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

Prior to his July 23, 2008 work accident, petitioner underwent a right medial collateral ligament arthroscopic repair in 1999. There is no evidence rebutting petitioner's credible testimony that from 2000 through July 22, 2008, he underwent no medical care, missed no time from work, and had no further problems with his right knee. Further, petitioner testified at arbitration that when commencing his apprenticeship with the plumber's union, he had to undergo a physical which he passed.

On July 23, 2008, petitioner suffered injury to his right knee as a result of his work accident which involved him carrying a ten foot length of cast iron pipe weighing sixty to eighty pounds. He attempted to kick a piece of sheet metal out of his path with his right foot. As he did so, his foot slipped causing him to twist his right knee resulting in him losing his balance, falling, and landing directly on his right knee while it was bent. He noticed immediate pain but attempted to finish his work shift.

The following morning, July 24, 2008, his pain had not improved so respondent directed him to Advocate Occupational Health. There, he was diagnosed with a strain of the right knee and his examination revealed tenderness with palpation of the right knee. (P.Ex.1). He was instructed to utilize rest, ice, and an ACE wrap, as well as medication and to return to the clinic for further evaluation. Additionally, he was instructed to perform no climbing, squatting, or kneeling. Following rest and working light duty performing office work for respondent, petitioner returned to the Advocate Occupational Health Clinic on July 29, 2008, at which time he noted significant improvement with his right knee, his pain going from a seven out of ten down to two out of ten. (P.Ex.1). He was then released fully duty from the clinic and was told to return if needed.

Petitioner was scheduled to return to regular work the following day. However, his right knee pain increased and he was unable to do so. Next, he attempted to follow up with his personal doctor, Dr. Dicillo, however respondent would not authorize that appointment so petitioner's attempts to see Dr. Dicillo in August of 2008 were thwarted. Shortly thereafter, petitioner utilized his personal insurance and made an appointment to see orthopedic surgeon Dr. David Trotter. Petitioner was first able to be seen by Dr. Trotter on October 2, 2008. Then, Dr. Trotter noted a consistent history of accident and noted he was experiencing severe pain. (P.Ex.2). He immediately took petitioner off work and ordered an MRI which was performed on October 9, 2008. That MRI revealed a rupture of the ACL with a joint effusion as well as a rounded

contusion of the posterior aspect of the lateral femoral condyle away from the articular surface and condyle degeneration and mild subchondral marrow reactive changes in the tibial femoral joint especially in the medical compartment. (P.Ex.3). Thereafter, Dr. Trotter ordered an ACL brace as well as physical therapy noting that surgery including possible ACL construction and other procedures for the arthrosis of the knee, which could be considered chronically aggravated by the work place injury, might be indicated. (P.Ex.2).

On December 2, 2008, Dr. Trotter noted that there was an indication for surgical procedure consisting of ACL construction as well as interpositional knee disc, resurfacing procedures, partial replacement, complete replacement, or even of replacement surgery. (P.Ex.2). On January 27, 2009, Dr. Trotter opined that petitioner "aggravated his arthrosis, has developed post-traumatic arthritis of the knee since the knee has become clearly more unstable than it ever was in his life due to the work place injury." (P.Ex.2). Petitioner then underwent therapy at Athletico, during which there were multiple notations of petitioner's right knee giving out. (P.Ex.4). Petitioner reported that his knee would give out spontaneously, but especially when descending stairs.

Ultimately, Dr. Trotter performed right knee ACL repair as well as right knee arthroscopic chondroplasties with microfractures, lateral femoral condyle and condroplasty of the medial femoral condyle as well as a GPS autologous platelet construct injection at St. Alexius Medical Center on April 7, 2009. (P.Ex.5).

Postoperatively, petitioner initially noted decreased pain and increased stability. (P.Ex.2). Thereafter, petitioner testified that although the right knee remained stable and was not giving out, the pain persisted and he became depressed because he had hoped and expected the surgery to fix his knee. Specifically, on May 28, 2009, Dr. Trotter noted that petitioner missed some therapy visits due to personal issues going on with his family and he has been feeling depressed and he recommended petitioner follow up with his family doctor, Dr. Dicillo regarding the depression. (P.Ex.2).

Later in the summer of 2009, Dr. Trotter maintained petitioner's off work status and ordered an injection as well as aspiration of the knee due to the effusion. (P.Ex.2) On July 23, 2009, although Dr. Trotter indicated he was keeping petitioner off work, petitioner had requested restricted duty and Dr. Trotter indicated he could perform work with limited walking, ambulating, bending, and stooping as tolerated. (P.Ex.2) Unfortunately, no light duty work was available for petitioner so he remained off work and he continued to treat and follow up with Dr. Trotter and his treatment included a series of injections of Euflexxa. (P.Ex.2). The final injection of Euflexxa occurred on November 10, 2009.

On February 2, 2010, Dr. Trotter noted that petitioner had ongoing pain and recurrent swelling in the right knee due to the work injury. (P.Ex.2). He also opined that it was unlikely petitioner could return to work as a plumber because of his injury and given his young age, a knee replacement or partial knee replacement would not be indicated. (P.Ex.2). Therefore, he recommended vocational retraining and also prescribed Flexor and lido-derm patches. (P.Ex.2).

In the Summer of 2010, Dr. Trotter performed three Supartz injections and aspirated the knee as well. On July 29, 2010, Dr. Trotter indicated the need for an independent and non-biased functional capacity evaluation to get a reasonable assessment of petitioner's current condition because he believed the prior FCE was invalid. (P.Ex.2).

Thereafter, on September 8, 2010, petitioner underwent a functional capacity evaluation at ATI which revealed petitioner could perform at the medium physical demand level with occasional lifting up to 62 and frequent lifting up to 36 pounds. (P.Ex.6). Further, it was noted that petitioner could perform bending, stooping, crouching, squatting and stair ambulation on an occasional basis only. It was also noted that this FCE was a valid representation of petitioner's capabilities based upon consistency testing performed throughout the evaluation. (P.Ex.6). The evaluator also indicated petitioner's work as a plumber requires abilities at the heavy physical demand level with occasional lifting up to one hundred pounds and petitioner's capabilities fell below that level. Lastly, additional work hardening was recommended. Dr. Trotter then adopted the FCE findings. (P.Ex.2, P.Ex.7p.19).

Petitioner attended ten work hardening visits from October 4, 2010 through October 10, 2010. (P.Ex.6). On October 28, 2010, Dr. Trotter opined that petitioner could lift up to about forty pounds occasionally and twenty pounds frequently on a permanent basis. He also indicated that petitioner could only bend and stoop occasionally and walk or stand for no more than 40 minutes at a time. (P.Ex.2, P.Ex.7pp.10-11). He also indicated that petitioner reached maximum medical improvement as his condition was unchanged. (P.Ex.2). Lastly, Dr. Trotter opined petitioner permanently disabled from his prior work place activities.

The only evidence offered by Respondent attempting to refute causal connection was the testimony and reports of its independent medical examiner Dr. Michael Zoellick, the investigative report and surveillance footage of petitioner and its argument that Petitioner's criminal conduct through the course of his treatment resulted in unnecessary treatment delays and non-compliance with treatment.

The Arbitrator notes that the video was taken prior to Petitioner's knee surgery. The surveillance does not show or depict petitioner working. The video depicts Petitioner walking seemingly without difficulty to and from his car on numerous occasions as well as seemingly limping and walking with altered gait on other points in the video. RX 3. Given that the surveillance took place prior to petitioner's surgery, which all doctors have indicated was reasonable, necessary, and appropriate; and that no doctor has offered any opinion that this surveillance film in any way impacts their causal connection opinion, the Arbitrator is not persuaded by the surveillance evidence offered by respondent insofar as it relates to a finding of causal connection.

Regarding Dr. Zoellick's causal connection opinion, the Arbitrator notes that initially, Dr. Zoellick opined in both reports that petitioner's ACL tear was causally related to the July 23, 2008 work accident as an aggravation of a pre-existing right ACL tear. (R.Ex1 ex.2). He further opined that all treatment received was reasonable and necessary. Dr. Zoellick was not shown the

video and had no opinion on Petitioner's condition based on a review of the reports of petitioner's treatment after April 25, 2010, including the valid FCE performed at ATI in September of 2010 and Dr. Trotter's final restrictions imposed in October 2010.

The Arbitrator finds that the evidence regarding Petitioner's criminal conduct and incarcerations does not sufficiently outweigh the medical evidence supporting a finding of causal connection for his continued condition of ill-being as presented by the medical records and opinions of his treating physician, Dr. Trotter. Dr. Trotter consistently related petitioner's complaints to his July 23, 2008 work place injury. Specifically, Dr. Trotter opined that the work place injury caused a partial tear of the ACL and aggravation of petitioner's arthrosis and degenerative arthritis in the right knee. (P.Ex.2). Similarly, petitioner's credible testimony as to his complaints and problems is consistent with Dr. Trotter's opinions and the results of the valid FCE performed at ATI on September 8, 2010. As such, the Arbitrator is persuaded by the treating physician Dr. Trotter and his opinions as to causal connection. Based on the above, the Arbitrator finds petitioner's present condition of ill-being involving his right knee is causally connected to his July 23, 2008 work accident.

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

Based on the Arbitrator's findings of the issue of causal connection as stated above, the Arbitrator further finds that Petitioner's treatment received to date has been reasonable and necessary. Respondent's objection was based on liability. ARB EX 1. Respondent is to pay Petitioner's reasonable and necessary medical expenses incurred in connection with that treatment pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid.

K. What temporary benefits are in dispute? TTD/Maintenance/TPD, L. What is the nature and extent of the injury?

Respondent alleges TTD should be awarded only through April 5, 2010 based upon its IME's opinion that as of that date petitioner reached MMI. (R.Ex.1 Exhibit 4). Based on the findings regarding causal connection as stated above, the Arbitrator further finds that Petitioner was not at MMI on April 5, 2010 per Dr. Zoellick and that he continued to treat with Dr. Trotter thereafter until he was found at MMI with permanent restrictions on 10/28/10. Accordingly, the Arbitrator finds that Petitioner was temporarily and totally disabled for a period of 111-3/7 weeks commencing 10/2/08 through 10/28/10.

The Arbitrator notes Petitioner's request for maintenance benefits thereafter during the period he looked for work in a self-directed job search after Dr. Trotter's MMI finding on 10/28/10. Petitioner requests maintenance for the period of 10/29/10 through 4/30/12 which covers his self-directed job search until he found his current job with HOH. The Arbitrator notes those efforts are completely without documentation in the form of job logs and are based on the testimony of

Petitioner. The Arbitrator notes that Petitioner's job search efforts are reported to Mr. Rascati on 12/27/10, 8/24/11 and 6/18/12. In his reports, Mr. Rascati notes that Petitioner was looking for work within his restrictions but without success. Petitioner's 2011 jobs selling cologne and vacuums were short lived and did not produce income. Petitioner's February 2012 "online store front" job was equally short and unproductive. Mr. Rascati also noted in each report that Petitioner's efforts were performed completely without vocational assistance. Petitioner testified without rebuttal that respondent never offered him light duty work or vocational rehabilitation assistance. In January 2011, Petitioner's counsel demanded vocational rehabilitation assistance but none was provided by respondent. (P.Ex.16). During the period of requested maintenance, Petitioner was sentenced to home confinement for 12 months beginning in June 2011 through April 14, 2012. Again, Petitioner testified that he continued to look for jobs while confined at home and found the above mentioned jobs in 2011 and 2012. Mr. Rascati documents his reported efforts during that period.

On or about March 1, 2012, through his self-directed job search efforts, Petitioner started a job with Outsource Marketing. This job was a telemarketing job involving calling people in Canada and setting up banking appointments. Petitioner testified that he earned $10.00 an hour for this job and averaged twenty-four hours per week.

On April 14, 2012, petitioner was granted early release from his home confinement based upon his petition to the court. Shortly thereafter, following his interview, he commenced employment on April 30, 2012 with H-O-H Water Technology as an assistant technician.

Based on petitioner's credible testimony as to the efforts he made looking for, and ultimately securing various alternative employment opportunities; that petitioner ultimately secured stable, well-paying alternative employment with H-O-H Water Technologies; given certified vocational rehabilitation counselor Rascati's opinions as to the diligence and reasonableness of petitioner's job search; and the lack of any evidence to the contrary, the Arbitrator finds that petitioner conducted a reasonably diligent job search and ultimately was successful in securing alternative employment. There is no persuasive evidence to find that Petitioner's home confinement adversely impacted the effectiveness of his job search. Further, the Arbitrator notes that petitioner attempted at least four other employment opportunities during his period of vocational rehabilitation and he continued to look for better occupations that would generate more income, ultimately securing employment with a $30,000.00 per year salary.

Accordingly, the Arbitrator finds petitioner is entitled to maintenance from October 29, 2012, the day after which Dr. Trotter deemed him at MMI and released him with permanent restrictions, through February 29, 2012, the day prior to when he commenced employment earning an hourly wage performing the telemarketing job.

Thus, the Arbitrator orders Respondent to pay petitioner temporary total disability benefits from October 2, 2008 through October 28, 2010, representing 108-1/7ths weeks, and maintenance pursuant to Section 8(a) paid at the TTD rate from October 29, 2010 through February 29, 2012 totaling 69-6/7ths weeks.

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

The record at trial supports a finding that Petitioner is partially incapacitated from pursuing his usual and customary line of employment as a plumber. Dr. Trotter clearly opined that Petitioner could not return to work as a plumber given his restrictions. The September 8, 2010 FCE performed at ATI physical therapy at Dr. Trotter's behest was deemed a valid representation of petitioner's present physical capabilities based upon consistency testing performed as part of the FCE. (P.Ex.6). Specifically, that testing demonstrated petitioner's functional capabilities at the medium physical demand level with lifting capabilities including occasional lifting up to 62 pounds with frequent lifting of 36 pounds. Further, the evaluator noted that bending, stooping, crouching, squatting, and stair ambulation would be recommended on an occasional basis only. Lastly, the evaluator noted that petitioner's work as a plumber is considered in the heavy physical demand level requiring occasional lifting of up to one hundred pounds and that petitioner's present capabilities fall below that level. (P.Ex.6).

On September 30, 2010, Dr. Trotter agreed with the restrictions per the FCE. (P.Ex.2). He also ordered some further work conditioning which petitioner underwent in early October 2010 at ATI. (P.Ex.2). Thereafter, on October 28, 2010, Dr. Trotter indicated petitioner reached maximum medical improvement and in his work status report indicated petitioner had restrictions at the medium physical demand level of work per the FCE. (P.Ex.2). Dr. Trotter testified that he agreed with the findings of the FCE at ATI and adopted those findings as petitioner's permanent restrictions. (P.Ex.7p.10). Further, in his October 28, 2010 office note, Dr. Trotter again opined that petitioner could not perform the full work place activities as a plumber and that he will require additional treatment in the future, however, presently there is no indication for surgery. (P.Ex.2). Dr. Trotter went on to note that petitioner has an indication for intermittent use of NSAIDs, either a topical gel or Pennsaid as prescribed. Lastly, Dr. Trotter noted that vocational rehabilitation could be a consideration provided it was within petitioner's limitations. In finding that Petitioner could not return to work as a full duty plumber, the Arbitrator finds the FCE of September 2010 more persuasive than the results of the earlier April 2010 FCE.

The Arbitrator notes Petitioner's request for a wage differential pursuant to Section 8(d)(1) of the Act based in part on his inability to return to work as a plumber discussed above. The Arbitrator finds that Petitioner has established the ability to earn $10 in the suitable employment for Outsource Marketing for the period of March 1, 2012 through April 29, 2012. On April 30, 2012, Petitioner obtained a job with HOH earning approximately $14.42 per hour or $577.50 per week. Then, effective January 1, 2013, his pay increased to $16.25 an hour or $650.00 per week. Petitioner Petitioner's Exhibit 16 as being copies of his first and most recent pay stubs as well as payment summary of all of his earnings at H-O-H provided by the payroll service. (P.Ex.15). Mr. Rascati opined that given petitioner's work history and limited education, that petitioner's alternative employment in these jobs was suitable. (P.Ex.11).

Given the Arbitrator's findings as to maintenance and reasonableness of his job search noted above; the opinions of certified vocational counselor, Edward Rascati; the absence of any

vocational evidence to the contrary; and petitioner's credible testimony, the Arbitrator finds that petitioner's work at Outsource Marketing from approximately March 1, 2012 through April 29, 2012 earning $10.00 an hour and averaging 24 hours per week, and his subsequent fulltime employment at H-O-H Water Technology commencing on April 30, 2012 and earning approximately $14.42 per hour or $576.92 per week through December 31, 2012 and getting an pay increase to $16.25 per hour and $650.00 per week from January 1, 2013 continuing through, the date of arbitration, constitutes the average amount he was earning and was able to earn in suitable alternative employment following his July 23, 2008 work accident.

Finally, based on Petitioner's testimony and on PX 14, the Arbitrator finds that Petitioner would be able to earn $45 per hour in the full performance of his duties in the occupation in which he was engaged at the time of the accident. Respondent offered no evidence rebutting petitioner's testimony, Mr. Rascati's testimony, or Petitioner's Exhibit 14 regarding what petitioner would currently be earning working for respondent as a union journeyman plumber. Accordingly, the Arbitrator finds that as of June 11, 2013, the date for the arbitration hearing, petitioner would be able to earn $1,800.00 ($45.00 x 40 hours) per week in the full performance of his duties of his occupation as a journeyman plumber. As noted in the 8(d)(1) calculations below, the Arbitrator notes the application of the Wage Differential Maximum mandated by Sections 8(d)(1) and 8(b)(4) of the Act.

The Arbitrator hereby orders respondent to pay petitioner benefits pursuant to Section 8(d)(1) as follows:

a. $966.72 per week (wage differential maximum applied) from March 1, 2012 through April 29, 2012 totaling 8 4/7ths weeks, representing 66-2/3% of the difference between the $1,800.00 per week petitioner would earn in the full performance of his occupation as a journeyman plumber and the average of $240.00 he earned performing telemarketing for Out Source Marketing; the calculated differential is $1,040.00 per week but the statutory maximum is applied capping the weekly rate at $966.72 pursuant to Sections 8(d)(1) and 8(b)(4) of the Act.

b. $815.46 per week from April 30, 2012 through December 31, 2012 totaling 35 1/7 weeks, representing 66-2/3% of the difference between the $1,800.00 per week petitioner would earn in the full performance of his occupation as a journeyman plumber and the average of $576.80 he actually earned working as an assistant technician at H-O-H Water Technology, Inc.; and

c. $766.67 per week from January 1, 2013 through June 11, 2013, the arbitration hearing date, totaling 23 1/7ths weeks and ongoing for the duration of petitioner's disability, representing 66-2/3% of the difference between the $1,800.00 per week petitioner would earn in the full performance of his occupation as a journeyman plumber and the average of $650.00 per week he actually earns at his suitable alternative employment as an assistant technician at H-O-H Water Technology, Inc.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brenda Beard,

Petitioner,

vs. NO. 11WC44232

14IWCC0711

Olin Winchester,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue(s) of accident, nature and extent and causal connection to Petitioner's condition of carpal tunnel syndrome and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Petitioner sought review of the issue whether the Petitioner sustained a repetitive trauma injury to her hands that arose out of the course and scope of her employment with the Respondent. Petitioner sought also to reverse the conclusion of the arbitrator that the repetitive trauma injury was not related to the September 23, 2011 fall or any work related duties for Respondent. Petitioner sought payment for medical bills incurred in the treatment of her hands. Additionally, Petitioner sought modification of the award and petitioned that Respondent be ordered to pay an additional $491.15 per week for 57 weeks pursuant to Section 8(e) due to 15% loss of use of the right and left hands.

Dr. Beatty is an orthopedic surgeon specializing in upper extremities. He initially saw Petitioner on June 7, 2012. The Petitioner presented with a known diagnosis of carpal tunnel syndrome. She had numbness and tingling of both hands. She had been seen by Drs. Rotman and Phillips and related a history of a fall. By history she reported that at the time of her fall she braced herself with her hands and arms while falling forward. She had positive Tinel's sign on both wrists, positive Phelan's test bilaterally and positive Tinel's sign over the left cubital tunnel area at the elbow.

14IWCC0711

An EMG was performed which showed a severe bilateral carpal tunnel syndrome and left ulnar sensory entrapment at the wrist.

Dr. Beatty recommended a left carpal tunnel release and a left Guyon's canal procedure. He also recommended a right carpal tunnel release. Dr. Beatty performed the first surgery on August 1, 2012. He did a Guyon's tunnel release and a carpal tunnel release on the left. The Petitioner had an uneventful recovery.

Dr. Beatty performed a second surgical procedure, a right carpal tunnel release, on August 29, 2012. The Petitioner subsequently underwent physical therapy. She was released to full duty, maximum medical improvement on October 8, 2012. Petitioner had previously retired from Respondent's employment. The preponderance of the evidence shows that the medical treatment and corresponding charges were reasonable and necessary to address the conditions in Petitioner's hands.

Dr. Beatty has treated other individuals besides Petitioner who were hand packers at Olin over the years. Dr. Beatty reviewed a DVD (PX14) depicting the work activities of a hand-packer. It was Dr. Beatty's opinion to a reasonable degree of medical certainty that Petitioner's job activity as a hand packer would be a causative basis for the treatment the witness provided to Petitioner or worsening of pre-existing carpal and ulnar nerve issues.

For the foregoing reasons the Commission finds that the Petitioner, by a preponderance of the evidence, met her burden in showing that the condition of ill-being related to her right and left upper extremities and condition of carpal tunnel syndrome is the result of an injury that arose out of and in the course of her employment with Respondent.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $491.00 per week for a period of 57 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 15% of the right and left hands.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $23,220.33 for medical expenses under §8(a) of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $52,000.00.

14IWCC0711

The party commencing 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: AUG 2 1 2014
SJM/msb
o-6/26/14
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BEARD, BRENDA
Employee/Petitioner

Case# **11WC044232**

14IWCC0711

OLIN
Employer/Respondent

On 12/2/2013, 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:

1580 BECKER SCHROADER & CHAPMAN PC
NATHAN A BECKER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

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

14IWCC0711

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

Brenda Beard
Employee/Petitioner

v.

Olin
Employer/Respondent

Case # 11 WC 44232

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 23, 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 23, 2011, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did sustain an accident, but did not sustain a repetitive trauma injury 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, in regard to the right and left legs, to the accident, but not to the repetitive trauma injury.

In the year preceding the injury, Petitioner earned $40.929.50; the average weekly wage was $818.59.

On the date of accident, Petitioner was 55 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 8, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. This is limited to the medical services provided to Petitioner for evaluation and treatment of Petitioner's knee/leg injuries. Respondent to 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 permanent partial disability benefits of $491.15 per week for 21.5 weeks because the injury sustained caused the five percent (5%) loss of use of the right leg and five percent (5%) 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.

William R. Gallagher, Arbitrator

November 25, 2013
Date

DEC 2 - 2013

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained both an accidental injury and repetitive trauma injury arising out of and in the course of her employment for Respondent. According to the Application, Petitioner fell in a hole and sustained repetitive trauma which resulted in injuries to the hands, arms and legs. The date of accident/manifestation was alleged as September 23, 2011. Respondent denied liability on the basis of accident and causal relationship.

Petitioner testified that she worked for Respondent as a hand packer for approximately 35 years. Petitioner retired on October 31, 2011, because her department was in the process of being eliminated and all of the hand packers were going to be laid off. Because of her age and years of employment, Petitioner was able to retire.

Petitioner testified that on September 23, 2011, she had completed her shift, clocked out and was walking with a number of co-workers to her car located in the employee parking lot. The route to the parking lot was on Respondent's premises and was not open to the general public. Petitioner testified that she fell in a hole and that she fell forward landing on her knees and outstretched arms. None of Petitioner's co-workers that were present at the time of the fall testified at trial.

Respondent tendered into evidence five photos of the area where Petitioner fell. The photos are of the parking lot and an area adjacent to it that has yellow lines that mark an area used as a walkway. The first and fourth photos clearly revealed a triangular shaped defect in the walkway which Petitioner testified was probably the defect which caused her to sustain the fall. There was no precise measurement of the depth of this triangular shaped defect. Petitioner was uncertain of the precise circumstances that caused her to sustain the fall, whether she stepped in the hole or her toe got caught in the front of it. When she observed the photos, she testified that the area depicted in photos number one and four had to be the area where she fell. (Respondent's Exhibit 4).

Following the accident Petitioner was seen in the ER of Alton Memorial Hospital on September 25, 2011. At that time, Petitioner's complaints were limited to the right knee. Petitioner was later seen by Dr. Shaping Sun, Respondent's company physician, who ordered an MRI of the right knee. An MRI of the right knee was obtained on October 3, 2011, which, according to the radiologist, revealed degenerative changes, a non-displaced fracture of the tibia, and tears of both the medial meniscus and ACL. Dr. Sun referred Petitioner to Dr. Lyndon Gross, an orthopedic surgeon.

Dr. Gross saw Petitioner on October 6, 2011. At that time, Petitioner's complaints were both the right and left knees; however, the right knee was more symptomatic than the left. Dr. Gross examined Petitioner and noted that Petitioner had an MRI of the right knee performed on February 12, 2004, and that the findings were very similar to those noted in the MRI of October 3, 2011. Dr. Gross opined that Petitioner had exacerbated the pre-existing degeneration of the right knee and recommended conservative treatment including physical therapy and imposed some work/activity restrictions.

Dr. Gross saw Petitioner on October 27, 2011, and Petitioner's complaints were limited to the right knee. Dr. Gross gave Petitioner's right knee an injection and continued her physical therapy and work/activity restrictions. When Dr. Gross saw Petitioner on November 3, 2011, Petitioner had complaints in regard to both the right and left knees. At that time, Dr. Gross gave Petitioner's left knee an injection and continued her work/activity restrictions.

When Dr. Gross saw Petitioner on November 17, 2011, she still had complaints of right and left knee pain. At that time, Dr. Gross ordered an MRI scan of the left knee which was performed on November 23, 2011, which revealed degenerative changes, a torn medial meniscus and a possible old injury to the ACL. Dr. Gross saw Petitioner on November 28, 2011, and reviewed the MRI and opined that Petitioner exacerbated the degenerative changes in her left knee when she fell. He authorized Petitioner to return to work without restrictions and discharged her from care.

At the direction of the Respondent, Petitioner was examined by Dr. Mitchell Rotman, an orthopedic surgeon, on October 20, 2011, for evaluation of her bilateral shoulder and arm pain. Dr. Rotman examined Petitioner and reviewed her medical treatment records and noted that she did not previously complain about upper extremity symptoms. At that time, Petitioner's primary complaints were of right shoulder/arm pain. Dr. Rotman's findings on clinical examination were benign but he ordered that Petitioner have nerve conduction studies performed and he referred Petitioner to Dr. Dan Phillips. Dr. Phillips performed nerve conduction studies on November 2, 2011, and they were positive for bilateral carpal tunnel syndrome. In an intake form completed by Petitioner, she described right side shoulder/arm pain and left side numbness. She also indicated that repetitive activities aggravated her symptoms. Dr. Rotman saw Petitioner on November 3, 2011, and reviewed the nerve conduction studies. He opined that Petitioner required surgery for the bilateral carpal tunnel syndrome; however, he stated that this condition had nothing to do with the accident of September 23, 2011, because there were no upper extremity complaints following that accident and Petitioner also had the increased risk factors of being an insulin-dependent diabetic and being 5'6" tall and weighing 350 pounds.

Petitioner sought treatment for her bilateral carpal tunnel syndrome with Dr. Michael Beatty, a plastic/hand surgeon, who initially examined her on June 7, 2012. Dr. Beatty examined Petitioner and opined that she had bilateral carpal tunnel syndrome. He ordered new nerve conduction studies which were performed on June 24, 2012, which confirmed the diagnosis.

On August 1, 2012, Dr. Beatty performed surgery consisting of a left carpal tunnel release and release of Guyon's canal at the wrist. On August 29, 2012, Dr. Beatty performed surgery consisting of a right carpal tunnel release. Following the surgeries, Dr. Beatty prescribed physical therapy and on October 8, 2012, noted Petitioner was at MMI and released her from treatment.

Petitioner tendered into evidence a DVD video which depicted various tasks performed by Petitioner which included packing bullets and moving styrofoam containers. Petitioner testified that she also packed quantities of bullets into green metal containers used by the military. Petitioner testified that she did not make a written complaint to Respondent for hand

numbness/tingling prior to filing the Application for Adjustment of Claim and that she did not seek treatment for carpal tunnel syndrome prior to the time she was seen by Dr. Rotman.

Dr. Beatty was deposed on August 1, 2013, and his deposition testimony was received into evidence at trial. Dr. Beatty's testimony regarding his treatment of Petitioner was consistent with his medical records. In regard to causality, Dr. Beatty testified that he had treated other patients who were hand packers for Respondent and that he watched the video which showed the hand packers performing job duties. Dr. Beatty opined that Petitioner's work activities either caused or aggravated her bilateral hand conditions and the need for treatment. However, Dr. Beatty agreed that Petitioner did not discuss with him the nature of her job duties nor did she describe a gradual onset of symptoms. Rather, Petitioner stated that she experienced a sudden onset of symptoms.

Dr. Rotman was deposed on September 18, 2013, and his deposition testimony was received into evidence at trial. Dr. Rotman's testimony was consistent with his medical reports and he reaffirmed his opinion that Petitioner had bilateral carpal tunnel syndrome and that surgery was indicated. Dr. Rotman further opined that Petitioner's bilateral hand condition was not related to either the fall she sustained on September 23, 2011, or the repetitive use of her hands at work. This was based on the lack of any hand complaints by Petitioner as well as Petitioner's other risk factors, in particular, Petitioner's diabetes and obesity.

At trial, Petitioner testified that both of her knees still hurt. In regard to her hands, Petitioner testified that the numbness, pain and tingling were resolved following the surgeries.

Conclusions of Law

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

The Arbitrator concludes that Petitioner sustained an accidental injury arising out of and in the course of her employment for Respondent to both of her knees/legs on September 23, 2011.

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injury to her upper extremities arising out of and in the course of her employment for Respondent.

In support of these conclusions the Arbitrator notes the following:

Petitioner slipped and fell on a walkway adjacent to the employee parking lot. This area was on Respondent's premises and was not open to the general public. The Arbitrator examined the photos of the area in question and the triangular shaped area noted in photos one and four of the exhibit which is clearly a defect in the area's surface. While the depth of this triangular shaped hole was not indicated, it appears to be of sufficient depth to cause someone to trip while walking across it.

The Arbitrator finds that there was no dispute that the area adjacent to the employee parking lot where Petitioner sustained this fall was provided by the employer for the use of the employees and not to the general public. This is an extension of the employer's premises. See Mores-Harvey v. Industrial Commission, 804 N.E.2d 1086 (Ill.App. 3rd Dist. 2004). Whether such a fall is

compensable is determined by whether the employee was exposed to a greater or increased risk or hazard than the general public. Caterpillar Tractor Co. v. Industrial Commission, 541 N.E.2d 665 (Ill. 1989).

In the instant case, Petitioner was walking on the designated walkway on the employer's premises adjacent to the employee parking lot and sustained a fall because of a defect in the surface.

The Arbitrator hereby concludes that Petitioner was subjected to a greater or increased risk than that of the general public and that the accident of September 23, 2011, did arise out of and in the course of her employment for Respondent.

Petitioner was not diagnosed with bilateral carpal tunnel syndrome until the nerve conduction studies were performed on November 2, 2011. Petitioner was not treated for any upper extremities symptoms following the accident of September 23, 2011, until she was seen by Dr. Rotman on October 20, 2011, primarily for right shoulder/arm pain. Accordingly, the Arbitrator is unable to find any basis for a manifestation date of September 23, 2011.

While Petitioner's job duties did require repetitive use of her hands, she also had significant risk factors for the development of carpal tunnel syndrome, in particular, diabetes and obesity as was specifically noted by Dr. Rotman.

The Arbitrator finds the opinion of Dr. Rotman to be more persuasive than that of Dr. Beatty in regard to the issue of causality. Even though Dr. Beatty opined that Petitioner's work duties caused or aggravated the carpal tunnel syndrome, he agreed that Petitioner did not describe a gradual onset of symptoms but that they occurred suddenly.

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

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to her knees is causally related to the accident of September 23, 2011.

In support of this conclusion the Arbitrator notes the following:

Dr. Gross opined that Petitioner's had significant pre-existing conditions in both of her knees which were exacerbated by the accident of September 23, 2011. There was no expert medical opinion to the contrary.

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

The Arbitrator concludes that all the medical services provided to Petitioner in regard to the knees/legs (related to the accident of September 23, 2011) were 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 8, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. This is

limited to the medical services provided to Petitioner for evaluation and treatment of Petitioner's knee/leg injuries. Respondent to be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of five percent (5%) loss of use of the right leg and five percent (5%) 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 worked as a hand packer but has since retired.

Petitioner was 55 years of age at the time of the accident.

There was no evidence that this injury resulted in any diminished earning capacity.

The medical treatment records revealed that Petitioner had significant degenerative changes in both the right and left knees that pre-existed the accident. Dr. Gross opined that the accident exacerbated these degenerative changes. Petitioner's complaint that she still has knee pain was corroborated by and consistent with the medical treatment records.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas Daffron,
Petitioner,

vs.

NO: 12 WC 42573
14 IWCC0712

Menard Correctional Center
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 August 22, 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 August 22, 2014 is hereby vacated and recalled pursuant to Section 19(f) for clerical errors 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: SEP 11 2014
KWL:vf
42

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

THOMAS DAFFRON,

Petitioner,

vs.

NO: 12 WC 42573
14 IWCC0712

MENARD CORRECTIONAL CENTER,

Respondent.

CORRECTED 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, notice, causal connection, medical expenses, and prospective medical treatment, and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons specified 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).

Findings of Fact and Conclusions of Law

1) Petitioner testified he began working as a correctional officer for Respondent in 2001, and that during the course of his employment from 2001 through 2012 he worked a variety of assignments, of which 75% was work in the cell house or gallery. Petitioner testified he initially worked in the condemned unit, then in North 2 cell house, the segregation unit, until 2008, when he began working as a Relief Officer. Petitioner testified that his job duties while on gallery assignment included cranking cell house

doors off deadlock, opening and closing cell doors, cuffing and uncuffing inmates, rapping cell doors, locking and unlocking food slots, and securing gallery doors. Petitioner also testified that 90% of his time was spent working the midnight shift from 11:00 p.m. until 7:00 a.m. (T11-22).

2) On cross examination, Petitioner admitted he has numbness and tingling symptoms in his hands and elbows started in 2004, that he never sought medical care for those problems, that the symptoms were not severe initially, that he continued working, that he believed his symptoms were a result of his work duties but that he never reported his condition to Respondent up until the filing of his Application for Adjustment of Claim. (T53-55). Petitioner also admitted that he did voice complaints of numbness and tingling in his hands in 2009 when he was treating with Dr. Bassman for a prior shoulder injury, but that the doctor never advised him of the cause for his symptoms or of a possible diagnosis for his complaints. (T56-58).

3) Petitioner testified that on November 2, 2012, he injured his right shoulder while carrying an inmate in a sit-chair down a flight of stairs to the health care unit. (T24-25). Petitioner filed an Application for Adjustment of Claim with respect to this November 2, 2012 right shoulder injury, under 12 WC 42573. This claim was pending on review as of the date of oral arguments in this matter.

4) On November 21, 2012 Petitioner sought treatment with Dr. Paletta for his right shoulder condition. Petitioner testified that he advised Dr. Paletta of his right shoulder injury, and that he also discussed symptoms he was having in his wrists and elbows, including tingling and numbness in his hand and both arms. Petitioner testified he previously discussed symptoms of bilateral hand numbness with Dr. Bassman, the physician who performed his prior left shoulder surgery, but that no physician had ever discussed carpal tunnel or cubital tunnel syndrome with him. (T26-27).

5) Dr. Paletta's November 21, 2012 office visit note indicates Petitioner provided a history of working as a correctional officer for 11 years, and that on November 2, 2012 he sustained a right shoulder injury while carrying an inmate down a flight of stairs. Petitioner also reported a several-year history of numbness and tingling into both hands, and pain in the elbows and wrists. Petitioner provided a history of increased right elbow pain and symptoms since the November 2, 2012 injury. Dr. Paletta diagnosed a possible recurrent labral tear of the right shoulder, bilateral cubital tunnel syndrome, and possible bilateral carpal tunnel syndrome. Dr. Paletta recommended an MRI arthrogram of the right shoulder, and EMG/NCV studies of the upper extremities. Dr. Palletta opined at that November 21, 2012 office visit that the November 2, 2012 work related injury was a causative factor in Petitioner's current right shoulder condition. (PX3).

6) On December 3, 2012, Petitioner underwent an EMG/NCV study of the upper extremities. At that time, he provided a seven-year history of gradually progressive sharp throbbing and aching bilateral hand pain, weakness, intermittent global hand numbness, shooting forearm pain. Petitioner attributed his symptoms to overuse at work. The EMG/NCV study was significant for bilateral carpal tunnel syndrome, left greater than right, and mild to moderate bilateral cubital tunnel syndrome. (PX4).

7) On December 10, 2012 Dr. Paletta recommended a course of conservative care for Petitioner's bilateral hand, elbow, and shoulder symptoms, including injections of the glenohumeral joint and AC joint, Medrol Dosepak, Naprosyn, and physical therapy for Petitioner's right shoulder condition. (PX3, RX3).

8) On January 28, 2013, Dr. Paletta recommended continued physical therapy or shoulder debridement surgery based upon Petitioner's continued complaints and MRI results. Following a course of physical therapy, Petitioner underwent right shoulder surgery on September 10, 2013. (PX3, T30).

9) On July 15, 2013, Petitioner was seen in follow up by Dr. Paletta. Petitioner complained of continued intermittent numbness and tingling in his fingers, particularly in his fourth and fifth fingers. Dr. Paletta diagnosed bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. Based upon Petitioner's continued symptoms, he recommended Petitioner proceed with bilateral carpal tunnel and bilateral cubital tunnel surgeries, after Petitioner underwent right shoulder surgery. With regard to the issue of causation, Dr. Paletta opined that "based on the duration of his job and his job duties and the correlation of onset and worsening of his carpal tunnel and cubital tunnel symptoms to those job activities, that his job is a causative or aggravating factor in both the cubital tunnel and carpal tunnel syndromes." Dr. Paletta further opined that Petitioner's ongoing treatment for his carpal tunnel and cubital tunnel is related to his job activities. (PX3).

10) Petitioner testified he thoroughly explained his job duties and outside activities to Dr. Paletta during the course of his treatment, including a history of symptoms in his hands and arms while working, with worsening of same while performing activities such as turning keys, pulling on doors, rapping bars, opening or closing of food slots. Petitioner testified that he sometimes used both hands to turn keys because the locks were sticky and hard to turn, and that while he is left-handed, he used his left hand for most tasks until the pain became too much and then he would switch and use his right hand. Petitioner testified that half of the locks in the galleries turn right, and other half turn left, and that he had to use both arms usually to turn all the locks, to open doors, and to rap bars. (T32-35).

In Durand v. Industrial Commission, 224 Ill.2d 53, 65(2006), the Illinois Supreme Court found that the "date of manifestation is not necessarily when symptoms first began, but the date on which both the injury and its causal link to the employee's work become plainly apparent to a reasonable person. The Court also held that "an employee who continues to work on a regular basis despite his own progressive ill-being should not be punished merely for trying to perform his duties without complaint." Id. The Commission notes that, as in Durand, Petitioner's description and understanding of his bilateral upper extremity pain prior to November 21, 2012 was sketchy and equivocal, having gradual worsening symptoms and no medical treatment or diagnosis for same. Therefore a reasonable person would not have known of this injury and its putative relationship to his work activities before November 21, 2012.

Based upon a review of the record as a whole, and relying on Durand v. Industrial Commission, the Commission finds Petitioner sustained accidental repetitive trauma injuries arising out of and in the course of his employment on or about November 21, 2012, and that his current condition of ill-being with respect to his bilateral hands and elbows is causally related to same. The medical records and Petitioner's testimony indicate Petitioner had a seven-year history of bilateral hand and elbow symptoms prior to presentation to Dr. Paletta on November 21, 2012. The medical records and Petitioner's testimony further indicate that November 21, 2012 was the date Petitioner actually became aware of his physical condition and its relation to his work duties through medical consultation with Dr. Paletta. On the date of that medical consultation Dr. Paletta diagnosed bilateral carpal tunnel and bilateral cubital tunnel syndrome. Dr. Paletta specifically opined that based on the duration of Petitioner's job, job duties, and the correlation of onset and worsening of his carpal tunnel and cubital tunnel symptoms to those job activities, that Petitioner's job is either a cause or aggravating factor with regard to his cubital tunnel and carpal tunnel syndromes. Dr. Paletta also opined the need for ongoing treatment for carpal and cubital tunnel syndrome was related to Petitioner's job duties. As noted by the Court in Durand, an employee who diligently works through their progressive symptoms until it affects their well-being should not be penalized. The Commission finds Petitioner's testimony and medical records indicate he diligently worked through his gradual and progressive hand and elbow symptoms until his symptoms became so severe that he sought treatment for same on November 21, 2012. The Commission also mindful that the record is absent of any Section 12 examiner's opinion to rebut the opinions offered by Dr. Paletta. Accordingly, the Commission finds Petitioner's manifestation date was November 21, 2012.

With regard to the issue of notice, the Commission finds Petitioner provided timely notice pursuant to Section 6(c). Petitioner's repetitive trauma injuries manifested themselves on or about November 21, 2012. Petitioner filed his Application for Adjustment of Claim on December 11, 2012. On December 5, 2012, Petitioner mailed a copy of his Application to Respondent, or 14 days after the date of injury, as evidenced by the proof of service. (ARB EX2). Based upon the above, the Commission finds Petitioner provided notice of his accident to Respondent within the 45 days set by statute.

Based upon the findings of accident, notice, and causal connection herein, the supporting medical records, and Dr. Paletta's surgical recommendations, the Commission finds Petitioner it entitled to an award of prospective medical recommended by Dr. Paletta, to include bilateral carpal tunnel surgeries, and bilateral cubital tunnel surgeries.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 24, 2013, is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $3,425.00 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the prospective medical treatment prescribed by Dr. George Paletta, including bilateral carpal tunnel surgeries, and bilateral cubital tunnel surgeries, pursuant to §8(a) of the 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.

DATED: SEP 11 2014
KWL/kmt
O-05/06/14
42

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the decision of the majority. I disagree with the majority's interpretation of the record. I find Arbitrator Granada's opinion to be both thorough and well reasoned. I would affirm this decision in its entirety without modification.

Kevin W. Lamborn

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

14IWCC0712

DAFFRON, THOMAS
Employee/Petitioner

Case# **12WC042573**

MENARD CORRECTIONAL CENTER
Employer/Respondent

On 10/24/2013, 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:

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

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

0558 ASSISTANT ATTORNEY GENERAL
FARRAH L HAGAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

0498 STATE OF ILLINOIS
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

OCT 24 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

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)

14IWCC0712

Thomas Daffron
Employee/Petitioner

v.

Menard Correctional Center
Employer/Respondent

Case # 12 WC 42573

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 **Collinsville, IL**, on **09/23/13**. 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

14IWCC0712

On the date of accident, **11/21/2012**, 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 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, the Petitioner's average weekly wage was **$1,135.15**.

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

ORDER

No benefits are awarded since Petitioner did not sustain accidental injuries on November 21, 2012, that arose out of and in the course of his employment with Respondent. Claim 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.

Gerald A. Granado

Signature of Arbitrator

10/23/13
Date

ICArbDec19(b)

OCT 24 2013

FINDINGS OF FACT

Petitioner is a 40-year-old, left-hand dominant correctional officer from Menard Correctional Center. Petitioner alleges a date of accident of November 21, 2012, for repetitive trauma injuries to his right and left hands and right and left arms as a result of his job duties with Respondent. This case proceeded to hearing pursuant to Section 19(b). The issues in dispute are: 1) accident, 2) notice, 3) causal connection, 4) medical expenses, and 5) prospective medical treatment.

Petitioner testified that he began his career as a correctional officer on October 8, 2001. He testified that he has worked a variety of assignments as a correctional officer at Menard Correctional Center. 90 percent of the time, he has been assigned to the midnight shift from 11 p.m. to 7 a.m. shift. His first assignment was in the condemned unit where he worked until the beginning of 2003. He then worked in the north 2 cell house or the segregation unit. He estimated that he worked in the north 2 cell house or the segregation unit for five years. Then, his assignment was as a general relief officer. Petitioner estimated that he spent 75% of his time in the cell house of the galleries. Petitioner worked at Menard MSU or medium security unit from June to September 2012.

Petitioner served on the tactical team from 2002 to 2003. As part of his duties, he performed cell extractions and worked with batons while on the tactical team. As a member of the tactical team, he practiced twice a month for two hours. During the practices, he would do various things during the two hours depending on what they were focusing on. If they were called into action, they would have to do a cell extraction.

Petitioner testified that his job duties at Menard Correctional Center have included cranking cell house galleries off deadlock; opening and closing doors; handcuffing and uncuffing inmates; bar rapping gallery and entrance doors; rapping shower doors, yard doors; locking and unlocking padlocks; opening and closing food slots; and 30 minute mandatory gallery checks. On cross-examination, Petitioner testified that on the 11 p.m. to 7 a.m. shift, he would normally only crank the cell houses if he worked the gallery once per shift. He estimated that the cranking of the cell house galleries off deadlock would take approximately five to ten minutes total, including any travel time to the other gallery cranks. He estimated that he would open or close a cell door on the 11 p.m. to 7 a.m. shift zero to ten times per shift. Petitioner estimated that he would handcuff or uncuff inmates zero times per shift when working in the general division cell house. When working in the north 2 cell house or segregation house, he would cuff and uncuff the inmates who needed insulin, but the last time he was assigned to the north 2 cell house or segregation house was in 2008. Petitioner testified that on the 11 p.m. to 7 a.m. shift, he did not rap cell doors. He only rapped gallery and entrance doors. He would rap two to five doors on the 11 p.m. to 7 a.m. shift, depending on which cell house he worked in. On the 11 p.m. to 7 a.m. shift, he would rap bars for approximately ten minutes. As for locking and unlocking padlocks, Petitioner would only do this in the north 2 cell house or the segregation house for the food slots, and he had not worked in the north 2 cell house or the segregation unit since 2008.

Petitioner also worked in the gallery, in the tower, as a school officer, and as a chapel officer. As a school officer and a chapel officer, there would not be any bar rapping and very little turning keys. As a tower officer, he would not be turning keys or rapping bars. Petitioner confirmed that he was assigned to the tower in 2009. He testified that that if he was assigned to the tower the first half of the shift, he would work in the cell house the second half. If he was assigned to the tower in the second half, he started the night in the cell house. If he was assigned as a wing officer the first half of the shift, he would not be cranking any doors open.

Petitioner described the following work activities worsened his symptoms in his hands and arms:

> Turning keys would cause pain in both my right arm and left arm. Pulling on the doors, checking to see if they're locked, rapping bars, opening and closing the food slots.

Petitioner testified that he had symptoms of numbness and tingling since 2004. He started feeling numbness in his hands and tingling in his elbows. He never saw any doctor for his problems. He explained that the symptoms were not very strong in the beginning, but he noticed something was different. Petitioner testified that he believed in 2004 that his symptoms were coming from his work duties. He continued to have symptoms and did not report his condition to Menard until filing an Application for Adjustment of Claim.

On November 21, 2012, Petitioner first saw Dr. George Paletta at The Orthopedic Center of St. Louis. He primarily presented for evaluation of a chief complaint of right shoulder, but also has associated complaints of numbness and tingling into both hands; elbow pain; and wrist pain. Petitioner's history of right shoulder symptoms dated to an episode or incident, which occurred on November 2, 2012 involving an incident where Petitioner was lifting a 190 pound inmate. As he attempted to lift the inmate, he noted immediate pain in the right shoulder. He finished his shift that day, but had ongoing pain. He then reported it the next day, but had not had any medical attention to date. He used Advil and Tylenol with minimal relief of symptoms. Petitioner complained of pain deep within the shoulder.

Petitioner had a prior history of nonwork-related shoulder problem that ultimately led to surgery performed by Dr. Donald Bassman in August of 2011. Petitioner was back to full work by November 2001 and denied residual problems with the shoulder up until the point of his injury. Petitioner had two previous surgeries on the left shoulder, both by Dr. Bassman. Petitioner reported some residual issues with the left shoulder, but nothing related to this work incident.

Petitioner reported to Dr. Paletta that this work incident resulted solely in injury to the right shoulder. In addition, Petitioner complained of several-year history of numbness and tingling into both hands, as well as, elbow pain and some wrist pain bilaterally. The right elbow pain and symptoms had increased since this injury which occurred on November 2, 2012. Petitioner reported continuing to work full duty. He reported the pain was confined to the shoulder itself. He felt like at times the shoulder wants to slip out of place, but he really had no true instability episodes. Petitioner reported a lot of pain at night and difficulty sleeping on the affected side. He stated that his current right shoulder pain felt similar to the labral pain he recalled with his previous shoulder problem. Physical examination was performed. Dr. Paletta's impressions included the following: 1) possible recurrent labral tear, right shoulder; 2) bilateral cubital tunnel syndrome; and 3) possible bilateral carpal tunnel syndrome. Dr. Paletta noted that with respect to Petitioner's more chronic complaints of numbness and tingling in elbow and wrist pain, he recommended EMG and nerve conduction studies of both upper extremities. Dr. Paletta recommended that Petitioner continue to work full duty.

On December 3, 2012, Petitioner presented to Dr. Daniel Phillips at Neurological & Electrodiagnostic Institute, Inc. to evaluate bilateral upper extremity pain and numbness on a referral from Dr. Paletta. Petitioner completed a document entitled "Patient Questionnaire/Health History". Petitioner reported numbness in fingers, hands, wrists, tingling in fingers, hands, wrists. Petitioner reported that his symptoms began 7 years ago. Petitioner reported that the pain wakes him up at night. He also reported pain/stiffness/numbness/tingling upon getting out of bed in the morning. When asked what aggravated his sympomts, he reported "work lifting

weights". Petitioner was noted to be a 39-year-old left-handed gentleman with a long history of gradually progressive sharp throbbing aching bilateral hand pain, weakness and intermittent global hand numbness. Petitioner reported shooting forearm pain. Cervical radicular symptoms were not reported. Bilateral upper extremity electrical diagnostic studies were requested. Petitioner's hobbies included golf and weightlifting. Petitioner was noted to be 6'6" and 318 lbs. Petitioner exhibited positive Tinel signs at the cubital tunnels, positive Tinel signs at the carpal tunnels. Dr. Phillips noted moderate sensory motor median neuropathy across the left carpal tunnel and milder median sensory neuropathy across the right carpal tunnel. There was also mild-moderate demyelinative ulnar neuropathies across the elbows.

On December 10, 2012, Dr. Paletta reviewed the EMG and Nerve Conduction Study performed by Dr. Phillips at the Neurological and Electrodiagnostic Institute on December 3, 2012. Dr. Paletta noted that the studies demonstrated evidence of moderate sensory and motor median neuropathy across the left carpal tunnel with more mild right carpal tunnel. There was also evidence to mild-to-moderate demyelinative ulnar neuropathies across the level of the elbows bilaterally. Dr. Paletta recommended conservative treatment included anti-inflammatories and night splints. Petitioner was to follow-up in six to eight weeks to assess his reponse to the nonsurgical treatment. Dr. Paletta noted that the upper extremity EMGs did not change the recommendation with regard to work restrictions.

On July 15, 2013, Petitioner returned to Dr. Paletta for follow-up of both his right shoulder, as well as, his bilateral elbow and wrist complaints. Petitioner was previously diagnosed with bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. Petitioner complained of numbness and tingling involving the fourth and fifth fingers. Dr. Paletta noted that the shoulder was the most problematic. He recommended an arthroscopic surgery. Dr. Paletta noted that with respect to the cubital tunnel syndrome and carpal tunnel syndrome, Petitioner continued to be symptomatic. Petitioner had electrophysiologic abnormalities that confirm the diagnosis. Dr. Paletta did not recommend doing the shoulder surgery with the carpal tunnel and cubital tunnel surgery. Dr. Paletta opined that based on the duration of his job and his job duties and the correlation of onset and worsening of his carpal tunnel and cubital tunnel symptoms to those job activities, that his job is a causative or aggravating factor in both the cubital tunnel and carpal tunnel syndromes.

Petitioner's attorney entered into evidence a deposition of Dr. Anthony Sudekum in the case of James Bauersachs a/k/a "Correctional Officer" v. Menard Correctional Center. In this deposition, Dr. Sudekum described the activity of bar rapping the cell bars on each of the 55 cells by one officer which he believed could aggravate carpal or cubital tunnel syndrome. He testified that this task was performed on two out of the three shifts. In the present case, Petitioner confirmed on cross-examination that he did not bar rap the individual cells on the 11 p.m. to 7 a.m. shift. Additionally, Dr. Sudekum testified that the frequency and duration of the activities being performed was important. He testified that if one performed the activities on a nominal basis or a less frequent basis that would have no effect, essentially, on the etiology of those conditions. He explained that if these types of activities were performed very infrequently or rarely or even say for 10 minutes a day versus an hour a day, that could make a very significant difference regarding the etiologic potential of the conditions. Petitioner testified that he performed bar rapping on the 11 p.m. to 7 a.m. shift right around ten minutes per shift.

CONCLUSIONS OF LAW

1. Petitioner failed to establish a manifestation of repetitive trauma injuries to his bilateral hands and arms on November 21, 2012, that arose out of and in the course of his employment at Menard Correctional Center. The medical records of Dr. Paletta and Dr. Phillips clearly document that Petitioner's alleged hand and arm symptoms began 7 years prior to his presentment to them in November and December 2012. Additionally, Petitioner's claim of repetitive activities that allegedly contributed to his condition is not supported by the evidence. He testified that he worked the 11 p.m. to 7 a.m. shift roughly 90% of the time since his date of hire and that during that time, he performed bar rapping right approximately 10 minutes a day during that shift. The opening and closing of cell doors was minimal on the 11 p.m. to 7 a.m. shift. Taking all these factors into account, Petitioner's claim for repetitive trauma injuries to his bilateral hands and arms is denied.

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

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

Robert Wallace,

Petitioner,

14IWCC0713

vs.

NO: 12 WC 17721

Armstong Service,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, TTD and penalties and fees and being advised of the facts and law, reverses the April 30, 2013, 19(b) Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Arbitrator found Petitioner failed to prove that he sustained an accident that arose out of an in the course of his employment on April 16, 2012. In support of the finding, the Arbitrator noted Petitioner was asked if he had injured himself at work and responded that he hadn't. Also of significance to the Arbitrator was Petitioner's failure to both follow Respondent's accident reporting protocol and to make it aware to Respondent that he was a claiming a job injury prior to filing an Application for Adjustment of Claim. The Commission views the record differently.

The Commission acknowledges Petitioner testified that he was asked by David Giere, his site supervisor, if he had done anything to hurt himself during his work shift and told Giere that

he had not. Petitioner then testified that he misunderstood Giere's question. The Arbitrator noted this claim as well. Unlike the Arbitrator, the Commission is satisfied with Petitioner's explanation as to why he answered the way he did.

The Commission also finds it less significant than the Arbitrator that Petitioner did not follow Respondent's formal accident reporting procedures and questions the conclusion that Petitioner failed to make Respondent aware of his work injury prior to filing an Application for Adjustment of Claim. Giere testified that Petitioner complained of his back hurting during the April 16, 2013, shift change and also that he was told by Ricky Rodriguez that Petitioner had informed him that he had loaded salt into the water softener tank. Giere also testified that Petitioner's action of adding salt into a water softener tank did not necessarily suggest to him that Petitioner's injury was work related. The Commission believes Giere had sufficient information about Petitioner's work activities on April 15, 2013, and April 16, 2013, to reasonably conclude it was somehow related to Petitioner's claim of his back hurting. Given this, the need for formal notice before filing an application with the Commission is deemed to be superfluous.

With respect to accident, the Commission finds Petitioner credible. Petitioner testified to working the overnight shift that began the evening of April 15, 2012, and ended the morning of April 16, 2012. He testified further that, he felt fine when he arrived to work that evening but also to injuring his low back shortly before the end of his shift on April 16, 2012. Rodriguez, however, testified about Petitioner, upon reporting to work on April 15, 2012, claimed that his back was stiff. As noted above, Petitioner, in retelling his medical history, confided in Dr. Herman of his back being stiff prior to the beginning of his work shift on April 15, 2012. The Commission does not necessarily find there to be a significant inconsistency between Petitioner claiming both that his back was "fine" and "stiff" prior to commencing work on April 15, 2012, but it does find a difference between Petitioner's back being either fine or stiff at the beginning of the shift and it becoming painful during it. On the basis of Petitioner's credible testimony, the Commission finds Petitioner, on April 16, 2012, experienced an injury during his work shift that resulted in low back pain. Accordingly, the Commission reverses the arbitrator decision with respect to accident and finds Petitioner did sustain an accidental injury that arose out of and in the course of his employment.

Petitioner was initially treated by his family physician, Dr. Tony Nahhas. He ordered an MRI of Petitioner's low back that resulted in the finding of herniations to the L4-5 and L5-S1 levels along with mild bilateral neuroforminal narrowing. Petitioner came to be treated by Dr. Todd Sinai, a chiropractor, over sixty times for chiropractic treatment to his low back. Dr. Sinai, in turn, referred Petitioner to Dr. Martin Herman, a board certified neurosurgeon. He recommended physical therapy and a course of injections and, later, to Dr. Ernesto Padron, who assumed primary responsibility for active treatment of Petitioner's low back. It was Dr. Herman who testified that the findings of the MRI were consistent with a trauma-type injury, noting that Petitioner's neuroforminal narrowing could have been exacerbated and the herniations caused by Petitioner's injury. It was also Dr. Herman who, after Petitioner failed to improve through conservative measures, recommended surgical intervention, specifically suggesting Petitioner

undergo L4-S1 laminectomy, foraminotomy, nerve compression and fusion. The Commission finds the medical treatment Petitioner received concerning his lower back to be causally connected to his April 16, 2012, accident, and Dr. Herman's recommendation to be a reasonable and necessary measure to address Petitioner's low back complaints. Given these facts, and Dr. Herman's credible opinion, the Commission holds Respondent liable for both the costs Petitioner has already incurred in treating his low back injury, as compiled in Petitioner's arbitration hearing exhibit #9, as well as any future reasonable and necessary treatment and costs for the same.

As a result of Petitioner's injury, Dr. Nahhas recommended Petitioner cease working altogether, a recommendation Petitioner's succeeding physicians concurred with. As result, Petitioner ceased working on April 28, 2012, the day Dr. Nahhas recommended he stop working, up through the date of the arbitration hearing on March 5, 2013. The Commission takes notice that Petitioner, on December 27, 2012, undertook a "fitness for duty" examination which resulted in finding that Petitioner was unable to meet the physical demands the position of a boiler operator required. Absent any indication Petitioner was found capable of working in any capacity, the Commission presumes Petitioner's condition of temporary total disability continued at least through the date of the arbitration hearing.

The Commission, however, declines to find Respondent's actions merit the punitive measures permissible under Section 16, Section 19(k) and Section 19(l) of the Act. It is found Respondent, given the conflicting statements Petitioner initially made concerning the condition of his low back, had reasonable cause to dispute the relationship between Petitioner's low back injury and his employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $818.72 per week for a period of 44-4/7 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 $81,824.74 for medical expenses under §8(a) of the Act.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury, including the $13,567.52 Respondent has paid towards Petitioner's TTD benefits.

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: AUG 2 2 2014
KWL/mav
O: 06/24/14
42

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the decision of the majority. Arbitrator Thompson-Smith's findings are both thorough and well reasoned. This decision is correct and should be affirmed

Kevin W. Lamborn

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

14IWCC0713

WALLACE, ROBERT
Employee/Petitioner

Case# **12WC017721**

ARMSTRONG SERVICE
Employer/Respondent

On 4/30/2013, 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 0.08% 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:

1067 ANKIN LAW OFFICE LLC
SCOTT GOLDSTEIN
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

1120 BRADY CONNOLLY & MASUDA PC
IVAN NIEVES
ONE N LASALLE STSUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC0713

ROBERT WALLACE
Employee/Petitioner

v.

ARMSTRONG SERVICE
Employer/Respondent

Case # **12** WC **17721**

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 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. ☒ 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 _____

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FINDINGS

On the date of accident, **Armstrong Service**, Respondent *was* 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 **$63,860.68**; the average weekly wage was **$1,228.09**.

On the date of accident, Petitioner was **50** 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 **$13,567.52** for TTD, **$0** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$13,567.52**.

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

ORDER

Arbitrator does not award medical benefits or TTD benefits, finding that petitioner did not sustain an injury to his lumbar spine arising out of or in the course of his employment on April 16, 2012.

The Arbitrator does not award penalties and attorney fees.

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

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 30, 2013

ICArbDec19(b)

APR 30 2013

14IWCC0713

FINDINGS OF FACT

The disputed issues in this matter are: 1) accident; 2) causal connection; 3) medical bills; 4) temporary total disability; 5) penalties; 6) attorney's fees; and 7) prospective medical services. *See*, AX1.

Robert Wallace (hereinafter referred to as "Petitioner") was employed by Armstrong Service (hereinafter referred to as "Respondent") as a night shift operating engineer and testified that he worked the night shift from 6:00 p.m. to 6:00 a.m. Petitioner further testified that on April 15, 2012, he relieved his supervisor, Mr. Rick Rodriguez. He testified that during his shift, he lifted 10 bags of salt weighing 40 pounds each, injuring his back. Petitioner testified that he orally reported the work accident to his supervisor, Mr. Rodriguez, the following day, April 16, 2012. Petitioner claimed that he could not complete his shift and that Mr. Rodriguez allowed him to leave early on April 16, 2012 at 5:30 a.m. *See,* RX2.

Mr. David Giere, Site Supervisor, and Mr. Rodriguez, Chief Engineer, testified on behalf of Respondent, pursuant to "ASI Crew Statement" prepared in conjunction with the employer's investigation of petitioner's alleged back injury; as testified to by Mr. Giere. Petitioner called Mr. Giere on Monday at 3:00 p.m., reporting that his back hurts. Mr. Giere inquired of Petitioner if he was calling off work for the night, to which he replied no, that he should make it in, but was moving slowly. Mr. Giere specifically inquired of Petitioner if his back problem was a workplace injury. Petitioner replied "it was not." Mr. Giere advised petitioner that if, in fact, he had sustained a workplace injury, he needed to report it within 24 hours and follow ASI policy and procedures. Mr. Rodriguez testified that all employees received training regarding the reporting of work accidents and that Petitioner never reported to him a work injury having occurred on April 16, 2012. Petitioner claimed, per his testimony that he was not clear what Mr. Giere meant with his question; that he thought Mr. Giere was asking whether he had had an accident outside of work. *See,* RX3.

Mr. Rodriguez stated that he worked the day shift (6 a.m.-6 p.m.) on Sunday, April 15, 2012, with the petitioner relieving him Sunday evening at 5:30 p.m. to work the 6:00 p.m. to 6:00 a.m. shift. Mr. Rodriguez stated that "during the shift change, Bob mentioned his back was stiff" and at the respondent's request, wrote a statement to that effect. Mr. Rodriguez's statement is supported by the June 26, 2012 medical examination report of Petitioner's neurosurgeon, Dr. Martin Herman, in which noted, "he woke up with mild back stiffness, not atypical..." Mr. Rodriguez testified that on Monday morning, April 16, 2012, when he relieved Petitioner at 5:30 a.m., Petitioner complained that his back was hurting and mentioned that he had loaded salt into the water softener tank. Mr. Rodriguez further testified that the petitioner never stated that he specifically injured his back from loading salt. Mr. Rodriguez also testified that he did not "allow" Petitioner to leave early but often times, employees will leave before their shift ends if their work was completed and/or if the employee coming in to replace them had arrived. The Arbitrator notes that on re-cross examination, Mr.

Rodriguez did, on one occasion, answer Petitioner's counsel's question as to whether the petitioner said he hurt back lifting salt, at work, in the affirmative however; the Arbitrator takes judicial notice that the witness testified at least twice, that the petitioner did not specifically tell him that he had hurt his back, lifting the bags of salt into the machine, on April 16, 2012 and authored a statement citing what was said regarding the subject. *See*, RX3.

Mr. Giere testified that the employer's first notice of the petitioner alleging a work injury to his back was upon the employer receiving the Application for Adjustment of Claim filed May 22, 2012; after Petitioner was advised that his sick/vacation time was running out.

In contrast to Petitioner's testimony, Mr. Giere and Mr. Rodriguez testified that based on the salt levels at the end of Mr. Rodriguez's April 15, 2012 shift, the most bags the petitioner would have had to add was five (5).

On September 24, 2012, Dr. Andrew Zelby examined Petitioner, at the request of Respondent. Dr. Zelby testified at his November 14, 2012 deposition that he reviewed petitioner's medical treatment records and job description. Dr. Zelby testified that petitioner provided a history of an injury at work on April 15, 2012, that he lifted approximately ten (10) 40-pound bags of salt from the floor, five of them up a three-step ladder; pouring them into a large container at shoulder height and another five (5) into a lower container. That he felt pain in the low back and over the remainder of his shift, the pain worsened. The next day when he awoke, he had severe back pain and very severe pain radiating down the entire circumference of the right lower extremity; with a feeling of stabbing and burning in the entire right lower extremity. He had no symptoms on the left side. He went to his primary care physician and was given medications but his symptoms persisted. After a couple of weeks, he was sent for an MRI because of persistent back and right leg pain. Petitioner then obtained an attorney and was referred to a chiropractor. He began physical therapy and chiropractic treatment and at the time Dr. Zelby examined petitioner on September 24, 2012, petitioner remained in that treatment three (3) times per week. He also underwent three epidural steroid injections in the low back, the last one about five days prior to Dr. Zelby's examination. Dr. Zelby testified that the petitioner felt that none of the treatment helped with his symptoms but he did feel that the symptoms changed because, for the preceding month or so, he also developed pain radiating into the left lower extremity. He had no idea what brought on the left leg pain but still felt the right leg pain was a little more severe than the left. Dr. Zelby testified that at the time he examined petitioner, he reported constant pain in the mid to low lumbar region and pain in the lower extremities; more on the posterior aspects of the lower extremity than the anterior aspects; and more on the right than the left. Petitioner stated that he was getting constant numbness and tingling in both feet and that he felt that his symptoms were aggravated by everything he did; and he had found nothing that gave him relief. He was able to drive a car and put on his shoes and socks. *See*, RX6, p. 9-12.

Dr. Zelby testified as to the results of his September 24, 2012 physical examination that the petitioner's lumbar spine appeared normal; and that he had tenderness to palpation in the lower lumbar and upper gluteal regions even with non-physiologic light touch. Range of motion of the lumbar spine was normal except for modestly diminished forward flexion. The petitioner was able to squat almost all the way down. Lying straight leg raise was positive bilaterally in the back only. Sitting straight leg raise was negative, bilaterally. There was no sciatic notch tenderness. Toe walking and heel walking were normal and Patrick's test was normal. Gait was mildly antalgic favoring the right leg. Posture was normal for body habitus. There was no paraspinal muscle spasm and strength in the lower extremities was normal. Sensation to pin in the lower extremities was diminished circumferentially in the entire right lower extremity below the knee, but otherwise preserved. Vibratory sensation in the lower extremities was diminished in the entire right lower extremity, but otherwise preserved. Deep tendon reflexes in the lower extremities were absent. The toes were down-going bilaterally. Clonus was absent. Inconsistent behavioral responses were positive for pain on superficial light touch, pain on simulation, diminished pain on distraction and non-anatomic sensory changes. Measurement of the extremities demonstrated that they were symmetric and without atrophy. Distal pulses were normal and symmetric bilaterally. Dr. Zelby testified that Petitioner's inconsistent behavioral responses were significant; and by Petitioner having four out of five positive Waddell signs, suggested a poor outcome irrespective of treatment and that Petitioner's symptoms could be unrelated to any infirmity or lack of infirmity in the spine. *See*, RX6, p. 15-16.

Dr. Zelby further testified that he reviewed the MRI dated May 3, 2012, of the petitioner's lumbar spine which revealed mild degenerative disk disease at L4-5 and L5-S1 more than L3-4 without loss of disk space heights. Also noted were multiple chronic Schmorl's nodes at L2-; and, there was a minuscule bulging disk at L3-4. There was a modest bulging disk and minimal thickening of the ligamentum flavum without stenosis or neural impingement at L4-5; there was a broad based para-central left disk protrusion or disk/osteophyte complex with mild effacement of the ventral CSF to the left. There was also mild thickening of the ligamentum flavum with resultant mild left lateral recessed stenosis at L5-S1 and a small broad based bulging disk and perhaps trace effacement of the ventral CSF centrally. There was mild thickening of the ligamentum flavum with slight central and bilateral lateral recessed stenosis; and incidentally noted was a Tarlov cyst at the level of S-2. *See*, RX 6, p. 17-19.

Dr. Zelby testified that he diagnosed the petitioner as having lumbosacral spondylosis, which he defined as a degenerative condition of the spine. Dr. Zelby testified that Petitioner's lumbar condition was not caused by the alleged work injury as "Mr. Wallace reported an injury at work and had complaints of back pain, as well as non-radicular pain extending into the right lower extremity. He ascribed all of those complaints to his injury but his MRI showed a disk protrusion or disk/osteophyte complex to the left and I said that that would not result in right-sided leg symptoms. Mr. Wallace had an essentially normal neurologic examination other than obviously non-anatomic sensory change; the lack of correlation between his symptoms and his radiographic findings, documents that his injury did

not cause the radiographic findings. It also highlights that in addition to having no relationship to his work injury, the lack of correlation between his symptoms and his radiographic findings shows there's no indication to pursue the treatment that he had undergone; particularly the epidural steroid injections. Mr. Wallace also had four to five positive Waddell signs with significant symptom amplification. I said that the symptom amplification, combined with a clear lack of correlation between his symptoms and his radiographic findings, indicated that Mr. Wallace's symptoms were unrelated to any injury or any condition of infirmity in his spine. There is no identifiable medical evidence to suggest that his reported injury resulted in any injury to his spine or nervous system or that his reported injury has resulted in any ongoing condition of infirmity or disability. At the most, based on the mechanism of injury he reported, taken in the context of his objective findings, Mr. Wallace might have sustained a lumbar strain and nothing more." *See,* RX6, p. 19-21.

Concerning Petitioner's need for prospective medical treatment and work restrictions, Dr. Zelby testified that the petitioner had undergone more than an adequate amount of treatment for his condition and an ample amount of time to have reached maximum medical improvement for any infirmity arising as a consequence of his reported work injury. In addition, there was no objective medical evidence to suggest that Mr. Wallace is not qualified to pursue all of the same vocational and avocational activities that he performed prior to April 15, 2012 without restriction. He testified that the petitioner was at no increased risk for injury even with a return to work on a full duty capacity and that Mr. Wallace required no additional diagnostic studies or any further directed treatment for his spine or nervous system irrespective of cause. Dr Zelby suggested that he be encouraged to pursue a diligent daily self-directed range of motion stretching and core strengthening exercise program and also maintain a more healthy body weight; both for the general health of his spine and his blood pressure, which was dangerously elevated. Dr. Zelby urged him twice to either see his primary care physician or go to an emergency room that day specifically for urgent treatment of his blood pressure. In addition, Dr. Zelby testified that the epidural steroid injections administered to petitioner were not reasonable and necessary or causally related stating, "My opinions relating to the necessity of his epidurals had nothing to do with reviewing the reports. It had to do with the fact looking at his MRI films, looking at the patient, correlating those things and the lack of correlation. Simply because a patient has radiographic findings, it doesn't mean that there's a procedure indicated unless there are certain factors that are met. Since Mr. Wallace didn't have those, there's no reason to pursue them irrespective of cause..." *See,* RX6, pgs. 22-27.

Dr. Zelby further testified that he reviewed Dr. Herman's medical examination report dated November 13, 2012, in which Dr. Herman opined that Petitioner had failed conservative therapy and the only potential treatment to be offered was a L4-S1 lamiforaminotomy and fusion for nerve decompression and fixation. Dr. Zelby disagreed with Dr. Herman's recommendation for surgery. Dr. Zelby testified that there was mild narrowing without convincing neural impingement on Petitioner's MRI and that Mr. Wallace was neurologically normal. He had no radicular symptoms and findings upon examination; and although he did report symptoms in his legs, they did not follow a

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nerve or a nerve root distribution therefore, they were not radiculopathy. In addition, there is no reason to decompress nerves that were not causing any symptoms for the patient. As for the fusion, Dr. Zelby opined that the petitioner did have degenerative disk disease, but that it is very mild and guidelines for the treatment of such a mild disk disease, even in the context of low back pain, did not include fusion as part of the treatment pathway. He then stated that it is well known that those patients are not likely to benefit from such surgery. Finally, Dr. Zelby opined that performing such invasive surgery on a patient who is obese and a smoker, would significantly diminished any chance of helping his situation and he saw no upside for the patient. *See,* RX6, p. 24-26.

Petitioner was contacted by the respondent on October 16, 2012 and requested his return-to-work pursuant to the results of Dr. Zelby's September 24, 2012 examination. Petitioner testified that he attempted to return to work however; he failed the fitness examination on December 27, 2012 and has not worked since that date. *See,* RX1.

14IWCC0713

CONCLUSIONS OF LAW

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. *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. *Hannibal, Inc. v. Industrial Commission*, 38 Ill. 2d 473, 231 N.E. 2d 409, 410 (1967).

Pursuant to the testimony given at trial and the exhibits submitted into evidence, the Arbitrator finds that the Petitioner failed to prove, by a preponderance of the evidence that an accident arose out of and in the course of his employment for Respondent. It is well settled law in Illinois that an injury arises out of one's employment if its origin is in a risk connected with or incidental to the employment so that there is a causal connection between the employment and the accidental injury. An employee's unrebutted description of an alleged accident can be the basis for an award of benefits, provided the allegations are supported by the evidence presented. Here, the Petitioner was specifically asked if his back injury happened at the job and reminded that certain procedures had to be enacted if it did. Petitioner answered these questions in the negative. Petitioner testified that he misunderstood the question however; he did not initiate the employer's procedures to report a job injury and no one at his place of employment was aware that he was claiming a job injury until he filed an application for notice of claim with the Commission. In addition, Petitioner admitted to Dr. Herman that prior to beginning his work shift on April 15, 2012, he already had back stiffness.

The Arbitrator finds the testimonies of Misters Giere and Rodriguez to be more credible than the testimony of the petitioner, in finding that Petitioner has not proven, by a preponderance of the evidence, that he sustained an accident that arose out of and in the course of his employment, on April 16, 2012. Having found no compensable accident the remaining issues are moot and will not be addressed.

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

Deborah Reeves,

Petitioner,

14IWCC0714

vs.

NO: 10 WC 11567

Village of Dixmoor Police Department,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 27, 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: AUG 2 2 2014
KWL/vf
O-6/24/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF 19(b) DECISION OF ARBITRATOR

14IWCC0714

REEVES, DEBORAH
Employee/Petitioner

Case# **10WC011567**

VILLAGE OF DIXMOOR POLICE DEPT
Employer/Respondent

On 8/27/2013, 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:

2573 MARTAY LAW OFFICE
DAVID W MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

1295 SMITH AMUNDSEN
GAIL A GALANTE
3815 E MAIN ST SUITE A-1
ST CHARLES, IL 60174

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)

14IWCC0714

Deborah Reeves
Employee/Petitioner

Case # 10 WC 11567

v.

Consolidated cases: _____

Village of Dixmoor Police Department
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 **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **August 1, 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 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 *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$12,480.00**; the average weekly wage was **$240.00**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **6** dependent children.

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

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

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

ORDER

The Arbitrator awards prospective medical care which is reasonable and necessary to relieve Petitioner of her pain per the direction of her surgeon, Dr. Gourineni including surgery to her right hip, 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.

Deborah L. Simpson
Signature of Arbitrator

Aug 22, 2013
Date

ICArbDec19(b)

AUG 27 2013

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Deborah Reeves,	)	
	)	
Petitioner,	)	**14IWCC0714**
	)	
vs.	)	**No. 10 WC 11567**
	)	
Village of Dixmoor Police Department,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on January 15, 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; and (2) Is the Petitioner entitled to any prospective medical care.

STATEMENT OF FACTS

The Petitioner began her employment with the Respondent in June of 2008, as a Village Service Attendant. It was a part time position in which she was responsible for office clerical work and writing parking tickets. She usually began her shift at 8:00 a.m. At the time she was 33 years of age, single and had six dependent children.

On January 15, 2010, while walking in front of the Police Department, in order to enter the building and begin her shift, she slipped on some ice and fell to the ground landing on her right elbow and side. She testified that she noticed pain to her right elbow and her right hip. Petitioner entered the building and reported the accident to her supervisor, Sergeant Johnson, who wrote a report of the incident. The report was admitted into evidence as Petitioner's exhibit number 1.

The report prepared by Sgt. Johnson indicates that the Petitioner reported that she was on her way into the Dixmoor Police Department to punch in for work and she slipped on ice in front of the Police Department. She said she landed on her right hip bone and in the process hurt her right elbow, that she had a small cut on her right elbow as a result of the fall. She refused medical treatment. Sgt. Johnson wrote that he questioned her about needing medical attention. The Petitioner said she was "ok for now, but I don't know how I'm going to feel later." Sgt. Johnson also questioned her about continuing to work. The Petitioner stated, "I can work. I'm just working in pain at the moment." (P. Ex. 1.)

Sgt. Johnson also completed the Illinois Form 45 which stated that on January 15, 2010, the Petitioner slipped on ice in front of the Dixmoor Police Department and injured her right hip bone and right elbow. (P. Ex. 2)

Records from Ingalls Occupational Health state that on January 15, 2010, the Petitioner was treated in the Emergency Department at 11:18 a.m. At the time the Petitioner told medical personnel that she had slipped on ice and fallen onto the concrete. She indicated that she landed on her right side, hurting her right hip and elbow. According to the records, there was no pain to her hip at the time, but the records indicate that the pain in her elbow was a 3 without movement, an 8 with movement or a 5 all the time and movement did not affect it, depending upon which report you are reading. (P. Ex. 4, 7) The Petitioner's elbow was x-rayed, there were no fractures so she was released to return to work with lifting restrictions for her right arm and prescribed ibuprofen. (P. Ex. 4, 7)

The Petitioner returned to Ingalls Occupational Health on January 25, 2010, for follow-up. At that time she reported that her elbow was improving but the pain in her hip was increasing. She reported that prolonged standing seemed to aggravate the pain. (P. Ex. 4, 7) Petitioner was given different medication and permitted to return to work, the lifting restriction for her arm was increased to 15 pounds, restrictions including no ladder climbing, minimal stairs/inclines, standing only 20 to 40 minutes per hour and no squatting were added. (P. Ex. 4, 7).

When the Petitioner returned for further follow-up on February 10, 2010, she reported that her elbow pain was completely resolved. She stated that she had been working restricted duty without any problems, however the pain in her hip was worst when standing and walking. The pain was improved with resting, heat and medication. (P. Ex. 4) X-rays of her hip were taken that day, which were normal, her medication was changed, and she was ordered to begin physical therapy 4 times per week for one week and to return after the physical therapy. (P. Ex. 4).

Petitioner started physical therapy at Ingalls Occupational on February 16, 2010. (P. Ex. 4, 7) She presented back to Ingalls Occupational for a follow up on February 22, 2010 with continued pain to her right hip. (P. Ex. 4, 7). She was referred to see an orthopedic surgeon, Dr. Neal Labana, to evaluate her right hip. (P. Ex. 4, 7)

Petitioner presented to Dr. Labana at Southland Bone & Joint Institute on March 2, 2010 for an evaluation (R. Ex. 4). Her initial complaints were of right hip pain and some low back pain. (R. Ex. 4). Dr. Labana recommended physical therapy and a trial of Mobic. (R. Ex. 4).

Following this exam, Petitioner underwent unrelated carpal tunnel release surgery on March 22, 2010 with Dr. Boonmee Chunprapaph at UIC Medical Center. (R. Ex. 6).

She returned to Dr. Labana on October 7, 2010 with continued right hip and low back pain (R. Ex. 4). Dr. Labana ordered an MRI of Petitioner's lumbar spine and released her back to work with no lifting over 10 lbs. (R. Ex. 4). Petitioner underwent an MRI of her lumbar spine on November 5, 2010 which revealed no significant abnormalities. (R. Ex. 4). She returned to see Dr. Labana on November 9, 2010, and he referred her to see Dr. George Miz at Bone & Joint Physicians. (R. Ex. 4).

Petitioner saw Dr. Miz for an evaluation on December 14, 2010, with complaints of a relatively mild degree of back pain but more consistent right hip and proximal thigh pain with some intermittent radiation in to the groin area. (R. Ex. 5). Dr. Miz felt her lumbar spine was doing alright but she needed to continue treatment for her right hip with Dr. Labana as the right hip was the more pressing issue. (R. Ex. 5)

Dr. Labana saw Petitioner again on January 25, 2011, and he referred her for an MRI of her right hip and kept her on a 10 lbs. lifting restriction. (R. Ex. 5). The MRI was done at Ingalls Memorial Hospital on February 24, 2011, and revealed a small superior labral tear, cam type femoral acetabular impingement and minimal bilateral trochanteric bursitis (P. Ex. 6). Petitioner followed up with Dr. Labana on March 3, 2011, and was referred to see Dr. Prasad Gourineni at Pediatric & Young Adult Orthopaedics (R. Ex. 5).

Petitioner presented to Dr. Gourineni for an initial evaluation on March 15, 2011. (P. Ex. 3 at 7). She was complaining of right hip pain shooting down to her thigh (P. Ex. 3 at 8). Dr. Gourineni looked at the right hip MRI films and diagnosed Petitioner with a cam deformity of the femoral head-neck junction and a labral tear (P. Ex. 3 at 9). To treat her issues, Dr. Gourineni administered an injection in to Petitioner's right hip which provided Petitioner some pain relief (P. Ex. 3 at 9-10).

Dr. Gourineni saw Petitioner for a follow up on March 22, 2011, and noted Petitioner was doing better but still had a bony block (P. Ex. 3 at 10). He ordered some x-rays which confirmed the cam morphology and also showed a cyst on the femoral head called an impingement cyst (P. Ex. 3 at 10-11). Dr. Gourineni recommended Petitioner undergo arthroscopic surgery to cut out the deformity in Petitioner's right hip and Petitioner wanted to proceed with the surgery (P. Ex. 3 at 11). Petitioner testified this surgery was denied by Respondent.

At the request of Respondent, Petitioner presented to Dr. Charles Mercier at Chicago Orthopaedics & Sports Medicine on May 31, 2012, (R. Ex. 1 at 6). She was complaining of right hip pain, trouble sitting and walking for long periods of time and a clicking in the right hip (R. Ex. 1 at 7). As it related to Petitioner's work-injury on January 15, 2010, Dr. Mercier opined Petitioner only suffered a contusion of her right elbow and suffered no right hip injury. (R. Ex. 1 at 10-11).

Petitioner followed up with Dr. Gourineni on September 20, 2012, (P. Ex. 3 at 12). He continued to recommend Petitioner proceed with arthroscopic surgery (P. Ex. 3 at 13). Petitioner

saw Dr. Gourineni for a final time on November 6, 2012, in order to review Dr. Mercier's IME report. (P. Ex. 3 at 13). Dr. Gourineni noted some differences of opinion with Dr. Mercier specifically pointing to the x-rays. Dr. Gourineni believed Dr. Mercier missed Petitioner's cyst on the right hip which was causing her impingement (P. Ex. 3 at 15-16). He also continued to recommend Petitioner undergo arthroscopic hip surgery and that a continued delay in the surgery could cause Petitioner more damage to her right hip (P. Ex. 3 at 18).

Petitioner testified she continues to experience pain in her right hip and would like to proceed with the surgical procedure recommended by Dr. Gourineni. She testified her right hip was never a problem for her before her fall at work on January 15, 2010. She testified tearfully, that at times the pain is unbearable, especially when walking, sitting down and being with her children. She stated that it is difficult for her to walk two blocks. In order to treat her pain, she takes ibuprofen and Aleve twice a day. She testified further that she does not like taking the pain medications and only takes them before work or after work when she is at home.

The Petitioner testified that her current position with the Respondent is as a dispatcher, which requires that she sit for long periods of time. Given the current state of her hip, this is quite painful. She was interested in becoming a police officer and took the written examination and passed it, but is not able to pass the physical agility tests because of her hip.

CONCLUSIONS OF LAW

The employee bears the burden of proving by a preponderance of the evidence all of the elements of his claim. *R & D Thiel v. Workers' Compensation Comm'n*, 398 Ill. App. 3d 858, 867 (2010). Among the elements that the employee must establish is that his condition of ill-being is causally connected to his employment. *Elgin Board of Education U-46 v. Workers' Compensation Comm'n*, 409 Ill. App. 3d 943, 948 (2011).

For compensability of a claimed injury, where a pre-existing condition exists, recovery will depend on the employee's ability to show that a work-related injury aggravated or accelerated the pre-existing condition such that the employee's current condition of ill-being is said to have been causally connected to the work-related injury and not simply the natural sequelae process of the pre-existing condition. *Sisbro Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 278 Ill. Dec.70, 797 N. E. 2d 665 (2003).

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).

When a preexisting condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition."

St. Elizabeth's Hospital v. Workers' Compensation Commission, 864 N.E.2d 266, 272-273 (5th Dist. 2007)

Is Petitioner's Current Condition of Ill-being Causally Related to the Injury?

The Arbitrator finds Petitioner's condition at the time of trial with respect to her right hip is causally related to the January 15, 2010, accident when she slipped and fell on the ice in front of the Police Station. The Petitioner reported the incident immediately to her supervisor, Sgt. Johnson who made two reports about the incident, P. Ex. 1, the Respondent's General Report and P. Ex. 2, Illinois Form 45: Employer's first report of injury, both dated January 15, 2010, signed by Sgt. Johnson, listing the injury as the right hip bone and right elbow.

At Ingalls Occupational Health Center in Tinley Park, approximately three hours after she slipped and fell, the Petitioner reported slipping and falling on the ice in front of the Police Department injuring her right hip and right elbow. The reports vary as to the extent of the pain while in the emergency department, the same person apparently recording it as no pain for the hip currently, but the elbow ranging from 5 all the time, to 3 when at rest and 8 when moving it. She was examined, given medications, released to return to work with some restrictions and told to report back in two weeks which she did.

When the Petitioner returned for follow-up, she reported her elbow as improving and her hip as getting worse, especially with prolonged standing. She was given additional limitations on her work release, different medications and asked to follow-up again. The complaints the Petitioner made regarding her hip pain and how she was injured remained consistent which each medical provider Petitioner saw, whether it was a treating physician or an examining physician pursuant to section 12 of the Act.

Throughout her medical treatment she was consistent in relating to Ingalls Occupational Health, Dr. Labana, Dr. Miz and Dr. Gourineni that her right hip was causing her pain and that the pain began when she fell at work on January 15, 2010. This is even confirmed by Respondent's IME physician, Dr. Mercier, when he was asked by Petitioner' attorney, "In any of the medical notes or reports that you reviewed...did she ever give a different history on injuring her hip other than the slip and fall on January 15, 2010" (R. Ex. 1 at 26). Dr. Mercier's reply was a simple, "no." (R. Ex. 1 at 26)

The Arbitrator gives the opinions of Dr. Mercier little weight. His opinions rely almost entirely on Petitioner's physical exam of her right hip, which was taken at Ingalls Occupational Health on January 15, 2010 being normal (R. Ex. 1 at 11). He has no explanation for why her hip would be examined if she did not complain of being injured there other than she said she fell on it. Dr. Mercier completely ignores the fact that when Petitioner presented for a follow up exam on January 25, 2010 she clearly stated her right hip pain was getting worse (P. Ex. 7, R. Ex. 3). When asked by Petitioner's attorney, "You think she started experiencing pain unrelated to the fall between January 15, 2010 and January 25, 2010,?" Dr. Mercier's answer was, "She must have" (R. Ex. 1 at 26). Dr. Mercier did not give any basis for that opinion or point to anything recorded in the medical records he reviewed or questions he asked upon examination of the Petitioner to explain or support that statement.

Although Dr. Mercier found no objective findings during his independent medical exam with Petitioner, he still had no objection to Dr. Gourineni proceeding with arthroscopic surgery for Petitioner's right hip (R. Ex. 1 at 28 & 31). Dr. Mercier also admitted he did have a chance to review the same x-rays films Dr. Gourineni saw in order to diagnose Petitioner's right hip femoral head cyst. (R. Ex. 1 at 28).

The Arbitrator gives the opinions of Dr. Gourineni greater weight in this claim than those of Dr. Mercier and Dr. Agarwal, who conducted a review of the medical records and prepared a report based upon them with no physical examination or discussion with the Petitioner. After Petitioner's initial visit on March 15, 2011, Dr. Gourineni saw Petitioner for a second time on March 22, 2011 and ordered new x-rays (P. Ex. 3 at 10). The new x-rays, which Dr. Mercier never saw, confirmed cam morphology and showed a cyst on the femoral head called an impingement cyst (P. Ex. 3 at 11). Dr. Gourineni testified the cyst was causing some impingement in Petitioner's right hip which was causing her pain. He noted the impingement and cyst were preexisting conditions which were, in his opinion, aggravated by Petitioner's fall on January 15, 2010. (P. Ex. 3 at 20 & 27). Dr. Gourineni formed this opinion based upon the fact Petitioner had no right hip pain and no documented treatment for her right hip prior to her fall at work on January 15, 2010. (P. Ex. 3 at 10, 17 & 23). Dr. Gourineni believed Petitioner required arthroscopic surgery to repair the right hip and relieve her of her pain. (P. Ex. 3 at 11).

One other issue here is the gaps in Petitioner's treatment. Petitioner credibly testified the gaps were due to the fact Respondent was denying her continued medical care for the right hip. Dr. Gourineni confirmed she sought medical care and scheduled her surgery multiple times, but the procedure was always cancelled due to lack of approval by Respondent. (P. Ex. 3 at 12 & 34).

Petitioner credibly testified she continues to suffer right hip pain. The medical records clearly show Petitioner was complaining of right hip pain the date she was injured at work from the time she made the report immediately after the fall. Dr. Gourineni's opinions point to the fact Petitioner suffered a fall on her right hip on January 15, 2010 which aggravated her preexisting condition.

The Arbitrator finds Petitioner has proven by a preponderance of the evidence that she continues to suffer right hip pain and that her current condition of ill-being is directly related to her work-injury on January 15, 2010, while employed by Respondent.

Is the Petitioner Entitled to Prospective Medical Care?

Dr. Gourineni opined Petitioner required right hip surgery in order to fix the impingement cyst in her right hip (P. Ex. 3 at 17 & 18). He noted the fall caused her to start having symptoms from her impingement and her issues were unlikely to go away without treatment (P. Ex. 17).

Since Petitioner's present condition of ill-being is causally related to her work-injury, the further medical treatment prescribed by Dr. Gourineni for Petitioner to reach maximum medical improvement is deemed reasonable and necessary. According to Dr. Gourineni, physical therapy and other conservative treatments, which have been tried by other physicians before Petitioner

was referred to Dr. Gourineni, will not work because of the pre-existing condition that was aggravated by the accident on January 15, 2010. The medical procedures such as surgical intervention should be approved immediately as Dr. Gourineni opined further delays could further damage Petitioner's right hip. (P. Ex. 3 at 18)

ORDER OF THE ARBITRATOR

The Arbitrator awards prospective medical care which is reasonable and necessary to relieve Petitioner of her pain per the direction of her surgeon, Dr. Gourineni.

Deborah L. Simpson
Signature of Arbitrator

Aug 22. 2013
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jennifer Rzepczynski-Atlas,

Petitioner,

vs.

NO: 12 WC 03578

Palos Community Hospital,

14IWCC0715

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability benefits, and the Arbitrator's evidentiary rulings, and being advised of the facts and law, reverses the Arbitrator's findings regarding medical expenses and temporary total disability benefits and remands the case back to the Arbitrator for further proceedings consistent with this decision.

Hearing commenced on this matter on February 28, 2013. The issues at hearing were the date of accident, causation, medical expenses, temporary total disability benefits, prospective medical care under Section 8(a) of the Act, and penalties and attorney's fees. After Petitioner's testimony was taken, the matter was continued to March 5, 2013, in order for Respondent to bring in its investigators to testify.

The parties met before the Arbitrator on March 5, 2013, at which time the matter was again continued to April 30, 2013. No record was taken on March 5, 2013.

On March 18, 2013, Respondent filed an Application for Dedimus Potestatem. (T2.17) The application explained that following the March 5, 2013 hearing, "a discussion regarding Respondent Exhibits was had and the Petitioner advised he would not waive a hearsay objection to utilization review reports." (RX5) The application further explained that said utilization

review reports had been served on Petitioner's counsel on June 13, 2012 and February 12, 2013. Finally, the application indicated that depositions had been set for the authors of the utilization review reports, specifically, Dr. David Trotter was set for an audio deposition on April 9, 2013 and Dr. Steven Blum was set for deposition on April 10, 2013.

On April 1, 2013, the parties were again before the Arbitrator, this time regarding Respondent's Application for Dedimus Potestatem. Petitioner's counsel "made it clear he was objecting to the depositions themselves." (RX6) Petitioner's counsel argued that he "would not have agreed to put my Petitioner on the stand, subject her to cross-examination, if there was going to be additional discovery that was going to be completed." (T2.28) Petitioner's counsel further argued that Respondent's counsel set the depositions during a period of time when counsel knew Petitioner's counsel was unavailable due to another trial. (T2.29)

Respondent's counsel argued that she became aware of Petitioner's counsel's objection to Respondent's utilization reports being admitted into evidence on March 5, 2013. (T2.9) Respondent's counsel explained that once she knew Petitioner's counsel would not agree to the submission of the utilization review reports, "it became apparent that we had to set the depositions pursuant to that part of the Act. Due to the final trial date and the short amount of time involved and the fact that these are treating physicians, we got the earliest dates that we could. Anticipating that counsel would not be in agreement with that either, we arranged for a dedimus as the rules provided therein, the dedimus rules. And we were able to obtain in that limited time span an audio deposition of Dr. Trotter for April 9th, as he is out of state, and Dr. Steven Blum, April 10th, in Schaumburg, Illinois, at the offices of GENEX....I've made every effort to exercise my rights to defend my client in the best manner that I can, and to follow the rules for the Application for Dedimus as well as Section 8.7(i), 5 of the utilization review records." (T2.11-13)

Respondent's counsel further explained that she did not tender her exhibits to Petitioner's counsel on February 28, 2013, as the Arbitrator had recommended, because she was "desirous of cross-examination testimony before I disclosed surveillance." (T2.14-15) Furthermore, Respondent's counsel argued that because there were outstanding surveillance video issues, she did not feel that the hearing would be completed on February 28, 2013. (T2.13-14)

On April 2, 2013, the Arbitrator issued her ruling, denying Respondent's Application for Dedimus Potestatem. (RX6) The Arbitrator found that a utilization review report is, "by its nature, hearsay evidence. A party who wishes to get such a report into evidence cannot assume that the other side will agree to its admission. The reports at issue herein also appear to be cumulative of other admissible deposition evidence. By waiting until after the initial hearing to inform her opponent of her intent to offer such reports, Respondent's counsel assumed a significant risk." (RX6)

The Arbitrator noted that Section 8.7(i)(5) of the Act provides that "nothing in this Section shall be construed to diminish the rights of employees to reasonable and necessary medical treatment." (RX6) The Arbitrator determined that "allowing depositions of two utilization review physicians to proceed in the middle of a specially set trial would unduly diminish Petitioner's Section 8(a) and due process rights." (RX6)

Petitioner filed Petitions for Penalties and Attorney's Fees on September 14, 2012 and December 18, 2012.

On April 10, 2013, Respondent filed Respondent's Response to Petitioner's Petition for Assessment of Penalties and Attorney's Fees. (RX7) In its response, Respondent argued that it "obtained Utilization Review reports, pursuant to Section 8.7 of the Act" and that it had/will satisfy the Certification Recommendations in the reports. (RX7) Respondent's counsel also cited Section 8.7(j) of the Act which states that:

> "[w]hen an employer denies payment of or refuses to authorize payment of first aid, medical, surgical, or hospital services under Section 8(a) of this Act, if that denial or refusal to authorize complies with a utilization review program registered under this Section and complies with all other requirements of this Section, then there shall be a rebuttable presumption that the employer shall not be responsible for payment of additional compensation pursuant to Section 19(k) of this Act." 820 ILCS 305/8.7(j) (2013)

Respondent explained that the "Utilization Review determinations obtained by Respondent comply with all applicable regulations as set forth in Section 8.7 of the Act." (RX7)

During the June 3, 2013 hearing, Respondent's counsel introduced and the Arbitrator admitted into evidence the Arbitrator's Order denying the Application for Dedimus. (RX6) Respondent's counsel then attempted to introduce into evidence her Response to Petitioner's Petition for Penalties and Attorney's Fees. (T3.223) Petitioner's counsel objected, noting that the Response had the rejected utilization review reports attached. (T3.223-224)

Respondent's counsel argued that the utilization review reports were not being offered "for the truth of the matter asserted but for the fact that it is specifically provided in the amendments to the Act that if you have a utilization review and act in accordance therewith, you can't be subject to penalties....This is totally separate from what I will make an offer of proof on; that is, taking the deposition of the doctors underlying. There is no way to make use of the statutory provisions holding that if a utilization review is performed and Respondent acts in accordance therewith, that the Respondent cannot be subject to penalties." (T3.224)

The Arbitrator asked the parties if they were willing to stipulate "that the utilization review was obtained by Respondent on whatever dates it was obtained, and I can let in the response to the penalties petition without letting in the exhibits with that stipulation unless the petition response adequately delineates the dates on which you obtained the [utilization review report]?" (T3.225) The Arbitrator noted that the utilization review reports "might be relevant to my consideration of penalties but without letting in the reports themselves....So are you willing to just put in the response without the attachments, or do you wish the full response to come in and I will mark the attachments as rejected exhibits.?" (T3.225-226) Respondent's counsel agreed to the latter and the Arbitrator admitted Respondent's Response to Petitioner's Petition for Penalties, but rejected the attached utilization review reports. (T3.226,RX7)

14IWCC0715

As previously noted, Section 8.7(j) of the Act states, in pertinent part, that if a denial or refusal to authorize treatment by an employer complies with a utilization review report's recommendations, "then there shall be a rebuttable presumption that the employer shall not be responsible for payment of additional compensation pursuant to Section 19(k) of this Act." 820 ILCS 305/8.7(j) (2013) Once Respondent's counsel became aware that Petitioner's counsel was going to object to the admission of the utilization review reports, Respondent's counsel sought a dedimus to get the testimony of the authors of the utilization review reports, pursuant to Section 8.7(i)(5) of the Act. The Commission notes that Petitioner's counsel's decision to object to the utilization review reports made Respondent's counsel's request to take the depositions of the authors of the utilization review reports necessary. The Commission further notes that Respondent's defense to Section 19(k) penalties, statutorily, are the utilization review reports. The Commission finds that the Arbitrator's decision to reject the utilization review reports and denial of Respondent's Application for Dedimus Potestatem denied Respondent the ability to put on its defense to Section 19(k) penalties per the Act, violating Respondent's due process rights.

The Arbitrator also indicated that the utilization review reports appeared "to be cumulative of other admissible deposition evidence." (RX6) The Commission finds that statement indicative of the Arbitrator's having reviewed the utilization review reports, an opportunity denied the Commission when reviewing the case at bar. Furthermore, regardless of the cumulative nature of the utilization review reports, the Commission finds that the pertinent point is that Respondent relied on the recommendations of the utilization review reports to deny payment of treatment and it is those reports that Respondent requires, per the Act, to defend itself, in the case in chief and against Petitioner's claim for penalties and fees.

Therefore, based on the above, the Commission finds that the Arbitrator's denial of Respondent's Application for Dedimus Potestatem and rejection of the utilization review reports into evidence was reversible error and remands the matter back to the Arbitrator with instructions to grant Respondent's Application for Dedimus Potestatem, or in the alternative, if Petitioner's counsel is willing to withdraw his objection to the admission of the utilization review reports, admit the reports into evidence. The Commission further instructs the Arbitrator to issue findings regarding medical expenses and temporary total disability benefits after taking into account the deposition testimony of Dr. Trotter and Dr. Blum and/or the utilization review reports.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's findings on medical expenses and temporary total disability benefits are reversed and the case 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.

14IWCC0715

DATED: AUG 2 2 2014
MJB/ell
o-06/24/14
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamboley

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

ATLAS, JENNIFER RZEPCZYNSKI
Employee/Petitioner

Case# 12WC003578

12WC003577

14IWCC0715

PALOS COMMUNITY HOSPITAL
Employer/Respondent

On 12/9/2013, 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 0.10% 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:

0391 THE HEALY LAW FIRM
KEVIN T VEUGELER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

1295 SMITH AMUNDSEN LLC
ANITA S JOHNSON
150 N MICHIGAN AVE SUITE 3300
CHICAGO, IL 60601

14IWCC0715

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)

JENNIFER RZEPCZYNSKI ATLAS
Employee/Petitioner

v.

PALOS COMMUNITY HOSPITAL
Employer/Respondent

Case # **12** WC **3578**

Consolidated cases: **12 WC 3577**

An *Application for Adjustment 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 **2/28/13, 4/1/13, 4/30/13, 6/3/13 and 10/4/13**. 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

14IWCC0715

FINDINGS

On the date of accident, **4/18/11**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**13,627.64**; the average weekly wage was $**262.07**.

On the date of accident, Petitioner was **27** 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 $**1,412.80** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**1,412.80**. Arb Exh 3.

Respondent is entitled to a credit of $**4,717.31** under Section 8(j) of the Act. Arb Exh 3.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $262.07 per week for 95 2/7 weeks, from May 2, 2011 through May 25, 2011 and from August 31, 2011 through June 3, 2013, as provided in Section 8(b) of the Act, with Respondent receiving credit for the $1,412.80 in benefits it paid prior to the hearing, pursuant to the parties' stipulation. Arb Exh 3.

The Arbitrator awards Petitioner the medical expenses enumerated in PX 8-13, subject to the fee schedule and with Respondent receiving credit for the $7,072.42 it paid to ATI on April 2, 2013. RX 12.

For the reasons set forth in the attached conclusions of law, the Arbitrator declines to award penalties or fees in this case.

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

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

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

Molly C Mason
Signature of Arbitrator

12/9/13
Date

DEC 9 – 2013

Jennifer Atlas Rzepczynski v. Palos Community Hospital
12 WC 3577-8 (consolidated)

Arbitrator's Findings of Fact

Two claims are on file but the parties agree Petitioner had only one accident. They also agree the accident took place on a Monday in April 2011. Petitioner filed two Applications because of some uncertainty as to whether the accident occurred on April 11, 2011, as alleged in 12 WC 3577 (Arb Exh 2), or on April 18, 2011, as alleged in 12 WC 3578 (Arb Exh 4). Respondent stipulated to accident in 12 WC 3578 (Arb Exh 3) based on an employee incident report showing an accident date of April 18, 2011. T. 2/28/13 at 18. RX 1.

At the initial hearing, held on February 28, 2013, Petitioner testified she has worked as a certified nurse's assistant for Respondent for four years. T. 2/28/13 at 15. Her job involves assisting nurses with such tasks as transferring, bathing and toileting patients. The patients range in weight from 50 to 400 pounds. T. 2/28/13 at 15-16.

Petitioner denied having any back pain or undergoing any back-related care prior to her work accident. As of the accident, she was about three months pregnant. T. 2/28/13 at 16-17.

Petitioner testified that, immediately before the accident, she and a nurse were using a gait belt to transfer a patient from a bed onto a commode. T. 2/28/13 at 16. During the transfer, the patient grabbed Petitioner's mid-section, jolting Petitioner forward. Petitioner testified she experienced an immediate onset of excruciating lower back pain when this occurred. T. 2/28/13 at 21-22.

Petitioner testified the accident occurred on a Monday. T. 2/28/13 at 21. She was not sure whether it took place on Monday, April 11th or the following Monday. She continued working after the accident but her pain worsened. She was having trouble with ordinary activities such as caring for her children, bathing and getting dressed. T. 2/28/13 at 21-22. On April 30, 2011, she consulted a chiropractor, Dr. Battaglia. T. 2/28/13 at 22.

Dr. Battaglia's chart contains a "confidential patient data" form that appears to have been completed by Petitioner on April 30, 2011. The form reflects a history of shoulder surgery in 1998. It also reflects complaints of left-sided lower back pain, rated 10/10, and left hip pain, rated 9/10, of three days' duration.

Dr. Battaglia's initial typed note of April 30, 2011 sets forth the following history:

> "Mrs. Atlas indicated her major complaints developed as a result of an unknown specific cause but may be due to lifting patients at work 2 weeks ago. The symptoms have [been] constant for 2 weeks but worsened 3 days prior while

reaching overhead in a kitchen cabinet."

Dr. Battaglia also noted that Petitioner indicated she might be pregnant.

On lumbar spine examination, Dr. Battaglia noted a reduced range of motion, palpatory tenderness in the thoracic region through the sacrum on the left, muscle spasm in the lumbar region at L1 bilaterally through L5 bilaterally , extensive restrictions in the thoracic, lumbar and lumbosacral region and trigger point sensitivity. He also noted positive straight leg raising on the left at 30 degrees. The doctor did not obtain X-rays due to the possible pregnancy. He recommended a course of chiropractic care. PX 2. Petitioner testified this care consisted of heat applications, stimulation and manipulation. T. 23.

Petitioner returned to Dr. Battaglia on May 2, 2011, at which time the doctor noted slight improvement. PX 2.

Petitioner testified she notified Respondent of the accident and completed an incident report. The incident report (RX 1) is dated May 2, 2011. It bears the signatures of Petitioner and Carla Bock, R.N. It reflects that Petitioner injured her "lower left back" on April 18, 2011 while using a gait belt with a co-worker to transfer a patient from a bed to a commode.

On May 2, 2011, Petitioner saw Dr. Mochizuki at Respondent's direction. T. 23. She saw this physician at Respondent hospital. T. 2/28/13 at 23-24.

Dr. Mochizuki recorded the following history when he first saw Petitioner:

> "She is seeing me for a 1-2 week history of left low back and gluteal pain. This initially began after a transfer of a patient from bed to commode. She had another person assisting her. The patient also had a gait belt. The patient grabbed her during the transfer, however, and there was a slight jerk. She had some soreness of the low back. This remained in a fairly stable situation up until 4/28/11. At that time, she was reaching to grab a bowl at home and had a sudden increase in her discomfort extending to the gluteal region. At times, the hip feels 'unstable' when she is walking. The pain has reached 10 on a scale of 10. It does not extend into the extremities. There is no associated numbness, tingling or weakness."

Dr. Mochizuki noted that Petitioner had seen a chiropractor twice and was taking Motrin. He described Petitioner's past medical history as negative. He noted that Petitioner was "going to be evaluated for pregnancy."

On lumbar spine examination, Dr. Mochizuki noted limited forward flexion and extension, tenderness over the lumbar paraspinal muscles and into the mid belly of the fluteus maximum/medius, a full and painless range of hip motion with the exception of internal rotation and stretch to the piriformis/external rotators, negative straight leg raising and a slight asymmetry to pinprick over the medial foot, "being slightly reduced on the left."

Dr. Mochizuki assessed a "left lumbar and gluteal strain, improving." He indicated that "after some discussion," he agreed to allow Petitioner to continue with chiropractic care, since she was finding it helpful. He also recommended physical therapy. He took Petitioner off work and directed her to return in one week. PX 3. T. 24.

Petitioner returned to Dr. Battaglia on May 3, 2011, with the doctor noting "great improvement" of Petitioner's low back and left hip pain.

Petitioner began a course of physical therapy at Respondent hospital on May 2, 2011. The evaluating therapist, Christopher Egizio, PT, noted that Petitioner had injured her lower back about two weeks earlier "while attempting to transfer a patient from bed to commode" and had "exacerbated this condition recently while attempting to reach into an overhead cabinet with her left arm." Egizio noted that Petitioner complained of pain in the left side of her lower back radiating to her left lateral hip. He described Petitioner's gait and mobility as "significantly guarded." He was not able to fully examine Petitioner due to a "significant increase in left-sided lumbosacral region pain." The following day, May 3, 2011, Egizio noted that Petitioner complained of increased centralized low back pain while standing and performing exercises against a wall. He also noted that Petitioner reported having seen a chiropractor that day. Petitioner indicated she planned to return to this chiropractor on May 4th and 6th. Egizio stated he was placing therapy on hold until the chiropractic care had been completed. He further stated he planned to discuss this "conflict" with "Dr. Ron" (presumably Ronald Mochizuki, M.D.). PX 4.

On May 4, 2011, Petitioner returned to Dr. Battaglia and reported her low back pain had worsened since the therapy session. The doctor noted that "all future P.T. sessions were cancelled." He also noted that Petitioner reported her left hip pain typically began in the afternoon with walking.

On May 5, 2011, Dr. Battaglia noted an increased lumbar range of motion and a report of left hip pain the previous afternoon. He also noted that Petitioner's pregnancy had been confirmed via ultrasound. PX 2.

On May 6, 2011, Dr. Battaglia noted that Petitioner continued to report improvement but was still complaining of low back and left hip pain. PX 2.

Petitioner returned to Dr. Mochizuki on May 9, 2011. The doctor noted that Petitioner had experienced a flare-up of pain during a therapy evaluation, with therapy being discontinued thereafter in favor of ongoing chiropractic care. [Petitioner testified she

experienced excruciating pain during a therapy session when the therapist had her stand next to a wall and shift her hips to the right. T. 26]. Dr. Mochizuki also noted that Petitioner rated her current pain level at 3/10 and reported deriving improvement from electrical stimulation. He further noted that Petitioner reported being 16 weeks pregnant and seeing her obstetrician, who approved her current course of care as well as the use of Tylenol and Vicodin as needed. PX 3. T. 25. Petitioner testified she did not want to take Vicodin because of her pregnancy. T. 26.

On examination, Dr. Mochizuki noted a mild shift to the right, negative Trendelenburg's, full strength, pain with abduction of the left hip and tenderness along the gluteal muscles.

Dr. Mochizuki assessed Petitioner as having a "co-existing gluteal strain." He re-enrolled Petitioner in therapy to address this and continued the chiropractic care. He instructed Petitioner to stay off work for another week. PX 3.

Petitioner resumed physical therapy at Respondent hospital on May 13, 2011, with the therapist now noting a complaint of "central LBP" and left hip weakness. The therapist noted that Petitioner planned to return to her chiropractor and Dr. Battaglia. PX 4.

Petitioner continued seeing Dr. Battaglia thereafter.

On May 19, 2011, Petitioner returned to Dr. Mochizuki and reported experiencing another flare-up after re-starting therapy on May 13, 2011. Petitioner rated her pain at 4-5/10 and indicated her gluteal discomfort seemed to occur at the end of the day, after she had been up on her feet. Dr. Mochizuki did not indicate exactly where in the gluteal area Petitioner was experiencing pain. He noted that Petitioner was "finding it difficult to lift her 2-year-old child." He also noted that Petitioner "believes she could return to work with some limitation in lifting." He released Petitioner to light duty with no lifting over 10 pounds. He instructed Petitioner to return to him in one to two weeks. PX 3.

On May 25, 2011, Petitioner returned to Dr. Mochizuki. Petitioner reported having "continued with chiropractic." She indicated she did not attend scheduled therapy sessions due to a medical emergency involving her child. She rated her pain at about 2/10. The doctor indicated she reported being able to perform child care and housework "without problem."

On examination, Dr. Mochizuki noted that Petitioner was "moving in an unrestricted fashion." He noted no tenderness over the left gluteal region. He released Petitioner to full duty and discharged her from care. PX 3. T. 28.

RX 1, the employee incident report, reflects that Petitioner resumed working on May 30, 2011.

Petitioner testified that, after she resumed full duty, she experienced extreme lower back pain and difficulty performing her job. She was unable to lift patients and could not walk

fast enough to keep up with patients. T. 29. She continued seeing Dr. Battaglia and made him aware of these issues. T. 29.

Dr. Battaglia's records from May 26, 2011 through August 4, 2011 reflect that Petitioner regularly complained of low back pain. On June 21, 2011, the doctor noted a complaint of "right lateral thigh numbness and tingling." On July 5, 2011, the doctor noted that right hip flexion caused worsening pain in the right hip and sacroiliac joints. On July 12, 2011, the doctor noted that Petitioner reported worsening lower back pain during the preceding two days due to "pushing and lifting at work." Petitioner reported that her obstetrician had prescribed Flexeril. On July 19, 2011, the doctor noted complaints of sharp right-sided lower back and buttock pain. On August 4, 2011, Petitioner complained of low back and right hip pain. She also indicated that her right hip and SI "kept popping out." She told Dr. Battaglia she was leaving for a 2-week vacation that afternoon. PX 2.

On August 19, 2011, Petitioner returned to Dr. Battaglia and complained of pain in her right lower back and pelvis, as well as "aching" radiating down her right leg into the three lateral toes. The doctor noted that, while Petitioner was vacationing, her "low back/pelvis symptoms were worse on the right compared to the left side." PX 2.

On August 30, 2011, Petitioner saw Dr. Mochizuki for an "emergency re-evaluation." In his note of that date, the doctor indicated he had last seen Petitioner three months earlier for a left lumbar and gluteal strain. He also noted that Petitioner did fairly well for about two months after returning to work and "then took a month off and stayed with family in Florida where she did very little physical activity." He indicated that Petitioner remained symptomatic during this time, with her gluteal pain "shift[ing] from side to side." On that day, Petitioner described her pain as right-sided. Petitioner also complained of her hips occasionally "popping out" and significant low back pain extending to the right and into the third, fourth and fifth toes of her foot.

Dr. Mochizuki noted that Petitioner was tearful. On lumbar spine examination, he noted forward flexion limited to perhaps 10 or 15 degrees. Straight leg raising in a seated position was negative and strength was full. He noted tenderness over the right gluteus medius tendon, at the SI joint.

Dr. Mochizuki noted that Petitioner's obstetrician had given her Flexeril and Tramadol but that Petitioner was very reluctant to take these medications. He also noted that Petitioner was continuing to derive some transient improvement from chiropractic care.

Dr. Mochizuki noted that Petitioner declined his offer of physical therapy since she felt therapy had made her worse three or four months earlier. He indicated she was not a candidate for injections. He recommended she take the medication prescribed by her obstetrician. He also suggested she apply ice to the affected areas. He directed Petitioner to stay off work for two weeks and then return to him. PX 3.

Petitioner returned to Dr. Mochizuki on September 13, 2011 and again complained of back and right-sided radicular pain. On examination, the doctor noted some asymmetry to pinprick, reduced over the right medial knee and lateral foot, negative straight leg raising, forward flexion to about 45 degrees and "negligible" extension.

Dr. Mochizuki described Petitioner as having "persistent pain with very low tolerance for physical activity." He did not anticipate her being able to resume working before delivering her baby. He reiterated his previous recommendations and instructed Petitioner to stay off work for two more weeks. PX 3.

Petitioner also saw Dr. Battaglia on September 13, 2011. The doctor noted complaints relative to the right pelvis, right lower back and right leg. He indicated that Petitioner reported experiencing "the worst pain ever" the previous evening. PX 2.

On October 11, 2011, Petitioner returned to Dr. Battaglia and reported having lost her vision while driving over the weekend. Petitioner also reported undergoing a brain MRI at an unspecified hospital after this episode and being diagnosed with dehydration. Petitioner complained of lower back pain radiating into the right sacrum and mid-back. PX 2.

Petitioner testified she gave birth to a son on October 20, 2011. T. 32. On October 25, 2011, she returned to Dr. Mochizuki. The doctor noted complaints of continued pain in the mid and low back on the right with radiation into the right leg. He also noted that Petitioner complained of numbness and tingling in the second through fourth toes of her right foot.

Dr. Mochizuki described Petitioner as moving fluidly and walking normally. He described straight leg raising as "marginally positive." He noted that rotation of the right hip caused low back pain and that Petitioner complained of right-sided low back pain "in a fairly diffuse distribution." He prescribed an MRI and an EMG of the lower extremities. He also recommended that Petitioner re-start therapy and "begin a general conditioning program." He prescribed Skelaxin and Norco and instructed Petitioner to return to him in two weeks. PX 3.

The lumbar spine MRI, performed without contrast on November 7, 2011, showed "mild congenital narrowing of the central canal from the level of the L3 vertebral body down to the lumbosacral junction" and "mild degenerative disc and facet joint disease."

The EMG, performed the same day, was "essentially normal," per Dr. Mochizuki. The doctor noted "low level membrane irritability limited to the right paraspinal muscles." He indicated this "can be seen with underlying root irritation" but viewed it as "non-specific and non-diagnostic" in Petitioner's case. PX 3.

At Dr. Mochizuki's recommendation, Petitioner underwent an L3-L4 epidural steroid injection at Respondent hospital on November 10, 2011. T. 33-34. PX 4. She began a course of therapy at the hospital on November 28, 2011. T. 34. The evaluating therapist, Vincent Gutierrez, PT, noted a "major limitation with lumbar extension" and a "moderate limitation

with left side gliding in standing." Gutierrez noted no limitation with lumbar flexion or right side gliding. He noted gross lower extremity strength of 5/5 except for 4/5 strength in the right hip. He also noted "decreased light touch sensation at R S1 dermatome." PX 4.

Petitioner returned to Dr. Mochizuki on December 6, 2011. T. 34. She reported worsening of her back pain and a persistent headache since the injection. On examination, the doctor noted fairly smooth forward flexion to 80 degrees, extension to 20 degrees with some complaints of pain, some midline low back tenderness and negative seated straight leg raising.

Dr. Mochizuki described the MRI and EMG as "unrevealing." He recommended a trial of acupuncture and started Petitioner on Lidoderm patches and Celebrex. He instructed Petitioner to continue therapy and stay off work. PX 3. T. 34.

Petitioner next saw Dr. Mochizuki on December 13, 2011. The doctor noted that Petitioner described her pain as "horrible" that day. Petitioner was able to tolerate walking on a treadmill for only four minutes. She reported difficulty sleeping.

Dr. Mochizuki performed acupuncture. He started Petitioner on Elavil and recommended weekly acupuncture sessions and aqua therapy. Petitioner testified she participated in aqua therapy at a hospital-affiliated fitness center thereafter. T. 35. PX 3.

At the next visit, on January 3, 2012, Dr. Mochizuki noted that Petitioner did not respond to acupuncture but was finding aqua therapy helpful. On examination, he noted some limitation on flexion, full strength and no spasm. He released Petitioner to light duty and instructed her to return in three weeks. PX 3.

Petitioner testified she continued to stay off work after January 3, 2012 because Respondent was unable to provide light duty. T. 37-38.

On January 5, 2012, Petitioner went to the Emergency Room at Respondent hospital. The Emergency Room records set forth the following history:

> "C/o shooting pain from left lower back to ankle w/ numbness to the entire left foot. Onset abd 12 mn. States she has had numbness [in] the 3 outer toes of her rt foot. Pt states she injured her back on 11 April while transferring a pt. MRI done 2 mos ago after she delivered her baby. Tx by Dr. Ron in phys therapy."

Petitioner rated her pain level at 9/10. The Emergency Room physician, Dr. Borke, diagnosed an acute exacerbation of chronic back pain. She administered a Toradol injection. Petitioner was discharged with Valium and was instructed to seek follow-up care. PX 4.

A note in Dr. Battaglia's chart reflects that Petitioner called the doctor's office on January 17, 2012 and reported that a "W.C. physician" instructed her to discontinue all chiropractic visits. The note also reflects that Dr. Battaglia referred Petitioner to Dr. Nolden. PX 3. No records from Dr. Nolden are in evidence.

On January 24, 2012, Dr. Mochizuki noted that Petitioner reported feeling "miserable." On examination, he noted guarding with forward flexion, intact reflexes, full strength "with some give away weakness on the right," symmetric reflexes and negative seated straight leg raising.

Dr. Mochizuki noted that Petitioner did not respond to conservative care or medication. He described her examinations as "unrevealing." He referred Petitioner to the pain program at the Rehabilitation Institute of Chicago. He also noted that Petitioner was seeing Dr. Mekhail. PX 3.

Petitioner testified that Dr. Mochizuki recommended she see Dr. Mekhail. T. 39.

Petitioner first saw Dr. Mekhail on January 26, 2012. See the summary of Dr. Mekhail's deposition testimony below for his initial findings and treatment recommendations.

Petitioner testified that Respondent set up an appointment for her to be examined by Dr. Zelby on February 20, 2012. She did not attend this appointment because she did not receive notice of it until February 21, 2012. T. 43.

At Respondent's request, Petitioner saw Dr. Skaletsky for a Section 12 examination on March 8, 2012. The doctor's report of that date sets forth the following history:

> "This is a 28-year-old female who is employed as a CNA at Palos Community Hospital. She was in her usual state of good health until April 18, 2011. On that date, she was assisting in the transfer of a patient and the gentleman became agitated and grabbed her. She noted a twisting of her low back and the immediate onset of mild low back pain. about ten days later, she was reaching for a bowl at home and she had an acute worsening of her low back pain that began to radiate to the right lower extremity."

Dr. Skaletsky noted that Petitioner "was allowed to return to work at the end of May 2011," after undergoing therapy and chiropractic care, but remained symptomatic. He also noted that Petitioner eventually underwent two epidural steroid injections but reported only one day of pain relief following each of these. He indicated that, based on an MRI, Dr. Mekhail was not recommending a lumbar discogram.

Dr. Skaletsky noted that Petitioner denied any left leg involvement and complained of severe low back pain radiating down her right leg into her foot as well as right leg numbness. He also noted that Petitioner reported worsening of this pain with any activity.

Dr. Skaletsky indicated that Petitioner appeared "mildly uncomfortable" and was "tak[ing] weight off the right gluteal region while seated. He also indicated that Petitioner walked slowly, favoring her right leg. He described strength as "decreased slightly in the right lower extremity diffusely." He described sensory as "diminished diffusely and circumferentially on the entire right lower extremity." Minimal palpation to the skin of the lower back to the right of midline was "exquisitely painful." Lumbar range of motion was restricted to "no more than ten degrees in any direction." Straight leg raising caused lower back pain on the left at 75 degrees and on the right at 45 degrees.

Dr. Skaletsky indicated he reviewed CD-ROM images of the November 7, 2011 lumbar spine MRI. He interpreted the MRI as showing a "congenitally narrow spinal canal, but no evidence for central or lateral stenosis." He noted mild loss of hydration at L3-L4 and L5-S1 but "no herniation at any level."

Dr. Skaletsky indicated he reviewed records from Dr. Mochizuki and Dr. Mekhail along with various physical therapy notes.

Dr. Skaletsky assessed Petitioner as having chronic low back and right leg pain but he found "no anatomic or physiologic basis for her symptoms." He described Petitioner's neurologic examination as normal. He indicated that the normal EMG, "combined with the non-compressive results of the lumbar spine MRI scan, conclusively rule out any organic basis for the symptoms." He found no relationship between the "reported injury of April 28, 2011" and Petitioner's symptoms. He opined that Petitioner "was not injured at all on that date."

Dr. Skaletsky saw no need for any additional care. He stated that Petitioner is, "without question, not a candidate for lumbar discography or the consideration of any surgical procedure for the lumbar spine." He found Petitioner capable of full duty and unrestricted activity. RX 8A.

Petitioner underwent a lumbar discogram on May 4, 2012. Dr. Bayran performed this study. He noted a report of left-sided pain, rated 9/10, at L3-L4 and a report of bilateral pain, rated 10/10, at L5-S1. In his report, he described Petitioner's pain as "dis-concordant" at these two levels.

Petitioner testified she was lying face down during the discogram. She could not see what was going on behind her. T. 44-45.

Petitioner testified that, on May 21, 2012, Dr. Mekhail discussed the discogram results with her and prescribed physical therapy. T. 45-46. Petitioner performed that therapy at

Parkview Orthopaedics. T. 47. At the next visit, on June 21, 2012, Dr. Mekhail took her off work and prescribed a brace and a functional capacity evaluation. T. 47.

Petitioner underwent the functional capacity evaluation on July 12, 2012. T. 47. The evaluation was rated as valid. Petitioner tested out at the sedentary to light level, with the evaluator rating her CNA job at the medium level per the Dictionary of Occupational Titles. PX 1. At the evaluator's recommendation, Dr. Mekhail ordered a course of work conditioning. T. 48.

On August 6, 2012, Dr. Mekhail noted that Petitioner was still complaining of pain and numbness in her right leg. He also noted that Petitioner was making efforts to decrease her pain medication pursuant to his instructions. He prescribed an anti-inflammatory and a sleep aid. He instructed Petitioner to start work conditioning. He wrote out a slip imposing sedentary to light work, with no lifting over 15 pounds, but indicated restricted duty should be "held" until Petitioner finished work conditioning. PX 1, 14.

Petitioner testified she underwent the recommended work conditioning at ATI. T. 48-49. PX 1.

On August 14, 2012, the therapist overseeing the work conditioning noted that Petitioner entered the program at a sedentary level and reported low back pain with all activity. He also noted that Petitioner complained of occasional pain going down her right leg. He described Petitioner as "severely deconditioned." On August 21, 2012, the therapist indicated Petitioner was still functioning at a sedentary level. He stated she could benefit from a H-wave machine for home use. [Dr. Mekhail prescribed a 30-day trial of an H-Wave Homecare System on September 5, 2012, PX 11.] On August 28, 2012, the therapist noted that Petitioner had progressed to a light level. On September 4, 2012, he noted that Petitioner was progressing, strength-wise, but her pain levels had not decreased. He indicated Petitioner reported having injured her ankle due to her right leg giving out. On September 11, 2012, he noted that Petitioner complained of back pain while lifting but described her right ankle pain as improved. On September 18, 2012, he discharged Petitioner from work conditioning. He noted that Petitioner was still functioning at a light level. He also noted that he had not been able to decrease Petitioner's pain reports, despite the use of massage and H-wave therapy. He indicated Petitioner was "starting to have an increase in pain while walking." He recommended that Petitioner consult her physician. PX 1.

On September 20, 2012, Petitioner returned to Dr. Mekhail, with the doctor noting the discharge from work conditioning. The doctor indicated he was keeping Petitioner at light duty. He noted that Petitioner had cut back on her pain medication and was using only one Norco at night. He "urged [Petitioner] to continue exercising on her own" and recommended she return to him after undergoing a procedure recommended by Dr. Bayran. PX 1.

On October 15, 2012, Dr. Bayran found Petitioner to be a candidate for a percutaneous discectomy procedure. He noted he was still awaiting authorization for this procedure. He

released Petitioner to light duty, with no lifting over 25 pounds, and instructed her to continue her medication. PX 1.

At Respondent's request, Dr. Skaletsky re-examined Petitioner on November 27, 2012. Dr. Skaletsky also reviewed the records concerning the treatment conducted since his original examination.

Dr. Skaletsky again noted that Petitioner denied any left leg complaints. He indicated that Petitioner complained of low back pain radiating down her right leg to her foot, as well as right leg weakness. Petitioner reported having fallen on one occasion, spraining her right ankle, because her right leg gave out on her. Petitioner reported deriving some transient benefit from the H-wave machine. According to Dr. Skaletsky, Petitioner described herself as "very sedentary at home" and requiring assistance from family members to accomplish ordinary activities. Petitioner also reported that work conditioning increased her symptoms.

Dr. Skaletsky noted that Petitioner "appears to be in some discomfort" and "elevates the right hip and pelvis while seated." He described Petitioner as bending forward from the waist while walking, slightly favoring her right leg. He noted diminished strength diffusely in the right leg due to pain and decreased sensory on the outer aspect of the right leg. Lumbar range of motion was decreased by about 50% in all directions secondary to pain and straight leg raising was negative to 90 degrees bilaterally.

Dr. Skaletsky indicated he agreed with the radiologist's interpretation of the November 7, 2011 lumbar spine MRI and with Dr. Bayran's interpretation of the radiographic portion of the discogram.

Dr. Skaletsky indicated his previous opinions remained unchanged. He continued to view Petitioner's symptoms as non-anatomic. He indicated that Dr. Bayran's interpretation of the discogram ran counter to Dr. Mekhail's diagnosis of discogenic low back pain. He also indicated that, at the very least, the discogram ruled out the discs as the source of Petitioner's right-sided symptoms since the pain produced at L3-L4 was "to the left of midline with the annular tear on the left" and the pain at L5-S1 was bilateral, with "the contrast restricted to the left side of the disc." He found no reason for Petitioner to have undergone a discogram, noting that the study, by its nature, "requires the creation of an annular tear at the control levels."

Dr. Skaletsky noted that Petitioner's initial symptoms were left-sided, with the right-sided localization not starting until about four months after the work injury. He found "no anatomic or physiologic basis for this abrupt 'switching' of the sidedness of the pain." He found no relationship between the work accident and the right-sided symptoms.

Dr. Skaletsky indicated he was puzzled by Dr. Mekhail's testimony that Petitioner's pain contributed to disc degeneration. He stated there "is no medical basis for such a conclusion." Dr. Skaletsky stated there was no need for any kind of discectomy given that Petitioner "does not have a disc herniation of any kind at any level." He saw no need for Petitioner to use the H-

wave device since use of this device "forces immobility upon" Petitioner and "there is no carryover once the device is switched off."

Dr. Skaletsky opined that it would be not only safe but also beneficial for Petitioner to return to normal activities since "her current sedentary lifestyle is contributing to continuing deconditioning." He went on to state that, "though the functional capacity evaluation was considered valid, there was no objective basis for the limitation set forth." RX 8B.

Records in PX 6 reflect that, on December 27, 2012, Petitioner sought treatment at the Emergency Room at Silver Cross Hospital for chronic lower back pain dating back to the work accident. Petitioner indicated she had experienced an asthma attack earlier that day and "twisted funny" during the attack. Petitioner also indicated that, following the attack, she felt "increased pain in the right low back with worsening numbness in the right leg." The Emergency Room physician, Dr. Murino, noted a decreased range of lumbar spine motion and positive straight leg raising on the right at 30 degrees. He diagnosed an acute exacerbation of chronic low back pain. He administered Dilaudid and Norflex injections. He instructed Petitioner to continue taking Norco and start taking Valium and a Medrol Dose Pak. He also instructed Petitioner to follow up with Dr. Mekhail. PX 6.

Petitioner returned to Dr. Mekhail on December 28, 2012. The doctor's note reflects that, the day before, Petitioner bent over and coughed while having an asthma attack and felt pain and numbness in her right leg. The note also describes Petitioner's visit to the Emergency Room. On examination, the doctor noted "decreased sensation in the right lower extremity, more on the lateral aspect" and no weakness. He recommended a repeat lumbar spine MRI. PX 1.

Petitioner returned to Dr. Bayran on January 14, 2013 and noted she was still awaiting approval of the recommended repeat MRI. On examination, Dr. Bayran noted positive straight leg raising on the right. He noted Petitioner planned to follow up with Dr. Mekhail after the MRI. PX 1.

On January 26, 2013, Dr. Mekhail noted that Petitioner was still complaining of significant numbness in her right leg down to the foot. He indicated the repeat MRI "doesn't really show any significant neural compression to explain [the] symptoms." He prescribed Neurontin to "help [Petitioner] identify her numbness and tingling." PX 1.

On February 4, 2013, Dr. Bayran noted that Petitioner reported drowsiness secondary to the Neurontin. He again found Petitioner to be a candidate for a Disc-FX procedure or percutaneous discectomy. He indicated he was going to make an effort to have Petitioner's private health insurance approve this procedure. PX 1.

At Respondent's request, Dr. Skaletsky conducted a records review and issued a third report on February 14, 2013. In his report, he indicated he reviewed records from Dr. Bayran,

Dr. Mekheil and Respondent's Emergency Room, along with a report concerning the repeat lumbar spine MRI of January 22, 2013.

Dr. Skaletsky stated that the repeat MRI "shows the same results as" the previous MRI and the post-discogram CT scan. He indicated he did not review the repeat MRI scan but would do so if asked. He agreed with Dr. Mekhail's interpretation of the repeat MRI. He also indicated it was reasonable for Dr. Mekheil to order the repeat study based on Petitioner's history.

Dr. Skaletsky indicated that Petitioner's asthma-related episode of December 27, 2012 had no effect on her lumbar spine condition.

Dr. Skaletsky indicated he disagreed with Dr. Bayran's statement that the source of Petitioner's pain is discogenic, citing the "dis-concordant" discogram and post-discogram CT results.

Dr. Skaletsky again found Petitioner to be neurologically intact, in need of no further care and capable of full duty. RX 8C.

At the February 28, 2013 hearing, Petitioner complained of lower back pain radiating down her right leg. She also complained of numbness and tingling in her right leg. She feels less strong than she used to feel. T. 2/28/13 at 53-54. She remains under treatment and is still taking Norco, Neurontin and an anti-inflammatory. T. 2/28/13 at 52.

Petitioner testified that, while she was undergoing work conditioning, she received a call from Colleen of Respondent's employee health office. Colleen asked her if she would be willing and able to return to a light duty position in communications. Petitioner testified she told Colleen she was willing to perform light duty but was currently off work per her physician. She sent PX 14, which she described as an "off work" note, to Colleen via E-mail. [The Arbitrator notes that PX 14, Dr. Mekhail's note of August 6, 2012, discusses work restrictions but indicates that restricted duty should be "held" until Petitioner finished work conditioning.] She told Colleen she would perform light duty once she had completed work conditioning. T. 2/28/13 at 55-56.

Under cross-examination on February 28, 2013, Petitioner testified she began working as a CNA for Respondent on January 7, 2008. T. 2/28/13 at 57. At that time, she was categorized as a "point 8," meaning she worked four days a week. T. T. 2/28/13 at 57-58. At some later point, possibly in June of 2010, she changed to a "flex" position, meaning she could work as few or as many days as she was able. T. 2/28/13 at 59. She would advise Respondent hospital of her availability about a month in advance. During this time, she typically worked an eight-hour day shift on Mondays and Tuesdays. T. 2/28/13 at 60. She resides in Tinley Park, Illinois with her husband and three children. Her children are 1, 4 and 8 years old. T. 2/28/13 at 61-62. As of the accident, she was about three months pregnant with her third child. T. 63. She did not report the accident until May 2, 2011. T. 2/28/13 at 64. Between the accident and

May 2, 2011, she continued working but she is not sure how many days she worked. T. 2/28/13 at 64. On the day of the accident, she and a co-worker were using a gait belt together to transfer a female patient. She was in front of the patient. As they transferred the patient, the patient grabbed her mid-section and sat back on a commode, pulling her forward. T. 2/28/13 at 65. The accident occurred in Room 320, near bed 1. T. 2/28/13 at 66. Petitioner testified that she completed part of RX 1, an incident report dated May 2, 2011. RX 1 reflects an accident date of April 18, 2011 but there was uncertainty as to whether this date was correct. T. 2/28/13 at 67. She saw Dr. Mochizuki in employee health on May 2, 2011. T. 2/28/13 at 68.

Petitioner testified that, as a CNA, she would get assistance when she had to lift or transfer a heavy patient. She and her co-workers used gait belts, slide sheets and slide boards to transfer patients. T. 2/28/13 at 69. The individual who conducted her functional capacity evaluation was aware of the duties of a CNA. T. 2/28/13 at 70.

Petitioner testified she first saw Dr. Battaglia on April 30, 2011. She had never previously seen him. A family member had treated with him. T. 2/28/13 at 70. She did not see any medical provider between the accident and her first visit to Dr. Battaglia. T. 2/28/13 at 71. She continued working and caring for her family during that interval but she believes she called in sick on a day when she was scheduled to work. T. 2/28/13 at 71. Her husband works midnights. During the day she would be home with her children. T. 2/28/13 at 71-72.

Petitioner testified that, during her course of care with Dr. Battaglia, the doctor examined her on a regular basis and asked about the location of her pain. T. 2/28/13 at 72-75. He treated her with stimulation, heat and manipulation. He also applied tape to her back. T. 2/28/13 at 75. She told Dr. Battaglia about the work accident and a reaching incident that occurred at home. T. 2/28/13 at 73. Her back pain was initially left-sided but it also went into her right hip. T. 2/28/13 at 74.

Petitioner testified she told Dr. Mochizuki that throughout her pregnancy her low back complaints "switched back and forth" in terms of left versus right. T. 76. Initially, she complained of left-sided back, gluteal and hip pain. T. 77. She attended therapy at his direction. During the therapy, she performed core strengthening exercises. She also stood by a wall, shifting her hips. T. 2/28/13 at 79.

Petitioner did not recall Respondent offering her a light duty position during a different shift within Dr. Mochizuki's initial 10-pound lifting restriction. T. 2/28/13 at 80. Dr. Mochizuki released her to full duty on May 25, 2011. If his note of that date reflects that she had improved and was able to do housework and care for her children, the note is incorrect. T. 2/28/13 at 81. She was still in pain on May 25, 2011. T. 2/28/13 at 81-82. After May 25, 2011, she resumed her "flex" position with Respondent. T. 2/28/13 at 83. Between May 25 and late August 2011, she continued seeing Dr. Battaglia and obtained assistance from her husband, sister-in-law, parents, brother and neighbors in caring for her children. Everyone worked together to accommodate her. Up until May 25, 2011, her pain was left-sided. T. 2/28/13 at 83. It is possible that Dr. Battaglia first noted right-sided complaints on June 9, 2011. T.

2/28/13 at 85. In August of 2011, she took a family vacation to Florida. During this vacation, she relaxed while her parents took care of her children. T. 2/28/13 at 86. After the vacation, she resumed her "flex" work schedule. She also resumed treatment with Dr. Battaglia. T. 2/28/13 at 87. She first noticed right-sided symptoms in May, when she performed hip shifting exercises during therapy. T. 2/28/13 at 88-89. She believes she returned to Dr. Mochizuki on August 30th because that was the day her right leg gave out, causing her to fall onto a patient's bed. She reported this incident to Respondent. T. 2/28/13 at 89-90. Her obstetrician prescribed Flexeril and Tramadol for her in August 2011 but she did not take these medications on a regular basis. T. 2/28/13 at 91. She does not know when she first began experiencing pain radiating down into the toes of her right foot. She has limped for more than a year. T. 2/28/13 at 93-94. It is possible she refused to do therapy recommended by Dr. Mochizuki in September 2011. She was almost nine months pregnant at that point. T. 95. She continued seeing Dr. Battaglia during this same period. T. 2/28/13 at 97. She returned to Dr. Mochizuki five days after she gave birth. She was out on maternity leave from October 22 until December 7, 2011. T. 2/28/13 at 98. Her obstetrician did not place her off work during this period. T. 98. She did not obtain relief from the epidural injection Dr. Mochizuki prescribed on November 9, 2011. T. 2/28/13 at 100-101. It was after this that she underwent acupuncture at Dr. Mochizuki's recommendation. She recalls undergoing two acupuncture sessions. T. 101. She did not obtain relief from the acupuncture. T. 103. She sought Emergency Room care on January 5, 2012. It is possible her complaints were left-sided that day. On January 24, 2012, Dr. Mochizuki recommended she undergo treatment for chronic pain at the Rehabilitation Institute of Chicago. T. 2/28/13 at 103-104. She told Dr. Mochizuki she wanted to see Dr. Mekhail. Dr. Mochizuki did not tell her to go to Dr. Mekhail. T. 2/28/13 at 104. She first saw Dr. Mekhail two days later. T. 2/28/13 at 105. She is not sure whether she had already set up an appointment with Dr. Mekhail when she saw Dr. Mochizuki on January 24, 2012. T. 105. Since January 26, 2012, her complaints have been right-sided. T. 106. She told Dr. Mekhail about the treatment she had undergone to date. She brought Dr. Mekhail her MRI and possibly her EMG report. T. 2/28/13 at 108. She told Dr. Mekhail she underwent chiropractic care until about a week before she gave birth. T. 2/28/13 at 109. She told him her complaints varied in terms of left-sided versus right-sided. T. 2/28/13 at 110. She was not awake when Dr. Bayran inserted the needles during the discogram. When she woke up, the doctor asked her many times whether she could feel anything. T. 2/28/13 at 113. She could not see what the doctor was doing. She would rate her pain and state where she was feeling pain. T. 2/28/13 at 114. She returned to Dr. Mekhail after the discogram. She could not recall whether she was limping at that point. T. 2/28/13 at 116. Dr. Mekhail would refill Norco for her via telephone, without her having to see him. T. 2/28/13 at 116. She did not obtain Norco from any other physician. On May 21, 2012, Dr. Mekhail recommended she increase her activity level. He told her this would not be harmful. T. 2/28/13 at 117-118. It was after July 9, 2012 that Colleen Markham left a voice message for her indicating that Respondent had a temporary light duty position in central scheduling. She spoke with Markham, indicating she would love to work two days a week in central scheduling but that Dr. Mekhail still had her off work pending a functional capacity evaluation of July 12, 2012. T. 2/28/13 at 119. She later sent Markham an E-mail attaching PX 14, a slip reflecting a 15-pound lifting restriction. T. 2/28/13 at 121. She does not know whether the central scheduling job was a "flex" position. T. 2/28/13 at 121. Everything she

does causes pain. It is painful for her to walk, take a bath, go to the bathroom, sit and stand. She does not like to sit for more than a half hour. She avoids standing and walking for more than 20 minutes. T. 2/28/13 at 123. She can bend at the waist but it hurts to bend and twist. T. 2/28/13 at 124. She can lift lighter baby equipment. She has a stroller that weighs under 20 pounds. Her son weighed less than 20 pounds in the spring and summer of 2012. T. 2/28/13 at 125. Her family "does the majority of everything" for her. T. 2/28/13 at 126. On June 21, 2012, Dr. Mekhail recommended a functional capacity evaluation. As of that date, he had not mentioned work conditioning. T. 2/28/13 at 126. The functional capacity evaluation "wasn't fun." She had to lift as much as she could, walk while carrying weights, push, pull and stand while working at shoulder height. T. 2/28/13 at 127. On September 17, 2012, she complained to Dr. Bayran of her ankle. She did not complain of ankle numbness. Her leg gave out while she was on the stairs at home, causing her to fall and sprain her ankle. T. 2/28/13 at 127. She had ankle numbness before this incident. On October 15, 2012, she complained to Dr. Bayran only of back and tailbone pain. T. 2/28/13 at 130. She went to the Emergency Room at Silver Cross Hospital in December 2012. She bent over while having an asthma attack. When she stood up, she had stabbing pain in the right side of her lower back. T. 2/28/13 at 131. She was "beside herself" due to pain when she went to the Emergency Room. She received pain medication to tide her over to her appointment with Dr. Mekhail the following day. T. 2/28/13 at 132. It was after this that Dr. Mekhail prescribed another lumbar spine MRI. T. 133. Dr. Mekhail prescribed Neurontin on January 26, 2013. She no longer takes Neurontin. T. 134. Dr. Mekhail told her the repeat MRI did not show any changes. T. 135. After the discogram, she met with Dr. Bayran and he discussed possible procedures, pending approval. T. 137. After the Emergency Room visit, her symptoms worsened and her living arrangements changed. She is no longer able to lift her son. Her activity is "down to nothing." She now lives with her mother five days a week and at home two days a week. T. 137-138. After Respondent offered her light duty in July, she did not contact Respondent again to check on the availability of light duty. T. 140.

On redirect, Petitioner testified she continues to perform activities such as lifting and walking even those activities cause her pain. T. 2/28/13 at 140-142. She had no problems taking care of her children or performing routine activities before April 2011. T. 2/28/13 at 142. Dr. Mekhail is an orthopedic surgeon. She got to Dr. Mekhail via Dr. Battaglia. She and Dr. Battaglia had a conversation about her seeing a spine surgeon. She also discussed this idea with Dr. Mochizuki. T. 2/28/13 at 144. Dr. Mekhail instructed her to remain off work on June 21, 2012. She was off work per Dr. Mekhail when she received the call about the scheduling job. She does not recall Respondent offering her a light duty job at any point when she was subject to light duty restrictions. T. 2/28/13 at 151. She did not know Dr. Mekhail before her first visit to him. Dr. Mekhail had not treated anyone she knew. She first heard of Dr. Mekhail during her discussion with Dr. Mochizuki. T. 152. She no longer takes Neurontin because she felt as if this medication was making her slow and forgetful. She has not discussed this with Dr. Mekhail. T. 2/28/13 at 152-153.

Under re-cross, Petitioner testified she cannot recall being offered a job on a different shift after May 16, 2011, when Dr. Mochizuki released her to light duty. T. 2/28/13 at 153-154.

At a continued hearing, held on April 30, 2013, four investigators from PhotoFax testified on behalf of Respondent.

Marvin Suttles testified he has worked as a private investigator for PhotoFax for about a year. He is based in Georgia and covers the southeast region. T. 4/30/13 at 10-11, 14. Between 2007 and 2011, he served as an intelligence officer in the United States Army. T. 4/30/13 at 12. He has active private investigator licenses in Georgia and South Carolina. T. 4/30/13 at 14. He received an assignment, via E-mail, to conduct surveillance of Petitioner. On June 9, 2012, he parked at a spot about 75 yards from Petitioner's residence. He first observed Petitioner at 8:02 AM that day. T. 4/30/13 at 19, 28. As Petitioner exited her house, he started filming. He observed Petitioner bend at the waist and place some items inside her car. Petitioner then went back inside her house. T. 4/30/13 at 29-30. Later the same morning, he followed Petitioner as she drove from her house to Tinley Memorial Park. At the park, he saw Petitioner exit her vehicle and walk toward a baseball field. He did not capture this on film. At 8:33 AM, he started filming, although his view was obstructed at times. He observed Petitioner sitting down for "quite some time." T. 4/30/13 at 34. He also saw Petitioner pushing a stroller, lifting a small child, standing and placing the stroller and a folded chair in the back of her vehicle. He filmed these activities. T. 4/30/13 at 35. Petitioner then drove back to her house. Later he filmed her strap her child in the back seat and drive away. He lost her in traffic. T. 4/30/13 at 37. At around 12:12 PM, he filmed Petitioner as she removed a child from the back seat of her vehicle and went back in the house. T. 4/30/13 at 39. At 12:30 PM, he filmed her as she removed items from the trunk of the vehicle. T. 4/30/13 at 40. At 3:21 PM, he filmed Petitioner as she walked across the street and talked with an individual for a few minutes. T. 4/30/13 at 41. At 4:10 PM, he filmed Petitioner as she drove away from her house. He lost her in traffic again after that time. T. 4/30/13 at 42-43. He then went back to his hotel and secured his camera. T. 4/30/13 at 44. The next day, June 10, 2012, he filmed Petitioner twice as she pushed a stroller and bent over at the waist in order to pick up and drink from a water hose. T. 4/30/13 at 47-48. He never conducted surveillance of Petitioner after June 10, 2012.

Under cross-examination, **Suttles** testified he has never been a licensed private investigator in Illinois. T. 4/30/13 at 55. He underwent training after being hired by PhotoFax. T. 4/30/13 at 58-60. The surveillance he did of Petitioner was the first assignment he performed for PhotoFax after he completed training. T. 4/30/13 at 62, 66. A case manager sent him the assignment to conduct surveillance of Petitioner. The case manager informed him that Petitioner had a low back injury but did not send him medical records. He is not a doctor but he underwent some medical training in the Army. T. 4/30/13 at 65. He did not sign the report he generated. T. 4/30/13 at 67. His name does not appear anywhere in the report. T. 4/30/13 at 68. He does not know what items Petitioner placed in her vehicle. The video would show this. T. 4/30/13 at 68-70. In his report, he described Petitioner as moving fluidly. He did not see her grimacing. T. 4/30/13 at 73. He does not know the nature of Petitioner's back injury. It is possible Petitioner could have entered her vehicle in the manner he observed and yet still have had a back injury. T. 4/30/13 at 73. Someone else added information to his report. T. 4/30/13 at 82-83. RX 11B is not an accurate copy of the report he authored. T.

4/30/13 at 83. The weight of the hose Petitioner lifted would have been less than 10 pounds. T. 4/30/13 at 8485. He did not observe Petitioner doing yard work, washing windows or cleaning gutters. 4/30/13 at 86.

On redirect, **Suttles** testified he submitted his report electronically, which meant no signature could be affixed. T. 4/30/13 at 87. The case manager handled the billing-related aspects of the report. T. 4/30/13 at 88.

Under re-cross, **Suttles** conceded the video only shows portions of the two days he conducted surveillance. His job is to document activity. T. 4/30/13 at 91-92.

On further redirect, **Suttles** testified he might have turned the camera off during a time that Petitioner was sitting. At times, his view of Petitioner was obstructed. T. 4/30/13 at 93-95. At no time when he had the camera off did he observe Petitioner grimace, grab her back or limp. T. 4/30/13 at 95.

Nicholas Galvin testified he has worked for PhotoFax for a year. He is an investigator. T. 4/30/13 at 99. He served in the Marine Corps from October 2002 through October 2006. He did photography and worked in a photography lab while in the Marines. T. 4/30/13 at 100. After he got out of the Marines, he attended college and then began working for PhotoFax. T. 4/30/13 at 101. He is licensed in Illinois. He obtained a PERC card in May 2012. T. 4/30/13 at 101-103. He conducted surveillance of Petitioner on November 2 and 10, 2012. Another investigator, whose first name is "Vlad," worked with him those days. He received the surveillance assignment from Zarko Gligorevic, PhotoFax's "agent handler." T. 4/30/13 at 105-107. On November 2, 2012, he parked at a location 90 yards west of Petitioner's residence. T. 4/30/13 at 113, 124. On the morning of November 2, 2012, he observed Petitioner walking and carrying some "medium size" trash and a case of Coke. T. 4/30/13 at 114-115. He and "Vlad" combined their reports before E-mailing the reports to Zarko. T. 4/30/13 at 122. In the afternoon on November 2, 2012, he saw Petitioner get in her vehicle and drive away. T. 4/30/13 at 129. In his report, he indicated Petitioner remained stationary for an extended period. T. 4/30/13 at 130. On the morning of November 10, 2012, he filmed Petitioner intermittently for a total of 70 minutes. He would stop filming when Petitioner walked out of view. T. 4/30/13 at 137. At 2:01 PM, he again filmed Petitioner intermittently for a total of 140 minutes. T. 4/30/13 at 140.

Under cross-examination, **Galvin** testified he obtained an associate's degree. He had to be fingerprinted and undergo 20 hours of training in order to obtain his PERC card. T. 4/30/13 at 146. It is his belief that only a PERC card is required in order for an investigator to be licensed in Illinois. T. 4/30/13 at 147. He received information concerning Petitioner via E-mail. He was told that Petitioner had a back injury. T. 4/30/13 at 148. RX 15 is missing two pages and is not the complete report concerning his surveillance. T. 4/30/13 at 150. In his report, he indicated Petitioner appeared to be moving fluidly. To him, that means he did not see Petitioner limping. T. 4/30/13 at 157. He has no medical training. T. 4/30/13 at 160. He does not have a final copy of his report. T. 4/30/13 at 159-160. At one point, he observed Petitioner

"folding" Christmas lights. He did not see Petitioner climbing a ladder, lifting anything over 15 pounds, washing windows, cutting grass or trimming bushes. Nor did he see Petitioner go to a place where she appeared to be working. T. 4/30/13 at 162.

On redirect, **Galvin** indicated his job does not require him to author a cover letter for an investigation report. The case manager would prepare such a letter. A final copy of a report contains not only the surveillance report but a cover letter and a summary of what the surveillance showed. T. 4/30/13 at 171. PX 15 appears to be an accurate representation of his own entries. T. 4/30/13 at 172. He conducted surveillance of Petitioner on February 8 and 9, 2013. He did not observe Petitioner on February 8, 2013. On February 9, 2013, he saw Petitioner very briefly as she got in her vehicle and drove away. T. 4/30/13 at 174.

Under re-cross, **Galvin** acknowledged that PX 15 starts with "page 3" and that he does not know what the first two pages consisted of. Typically, the first two pages of a PhotoFax report consist of a cover letter to the customer and a summary of the investigator's surveillance. T. 179. In a very few cases, but not Petitioner's, he has knocked on an individual's door in order to determine whether the individual was home. T. 180-184.

Vlad Ivanyshyn testified he worked as a private investigator for PhotoFax from June 7, 2011 through April 1, 2013. T. 195. He has a PERC card which is valid until 2015. T. 196. He conducted surveillance of Petitioner on August 25, 2012, November 2, 2012, November 10, 2012 and February 27, 2013. T. 197. He received the assignments via E-mails from the case manager, Zarko Gligorevic. T. 199. He typically writes his surveillance reports at the scene, as soon as he has finished the surveillance. T. 201. On August 25, 2012, he first observed Petitioner at 11:32 AM. He took video of Petitioner as she walked across the street and then, a minute later, walked back across the street to her house. T. 211. At 12:59 PM, he again taped Petitioner as she walked across the street. He next saw Petitioner walk across the street at 1:26 PM but did not tape her because the action was "too short." T. 214. On November 2, 2012, at 10:10 AM, he "tailed" Petitioner to a Dunkin donuts drive-through. He lost Petitioner in traffic thereafter. T. 222. At 3:12 PM, he watched Petitioner arrive at Fulton School and carry a baby from her car to the school. He did not video this because there were cars blocking his view. T. 222-224. He continued watching and saw Petitioner walk back to her car with a second child in tow. T. 225-227. He did not video this either. On November 10, 2012, he sat outside Petitioner's house for eight hours but never saw her. He went home at 3:00 PM. T. 230. On February 27, 2013 he watched but did not tape Petitioner as she drove to a neighbor's house and "sat there for a couple of minutes." T. 232. A school bus subsequently arrived and Petitioner then drove home. At 3:01 PM, Petitioner drove by him. He noticed that she kept looking at him and his vehicle. T. 235. He left the area at 4:00 PM and went home. T. 235.

Under cross-examination, **Ivanyshyn** testified he graduated from college before he started working for PhotoFax. He left PhotoFax in order to remodel a condo and because it was "time to change gears." T. 240. A PERC card allows him to work as a security officer and a detective. T. 241. At PhotoFax, he underwent training for about 2 ½ weeks. T. 242. He was told that Petitioner had a back injury. He has no medical training. T. 242-243. His report (PX

15) begins on page 3. Pages 1 and 2 would have consisted of a cover letter thanking the customer and summarizing the surveillance. T. 243. PX 15 is not a complete copy of the report that PhotoFax sent to the customer. T. 244. There is no video to verify his comments as to what he observed at the school. T. 246-247. He used the term "fluidly" when describing Petitioner's movements to indicate Petitioner moved "normally." T. 247. If he wrote in a report that Petitioner moved fluidly at 11:32 AM, that means she moved in the same fashion the remainder of the day. T. 249. He never saw Petitioner shoveling snow or doing yard work. He saw Petitioner carrying a child. He would say the child weighed over 15 pounds, based on his own workouts, but he has no independent knowledge of the child's weight. T. 252. He never saw Petitioner going somewhere to work. T. 253.

On redirect, **Ivanyshyn** testified he would have noted it in his report if he had seen Petitioner going to a job or washing windows. T. 253.

Nicholas Boyd testified he worked as a surveillance investigator for PhotoFax from September 2010 to July 2012. T. 256. He previously worked for a different investigator, Kenneth Boyd. T. 257. He is licensed in Illinois via a PERC card. T. 258. PhotoFax employed people under their investigative license. T. 259. He conducted surveillance of Petitioner on Saturday, April 21, 2012. He received the assignment via an E-mail from Zarko Gligorevic. T. 260. He believes he received information indicating Petitioner had a low back injury and was subject to lifting restrictions. T. 4/1/13 at 261. He filmed Petitioner for 121 minutes on April 21, 2012. T. 262. He ended the surveillance at 3:00 PM that day and sent the video via SD card to PhotoFax. T. 4/1/13 at 267, 272.

Boyd testified that, on April 21, 2012, he arrived at Petitioner's residence at about 6:56 AM and established a surveillance position about 75 yards southeast of the residence. He first saw Petitioner at 8:58 AM. At that time, Petitioner walked to her vehicle, opened a rear door of the vehicle, removed a sports bag from the vehicle and set the bag on the ground. Petitioner then re-entered her residence. She came back out at about 8:59 or 9:00 AM, pulling a stroller with her right hand. She placed the stroller inside a vehicle, got in the vehicle and left as a passenger. T. 4/1/13 at 274-276. Boyd testified he tailed the vehicle and eventually found Petitioner at a park. He watched Petitioner as she watched a baseball game and eventually returned to the vehicle. He did not see Petitioner exit the vehicle. T. 4/1/13 at 279. He filmed Petitioner continuously for 121 minutes as she watched the game. T. 4/1/13 at 280-281. He also filmed Petitioner as she pushed a stroller from the field back to the vehicle and placed the stroller back in the vehicle. T. 4/1/13 at 282. He tailed the vehicle back to Petitioner's residence. Petitioner had arrived ahead of him and he did not see the bag or stroller again. T. 4/1/13 at 284. He remained outside the residence for another hour and fifty minutes and stopped for the day at 3:00 PM. T. 4/1/13 at 285.

Under cross-examination, Boyd reiterated he has a PERC card. He acknowledged that a PERC card is not equivalent to a private investigator's license. He would have to undergo additional training and gain additional experience in order to obtain a private investigator's license. T. 4/1/13 at 287. His father, Kenneth Boyd, is a licensed private investigator. Before

he performed surveillance of Petitioner, he was told that Petitioner had a low back injury and he reviewed some doctor's restrictions. T. 4/1/13 at 291-292. He cannot recall seeing Petitioner lift anything outside of her restrictions at any time on April 21, 2012. T. 4/1/13 at 292. He described Petitioner as moving fluidly, based on the manner in which she pushed the stroller across a large area. T. 4/1/13 at 294. He did not see Petitioner limp. T. 4/1/13 at 295. He has no medical training. An opinion as to the fluidity of Petitioner's motion or whether she exceeded her restrictions would be a medical opinion. T. 4/1/13 at 296. The exhibit marked as 11A R is his full report, which starts on page 3. He does not know what pages 1 and 2 consisted of. T. 4/1/13 at 297. He cannot testify that 11A R is a full copy of the report that was issued by PhotoFax. T. 4/1/13 at 298. He never observed Petitioner doing any yard work or going to alternate employment. T. 4/1/13 at 298-299.

At a continued hearing held on June 3, 2013, **Michael Sommerfeld** testified he has worked for PhotoFax for over five years. T. 6/3/13 at 6. He holds a PERC card in Illinois. T. 6/3/13 at 13. He conducted surveillance of Petitioner on October 19, 2012, after receiving some information concerning Petitioner via E-mail. T. 6/3/13 at 8. He relied on his report, RX 11 D/R, while testifying concerning this surveillance. T. 6/3/13 at 12. He arrived in Petitioner's neighborhood at about 7 AM on October 19, 2012 and positioned himself about 175 yards west of Petitioner's residence. T. 6/3/13 at 14. He first observed Petitioner at 8:06 AM, at which time Petitioner was using her right hand to push a very young child in a stroller. T. 6/3/13 at 15-16. Petitioner walked to a school bus stop, conversed with another female, waited for an older child to get on a school bus and then pushed the stroller back to her residence. T. 6/3/13 at 16. At 9:04 AM, Sommerfeld observed Petitioner leave her residence, while carrying a diaper bag, open the hatch of an SUV, place the bag inside the SUV, close the hatch and drive away. T. 6/3/13 at 17-19. Sommerfeld testified he tailed Petitioner to a Sam's Club store and filmed Petitioner as she walked into the store while carrying a very young child and holding the hand of an older child. T. 6/3/13 at 19-20. Sommerfeld then set up his "hidden camera," entered the store and intermittently filmed Petitioner as she tried on jackets, conversed with another woman and lifted her infant in and out of a shopping cart. T. 6/3/13 at 21-23. Sommerfeld then returned to his vehicle and filmed Petitioner as she exited the store at 9:40 AM, while pushing a shopping cart containing both children, winter jackets and a small box. T. 6/3/13 at 25-26. He continued filming as Petitioner opened the hatch of her vehicle, placed the jackets and box inside the vehicle, closed the hatch, placed the older child in a car seat and returned the cart to a "corral." Sommerfeld testified that, while Petitioner was returning the cart, she dropped her purse. He watched her bend at the waist and use her right hand to pick up the purse. T. 6/3/13 at 27. Sommerfeld testified he lost sight of Petitioner in traffic and went to Petitioner's house. Petitioner arrived at the house at 3:39 PM, removed the younger child from the vehicle and carried the child into her house. T. 6/3/13 at 30-31.

Sommerfeld testified he left Petitioner's residence at 5:00 PM, returned to his home, prepared his report and submitted his report and film to his "agent handler" via E-mail. T. 6/3/13 at 32. Sommerfeld testified that the disc marked as 11D contains the footage he obtained on October 19, 2012. He edited the footage only by removing some "descriptive footatge," i.e., footage showing the time and his general location. T. 6/3/13 at 36. The footage

on 11D does not show every activity he observed. It only shows the activities he filmed. T. 6/3/13 at 35-37.

Under cross-examination, Sommerfeld testified he does not know whether there is a distinction between the PERC card he holds and a private investigator's license. T. 6/3/13 at 38-39. He underwent training at PhotoFax in 2007. T. 6/3/13 at 39-40. PhotoFax has an office in Hampshire, Illinois. At that office, there is a file concerning the surveillance conducted in Petitioner's case. T. 6/3/13 at 41-42. His report begins on page 3. The first two pages of the report would be "on the final copy." T. 6/3/13 at 42. RX 11 D/R is thus not a complete copy of the report that PhotoFax generated concerning his surveillance. T. 6/3/13 at 42-43. His name appears nowhere on RX 11 D/R. His "agent handler" as of the surveillance was Zarko Gligorevic. T. 6/3/13 at 43. He does not know the weight of the infant, diaper bag or box that Petitioner carried. T. 6/3/13 at 44-45. He does not know whether Petitioner was subject to restrictions. T. 6/3/13 at 45. He never saw Petitioner working. He "edited" the video in the sense of removing descriptive footage and turning his camera off at times. T. 6/3/13 at 46.

On redirect, Sommerfeld testified that Zarko Gligorevic sent reports to clients. T. 6/3/13 at 49.

Under re-cross, Sommerfeld testified he described Petitioner as moving in a fluid and unrestricted manner. He did not see Petitioner hold back or use any assistive device or brace. He did not see "any signs of what appeared to be discomfort on [Petitioner's] face." T. 6/3/13 at 49-50. He used the phrase "fluid and unrestricted manner" at PhotoFax's direction. T. 6/3/13 at 50.

On further redirect, Sommerfeld clarified he used the term "fluid and unrestricted manner" if that term "fit" with what he observed. T. 6/3/13 at 50.

Under re-cross, Sommerfeld acknowledged he did not observe Petitioner throughout October 19, 2012. If Petitioner had difficulty performing an activity and he did not observe this, the difficulty would not be recorded in his report. T. 6/3/13 at 51.

Nebojsa Gligorevic testified he has worked for PhotoFax since May 2010. He is a field investigator. He has a PERC card but did not bring it to the hearing. T. 6/3/13 at 52-54. PhotoFax has a licensing department. Employees in this department told him how to go about obtaining a PERC card. T. 6/3/13 at 54.

Gligorevic testified he conducted surveillance of Petitioner on August 4, 2012, after receiving a "set-up sheet" and reports performed by other agents. T. 6/3/13 at 56-58. He arrived in Petitioner's neighborhood at about 8 AM on August 4, 2012 and established himself at a position that was about 75 yards away from Petitioner's house. T. 6/3/13 at 60. At 8:17 AM, he observed Petitioner for about six minutes as she placed a small child inside a SUV, took some garbage out of the SUV, carried the garbage out of view and closed the trunk of the SUV while bending at the waist. T. 6/3/13 at 61-62. During this time, he filmed only while Petitioner

was in view. T. 6/3/13 at 62. He filmed Petitioner as she got in the SUV and drove away. He tailed Petitioner to a Dunkin' Donuts that was about a mile or so from her house. Petitioner picked up something at the drive-through window, briefly parked her vehicle in a lot and then left. Petitioner did not exit her vehicle during this interval. T. 6/3/13 at 63-64. He resumed tailing Petitioner but stopped the surveillance after it became clear to him that Petitioner was aware of his presence. T. 6/3/13 at 64-65. He then went home, reviewed the footage, prepared his report and E-mailed the report to his case handler. T. 6/3/13 at 65-66, 68. His report accurately depicts what he observed. T. 6/3/13 at 69-70.

Under cross-examination, Gligorevic testified he and Zarko are cousins. T. 6/3/13 at 70. He has a PERC card but is not a licensed private detective. T. 6/3/13 at 70-71. He filmed Petitioner when she was in his view. T. 6/3/13 at 71. His report starts on page 3. He does not know what happened to pages 1 and 2. He did not author all of the material contained in RX 11C. RX 11C is not a complete copy of the report PhotoFax issued. T. 6/3/13 at 75.

On redirect, Gligorevic testified he re-watched the video he obtained on his computer before testifying. T. 6/3/13 at 76.

Zarko Gligorevic testified he has worked for PhotoFax for over five years. He started out as an investigator and became a case manager 1 ½ years ago. T. 6/3/13 at 77-78. As a case manager, he oversees surveillance conducted by other employees. He does not conduct surveillance on his own. T. 6/3/13 at 79. He reviews reports prepared by other employees. He also watches "parts of the films" taken by these employees. He does not edit the footage. T. 6/3/13 at 80. After he reads a report, he writes a "summary page" to make it easier for his client to understand the surveillance. T. 6/3/13 at 81. He was assigned to work on Petitioner's case because Petitioner lives in his assigned territory. T. 6/3/13 at 81. He has a PERC card. RX 14. With the exception of Marvin Suttles, all of the PhotoFax employees who performed surveillance in Petitioner's case have PERC cards. T. 6/3/13 at 83. PhotoFax conducts business in multiple states. PhotoFax has an Illinois license. T. 6/3/13 at 84. RX 13 is a copy of that license. T. 6/3/13 at 84-85. PhotoFax investigators have a 45-day grace period within which to obtain their PERC cards. T. 6/3/13 at 85-86. They undergo training at Respondent's headquarters in Hampshire, Illinois. T. 6/3/13 at 86. All the states have different requirements when it comes to licensing procedures. Some states do not require licenses. T. 6/3/13 at 87. When Marvin Suttles conducted surveillance of Petitioner, he was in the midst of training and did not yet have a PERC card. T. 6/3/13 at 87-88. The remaining investigators had PERC cards. T. 6/3/13 at 95. He [Gligorevic] communicated with Respondent's counsel during the course of this case. T. 6/3/13 at 96. In his "summary pages," he summarized the surveillance and made recommendations. T. 6/3/13 at 98. Based on RX 11S and RX C1, employees of PhotoFax conducted surveillance on January 25, January 26, February 8, February 9, February 14 and August 3 but did not observe Petitioner on those dates. T. 6/3/13 at 99-100. PhotoFax also conducted surveillance of Petitioner via an "unmanned drone," i.e., an "unmanned stationary vehicle" positioned outside Petitioner's house that had a camera that operated 24 hours per day. The camera was controlled via the Internet and via an investigator who was at PhotoFax's headquarters. T. 6/3/13 at 100. The drone surveillance footage is on RX 11H and H/R. That

footage was captured on February 21, 22, 23, 24 and 25, 2013. T. 6/3/13 at 102. The discs concerning this surveillance contain only the footage showing activity. On January 26, 2013, Petitioner was seen inside a vehicle. On the remaining dates, no activity was observed. T. 6/3/13 at 104.

Under cross-examination, Gligorevic testified he does not hold a private investigator license. He has a PERC card and works under PhotoFax's license. T. 6/3/13 at 105-106. He monitored the investigators who performed surveillance of Petitioner. T. 6/3/13 at 108. He cannot recall what type of injury Petitioner had. T. 6/3/13 at 110. At no point during the period of drone surveillance was Petitioner seen shoveling snow or performing heavy lifting. T. 6/3/13 at 133-134. PhotoFax employs about 150 individuals. He is not familiar with PhotoFax's human resources or licensing procedures. T. 6/3/13 at 136-138.

On redirect, Gligorevic testified that PhotoFax has a website but the website does not set forth information concerning PhotoFax's licenses. T. 6/3/13 at 141.

Nebojsa Gligorevic was recalled, over Petitioner's objection. Gligorevic testified he viewed a CD marked as RX 11C during a break. The CD shows all of the footage he obtained of Petitioner on August 4, 2012. T. 6/3/13 at 145-146.

Under cross-examination, Gligorevic acknowledged he did not re-check the SD card, during the break, to make sure the footage on the card was properly transferred to the CD. T. 6/3/13 at 148. As far as he knows, however, all of the film he took of Petitioner is on the CD. T. 6/3/13 at 148-149. The CD contains about 6 minutes of video. T. 6/3/13 at 151.

On redirect, Gligorevic testified that he remembers obtaining 6 minutes of video of Petitioner. The video on the CD correlates because it is 6 minutes long. T. 6/3/13 at 152-153.

Petitioner was recalled in rebuttal. She testified she returned to Dr. Mekhail on March 11, 2013. On that date, the doctor recommended she continue pain management with Dr. Bayran. She returned to Dr. Bayran on March 18, 2013. Dr. Bayran again recommended the Disc-FX procedure. He also directed her to continue her medications. T. 6/3/13 at 155-156. She underwent the recommended procedure on April 26, 2013. The procedure consisted of a two-level discectomy. She returned to Dr. Bayran on May 13, 2013. On that date, Dr. Bayran removed her stitches and prescribed physical therapy. She is currently attending therapy at ATI. She is in the fourth week of therapy. She is continuing to take Norco and Flexeril as needed. She remains off work. T. 6/3/13 at 158. She is scheduled to return to Dr. Bayran on June 10, 2013. She is "not 100%" but is "much better" since the surgery. She can walk more easily. She is not as strong as she used to be but she is "working on it." T. 6/3/13 at 159.

Under cross-examination, Petitioner testified that pre-operatively, her pain level was "anywhere from 10 and above." Now her pain level averages 4 to 5. At its worst, her pain level is 6 to 7. T. 6/3/13 at 161. Her pain is still in her lower back and down her right leg. T. 6/3/13 at 161. Strengthening is one of the goals at therapy. T. 6/3/13 at 162. She has watched the

surveillance videos. She is depicted in these videos. T. 6/3/13 at 162. The videos do not show her pain. They show she is "able to move a little bit." The videos "jump from segment to segment." The segments she watched show the activities she performed at the time of filming. T. 6/3/13 at 164.

On redirect, Petitioner acknowledged she did not watch every single video. Some of the videos show members of her family and a neighbor. The videos she watched did not show her family members providing assistance to her. T. 6/3/13 at 165.

In addition to the exhibits previously described, Petitioner offered into evidence the following bills: 1) ATI, work hardening and post-operative therapy, $13,751.63 (PX 8); 2) Parkview Orthopaedics Group (Drs. Mekhail and Bayran), $24,381.00 (PX 9); 3) Lindenhurst Anesthesia, 2/10/12 and 5/4/12 (Dr. Bayran), $4,045.24 (PX 10); 4) Electronic Waveform Lab, Inc., 10/2/12 (H-wave device prescribed by Dr. Mekhail), $414.92 (PX 11); and 5) Silver Cross Hospital, 12/27/12 (Emergency Room visit), $1,066.80 (PX 13). With respect to the ATI bill, Respondent offered into evidence documents reflecting it paid $7,072.42 to ATI on April 2, 2013. RX 12. Petitioner did not object to RX 12.

Petitioner also offered into evidence the deposition of Dr. Mekhail, taken on June 11, 2012. PX 7. Dr. Mekhail testified he is board certified in orthopedic surgery. He completed a four-year residency in Cairo and a five-year residency at the University of Illinois at Chicago. PX 7 at 6-7. After he finished the second residency, he underwent fellowship training in spine surgery at the Cleveland Clinic, followed by "mini-fellowships" in Nottingham, England and Miami. PX 7 at 8-9. He has authored articles in peer-reviewed journals. PX 7 at 9-10. He has privileges at various hospitals, including Respondent hospital. PX 7 at 10.

Dr. Mekhail testified he first saw Petitioner on January 26, 2012. On that date, Petitioner complained of low back pain radiating down her right leg. Petitioner indicated these symptoms started following a work injury on April 11, 2011. PX 7 at 11. Petitioner indicated she had undergone therapy per Dr. Mochizuki and one epidural injection. Petitioner complained of worsening and headaches since the injection. PX 7 at 11-12. Dr. Mekhail testified he questioned whether the injection had been performed properly, based on these complaints. PX 7 at 12. He reviewed the November 2011 MRI, which showed protrusions at L3-L4 and L5-S1. He viewed the degenerative changes at L5-S1 as "significant enough to explain [Petitioner's] right leg symptoms." PX 7 at 17-18. He recommended another injection and prescribed pain medication and an anti-inflammatory. PX 7 at 12. He discussed Petitioner's condition with Sonya Rose, R.N., a nurse case manager who was present that day. PX 7 at 12-13. Petitioner underwent the recommended second injection on February 10, 2012 and returned to him on February 20, 2012. Petitioner reported about 50% improvement of her right leg symptoms. Petitioner "wanted to explore surgical options because her pain had been going on for quite some time." PX 7 at 13. Dr. Mekhail testified there was a diagnostic component to the second injection, in that the injection alleviated some of the inflammation around the nerve root. PX 7 at 14. He recommended a discogram and released Petitioner to light duty. Petitioner underwent the discogram on May 4, 2012. The discogram, performed by

Dr. Bayran, "was positive at L3-4 and L5-S1." The "prominent finding on the MRI was L5-S1 and now [Petitioner] also had degeneration at L3-L4 by the discogram with some leakage of the dye and positive results at this level." PX 7 at 16.

Dr. Mekhail testified that, on May 21, 2012, following the discogram, he explained to Petitioner that, since the involved discs were not contiguous, he was "reluctant to just jump into surgery," especially given Petitioner's young age. Petitioner agreed. Dr. Mekhail prescribed four weeks of therapy. He clarified that he did not rule out surgery entirely. He simply wanted to "exhaust all conservative treatment." He also wanted to wean Petitioner off any pain medication, have her increase her activity level and strengthen her core muscles. By definition, Petitioner's pain was "now chronic." He anticipated that, with modalities and therapy, Petitioner's pain could be "contained" so as to avoid the need for surgery. PX 7 at 21-22.

Dr. Mekhail testified that, barring receipt of other information, he believed Petitioner's condition started "after her alleged injury at the hospital." PX 7 at 19.

Under cross-examination, Dr. Mekhail testified he did not recall reviewing any records concerning the treatment Petitioner had undergone before her first visit to him. PX 7 at 23. His notes reflect that it was Dr. Battaglia who referred Petitioner to him but he did not recall reviewing any records from Dr. Battaglia. PX 7 at 24-25. He was aware that Petitioner could not complete previously recommended therapy because she was pregnant. PX 7 at 26. Petitioner told him she was willing to undergo additional therapy. PX 7 at 26. He was not aware of the duration of Petitioner's chiropractic care. Nor was he aware of the type of treatment Dr. Mochizuki rendered. PX 7 at 27. Petitioner told him the therapy she previously underwent "made her worse." PX 7 at 28. Petitioner did not discuss the issue of child care with him. PX 7 at 28. He reviewed the MRI film as well as the report. PX 7 at 29. The pathology at L5-S1 would account for the leg symptoms. Pathology at L3-L4 would not cause pain "all the way down." PX 7 at 29. It would cause symptoms in the front of the thigh. Petitioner did not have such symptoms. PX 7 at 37. The degeneration he observed on the MRI pre-existed the work accident. PX 7 at 30. He characterized the degeneration as mild. PX 7 at 32. Tenderness to palpation is a clinical finding. It is up to the clinician to determine whether the tenderness is in an anatomic distribution. PX 7 at 33. When he checks for tenderness, he looks at the patient's face to check for a grimace. He also asks the patient if he has pain with palpation. PX 7 at 34. When he examined Petitioner, he described sensation, reflexes, power and straight leg raising as negative. PX 7 at 34. Petitioner did not voice any complaints relative to her feet. PX 7 at 35. Petitioner's negative EMG told him there was no nerve damage causing denervation of the muscles. PX 7 at 36. "A lot of people who have herniated discs have pain down the leg and they have normal EMGs." PX 7 at 36. He does not know when Petitioner's pregnancy took place in relation to the back-related treatment. PX 7 at 37. He is not saying that the person who performed the first epidural injection "did it wrong." Rather, Petitioner's post-injection headache suggests that the needle went farther than it should have, causing a cerebro-spinal fluid leak. PX 7 at 38. The "medicine" in the injection might not have reached the area it was intended to reach. PX 7 at 39. Dr. Bayran performed a second injection on February 10, 2012.

On February 20, 2012, Petitioner returned to him and reported 50% improvement of her right leg pain following the second injection. PX 7 at 41. He released Petitioner to light duty that day. When he uses the term "light duty," he typically means the patient is to lift no more than 20 pounds. PX 7 at 42. Petitioner could have performed light duty, with no lifting over 20 pounds, between February 20, 2012 and May 2012. PX 7 at 43. He relied on Dr. Bayran's discogram report. He viewed the discogram as positive at L3-L4 and L5-S1. PX 7 at 45. The MRI report mentions a small protrusion and mild congenital narrowing. It does not mention stenosis or impingement. PX 7 at 46. The chances are that the protrusion is causing chemical irritation. PX 7 at 46. His take is that it is the L5-S1 disc that is causing Petitioner's leg symptoms. PX 7 at 47. The L3-L4 disc may be contributing to Petitioner's back pain. PX 7 at 48. The L5-S1 disc is "definitely a culprit" which caused 10/10 pain during the discogram. PX 7 at 50. He did not see Dr. Mochizuki's recommendation of a pain management program and "can't agree with something [he] didn't see," but, as of the deposition, he would recommend therapy and then "gradually wean [Petitioner] off pain medication." PX 7 at 54. On February 20, 2012 he prescribed Ultram ER. On May 21, 2012, he prescribed Oxycontin to try to provide extended pain relief so as to allow Petitioner to participate in therapy. PX 7 at 55, 57. At that point, Petitioner was still on Norco for "breakthrough" pain. PX 7 at 55. He does not know from whom Petitioner was obtaining prescription refills between February and May 2012. PX 7 at 55. On May 21, 2012, he told Petitioner that, while her condition was painful, it was not serious and she should increase her activity level. PX 7 at 57. He does not know what activities, if any, Petitioner was engaging in at that point. PX 7 at 58. He expected Petitioner to experience pain while performing light duty. PX 7 at 60. Petitioner would be capable of bending but it would be painful for her to do so. PX 7 at 61. His charges are reasonable and customary but he does not know whether they have been reduced per the fee schedule. PX 7 at 64-65.

On redirect, Dr. Mekhail testified he is familiar with the job duties of a CNA but he cannot say whether those activities contributed to Petitioner's degenerative spinal condition. He can only say that the work injury aggravated that condition. PX 7 at 66. The MRI and discogram findings are objective in nature and consistent with Petitioner's subjective complaints. PX 7 at 66-67.

Under re-cross, Dr. Mekhail testified that Dr. Bayran probably performed the discogram at Parkview but he is not sure. PX 7 at 67.

Petitioner also offered into evidence updated records from Drs. Mekhail and Bayran. Those records show that, on March 11, 2013, Dr. Mekhail urged Petitioner to wean off her pain medication and kept her off work. They also show that Dr. Bayran recommended weight loss on March 18, 2013, prescribed Topamax on April 1, 2013 and refilled the Norco on April 16, 2013 after Petitioner reported side effects from the Topamax. PX 1. Dr. Bayran performed a percutaneous lumbar discectomy at L3-L4 and L5-S1 on April 26, 2013. At the end of this procedure, he instructed Petitioner to avoid bending and lifting and to lift no more than 10 pounds. On May 13, 2013, Dr. Bayran noted that Petitioner reported 75% to 80% pain relief following the procedure but was still taking Norco on an occasional basis. The doctor removed

Petitioner's stitches. He prescribed physical therapy and instructed Petitioner to "continue with Norco." He continued to keep Petitioner off work. PX 1. Petitioner underwent a therapy evaluation at ATI on May 14, 2013 and began attending therapy thereafter. PX 5.

In addition to the exhibits previously described, Respondent offered into evidence the deposition of Dr. Skaletsky, taken on February 19, 2013. RX 9.

Dr. Skaletsky testified he devotes 20% of his practice to evaluations, with 75% of those evaluations taking place in workers' compensation claims. RX 9 at 6. 85% of the evaluations he performs are for defendants. He devotes the remaining 80% of his practice to "evaluation and treatment without surgery." RX 9 at 6. He has not performed surgery since late 2001 due to a degenerative cervical spine condition. RX 9 at 7.

Dr. Skaletsky testified that, if a person had nerve impingement at L3-L4, he would typically experience pain from the back to the anterior thigh to the knee. If the impingement was at L5-S1, the individual would experience pain, numbness or weakness radiating down the posterior aspect of the leg to the lateral aspect of the foot and toes. RX 9 at 9.

Dr. Skaletsky testified he reviewed Petitioner's MRI scans and discogram. He saw no disc herniation that would cause nerve impingement. RX 9 at 10.

Dr. Skaletsky described a "Disc FX" as a minimally invasive discectomy. The indication for such a procedure is a herniated nucleus pulposus with appropriate clinical and radiographic symptoms. Nerve root irritation would have to be evident in order for a Disc-FX to be indicated. RX 9 at 16.

Dr. Skaletsky testified he reviewed Dr. Mekhail's records and deposition, along with the utilization reports, the Silver Cross records and the radiographic studies. He reviewed a DVD of the lumbar spine MRI performed on January 22, 2013. RX 9 at 20-21.

Dr. Skaletsky testified that Petitioner indicated her right lower extremity symptoms started when she reached for a bowl about ten days after the work accident. RX 9 at 22. Per his own review, the right-sided symptoms were first noted on August 30, 2011. RX 9 at 33. Petitioner appeared uncomfortable during his initial examination. She was "sitting crooked," leaning toward her left. On examination, he noted slightly decreased strength diffusely in the right lower extremity. RX 9 at 24-25. He attributed this to pain as opposed to any neurological injury. RX 9 at 26. He also noted decreased sensation in the entire right leg. This was non-anatomic. RX 9 at 27-28.

Dr. Skaletsky testified that the DVD of the lumbar spine MRI performed on November 7, 2011 showed congenital narrowing but no stenosis. RX 9 at 31.

Dr. Skaletsky testified there was no neurological basis for the shifting of Petitioner's symptoms from left to right. RX 9 at 34.

Dr. Skaletsky testified the negative EMG was indicative of no radiculopathy. An EMG is 90% accurate for this. RX 9 at 35.

Dr. Skaletsky testified that Dr. Mochizuki's referral to the pain program at the Rehabilitation Institute of Chicago was "appropriate when made." RX 9 at 39-40.

Dr. Skaletsky testified that, as of his initial examination, Petitioner needed no treatment and was capable of full duty. RX 9 at 44. He re-examined Petitioner on November 27, 2012, following the discogram. Petitioner again seemed uncomfortable and exhibited a slight limp. RX 9 at 51. The discogram showed the dye to be concentrated on the left side at L5-S1 but Petitioner's symptoms were all right-sided. Petitioner's pain was thus non-concordant. Dr. Bayran used the term "dis-concordant" when describing both tested levels. RX 9 at 56.

Dr. Skaletsky opined there was no need for a functional capacity evaluation since Petitioner's neurological examination was unremarkable. RX 9 at 62. The functional capacity evaluation results were attributable to deconditioning. They were non-anatomical. RX 9 at 70.

Dr. Skaletsky testified it was reasonable for Dr. Mekhail to order another lumbar spine MRI on December 28, 2012, following Petitioner's visit to the Emergency Room, but the need for this MRI did not stem from the work accident. RX 9 at 72. The results of the repeat MRI were essentially unchanged. RX 9 at 73.

Under cross-examination, Dr. Skaletsky admitted he has no privileges at any hospital, is not currently a member of any professional organization and has never published in a peer review journal. RX 9 at 76-78. Dr. Skaletsky further admitted he is unable to identify any publication that would be considered authoritative in the field of neurosurgery. RX 9 at 79. He sees examinees twice weekly in a chiropractic office located in a strip mall. The office is owned by his neighbor, a chiropractor. RX 9 at 79. Dr. Skaletsky admitted he "eyeballs" when it comes to measuring range of motion. RX 9 at 80. He has had no malpractice insurance for more than ten years. RX 9 at 80. Through 2002, he gave at least one deposition per week. RX 9 at 84. In the workers' compensation arena, virtually all of the reviews he performs are for respondents. RX 9 at 86. In 2005, he was retained by a defendant in a motor vehicle case involving a plaintiff named "Roti." In that case, he opined that Roti did not establish causation or permanency. Five years later, he was retained by Roti in a subrogation action arising out of the same accident. He did not perform a conflict check. In the subrogation action, he opined that Roti established an aggravation and the need for surgery. RX 9 at 91-92. He does not believe Petitioner is "faking" or lying about her symptoms. RX 9 at 93. Petitioner's perception is that she is experiencing pain in her lower back radiating into her right leg. RX 9 at 93. Since he is not a neuropsychiatrist, he cannot say whether that pain is psychosomatic. RX 9 at 94. The more information he receives, the more "refined" his opinions are going to be. RX 9 at 95. In his March 8, 2012 report, he mentioned that Petitioner was undergoing chiropractic care but he never reviewed or asked to review any chiropractic records. RX 9 at 96-97. On March 8, 2012, he noted that Petitioner denied having any low back problems prior to the work accident. RX 9

at 98. He has no evidence indicating that Petitioner had symptomatic degenerative changes in her lower back before the work accident. RX 9 at 99. If a person has a symptomatic herniated disc, he would likely have spasm. RX 9 at 101. The November 7, 2011 MRI was technically nor normal since it showed mild dehydration. The radiologist did not read this MRI as normal. RX 9 at 103. The radiologist noted protrusions at two levels. A protrusion is not a normal finding. RX 9 at 104. Dr. Skaletsky attaches great significance to the fact that Petitioner originally had left-sided symptoms. He noted the onset of right-sided symptoms on August 30, 2011 but if those symptoms were actually noted earlier, it would not affect his opinions. RX 9 at 105, 129. In 10 to 15% of the cases, a person can have radiculopathy and yet have a negative EMG. RX 9 at 106. He receives $750/hour with a two hour minimum for depositions. He charged $1,250 for his examination and report of March 8, 2012. RX 9 at 111. The discogram that Dr. Bayran performed was not reasonable or necessary. The discogram was, in fact, potentially harmful but Dr. Bayran did not commit malpractice in performing it. There is literature indicating that a discogram is reasonable for a patient with low back pain. RX 9 at 112. In his discogram report, Dr. Bayran noted internal disruption of the L3-L4 disc and no abnormalities of the L4-L5 disc. With respect to the L5-S1 level, Dr. Bayran noted that the contrast remained on the left side of the disc and that Petitioner reported 10/10 pain on both the left and right sides. RX 9 at 114. The provocative portion of a discogram is subjective but the radiographic portion is objective. RX 9 at 114. In the body of his report, Dr. Bayran described L3-L4 and L5-S1 as positive for concordant pain. Because he viewed the L4-L5 disc as non-concordant, he went on to test the L2-L3 disc. He found no concordant pain at L2-L3. RX 9 at 114-115. Dr. Skaletsky does not consider Dr. Bayran's conclusion as containing a typographical error. RX 9 at 116. He disagrees with Dr. Mekhail's statement that there was concordant pain at L3-L4 and L5-S1. RX 9 at 118. Dr. Skaletsky testified he disagrees with the results of the functional capacity evaluation. RX 9 at 121, 130. He does not, however, believe that Petitioner "faked" the evaluation. RX 9 at 121. A centrally herniated disc can cause symptoms on either the left or right side, but only if it is compressive. RX 9 at 121. Dr. Skaletsky testified he disagrees with all of Dr. Bayran's conclusions and recommendations. He does not believe that surgery is warranted. RX 9 at 125. Surgery would be inappropriate for Petitioner but he (Dr. Skaletsky) cannot say that it would constitute malpractice "because there is literature indicating that a percutaneous discectomy is an accepted method of treating" back pain. RX 9 at 126. He has never opined that Petitioner is malingering. RX 9 at 132.

On redirect, Dr. Skaletsky testified the discogram findings are consistent with Dr. Bayran's conclusion that Petitioner has "dis-concordant" pain at L3-L4 and L5-S1. Petitioner presented to Dr. Bayran with right-sided symptoms and the provocative portion of the discogram caused left-sided pain. RX 9 at 134. Dr. Bayran's typed note states Petitioner's pain was concordant but the handwritten notes state that she described her pain as on the left going to the right. RX 9 at 136. Dr. Skaletsky testified he agrees with Dr. Mekhail's testimony that Petitioner's MRI showed a small herniation with no foraminal stenosis. He disagrees only with Dr. Mekhail's suggestion that the protrusion could be causing chemical irritation. RX 9 at 137. There would have to be an annular tear in order for there to be chemical irritation but there was no annular tear. RX 9 at 138.

Under re-cross, Dr. Skaletsky reiterated that "dis-concordant" pain is unrelated to the pain complaints voiced by a patient. He does not know why Dr. Bayran is recommending a discectomy since, in his conclusion, he described two discs as "dis-concordant." RX 9 at 139.

[CONT'D]

Arbitrator's Credibility Assessment

Petitioner was an articulate witness. At the initial hearing, she became emotional while testifying to a high level of pain and dysfunction. She indicated she regularly required and received assistance from family members and friends in order to care for her children and perform other routine activities. When she was recalled to the stand on June 3, 2013, she acknowledged that the surveillance videos do not depict this type of assistance. She also testified that the videos do not "show her pain."

At the outset, the Arbitrator clarifies she has given consideration to all of the PhotoFax reports and videos. The Arbitrator has not disregarded any of the surveillance based on license-related considerations.

The surveillance in this case was extensive, with Respondent eventually resorting to unmanned drone observation of Petitioner's residence in February 2013, shortly before the first hearing. The investigators who testified in this case acknowledged they were not always able to see Petitioner clearly. They typically did not film Petitioner when their view of her was obstructed. Much of the footage shows Petitioner engaging in driving, shopping, pushing and occasionally lifting a stroller and caring for her children, without assistance from others. It does not show Petitioner engaging in employment or vigorous physical activity. In June of 2012, Petitioner can be seen bending at the waist in order to pick up a garden hose. On November 10, 2012, Petitioner can be seen helping an unidentified male hang Christmas lights outside her house. The male uses the ladder while Petitioner remains on the ground. Petitioner stands for fairly long intervals, reaches overhead to string lights and occasionally bends at the waist. The Arbitrator finds these activities consistent with Dr. Mekhail's May 21, 2012 recommendation that Petitioner increase her activity level and with the valid functional capacity evaluation of July 12, 2012.

In assessing Petitioner's credibility, the Arbitrator notes that Dr. Mochizuki, Respondent's employee health physician, treated Petitioner over a lengthy period and did not note any positive Waddell signs or symptom magnification. He recommended continued care when he last saw Petitioner on January 24, 2012. PX 3. Dr. Skaletsky, Respondent's Section 12 examiner, described Petitioner's examination as objectively normal but nevertheless diagnosed a pain syndrome. He did not view Petitioner as malingering.

While there are some discrepancies between Petitioner's testimony and the videos, the Arbitrator finds Petitioner credible overall.

Did Petitioner's undisputed work accident occur on April 18, 2011?

As stated at the outset, there was some uncertainty as to whether Petitioner's undisputed work accident occurred on April 11, 2011, as alleged in 12 WC 3577, or on April 18, 2011, as alleged in the instant case. Petitioner testified the accident occurred on a Monday in April. T. 2/28/13 at 21. RX 7, an employee incident report signed by Petitioner and Carla Bock, R.N. on May 2, 2011, reflects a date of injury of April 18, 2011.

Based on the incident report and Respondent's stipulation in 12 WC 3578, the Arbitrator finds that the accident occurred on April 18, 2011.

Did Petitioner establish a causal connection between the accident of April 18, 2011 and her current condition of ill-being?

The Arbitrator finds that Petitioner established a causal connection between the work accident of April 18, 2011 and her current condition of ill-being. In so finding, the Arbitrator relies in part on Petitioner's credible denial of pre-accident back problems and the fact that Petitioner was able to perform the lifting/maneuvering required of a CNA for four years prior to the accident. The Arbitrator also relies on the records of Drs. Battaglia, Mochizuki and Mekhail.

In finding causation, the Arbitrator acknowledges that Petitioner continued working for a period following the work accident and did not seek care until after a second incident, i.e., reaching into a cabinet for a bowl, which occurred at home. The Arbitrator notes that, when Petitioner first gave a history to a medical provider, Dr. Battaglia, she linked the onset of symptoms to patient lifting performed two weeks earlier and described the home incident as having caused those symptoms to worsen. She provided essentially the same history to Dr. Mochizuki. The Arbitrator views the home incident, which consisted of a relatively innocuous activity, as an aggravation rather than an intervening event. The Arbitrator also views Petitioner's condition as being further aggravated by the physical therapy she underwent on May 3, 2011 and her resumption of work activities in July 2011.

The Arbitrator also acknowledges that Petitioner's symptoms, which were initially left-sided, evolved over time. The Arbitrator attributes part of this change to the therapy-related aggravation. Petitioner testified to a new onset of excruciating pain during therapy, when she was standing against a wall and shifting her hips to the right. T. 2/28/13 at 26-27. The therapy note dated May 3, 2011 supports this testimony, with the therapist describing Petitioner's original left-sided complaints as "centralizing" that day. It was after this therapy session and Petitioner's resumption of CNA duties that Petitioner's providers began documenting right-sided pain. Petitioner's pain was by no means exclusively right-sided after May 3, 2011 but the records and testimony, when examined in detail, provide an explanation for the change.

The Arbitrator further finds a causal relationship between the work accident and the

Disc-FX procedure performed by Dr. Bayran. In so finding, the Arbitrator relies in part on the radiologist's interpretation of the November 7, 2011 MRI and on Dr. Bayran's handwritten notes concerning the discogram results. The Arbitrator also relies on Dr. Mekhail's records (especially his note of May 21, 2012) and testimony. The Arbitrator finds Dr. Mekhail infinitely more credible than Dr. Skaletsky. Dr. Mekhail is a fellowship-trained spine surgeon who regularly treats patients like Petitioner. He has privileges at Respondent hospital. He saw Petitioner over an extended period while Dr. Skaletsky saw her twice. The Arbitrator finds not credible Dr. Skaletsky's testimony that he devotes 80% of his time to patient care, given his admission that he has not had malpractice coverage for more than ten years. The Arbitrator also notes that Dr. Skaletsky did not have an accurate understanding of when Petitioner's right-sided symptoms began. He testified that those symptoms were first documented on August 30, 2011 (which would have been after Petitioner's vacation). That is not correct. The Arbitrator further notes Dr. Skaletsky's admission that, in the workers' compensation arena, he performs virtually all of his consulting for employers and obtains referrals from only one claimant's attorney. The Arbitrator views Dr. Skaletsky's opinions as to Petitioner's work capacity as inconsistent with the valid functional capacity evaluation.

As indicated earlier, Dr. Skaletsky made some significant concessions during his deposition. He clarified he viewed Petitioner as having a pain condition. He did not view Petitioner as malingering. He agreed with Dr. Mochizuki's recommendation of formal pain management, at least at the point at which that recommendation was made.

In discussing causation, it is also necessary to discuss some evidentiary issues. Petitioner's counsel argued that the Arbitrator should not consider Dr. Skaletsky's CV or examination reports since Respondent's counsel marked these as exhibits at the doctor's deposition but failed to offer them into evidence at that time. RX 9. Upon review of Dr. Mekhail's deposition (PX 7), the Arbitrator notes that virtually the same thing occurred. Petitioner's counsel was under the impression that he offered the doctor's lengthy CV and itemized bill into evidence but he never did so. The Arbitrator has elected to admit and consider all of the exhibits discussed at both depositions. The Arbitrator views Dr. Skaletsky's reports (Skaletsky Dep Exh 2-4) as largely cumulative in nature and not particularly helpful to Respondent. The Arbitrator notes that Dr. Skaletsky's first report, Dep Exh 2, contains an error in that it reflects Petitioner's right-sided symptoms started with the reaching incident at home. In his second report (Dep Exh 3), the doctor described Petitioner's symptoms as "abruptly switching" from the left to the right four months after the work accident. This is also erroneous. In his third report (Dep Exh 4), he indicated that no right-sided symptoms were noted until six months after the work accident. This, too, is erroneous.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims two intervals of temporary total disability benefits: May 2, 2011 through May 25, 2011 and August 30, 2011 through June 3, 2013. Arb Exh 3. T. 4/30/13 at 6-

7. At the initial hearing, Respondent stipulated Petitioner was temporarily totally disabled from May 2, 2011 through May 25, 2011, from August 31, 2011 through October 22, 2011 and from December 7, 2011 through March 24, 2012. Arb Exh 3. T. 2/28/13 at 8-9.

Respondent's counsel questioned Petitioner as to whether she was offered temporary light duty. Petitioner acknowledged the offer but testified she received it after August 6, 2012. PX 14 shows that Dr. Mekhail imposed restrictions on August 6, 2012 but simultaneously indicated restricted duty should be "held" until Petitioner finished work conditioning. There is no evidence indicating Respondent made another offer of light duty later on.

Having found in Petitioner's favor on the issue of causation, the Arbitrator finds that Petitioner was temporarily totally disabled from May 2, 2011 through May 25, 2011 (a period of 3 3/7 weeks) and from August 31, 2011 (the day after Dr. Mochizuki took Petitioner off work) through the last hearing of June 3, 2013 (a period of 91 6/7 weeks). These two intervals total 95 2/7 weeks. In accordance with the parties' stipulations, Respondent is entitled to credit for the benefits it paid prior to hearing. Arb Exh 3.

Is Petitioner entitled to medical expenses?

Based on the foregoing causation-related findings and noting that Petitioner reported improvement following the Disc-FX procedure of April 2013, the Arbitrator awards Petitioner the following medical expenses, subject to the fee schedule: 1) ATI, $13,751.63 (PX 8); 2) Parkview Orthopaedics Group, $24,381.00 (PX 9); 3) Lindenhurst Anesthesia, $4,045.24 (PX 10); 4) Electronic Waveform Lab, $414.92 (PX 11); and 5) Silver Cross Hospital, $1,066.80 (PX 13). The Arbitrator bases the award of the $414.92 in expenses relating to the H-wave device on the work conditioning notes, which reflect that Petitioner's therapist recommended Petitioner use such a device at home. Dr. Skaletsky testified this device would provide only transient relief but Section 8(a) of the Act contemplates palliative, as well as curative, treatment.

Respondent is entitled to credit for the $7,072.42 payment it made to ATI on April 2, 2013. RX 12.

Is Respondent liable for penalties and fees?

The Arbitrator declines to award penalties and fees in this case, as requested by Petitioner. While the Arbitrator places no stock in the opinions of Dr. Skaletsky, Respondent's Section 12 examiner, the Arbitrator does not view Respondent as acting in an objectively unreasonable manner in disputing causation in this case, given the various aggravating events and the discrepancies between Petitioner's reported extreme pain levels and some of the surveillance footage.

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

Angeline Collins,
Petitioner,
vs.
State of Illinois/Shawnee Correctional Center,
Respondent,

NO: 10 WC 40504
14IWCC0716

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, causal connection, medical expenses, prospective medical expenses, notice, whether Petitioner exceeded her 2 choices of doctors, 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 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.

No bond or summons for State of Illinois cases.

DATED: AUG 2 2 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
0:6/25/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COLLINS, ANGELINE
Employee/Petitioner

Case# **10WC040504**

14IWCC0716

SOI/SHAWNEE CORRECTIONAL CENTER
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:

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
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 16 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0716

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

Angeline Collins
Employee/Petitioner

v.

State of Illinois / Shawnee Correctional Center
Employer/Respondent

Case # 10 WC 40504

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 **Herrin**, on **March 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 **has Petitioner exceeded her choice of physicians**

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 **$41,184.00**; the average weekly wage was **$792.00**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Temporary Total Disability: Respondent shall pay Petitioner temporary total disability benefits of **$528.00**/week for **24** weeks, commencing **5/5/11-7/20/11** and **9/7/11-12/8/11**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **9/14/10** through **present**, and shall pay the remainder of the award, if any, in weekly payments.

Permanent Partial Disability: Respondent shall pay Petitioner permanent partial disability benefits of **$475.20**/week for **114.5** weeks, because the injuries sustained caused the **12.5%** loss of the **right and left hands (51.25 weeks)**, the **12.5%** loss of the **right and left arms (63.25 weeks)**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$475.20**/week for **75** weeks, because the injuries sustained caused the **15%** loss of the person as a whole (shoulder), as provided in Section 8(d)2 of the Act.

Medical Services: Respondent shall pay reasonable and necessary medical services of **$151,713.75**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

June 15, 2013
Date

JUL 16 2013

14IWCC0716

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angeline Collins,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 10 WC 40504**
	)	
State of Illinois,	)	
Shawnee Correctional Center,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on September 14, 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. They further agree that the Petitioner gave the Respondent notice of the accident which is the subject matter of this hearing involving except with respect to the left elbow within the time limits stated in the Act.

At issue in this hearing is as follows: (1) On September 14, 2010, did the Petitioner sustain an accidental injury or was she last exposed to an occupational disease that arose out of and in the course of the employment; (2) Did the Petitioner give the Respondent notice of the accident with respect to the left elbow within the time limits stated in the Act; (3) Is the Petitioner's current condition of ill-being with respect to the right shoulder causally connected to this injury or exposure; (4) Is Respondent liable for the unpaid medical bills listed in Petitioner's exhibit #1; (5) Is the Petitioner entitled to TTD from May 5, 2011 through July 20, 2011 and September 7, 2011, through December 8, 2011, representing 24 weeks; (6) What is the nature and extent of the injury; (7) Did Petitioner exceed her choice of physician.

STATEMENT OF FACTS

Petitioner filed an application for adjustment of claim with the Illinois Workers' Compensation Commission on October 20, 2010, alleging an accident date of September 14, 2010. Petitioner alleges that she sustained injuries to her right wrist, right elbow, right shoulder, left wrist and left elbow as a result of repetitive duties while working for Shawnee Correctional Center. This is a repetitive trauma claim where Respondent has disputed accident; notice to the

left elbow; causation to the right shoulder; medical expenses; 8(j) credit; liability for temporary total disability benefits; exceeded choice of physician; and nature and extent of the injury.

Petitioner testified that she had been employed at Shawnee Correctional Center as a records office/office assistant from January 1, 1999, to September 1, 2010. Petitioner testified that she currently was working at Tamms Correctional Center as the mailroom supervisor. She started that position in April of 2011. Her current job duties include lifting heavy tubs of mail, opening packages and letters 4-6 hours per day, and data entry on computers 2-3 hours per day.

Petitioner testified that the hardest part of her job duties as an office assistant was the actual opening of the filing system to put all the files in the 2000 inmate files. Petitioner explained that they have baskets of files for 2000 inmates coming in daily and the information has to be filed in a timely manner. Petitioner testified that she would file three hours, maybe more a day, some consistently and some periodically. Petitioner described the rolling filing system to be 25 feet long almost from ceiling to the floor with multiple sections that roll from the ceiling. There was a large wheel that was used to roll open the different sections so that you could access specific files. The system had nine sections, each section was an individual wall, and it took effort to turn the knobs and wheels to move the files from one side to the next. It was difficult to turn the wheels and move the files because things, including dead mice, would get stuck in the tracks. Petitioner stated that the files could be six inches to a foot wide in hard jackets. Petitioner testified that some of the jackets weighed twenty pounds. Petitioner testified that she would use a step ladder, but also testified to reaching up and pulling out a file and bringing it down the steps. Petitioner described the jackets as having metal prongs to put documents in the appropriate section, with five sections per file, each section had its own prongs.

On September 1, 2010, Petitioner got a new job as a clinical services associate at Shawnee Correctional Center. Petitioner testified that her main task as a clinical services associate was data entry for field services and all the counselors. This job involved duties such as entering computer data 5-6 hours per day, preparing manuals for inmates using large saddle-style hand stapler 200 times per day, and filing for 8 hours per week.

Petitioner testified that her arm started bothering her when she was in the records office. She testified that at one point from 1999 to 2010, there were four others working in the records office with her. Petitioner testified that at some point, one co-worker went out on leave and then there were three others working in the records office with her.

Petitioner testified on cross-examination that she typed out the work history/job description entered into evidence as Petitioner's Exhibit # 13 within the last couple of months before the hearing. She estimated that she typed out the work history/job description in December 2011. Petitioner testified that this document was not something that Dr. Paletta used when treating her or before the surgery. Petitioner testified that she gave Dr. Paletta a job description, but not this specific job description. Petitioner testified that the job description given to Dr. Paletta was the one used in his medical records.

On September 8, 2010, Petitioner underwent x-rays of her right shoulder for a history of pain at the Western Baptist Hospital. Degenerative changes involving the AC joint with spurring was observed inferiorly along the clavicle and acromion process. The radiologist's impression was (1) AC joint arthropathy and (2) no acute bony abnormality. (P. Ex. 3)

On September 14, 2010, Petitioner presented to Western Baptist Hospital. On the face sheet, it was noted when questioned as to where the accident took place and brief description: "Not an accident". This document appears to be signed by Angeline Collins. Petitioner was referred for a nerve conduction studies/EMG of the bilateral upper extremity by Dr. Jennifer Nelson for paresthesias. The patient's history was pain in her right shoulder. She stated her hands go to sleep at night. She was not diabetic. No blood thinners. No previous neck or back surgery. No history of chemotherapy or radiation. The study was impressive for median nerve entrapment at the wrist as in mild to moderate carpal tunnel syndrome. (P. Ex. 3, 4) Petitioner was referred to Dr. Burton Stoghill at the Orthopedic Institute of Western Kentucky.

On September 29, 2010, Petitioner presented to Dr. Stodghill for a consultation for a chief complaint of right shoulder pain and bilateral hand numbness and tingling. Petitioner reported a long history of increasing problems with her bilateral hands and right shoulder. She denied any trauma to her shoulder. She reported that it hurt quite a bit at night. Overhead work was a problem. She had been doing overhead work for her entire life and it was now becoming quite an issue. She began to have pain and loss of range of motion. She had numbness and tingling in both hands that woke her up at night. She had to shake her hands and when she drove, her hands would go numb. Examination of her shoulder revealed full range of motion. Petitioner had a positive Phalen's and positive Tinel's at the carpal tunnels. X-rays showed acromioclavicular joint osteoarthritis, otherwise normal. Examination of the nerve conduction studies showed bilateral carpal tunnel syndrome. Dr. Stodghill's impression was bilateral carpal tunnel syndrome and right rotator cuff tendinopathy. Dr. Stodghill noted that at this point, he recommended a MRI of the shoulder and get all the administrative ducks in a row before they proceed. She said she wants to start with her right carpal tunnel release and he would see her back after the MRI of the shoulder. It was noted that Petitioner's group health insurance was responsible for this bill. (P. Ex. 5)

On October 7, 2010, Petitioner returned to Dr. Stodghill. Petitioner's insurance company would not approve the MRI. Petitioner reported that she had taken nonsteroidal anti-inflammatory medications in the past. She has not done physical therapy. Her hands were still bothering her quite a bit, the right was worse than the left. She wanted to go ahead and take care of the right carpal tunnel. Dr. Stodghill again assessed Petitioner with bilateral carpal tunnel syndrome and right rotator cuff tendinopathy. Dr. Stodghill put Petitioner on the scheduled for right carpal tunnel release. (P. Ex. 5)

On October 12, 2010, Petitioner completed a CMS Workers' Compensation Employee's Notice of Injury. Petitioner reported that she injured "both hands—right arm and shoulder" from repetitive use of both hands—arm and right shoulder. Respondent disputed notice of the injury to Petitioner's left elbow/arm. Petitioner testified at trial that she simply forgot to put the "s" on arm. However, the Supervisor's Report of Injury also noted the injury as "carpal tunnel in both

hands; bone spurs on right shoulder per x-ray". There was no mention of an injury to the left elbow/arm.

Petitioner testified that she went to see Mr. Rich to see if he could get her medical treatment on the advice of Angela Harner, a friend from work. On November 15, 2010, Petitioner presented to Dr. David M. Brown at The Orthopedic Center of St. Louis on a referral from her attorney, Tom Rich. Petitioner presented for a work-related injury. Petitioner reported that she had filed a work comp claim for this problem and was represented by an attorney for this problem. Petitioner completed a "New Patient Questionnaire" which revealed her symptoms to be "right & left hands, wrists; right arm & right shoulder". Petitioner reported on this documentation that she had a "nerve conduction--6 or 7 years ago--some nerve damage or carpal tunnel not too bad at that time". (P. Ex. 6)

Petitioner was noted to be a 60 year old right hand dominant office associate clerical worker at Shawnee Correctional Center. Petitioner presented for evaluation and treatment for a problem with both of her upper extremities. She explained that she worked for the Illinois Department of Corrections since 1996. Petitioner worked eight hours a day, forty hours a week. She estimated that she does five hours of data entry a day. She reported filing two hundred sheets per day. She will lift up to fifty pounds at a time. Petitioner reported a six month history of gradual numbness and tingling in both her hands associated with medial elbow pain and some volar wrist pain. She was treated with wrist splint with no improvement in her symptoms. She underwent nerve conduction studies in September which were interpreted as revealing mild to moderate right carpal tunnel syndrome. Petitioner's past medical history was positive for left trigger thumb surgery in the past. Petitioner exhibited good active range of motion of both elbows, both wrists and all digits of both hands. She had a negative Tinel's sign over the ulnar nerve at the cubital tunnel. Direct compression test induced some discomfort and paresthesias bilaterally. Elbow flexion test was negative bilaterally. She had a negative Tinel's over both carpal tunnels. Direct compression test/Phalen's test was positive bilaterally. No intrinsic muscle atrophy was noted in either hand. Dr. Brown noted that Petitioner had symptoms and findings on examination consistent with bilateral carpal tunnel syndrome, possibly an ulnar neuropathy at both elbows. (P. Ex. 6)

Dr. Brown ordered repeated nerve conduction studies. Petitioner was given bilateral Titan wrist splints to wear over both wrists and bilateral elbow splints to wear over both elbows at night. Petitioner was instructed to take a nonsteroidal anti-inflammatory medication. Dr. Brown opined that based on Petitioner's job description for the State of Illinois doing data entry for five hours a day, he did believe her work would be considered in part an aggravating factor in the need for evaluation and treatment for a peripheral compression neuropathy including carpal tunnel syndrome and/or cubital tunnel syndrome. Dr. Brown released Petitioner to full duty work, no restrictions. (P. Ex. 6)

On December 20, 2010, Petitioner returned to Dr. David Brown. She reported that she had no improvement in her symptoms. She also complained of some right shoulder pain. On examination, Petitioner now exhibited a positive Tinel's and direct compression test over both cubital tunnels. Petitioner had a negative Tinel's over both carpal tunnels. Direct compression test/Phalen's test was positive bilaterally. Dr. Brown assessed Petitioner with chronic bilateral

cubital tunnel syndrome and bilateral carpal tunnel syndrome that failed to improve with conservative measures. Petitioner was a candidate for surgical intervention. (P. Ex. 6)

On February 11, 2011, Petitioner sought medical treatment from Dr. George Paletta at The Orthopedic Center of St. Louis. Petitioner presented for evaluation of a chief complaint of about a one year history of right shoulder pain. Petitioner related the onset of her symptoms to her work activities in the file room. Petitioner reported that she had to work with big rolling files which she had to turn a wheel to move the file and then to handle the files. Petitioner reported that she initially noted the onset of symptoms in conjunction with these repetitive activities. Petitioner reported that initially she did not think of it much, but eventually sought medical attention in September with physicians in Kentucky. Petitioner complained of continued pain in the right shoulder. (P. Ex. 7)

Dr. Paletta noted that she had been diagnosed with bilateral carpal tunnel syndrome, but that surgery was currently on hold. Dr. Paletta's impression included AC joint pain in the setting of AC joint arthritis and probably early osteolysis of distal clavicle. Dr. Paletta doubted a significant rotator cuff tear. Dr. Paletta recommended a MR scan to assess the extent of evaluation of the AC joint and also to evaluate the rotator cuff. (P. Ex. 7)

On February 11, 2011, Petitioner underwent a MRI of the right shoulder at MRI Partners of Chesterfield. (P. Ex. 8)

On February 21, 2011, Dr. Paletta reviewed the MRI of the right shoulder. Dr. Paletta's impression from the MRI was (1) acute AC joint inflammation in the setting of AC joint arthritis and (2) chronic supraspinatus tendinopathy with small focal full-thickness tear. Dr. Paletta recommended an injection and referred Petitioner to one of his partners, Dr. Matthew Bayes. (P. Ex. 7, 8)

On February 24, 2011, Petitioner presented to Dr. Bayes at The Orthopedic Center of St. Louis. Dr. Bayes performed a diagnostic and therapeutic AC joint steroid injection under ultrasound guidance. Dr. Bayes noted 50% pain relief in much of the physical exam. Dr. Bayes recommended physical therapy on a rotator cuff impingement syndrome protocol. Dr. Bayes noted that Petitioner could work full duty. (P. Ex. 9)

On March 18, 2011, Petitioner returned to Dr. Bayes. Petitioner reported near total pain relief following the injection on February 24, 2011. Petitioner reported that since that time, she had nearly three weeks of total pain relief and then had a return to pre-injection pain. Petitioner reported that the pain was only at the AC joint. Dr. Bayes referred Petitioner back to Dr. Paletta for possible arthroscopic distal clavicle excision and any other indicated procedure. Petitioner was to continue working full duty. (P. Ex. 9)

On April 13, 2011, Petitioner returned to Dr. Paletta. It was noted that Petitioner was previously diagnosed with adhesive capsulitis and ongoing AC joint issues. Dr. Paletta's impression was resolved adhesive capsulitis and persistent AC joint pain. Dr. Paletta gave Petitioner the option of surgery. Petitioner noted that she would consider the options and make a

decision with regard to treatment. She recently had switched jobs and is at a different correctional facility. She is working in the mail room. Dr. Paletta recommended against repetitive reaching cross body and against repetitive overhead lifting. (P. Ex. 7)

On April 26, 2011, Petitioner saw Dr. Jennifer Nelson for a pre-surgical work up. Petitioner was noted to be 60 years old and scheduled for surgery to her right shoulder and elbow with Dr. George Paletta in St. Louis on 05/05/2011. Past medical history was significant for fibrocystic disease, basal cell carcinoma, and mild osteopenia left hip 9-10. Petitioner was employed. Dr. Nelson noted that Petitioner denied any complaints except for shoulder pain and needs surgery. (P. Ex. 3)

On May 5, 2011, Petitioner underwent arthroscopy and rotator cuff repair of the right shoulder with Dr. Paletta at St. Louis Surgical Center. The post-operative diagnoses included right shoulder pain, right shoulder impingement syndrome, right shoulder rotator cuff tear, right shoulder AC joint DJD, right shoulder labral tear, and osteochondral lesion, humeral head. Petitioner was placed off work. (P. Ex. 7, 10)

On May 16, 2011, Petitioner returned to Dr. Paletta. She was doing well. Petitioner was to begin physical therapy. Petitioner was to remain off work. (P. Ex. 7)

On June 17, 2011, Petitioner returned to Dr. Paletta. Dr. Paletta recommended an ultrasound to the right shoulder due to a fall in which Petitioner sustained a right ankle contusion and sprain. (P. Ex. 7)

On July 7, 2011, Dr. Paletta reviewed an ultrasound of the right shoulder which revealed no evidence of recurrent rotator cuff tear. However, there was subacromial bursitis noted. Dr. Paletta recommended an injection with Dr. Bayes. Dr. Paletta noted that there was no evidence of a surgical lesion. He transferred care of Petitioner back to Dr. Bayes. (P. Ex. 7)

On July 19, 2011, Petitioner saw Dr. Richard Lehman for an medical examination pursuant to Section 12 of the Act, at the request of the Respondent, for her right shoulder. Based on Petitioner's history, medical records, diagnostic imaging, and examination, Dr. Lehman opined that Petitioner's job duties were not in any way related to altering, exacerbating or in any way changing the condition of her right shoulder. Dr. Lehman noted that Petitioner had significant degenerative arthritis consistent with her stated age. Dr. Lehman opined that after reviewing the job and Petitioner's claims of discomfort, Petitioner's problem was degenerative in nature and unrelated to her job. (R. Ex. 3)

On July 20, 2011, Petitioner returned to Dr. Bayes on a transfer of care from Dr. Paletta for right shoulder pain. Dr. Bayes performed a subacromial steroid injection to the right shoulder. (P. Ex. 9)

On August 4, 2011, Dr. Paletta authored a letter to Petitioner's attorney, Thomas C. Rich. He reviewed Dr. Lehman's report dated July 19, 2011. Dr. Paletta noted that he disagreed with Dr. Lehman as to whether Petitioner's work activities were an aggravating or exacerbating factor of the degenerative changes in her shoulder. (P. Ex. 7)

On August 8, 2011, Petitioner returned to Dr. Paletta for a second opinion for evaluation of a chief complaint of numbness and tingling in both hands. Dr. Paletta noted that Petitioner underwent nerve conduction studies with Dr. Phillips in the fall of 2010. The studies demonstrated moderately severe carpal tunnel and more mild-to-moderate cubital tunnel in both upper extremities. Petitioner was assessed with chronic carpal tunnel syndrome, bilateral wrists and chronic cubital tunnel bilateral elbows, right greater than left. Dr. Paletta noted that Petitioner had clearly failed nonsurgical treatment. Dr. Paletta recommended right carpal tunnel release and ulnar nerve transposition. Dr. Paletta noted that he believed that Petitioner's current elbow and wrist complaints are causally related to the repetitive nature and hand intensive requirements of her job. (P. Ex. 7)

On August 17, 2011, Petitioner returned to Dr. Bayes for follow-up of her right shoulder pain. Dr. Bayes noted that Petitioner was having some head biceps tendonitis and impingement pain. Petitioner was instructed to undergo continued physical therapy. (P. Ex. 9)

On September 8, 2011, Petitioner underwent a right carpal tunnel release and right ulnar nerve transposition performed by Dr. Paletta. (P. Ex. 7)

On September 26, 2011, Petitioner returned to Dr. Paletta for a postop visit status post ulnar nerve transposition and carpal tunnel release. Overall, Petitioner was doing quite well, but she is complaining of tingling over the common extensor tendon origin down over the dorsum of the forearm. Petitioner denied any numbness in the distribution of the medial antebrachial cutaneous nerve. Petitioner denied any significant numbness or tingling involving the fingers. Dr. Paletta "reassured her with respect to the numbness" and noted that it really did not make a lot of anatomic sense as they were not anywhere near the lateral antebrachial cutaneous nerve. Dr. Paletta opined that this would likely resolve spontaneously. Petitioner was to begin physical therapy. (P. Ex. 7)

On September 26, 2011, Petitioner returned to Dr. Bayes for follow-up of the right shoulder. Dr. Bayes noted that the physical therapy to the shoulder was put on hold due to carpal tunnel surgeries being performed by Dr. Paletta. Dr. Bayes noted that Petitioner was continuing to improve. (P. Ex. 9)

On October 11, 2011, Petitioner underwent surgery performed by Dr. Paletta at Frontenac Surgery & Spine Care Center. The surgery was a left carpal tunnel release and left ulnar nerve transposition. (P. Ex. 12)

On October 31, 2011, Petitioner returned to Dr. Bayes for follow-up of the right shoulder. Petitioner continued to show slow but steady improvement in her right shoulder pain. Petitioner was to continue with physical therapy. (P. Ex. 9)

On December 2, 2011, Petitioner went to The Orthopedic Center of St. Louis for follow-up and saw Dr. Luke Choi, who noted that Dr. Bayes had recently left the practice. Dr. Choi noted that Petitioner had occasional pain and discomfort that was intermittent in nature. However, Petitioner stated that her pain level was very mild and rated it as only at 3 on a scale of

0 to 10. Petitioner denied any popping, locking, grinding, and stiffness episodes. Petitioner did not have any night pain, which awakens her at night. Petitioner noted improvements with the use of her right upper extremity in terms of functional activities such as using her arm overhead and reaching behind her back. Dr. Choi noted that Petitioner had made significant improvements with increase in range of motion, strength, as well as pain control. Dr. Choi placed Petitioner at maximum medical improvement. (P. Ex. 9)

On December 7, 2011, Petitioner returned to Dr. Paletta for continued follow-up of her bilateral upper extremities. Petitioner was doing reasonably well. Petitioner's symptoms at night had disappeared. Petitioner reported that her hands do not fall asleep. Petitioner was complaining of some pain across the thenar eminence on the left side. She was complaining of a trigger thumb on the right side. Dr. Paletta explained that the trigger thumb was not in any way related to the carpal tunnel release. Petitioner had good relief of her symptoms. Petitioner was still having some mild residual soreness in the left hand and some soreness at the elbows, but Dr. Paletta noted that those symptoms should resolve. Dr. Paletta noted that Petitioner did not require additional formal physical therapy. Petitioner was returned to work full duty and at maximum medical improvement. Dr. Paletta informed Petitioner to see her primary care physician for the trigger thumb, as this was not related to the carpal tunnel release. (P. Ex. 7)

Petitioner testified at trial to difficulties sleeping on her right shoulder and awkwardness with the scar indentation and her bra strap. Petitioner testified that she takes one Hydrocodone at night to help her sleep. She testified that her family physician, Dr. Nelson had given her this prescription. Petitioner testified as not resting her elbows on an arm chair due to tingling. Petitioner also testified at trial with regard to difficulty manipulating papers for filing, and having to rest her hands and elbows after about an hour of entering data. Petitioner testified that she has difficulty twisting jars. Petitioner testified on cross-examination that she takes Tylenol usually twice a day.

With respect to the form 45 (R. Ex. 4) that the Petitioner filled out that she forgot to put the "s" on arms, it was both arms. She stated that she specifically left out the left shoulder. This explanation does not take into account that what Petitioner actually wrote, in the section for describe injury (indicate part(s) of body affected), "Both hands – Right Arm & Shoulder" (R. Ex. 4).

CONCLUSIONS OF LAW

An injury is accidental within the meaning of the Worker's Compensation Act when it is traceable to a definite time, place and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v Industrial Board,* 284 Ill. 378, 120 N.E. 2d 249, 251 (1918)

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,*58 Ill. 2d 226, 317 N.E.2d

515 (1974) "Arising out of" is primarily concerned with the causal connection to the employment. The majority of cases look for facts that establish or demonstrate an increased risk to which the employee is subjected to by the situation as compared to the risk that the general public is exposed to.

The burden is on the party seeking the award to prove by a preponderance of credible evidence the elements of the claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Hannibal, Inc. v. Industrial Commission,* 38 Ill.2d 473, 231 N.E.2d 409, 410 (1967)

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).

When a preexisting condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [condition] such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition." *St. Elizabeth's Hospital v. Workers' Compensation Commission*, 864 N.E.2d 266, 272-273 (5th Dist. 2007)

An employee who suffers a repetitive trauma injury must meet the same standard of proof under the Act as an employee who suffers a sudden injury. See *AC & S v. Industrial Comm'n,* 304 Ill.App.3d 875, 879, 710 N.E.2d 837 (1st Dist. 1999)

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.

Section 6(c) of the Illinois Workers' Compensation Act states that notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident. Section 6(c) (2) states that "[n]o defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he is unduly prejudiced in such proceedings by such defect or inaccuracy." *820 ILCS 305/6(c)* (West 2004)

The purpose of the notice provisions is to enable the employer to investigate promptly and to ascertain the facts of the alleged accident. *City of Rockford v. Industrial Commission,* 214 N.E.2d 763 (1966) The giving of notice under the Act is jurisdictional and a prerequisite of the right to maintain a proceeding under the Act. However, the legislature has mandated a liberal construction on the issue of notice. *S&H Floor Covering v. The Workers Compensation Commission,* 870 N.E.2d 821 (2007)

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

The Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of her employment with Respondent. Petitioner credibly testified that she performed repetitive clerical duties over the course of several job positions for Respondent. Respondent appears to be challenging the cubital tunnel syndrome in the left arm only, on the basis of notice, as well as the right shoulder injury.

It is a well-known axiom of law that an injury is accidental within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel. Co. v. Industrial Commission*, 128 N.E.2d 718, 720 (1955); *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (1982). Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 205 (2003) (emphasis added). Petitioner denied any prior shoulder problems that predate her onset of symptoms and there is no contrary medical evidence.

Petitioner testified that she performed repetitive duties on behalf or Respondent for 16 years. As a mailroom supervisor at Respondent's Tamms Supermax Correctional Center, she lifts heavy tubs of mail, opens packages and letters 4-6 hours per day, and performs data entry on computers 2-3 hours per day. In her duties as a clinical services associate, she entered computer data 5-6 hours per day, prepared manuals for inmates using a large stapler 200 times per day, and filed 8 hours per week. As an office assistant, Petitioner performed data-entry for 4-5 hours per day, pulled heavy files weighing up to 20lbs for 2,000 inmates - some of which were located over her head, lifted boxes of packaged files weighing 50lbs or more, and opened and closed metal fasteners to place paper securely in those files. As a secretary to the college coordinator at Shawnee Community College, she performed data entry on a computer 6-7 hours per day. Petitioner's testimony regarding her job history and duties is unrebutted. Petitioner's description of her job duties is consistent with the type of activities the Commission has found to constitute a compensable accident under the Act. *See Durand v. Industrial Commission*, 862 N.E.2d 918 (2007); *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture*, 99 I.I.C. 0961; *Rebecca McCowen*, 11 I.W.C.C. 1230 (2011);

While performing her job duties at Shawnee Correctional Center, her hands started showing symptoms of numbness and pain with activity. She described these as worse at the end of a shift, than at the start of a shift. These included symptoms in her hands and right shoulder. Petitioner sought treatment for these symptoms and underwent nerve conduction studies on September 14, 2010, which revealed bilateral carpal tunnel syndrome believed to be related to her employment. On September 29, 2010, Dr. Stodghill examined Petitioner, discussed her symptoms, and diagnosed Petitioner with bilateral carpal tunnel syndrome and right rotator cuff tendinopathy.

Petitioner sought treatment with Dr. Brown who ordered repeat nerve conduction studies. These were done on November 15, 2010, and revealed bilateral cubital tunnel syndrome in addition to bilateral carpal tunnel syndrome. It is curious that the first few medical records do

not show any complaints to her bilateral elbows and the first nerve conduction study was negative for cubital tunnel syndrome. It wasn't until two months later when she was referred by her attorney to Dr. Brown and underwent a second nerve conduction study with Dr. Phillips that there was any problem with her bilateral elbows.

The MRI of Petitioner's shoulder on February 11, 2011, revealed chronic tendinopathy with a small focal full-thickness tear. Objective inter-operative findings revealed conditions of right shoulder impingement syndrome, rotator cuff tear, labral tear, and degenerative acromioclavicular joint disease.

Petitioner selected September 14, 2010, as her manifestation date. Although subsequent treatment and consultations further refined the extent of Petitioner's injuries, September 14, 2010, is the date Petitioner testified that she became aware that she sustained repetitive injuries as a result of her work duties for Respondent. The date of the accident can be determined several different ways: **(a)** the date the employee actually became aware of the physical condition and its relation to work, presumably through medical consultation; **(b)** the date the employee requires medical treatment; **(c)** the date on which the employee can no longer perform work activities; or **(d)** when a reasonable person would have plainly recognized the injury and its relation to work. *Durand v. Industrial Commission*, 862 N.E.2d 918 (2007), *see also Peoria County Belwood Nursing Home v. Industrial Commission*, 505 N.E.2d 1026 (1987); *Oscar Mayer & Co. v. Industrial Commission*, 531 N.E.2d 174 (1988); *Three "D" Discount Store v. Industrial Commission* 556 N.E.2d 261 (1989). Petitioner's manifestation date, September 14, 2010, is the date that she became aware that she sustained repetitive injuries as a result of her work through medical consultation. Therefore her manifestation date is proper under the Act.

Based upon the unrebutted description of Petitioner's repetitive job duties and her lack of problems predating her manifestation date, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course her employment with Respondent with regard to her hands, arms, and shoulder.

Was timely notice of the accident given to Respondent (with regard to the left elbow)?

Petitioner testified that outside of leaving off one letter, the accident report and Supervisor's Report of Injury were accurate. This is debatable since the notices indicate both hands and Right Arm and shoulder, so that adding an "s" to "arm" would not really change the notice given. However, the Petition for Adjustment of Claim filed the day after the written notice was given and that was admitted into evidence as Arbitrator's exhibit number 1, lists Right and left hands, right and left arms and right shoulder as the parts of the body affected.

Respondent has not shown that they have been unduly prejudiced by the notice provided by the Petitioner.

The purpose of the notice requirement of the Act is to enable an employer to investigate an alleged accident. *Gano Electric Contracting v. Industrial Comm'n,* 260 Ill.App.3d 92, 95, 197 Ill.Dec. 502, 631 N.E.2d 724, 727 (1994). The notice requirement is met if the employer possesses known facts related to the accident within 45 days, and a claim is barred only if no notice whatsoever is given. *Gano,* 260 Ill.App.3d at 96, 197 Ill.Dec. 502, 631 N.E.2d at 727. Our General Assembly has mandated a liberal construction of the notice requirement, and, therefore, if some notice has been given, even if inaccurate or defective, the employer must show that it has been unduly prejudiced. *Gano,* 260 Ill.App.3d at 96, 197 Ill.Dec. 502, 631 N.E.2d at 727.

Respondent has not shown any prejudice. Respondent did have notice that Petitioner was experiencing symptoms in both hands bilaterally. No one provided a specific enough description as to what the symptoms were and what part of the hands were involved, let alone whether the left hand differed from the right hand. Therefore the Arbitrator finds that Petitioner provided sufficient notice under the Act.

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

This dispute only extended to Petitioner's right shoulder. To dispute this, Respondent obtained an examination with Dr. Richard Lehman who opined that Petitioner's long history of repetitive use of both upper extremities had nothing to do with her right shoulder condition.

Dr. Paletta reviewed Dr. Lehman's report and disagreed, based not only on his clinical examination and review of the films, but more importantly, because the operation itself resulted in findings of an acute inflammatory process. Dr. Paletta noted that there was evidence of a pre existing underlying degenerative joint disease of the AC joint, however the inflammation was evidence that she also demonstrated ongoing inflammatory changes which he opines were caused by her activities on the job. The Arbitrator finds that Petitioner has met her burden of proof regarding the issue of causation on her right shoulder.

Respondent did not dispute causation on the condition of Petitioner's wrists and elbows.

Were the medical services, that were provided to Petitioner, reasonable and necessary and have Respondent paid all appropriate charges for all reasonable and necessary medical services?

Petitioner's care and treatment was initially conservative and reasonable. Dr. Stodghill tried to obtain an MRI to evaluate Petitioner's problem, and when this was denied, Petitioner sought treatment with Dr. Brown, who performed diagnostic studies on her elbows and wrists which were positive. He initially recommended conservative treatment in the form of splinting and non-steroidal anti-inflammatories, both at the elbows and wrists. Only after this failed did he recommend surgery.

Likewise, Dr. Paletta's approach was conservative with regard to Petitioner's right shoulder. He initially tried an injection which was both diagnostic and therapeutic, but the relief was only temporary. When he performed surgery, Dr. Paletta found right shoulder impingement syndrome, rotator cuff tear, labral tear, and degenerative acromioclavicular joint disease. Further, Petitioner's right shoulder condition improved significantly after surgery. The same occurred after Dr. Paletta performed bilateral carpal tunnel and cubital tunnel releases.

Respondent did not dispute the need for treatment, and Dr. Lehman did not criticize Dr. Paletta's surgery or the need for same.

Therefore, Respondent is ordered to 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.

What temporary benefits are in dispute (TTD)?

Petitioner was allowed to continue working full duty, except for the times she was off recovering from surgery. For a total of 5 surgeries, Petitioner only missed 24 weeks of work. During this time, she received non-occupational disability benefits which the parties stipulated she had to repay.

Respondent produced no opinion indicating that Petitioner should have been working during the surgical recovery time, and prior to live testimony, stipulated that Petitioner was legitimately off work recovering from surgery and did not pay TTD benefits based on the issue of accident, notice to her left elbow, and causation to the right shoulder.

Based on the foregoing, Respondent shall pay Petitioner temporary total disability benefits of $528.00 per week for 24 weeks, commencing 5/5/11-7/20/11 and 9/7/11-12/8/11, that being the period of temporary total disability for which compensation is payable.

What is the nature and extent of the injury?

As a result of her repetitive arm intensive work activities for Respondent over the course of 16 years, Petitioner sustained injuries to her bilateral wrists, elbows, and right shoulder. As a result of her shoulder condition, Dr. Paletta diagnosed conditions of right shoulder impingement syndrome, rotator cuff tear, labral tear, and degenerative acromioclavicular joint disease. He also performed carpal and cubital tunnel releases with ulnar nerve transpositions which improved Petitioner's condition. Petitioner testified candidly at Arbitration that the surgeries helped her symptoms significantly.

Despite the improvement from surgery, Petitioner testified that she still has problems reaching backwards with her right arm. She has difficultly laying on her right shoulder at night to sleep and narcotic pain medication from Dr. Nelson. She has tried to play tennis since recovering from surgery, but it did not go well. With regard to her elbows, she still has some numbness and has pain when working. For this she drops her arms to the side and rests them after about an hour of work. She has pain when resting her elbows on hard surfaces and performing household activities, such as opening jars.

Respondent shall pay Petitioner permanent partial disability benefits of $475.20/week for 114.5 weeks, because the injuries sustained caused the 12.5% loss of the right and left hands (51.25 weeks), the 12.5% loss of the right and left arms (63.25 weeks), as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $475.20/week for 75 weeks, because the injuries sustained caused the 15% loss of the person as a whole (shoulder), as provided in Section 8(d)2 of the Act. *Will County Forest Preserve District v. Illinois Workers' Compensation Commission*, 2012 IL App (3d) 110077WC (3rd Dist., February 17, 2012).

Did Petitioner exceed her choice of physicians?

Petitioner initially received treatment from her family physician, Dr. Nelson, who referred her to Dr. Stodghill. When Dr. Stodghill could not get approval for an MRI from Respondent, Petitioner sought treatment with Dr. Brown. When Dr. Brown could not get approval for surgery he would not perform surgery without authorization and put her on hold. Petitioner testified that because of this she was referred to Dr. Brown's partner, Dr. Paletta.

In short, Petitioner elected treatment with her family physician who referred her to one orthopedic specialist and chose another specialist who referred her to his partner. Petitioner has chosen two physicians, and has not exceeded her choice of physicians.

ORDER OF THE ARBITRATOR

Respondent shall pay Petitioner temporary total disability benefits of **$528.00**/week for **24** weeks, commencing **5/5/11-7/20/11** and **9/7/11-12/8/11**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **9/14/10** through **present**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay Petitioner permanent partial disability benefits of **$475.20**/week for **114.5** weeks, because the injuries sustained caused the **12.5%** loss of the **right and left hands**

(51.25 weeks), the **12.5%** loss of the **right and left arms (63.25 weeks)**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$475.20**/week for **75** weeks, because the injuries sustained caused the **15%** loss of the person as a whole (shoulder), as provided in Section 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical services of **$151,713.75**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Deborah L. Simpson
Signature of Arbitrator

July 15, 2013
Date

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

David D. Pittman,
Petitioner,

vs.

NO: 10 WC 33140

John Deere,
Respondent,

14IWCC0717

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, temporary total disability, causal connection, 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 June 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $57,000.00. 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: AUG 2 2 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:6/25/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PITTMAN, DAVID D
Employee/Petitioner

Case# **07WC033140**

14IWCC0717

JOHN DEERE
Employer/Respondent

On 6/5/2013, 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 0.08% 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:

2028 RIDGE & DOWNES LLC
JOHN E MITCHELL
415 N E JEFFERSON AVE
PEORIA, IL 61603

2119 CALIFF & HARPER PC
STEVE L NELSON
506 15TH ST SUITE 600
MOLINE, IL 61265

14IWCC0717

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

DAVID D. PITTMAN,
Employee/Petitioner

v.

JOHN DEERE,
Employer/Respondent

Case # 07 WC 33140

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 **Kewanee**, on **December 6, 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: _____

14IWCC0717

FINDINGS

On **August 10, 2005**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

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

On the date of accident, Petitioner was **46** years of age, ***married*** with **one** dependent child under 18.

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

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

Respondent shall be given a credit of **$ 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 **$ 3,677.80** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$640.00**/week for **7-4/7** weeks, commencing **August 11, 2005** through **October 2, 2005,** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$576.00**/week for **100** weeks, because the injuries sustained caused the **20%** loss of use of his **person as a whole**, as provided in Section 8(d)2 of the Act.

Petitioner is now entitled to receive from Respondent compensation that has accrued from **February 2, 2012** through **December 6, 2012,** and the remainder, if any, of the award is to be paid to Petitioner by Respondent in weekly payments.

Respondent shall pay reasonable and necessary medical services of **$ 58.00,** as provided in Sections 8(a) and 8.2 of the Act.

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

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

Signature of Arbitrator **JOANN M. FRATIANNI**

June 3, 2013
Date

ICArbDec p. 2

JUN - 5 2013

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

Petitioner was working for Respondent in 1979 as a picker. Petitioner testified that a picker obtains items out of a bin for distribution. Petitioner testified that approximately 100 times a day he would bend over and twist to get items out of the bin. Petitioner described the bin as being waist high and he was required to bend over to reach inside. Petitioner performed this work for Respondent until 1988, when he was laid off. Following this layoff, Petitioner worked for Bonnett's nursery for a few months until recalled by Respondent in 1995. When recalled, Petitioner initially returned to his picking job, and shortly thereafter, became a welder. Petitioner testified that welding involved taking a main frame that is the basic frame of the machine, and weld it with fixtures. This would require him to lift items weighing up to 40 pounds, and to twist, squat, reach, stretch and reach with weight in his hands, or crawl under the machine and weld overhead.

Petitioner testified that on August 10, 2005, he was performing work as a welder. Towards the end of the shift, right after he was finishing, he experienced a lack of feeling in his left leg. Petitioner then took a shower, went home, and felt a little better, but still experienced the lack of feeling in his left leg.

Petitioner testified the following morning he awoke, got out of bed and fell down because his left leg would not support him. Petitioner testified he then immediately contacted Dr. Hassan Diab, his family physician. Petitioner saw Dr. Diab later that day with complaints of pain in his lower back and down his left leg that started a week ago. Dr. Diab noted left foot dorsiflexion was weak and prescribed a lumbar MRI. That MRI was performed the same day and revealed disc material on the left root foramen fairly out laterally and then on the right side.

Following the MRI, Dr. Diab referred Petitioner to see Dr. Scott Collins, an orthopedic surgeon. Petitioner also saw Dr. Collins on August 11, 2005. Dr. Collins recorded a history of back pain for multiple years with increasing forward left extremity pain over the last several weeks, and increasing weakness in the left leg the last couple of days. Examination revealed weakness and pain running down his left leg in the L4-L5 distribution, positive tension sign and LaSegue sign. Dr. Collins noted the MRI that he interpreted as revealing a foraminal disc herniation that was somewhat lateral. Dr. Collins prescribed surgery.

Petitioner then underwent surgery with Dr. Collins that same day, or on August 11, 2005. Noted during surgery were disc fragments after moving the dura and nerve root in the midline area. Multiple fragments were removed from the foraminal disc space at L4-L5. Post surgery, Petitioner was seen on August 19, 2005. Petitioner reported relief from his symptoms immediately after surgery, but was now experiencing some recurrence of his symptoms. A second MRI was prescribed which revealed a small disc fragment in the left paracentral area. By August 31, 2005, Petitioner reported to Dr. Collins he was doing better. Dr. Collins interpreted the MRI to show some layer scar tissue and possible reherniation that appeared to be small.

Petitioner then saw Bev Davidson, RN, of the John Deere Medical facility on August 31, 2005. A history was recorded that he had been working HEM when his back began to hurt him. He then continued to work through the pain that was not too severe. She noted he was still having a lot of left leg pain along with a burning sensation into his left shin. Petitioner was taking medication to help him sleep. Petitioner also maintained he reported to medical after the surgery was performed and felt this was a Workers' Compensation claim from working with heavy parts when his body was not conditioned from performing that type of work.

Petitioner denied experiencing problems or symptoms to his back up until or near the time of his August 10, 2005 work activities. There is nothing in the evidence before this Arbitrator that would indicate a difference source or cause of injury in this case, other than symptoms that predate this accident that worsened on the date of injury.

Based upon a review of the introduced medical evidence and the testimony of Petitioner, the Arbitrator finds that Petitioner sustained an accidental injury that arose out of and in the course of his employment with Respondent on August 10, 2005.

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

See findings of this Arbitrator in "C" above. On September 6, 2005, Petitioner began treatment with Rock Valley Physical Therapy on referral by Dr. Collins. Petitioner attended these therapy sessions through September 30, 2005.

On September 27, 2005, he saw nurse Bev Davison, and stated that he could bend backwards well but not forward. He then saw Dr. Collins on September 30, 2005, who noted no leg pain other than a bit of stretching down his left leg when bending over at the waist. The rest of the examination revealed full range of motion and strength.

Petitioner then returned to work on October 3, 2005 with certain medical restrictions, after seeing Cheryl Street, RN, at the John Deere Medical facility. Ms. Street noted a release to return to work with restrictions of no lifting of more than 40 pounds, no repeated lifting, bending, twisting or reaching. Petitioner then saw Dr. William Candler of the same medical department that same day. Dr. Candler noted Petitioner's job requires occasional lifting of 60 pounds. His examination revealed problems with heel and toe walking with the left leg, but good range of motion and some limitations of flexion. Dr. Candler restricted Petitioner to no lifting of greater than 40 pounds, no repeated bending, twisting or reaching. Ms. Bev Davidson, RN, also noted that same day that Petitioner was returned to restricted duty work.

Petitioner was assigned to work his welding job. Petitioner continued working that job until transferred to Department 501 in Harvester East Moline. After his transfer, Petitioner was confronted with lifting upwards to 75 pounds, which was well above his medical lifting restrictions. Petitioner testified this lifting caused an increase in his back pain.

Petitioner returned to see Dr. Candler on October 24, 2005 and reported that he had recovered fully and his back pain was resolved. Dr. Candler released him to work with no restrictions. Following that date, Petitioner appeared at Respondent's medical department on various dates with flare-ups of his symptoms from November 8, 2005 through May of 2007. Dr. Chandler placed Petitioner on lifting restrictions, the last being no lifting above 25 pounds and no repeated bending or twisting.

On August 3, 2007, Petitioner underwent a functional capacity evaluation (FCE). Following the FCE, it was noted that Petitioner was functioning at a medium level based on demonstrated ability to lift, carry/exert forces ranging from the low of 40 pounds to eye level and 60 pounds pushing, all on an occasional basis. Left leg strength was the primary limiting factor while stair climbing, kneeling directly using the leg, or climbing a stepladder. No self-limiting behavior was noted.

Petitioner saw Dr. Deignan on February 18, 2009. This was at the request of Respondent. Dr. Deignan recorded the history of permanent medical restrictions, reviewed the FCE and restated those findings and conclusions. Dr. Deignan concluded based on a review of certain medical literature that there was not a strong correlation between occupational factors and disc herniations. Based on this, she concluded that the surgery of August 11, 2005 was not caused by occupational factors.

Petitioner then saw Dr. Nord for an examination. Dr. Nord after obtaining a history and reviewing certain medical records, concluded that Petitioner did sustain an acute lumbar disc herniation at work on August 10, 2005. Dr. Nord also felt there may still be an L4 disc fragment present causing his back discomfort. Dr. Nord felt the pre-existing degenerative disc disease was likely aggravated by his work and positioning as well as flexion and extension and crouching to perform his work. Dr. Nord believed the work injury was caused when welding under frames and performing a lot of stooping, bending, twisting and turning. Dr. Nord concluded Petitioner should be restricted from performing repetitive twisting, turning, bending, and lifting involving the lumbar spine with a weight limit under 40 pounds.

Petitioner denied experiencing problems or symptoms to his back up until or near the time of his August 10, 2005 work activities.

Based upon the above, the Arbitrator finds that the conditions of ill-being as noted above are causally related to the accidental injury which arose out of and in the course of Petitioner's employment with Respondent on August 10, 2005. The Arbitrator affords little weight to the opinions of Dr. Deignan, specially her generalization that work activity would not cause the disc herniation. Dr. Deignan further failed to address the issue if the injury resulted from an aggravation of a preexisting or degenerative condition. Under these circumstances, the Arbitrator strongly relies on the opinions of Dr. Nord as to this issue.

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

Petitioner introduced into evidence out of pocket co-payments in to Orthopedic & Rheumatology Associates in the amount of $58.00. (Px3)

The remaining charges were paid by Respondent's group health insurance carrier.

See findings of this Arbitrator in "C" and "F" above.

Based on said findings, the Arbitrator further finds Respondent to be liable to Petitioner for the above charges which total $58.00.

K. What temporary benefits are in dispute?

See findings of this Arbitrator in "F" above.

Based upon said findings, the Arbitrator further finds that as a result of this accidental injury, Petitioner was temporarily and totally disabled from work commencing August 11, 2005 through October 3, 2005, and is entitled to receive compensation from Respondent for this period of time. October 3, 2005 represents the date Petitioner returned to work with certain medical restrictions.

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

See findings of this Arbitrator in "F" above.

Petitioner returned to work at his welding job and has been placed on certain medical restrictions. Respondent has accommodated these restrictions with ergonomic changes and Petitioner also has devised various methods to allow him to perform his work standing erect rather than crouching, bending or twisting. Petitioner testified that since his surgery he no longer performs things as quickly as before. Petitioner continues to experience back pain with periods of recurrence or exacerbation of his symptoms that run down his left leg to his foot. Petitioner testified that he takes over the counter Ibuprofen to the maximum dose for these symptoms.

Based upon the above, the Arbitrator finds that Petitioner has sustained permanent partial loss of use to his person or man as a whole representing 20% disability.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gwendolyn Stratton,

Petitioner,

vs.

NO: 13 WC 7280

14IWCC0718

UPS,

Respondent.

DECISION AND OPINION ON REVIEW

Petitioner appeals the June 12, 2013 Order of Arbitrator Flores granting Respondent's Motion to Dismiss Petitioner's Application for Adjustment of Claim. Arbitrator Flores found that the Application for Adjustment of Claim for case 13 WC 7280 was duplicative of the Application for Adjustment of Claim for case 12 WC 6684, which had been dismissed by Arbitrator Kane for want of prosecution with no reinstatement sought. The sole issue on Review is whether Arbitrator Flores' granting Respondent's Motion to Dismiss Petitioner's Application for Adjustment of Claim was proper. The Commission, after reviewing the entire record, affirms the June 12, 2013 Order of Arbitrator Flores granting Respondent's Motion to Dismiss Petitioner's Application for Adjustment of Claim and denies Petitioner's claim for the reasons set forth below. Respondent filed a Motion to Strike Petitioner's Request for Oral Arguments and the Commission finds this Motion to be moot as Oral Arguments had already been denied as reviewing party Petitioner failed to file a Statement of Exceptions and/or Additions and Supporting Brief which constituted waiver of the right to Oral Argument (Commission Rule 7040.70(d)).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner filed an Application for Adjustment of Claim on February 24, 2012 which listed a date of accident of November 7, 2011 and alleged injuries to her left hip, lower back and person as a whole as a result of pushing back heavy rollers used to load a truck with boxes. The claim was given case number 12 WC 6684 and was assigned to Arbitrator Kane.

2. On November 1, 2012, Arbitrator Kane dismissed case number 12 WC 6684 for want of prosecution. Notice of Case Dismissal dated November 15, 2012 was sent to the parties. No request for reinstatement of the case was filed by Petitioner and the dismissal became final.

3. Petitioner filed an Application for Adjustment of Claim on March 5, 2013 which listed a date of accident of November 7, 2011 and alleged injuries to her left hip, lower back and person as a whole as a result of pushing back heavy rollers used to load a truck with boxes. The claim was given case number 13 WC 7280 and was assigned to Arbitrator Flores. On this Application it is noted that prior Application for case number 12 WC 6684 was dismissed.

4. On April 19, 2013, Respondent filed a Motion to Dismiss Petitioner's Application for Adjustment of Claim for case number 13 WC 7280. In its Motion, Respondent's attorney noted the above information and requested that the Application for case number 13 WC 7280 be dismissed. Respondent's attorney set the Motion to be heard by Arbitrator Flores on May 1, 2013. On that date, the matter was continued to June 12, 2013.

5. On June 12, 2013, a hearing on Respondent's Motion to Dismiss Petitioner's Application for Adjustment of Claim for case number 13 WC 7280 was held before Arbitrator Flores and a record was made. Both parties were present. Arbitrator Flores noted that the parties returned to see her on May 16, 2013 and she requested a response in writing from Petitioner's attorney to Respondent's Motion. This response was filed on June 12, 2013. In its response, Petitioner's attorney noted that the Application for Adjustment of Claim for case number 13 WC 7280 was filed within the three year Statute of Limitations period. Petitioner's attorney additionally noted that in this Application, it was noted that prior Application for case number 12 WC 6684 was dismissed and argued that this line on the form clearly indicates the appropriateness for filing a second Application as the form requests that information be provided. Petitioner's attorney lastly argued that Respondent was in no way prejudiced by the filing of the Application for case number 13 WC 7280. Petitioner's attorney requested that Respondent's Motion to Dismiss be denied.

Arbitrator Flores indicated that she had reviewed Respondent's Motion to Dismiss Petitioner's Application for Adjustment of Claim for case number 13 WC 7280 and Petitioner's Response (Tr 4). Arbitrator Flores granted Respondent's Motion to Dismiss Petitioner's Application for Adjustment of Claim for case number 13 WC 7280, finding that the Application for case number 13 WC 7280 is a duplicate filing of the Application for Adjustment of Claim for case number 12 WC 6684, which had been dismissed and not reinstated (Tr 4-5).

14IWCC0718

6. Petitioner filed a timely Petition for Review on June 26, 2013 with the sole issue on Review being Dismissal of Application.

7. On June 24, 2014, Respondent filed a Motion to Strike Petitioner's Request for Oral Arguments. The Commission finds this Motion to be moot as Oral Arguments had already been denied as reviewing party Petitioner failed to file a Statement of Exceptions and/or Additions and Supporting Brief, which constituted waiver of the right to Oral Argument (Commission Rule 7040.70(d)).

Based on the record as a whole, the Commission affirms the June 12, 2013 Order of Arbitrator Flores granting Respondent's Motion to Dismiss Petitioner's Application for Adjustment of Claim and denies Petitioner's claim. The Commission has compared the Application for case number 12 WC 6684 to the Application for case number 13 WC 7280 and finds them to be identical, except for the information that case number 12 WC 6684 was dismissed. The Commission finds that Arbitrator Flores was correct that the Application for case number 13 WC 7280 is a duplicate filing of the Application for Adjustment of Claim for case number 12 WC 6684, which had been dismissed and not reinstated. Therefore, the Application for Adjustment of Claim for case number 13 WC 7280 is hereby dismissed and Petitioner's claim is hereby denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner' Application for Adjustment of Claim for case number 13 WC 7280 is hereby dismissed and Petitioner's claim is hereby denied.

DATED: AUG 2 2 2014
MB/maw
o07/17/14
43

Mario Basurto

Stephen J. Mathis

David L. Gore

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ismael Marquez,

Petitioner,

vs.

NO: 05 WC 3165
06 WC 7394

Lutheran School of Theology,

14IWCC0719

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant to remand Order of the Circuit Court of Cook County, Judge Robert Lopez Cepero. In his August 1, 2013 remand Order, Judge Cepero remanded to the Commission to specifically articulate the basis for its findings on causal connection and if the Commission makes any findings on credibility of the evidence or witnesses to specifically articulate the basis for these findings as well.

In his April 5, 2012 §19(b) Decision, Arbitrator Williams found Petitioner sustained accidental injuries arising out of and in the course of his employment on November 3, 2004 (claim 05 WC 3165) and on February 2, 2006 (claim 06 WC 7394). The Arbitrator found causal connection. The Arbitrator found Petitioner had a preexisting condition of degenerative disc disease and stenosis at L4-5 and L5-S1 which was aggravated by the November 3, 2004 injury. The Arbitrator found that although Petitioner did not have complete relief of his lumbar symptoms after the November 3, 2004 injury, Petitioner continued to work and stopped treating 4 months later. On February 2, 2006, Petitioner did not have work restrictions. On that day, while carrying a heavy cabinet, Petitioner tripped and fell. After February 2, 2006, Petitioner complained of more severe symptoms than he did in 2004 and 2005 and also complained of problems with his left leg and foot. Petitioner sought continuous medical care since February 2, 2006 and underwent several lumbar surgeries. The Arbitrator found that Petitioner's lumbar injuries sustained on November 3, 2004 were superseded by his later lumbar injuries on

February 2, 2006. The Arbitrator noted that treating Dr. Mekhail disagreed with §12 Dr. Ghanayem regarding the effects of the February 2, 2006 injury. The Arbitrator found Dr. Mekhail's opinion was supported by the opinions of §12 Dr. Shermer and §12 Dr. Fardon.

The Arbitrator found TTD from November 7, 2004 through November 15, 2004, 1-2/7 weeks at $263.20 per week and from February 3, 2006 through April 15, 2006 and from July 17, 2006 through January 2, 2007 and from May 15, 2007 through September 27, 2010, 210-4/7 weeks at $277.46 per week. The Arbitrator found the medical bills were reasonable and necessary and ordered Respondent to pay the medical bills incurred after February 1, 2006 according to the medical fee schedule. Respondent was given credit for any amount paid towards medical bills, including payments by the group health insurer. The Arbitrator found Petitioner failed to prove that a spinal cord stimulator is reasonable medical care necessary to relieve the effects of his work injuries. The Arbitrator noted that the parties agreed that for claim 06 WC 7394, Respondent paid $13,098.24 in TTD benefits and $45,670.68 in indemnity benefits and for claim 05 WC 3165, Respondent paid $19,474.80 in indemnity benefits and credit under §8(j) was given for indemnity benefits paid. The parties agreed that Respondent is entitled to credit under §8(j) for group health insurance payments of $60,821.76. The Arbitrator noted that Respondent agreed to pay Petitioner $33,297.86 for claim 06 WC 7394. The Arbitrator denied penalties in claim 09 WC 43496.

Respondent filed a timely review of the Arbitrator's Decision. In a Decision and Opinion of Review dated October 29, 2012, the Commission modified the Arbitrator's Decision finding that Petitioner failed to prove he was temporarily totally disabled from November 7, 2004 through November 15, 2004. The Commission found that there was no basis for the Arbitrator's TTD award for that period. Petitioner testified that from November 3, 2004 until he was released by Accelerated Rehabilitation on December 14, 2004, he continued working at Respondent. He kept working his janitor job doing cleaning, the same job he had before the November 3, 2004 injury. The medical records from the University of Chicago Occupational Medicine and Dr. Korn showed Petitioner was not authorized off work. The Arbitrator had also denied penalties in claim 09 WC 43496 and the Commission found that this claim number was not part of the consolidation of claims and a search of the Commission database showed that Petitioner was not the claimant in case 09 WC 43496. The Commission also modified the Arbitrator's Decision to strike this sentence. The Commission affirmed all else.

Respondent appealed to the Circuit Court of Cook County and Judge Cepero issued his remand Order on August 1, 2013. The Commission, after due consideration, modifies and otherwise affirms the Decision of the Arbitrator for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. At the August 30, 2011 arbitration hearing, Petitioner, a 51 year old janitor, testified through an interpreter. On November 3, 2004, he was cleaning the floors and was going to clean the stairs because there was a lot of snow. He was taking some things up the stairs. Petitioner slipped on the 5th stair at the top and flew all the way down and was hitting himself in the low back at the edge of the steps (Tr 13-14). Petitioner noticed that he was in a lot of pain (Tr 14). Following this accident, he received treatment at the University of Chicago Hospital and was seen there by Dr. Korn (Tr 15). X-rays were taken and he was prescribed medications. Petitioner had a prior back injury in 2002 and at that time attended physical therapy for 3 or 4 weeks. He then felt fine and did not treat for his back until after November 3, 2004 (Tr 16). He had undergone a lumbar MRI on September 5, 2002 (Tr 17).

After treating at the University of Chicago Hospital, Petitioner was then sent to Accelerated Rehabilitation for physical therapy, which he attended there 6 or 7 times (Tr 18). Petitioner was released to return to work with restrictions on November 17, 2004 (Tr 18). However, from November 3, 2004 until he was released by Accelerated Rehabilitation, Petitioner continued working at Respondent (Tr 19). Petitioner had no knowledge of whether the charges for Accelerated Rehabilitation services were paid or not (Tr 19). He kept working his janitor job doing cleaning, the same job he had before the November 3, 2004 injury (Tr 19-20).

Petitioner was still employed with Respondent on February 2, 2006. On that date, he was helping take things out of the basement (Tr 20). Petitioner was carrying a cabinet backwards and tripped on a 4 x 4 piece of wood. He fell to the floor and it grabbed his testicle and the nerve and felt like the disc came out of place. He stayed there for a half hour, then got up and walked with his legs opened (Tr 21). He had fallen to the floor onto the left side of his low back (Tr 23). He felt pain in the left side of his low back and his testicle (Tr 24). Between the accident of November 3, 2004 and the accident of February 2, 2006, Petitioner was in a lot of pain. He always felt the pain stronger on his foot and it also felt that his foot was swollen (Tr 25). Between the time he was released from Accelerated Rehabilitation after the November 3, 2004 accident and the accident of February 2, 2006, Petitioner did not seek treatment for the pain he described (Tr 25-28). He did not request any authorization for further medical treatment during that time (Tr 29). He then stated he returned to Dr. Korn, but was told that he had already been released (Tr 30). Petitioner did not go to any other doctors during that time (Tr 30).

After the February 2, 2006 accident, Petitioner treated at Little Company of Mary Hospital on February 13, 2006 (Tr 30-31). He told the ER personnel that on February 2, 2006, he was lifting heavy cabinets and he lost his balance and fell backwards (Tr 31). At that time, Petitioner complained pain in his low back and in his legs (Tr 31). He had waited 11 days to seek treatment between February 2, 2006 and February 13, 2006 because Respondent's big boss was not there as he was on vacation and Petitioner had to wait for his authorization (Tr 32). The ER took x-rays, prescribed medication and referred him to Dr. Mekhail of Parkview Orthopedics (Tr 32). Petitioner began treating with Dr. Mekhail, who ordered various tests and referred him

to other doctors (Tr 34). On July 16, 2006, Petitioner underwent surgery consisting of a decompressive microdiscectomy with hardware (Tr 34). Prior to that surgery, he saw Dr. Ubiluz for a second opinion (Tr 35). He reported to Dr. Ubiluz that he was having trouble sleeping and that his left leg was asleep (Tr 35). Dr. Ubiluz prescribed medications, as did Dr. Mekhail (Tr 35- 36). Prior to his July 16, 2006 surgery, Petitioner had been given a number of epidural steroid injections. He had been referred to pain care treatment by Dr. Mekhail and his associate Dr. Baylis (Tr 36).

Petitioner underwent another surgery in March 2007 (Tr 36). Prior to that surgery, he saw Dr. Shahbain on a referral from Dr. Mekhail (Tr 37). He also saw Dr. Zulfigari for low back pain. Dr. Zulfigari examined him and advised him to go back and see Dr. Mekhail and Dr. Shahbain. All during this time, Petitioner continued to treat with Dr. Mekhail. On April 18, 2008, Petitioner saw Dr. Earman for a second opinion (Tr 38-39). He told Dr. Earman that he was having continuous and persistent pain and that when he was out of prescribed medications, his pain increased (Tr 39). He also complained of numbness in his left lower extremity. Dr. Earman reviewed his x-rays and CT scan and recommended he return to Dr. Mekhail (Tr 40). On referral from Dr. Mekhail, Petitioner then began treating with Dr. Abusharif at the Pain Treatment Center (Tr 40). During that treatment, he received additional epidural steroid injections (Tr 40).

On October 13, 2009, Petitioner underwent another surgery by Dr. Mekhail at Christ Medical Center (Tr 40). Following that surgery, he continued to follow-up with the Pain Treatment Center (Tr 41). Petitioner discussed with Dr. Kalec the recommendation to have a spine stimulator because Dr. Mekhail asked him to do so because he said Petitioner needed it (Tr 41). He has not had a spine stimulator put in because the insurance does not want to pay for anything (Tr 42). To this date, he is still seeing Dr. Mekhail (Tr 42). He wants to have a spine stimulator (Tr 42). Petitioner was not paid any benefits from February 3, 2006 through April 25, 2006 or from July 17, 2006 through January 2, 2007 or from May 15, 2007 through this hearing, a total of 260 weeks (Tr 43). But there was some money that was paid to him in the interim by the various insurance companies (Tr 43-44). Following his last surgery, Petitioner attended physical therapy at Advocate Home Health Services (Tr 44). He does not know anything about the medical bill payments (Tr 44).

Petitioner currently noticed he has a lot of low back pain and pain from his foot up the leg (Tr 45). The pain makes him cry (Tr 45). There is no time where the pain is worse and the pain is all the same (Tr 45). He is taking prescribed medications to calm the pain (Tr 45). Petitioner's attorney noticed Petitioner was walking with a cane (Tr 45). Petitioner stated he has used the cane ever since the first surgery (Tr 45-46). He is not aware of the last date that he worked a job (Tr 46). He did see a doctor on August 15, 2011 and paid him $15, but did not remember his name; this doctor wrote him a prescription (Tr 46-47). Dr. Mekhail's clinic also goes under the name of Combined Orthopedic Specialists, a/k/a Parkview Orthopedics (Tr 47). On June 23, 2007, Petitioner underwent a MRI at Southwest Hospital's MRI Center (Tr 48).

On cross-examination by Respondent's attorney for case 05 WC 3165, Petitioner testified that he would not know if Respondent paid $5,486 to Accelerated Rehabilitation for medical bills as he never got a medical bill from them (Tr 49-50). The cabinet he was carrying on February 2, 2006 when he had his accident weighed 100 pounds (Tr 50).

On cross-examination by Respondent's attorney for case 06 WC 7394, Petitioner testified that between the time he was discharged from Accelerated Rehabilitation from his accident in November 2004 and his accident on February 2, 2006, he wanted to see doctors during that time for treatment (Tr 50). The reason he did not see a doctor during that period of time was because the insurance company would no longer pay for treatment (Tr 52). During that time between when he ended his treatment from the accident in November 2004 and the accident on February 2, 2006, Petitioner remained in a lot of pain (Tr 52). Just his low back was hurting him from 2004 to 2006 (Tr 53). He did not have pain in his foot during that time (Tr 53). He saw Dr. Korn for the November 2004 accident. Dr. Korn referred him to Dr. Fessler (Tr 53-54).

2. The records of the University of Chicago Hospitals Occupational Medicine Center, Px1, indicate Petitioner was seen in the emergency room on August 5, 2002 for complaints of low back pain this day after he lifted a heavy carpet cleaning machine at work. He was diagnosed with a back strain and prescribed medication. Other records from that date indicate Petitioner complained of low back pain and buttock pain since he tried to lift a carpet cleaner up stairs. He reported his pain was a constant 10/10. Petitioner was diagnosed with a back strain with radiculopathy. He was to follow-up with his primary care physician.

Petitioner saw Dr. Chutkow on August 13, 2002 and reported he developed acute low back pain and sciatica after an injury at work 24 hours before. He reported using a large carpet machine at work and felt a grinding sharp pain to his lower back and pain that shot down his left lower leg to his foot. Dr. Chutkow assessed acute low back pain, noted there was no indication for diagnostic testing at that time and prescribed medications. On August 27, 2002, it was noted that Petitioner appeared to be failing treatment of physical therapy and medications. It was also noted that Petitioner did not have severe enough symptoms for a referral to a neurosurgeon, but a MRI was ordered and he was referred to the Pain Clinic. On September 17, 2002, Petitioner received a lumbar epidural steroid injection. Petitioner saw Dr. Chutkow on September 24, 2002 for follow-up for complaints of acute low back pain. Dr. Chutkow noted that Petitioner appeared to have done well with treatment of physical therapy, prescribed medications and the Pain Clinic injection. Petitioner complained of occasional low back pain that was radiating too, but stopping at the buttocks. Dr. Chutkow assessed sciatica/low back pain. Dr. Chutkow noted that a September 5, 2002 lumbar MRI showed degenerative disc changes to his lumbosacral spine with mild stenosis at L4 and L5. Dr. Chutkow opined that these changes were not significant enough to require surgery. Petitioner was to continue his current pain injection treatment and he was to be seen as needed.

3. According to Dr. Korn's records, Rx1B (06 WC 7394), Petitioner was seen on November 3, 2004 at the University of Chicago Hospitals Occupational Medicine Center by Caroline Guenette, M.S., APN-C, who noted he is a 50 year old janitor complaining of low back pain. Ms. Guenette noted, "States he was sweeping a stairwell when he lost his balance and fell down two stairs, hitting his back on the edge of the stairs." Petitioner complained of pain across his lower back which he rated 7-8/10. He reported the pain radiated from his back to his buttocks, down the posterior of his right leg to the knee. He denied any numbness or tingling. He also reported his right leg felt weak when walking.

Ms. Guenette noted Petitioner's past medical history was significant for a low back injury approximately 2 years ago after heavy lifting. She noted a MRI done on September 5, 2002 showed degenerative disc disease with mild stenosis at L4-L5 and there was disc bulging present. Treatment at that time was physical therapy and one epidural steroid injection and Petitioner returned to work without restrictions. Petitioner reported he had not had any chronic problems with his lower back since that time. Ms. Guenette's impression was: 1) back contusion after fall; 2) preexisting degenerative disc disease of the lumbar spine. Ms. Guenette's treatment plan was x-rays, Ibuprofen, ice, gentle stretching exercises and modified duty. Petitioner was to follow-up on November 10, 2004. In her Work Status Report, Ms. Guenette noted that Petitioner may return to work on November 4, 2004 with restrictions of no sweeping or mopping.

According to the November 3, 2004 X-ray Report, x-rays were taken and compared to those x-rays taken on August 27, 2002. The findings were no fracture and degenerative disease at the L5-S1 disc space. There was mild degenerative disease in the visualized lower thoracic spine and mild facet osteoarthritic changes at the lower lumbar levels. There were no changes from the previous study.

Petitioner saw Dr. Korn on November 10, 2004 and reported persistent 8/10 low back pain and to the posterior aspect of the right leg. Functioning capacity was rated by Petitioner at 90%. Dr. Korn noted his past medical history. On examination, Dr. Korn found no spinal tenderness, moderate bilateral superior lumbar paraspinal muscle tenderness and Petitioner could forward flex to bring his fingertips to within 6 inches of the floor. Examination of the lower extremities indicated straight leg raises were negative, the sensory examination was normal and equal and strength was 5/5 bilaterally. Dr. Korn's impression was back pain and he ordered physical therapy and increased the Ibuprofen dosage. Petitioner was released to return to work with a 10 pound lifting restriction.

On November 17, 2004, Petitioner saw Ms. Guenette and reported being about the same. He complained of low back pain which was exacerbated by prolonged sitting and extension. He also complained of pain radiating down both legs with intermittent numbness and tingling. The prescribed medication was not helping. He rated his pain at 7/10. On examination, Ms. Guenette found tenderness to palpation over the midline of L1 through L5 as well as bilateral

lumbosacral paraspinal area, forward flexion was the same, extension was decreased and reproduced pain, there was full side bending and rotation, straight leg raises were mildly positive at 70 degrees, sensation was intact and gait was steady. The pain drawing by Petitioner showed pain from bilateral buttocks down the back of the legs to the ankles. Ms. Guenette's impression was low back pain not significantly improved. Petitioner was referred to Accelerated Physical Therapy, prescribed medication and a home exercise program. The Work Status Report indicated Petitioner may return to work this day with restrictions.

Petitioner reported no significant improvement to Ms. Guenette on December 1, 2004. He complained of pain when changing positions from sitting to standing and with forward flexion. He reported a sensation of something protruding in his back when he bent forward. He also complained of pain radiating down both legs to the foot, right worse than left. He rated his pain at 9/10. Ms. Guenette noted that Accelerated Physical Therapy evaluated Petitioner, however, Cambridge had not authorized any further visits. Ms. Guenette noted, "Patient is working at his current job without a problem except for reported back pain." Ms. Guenette's impression was subjective reporting of low back pain not significantly improved and some symptom magnification. Ms. Guenette ordered a lumbar MRI due to complaints of worsening radiculopathy. She also recommended physical therapy and follow-up with his primary care physician if Cambridge did not authorize treatment. The Work Status Report indicated Petitioner may return to work with restrictions.

According to the records from Accelerated Rehabilitation, Px2, Petitioner attended physical therapy from November 22, 2004 through December 14, 2004. In the December 14, 2004 Progress Note, the therapist noted that Petitioner reported no significant improvement with physical therapy. It was noted that Petitioner complained of continued low back pain and bilateral radicular pain into his legs.

Petitioner saw Dr. Korn on December 15, 2004 and reported no significant improvement. He was still experiencing pain when changing positions from sitting to standing and with flexion. Petitioner also reported pain and numbness down both thighs and lower legs and feet. He rated his pain 10/10. He had less range of motion. Dr. Korn's impression was persistent severe low back pain. Dr. Korn prescribed physical therapy, medications and ordered a lumbar MRI. Petitioner was to continue working at modified duty.

4. At Respondent's request, Petitioner saw Dr. Shermer for a §12 evaluation on December 20, 2004. In his report, Rx1-A (05 WC 3165), Dr. Shermer noted the November 3, 2004 accident and Petitioner treatment to that date. Dr. Shermer noted his past medical history of back problems for the last 4 years and that he had an injection and got better and that he underwent a lumbar MRI two years ago. Petitioner reported aching pain in low back and buttocks. Dr. Shermer noted, "There is no radiculopathy to the legs." On examination, Dr. Shermer found Petitioner could forward flex to his knees with complaints of low back pain, extension, tilting left and right and rotation left and right were all at 30 degrees and straight leg

raises were to 80 degrees bilaterally. Dr. Shermer diagnosed: 1) lumbosacral sprain; 2) lumbar stenosis syndrome. Dr. Shermer opined that the residual findings at this time appeared most likely associated with degenerative disc disease and most likely a lumbar stenosis condition. Dr. Shermer recommended Petitioner undergo a lumbar MRI and possibly epidural steroid injections and opined he would require physical therapy. Petitioned was to continue light duty work.

5. Petitioner saw Dr. Korn on January 10, 2005 and reported no improvement. He reported he had not been given modified duty and was performing regular job duties and needed to take frequent breaks due to pain. He reported seeing a doctor as per the insurance company, but did not get a MRI. His examination findings were the same. Dr. Korn's impression was persistent severe low back pain with radiculopathy – suspected a herniated lumbar disc. Dr. Korn again ordered a lumbar MRI and prescribed medication. Dr. Korn released Petitioner to return to work with a 10 pound lifting restriction.

On January 19, 2005, Dr. Korn noted that Petitioner had undergone a lumbar MRI the previous week. He reported no improvement and his examination was unchanged. Dr. Korn noted he reviewed the MRI report, which showed L4-L5 right lateral nerve root impingement. Dr. Korn's impression was: 1) severe, persistent low back pain; 2) L4-L5 right lateral nerve impingement. Dr. Korn noted he spoke with the Cambridge adjuster and received approval for referral to Dr. Fessler for a neurosurgical opinion. (Rx1B).

6. At Respondent's request, Petitioner again saw Dr. Shermer for a §12 evaluation on February 3, 2005. In his report, Rx2-A (05 WC 3165), Dr. Shermer noted Petitioner reported continued low back pain and numbness in his legs primarily at night. During the day he had no numbness. He had continued working light duty. Petitioner reported he no longer attended physical therapy as he was getting headaches during same. Dr. Shermer noted that Petitioner was essentially unchanged from his prior examination and his diagnosis remained the same. Dr. Shermer noted Petitioned claimed to be much more restricted. Dr. Shermer noted Petitioner's various tension nerve tests were not consistent and there was no neurological loss. Dr. Shermer reviewed the January 14, 2005 lumbar MRI, which showed degenerative disc disease at L3-4, L4-5 and L5-S1, multi-level disc bulging, multi-level stenosis and L4-5 level did show disc bulge and arthritic spurring and stenosis at the foraminal levels of L4-5. Dr. Shermer opined that Petitioner's present persistent complaints were related to degenerative disc disease and stenosis. Dr. Shermer opined that Petitioner appeared now to have recovered from the contusion sprain and required no further treatment regarding that element. Petitioner was to continue light duty work. Dr. Shermer opined that if in the future Petitioner did become a surgical candidate, it would be on the basis of multi-level degenerative disc disease with selective stenotic impingement producing recalcitrant stenotic pain syndrome. Dr. Shermer opined that he did not relate these stenotic conditions and degenerative disc disease to the November 3, 2004 injury.

7. According to Dr. Fessler's notes, Rx2B (06 WC 7394), Petitioner was seen on February 22, 2005. The Commission notes that Dr. Fessler's notes were handwritten and not legible. On March 9, 2005, Petitioner saw Dr. Korn and reported his symptoms were unchanged. Petitioner reported he saw Dr. Fessler on February 22, 2005 and stated that Dr. Fessler recommended surgery. Dr. Korn's impression was: 1) severe, persistent low back pain; 2) L4-L5 right lateral nerve impingement. Dr. Korn's plan was to prescribe medications, continue modified duty and have Petitioner follow-up with Dr. Fessler for surgical repair of the herniated disc. In his addendum report that date, Dr. Korn noted that he spoke with the adjuster who informed him that Petitioner had been sent for an independent medical evaluation and the evaluator opined that his discomfort was not work related.

8. On cross-examination by Respondent's attorney for case 06 WC 7394, Petitioner testified that any medical bills that he received, he sent them to his attorney (Tr 67). Petitioner stated his boss, Bob Berridge, gave him approval to see all these doctors for the past 5 years and that he talked to him on each occasion (Tr 68). Petitioner did not remember receiving his salary for approximately one month following the February 2, 2006 accident (Tr 70). Dr. Mekhail prescribed the cane he used (Tr 70). He had no low back injuries before 2002 (Tr 73). He has not worked anywhere since May 15, 2007 and has not attempted to work anywhere since that time (Tr 73). Petitioner did not remember if he worked light duty between January 3, 2007 and May 15, 2007 (Tr 74-75). The doctors he has been seeing for pain treatment, Dr. Kalec and Dr. Bayran, ran tests for the medication he had been taking and as part of those tests, neither doctor informed him that he tested positive for some drugs that were not prescribed (Tr 75-76). Dr. Bayran did tell him on October 25, 2010 that she was discharging him from her care and to see another doctor because he tested positive for a drug other than what was prescribed. Petitioner stated he does not take drugs or drink alcohol (Tr 76). He had no accidents after February 2, 2006 (Tr 77). Petitioner acknowledged he understood some of the questions in English (Tr 77). The only activity he currently performs around his house during the day is walking (Tr 78). He cannot do hobbies or sports (Tr 78).

On re-direct examination, Petitioner testified he has known his boss Mr. Berridge for 9 years. He stated that after filling out accident paperwork for the November 2004 accident, Mr. Berridge told him he could go see a doctor. Petitioner did not get permission from Mr. Berridge every time he saw a doctor (Tr 79-80). None of his treating doctors have released him to return to work at full duty or light duty after May 15, 2007 and he has not worked since then (Tr 80). No doctor has kept him off work since May 15, 2007 and they have never said anything to him (Tr 82). Dr. Mekhail has not released him from his care (Tr 82). Petitioner did not remember if he was off work from February 3, 2006 through April 25, 2006 (Tr 83). From July 17, 2006 to January 2, 2007, those dates until 2007 he was not working (Tr 83). Dr. Mekhail told him he could not work (Tr 84). Petitioner denied doing drugs or drinking and he does take pain medications (Tr 84). Dr. Mekhail and the pain specialist have prescribed his medications (Tr 85).

9. According to the medical records from Little Company of Mary Hospital, Px3, Petitioner was seen in the emergency room on February 13, 2006. The Triage Note from that date noted the following history: "Pt states he was lifting heavy cabinets, lost his balance and fell backwards 2/2/06." Petitioner complained of low back pain and pain into the bilateral legs. Other records noted the following history: "Fell one week ago, Feb 2, 2006 in the groin area." The X-ray Report that day noted that lumbar x-rays were taken and showed discogenic degenerative changes at the L3-4, L4-5 and L5-S1 levels with mild marginal endplate osteophyte formation and there was mild disc space narrowing at the L5-S1 level. There were mild lower thoracic discogenic degenerative changes.

10. The records from Parkview Musculoskeletal Institute, Px16, indicate Petitioner saw Dr. Baylis on February 28, 2006 and reported he fell at work on February 2, 2006. Petitioner complained of low back pain with left sciatica and numbness and tingling to his left foot. Petitioner denied a history of similar problems in the past. On examination, Dr. Baylis found limited range of motion, positive straight leg raises and slight weakness of toes extensors on the left. He noted the x-rays showed degenerative disc disease at L5-S1. Dr. Baylis' impression was back pain with left-sided sciatica, rule out disc herniation. Dr. Baylis authorized Petitioner off work and ordered a lumbar MRI.

Petitioner underwent a lumbar MRI on March 2, 2006 that had been ordered by Dr. Baylis. The MRI report, Px4, indicated the radiologist's impression was: 1) left paracentral protrusion L5-S1 disc, with moderate left and mild central canal narrowing; 2) disc bulging and facet arthropathy at L4-L5 with a moderate right and mild left foraminal narrowing; 3) bulging and facet arthropathy at L3-4.

On March 14, 2006, Dr. Baylis noted that the lumbar MRI was consistent with left paracentral protrusion L5-S1 with moderate left mild canal narrowing, disc bulging, facet arthropathy L4-5 with moderate right and mild left foraminal narrowing and bulging facet arthropathy L3-4. On examination, Dr. Baylis found Petitioner's gait was okay and straight leg raises were equivocal. Petitioner was to continue off work and he was to set up for epidural steroid injections.

11. According to the records from Pain Care Specialists, Px5, Petitioner saw Dr. Jain on March 21, 2006 on referral from Dr. Baylis. Dr. Jain noted a history that Petitioner developed lower back and lower extremity pain when he fell at work on February 2, 2006. Dr. Jain noted, "The patient works moving large cabinets and he fell back and hit his back and left hip." Petitioner complained of low back pain radiating into both legs, down the entire left leg into the bottom of the foot and down the posterior and lateral aspect of the right leg. He described the pain as sharp, shooting and stabbing with some cramping, throbbing and occasional numbness. His pain was present 24/7 and he rated his pain at 9-10/10. Petitioner reported significant difficulty walking or weight bearing on his left foot and prolonged sitting also was painful. Dr. Jain noted that Petitioner saw Dr. Baylis twice and he had physical therapy for two weeks, which

he did not tolerate. On examination, Dr. Jain found limited range of motion of the lumbar spine, left straight leg raises were positive at 75 degrees and there was a diminution to pinprick in the L5 distribution. Dr. Jain noted the March 2, 2006 MRI results. Dr. Jain's impression was lumbosacral radiculopathy. Dr. Jain's plan was to administer a bilateral L5-S1 transforaminal epidural steroid injection and a left S1 joint injection, which he performed on April 3, 2006.

On April 11, 2006, Petitioner reported to Dr. Jain 20% to 30% improvement with the injections. Petitioner still complained of low back pain radiating to his left lower extremity. Dr. Jain noted Petitioner was currently off work. Dr. Jain's impression was persistent lumbosacral radiculopathy. Dr. Jain recommended a second injection on the left side of L4-L5 and L5-S1. Dr. Jain opined Petitioner was not at maximum medical improvement and needed to be off work.

12. According to the records of neurologist Dr. Ubiluz, Px4, Petitioner was seen on April 12, 2006 for complaints of low back pain which had been present since he fell down on February 2, 2006. Dr. Ubiluz noted that Petitioner went 1½ weeks before seeing a physician. Petitioner reported that he also felt some sensation of something being broken in between his legs behind his testicles. He also reported his lower back made noises, his left leg was numb and he had pain from his lower back down into his left leg. He was not improved with physical therapy. Dr. Ubiluz noted that Petitioner had undergone a lumbar MRI, but no report was available. On examination, Dr. Ubiluz found a positive left Lasegue test and also trigger points in the left lumbar region. Dr. Ubiluz's assessment was L5-S1 disc herniation on the left. Dr. Ubiluz prescribed medications, ordered an EMG and authorized Petitioner off work for the next two weeks.

On April 18, 2006, Dr. Jain performed a left L4-L5 and L5-S1 transforaminal epidural steroid injection with selective nerve block. (Px5).

13. Petitioner underwent an EMG on April 19, 2006 performed by Dr. Ubiluz and the results showed denervation potentials in muscle groups innervated by roots L5 and S1 on the left. The left superficial perineal nerve was non-responsive and there was decreased nerve condution velocity for the right sural. Dr. Ubiluz's impression was that the EMG was consistent with a left L5 radiculopathy. (Px4).

Petitioner saw Dr. Dave, Dr. Jain's associate, on April 25, 2006 and reported no relief. He rated his pain 10/10. He had the same complaints of low back pain radiating into his left leg and down to his foot on the left side. Dr. Dave noted the February 2, 2006 injury. Dr. Dave changed the prescribed medications and recommended left-sided L3-L4 through L5-S1 facet joint injections and a left sacroiliac joint injection. (Px5).

Petitioner also saw Dr. Baylis on April 25, 2006, who noted he was still complaining of low back pain and left leg pain. Dr. Baylis noted Petitioner had undergone epidural steroid injections and that he was walking this day without using an assistive device. Dr. Baylis noted

that Petitioner reported he had returned to work at full duty on April 13, 2006. Dr. Baylis prescribed medications and home exercises. (Px16).

On May 5, 2006, Dr. Ubiluz opined that both the MRI and EMG were in line with a L5 radiculopathy. Petitioner complained of low back pain and occasional left leg and foot numbness. Petitioner reported he could not put his left foot out in order to start walking. His examination and assessment were the same. Dr. Ubiluz recommended chiropractic management and prescribed medications. (Px4).

Petitioner saw Dr. Baylis on May 23, 2006 and reported he was doing about the same and epidural steroid injections did not help. Dr. Baylis noted Petitioner was working full duty. On examination, Dr. Baylis found full range of motion, negative straight leg raises and subjective paraesthesias to the medial, plantar and lateral aspect of his left foot. Dr. Baylis noted that the EMG done April 19, 2006 was consistent with left L5 radiculopathy. He wanted Petitioner to try a third epidural steroid injection. Dr. Baylis wanted Petitioner to continue full duty work and follow-up in 4 weeks. Dr. Baylis noted that if Petitioner was still complaining of increased numbness at that time, he would refer him to Dr. Mekhail. (Px16).

14. Petitioner saw Dr. Ubiluz on June 2, 2006 and reported no pain improvement. He complained of localized low back pain with numbness into his left leg. Petitioner reported that it felt like his left heel was being stretched out. He could not even bend over. He rated his pain 10/10. He could not sleep due to pain, which was constant. Dr. Ubiluz noted that Petitioner had not gone for chiropractic management. His examination was the same. Dr. Ubiluz's assessment was: 1) left L5 radiculopathy; 2) L5-S1 disc herniation. Dr. Ubiluz noted that Petitioner had been asked to get a chiropractor in the city. Dr. Ubiluz warned him about the use and misuse of Vicodin. Petitioner was discharged from care to be seen as needed. (Px4).

15. According to the records of Parkview Orthopedics, Px10, Petitioner saw Dr. Baylis on June 20, 2006 and reported he still had pain to his left leg. He was following up for left-sided sciatica secondary to some foraminal stenosis. Dr. Baylis noted Petitioner did get a third epidural steroid injection. Petitioner complained of pain, numbness and tingling to his lower leg. On examination, straight leg raises were equivocal. There were no right lower extremity problems. Dr. Baylis prescribed medications and referred Petitioner to Dr. Mekhail, an associate, for evaluation. Dr. Baylis was to be seen as needed.

16. Petitioner saw Dr. Mekhail of Parkview Orthopedics on July 10, 2006 and complained of low back pain going down the left side to the left leg all the way down to the heel. Petitioner reported that his pain started on February 2, 2006 after falling and it had been getting worse. He rated his pain 10/10. His pain was worse with activity, better with medications. Epidural steroid injections did not help much and physical therapy did not help at all. On examination, Dr. Mekhail found positive straight leg raises on the left side with pain shooting down to the left heel, decreased sensation in S1 distribution, decreased DTR on the left v. the right and left

Achilles weakness. Dr. Mekhail reviewed the March 2, 2006 lumbar MRI and noted a left L5-S1 disc herniation that could explain Petitioner's symptoms. Dr. Mekhail's assessment was left-sided L5-S1 herniated disc that was causing significant symptoms that were not responding to treatment. Dr. Mekhail noted that Petitioner wanted to explore surgical options. They discussed decompression microdiscectomy and Petitioner wanted to proceed. Surgery was to be scheduled. He continued pain medications. (Px10).

Palos Community Hospital records, Px7, indicate Petitioner underwent surgery on July 19, 2006 performed by Dr. Mekhail. Pre-operative diagnosis was noted as left L5-S1 herniated disc and left lumbar radiculopathy. A left L5-S1 decompressive microdiscectomy was performed.

On July 28, 2006, Dr. Mekhail noted that Petitioner reported he did not have any radicular symptoms, but his back was sore. Dr. Mekhail continued pain medications and ordered physical therapy. (Px10).

According to records of Accelerated Rehabilitation, Px6, Petitioner began physical therapy on August 1, 2006. On August 18, 2006, Dr. Mekhail noted that Petitioner reported he recently started getting some recurrent radicular symptoms down the left leg. His pain medications barely worked. Dr. Mekhail continued his medications and ordered a work conditioning program. (Px10). A functional capacity evaluation was performed on August 24, 2006 and the therapist found Petitioner at a sedentary to light physical demand level. The therapist noted that Petitioner did not meet the job demands of janitor at a medium physical demand level. Petitioner displayed 4 out of 7 positive Waddell signs. Petitioner attended physical therapy through September 6, 2006. (Px6).

17. Petitioner saw Dr. Mekhail on September 12, 2006 and reported he was still having low back pain, which was worse than his radicular pain down the left leg. His pain medications barely helped and he was not tolerating physical therapy. Dr. Mekhail held off on physical therapy, ordered a lumbar MRI and prescribed medications.

Petitioner underwent a lumbar MRI on September 19, 2006. The radiologist's impression was: 1) degenerative changes; 2) at L3-L4, shallow rightward disc protrusion with mild right-sided neural foraminal narrowing; 3) at L5-S1, shallow leftward disc protrusion with moderate left-sided neural foraminal narrowing which may be contributing to a left L5 radiculopathy.

On October 2, 2006, Petitioner reported to Dr. Mekhail that he was having significant low back pain as well as left lumbar radiculopathy. Dr. Mekhail noted the September 19, 2006 MRI results. Dr. Mekhail noted that Petitioner indicated the pain was more severe and it was in a slightly different distribution. Dr. Mekhail noted that obviously it was hard to tell. On examination, Dr. Mekhail found significant low back pain with range of motion and positive

straight leg raises. He noted Petitioner had degeneration of the disc. They discussed surgical options and Petitioner wanted to proceed with a redo decompression and fusion. (Px10).

On October 5, 2006, Petitioner saw Dr. Shahbain for a pre-operative physical examination for surgery scheduled for October 25, 2006. In his records of that date, Px8, Dr. Shahbain noted that Petitioner reported he fell at work on February 2, 2006. Dr. Shahbain noted that Petitioner was status post-op 3 months ago and he reported he never got better. The Commission notes that the rest of Dr. Shahbain's notes are unreadable.

18. The Commission notes that Petitioner saw Dr. Wehner for a §12 evaluation on November 1, 2006. Dr. Wehner's report, Rx3-B (06 WC 7394), was rejected by the Arbitrator.

Petitioner saw Dr. Mekhail on November 14, 2006 and reported he still had severe leg pain and also back pain which went down to his testicle. Dr. Mekhail noted Petitioner was scheduled for surgery, but went for an independent medical evaluation and apparently did not have the MRI with him and surgery was not approved. Petitioner reported his pain was getting worse. His examination was the same. Dr. Mekhail requested copy of the independent medical evaluation report. Petitioner reported he also went for a second opinion who agreed with the procedure and Dr. Mekhail requested a copy of that report. Dr. Mekhail prescribed medications and had Petitioner remain off work. (Px10).

In his November 20, 2006 report, Px10, Dr. Boscardin noted he saw Petitioner for second opinion requested by his partner Dr. Mekhail. Dr. Boscardin noted the February 2, 2006 accident and treatment and reviewed Dr. Wehner's report. Dr. Boscardin noted, "The gentleman did indicate that he had some previous back problems several years ago which appeared to resolve to some degree which ultimately he was allowed to return to work." On examination, Dr. Boscardin found severe tenderness diffusely about his low back which was totally out of proportion to the pressure being applied, extremely limited range of motion, positive straight leg raises both sitting and laying down, but when distracted his straight leg raises were normal and his sensory examination was not anatomical. Dr. Boscardin noted he had reviewed the September 19, 2006 MRI scan, the March 20, 2006 MRI, the EMG and Operative Report. Dr. Boscardin opined that Petitioner may well have some low grade L5 radiculopathy. Dr. Boscardin also opined Petitioner had significant psychological overlay and did not feel he was a good candidate for surgery. Dr. Boscardin recommended a L5 nerve block. Dr. Boscardin also recommended encouragement to Petitioner to return to work at some form of sedentary occupation with frequent position changes and no lifting over 10 to 15 pounds.

On November 30, 2006, Dr. Mekhail noted Petitioner's complaints were the same. Dr. Mekhail noted he had reviewed the reports of Dr. Wehner and Dr. Boscardin. Dr. Mekhail noted he believed Petitioner had some symptoms consistent with radiculopathy. Dr. Mekhail did not recommend surgery until Petitioner's out of proportion back symptoms subsided. Dr. Mekhail

recommended work conditioning and pain medications and gave Petitioner a 20 pound weight restriction. (Px10).

19. In her December 15, 2006 report, Rx4-B (06 WC 7394), Dr. Wehner noted she had previously evaluated Petitioner on November 1, 2006. Dr. Wehner reviewed the September 19, 2006 MRI and noted it showed normal post-operative findings at the L5-S1 level, some mild other diffuse changes and some mild degeneration at L4-5. Dr. Wehner opined these were all normal post-operative findings. Dr. Wehner opined there was nothing on the MRI to explain the extent of Petitioner's subjective complaints. Dr. Wehner opined Petitioner would make an extremely poor candidate for lumbar fusion and that there were no significant radiologic findings to recommend a fusion. Dr. Wehner opined Petitioner's subjective complaints were not supported by specific clinical or radiographic findings. Dr. Wehner opined that there was no basis to recommend a discogram or any further surgery on Petitioner. Dr. Wehner continued to recommend 2-3 weeks of work hardening and opined that based on his progress in that, Petitioner would most likely be at maximum medical improvement at that time.

Petitioner saw Dr. Mekhail on December 28, 2006 and his complaints were the same. Dr. Mekhail's examination findings were the same. Dr. Mekhail noted that Petitioner began physical therapy on December 4, 2006. Petitioner was to continue work hardening and his 20 pound restriction.

On January 4, 2007, Dr. Mekhail noted that the physical therapist indicated Petitioner had inconsistencies in his behavior and opined he had plateaued. Petitioner could lift up to 23 pounds. Dr. Mekhail noted they discussed whether Petitioner could return to work at full duty and he was willing to try. Dr. Mekhail noted Petitioner would like to try pain management. On examination, Dr. Mekhail found mildly positive straight leg raises and limited range of motion. Dr. Mekhail referred Petitioner to pain management. (Px10).

20. According to the records of Pain Care Specialists, Px5, Petitioner saw Dr. Dave on January 23, 2007, who noted he underwent a laminectomy by Dr. Mekhail in July 2006. Petitioner reported he had been experiencing significant left-sided low back, buttock and leg pain and numbness in his groin and perineal region. Petitioner reported he had been working the last 3 weeks, but was having significant difficulty doing so. He rated his pain 10/10. Petitioner reported he stopped physical therapy 3 weeks ago when he began working. He continued to have significant difficulty walking. Dr. Dave noted Petitioner last saw Dr. Mekhail on January 4, 2007. On examination, Dr. Dave found significant bilateral lumbosacral spasm and increased pain with extension and flexion. Dr. Dave recommended a series of epidural steroid injections and changed the dosage of prescribed medications.

On February 20, 2007, Dr. Dave noted Petitioner was to have an epidural steroid injection on March 6, 2007. Petitioner reported he had continued to work full time. Petitioner reported increased pain and was using pain medications greater than prescribed. He was

currently out of prescribed medications. He rated his pain 10/10. Dr. Dave noted the same examination findings. Dr. Dave instructed Petitioner not to utilize increased amounts of pain medications and he would not be receiving any early refills this day. Dr. Dave changed his prescribed medications.

On March 6, 2007, Dr. Jain gave Petitioner a left L4-L5 and L5-S1 transforaminal epidural steroid injection with selective nerve block. Petitioner saw Dr. Dave on March 13, 2007 and reported no relief and he had the same pain complaints. Petitioner continued to work full time. Dr. Dave noted that Petitioner appeared to have taken once again pain medications greater than prescribed. Dr. Dave again instructed Petitioner not to utilize increased amounts of pain medications. A urine sample was taken for routine drug testing. Dr. Dave changed the dosage of the prescribed medications and did not give an early refill. Dr. Dave referred Petitioner to Dr. Brown, a pain psychologist, and recommended a left lumbar sympathetic block.

Dr. Dave noted on May 15, 2007 that insurance did not approve the left lumbar sympathetic block. Dr. Dave noted Petitioner continued working full time and had the same pain complaints, which he rated 10/10. Dr. Dave noted Petitioner reported he saw Dr. Brown, who did not find him to be demonstrating addictive behavior or overusing his medications. Dr. Dave changed the prescribed medications and recommended a left lumbar sympathetic block. Dr. Dave authorized Petitioner off work and referred him to Dr. Mekhail for further surgical evaluation. (Px5).

21. According to the records of Southwest MRI, Px9, Petitioner underwent a lumbar MRI on June 23, 2007. The radiologist's impression was: 1) there were post-surgical changes at L5-S1 level with a small left-sided laminectomy defect, and mild epidural fibrosis to the left of the dural sac; 2) there was moderate encroachment on the left L5-S1 neural foramen which appeared to be due to a combination of facet arthropathy, mild left posterolateral disc bulging, and marginal osteophyte formation; 3) at L3-L4 there was asymmetric right posterolateral annulus bulging and mild facet arthropathy causing mild encroachment on the right neural foramen; 4) at L4-L5 there was mild annulus bulging and moderate facet arthropathy causing only mild effacement of the dural sac; 5) no evidence of central disc herniation or high grade spinal stenosis.

22. According to the records of Palos Community Hospital, Px7, Petitioner underwent surgery on June 27, 2007. The Operative Report indicated a pre-operative diagnosis of recurrent left lumbar radiculopathy and L5-S1 degenerative disc disease. The following procedures were performed: left L4-L5-S1 decompression laminotomy, foraminotomy, partial facetectomy and a L5-S1 spinal fusion with pedicle screw instrumentation using Blackstone medical instrumentation as well as transforaminal lumbar interbody fusion using Peck cage and local bone graft and graft on Orthoplant.

On July 30, 2007, Dr. Mekhail noted Petitioner reported his leg pain had improved significantly compared to before surgery done on June 27, 2007. Petitioner reported some back pain and stiffness. X-rays showed good hardware position. Dr. Mekhail ordered physical therapy and continued pain management. (Px10).

23. Petitioner saw Dr. Zulfigari on August 21, 2007. Dr. Zulfigari assessed status post laminectomy and low back pain. Petitioner was advised to see Dr. Mekhail and Dr. Shahbain. (Px11).

Petitioner saw Dr. Mekhail on August 30, 2007 and reported his back pain was much better than before surgery. There was some residual numbness. Petitioner had not attended physical therapy. Dr. Mekhail noted that the workers' compensation insurer was not approving his seeing anyone else. Dr. Mekhail ordered physical therapy and prescribed medications. In an Addendum, Dr. Mekhail noted that Petitioner asked to address his scrotal pain that has been going on, which he had residually. Dr. Mekhail recommended Petitioner see an urologist. (Px10).

24. At Respondent's request, Petitioner saw Dr. Ghanayem on September 21, 2007 for a §12 evaluation. In his report, Rx5-B, Ex2 (06 WC 7394), Dr. Ghanayem noted the February 2, 2006 accident and Petitioner's treatment, including his surgeries. Dr. Ghanayem noted Petitioner reported the surgeries had not relieved his pain and at times he felt worse. Petitioner report pain in the lumbar base with referral into the buttocks regions bilaterally and down into the left posterior thigh and calf. Dr. Ghanayem noted, "He states that prior to the 2006 work injury, he did not have any back problems." On examination, Dr. Ghanayem found tenderness throughout the lumbar base and mid and upper lumbar regions, no spasm, some tightness, extension at 20 degrees and flexion to 45 degrees. Dr. Ghanayem reviewed the June 2007 MRI scan. Dr. Ghanayem noted that by report Petitioner had a back injury and MRI that preceded the 2006 injury. He noted a lumbar MRI was done in 2002 and another done in January 2005. He did not review March 2006 MRI scan. Dr. Ghanayem noted that Petitioner did improve after lumbar discectomy and then returned to work at his regular activities. Dr. Ghanayem noted that he did not know why Petitioner's symptoms degraded over time. Dr. Ghanayem was concerned about Petitioner's significant narcotic pain medication usage in the past. He requested the MRI scans. Dr. Ghanayem opined that Petitioner was recovering from his lumbar fusion and recommended he complete a course of post-operative rehabilitation related to the fusion, which takes about 3 months, then undergo a functional capacity evaluation.

25. Petitioner saw Dr. Sreckovic, a urologist, on September 27, 2007 for complaints of complaints of bilateral testicular pain. Dr. Sreckovic noted a history of the February 2, 2006 accident, two back surgeries and persistent discomfort since that accident. On examination, Dr. Sreckovic found positive right testicular atrophy. Dr. Sreckovic ordered a scrotal ultrasound. (Px10).

26. In his October 12, 2007 report, Rx5-B, Ex3 (06 WC 7394), Dr. Ghanayem noted he had reviewed the January 14, 2005 MRI scan, which showed spinal stenosis at L4-5 level and L5-S1 level and a disc herniation at L5-S1. Dr. Ghanayem opined that the stenosis at L4-5 remained stable from the 2005 scan compared to the June 2007 MRI scan. Dr. Ghanayem opined that March 2006 MRI scan confirmed the same disease process. Dr. Ghanayem opined that therefore, it would appear that Petitioner had a disease process that was at least radiographically present and symptomatic prior to the February 2, 2006 work injury. A discectomy was technically well done. Dr. Ghanayem opined that he would not have recommended a fusion for a degradation of symptoms of low back pain. Dr. Ghanayem opined that in addition, Petitioner had stenosis that was ongoing at the L4-5 level which may also be a reason for his progression of symptoms and ongoing problems. The stenosis was degenerative in nature. Dr. Ghanayem opined that while the initial discectomy may be related to his work injury, the subsequent fusion would be related to progression of his degenerative disease.

27. Petitioner saw Dr. Mekhail on October 22, 2007 and reported he felt better than before the surgery, but still was in significant discomfort in his back and left leg. On examination, Dr. Mekhail found significant back stiffness and left ankle weakness. X-rays showed good hardware positioning, it appeared healed and there was no evidence of hardware loosening. Dr. Mekhail believed there was some element of dysfunctional pain syndrome. Petitioner reported the physical therapist informed him he was not really benefiting. Dr. Mekhail ordered a functional capacity evaluation. Petitioner reported he went to an urologist, who found a discrepancy in the size of the testicles, and insurance was denying him that. Petitioner was to continue pain medications and perform home exercises. (Px10).

28. Palos Community Hospital records, Px7, indicate Petitioner underwent a testicular ultrasound on November 9, 2007 for complaints of bilateral testicular pain. The impression was notes as: 1) bilateral hydrocele left greater than right; 2) small cyst in the epididymal heads bilaterally.

29. Dr. Mekhail noted on December 3, 2007 that Petitioner reported he had attended an independent medical evaluation which actually recommended against the surgery he had. Dr. Mekhail noted Petitioner had improved after surgery. He was still on pain medications. The functional capacity evaluation was not approved. Dr. Mekhail opined Petitioner could not do his job. Dr. Mekhail opined Petitioner could do light duty and gave a 10 pound restriction. He noted Petitioner cannot stand or walk for a long time. Dr. Mekhail continued medications and home exercises.

On January 8, 2008, Petitioner reported to Dr. Mekhail that his leg symptoms were getting worse. Petitioner reported he can function on pain medications. Petitioner informed that Respondent would not accommodate his 10 pound restriction. His examination findings were the same. Dr. Mekhail ordered a lumbar CT myelogram and opined that if the bone was healed and there was no evidence of any neural compression, Petitioner would be at maximum medical

improvement. Petitioner complained of the same left-sided radicular symptoms to Dr. Mekhail on February 26, 2008. Dr. Mekhail reviewed the CT myelogram, which showed a bony spur with some foraminal stenosis at L5-S1. Treatment options were discussed and Petitioner did not want any more injections. Dr. Mekhail prescribed pain medications and referred Petitioner for a second opinion. Dr. Mekhail opined that the only thing he could see doing was to redo the decompression, but explained to Petitioner that there was no guarantee this would help him. He continued the 10 pound lifting restriction.

Petitioner saw Dr. Earman of the Orthopedic Center for a second opinion on April 15, 2008. In his report, Px12, Dr. Earman noted the February 2, 2006 accident and Petitioner's treatment. Dr. Earman reviewed the lumbar CT scan and noted that the cages appeared to be in good position, but there was at least a question of possible sclerosis. Dr. Earman recommended bone scan for possible psueudoarthrosis at L5. Dr. Earman noted that depending on results, this was a chronic pain management problem. Petitioner was to follow-up with Dr. Mekhail.

30. On May 19, 2008, Petitioner saw Jim Hanna, RN-MSN-NP-C at Parkview Orthopedics, who noted that Dr. Mekhail had sent him to Dr. Earman for a second opinion. Petitioner complained of low back pain and cervical pain. Petitioner reported he was being denied workers' compensation. Petitioner also complained of severe pain to the left anterior thigh and left hand. No copy of Dr. Earman report had been received yet. Mr. Hanna recommended an epidural steroid injection, which Petitioner would go for. (Px10).

According to the records of the Pain Treatment Center, Px13, Petitioner saw Dr. Abusharif on June 6 and June 20, 2008 and received transforaminal epidural steroid injections at L5-S1 on the left. Petitioner underwent a bone scan on July 5, 2008 at Palos Community Hospital to rule out pseudo arthrosis. The radiologist's impression was that the bone scan was normal. (Px7).

Petitioner reported to Dr. Abusharif on July 11, 2008 that the injections provided very little change in pain relief. A caudal epidural steroid injection was given to see if there were any adhesions in the epidural space that could potentially be lysed. Petitioner was informed that if this did not provide any relief, he was certainly a candidate for spinal cord stimulator trial. (Px13).

On July 31, 2008, Dr. Mekhail noted that Petitioner was still having recurrent left lumbar radiculopathy and left ankle weakness. He noted the bone scan was negative. Dr. Mekhail ordered a CT myelogram to see if there was union of the fusions and any evidence of facet stenosis. Petitioner was to continue pain medications and exercises. (Px10).

Dr. Abusharif noted on August 10, 2008 that in the CT myelogram the contrast did extravasate throughout the epidural space, confirming no particular impingement of the nerve roots. Dr. Abusharif recommended a spinal cord stimulator trial and to seek authorization for same. He prescribed medications. On September 14, 2008, Dr. Abusharif noted he was awaiting authorization for a spinal cord stimulator trial. (Px13).

31. Petitioner saw Dr. Mekhail on October 9, 2008 and reported worsening radicular symptoms in his left leg. He had partial left foot drop. Petitioner reported he wore an AFO, which helped him from getting repetitive ankle sprains, and he used a cane. Dr. Mekhail noted Petitioner had decreased sensation in the L5 distribution. Dr. Mekhail noted that the CT myelogram showed recurrent stenosis at L5-S1 which was fairly severe and opined it was hard to tell if this was really what was causing his symptoms or not. Petitioner had bone re-growth despite redo decompression and removing this bone and it was hard to tell if he had permanent nerve damage versus something that could be fixed surgically. On CT scan it looked like there was bone bridging interbody in the posterior part of the disc and it was hard to tell whether in the middle it was healed, but there was no evidence of hardware failure. Dr. Mekhail noted that he would like to avoid another surgery with a lesser chance of success. He noted that pain management believed a spinal cord stimulator might be very helpful with his condition. Dr. Mekhail noted that Petitioner was going to have a trial of a spinal cord stimulator. Dr. Mekhail opined that the only alternative was to redo the decompression. (Px10).

Dr. Abusharif noted on October 28, 2008 that Dr. Mekhail agreed with the plan. Dr. Abusharif assessed post-laminectomy syndrome. On December 19, 2008, a percutaneous Medtronic spinal cord stimulator was surgically placed. On December 22, 2008, Petitioner reported minimal relief with spinal cord stimulator. The stimulator was reprogrammed. Petitioner reported no relief on December 23, 2008 and the trial leads were removed. On December 29, 2008, Dr. Abusharif noted that Petitioner's pain did significantly increase after removal of the electrodes. Dr. Abusharif opined that the increased pain did confirm that the spinal cord stimulator did provide approximately 50% reduction in pain levels. Dr. Abusharif opined that based on these findings, Petitioner was a candidate for an implanted device. Petitioner reported on January 28, 2009 that several days ago he felt as if there was a cracking or popping sensation in his low back and felt pain radiating into the gluteal, rectal and groin region. The pain was not more than it had been, just in a different area. Petitioner was concerned that the hardware may have dislodged. Dr. Abusharif recommended a CT scan and also recommended a permanently implanted spinal cord stimulator. Petitioner was to consider this. (Px13).

Petitioner had the same complaints to Dr. Mekhail on February 21, 2009 and his examination was unchanged. Dr. Mekhail noted that Petitioner had tried epidural steroid injections, which did not help and underwent a trail of spinal cord stimulator, which did not help. Dr. Mekhail believed it was reasonable to redo the left L5-S1 decompression. Dr. Mekhail

informed Petitioner that he did not think he was going to be 100% relieved of his symptoms. Petitioner agreed to proceed. (Px10).

On March 10, 2009, Dr. Abusharif noted that Petitioner was to see Dr. Mekhail about possible extension of fusion. On April 13, 2009, Petitioner saw Dr. Kalec at the Pain Treatment Center, who prescribed medications. (Px13).

32. At Respondent's request, Petitioner saw Dr. Ghanayem again on May 27, 2009 for a §12 evaluation. In his report of that date, Rx5-B, Ex4 (06 WC 7394), Dr. Ghanayem noted Petitioner complained of ongoing back pain, left-sided leg pain, occasional right buttocks pain and testicular pain. Dr. Ghanayem noted Petitioner underwent physical therapy and trial of a spinal cord stimulator, but neither helped his symptoms. He noted Petitioner used a left foot brace for persistent weakness. Petitioner reported that additional surgery had been recommended. Dr. Ghanayem noted that Petitioner stated he did not have back problems prior to his 2006 injury. Dr. Ghanayem specifically asked Petitioner about a 2004 injury and he then recalled he hurt his back at that time and developed back and leg pain as he had now, but stated that nobody believed him after that injury and he continued to have ongoing back and bilateral leg pain up until his new injury in 2006. Dr. Ghanayem noted that this history was obtained using an interpreter. On examination, Dr. Ghanayem found tenderness in the paraspinal musculature, extension increased his pain more than flexion, ongoing complaints of low back pain with axial compression of the head, truncal rotation through the knees and distraction through the shoulders and diminished sensation for the posterior lateral left calf. Dr. Ghanayem reviewed the February 2009 CT scan, which showed ongoing stenosis at the L4-5 level, facet joint impingement at the mobile L4-5 facet joints with pedicle screws placed at the L4-5 level. Dr. Ghanayem re-reviewed the MRI scans before and after the 2006 work injury and noted there was no substantive change in the nature of his disc pathology at L5-S1 as well as the stenosis at the L4-5 level.

Dr. Ghanayem opined that it would appear that Petitioner's symptoms that he noted after the 2006 injury were already present and they appeared to be related to his November 2004 work injury. This explained the MRI scan obtained in 2006 with a lack of any change between the two studies on either end of his 2006 work injury. Petitioner's current problem was low back pain status post lumbar fusion with ongoing stenosis at the L4-5 level and facet joint impingement at the L4-5 secondary to malpositioning of his L5 pedicle screws. Petitioner had a residual foot drop related to his L5-S1 repeat laminectomy and fusion. Dr. Ghanayem opined that the L5-S1 fusion was not medically necessary relative to his 2006 work injury. Dr. Ghanayem opined that given the new information about his 2004 work injury, it would appear that the intervening accident in 2006 was not responsible for his need for surgical intervention. Dr. Ghanayem noted that Petitioner was released to regular work in 2007 and did work for roughly 5 months in 2007. Petitioner had a worsening of low back pain in July 2007 requiring a hospital admission. Dr. Ghanayem opined that this admission was apparently due to the underlying problems in his back, which appeared to be ongoing stenosis at the L4-5 level and what appeared to be facet joint impingement at L4-5 as well. Dr. Ghanayem opined that Petitioner's readmission to the hospital

after his lumbar fusion would be related to that fusion procedure and the complications associated with that and not his 2006 work injury. Dr. Ghanayem opined that Petitioner had ongoing structural problems in his back, but he may be amenable to some revision surgery and opined this would not be related to the 2006 work injury. Dr. Ghanayem opined Petitioner had multiple nonorganic physical findings consistent with symptom magnification, which greatly diminished the chance of him having any substantial improvement from additional surgical intervention. Dr. Ghanayem opined, "Relative to the 2006 injury, I do not think the nature of his back problem changed to any significant degree, in that he had an ongoing problem from 2004, both symptomatically and radiographically. Therefore, the injury in 2006 may have temporarily aggravated his symptoms, but the need for invasive care would be related to the 2004 injury."

33. Petitioner saw Dr. Kalec on June 2, 2009 and he was prescribed medications. An EMG was performed on June 9, 2009 and the findings were compatible with mild radiculopathy bilaterally at the L2-L3, L3-L4, L4-L5 and L5-S1 levels, slightly worse on the left side. That same day, Dr. Kalec noted the EMG findings. Dr. Kalec noted Petitioner was to see his orthopedic surgeon for more definitive care and possible surgery. He was to follow-up with Dr. Kalec for his medications. (Px13).

On June 25, 2009, Dr. Mekhail noted that Petitioner had undergone an EMG, which showed evidence of radiculopathy, left greater than right. Dr. Mekhail believed Petitioner's symptoms were coming from the L5-S1 level. He noted that Petitioner wanted to have a redo decompression. Dr. Mekhail noted that he did not think the fusion should be addressed. Dr. Mekhail prescribed medications and Petitioner was to remain off work. Dr. Mekhail noted he did not have Dr. Ghanayem's May 27, 2009 report and requested same.

Petitioner saw Dr. Kalec on July 1, 2009 and reported he did see his orthopedic surgeon who was in contact with his lawyer. Dr. Kalec reviewed Petitioner's drug screen and noted he was positive for marijuana. Petitioner told Dr. Kalec that this was only because he was in a car where the driver was smoking marijuana. Petitioner was to go to Cook County Hospital to see his primary care physician for high blood pressure and for his groin discomfort. (Px13).

34. Petitioner saw Dr. Mekhail on July 9, 2009 and reported the same complaints. Dr. Mekhail noted that he had received Dr. Ghanayem's report, who had opined that Petitioner's condition was related more to a 2004 injury, but aggravated by the 2006 injury. Dr. Mekhail noted that he believed that the 2006 injury had a causative relationship to his surgery. Dr. Mekhail noted that Dr. Ghanayem indicated that there were screws in L4-L5. Dr. Mekhail disagreed with that and noted the screws were in L5-S1 only. Dr. Mekhail noted that Dr. Ghanayem also mentioned malpositioning of the screws, which Dr. Mekhail completely disagreed with. Dr. Mekhail agreed with Dr. Ghanayem that Petitioner had preexisting L4-L5 stenosis, but Petitioner also had foraminal stenosis now at L5-S1. Dr. Mekhail opined that a redo decompression was a valid surgical option. Petitioner was to continue medications and home exercises pending approval for surgery. (Px10).

On July 29, 2009, Dr. Kalec noted that Petitioner reported that surgery was being planned. Petitioner was to continue the same medications. Dr. Kalec noted on August 28, 2009 that Petitioner was in need of surgery and was awaiting authorization. Dr. Kalec prescribed medications. (Px13).

On September 28, 2009, Dr. Mekhail noted that surgery authorization had been denied. Dr. Mekhail requested approval again and continued medications.

Petitioner underwent surgery performed by Dr. Mekhail on October 13, 2009. In his Operative Report, Dr. Mekhail noted a pre-operative diagnosis of recurrent left lumbar radiculopathy, low back pain and foraminal stenosis of the lumbar spine. Dr. Mekhail performed a redo left L5 and S1 decompression, laminotomy, foraminotomy, partial cystectomy, exploration arthrodesis L5-S1 and hardware removal of pedicle screw fixation. (Px10).

The records of Advocate Home Health Services, Px15, indicate Petitioner attended post-operative physical therapy from October 14, 2009 through October 24, 2009.

35. Petitioner saw Jim Hanna, RN-MSN-NP-C at Parkview Orthopedics, on November 5, 2009. Mr. Hanna noted that Petitioner had a redo of L5-S1 hardware removal decompression. Petitioner reported he still had some left leg pain and radiculopathy down the L4-L5 nerve root region. (Px10). On November 10, 2009, Dr. Kalec prescribed medications. (Px13). Petitioner reported to Mr. Hanna on November 23, 2009 that he was doing very well. He still had a little bit of left leg radiculopathy. Petitioner was to continue home exercises. (Px10). On December 15, 2009, Petitioner reported to Dr. Kalec that he had surgery in October 2009 and the pain was not as bad. Dr. Kalec prescribed medications. (Px13).

36. Petitioner reported to Dr. Kalec on January 12, 2010 that his pain has significantly worsened. (Px13). Petitioner saw Dr. Mekhail on January 14, 2010, who noted the hardware removal and redo decompression on October 13, 2009. Petitioner reported that his pre-operative pain down the left leg was almost completely resolved, but he still had numbness down the left S1 distribution. Petitioner reported no significant back pain. On examination, Dr. Mekhail found improved range of motion, negative straight leg raises, but decreased sensation in L5-S1 distribution. Petitioner was now complaining of right scrotal pain. Dr. Mekhail noted, "He has had this right scrotal pain since the second accident in 2006 and now it is coming back. It is annoying him." Dr. Mekhail referred Petitioner to a neurologist for the scrotal pain. Dr. Mekhail noted Petitioner was taking pain medications prescribed by pain management. (Px10).

37. At Respondent's request, Petitioner saw Dr. Ghanayem again on January 22, 2010 for a §12 evaluation. In his report of that date, Rx5-B, Ex4 (06 WC 7394), Dr. Ghanayem noted Petitioner had the hardware removed in October 2009. Petitioner reported he had a slight improvement in low back pain, but no change in leg symptoms. Petitioner used narcotic pain medications for residual pain. Petitioner had no post-operative physical therapy, although it had

been recommended. On examination, Dr. Ghanayem found flexion and extension at 10 degrees, noticed Petitioner could easily flex between 30 and 40 degrees when changing from the exam chair to exam table, had same complaints of pain with axial compression of the head, straight leg raises were negative bilaterally and slightly diminished sensation in the lateral/posterior left calf. Dr. Ghanayem's impression was some improvement in back symptoms after hardware removal. Dr. Ghanayem opined that a brief course of physical therapy for 3 to 4 weeks would be reasonable, then a functional capacity evaluation. Beyond that, no additional care was required. Dr. Ghanayem opined that light duty was medically reasonable from the objective structural condition of his back. Petitioner made no complaints of scrotal pain. A professional Spanish interpreter was used to communicate with Petitioner.

38. Petitioner saw Dr. Mekhail on February 25, 2010 and reported his scrotal pain was slightly better. Dr. Mekhail noted Petitioner saw a neurologist who prescribed medications. Petitioner reported he was doing really well, but now was getting worse. He complained of some back pain. His examination was the same. Dr. Mekhail referred Petitioner to pain management to see if this chronic condition could be treated with possible spinal cord stimulation. Dr. Mekhail did not recommend any surgical intervention. Dr. Mekhail noted Petitioner had scarring before. (Px10).

39. At Respondent's request, Petitioner saw Dr. Fardon on March 18, 2010 for a §12 evaluation. In his report of that date, Rx3-A (05 WC 3165), Dr. Fardon noted Petitioner reported both 2004 and 2006 accidents and that after the 2006 injury he could not feel his "parts" and gestured to his scrotal area and that his left leg was completely numb. Dr. Fardon noted the three surgeries and Petitioner's complaints. Dr. Fardon reviewed the September 5, 2002 lumbar MRI and the August 27, 2002 x-rays. Dr. Fardon reviewed the medical records from after November 3, 2004 and after February 2, 2006. Dr. Fardon noted the MRIs and surgeries. There were no medical records subsequent to February 3, 2009. There were no images to review subsequent to November 3, 2004. Dr. Fardon noted that those additional pieces of information could change his opinions. On examination, Dr. Fardon found extremely out of proportion complaints of pain during the examination. Dr. Fardon diagnosed: 1) chronic L5 radicular pain and back pain; 2) symptom magnification. Dr. Fardon opined that the medical records show Petitioner had a chronic degenerative condition of his low back. Dr. Fardon noted that the records of the physicians who treated Petitioner after the 2004 injury lacked prior injury information. Dr. Fardon opined, "The nature of his lower back problems and its course suggest that he has a chronic degenerating condition of his lower back that has been exacerbated and aggravated by repeated injuries." Petitioner had chronic degenerative disc and facet disease in the lumbar spine. Dr. Fardon opined that condition had been at least exacerbated by injury. Dr. Fardon opined, "The injury in 2006 has aggravated it, as perhaps have his disappointing results from efforts at surgical and medical management." Dr. Fardon recommended a functional restoration type program followed by a functional capacity evaluation.

40. Petitioner saw Dr. Kalec on March 26, 2010 and reported his orthopedic surgeon was recommending a spinal cord stimulator. Dr. Kalec prescribed medications. Petitioner reported the same complaints of low back pain and of his left leg on June 18, 2010. On July 27, 2010, Petitioner reported to Dr. Kalec that his pain was worse. On August 24, 2010, Petitioner reported no change and Dr. Kalec prescribed medications. (Px13).

41. On referral from Dr. Mekhail, Petitioner saw Dr. Bayran of Interventional Pain Management on August 30, 2010. Petitioner complained of pain mostly on the left side of his lower back with radiation into the posterolateral aspect of his left thigh and down to his foot. Petitioner also complained of left groin pain. He had occasional numbness and tingling in his left lower extremity. Petitioner reported his pain started in 2006 after he was carrying cabinets. Dr. Bayran noted Petitioner had undergone 3 back surgeries and noted treatment of epidural steroid injections and a trial of spinal cord stimulator. Dr. Bayran reviewed the Pain Clinic records and noted Petitioner reported very minimal relief with the spinal cord stimulator. Dr. Bayran noted Petitioner had been on heavy narcotic medications since then. Dr. Bayran reviewed the July 2010 lumbar MRI which showed at L4-5 mild to moderate central stenosis with mild to moderate right neural foraminal narrowing and at L5-S1, post-operative changes with moderate fibrosis at the left lateral recess and mild right and moderate left neural foraminal narrowing.

On examination, Dr. Bayran found flexion and extension painful at 10 degrees and right and left lateral bend to 10 degrees with no pain, sitting straight leg raises were negative on the right, positive on the left and decreased pinprick over the lateral left thigh and leg. Dr. Bayran's impression was low back pain and left leg pain status post surgery three times. Dr. Bayran noted that Petitioner had failed to respond to several procedures done by Dr. Abusharif and also failed to respond to the trial of a spinal cord stimulator. Dr. Bayran opined that the best option was to optimize his pain medications. Dr. Bayran changed his prescribed medications.

Petitioner saw Dr. Bayran on September 27, 2010 and reported that the medications were helping. The records showed that only some medications were given to Petitioner. Dr. Bayran requested a urine toxicology examination and Petitioner complied. Dr. Bayran noted that preliminary toxicology results showed the presence of cocaine. Dr. Bayran prescribed medications. Dr. Bayran noted that Petitioner's work status was to be determined by Dr. Mekhail. On October 25, 2010, Dr. Bayran noted that he informed Petitioner that the toxicology report showed positive for cocaine. Petitioner explained that a friend has slipped some cocaine into water he was drinking and this was unknown to him. He denied any further drug use. Dr. Bayran discharged Petitioner from his care. Dr. Bayran prescribed medications and advised Petitioner to find another pain physician. (Px10).

42. In his November 8, 2010 deposition, Rx5-B (06 WC 7394), Dr. Ghanayem testified he is a board certified orthopedic surgeon. Dr. Ghanayem recited from his reports, which are noted above. Dr. Ghanayem opined causal connection to the 2004 injury (Dp 17). Dr. Ghanayem

opined that Petitioner was a surgical candidate before the February 2, 2006 injury (Dp 17). Dr. Ghanayem opined that had the February 2, 2006 injury never occurred, Petitioner would still be in the same structural condition for which he had a surgical procedure performed when he had it performed (Dp 17). Dr. Ghanayem opined that Petitioner had some symptoms related to the February 2, 2006 injury, but that the symptoms in and of themselves were not such that it changed the nature of his surgical problem (Dp 17-18).

On cross-examination by Respondent's attorney for case 05 WC 3165, Dr. Ghanayem testified that he was not provided the September 5, 2002 lumbar MRI scan to review and did not recall reviewing the MRI report of that date (Dp 28). Dr. Ghanayem testified that Petitioner did not mention anything about having back problems in 2002 or medical treatment at that time (Dp 30). Dr. Ghanayem opined that a common cause of spinal stenosis is age and the structural condition of spinal stenosis can progress over time as one gets older (Dp 31-32).

On cross-examination by Petitioner's attorney, Dr. Ghanayem testified that the 2002 MRI showed mild central stenosis at L4-5 and no stenosis at L5-S1 and there were some degenerative changes, but no disc herniation. Dr. Ghanayem opined that this represented a structural difference between the two subsequent MRI scans in 2005 and 2006 (Dp 37). Dr. Ghanayem opined he would not operate on Petitioner based on the 2002 MRI report (Dp 37).

On re-direct examination, Dr. Ghanayem testified that assuming the 2002 MRI report was accurate, this would not change his opinions (Dp 41-42). Dr. Ghanayem opined that the 2006 accident was nothing more than a temporary aggravation of Petitioner's ongoing back condition as seen before his 2006 accident (Dp 42). Dr. Ghanayem opined that the condition for which Petitioner needed surgery existed prior to the 2006 incident (Dp 42-43).

On re-cross examination by Respondent's attorney for case 05 WC 3165, Dr. Ghanayem testified he did not actually see the September 5, 2002 MRI scan (Dp 43).

43. The Commission notes that the Arbitrator rejected Dr. Fardon's November 19, 2010 report, Rx4-A (05 WC 3165). However, this report was attached to Rx5-A (05 WC 3165), Response to Petitioner's Penalties Petition, which was admitted into evidence.

In his November 19, 2010 report, Dr. Fardon noted he reviewed the September 5, 2002 MRI report and the January 14, 2005 MRI report. Dr. Fardon compared the two MRIs and opined that the degenerative process had progressed slightly between 2002 and 2005 and that such changes are the natural progression of degenerative process and not related to trauma. Dr. Fardon concluded that the November 3, 2004 incident produced a sprain/strain injury with no permanency. Regarding the February 2, 2006 accident, Dr. Fardon opined that there was an additional clinically manifest disc herniation that became symptomatic after that injury and led to the July 19, 2006 surgery. Dr. Fardon opined that the need for the July 19, 2006 surgery was based both upon a preexisting degenerative back condition and the effect of the injury sustained

on February 2, 2006. Dr. Fardon opined that the second surgery was the result of the unsuccessful outcome of the first surgery on July 19, 2006. Dr. Fardon noted the records he had reviewed only go to February 3, 2009 and therefore he could not comment on the third surgery. Dr. Fardon opined Petitioner did not require any further treatment related to the November 3, 2004 injury. Dr. Fardon opined no permanent disability was related to the November 3, 2004 injury. Dr. Fardon opined that the records he reviewed were not sufficiently detailed to say when Petitioner had reached maximum medical improvement after November 3, 2004, but that maximum medical improvement would have occurred before the February 2, 2006 accident.

44. At the September 27, 2011 arbitration hearing, Respondent's attorney for case 05 WC 3165 brought a dedimus potestatem for the issuance of a deposition of Dr. Fardon (Tr 4). The Arbitrator denied the request, but would allow Dr. Fardon to testify live (Tr 8).

45. At the October 24, 2011 arbitration hearing, Dr. Fardon testified he is a board certified orthopedic surgeon (Tr 10). He performed a §12 evaluation on March 18, 2010 and generated a report (Rx3-A (05 WC 3165), noted above). Subsequent to his March 18, 2010 report, Dr. Fardon was asked to prepare an addendum report based on his review of additional medical records (Tr 16). Dr. Fardon reviewed the January 14, 2005 MRI Report and the September 5, 2002 MRI Report and generated his Addendum Report dated November 19, 2010 (Tr 18). Dr. Fardon opined there was not a significant difference between these two MRIs (Tr 18). There were some minor variations that could be explained by the circumstances of being done at different facilities and by different radiologists (Tr 18-19). There were no substantial difference in the findings (Tr 19). Dr. Fardon opined that on November 3, 2004, Petitioner sustained a temporary exacerbation of symptoms related to his preexisting condition (Tr 19). Dr. Fardon opined that the need for the July 19, 2006 surgery by Dr. Mekhail was caused by Petitioner's long standing and moderately extensive degenerative condition in his low back that was complicated by a disc protrusion that became symptomatic in 2006 (Tr 20). Dr. Fardon opined that the June 27, 2007 fusion was done because the previous surgery failed to give a satisfying result (Tr 20). Dr. Fardon opined that he had not found any objective evidence of a permanent injury that occurred on November 3, 2004 (Tr 21). Dr. Fardon opined that Petitioner did not require additional treatment related to the November 3, 2004 injury (Tr 21). Dr. Fardon opined that Petitioner did not sustain a permanent impairment or disability as a result of the November 3, 2004 injury (Tr 21-22). Dr. Fardon opined that sometime between the beginning of 2005 and early 2006, Petitioner had reached maximum medical improvement from the November 3, 2004 injury (Tr 22). He could not give a specific maximum medical improvement date (Tr 24). Petitioner was having some trouble in February 2005 and then there are no medical records until February 2006 and Dr. Fardon opined Petitioner reached maximum medical improvement between those dates (Tr 24-25). Petitioner was working when he was injured again on February 2, 2006 (Tr 25). His opinions would not change if he knew Petitioner had lifted 100 pounds on that date (Tr 25). Dr. Fardon was not aware that Petitioner had testified that he did not have any foot pain prior to February 2, 2006 (Tr 28). This did not change his opinions (Tr 28).

On cross-examination by Petitioner's attorney, Dr. Fardon testified he did not examine Petitioner on November 19, 2010 (Tr 30). He did not review the MRI scans, he reviewed the MRI reports (Tr 33). His conclusions are based on the reports of the MRI radiologists (Tr 33). Dr. Fardon reads his own MRIs. Over the years he has had different interpretations of MRI scans than radiologists (Tr 34). Maximum medical improvement opinions can vary from physician to physician (Tr 35). There is nothing to indicate Petitioner had ongoing problems after that initial evaluation and treatment up until Petitioner had another injury in 2006 (Tr 36).

On cross-examination by Respondent's attorney for case 06 WC 7394, Dr. Fardon testified that his notes reflect Petitioner did not continue to have back pain between February 2005 and February 2006 and if Petitioner testified that he did, this would not change his opinion about maximum medical improvement, but it would be a factor he would consider (Tr 40). Dr. Fardon read Petitioner's testimony that he wanted to treat after being discharged from Accelerated Rehabilitation, but the insurance company would no longer pay for his treatment (Tr 44-45). Dr. Fardon testified he would have to take this into consideration and he would not say it was enough to change his opinion, given all the other information available to him (Tr 45). Dr. Fardon was shown Dr. Korn's records which indicate Petitioner reported that Dr. Kessler recommended surgery (Tr 46). Dr. Fardon opined Petitioner was still at maximum medical improvement during a point in the several months following March 2005 (Tr 49). Dr. Fardon did review a MRI report from March 2006 (Tr 50). Dr. Fardon had not reviewed Dr. Ghanayem's testimony (Tr 50). If he had reviewed Dr. Ghanayem's reports, Dr. Fardon would have noted that in his reports (Tr 51).

46. At the February 22, 2012 arbitration hearing, in exchange for withdrawl of the penalities petition against Respondent in claim 06 WC 7394, Respondent agreed to pay Petitioner $33,297.86 for indemnity benefits and Petitioner agreed to withdraw the petition (Tr 5-6). Joint Rx6A (05 WC 3165), which showed payments made by the group health carrier, was admitted into evidence.

Petitioner was recalled and testified that since he last testified he was still under Dr. Mekhail's care (Tr 17). He is no longer under his care as Petitioner had been referred to another doctor. He last saw his doctor for his low back a year ago (Tr 18). Petitioner then stated he last saw a doctor for his low back on January 27, 2012 (Tr 18). His next appointment is February 27, 2012 (Tr 18). He had no accidents since he last testified on August 30, 2011 (Tr 19). There was no cross-examination conducted.

Petitioner submitted medical bills Px18A through Px18Y and these were admitted into evidence.

Based on the record as a whole, the Commission modifies and otherwise affirms the Decision of the Arbitrator. The Commission affirms the Arbitrator's finding that Petitioner had a preexisting condition of degenerative disc disease and stenosis at L4-5 and L5-S1 which was aggravated by the November 3, 2004 injury. The Commission also affirms the Arbitrator's finding that Petitioner's lumbar injuries sustained on November 3, 2004 were superseded by his later lumbar injuries on February 2, 2006.

Petitioner testified he had a prior back injury in 2002 and at that time attended physical therapy for 3 or 4 weeks. He then felt fine and did not treat for his back until after November 3, 2004. He underwent a lumbar MRI on September 5, 2002. The records of the University of Chicago Hospitals Occupational Medicine Center indicate Petitioner was seen in the emergency room on August 5, 2002 for complaints of low back pain after he lifted a heavy carpet cleaning machine at work. He was diagnosed with a back strain and prescribed medication. Petitioner subsequently treated with Dr. Chutkow.

A lumbar MRI performed on September 5, 2002 showed degenerative disc changes to his lumbosacral spine with mild stenosis at L4 and L5. Dr. Chutkow noted on September 24, 2002 that he assessed sciatica/low back pain and that Petitioner appeared to have done well with treatment of physical therapy, prescribed medications and a Pain Clinic injection and he was to be seen as needed.

Petitioner testified that on November 3, 2004, he slipped and fell down stairs at work, hitting his low back on the edge of some stairs. He was seen at the University of Chicago Hospitals Occupational Medicine Center that day and complained of pain across his lower back and radiated from his back to his buttocks, down the posterior of his right leg to the knee and his right leg felt weak when walking. He denied any numbness or tingling. Petitioner was diagnosed with a back contusion and preexisting degenerative disc disease of the lumbar spine. He was released to return to work with restrictions. Petitioner subsequently treated with Dr. Korn.

Dr. Korn's records indicate Petitioner complained of low back pain and pain down his right leg and later down both legs, along with numbness and tingling later. §12 Dr. Shermer on December 20, 2004 noted no radiculopathy to the legs. Petitioner did not treat after he last saw Dr. Korn on March 9, 2005 until after the February 2, 2006 injury. Petitioner testified that he did not treat during that time because Respondent's insurer would not authorize/pay for treatment. Petitioner testified that from November 3, 2004 until he was released by Accelerated Rehabilitation on December 14, 2004, he continued working at Respondent. Therefore, Petitioner would not be entitled to TTD for that period. Petitioner testified he continued in pain. In reviewing the medical records, there is a slight difference in Petitioner's complaints. For example, Petitioner complained to Dr. Ubiluz on April 12, 2006 that he also felt some sensation of something being broken in between his legs behind his testicles. He complained of the same low back pain and left leg numbness. On January 19, 2005, Dr. Korn had noted that Petitioner

underwent a lumbar MRI the week before and the MRI report showed L4-L5 right lateral nerve root impingement. On February 3, 2005, §12 Dr. Shermer reviewed the January 14, 2005 MRI which showed degenerative disc disease at L3-4, L4-5 and L5-S1, multi-level disc bulging, multi-level stenosis, the L4-5 level showed disc bulge and arthritic spurring and stenosis at the foraminal levels of L4-5. The March 2, 2006 lumbar MRI showed: 1) left paracentral protrusion of the L5-S1 disc, with moderate left and mild central canal narrowing; 2) disc bulging and facet arthropathy at L4-L5 with a moderate right and mild left foraminal narrowing; 3) bulging and facet arthropathy at L3-4. On July 10, 2006, Dr. Mekhail reviewed the March 2, 2006 lumbar MRI and noted a left L5-S1 disc herniation that could explain Petitioner's symptoms. Based on the two above noted MRIs, the Commission finds Petitioner's condition worsened following the February 2, 2006 accident.

§12 Dr. Shermer opined no causal connection to the November 3, 2004 accident and that Petitioner's condition related to preexisting degenerative disc disease and stenosis. §12 Dr. Fardon in his March 18, 200 report opined that the November 3, 2004 accident exacerbated Petitioner's preexisting condition and the February 2, 2006 accident aggravated his preexisting condition at that time. In his November 19, 2010 report, §12 Dr. Fardon compared the September 5, 2002 MRI report and January 14, 2005 MRI report and opined that the degenerative process had progressed slightly between 2002 and 2005 and that such changes are the natural progression of degenerative process and not related to trauma. He concluded that the November 3, 2004 incident produced a sprain/strain injury with no permanency. Regarding the February 2, 2006 accident, §12 Dr. Fardon opined that there was an additional clinically manifest disc herniation that became symptomatic after that injury and led to the July 19, 2006 surgery. He opined that the need for the July 19, 2006 surgery was based both upon a preexisting degenerative back condition and the effect of the injury sustained on February 2, 2006. §12 Dr. Ghanayem opined that relative to the February 2, 2006 injury, he did not think the nature of Petitioner's back problem changed to any significant degree, in that he had an ongoing problem from 2004, both symptomatically and radiographically and therefore, the injury in 2006 may have temporarily aggravated his symptoms, but the need for invasive care would be related to the 2004 injury. The Commission finds the opinions of §12 Dr. Fardon more persuasive than the opinions of §12 Dr. Ghanayem.

The Commission modifies the Arbitrator's Decision finding that Petitioner failed to prove he was temporarily totally disabled from November 7, 2004 through November 15, 2004 as there is no basis for the Arbitrator's TTD award for that period. Petitioner testified that from November 3, 2004 until he was released by Accelerated Rehabilitation on December 14, 2004, he continued working at Respondent. He kept working his janitor job doing cleaning, the same job he had before the November 3, 2004 injury. The medical records from the University of Chicago Occupational Medicine and Dr. Korn show Petitioner was not authorized off work. The Arbitrator also denied penalties in claim 09 WC 43496. This claim number was not part of the consolidation of claims and a search of the Commission database shows that Petitioner is not the

14IWCC0719

claimant in case 09 WC 43496. The Commission modifies the Arbitrator's Decision to strike this sentence. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $277.46 per week for a period of 210-4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the medical expenses incurred after February 1, 2006 in accordance with the Act and the medical fee schedule. Respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of §8(j) of the Act, and any adjustments, and shall hold Petitioner harmless for all medical bills paid by its group health insurance carrier.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes that Respondent is entitled to §8(j) credit of $19,474.80 paid in indemnity benefits for claim 05 WC 3165 and $45,670.68 paid in indemnity benefits for claim 06 WC 7394. Respondent is entitled to credit of $13,098.24 in TTD benefits paid for claim 06 WC 7394. Respondent is also entitled to credit under §8(j) for group health insurance payments of $60,821.76.

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

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

No bond for the removal of this cause to the Circuit Court by Respondent is required as the credit exceeds the award. The party commencing 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: AUG 2 2 2014
MB/maw
o06/05/14
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Mario Basurto

Stephen J. Mathis

David L. Gore

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

BILLIE COOPER,

14IWCC0720

Petitioner,

vs.

NO: 07WC 46355

Consolidated cases:
01WC 7129, 01WC 7130,
02WC 52556, 04WC 23916,
04WC 23917, 04WC 48472,
05WC 52366, 05WC 54352

CITY OF CHICAGO,

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 medical expenses, maintenance, credit, vocational rehabilitation, permanent disability and temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 10, 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.

DATED: AUG 2 1 2014
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MJB/bm
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0720

COOPER, BILLIE
Employee/Petitioner

CITY OF CHICAGO
Employer/Respondent

Case# **07WC046355**

01WC007130
02WC052556
04WC023916
04WC023917
04WC048472
05WC052366
05WC054352
01WC007129

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:

0230 FITZ & TALLON LLC
PATRICK A TALLON
5338 MAIN ST
DOWNERS GROVE, IL 60517

0766 HENNESSY & ROACH PC
ERICA LEVIN
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

14IWCC0720

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

Billie Cooper
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **07** WC **46355**

Consolidated cases: 01 WC 07129, 01 WC 07130, 02 WC 52556, 04 WC 23916, 04 WC 23917, 04 WC 48473, 05 WC 52366, & 05 WC 54352

An *Application for Adjustment 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 **11/2/12 and 2/28/13**. 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 **Prospective Vocational Rehabilitation**

FINDINGS

On **September 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 left knee condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**58,356.48**; the average weekly wage was $**1,122.24**.

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

Respondent shall be given a credit of $**58,574.34** for TTD, $**0** for TPD, $**109,326.00** for maintenance, and $**22,032.52** for other benefits, for a total credit of $**189,932.86**.

ORDER

The parties agree Petitioner was entitled to temporary total disability/maintenance benefits from September 13, 2007 through January 2, 2012. They also agree that Respondent is entitled to credit for $58,574.34 in temporary total disability benefits and $109,326.00 in maintenance benefits paid prior to arbitration. Arb Exh 10. For the reasons set forth in the attached conclusions of law, the Arbitrator awards additional maintenance benefits at the rate of $748.14 per week, from January 3, 2012 through the initial hearing of November 2, 2012, a period of 43 4/7 weeks, as claimed by Petitioner. Arb Exh 10. [Petitioner did not claim any additional maintenance benefits at the second hearing, held on February 28, 2013.] Respondent is entitled to an additional credit in the amount of $22,032.52 for non-occupational disability benefits it paid during this period. Arb Exh 10. Respondent shall hold Petitioner harmless against any claims for reimbursement of the amount for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

For the reasons set forth in the attached conclusions of law, the Arbitrator awards Petitioner medical expenses in the amount of $2,369.45 for the left knee treatment she underwent at Oak Forest Hospital between April 18, 2011 and April 16, 2012, subject to the fee schedule. PX 1. Respondent shall be given a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless against 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, commencing March 1, 2013, of $574.92/week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

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

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

Molly C Mason
Signature of Arbitrator

4/10/13
Date

Arbitrator's Findings of Fact Relative to 07 WC 46355 (D/A 9/12/07)

Petitioner testified she began working for Respondent on April 17, 1998. T. 11/2/12 at 27.

Petitioner's accident of September 12, 2007 is not in dispute. Arb Exh 10. This accident involved Petitioner's left knee. Petitioner acknowledged having left knee problems prior to the accident. These problems dated back to 1999. Petitioner injured her left knee at work in 1999 and underwent an arthroscopy by Dr. Bush-Joseph the following March. Petitioner filed a claim in connection with this injury and obtained a settlement representing approximately 20% loss of use of the left leg in late 2000. T. 11/2/12 at 84, 100. Petitioner re-injured her left knee at work on December 6, 2000 and underwent a second left knee surgery in March of 2001. Petitioner resumed her regular laborer duties for Respondent in August of 2002. [See the decision in 01 WC 7130]. Petitioner reinjured her left knee at work on May 11, 2004 and June 18, 2004. Neither of these injuries required significant treatment. [See the decisions in 04 WC 48472 and 05 WC 54352]. Petitioner testified she injured her left knee again on July 19, 2005 but the Arbitrator has found that Petitioner failed to prove a compensable accident of that date. [See the decision in 05 WC 52366.] Petitioner resumed working as a laborer following this claimed re-injury and testified she was performing her regular laborer duties when the September 12, 2007 accident occurred. T. 11/2/12 at 60.

Petitioner testified she notified her supervisor of the September 12, 2007 accident. [Notice is not in dispute.] A Respondent form labeled "Report of Occupational Injury" reflects that Petitioner re-injured her left knee while working on South King Drive on September 12, 2007 and began limping as a result. PX 25.

Petitioner testified that, following the September 12, 2007 accident, she went to MercyWorks Occupational Medicine Centers at Respondent's direction. T. 11/2/12 at 60-61. A MercyWorks patient information form reflects that Petitioner was "pushing and pulling" while working behind a garbage truck on September 12, 2007 when her left knee started to hurt, causing her to lose her balance. PX 2, p. 148.

On September 13, 2007, Petitioner saw a certified physician's assistant, Leah Brown, PA-C [hereafter "Brown"], at HTP Associates. Brown's note reflects that Petitioner reported "twisting her left knee and hearing a pop while pulling bags of garbage." Brown also noted that Petitioner had a previous history of two left knee meniscal tears. Petitioner complained of pain radiating from the knee proximally to the quadriceps, causing her to lose her balance.

On left knee examination, Brown noted flexion to 90 degrees with associated pain, full extension, a positive Apley test and medial and lateral joint line tenderness. She prescribed X-

rays and an MRI of the left knee. She started Petitioner on Naproxen and Tramadol, recommended a cane and took Petitioner off work. PX 26, p. 4.

Petitioner underwent the recommended left knee MRI the same day. The radiologist who interpreted this MRI noted a "post-surgical appearance of the posterior horn of the lateral meniscus." He was unable to confirm a definite re-tear of the lateral meniscus. He also noted abnormal fluid surrounding the anterior cruciate ligament with cruciate cyst formation posterosuperiorly and anteroinferiorly. He indicated this "may relate to chronic inflammation or previous partial tear." PX 26 at pp. 6-7.

Petitioner also underwent the recommended left knee X-rays on September 13, 2007, with the radiologist noting no effusion or loose bodies and "mild tri-compartmental joint space narrowing with more prominent moderate degree of tri-compartmental articular osteophyte formation." PX 26, p. 8.

Petitioner returned to HTP Associates on September 16, 2007. On that date, Brown reviewed the MRI and X-ray results with Petitioner and prescribed physical therapy. Brown indicated that an arthroscopy might be needed if Petitioner failed to improve with therapy. PX 26, p. 10. Brown continued to keep Petitioner off work. PX 26, p. 11.

Petitioner started a course of therapy on September 17, 2007. The evaluating therapist noted an antalgic gait and "difficulty with all weight-bearing activities." The therapist also indicated that Petitioner's knee was occasionally "giving out on her and getting stuck either in flexion or extension." PX 26, pp. 13-14.

Petitioner returned to Brown on September 21, 2007 and complained of left knee stiffness and locking. Brown increased Petitioner's Tramadol dosage and instructed Petitioner to stay off work and continue therapy. PX 26, pp. 15-16. Petitioner continued attending therapy thereafter.

On September 27, 2007, Petitioner saw Brown again and complained of "catching and giving out in the left knee joint." Brown kept Petitioner off work and prescribed additional therapy. PX 26, p. 20.

A "work status discharge sheet" dated October 5, 2007 reflects that Brown released Petitioner from care. PX 26, p. 22.

Petitioner saw Dr. Pierson, an internist, on October 8, 2007. Dr. Pierson took Petitioner off work pending a consultation with an orthopedic surgeon. PX 28 at 7.

On October 12, 2007, Petitioner saw Dr. Egwele, an orthopedic surgeon. The doctor's note of that date reflects that Petitioner complained of left knee pain and weakness. The doctor indicated these symptoms began "approximately a month ago at work" with "no definite trauma." He also noted a history of prior left knee surgery.

On left knee examination, Dr. Egwele noted a minimal effusion, diffuse medial and lateral joint line tenderness, a negative McMurray's and Lachman's and weak quadriceps/hamstrings. He diagnosed "left quads/hamstrings insufficiencies, ankylosis left knee and s/p arthroscopic surgery." PX 28, p. 13.

On October 15, 2007, Dr. Egwele issued a note indicating he was seeing Petitioner for a work-related condition and taking Petitioner off work. PX 28, p. 18.

Petitioner began a course of therapy at Upright Physical Therapy & Rehabilitation, P.C. on October 16, 2007. The evaluating therapist recorded the following history:

> "Pt states knee popped while pulling garbage cart on 9/12/07. She claims to have lost balance and started limping. Received PT for 3 weeks @ another clinic. Stopped secondary to financial reasons."

The therapist also noted that Petitioner had been off work since September 12, 2007. Petitioner complained of left knee pain, rated 6-8/10, as well as left knee "catching" and "locking." PX 29, p. 6.

Respondent's Committee on Finance sent a letter to Dr. Egwele on October 23, 2007 indicating it had reviewed his invoice and was denying his charges. PX 28, p. 24.

Petitioner continued seeing Dr. Egwele thereafter. On October 30, 2007, Dr. Egwele noted Petitioner was using a cane to walk but reported some improvement secondary to therapy. The doctor instructed Petitioner to perform exercises at home and continue therapy. PX 28, p. 25. At the next visit, on November 12, 2007, the doctor described Petitioner's left knee ankylosis as "resolving." He again recommended home exercises and therapy. PX 28, p. 26. On November 29, 2007, Dr. Egwele released Petitioner to light duty and again prescribed home exercises and therapy. PX 28, pp. 31-32.

On January 10, 2008, Petitioner returned to Dr. Egwele and complained of pain in both knees. The doctor diagnosed "bilateral genu valgum deformity" and "bilateral quads/hamstrings insufficiency." He indicated that Petitioner had last attended therapy two weeks earlier and "has not been doing her exercises." He noted that Petitioner was able to walk without aids. He reviewed the home exercises with Petitioner and prescribed therapy. PX 28, p. 34.

Three weeks later, Dr. Egwele again noted bilateral knee complaints and indicated Petitioner was not attending therapy or performing her exercises. He again reviewed the exercises with Petitioner. He instructed Petitioner to continue therapy and return in five weeks for a functional capacity evaluation. PX 28, p. 36.

At Respondent's request, Petitioner saw Dr. Tonino for a Section 12 examination on February 4, 2008. In his report of the same date, Dr. Tonino indicated he reviewed records from MercyWorks, Mercy Radiology, the Center for Athletic Medicine, Dr. Egwele and Advanced Medical Imaging Center.

Dr. Tonino's report sets forth a history of the September 12, 2007 accident and the two prior left knee arthroscopies.

On examination, Dr. Tonino noted a range of motion of 0-160 bilaterally, no effusion, lateral joint line tenderness in the left knee and a negative McMurray's in the left knee. He obtained X-rays and described them as showing "some mild lateral compartment degeneration of both knees." PX 36, p. 14.

Dr. Tonino diagnosed lateral compartment chondromalacia and a possible lateral meniscal tear of the left knee. He recommended an arthroscopic evaluation, noting that Petitioner had undergone a long course of therapy without improvement.

Dr. Tonino addressed causation as follows:

> "After reviewing the records, examining the patient, taking her history, it is my impression within a reasonable degree of medical and surgical certainty the patient aggravated a pre-existing condition of her left knee when she injured herself on 9/12/07. Patient has had several surgeries on the left knee and was known to have had a prior meniscectomy and chondromalacia of her left knee but was working without restrictions from December 2004 until September of 2007 and at this point has not been able to re-gain her pre-September of 2007 condition. For that reason, I am recommending an arthroscopic evaluation of her knee."

Dr. Tonino characterized the treatment to date as reasonable and necessary. He found Petitioner capable of light duty with no squatting, twisting or climbing with her left knee and no lifting over 10 pounds. PX 36, pp. 6-7.

On March 6, 2008, Petitioner returned to Dr. Egwele and complained of "painful swelling" in her left knee for over a week. Petitioner denied any new trauma. On left knee examination, the doctor noted a Grade I-II joint effusion, mild joint line tenderness, no laxity, a negative Lachmann's and an antalgic gait. He indicated Petitioner "has been attending P.T." He diagnosed synovitis of the left knee and quadriceps insufficiency. He aspirated fluid from the left knee and administered an injection. He instructed Petitioner to continue therapy and her home exercises. PX 28, p. 38.

On April 9, 2008, Petitioner's therapist noted that Petitioner complained of increased left knee pain. The therapist indicated: "Pt states she went out of town. Drove 8 hrs to & fro." PX 28, p. 33. On April 16, 2008, the therapist noted that Petitioner reported having driven to Memphis over the preceding weekend. PX 28, p. 34.

On April 18, 2008, Petitioner returned to Dr. Egwele and complained of locking and weakness in her left knee "in spite of P.T." On left knee examination, the doctor noted a "greater than Grade I joint effusion," mild diffuse joint line tenderness and painful extremes of range of motion. He prescribed a repeat left knee MRI, to be performed with contrast, and left knee X-rays. PX 28, p. 40.

The repeat left knee MRI, performed on April 30, 2008, revealed a small to moderate sized effusion "with fluid extending through a defect in the lateral patellar retinaculum at its patellar attachment," chondromalacia of the patella, diffuse osteoarthritic changes, a fluid-filled defect involving a large portion of the posterior horn of the lateral meniscus and "abnormal tissue along the anterior joint line at this level adjacent to the anterior meniscal root." The radiologist characterized these findings as "suspicious for a large meniscal flap tear with a significant portion of the posterior horn flipped anteriorly." PX 28, p. 43.

Left knee X-rays taken on April 30, 2008 demonstrated osteopenia and diffuse osteoarthritic changes with joint space narrowing. PX 28, p. 44.

On May 5, 2008, Dr. Egwele sent a note to Respondent outlining the repeat MRI findings and recommending a left knee arthroscopy and possible selective lateral meniscectomy. PX 28, p. 45.

Dr. Egwele operated on Petitioner's left knee at Advocate Trinity Hospital on May 30, 2008. T. 11/2/12 at 65. In his operative report, he noted Grade 3-4 chondromalacia in the articular surface of the patella, Grade 2-3 chondromalacia of the femoral groove, no medial meniscus abnormalities, Grade 4 chondromalacia involving the major portion of the lateral tibial plateau, a complex tear involving the posterior and middle horns of the lateral meniscus and a partial tear of the anterior cruciate ligament. PX 28, pp. 50-51.

At the first post-operative visit, on June 9, 2008, Dr. Egwele noted that Petitioner denied left knee pain. On left knee examination, he noted a mild effusion, no joint line tenderness, stiffness and weakness. He removed Petitioner's stitches and prescribed therapy. PX 28, p. 53.

Petitioner began a course of therapy at Sports Ortho on June 11, 2008. The evaluating therapist noted that Petitioner was "pulling garbage cans" while working in an alley on September of 2007 when she noticed pain and popping in her left knee and almost lost her balance. PX 28, p. 57. PX 31, p. 6. The therapist indicated that, "given the number of previous surgeries on the L knee, [Petitioner] may not regain normal function in her L knee." PX 28, p. 60. PX 31, p. 9.

At the direction of Dr. Egwele, Petitioner continued attending therapy thereafter. On July 2, 2008, Petitioner's therapist, Stephanie Farney, DPT, advised Dr. Egwele that Petitioner was doing well in therapy but that her hips were still extremely weak, especially in her abductors and extensors. PX 31, p. 28.

On July 8, 2008, Petitioner saw Dr. Diadula at MercyWorks. Dr. Diadula noted that Petitioner denied left knee pain but complained of a "little locking up in the posterolateral aspect of the knee." Petitioner reported having seen Dr. Egwele the day before. Dr. Diadula indicated that Petitioner "walks with very minimal limp." PX 2, p. 194.

On July 22, 2008, Petitioner saw Dr. Gergang at MercyWorks. The doctor described Petitioner's gait as slightly antalgic. PX 2, p. 195.

On August 11, 2008, Petitioner returned to Dr. Diadula and indicated that she had been using "tools to massage her left knee to soften the scar and strengthen the muscles" but that the tools had "caused bruising of the left knee and the side of the leg." Petitioner rated her left knee pain at 7/10 and indicated she had cancelled therapy that day due to pain. Dr. Diadula recommended that therapy be placed on hold and that Petitioner follow up with Dr. Egwele. PX 2, p. 195.

On August 18, 2008, Petitioner informed Dr. Egwele that her left knee had "not felt better since had certain P.T. modality last week." PX 28, p. 83.

Petitioner returned to MercyWorks on August 25, 2008, and saw Dr. Diadula. Petitioner reported having aggravated her left knee pain while performing weight-bearing activities during therapy. Dr. Diadula noted that Petitioner's therapist, Stephanie Farney, had called him that morning to express her concern that Petitioner "might have re-torn her meniscus secondary to her bony alignment." On left knee examination, Dr. Diadula noted swelling, limited flexion and tenderness in the lateral and popliteal areas. He placed therapy on hold and instructed Petitioner to follow up with Dr. Egwele. PX 26, p. 24.

Petitioner returned to Dr. Egwele on September 2, 2008. The doctor described Petitioner's left knee as "painful and swollen." He noted a Grade 1 joint effusion. He aspirated fluid from Petitioner's left knee and administered an injection. He directed Petitioner to "continue P.T. at another venue." PX 28, p. 85. Petitioner saw Dr. Diadula later the same day and indicated Dr. Egwele had "suggested a new physical therapist." Dr. Diadula indicated Petitioner was going to start therapy at ATI. PX 26, p. 25.

Petitioner began a course of therapy at ATI thereafter. On September 12, 2008, she returned to Dr. Egwele and reported improvement. The doctor recommended additional therapy. PX 28, p. 89.

In late October of 2008, Petitioner's ATI therapist recommended a course of work hardening, noting that Petitioner was "not at the very heavy physical demand level which she

needs to return to her current job." PX 28, p. 96. Dr. Egwele prescribed two weeks of work hardening on October 24, 2008. PX 28, p. 97. Petitioner then started a course of work hardening at Sports Ortho. On November 7, 2008, following two weeks of work hardening, Petitioner's therapist noted improved endurance but indicated it did not appear Petitioner would be able to manage full duty. The therapist described Petitioner's left knee pain as "quite significant with work-related activities." She also indicated Petitioner could only walk for twelve minutes at a time secondary to pain. She recommended that Petitioner "return to work on a light duty basis until her endurance has improved enough to be able to handle full duty." PX 28, p. 101.

On November 10, 2008, Dr. Egwele noted that Petitioner complained of left knee pain stemming from the work hardening. He released Petitioner to light duty as of November 12, 2008, with no prolonged standing, walking, climbing or squatting for one month. PX 28, p. 103.

Petitioner returned to MercyWorks on November 11, 2008, and saw Dr. Diadula. Petitioner complained of left knee pain, rated 8/10, and locking. The doctor indicated that, per Petitioner, Dr. Egwele had placed work hardening on hold and had imposed restrictions. The doctor released Petitioner to light duty as of November 12, 2008, with no prolonged standing, walking, climbing or squatting. PX 2, p. 208. PX 26, p. 32.

Petitioner testified she made herself available for light duty but Respondent did not accommodate her. She continued to receive temporary total disability benefits. T. 11/2/12 at 67.

Petitioner returned to Dr. Egwele on December 8, 2008, and reported that no light duty was available and she had thus "been home all along." The doctor described Petitioner's gait as normal. On left knee examination, he noted a full and painless range of motion. He released Petitioner to full duty as of December 15, 2008 and released Petitioner from care on a "PRN" basis. PX 28, pp. 107-108.

The following day, December 9, 2008, Petitioner returned to MercyWorks and complained to Dr. Diadula of 7/10 left knee pain. Dr. Diadula noted limited flexion and tenderness on left knee evaluation. He noted that Petitioner was scheduled to undergo a functional capacity evaluation on December 15, 2008. He released Petitioner to light duty with no prolonged standing, walking, climbing and squatting. PX 2, p. 209. PX 26, pp. 38-39.

Petitioner underwent the recommended functional capacity evaluation on December 15, 2008, as scheduled. T. 11/2/12 at 67-68. The evaluation took place at Mercy Hospital. The evaluator, Martin Gonzalez, noted complaints of pain in the knee and low back "with radiating symptoms to left lower extremity." He indicated Petitioner "appears to demonstrate maximum effort" but also noted that Petitioner "scored high on symptom magnification scales." He found Petitioner capable of light duty with a standing/walking tolerance of 10 minutes, lifting of 20 pounds or less occasionally and lifting of 10 pounds or less frequently. PX 3, pp. 154-157.

Petitioner returned to MercyWorks on December 29, 2008, and again saw Dr. Diadula. Dr. Diadula reviewed the functional capacity evaluation. He noted that the evaluator "recommended return to work with demonstrated tolerances." Dr. Diadula found Petitioner to have achieved maximum medical improvement. He released Petitioner to work subject to the following restrictions: "1) unilateral carry, 20 lbs. occasionally; 2) bilateral lift floor to knuckles, 29 lbs. occasionally; 3) bilateral lift, floor to waist, 29 lbs., occasionally; 4) push: sustained force, 18-19 lbs. occasionally; 5) pull: sustained force, 18-19 lbs., occasionally; 6) bilateral carry, 29 lbs., occasionally; 7) no squatting; 8) minimum walking and stairs; and 9) no standing more than 10 minutes." PX 2, p. 209. Petitioner testified that Respondent was not able to accommodate these restrictions. T. 11/2/12 at 68. She remained off work and continued to receive temporary total disability benefits.

At Respondent's request, Petitioner saw Dr. Tonino for a Section 12 re-examination on May 28, 2009. T. 11/2/12 at 68. Dr. Tonino reviewed updated records from various providers, including Dr. Egwele, and noted that Petitioner had undergone the left knee arthroscopy he had recommended at the original examination.

On re-examination, Dr. Tonino noted no effusion, lateral joint line tenderness, negative McMurray's and ligamentous stability. He also noted a bilateral valgus deformity of both knees when Petitioner stood up. He obtained new X-rays and interpreted them as showing "bilateral lateral joint compromise, actually worse on the right than the left." Dr. Tonino indicated Petitioner was suffering from "persisting pain despite arthroscopic intervention on her left knee and post-operative injections." He found Petitioner to be a candidate for a total left knee arthroplasty. He indicated Petitioner would not reach maximum medical improvement until she had fully recuperated from this proposed surgery. He characterized the treatment to date as reasonable, necessary and appropriate. He found Petitioner capable of light duty with no squatting, twisting or climbing and no lifting over 20 pounds. PX 37, p. 4.

Dr. Tonino addressed causation as follows:

> "My opinion with regard to causation of her clinical condition now, including the restrictions for work, [is] unchanged from our prior correspondence of February 2008 where I indicated that her condition was causatively connected."

PX 37, p. 4.

On May 7, 2010, Petitioner saw Dr. Diadula at MercyWorks and complained of left knee pain, rated 6/10. Dr. Diadula noted limited flexion and tenderness on left knee examination. He continued the previous work restrictions. PX 2, p. 209.

On May 5, 2011, Petitioner saw Dr. Diadula again. On this occasion, Petitioner was using a cane to walk and rated her left knee pain at 8/10. The doctor noted that Petitioner was

unable to stand, walk or sit for very long. He noted limited flexion and tenderness, particularly laterally, on left knee examination. He continued the previous work restrictions. PX 2, p. 209.

Petitioner testified she met with Julie Bose at her attorney's office on August 22, 2011 after asking Respondent to provide vocational rehabilitation. T. 11/2/12 at 69-70. Bose interviewed her during that meeting. Following the meeting, she never again met with Bose. Instead, she began meeting with another woman, named "Laura," from Bose's office. T. 11/2/12 at 70-71. Between August of 2011 and the hearing of November 2, 2012, she met with Laura about twelve times. They generally met at a public library on 119th, near Halsted. T. 11/2/12 at 71.

Petitioner testified that Laura recommended that she take a class in order to learn MS word processing. Petitioner told Laura she was already familiar with this. Laura also recommended that Petitioner attend college. Petitioner testified she started looking for college classes near her residence but Laura "didn't want that." Instead, Laura arranged for Petitioner to take a class at Wright Junior College, "way up on Narragansett." Laura paid for this class. Petitioner testified she took the class and passed it. T. 11/2/12 at 72.

Petitioner testified that Laura also started setting up job interviews with car dealers. According to Petitioner, these car dealers were "always way out in Indiana somewhere" or were not hiring. Petitioner testified she felt it was a waste of time for her to apply for jobs with these car dealers but she applied anyway. T. 11/2/12 at 72. She was having "really serious car problems" at that point and sometimes had to get rides. It would take an hour each way to drive to some of the car dealers. She went to four or five such dealers to look for work. T. 11/2/12 at 77-78.

Petitioner testified that Laura initially encouraged her to apply for work everywhere she could think of. Petitioner applied to places like Target and Wal-Mart. Then Laura changed her approach and told Petitioner she needed to focus on office-type jobs. At Laura's direction, Petitioner started taking typing tests online three times weekly and applying to fifteen jobs per week. Laura provided her with "big packs of resumes" so that she "would not have an excuse to not write these different jobs down." T. 11/2/12 at 75. Petitioner was required to send Laura E-mails concerning all of the jobs she applied for. Sometimes Petitioner was unable to send these E-mails because her computer was not working or she was out of ink. She did the best she could to comply with Laura's instructions. T. 11/2/12 at 73.

Petitioner testified she and Laura attended some job interviews together. Laura did not want Petitioner to tell prospective employers the full story about her restrictions. For example, if a prospective employer asked Petitioner if she could stand all day, Laura wanted Petitioner to say "yes." Laura wanted her to "get the job first" and deal with the details later. T. 11/2/12 at 74. Petitioner disagreed with this approach. She wanted to be able to tell the truth. T. 11/2/12 at 74.

Petitioner testified she was "disqualified" a few times due to failing to E-mail Laura information concerning her job search. The process of looking for work "was getting frustrating." In late 2011, Petitioner's father was murdered. Petitioner testified she told Laura about this and indicated she was leaving town and could not attend a job interview. Laura called her later on to ask if everything was okay and Petitioner responded, "right now, I'm sitting in a funeral home." Twenty minutes later, Petitioner went to a cash station to obtain funds and there was "no money" in her account. Petitioner's son called her and let her know that Respondent had sent her a letter advising her that her workers' compensation benefits had been stopped. At that point, Petitioner was 500 miles away from home. After Petitioner made her way back to Chicago, she applied for "ordinary disability" through Respondent. Between January 3, 2012 and October 31, 2012, she netted a total of $22,032.52 in group disability benefits. T. 11/2/12 at 76. Although Respondent did not require her to continue looking for work while drawing group disability, she continued to try to find a Respondent job that was within her restrictions. She contacted Respondent's water department and also looked for a security guard job with Respondent. T. 11/2/12 at 78. Between January of 2012 and the hearing, she made about 50 or 60 job contacts, with no success. She was still looking for an alternative job as of the hearing. T. 11/2/12 at 79-80.

Petitioner testified that she has continued to undergo treatment since her benefits were suspended in January of 2012. In June of 2012, Dr. McCarthy administered a series of left knee injections. T. 11/2/12 at 81. She was scheduled to see a physician on November 14, 2012, in connection with her disability benefits. Respondent sent her a letter directing her to see this physician. T. 11/2/12 at 81.

Petitioner denied reinjuring her left knee at any point after September 12, 2007. T. 11/2/12 at 84.

Petitioner testified she finds it difficult to "get started" in the morning due to pain and "locking" in her left knee. Her right knee also hurts, due to relying on that knee secondary to the left knee problems. It is difficult for her to get out of a vehicle. She has to "rock" her body in order to gain enough momentum to stand up. T. 11/2/12 at 86. It is "never a good day." She may need additional surgery but "doesn't want to be cut up" anymore. T. 11/2/12 at 88. She takes Gabapentin, Ibuprofen and Nalopril for pain. These medications reduce the pain but they do not eliminate it. The medications make her feel sleepy. The left knee injections she underwent in the summer of 2012 helped in the sense that she is now able to walk a half block to a block. Before she underwent these injections, she could only walk the length of a couple of house before she had to grab on to something. T. 11/2/12. She is able to use stairs but not in a conventional manner. She goes up and down stairs backwards or sideways. T. 11/2/12 at 90. She has to use stairs in order to do laundry in her basement. T. 11/2/12 at 92. When she sees a garbage truck behind her house, it upsets her because she can no longer perform her garbage-related duties. She "loved [her] job." T. 11/2/12 at 98. She has gone out into the alley to test whether she could dump carts. After dumping seven or eight carts, she was unable to continue. She succeeded only in making herself upset. T. 90. She has also tried walking around in her work boots to build up tolerance but, after five minutes, she begins to experience foot and

knee problems. T. 11/2/12 at 97. Squatting is painful. If she drops an item and needs to kneel in order to retrieve it, she has to put pillows down but "it still hurts" to kneel on the pillows. T. 11/2/12 at 91. When she washes dishes, she has to lean against the sink. She now has a dishwasher but has to sit on a chair in order to load the dishes. She has to rest after cleaning or ironing for ten or fifteen minutes. T. 11/2/12 at 92. When she goes to bed, she "can't get the proper position without [her] knee locking." T. 11/2/12 at 93. She typically wakes up every two hours due to left leg pain. T. 11/2/12 at 94. She sometimes takes Ibuprofen in order to get back to sleep.

Petitioner testified that Respondent gave her a $10.00 stipend in connection with her visits to Dr. Tonino but never reimbursed her for the gas and ink cartridge expenses she incurred in connection with her job search. T. 11/2/12, p. 95.

Under cross-examination, Petitioner testified she received ordinary disability benefits during one period and later received temporary total disability benefits covering the same period. No one asked her to reimburse the Laborers' Board for the ordinary disability benefits. T. 11/2/12 at 99-100. She currently has no group health insurance. No one asked her to attempt to move garbage in an alley or walk around in her work boots. She did this on her own. T. 11/2/12 at 100.

Respondent called Julie Bose of Med Voc Rehabilitation to testify on its behalf. Petitioner raised Ghere and hearsay objections to Ms. Bose testifying. Petitioner argued that Ms. Bose met with Petitioner only once and lacked firsthand knowledge of what transpired thereafter in terms of rehabilitation efforts. Respondent pointed out that Ms. Bose co-authored all of the Med Voc reports concerning the job search process. Respondent also indicated that the other author, Laura Roberts of Med Voc, was out of state as of the hearing and that Petitioner could have objected to Ms. Bose's appearance earlier. T. 11/2/12 at 105-106. Respondent asked that the case be bifurcated so as to call Ms. Roberts as a witness. The Arbitrator allowed Ms. Bose to testify over Petitioner' standing objection and also ruled that Respondent would be allowed to call Ms. Roberts at a continued hearing. T. 11/2/12 at 107.

Ms. Bose testified she has been a vocational rehabilitation counselor for 29 years. She has a master's degree in rehabilitation. She has published articles on the topic of vocational rehabilitation and has taught at the Illinois Institute of Technology. She owns Med Voc Rehabilitation, a company that provides both medical management and rehabilitation services. T. 11/2/12 at 107-109.

Ms. Bose testified that she discussed her qualifications and approach with Petitioner's counsel, via telephone, before she began working with Petitioner. Respondent provided her with various medical records concerning Petitioner and Petitioner's counsel later provided her with additional records. T. 11/2/12 at 110. She reviewed all of these records. T. 11/2/12 at 110.

Ms. Bose testified she met with Petitioner and Petitioner's counsel on August 8, 2011. The meeting took place at Petitioner's counsel's office. Petitioner was "well groomed" and dressed in "business casual" clothing at the time of the meeting. T. 11/2/12 at 111. At the meeting, Petitioner told her she is 55 years old and lives on the south side of Chicago. Petitioner also informed her she attended a "business high school" and two junior colleges, Olive Harvey and Wright Community. Petitioner indicated she took courses in key punching, accounting and computer programming. Petitioner stated she obtained a certificate in keyboarding from Jones Commercial. Petitioner also indicated she served in the Army and then the Army Reserves. Petitioner indicated she had a long history of medical problems. Petitioner described her "worst" work-related problems as those involving her left knee and her lower back. T. 11/2/12 at 115. Petitioner indicated she worked in a customer service capacity for the Social Security Administration for a number of years before she began working as a laborer for Respondent. Petitioner described her laborer duties as heavy in nature. T. 11/2/12 at 117.

Bose testified she "felt it best to target sedentary clerical-type positions" for Petitioner given the functional capacity evaluation results and the limitations on Petitioner's ability to stand and walk for prolonged periods. T. 11/2/12 at 116, 119. Petitioner "had no skills generated from [Respondent] because she was a laborer" but "did have some skills from her position with Social Security." T. 11/2/12 at 117.

Bose testified that Petitioner had not formally applied for any alternative positions with Respondent but that Petitioner had posted her resume on Respondent's website. T. 11/2/12 at 117. Prior to her meeting with Bose, Petitioner had not looked for alternative work outside of Respondent. T. 11/2/12 at 117-118.

Bose testified she recommended that Petitioner update her computer skills. Following the initial meeting, Bose sent Petitioner a "career assessment inventory" so as to pinpoint Petitioner's vocational interests. T. 11/2/12 at 119. MedVoc created a resume and cover letter for Petitioner. At the initial meeting, Bose told Petitioner that MedVoc would help her look for work but that Petitioner was also responsible for looking for work on her own. T. 11/2/12 at 120-121. Bose could not recall whether she told Petitioner she was expected to make a certain number of job contacts per week. T. 11/2/12 at 122. As a general rule, MedVoc recommends ten contacts per week, with five of those being "in person." Bose testified it is "really important to make in-person contacts" because "it is a lot easier to reject a person for employment when you don't see that person's face." T. 11/2/12 at 123. Bose told Petitioner that MedVoc works as a team. Bose explained that she would "ultimately be responsible for" Petitioner's case but that she would enlist the aid of a job placement specialist to "pound on employers' doors" for Petitioner. T. 11/2/12 at 122.

Bose testified that, while she never met with Petitioner again, she talked with Petitioner and Petitioner's counsel by telephone, reviewed the career assessment inventory that Petitioner handed in and supervised Laura Roberts by meeting with her each week. T. 11/2/12 at 124. Petitioner did not fully complete the inventory. Over Petitioner's objection, Bose testified she did not find the partially completed inventory helpful because Petitioner "did not

demonstrate an interest in anything." Petitioner had what is called a "flat profile." Petitioner exhibited disinterest in continued education. T. 11/2/12 at 126.

Bose testified that she issued a report dated September 26, 2011 in which she opined that Petitioner "did not fully comply with her own individual job search." Petitioner did not meet the minimum number of job contacts in two out of four weeks and did not submit confirmation of online job contacts to MedVoc. Nevertheless, Bose recommended that vocational rehabilitation efforts continue. T. 11/2/12 at 127.

At this point in the hearing, Petitioner's counsel restated his objections to Bose's testimony and the Arbitrator granted Respondent's motion for bifurcation. T. 11/2/12 at 135-137.

The case was continued several times thereafter, by agreement of the parties.

On January 17, 2013, Petitioner met with Lisa Helma, a certified rehabilitation counselor associated with Vocamotive. Petitioner met with Helma at her attorney's request.

In her report (PX 46), Helma noted that Petitioner relied on a cane to walk. Helma noted complaints relative to the left knee, hands and feet. The report sets forth detailed information concerning Petitioner's educational, military and work experience. The report also reflects that, while Petitioner was no longer receiving workers' compensation benefits, she was continuing to look for work.

Helma indicated she reviewed the labor market survey prepared by Julie Bose. Helma indicated that the wage range set forth in this survey "varied tremendously" from $8.25 per hour to $18.25 per hour. Helma noted that Bose targeted an entry level wage of $12.78 per hour.

Helma noted that, at age 57, Petitioner is considered a "person of advanced age" by Social Security Administration standards. Nevertheless, Helma opined that Petitioner remains employable, that vocational rehabilitation, to include testing and computer training, would be beneficial and that Petitioner has the potential to earn between $9.00 and $11.00 hourly.

Helma formulated a rehabilitation plan, which essentially restates the opinions and recommendations set forth in her report. PX 46.

Proofs were closed on February 28, 2013. Respondent did not call any witnesses on that date but did offer two MedVoc "opinion reports" dated December 18 and December 24, 2012 co-authored by Julie Bose and Laura Roberts along with a MedVoc labor market survey dated December 26, 2012 [See a discussion of the "opinion reports" in the Arbitrator's conclusions of law, below.] Over Respondent's objection, Petitioner was recalled for limited rebuttal testimony. Petitioner testified that Laura Roberts cancelled a scheduled visit with her and arrived late on another occasion. T. 2/28/13 at 11. MedVoc did not reimburse her for travel-

related expenses she incurred while looking for work. T. 2/28/13 at 13. Nor did MedVoc advance her transportation costs. T. 2/28/13 at 13. MedVoc advised her to dress neatly when visiting prospective employers. She tried to follow this advice. T. 2/28/13 at 14. She tried her best to complete the job contact sheets. She never falsified any job search records. T. 2/28/13 at 15. She is still looking for work. The day before the continued hearing she went to Respondent and indicated she was available for restricted duty. No such duty was available. T. 2/28/13 at 15-16.

Under cross-examination, Petitioner testified that the MedVoc reports would not be correct if they reflect she admitted to speaking with individuals at businesses who did not actually work for those businesses. T. 2/28/13 at 16.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between her undisputed work accident of September 12, 2007 and her current left knee condition of ill-being?

The Arbitrator finds that Petitioner established a causal connection between her undisputed work accident of September 12, 2007 and her current left knee condition of ill-being. In so finding, the Arbitrator relies on the following: 1) the fact Petitioner was performing her regular laborer duties prior to September 12, 2007 despite her previous left knee injuries and surgeries; 2) the immediate onset of left knee pain following the September 12, 2007 accident; 3) the detailed history set forth in Leah Brown's note of September 13, 2007; 4) the absence of any distinct new left knee injury after September 13, 2007; and 5) perhaps most significantly, the emphatic causation opinions voiced by Respondent's Section 12 examiner, Dr. Tonino. When Dr. Tonino re-examined Petitioner, on May 28, 2009, he found that Petitioner's left knee remained symptomatic, despite the intervening arthroscopy, and that she required a knee replacement, which she has not undergone.

Is Petitioner entitled to temporary total disability benefits and/or maintenance?

Petitioner claims she was temporarily totally disabled through March 15, 2009 and entitled to maintenance thereafter. Respondent agrees Petitioner was temporarily totally disabled through March 15, 2009 and entitled to maintenance thereafter but only through January 2, 2012. Arb Exh 10. Respondent argues that Petitioner stopped cooperating with vocational rehabilitation as of January 2, 2012.

In the Arbitrator's view, the issue of whether Petitioner cooperated with vocational rehabilitation has to be considered in the context of Petitioner's significant knee disability and resultant limitations. On May 28, 2009, Respondent 's examiner, Dr. Tonino, found Petitioner to be in need of a left knee replacement. He also noted abnormalities in Petitioner's right knee. He recommended various work restrictions. Petitioner has elected to defer the recommended surgery because she is fearful of being "cut again." The Arbitrator finds this election to be reasonable. In May of 2010, Dr. Diadula of MercyWorks noted ongoing left knee complaints

and continued the restrictions. A year later, Dr. Diadula noted that Petitioner was relying on a cane and having difficulty walking even short distances. It was not until three months later, by which time Petitioner had reached the age of 55 and had been off work for almost four years, that Respondent initiated vocational rehabilitation through Julie Bose of MedVoc. Bose appropriately targeted sedentary jobs of a clerical nature, based on Petitioner's restrictions, but Petitioner had not performed clerical work for a significant period. If Petitioner was going to find clerical work anywhere, it was most likely going to be with Respondent, her current employer, but there is no evidence indicating MedVoc looked for such work with Respondent.

From the Arbitrator's perspective, substantial barriers to re-employment existed as of the date on which vocational rehabilitation got underway. One of those barriers, delay in initiation of rehabilitation efforts, was put in place by Respondent. If, upon receipt of Dr. Tonino's May 2009 re-examination report, Respondent had given thought to the question of whether Petitioner could be returned to the workplace and had prepared a written assessment in compliance with Rule 7110.10 of the Rules Governing Practice Before the Workers' Compensation Commission, this case might have had a different outcome. Had Respondent taken this step, it could have determined whether Petitioner wanted to defer the recommended replacement surgery and whether vocational rehabilitation was appropriate. See Ameritech Services, Inc. v. IWCC, 389 Ill.App.3d 191 (1st Dist. 2009), in which the Court held that "from a reading of [Rule 7110.10], it is clear that such written assessments are required even in circumstances where no plan or program of vocational rehabilitation is necessary."

Assuming, for the sake of discussion, that vocational rehabilitation in 2011, two years later, was feasible and warranted under National Tea Co. v. Industrial Commission, 97 Ill.2d 424, 432-33 (1983), despite Petitioner's worsening knee problems and urinary incontinence (see decision in 02 WC 52556), the Arbitrator cannot, on this record, conclude that Petitioner sabotaged job search efforts. Bose's assistant, Laura Roberts, the individual who actually interacted with Petitioner and accused Petitioner of such sabotage did not testify, even though Respondent sought a continuance of the trial for the specific purpose of having her do so. The "opinion reports" that Respondent offered into evidence at the continued hearing (with no hearsay objection from Petitioner) provide instances of non-compliant behavior but, in several respects, are not responsive to the testimony Petitioner gave at the first hearing. For example, the report dated December 18, 2012 states that Petitioner "refused to attend keyboarding classes." At the first hearing, Petitioner testified she discussed these classes with Roberts and told her she was already familiar with word processing. Petitioner also testified she attended and passed a class at Wright Junior College at Roberts' direction even though that school was far from home. [Also see a MedVoc progress report dated November 4, 2011 (PX 40), which reflects that Petitioner successfully completed a computer-related class at Wright College and other MedVoc reports reflecting Petitioner took typing classes online.] The report also states that Petitioner failed to target employers that were hiring. At the first hearing, Petitioner explained that some of the companies she was asked to contact were car dealerships that were over an hour away from her residence. The report also reflects that Petitioner cited "familial obligations and health considerations" as excuses for failing to look for work. In fact, Petitioner did have significant health considerations, several of which stemmed from work injuries. She

also had serious family obligations. Some of the MedVoc reports in PX 40 reflect that Petitioner acted as a caretaker for her mother, an Alzheimer's patient. Petitioner testified her father was murdered in late 2011. Petitioner testified she informed Roberts of this event but the "opinion reports" do not touch on it.

This is not to imply that vocational rehabilitation is a one-way street along which only the employer must drive. One of the accusations leveled against Petitioner is that she falsified job search records, with some of this falsification allegedly occurring in mid-December 2011. RX 8. At the second hearing, Petitioner denied doing this. The Arbitrator does not condone the kind of behavior Respondent alleges but believes that some of the problems identified in the opinion reports could have been averted had there been better communication between Petitioner and MedVoc. The serious illness of one parent and murder of the other parent are life-changing events that can significantly impact an individual's ability to look for work [see, e.g., Raymond Goodbody v. Highland Park Volvo-Chrysler, 2010 Ill.Wrk.Comp. LEXIS 810, in which the Commission upheld Arbitrator Erbacci's award of maintenance during a period when the claimant was able to participate in job search efforts only minimally due to taking care of his terminally ill mother]. Respondent did not put forth any evidence to refute Petitioner's testimony that her benefits were terminated after she advised Roberts of her father's murder and while she was out of town attending her father's funeral. If Petitioner was failing to pursue job leads at that point, as it appears she was, she had a valid reason for doing so, at least in the Arbitrator's view. Petitioner testified she resumed looking for work on her own at some point thereafter, although she did not offer any job search records in support of this testimony.

Having weighed Petitioner's testimony against Bose's testimony, the MedVoc reports offered by Petitioner and the opinion reports offered by Respondent, the Arbitrator finds that Petitioner is entitled to maintenance benefits during the disputed period, i.e., January 3, 2012 through the hearing of November 2, 2012, a period of 43 4/7 weeks, as claimed by Petitioner. Respondent is entitled to Section 8(j) credit for the net group disability benefits totaling $22,032.52 that Petitioner received during this period, with Respondent holding Petitioner harmless against any claims made in connection with the payment of these benefits.

Is Petitioner entitled to reasonable and necessary medical expenses?

In her proposed decision, Petitioner essentially asks the Arbitrator to "award the expenses set forth in PX 1." Petitioner's counsel made virtually no effort to correlate those expenses with the voluminous records concerning the treatment Petitioner has undergone since September 12, 2007. Respondent maintains that the treatment Petitioner underwent at Chiro One, Oak Forest Hospital and John H. Stroger Jr. Hospital bears no relationship to the injury at hand. Respondent points out that the bills from the other providers, including MercyWorks and Dr. Egwele, reflect zero balances. The records from Chiro One (PX 41) reflect knee complaints but describe primarily spine care rendered in 2011 and 2012. Petitioner did not mention this care during her testimony. The records from John H. Stroger Jr. Hospital (PX 38) relate primarily to treatment of the left ankle and right hand, not the left knee. The records from Oak Forest Hospital (PX 39) reflect that Petitioner underwent therapy and

injections for her left knee in 2011 and 2012. Petitioner testified that the injections relieved some of her left knee pain and allowed her to walk more easily. The Arbitrator views the treatment rendered by Oak Forest Hospital in 2011 and 2012 to be related, reasonable and necessary. The Arbitrator awards the unpaid medical expenses from Oak Forest Hospital totaling $2,369.45 for treatment rendered between April 18, 2011 and April 16, 2012 subject to the fee schedule.

Is prospective vocational rehabilitation appropriate? Is Petitioner entitled to wage differential benefits?

At the initial hearing, Petitioner claimed "prospective vocational rehabilitation," with Respondent alternatively asking the Arbitrator to address permanency. In her proposed decision, however, Petitioner seeks a permanency award, i.e., an award of wage differential benefits. Respondent also seeks a wage differential award, albeit at a somewhat lower rate.

Given Petitioner's age, the limited scope of her most recent employment, the fact she has not worked since 2007, her need for a left total knee replacement (per Respondent's examiner), her ongoing work-related and non-work-related health problems and the significant delay that occurred before the initiation of job search efforts in 2011, the Arbitrator agrees with the approach taken by the parties and declines to award prospective vocational rehabilitation. Having carefully considered the hourly earnings projected by Bose and Helma, along with the information concerning the hourly wage ($33.45) Petitioner would be earning if she were still able to work as a laborer (PX 48), the Arbitrator awards Petitioner wage differential benefits in the amount of $574.92 per week from March 1, 2013 forward and for the duration of her disability. The Arbitrator arrived at $574.92 by averaging the mean entry level hourly wage targeted by Bose, i.e., $12.78, and the highest hourly wage targeted by Helma, i.e., $11.00., to arrive at $11.89 per hour, multiplying that result by 40 to arrive at $475.60, subtracting $475.60 from $1,338 [$33.45 x 40] and dividing the result, $862.40, by two-thirds.

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

BILLIE COOPER,

Petitioner,

vs.

14IWCC0721

NO: 05WC 54352

Consolidated cases:
01WC 7129, 01WC 7130, 02WC 52556, 04WC 23916, 04WC 23917, 04WC 48472, 05WC 52366, 07WC 46355

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 medical expenses, credit, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 10, 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: AUG 21 2014
o081814
MJB/bm
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

14IWCC0721

COOPER, BILLIE
Employee/Petitioner

Case# **05WC054352**

01WC007130
02WC052556
04WC023916
04WC023917
04WC048472
05WC052366
01WC007129
07WC046355

CITY OF CHICAGO
Employer/Respondent

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:

0230 FITZ & TALLON LLC
PATRICK A TALLON
5338 MAIN ST
DOWNERS GROVE, IL 60517

0766 HENNESSY & ROACH PC
ERICA LEVIN
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

14IWCC0721

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

Billie Cooper
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **05** WC **54352**

Consolidated cases: 01 WC 07129, 01 WC 07130, 02 WC 52556, 04 WC 23916, 04 WC 23917, 04 WC 48473, 05 WC 52366, & 07 WC 46355

An *Application for Adjustment 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 **11/2/12 and 2/28/13**. 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 _____

14IWCC0721

FINDINGS

On **June 18, 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.

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that Petitioner failed to prove a causal relationship between the undisputed work accident of June 18, 2004 and any claimed current condition of ill-being.

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 **48** years of age, ***single*** with **0** dependent children.

Petitioner failed to establish any compensable lost time.

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**. Arb Exh 7.

ORDER

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that the undisputed work accident of June 18, 2004 resulted in a left knee sprain and a left hip strain which required treatment through June 23, 2004. The Arbitrator further finds that Petitioner failed to prove causation as to any claimed current condition of ill-being. Based on this causation finding, the Arbitrator awards no permanency in this case.

The Arbitrator awards no temporary total disability benefits in this case as Petitioner failed to establish compensable lost time.

Based on the causation finding, the Arbitrator finds that the treatment rendered by MercyWorks on June 21 and 23, 2004 was related, reasonable and necessary. Because the bills relating to this treatment reflect $0 balances, the Arbitrator awards no medical expenses in this case. PX 1.

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

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

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

Molly C Mason
Signature of Arbitrator

4/10/13
Date

APR 10 2013

Billie Cooper v. City of Chicago
05 WC 54352 (consolid. with 01 WC 7129-30, 02 WC 52556, 04 WC 23916-7, 04 WC 48472, 05 WC 52366 and 07 WC 46355)

Arbitrator's Findings of Fact Relative to 05 WC 54352 (D/A 6/18/04)

Petitioner testified she began working for Respondent on April 17, 1998. T. 11/2/12 at 27.

Petitioner's accident of June 18, 2004 is not in dispute. Arb Exh 7. Petitioner testified that, while pulling carts and lifting heavy bags on June 18, 2004, she felt a pop in her left knee. She reported the accident to her supervisor and, on June 21, 2004, went to MercyWorks Occupational Medicine Centers at Respondent's direction. T. 11/2/12 at 50.

Records from MercyWorks reflect that Petitioner saw Dr. Diadula on June 21, 2004 and indicated her left knee popped three days earlier while she was pulling carts and lifting heavy bags. Petitioner complained of left knee pain and swelling, rated 6/10, and pain "shooting up to the left hip." Dr. Diadula noted that Petitioner had undergone left knee surgery in March of 1999 and March 2000.

On left knee examination, Dr. Diadula noted limited flexion and tenderness and swelling in the inferomedial and infrapatellar areas. He also noted tenderness in the left thigh and hip. He obtained left knee and left hip X-rays. He indicated these X-rays showed no fractures or dislocations on preliminary reading. He diagnosed a left knee sprain and a left hip strain. He prescribed Ibuprofen and a knee elastic support. He took Petitioner "off work due to work related condition" and advised her to keep her leg elevated and return in two days. PX 2, pp. 101-102, 104.

Petitioner returned to MercyWorks on June 23, 2004, as directed, and again saw Dr. Diadula. Petitioner rated her left knee and hip pain at 4/10. Dr. Diadula indicated that "official" readings of the previous X-rays showed no acute findings. His examination findings and diagnoses remained unchanged. He released Petitioner to full duty as of June 24, 2004 and discharged her from care. PX 2, p. 102, 105. PX 2 contains no other records relating to the accident of June 18, 2004.

Petitioner testified she was off work from June 19 through June 23, 2004 and received no workers' compensation benefits during this period. Petitioner also testified she resumed her regular laborer duties after June 23, 2004. T. 11/2/12 at 51.

Arbitrator's Conclusions of Law

Did Petitioner establish causation?

Based on the MercyWorks records, the Arbitrator finds that the accident of June 18, 2004 resulted in a left knee sprain and a left hip strain which required treatment through June 23, 2004. Petitioner testified to persistent left knee problems at the hearing held on November 2, 2012 but failed to establish any connection between the accident of June 18, 2004 and those problems. Petitioner did not testify to any ongoing left hip problems.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims temporary total disability benefits from June 19, 2004 through June 23, 2004, a period of five days. Respondent claims that Petitioner did not lose time from work as a result of the June 18, 2004 accident. Arb Exh 7.

Based on the MercyWorks records, which reflect that Dr. Diadula kept Petitioner "off work due to work related condition" from June 21, 2004 through June 23, 2004, the Arbitrator finds that Petitioner was temporarily totally disabled on June 21, 22 and 23, 2004. However, since Petitioner's disability did not exceed three days, Respondent is not liable for temporary total disability benefits in this case. See Section 8(b) of the Act.

Is Petitioner entitled to reasonable and necessary medical expenses?

Based on the foregoing causation finding, the Arbitrator finds the treatment rendered by MercyWorks on June 21 and 23, 2004 to be related, reasonable and necessary. Petitioner claims the medical expenses associated with this treatment but the MercyWorks bills dated June 21 and 23, 2004 show $0 balances. PX 1. There are no outstanding medical expenses to award.

Is Petitioner entitled to permanency?

Based on the foregoing causation finding, the Arbitrator awards no permanency in this case.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BILLIE COOPER,

Petitioner,

vs.

NO: 05WC 52366
Consolidated cases:
01WC 7129, 01WC 7130, 02WC 52556,
04WC 23916, 04WC 23917, 04WC 48472,
05WC 54352, & 07WC 46355

14IWCC0722

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,medical expenses, credit, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 10, 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.

14IWCC0722

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

DATED:
o081814
MJB/bm
052

AUG 21 2014

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0722

COOPER, BILLIE
Employee/Petitioner

CITY OF CHICAGO
Employer/Respondent

Case# 05WC052366

01WC007130
02WC052556
04WC023916
04WC023917
04WC048472
01WC007129
05WC054352
07WC046355

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:

0230 FITZ & TALLON LLC
PATRICK A TALLON
5338 MAIN ST
DOWNERS GROVE, IL 60517

0766 HENNESSY & ROACH PC
ERICA LEVIN
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

14IWCC0722

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

Billie Cooper
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **05** WC **52366**

Consolidated cases: **01 WC 07129, 01 WC 07130, 02 WC 52556, 04 WC 23916, 04 WC 23917, 04 WC 48473, 05 WC 54352, & 07 WC 46355**

An *Application for Adjustment 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 **11/2/12 and 2/28/13**. 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 **July 19, 2005**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did not* sustain an accident that arose out of and in the course of employment. Based on this finding, the Arbitrator views the remaining disputed issues as moot.

Timely notice of this accident *was* given to Respondent. Arb Exh 8.

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 **49** years of age, ***single*** with **0** dependent children.

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

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

ORDER

The Arbitrator finds that Petitioner failed to prove she sustained an accidental injury on July 19, 2005 arising out of and in the course of her employment by Respondent. The Arbitrator views the remaining disputed issues as moot. The Arbitrator awards no benefits in this claim.

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.

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

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

4/10/13
Date

APR 10 2013

Billie Cooper v. City of Chicago
05 WC 52366 (consolid. with 01 WC 7129-30, 02 WC 52556, 04 WC 23916-7, 04 WC 48472, 05 WC 54352 and 07 WC 46355)

Arbitrator's Findings of Fact

This claim is the only one of Petitioner's nine consolidated claims in which accident is in dispute. Arb Exh 8.

Petitioner testified she began working for Respondent on April 17, 1998. T. 11/2/12 at 27.

Petitioner testified she was injured on July 19, 2005 while performing her regular laborer duties on a "can route." Petitioner explained that performing a "can route" involves hanging on to the side of a garbage truck and periodically jumping on and off in order to gather cans. Petitioner testified her left knee and right foot and ankle started "hurting [her] real bad" while she performed these duties on July 19, 2005. The "last time" she jumped off the truck she was unable to pull herself back up because her left knee and right foot and leg "just jammed." Petitioner testified she informed her supervisor of her injury and "they" completed an accident report. T. 11/2/12 at 56. No accident report is in evidence. At Respondent's direction, Petitioner sought treatment at MercyWorks Occupational Medicine Centers, where she saw Adrian Torres, R.N. and Dr. Marino. T. 11/2/12 at 56. PX 2, p. 129.

Nurse Torres' handwritten note of July 19, 2005 reflects that Petitioner complained of pain in her "R foot from 3rd to the 5th toe." The note contains no mention of a work accident or work activities. Dr. Marino noted the presence of "old surgical scars" on the second and third toes of Petitioner's right foot. He also noted tenderness in the third and fifth toes and callous formation in the plantar area of the fourth toe. He released Petitioner to full duty and referred Petitioner to Dr. Sclamberg. PX 2, p. 129.

Petitioner returned to MercyWorks on July 20, 2005 and indicated she was unable to wear her work boots due to right foot pain. Dr. Marino noted that Petitioner was scheduled to see Dr. Sclamberg the following day. He released Petitioner to light duty with no use of work boots. PX 2, p. 130.

Petitioner saw Dr. Sclamberg on July 21, 2005. T. 11/2/12 at 57. Neither the doctor's handwritten note of that date nor his typed note of August 1, 2005 contains any mention of an injury of July 19, 2005. The typed note sets forth the following history:

> "[Petitioner is] a 49-year-old who, on September 23, 2004, had a garbage truck [sic] fall onto his [sic] distal right foot. There was apparently bleeding at the time and he [sic] was seen by a podiatrist. He [sic] eventually returned to work on December 16, 2004.

> [He] stated he [sic] has done well until May when he [sic] started to develop pain in the 3rd and 4th toes which was aggravated by walking. The patient stated that, in 1980, he [sic] had hammertoe operations on the right 1st, 2nd and 3rd toes."

On examination, Dr. Sclamberg noted the "previous dorsal incisions" on Petitioner's first, second and third toes. He also noted tenderness over Petitioner's third and fourth toes and at the 3-4 web space. Right foot X-rays revealed "the previous distal 5th metatarsal osteotomy along with the hallux valgus and surgery on the 2nd and 3rd proximal interphalangeal joints of the toe."

Dr. Sclamberg attributed Petitioner's symptoms to a Morton's neuroma of the right 3-4 web space. He injected this space with Kenalog and released Petitioner to full duty. PX 4, pp. 65-67.

On July 26, 2005, Petitioner saw Dr. Gelles, a podiatrist who she had seen in the fall of 2004 at the referral of her personal physician, Dr. Meeks. T. 11/2/12 at 58. Dr. Gelles had diagnosed Petitioner with a right third interspace neuroma at that time and had administered an injection. PX 15, pp. 13-15.

Dr. Gelles' handwritten note of July 26, 2005 contains no mention of a work injury of July 19, 2005. Rather, it reflects Petitioner experienced no relief from the earlier injection after several months. Dr. Gelles diagnosed hallus varus, "dislocations of MPTs 2, 3 and 4" and hammertoes. He obtained right foot X-rays and discussed the possibility of surgery. PX 15, p. 16.

On July 26, 2005, Dr. Gelles wrote a note stating: "[Petitioner] was off work yesterday and today for painful feet. May return to work 7/27/05." PX 15, p. 18.

Petitioner testified she was off work at Dr. Gelles' direction on July 25 and 26, 2005. She then resumed her regular laborer duties. T. 11/2/12 at 58.

On August 4, 2005, Robert Serafin, director of workers' compensation for Respondent, wrote to Petitioner indicating that the Committee on Finance was "denying authorization for any surgery to [Petitioner's] right foot by Dr. Gelles." Serafin indicated that the Committee on Finance viewed Petitioner's diagnoses as non-work-related. PX 15, p. 19.

On November 3, 2005, Petitioner consulted Dr. Khan of Carrozza Foot Clinic. A history form reflects that Petitioner complained of excruciating right foot pain since September 30, 2004, with a recurrence on July 19, 2005. The form also reflects that Petitioner underwent a bunionectomy in January 1989.

Dr. Khan's handwritten note of November 3, 2005 reflects that Petitioner complained of pain in her right third and fourth toes of two months' duration. The note also states that Petitioner walks all day at work. A separate note, also dated November 3, 2005, reflects that Petitioner's pain "began again" on July 19, 2005 and that her job requires her to jump on and off of a garbage truck all day long. PX 16, pp. 5-6.

On right foot examination, Dr. Khan noted pain and audible clicking in the second and third interspaces and contraction of the fourth toe. He also noted pain on palpation of the peroneal tendons and Achilles tendon. He diagnosed a neuroma of the right second and third interspace, "secondary to trauma R foot" and tendonitis of the right foot. He discussed treatment options with Petitioner and ultimately prescribed therapy, noting that surgery might be needed. PX 16, p. 7.

Petitioner began a course of therapy at Total Rehab on November 3, 2005. The therapist who evaluated Petitioner on that date noted that Petitioner complained of significant pain in her right forefoot of several months' duration. The therapist indicated Petitioner denied a history of trauma. PX 17, p. 3.

Petitioner returned to Dr. Khan on November 14, 2005 and indicated her tendonitis had improved somewhat with therapy but she was still having pain after work. Dr. Khan scheduled Petitioner to undergo surgical decompression of the second and third digital nerves on November 23, 2005. PX 16, pp. 8-9. The surgery did not proceed.

Petitioner last underwent therapy at Total Rehab on December 5, 2005, with the therapist noting: "continue to hold exercises for surgery date." PX 17, p. 13.

On November 29, 2005, Petitioner filed an Application for Adjustment of Claim alleging a right foot injury of July 19, 2005. The Application characterizes the injury as a "recurrence" of the September 23, 2004 injury. Arb Exh 9.

On December 12, 2005, Petitioner saw Dr. French, a podiatrist. T. 11/2/12 at 59. The doctor's note of that date sets forth the following history:

> "This patient . . . presents with a chief complaint of pain to her right foot. She relates pain with walking and pain with shoes. Current medications consist of Ibuprofen as needed . . . Past medical history is unremarkable."

On examination, Dr. French noted pain between the third and fourth toes on the right and hammertoes of the fourth and fifth toes on the right with varus rotation. He discussed treatment options and recommended that Petitioner obtain an orthotic for the right foot. A subsequent note, dated December 27, 2005, reflects that the doctor referred Petitioner for a custom orthotic. PX 23, pp. 2-3.

Petitioner testified she continued performing her usual laborer duties after seeing Dr. French.

At the hearing, which was held seven years after the accident at issue, Petitioner testified she was "perfectly well" and able to wear 3 ½ inch heels before her various work accidents. T. 11/2/12 at 96. Petitioner further testified she is no longer able to wear work boots. She experiences knee and foot problems within five minutes of putting such boots on. T. 11/2/12 at 97.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident arising out of and in the course of her employment on July 19, 2005?

The Arbitrator finds that Petitioner failed to meet her burden of proof on accident. Petitioner testified to a specific "jamming" of her left knee and right foot on July 19, 2005 after a period of jumping on and off of a garbage truck while performing a "can route." Petitioner testified that someone prepared a report in connection with this event but no such report is in evidence. [Respondent's exhibits include multiple accident reports but none of these reports relates to an event of July 19, 2005.] The initial MercyWorks treatment note, dated July 19, 2005, contains no mention of a work accident or work activities. Dr. Sclamberg's note of July 21, 2005 and Dr. Gelles' treatment note of July 26, 2005 also contain no mention of a July 19, 2005 incident. Dr. Khan indicated Petitioner's foot pain recurred on July 19, 2005 but he did not indicate Petitioner sustained a work accident that day. Dr. French's note of December 12, 2005 contains no mention of work or a work accident.

Petitioner's testimony concerning a specific event is not supported by her treatment records. On this record, the Arbitrator is unable to find that Petitioner sustained an accident on July 19, 2005 arising out of and in the course of her employment by Respondent. The Arbitrator views the remaining disputed issues as moot. The Arbitrator awards no compensation in this claim.

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

BILLIE COOPER,

Petitioner,

vs.

14IWCC0723

NO: 01WC 7130
Consolidated cases: **01WC 7129, 02WC 52556, 04WC 23916, 04WC 23917, 04WC 48472, 05WC 52366, 05WC 54352, & 07WC 46355**

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 medical expenses, credit, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 10, 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:
o081814
MJB/bm
052

AUG 2 1 2014

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0723

COOPER, BILLIE
Employee/Pelitioner

CITY OF CHICAGO
Employer/Respondent

Case# **01WC007130**

01WC007129
02WC052556
04WC023916
04WC023917
04WC048472
05WC052366
05WC054352
07WC046355

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:

0230 FITZ & TALLON LLC
PATRICK A TALLON
5338 MAIN ST
DOWNERS GROVE, IL 60517

0766 HENNESSY & ROACH PC
ERICA LEVIN
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

14IWCC0723

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

Billie Cooper
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **01** WC **07130**

Consolidated cases: 01 WC 07129, 02 WC 52556, 04 WC 23916, 04 WC 23917, 04 WC 48472, 05 WC 52366, 05 WC 54352, & 07 WC 46355

An *Application for Adjustment 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 **11/2/12 and 2/28/13**. 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 _____

14IWCC0723

FINDINGS

On **December 6, 2000**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

For the reasons stated in the attached conclusions of law, Petitioner established a causal connection between the undisputed work accident of December 6, 2000 and her current left knee and lower back conditions of ill-being.

In the year preceding the injury, Petitioner earned **$41,539.68**; the average weekly wage was **$798.84**.

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

The parties agree Petitioner was temporarily totally disabled from January 18, 2001 through August 11, 2002, a period of 81 3/7 weeks, with Respondent receiving credit for the $43,365.60 in benefits it paid during this period. Arb Exh 2.

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 **$43,365.60** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$43,365.60**.

ORDER

For the reasons stated in the attached conclusions of law, the Arbitrator finds that Petitioner established a causal connection between the undisputed work accident of December 6, 2000 and her current left knee and lower back conditions of ill-being.

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that the treatment Petitioner underwent in connection with her December 6, 2000 accident was related, reasonable and necessary. All of the bills relating to this treatment reflect $0 balances other than the bill from the Bone & Joint Center, which reflects a balance of $27,355. Having carefully reviewed the underlying bill and signed certification (PX 1), the Arbitrator awards Petitioner the unpaid balance of $27,355.00.

Respondent shall pay Petitioner permanent partial disability benefits of $479.30/week for 62.5 weeks, because the lower back injuries sustained caused the 12.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act. As explained more fully in the attached conclusions of law, Respondent shall pay Petitioner no permanent partial disability benefits in this case in connection with the left knee injury due to the credit for the previous settlement in 99 WC 23237 representing 20% loss of use of the left leg.

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

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

Molly C Mason
Signature of Arbitrator

4/10/13
Date

Billie Cooper v. City of Chicago
01 WC 7130 (consolid. with 01 WC 7129, 02 WC 52556, 04 WC 23916-7, 04 WC 48472, 05 WC 54352, 05 WC 52366 and 07 WC 46355)

Arbitrator's Findings of Fact Relative to 01 WC 7130 (D/A 12/6/00)

Petitioner testified she began working for Respondent on April 17, 1998. T. 11/2/12 at 27.

This claim involves a left leg and back injury of December 6, 2000. Accident is not in dispute. Arb Exh 2.

Petitioner acknowledged injuring her left knee at work in 1998. She initially underwent treatment for this injury at MercyWorks Occupational Medicine Centers. She underwent left knee MRI scans at Mercy Hospital on March12, 1999 and August 27,1999. T. 11/2/12 at 82-83. The first MRI showed some increase of joint fluid volume but was otherwise negative. The second MRI showed "interval development of a small joint effusion" and "interval development of bone marrow edema within the lateral aspect of the lateral tibial condyle likely secondary to contusion." PX 3, pp. 4-5. RX 7. She began treating with Dr. Bush-Joseph in February of 2000. Dr. Bush-Joseph performed a left knee arthroscopy, debridement, partial lateral meniscectomy and arthroscopically assisted lateral retinacular release on March 1, 2000. Following therapy, a functional capacity evaluation and a short course of work hardening, Dr. Bush-Joseph released Petitioner to full duty in mid-June 2000. Petitioner experienced a flare-up after resuming work and returned to Dr. Bush-Joseph. The doctor aspirated Petitioner's left knee on July 12, 2000 and released Petitioner to light duty, with no lifting over 30 pounds, in August of 2000. RX 7. Petitioner pursued a workers' compensation claim against Respondent as a result of this injury and, in late 2000, settled this claim for an amount representing 20% loss of use of her left leg. T. 11/2/12 at 84, 100.

As of December 6, 2000, Petitioner was working as a laborer for Respondent. She testified that a ball of clay rolled out of a dump truck that day and landed on her left leg. She had to push the ball of clay off of her leg. She testified she injured her left knee and back in the process of doing this. T. 11/2/12 at 30-31. She notified her supervisor and was taken to Mercy Hospital via ambulance. T. 11/2/12 at 31, PX 2, p. 9. A foreman, Patrick Ibarra, completed an accident report indicating Petitioner was "struck on her left leg by a piece of clay from a truck dumping its load" and "was knocked on her left knee and ankle." RX 2.

The Mercy Hospital Emergency Room records of December 6, 2000 reflect that Petitioner injured her left leg and knee at a dump site earlier that day. One history reflects that a ball of clay fell onto Petitioner's left leg while another states that Petitioner was unloading a truck when a large piece of concrete fell onto her left knee and leg. PX 3, pp. 7, 10. Petitioner complained of and pain in her left leg and knee. PX 3, p. 10. Petitioner indicated she had undergone a left knee arthroscopy in March of 2000. A nurse noted a 6 centimeter abrasion on Petitioner's left lower leg. Left knee examination revealed a full range of motion and no

effusion. PX 3, p. 8. Petitioner underwent X-rays of the chest, left knee, tibia and fibula. The radiologist who interpreted the left knee, tibia and fibula X-rays noted no evidence of fracture or dislocation and no significant joint space narrowing. PX 3, p. 16. Petitioner was diagnosed with a left leg contusion. She was discharged the same day with instructions to take Motrin and apply ice packs to her leg. A note reflects she "left the ER ambulatory w/ a steady gait." PX 3, p. 11.

Petitioner testified she resumed working after the December 6, 2000 injury and next sought treatment in mid-January 2001, when she went to MercyWorks. T. 11/2/12 at 31.

Records from MercyWorks Occupational Medicine Centers reflect that Petitioner saw Dr. Marino on January 18, 2001, with the doctor recording the following history:

> "This is a 45 year old female who is a laborer/spotter for the City of Chicago. She states that on 12/6/00, while she was working at a jobsite, a large piece of clay fell off the truck and hit her left hip, leg, knee and ankle. She was taken by ambulance to Mercy Hospital Emergency Room where X-rays of her left knee and left leg were done and this was negative for acute fracture or dislocation. The patient did not follow up with any physician after the injury but she stated that she continued to work and she continued to have more pain in her left leg, left knee, left thigh, left hip and left lower back. She was taking Ibuprofen 600 mg, three times a day. Her past history, she had arthroscopic surgery on her left knee in March 2000."

Dr. Marino noted complaints of pain in the lower back and left knee, thigh and leg as well as left leg numbness.

On examination of Petitioner's left hip, Dr. Marino noted tenderness on the lateral hip area, a full range of motion and no swelling. On examination of the left thigh and leg, Dr. Marino noted diffuse tenderness and no swelling. On examination of the left knee, Dr. Marino noted tenderness lateral to the patella, flexion limited to 90 degrees with pain and a negative drawer sign. Straight leg raising was negative bilaterally, with a complaint of pain noted at 75 degrees. X-rays of the left hip was negative for an acute fracture or dislocation. X-rays of the left knee showed degenerative changes.

Dr. Marino diagnosed left thigh and leg contusions, left knee pain, with internal derangement to be ruled out, and lumbar radiculopathy. He prescribed MRIs of the left knee and lumbar spine. He took Petitioner off work and recommended that she continue taking Ibuprofen three times daily. PX 3, pp. 9-10. T. 11/2/12 at 31.

Petitioner underwent the recommended MRI scans at Mercy Hospital on January 22, 2001. The radiologist who interpreted the left knee MRI compared the images with those

obtained on August 27, 1999. He noted a joint effusion and a complex tear of the posterior horn of the lateral meniscus, which he described as a "new finding when compared with the prior examination." He also noted an increased signal intensity anterior to the patellar tendon "consistent with superficial infrapatellar bursitis." PX 3, p. 20. There are two reports concerning the lumbar spine MRI. Only the second page of the original report is in evidence. The amended report, which appears on pages 22 and 23 of PX 3, documents a central and left paramedian disc herniation with thecal sac compression and probable compression to some extent of the left S1 nerve root at L5-S1, early degenerative changes at L1-L2 and facet arthropathy.

Petitioner returned to MercyWorks on January 29, 2001 and again saw Dr. Marino. The doctor noted a complaint of urinary incontinence of two months' duration. He also noted complaints of left knee pain and "burning pain from the left hip to the posterior thigh and calf." On lumbar spine examination, he noted no tenderness and negative straight leg raising bilaterally. On left knee examination, he noted tenderness at both the medial and lateral joint lines. He noted the MRI results. He referred Petitioner to Dr. Wolin for her left knee and to Dr. Goldberg for the herniated disc. He instructed Petitioner to remain off work. PX 2, p. 10.

Petitioner saw Dr. Tarbet, Dr. Wolin's associate, on February 1, 2001. A "patient questionnaire form" dated February 1, 2001 sets forth a consistent account of the December 6, 2000 work injury and reflects complaints of pain in the left knee, left leg, left hip and lower back. PX 4, p. 11. The form also describes the previous left knee surgery of March 1, 2000.

On initial left knee examination, Dr. Tarbet noted a flexion contracture of 4 degrees and 120 degrees of flexion. He also noted an infrapatellar bursitis. Dr. Tarbet informed Petitioner he needed to review the report concerning that surgery before making any treatment recommendations. He dispensed Celebrex samples and instructed Petitioner to remain off work. He wrote to Dr. Marino and indicated he needed to review the 1999 MRI reports and Dr. Bush-Joseph's operative report before he could determine whether Petitioner had a new injury.

On February 12, 2001, Petitioner saw Dr. Goldberg. He recommended physical therapy and epidural steroid injections.

Petitioner returned to MercyWorks on February 12, 2001 and again saw Dr. Marino. Dr. Marino noted the results of Petitioner's visits to Drs. Tarbet and Goldberg. He kept Petitioner off work and referred her to Dr. Cupic for the recommended injections. PX 2, pp. 10-11.

Petitioner returned to Dr. Wolin's office on February 15, 2001 and again saw Dr. Tarbet, who recommended a left knee arthroscopy with partial lateral meniscectomy. Dr. Tarbet instructed Petitioner to remain off work. PX 4, pp. 16-17.

On February 15, 2001, Petitioner saw Dr. Marino again. The doctor again noted complaints of left leg numbness and left knee and back pain. He expressed agreement with Dr. Tarbet's surgical recommendation. He instructed Petitioner to remain off work. PX 2, p. 11.

On February 20, 2001, Dr. Cupic administered an epidural steroid injection at S1 on the left side. T. 11/2/12 at 35. PX 3, p. 24.

On March 6, 2001, Petitioner went to the Emergency Room at Mercy Hospital and complained of a sudden onset of pain in her left foot, knee and leg "when rising from bed." Petitioner provided a history of her recent lower back and left knee treatment. She denied any recent traumas or falls. She indicated she was unable to put weight on her left foot. Left foot X-rays demonstrated a chronic deformity in the fifth metatarsal distal aspect. The interpreting radiologist noted no acute fracture or dislocation. At discharge, Petitioner was instructed to take Motrin, keep her leg elevated and follow up with Dr. Marino. PX 3, pp. 42-48. Petitioner described her Emergency Room visit to Dr. Marino the following day, March 7, 2001. On left foot examination, Dr. Marino noted tenderness in the dorsum and arch of the foot and no swelling. He provided Petitioner with Ibuprofen and instructed her to remain off work. PX 2, p. 11.

On March 13, 2001, Dr. Cupic administered another epidural steroid injection, at L5-S1 on the left side, and a facet injection at the same level. PX 3, pp. 51-52. Petitioner returned to Dr. Marino on March 20, 2001 and complained of 8/10 lower back pain radiating to her left calf and foot. She also complained of left knee pain. On examination, Dr. Marino noted positive straight leg raising at 60 degrees on the left and 80 degrees on the right. He continued to keep Petitioner off work. PX 2, pp. 11-12.

On March 26, 2001, Petitioner saw Dr. Wolin. The doctor noted Dr. Tarbet's history. On examination, he noted a left knee range of motion of 0/110 degrees and a right knee range of motion of 0/140 degrees. He addressed causation and treatment as follows:

> "My impression is that this patient has meniscal and/or chondral pathology related to her work injury of December 6, 2000. I've recommended that she undergo arthroscopy with concurrent correction of meniscal and/or chondral pathology."

On March 29, 2001, Dr. Wolin performed a left knee arthroscopy and partial lateral meniscectomy at Columbus Hospital. T. 11/2/12 at 35. Respondent pre-certified this surgery. PX 2, pp. 11-12. Dr. Wolin's operative report contains the following history:

> "This 45-year-old lady injured her left knee at work on December 6, 2000. Her past medical history is that she previously underwent arthroscopy in March 2000 and did fairly well. The new injury resulted in significant increase in her pain. Examination revealed tenderness over the anterolateral aspect of the knee. An MRI showed changes consistent with prior resection of the meniscus with chondral

changes about the patella and lateral femoral condyle. It was recommended she undergo arthroscopy."

In his operative report, Dr. Wolin described the medial meniscus as intact and the lateral meniscus as showing "evidence of prior resection." He smoothed out the remaining portion of the lateral meniscus. He noted a full-thickness chondral defect on the weightbearing portion of the lateral femoral condyle and a partial-thickness chondral defect on either side of the patella. He debrided both of these areas. PX 18.

Following the left knee surgery, Petitioner underwent physical therapy for both her left knee and her lower back. She remained off work at the direction of Drs. Wolin and Marino. On May 14, 2001, Dr. Wolin noted a popping sensation laterally about Petitioner's left patella. He recommended patellar taping and/or bracing, arch supports and additional therapy. PX 4, p. 47. On May 21, 2001, Dr. Goldberg recommended a lumbar discectomy and fusion at L5-S1. This surgery was originally scheduled to proceed on June 26, 2001. It was then rescheduled to July 10, 2001 but the records from MercyWorks and Dr. Wolin reflect that Petitioner changed her mind and saw Dr. Sihota for a second opinion. On June 21, 2001, Petitioner underwent a sacroiliac injection. Several days later, Dr. Sihota administered another epidural steroid injection. On July 9, 2001, Dr. Wolin released Petitioner from treatment vis-à-vis the left knee but indicated Petitioner should undergo a work capacity evaluation once she concluded treatment for her lower back. He recommended that Petitioner "wear a patellar knee sleeve for activities." PX 4 at pp. 52-53. Petitioner also saw Dr. Marino on July 9, 2001. On that date, Petitioner complained of low back pain, rated 4/10, and occasional left knee soreness. She denied radicular symptoms. Dr. Marino noted that Dr. Wolin had discharged Petitioner from care. He recommended that Petitioner stay off work and continue therapy with Dr. Sihota. PX 2, pp. 14-15. On July 23, 2001, Dr. Sihota administered a left SI joint injection. On August 27, 2001, Dr. Marino indicated he might be able to transition Petitioner to work hardening within two weeks. Two weeks later, however, Petitioner complained of left leg pain and indicated that Dr. Sihota had referred her to Dr. Elias for her back. Dr. Marino continued to keep Petitioner off work. PX 2, p. 20.

Petitioner saw Dr. Elias, an orthopedic surgeon, on September 11, 2001. In a letter to Dr. Sihota, Dr. Elias noted that Petitioner was injured at work on December 6, 2000 when a 150-pound ball of clay fell out of a truck, striking Petitioner's left knee. Dr. Elias indicated that Petitioner underwent left knee surgery with Dr. Wolin and that her back pain persisted following that surgery. He indicated Petitioner denied bladder and bowel issues and complained of aching in the lower back as well as numbness and stiffness.

On examination, Dr. Elias noted that Petitioner was able to walk unsupported and could perform toe and heel walking. Straight leg raising was positive bilaterally with tight hamstrings. Patrick's testing was also positive bilaterally.

Dr. Elias reviewed lumbar spine X-rays and an MRI report. He interpreted the X-rays as showing "narrowing of the L5-S1 level with facet arthropathy." He diagnosed "left lumbar

radiculopathy with annular tear" and a herniated disc at L5-S1. He noted that Petitioner had been told she needed a "caged fusion in addition to posterior instrumentation." He recommended that Petitioner undergo a discogram before giving consideration to a fusion. He indicated that a discogram might show a "provocative fragment that could be eliminated easily with minimally invasive management." He prescribed Darvocet and therapy and took Petitioner off work for two weeks. PX 7.

Dr. Elias performed a discogram at five lumbar levels on September 21, 2001. He interpreted the study as showing a rupture of the posterior annulus at L4-L5 "with contrast extending along the posterior border of the L4 and L5 vertebral bodies." He also noted a "possible rupture of the annulus anteriorly and posteriorly at L5-S1." PX 7.

In a subsequent note, dated September 25, 2001, Dr. Elias indicated that the discogram showed a "Grade V tear of L1-L2 and also a Grade V tear of L4-L5 and L5-S1 with a high pain level for the L5-S1 level of 9/10." He reviewed the discogram results with Petitioner and recommended a "nucleoplasty of L1-L2 entering from the right and also an endoscopic spine of L4-L5 and L5-S1 entering from the left with a possible open decompression of the L5-S1 levels in the future if need be." PX 7. The MercyWorks records reflect that Respondent authorized these procedures at some point prior to October 4, 2001. PX 2, p. 25. Petitioner underwent the procedures at Thorek Hospital on October 12, 2001. T. 11/2/12 at 37. Dr. Elias also administered a "K/L/M" [Kenalog/Lidocaine/Marcaine] injection that day. PX 7.

On October 18, 2001 Dr. Elias met with both Petitioner and "Richard Fisher from the City." He noted that Petitioner was still experiencing low back pain but denied radicular discomfort. He prescribed therapy. PX 7. On November 8, 2001, Dr. Elias again noted that Petitioner denied radicular pain but complained of lower back pain. He prescribed Darvocet and Flexeril, along with continued therapy.

Petitioner returned to Dr. Elias on December 6, 2001 and complained of lumbar tenderness as well as "some burning on the lateral posterior thighs," rated 4/10. Dr. Elias instructed Petitioner to continue therapy. PX 7.

At the next visit, on January 3, 2002, Dr. Elias modified his therapy prescription to include hydrotherapy, noting that "some parts of rehab seem to affect [Petitioner] adversely." The doctor also prescribed Celebrex and a lumbosacral support. He continued to keep Petitioner off work. PX 7.

Petitioner underwent an initial therapy evaluation at HealthSouth on January 10, 2002, with the therapist recording the following history: "on 12/6/00 was at work and 150# block of clay hit L knee. Felt LBP after pulling clay off knee." Petitioner attended multiple land and water therapy sessions thereafter, with her therapist documenting gradual improvement. PX 9.

On March 1, 2002, Dr. Marino noted that Petitioner denied radicular symptoms and reported slow improvement. PX 2, p. 29. Following another "K/L/M" injection on April 29, 2002, Dr. Elias recommended that Petitioner start work hardening. PX 7.

Petitioner underwent a work hardening evaluation on May 15, 2002, with Donald Cepek, OTR [hereafter "Cepek"], noting that Petitioner was in an "accommodated position" as of her December 6, 2000 work accident due to persistent left knee pain following a previous knee injury of February 1999. Cepek indicated that, on December 6, 2000, a 150-pound "bottle" fell out of a truck, landing on Petitioner's left leg, and that Petitioner "reportedly injured her back as she attempted to push this 'bottle' away from her." Cepek noted that Petitioner had undergone knee and back surgery in 2001 and was currently taking Darvocet and Flexeril. Following the evaluation, Cepek recommended that Petitioner begin work hardening, to be performed six hours daily. He described Petitioner's potential for return to work as "uncertain, given her re-injury and the physical nature of her job." He referenced a written job description that indicated Petitioner had to be able to lift up to 50 pounds and operate a hoist device.

Petitioner reported increased lower back and left leg symptoms while undergoing work hardening. PX 2, p. 40.

In a work hardening progress note dated May 30, 2002, Cepek reported to Dr. Marino that Petitioner appeared to be putting forth maximal effort and was making gains. He noted that Petitioner reported 6-7/10 back pain during a May 21, 2002 session and skipped several tasks that day due to her pain. PX 8. In a subsequent progress note, dated June 14, 2002, Cepek indicated Petitioner appeared to be putting forth moderate effort and was currently functioning between a light and a light-medium level. He noted that Petitioner frequently complained of lower back and left leg pain and requested ice and/or heat daily. He recommended that Petitioner discontinue work hardening, due to lack of significant progress, and undergo a functional capacity evaluation. Cepek made the same recommendations on June 25, 2002, noting that Petitioner was omitting certain tasks and stretches due to reported pain. In his discharge summary of July 10, 2002, Cepek indicated Petitioner had been "unable to complete her work schedule" and complained of significant pain. He noted that, despite Petitioner's reported pain, she "continues to frequently push and pull a 120# and a 160# garbage cart" during simulation exercises. He again recommended a functional capacity evaluation. PX 8. Dr. Elias expressed agreement with this recommendation on July 11, 2002. He also prescribed Darvocet and Durogesic patches that day. PX 7.

Petitioner underwent a functional capacity evaluation at Mercy Medical on Michigan on July 16 and 19, 2002. T. 11/2/12 at 39-40. Cepek conducted this evaluation. In his report of July 19, 2002 he indicated that "questions exist regarding the validity of [Petitioner's] effort, during the FCE as well as while participating in work hardening." He recommended that Petitioner attempt to return to work "in an alternate position," with no lifting over 35 pounds from floor to knuckle occasionally and 30 pounds from floor to waist overhead, no bilateral carrying over 33 pounds, no unilateral carrying over 22 pounds, pushing/pulling limited to 29

pounds, no vertical climbing, limited stair usage and no squatting or kneeling. Cepek described Petitioner's improvement potential as low. Near the end of his report, he indicated Petitioner sometimes appeared to compensate for her left knee and demonstrated an antalgic gait. PX 8.

On July 23, 2002, Dr. Elias released Petitioner to "medium work as of 7/25/02 according to the guidelines of the work capacity evaluation." He prescribed additional therapy and instructed Petitioner to return to him in six weeks. PX 7.

Petitioner resumed therapy at HealthSouth on August 2, 2002, with a therapist noting that Petitioner was "doing well after PT" but was then "re-injured while lifting too much in work hardening in June/July 2002." PX 9.

On August 8, 2002, Dr. Elias noted that Petitioner "still has pain down the left leg." He also noted that Dr. Marino had called him several times, inquiring about Petitioner's condition. Dr. Elias indicated that "apparently, [Petitioner's] light duty status was not accepted." He had spoken with Dr. Marino that day, with the doctor indicating that Respondent would "consider [Petitioner] returning to work perhaps with some modification." Dr. Elias then went on to state that Petitioner had reached maximum medical improvement and could resume full duty as of August 12, 2002. PX 7.

HealthSouth discharged Petitioner from therapy on August 22, 2002 due to lack of insurance authorization. PX 9.

Petitioner testified she resumed working for Respondent in mid-August 2002, at which point she stopped receiving temporary total disability benefits. She further testified she was able to resume her full laborer duties by September of 2002. T. 11/2/12 at 40-41.

At the hearing, which was held twelve years after the accident at issue herein, Petitioner testified to ongoing left knee and back problems.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between her undisputed work accident of December 6, 2000 and her current left knee and lower back conditions of ill-being?

The Arbitrator finds that Petitioner established a causal connection between the work accident of December 6, 2000 and her current left knee condition of ill-being. While Petitioner had previously injured her left knee in 1999 and underwent surgery in March of 2000, she resumed working subject to a lifting restriction in August of 2000 and testified she was working as a laborer when the December 6, 2000 accident occurred. There is no evidence she continued to undergo treatment for the left knee between August and December of 2000. She credibly testified to a significant trauma, a heavy weight landing on her left leg, on December 6, 2000. She was transported to the Emergency Room by ambulance the same day. Dr. Wolin reviewed the 1999 MRI reports and March 2000 operative report before opining, on March 26,

2001, that the December 6, 2000 accident resulted in a "new" injury to the left knee. When Dr. Wolin released Petitioner from care, he recommended she use a knee sleeve for activities. He also recommended she undergo a functional capacity evaluation once she had concluded her back-related care. While attention then turned to Petitioner's back, Petitioner's left knee problems persisted. When Petitioner eventually underwent the functional capacity evaluation, in 2002, the evaluator noted an antalgic gait and persistent left knee complaints. PX 8.

The Arbitrator further finds that Petitioner established a causal connection between the undisputed work accident of December 6, 2000 and her current lower back condition of ill-being. In so finding, the Arbitrator relies in part on Petitioner's ability to perform a physical job before December 6, 2000 and the described mechanism of injury, with a very heavy weight falling onto Petitioner's left leg. While the earliest records do not reflect complaints relative to the lower back, the MercyWorks records from January of 2001 show that Petitioner's lower back complaints evolved out of the accident. Dr. Marino diagnosed lumbar radiculopathy when he examined Petitioner in January of 2001. A subsequent lumbar spine MRI showed significant pathology. There is no evidence indicating Petitioner suffered any kind of injury between December 6, 2000 and January of 2001, when she resumed care. In evaluating causation, the Arbitrator has also given consideration to the treatment recommendations of Dr. Goldberg, a spine surgeon of MercyWorks' selection. While Respondent elected not to offer Dr. Goldberg's reports into evidence, the MercyWorks records reflect that Dr. Goldberg initially recommended conservative care and subsequently recommended a lumbar discectomy and fusion. The Arbitrator finds it reasonable to infer that Dr. Goldberg found a causal connection between the December 6, 2000 accident and Petitioner's lower back condition. REO Movers, Inc. v. Industrial Commission, 226 Ill.App.3d 216 (1st Dist. 1992).

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner seeks an award of medical expenses from various providers but the medicall bill exhibit list labeled PX 1 reflects $0 balances on all bills other than the bills from Thorek Hospital and the Bone & Joint Center (Dr. Elias). PX 1 reflects total charges of $43,070.00 from the Bone & Joint Center, workers' compensation payments totaling $15,715.00 and a balance of $27,355.00. PX 1 also reflects total charges of $20,648.94 from Thorek Hospital, various workers' compensation payments and adjustments and a balance of $7,420.84.

In its proposed decision, Respondent contends that the Arbitrator should award none of the unpaid Bone & Joint Center expenses due to the insufficiency of the underlying evidence. Specifically, Respondent maintains that the Bone & Joint Center bill in PX 1 is incomplete in that it does not include the payments column. The Arbitrator has reviewed the bill in question, along with the "medical bill certification" signed by Shannon De Jesus of the Bone & Joint Center's billing department on March 27, 2012. The bill is itemized and clearly sets forth the date and amount of each "WC payment." De Jesus attests to a current account balance of $27,355.00. The Arbitrator finds the evidence sufficient and awards Petitioner the outstanding balance of $27,355.00 from the Bone & Joint Center. The Arbitrator declines to award the

claimed outstanding balance from Thorek Hospital because the underlying hospital bills and certification in PX 1 reflect $0 balances.

Is Petitioner entitled to permanent partial disability benefits?

Based on the records from MercyWorks, Dr. Tarbet and Dr. Wolin, with Dr. Wolin diagnosing a "new" left knee injury, performing an arthroscopy in March of 2001 and recommending use of a patellar knee sleeve in July of 2001, the Arbitrator finds that the left knee injury of December 6, 2000 resulted in permanency equivalent to 20% loss of use of the left leg. Since Respondent is entitled to credit for the previous settlement of 20% loss of use of the left leg, Respondent owes no permanency benefits in this case with respect to the left knee injury.

Based on the records from MercyWorks, HealthSouth and Dr. Elias, the Arbitrator finds that Petitioner established permanency equivalent to 12.5% loss of use of the person as a whole under Section 8(d)2 for her lower back injury. While Cepek noted some inconsistencies during work hardening and the functional capacity evaluation, he nevertheless recommended a host of work restrictions. Dr. Elias agreed with his recommendations. Although Dr. Elias subsequently released Petitioner to full duty, it appears he did so only after repeated requests from Dr. Marino of MercyWorks and only after Dr. Marino verbally assured him that some accommodation would be afforded Petitioner. Dr. Elias continued to document left-sided radicular complaints in August of 2002.

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

BILLIE COOPER,

Petitioner,

vs.

14IWCC0724

NO: 04WC48472
Consolidated cases: 01WC 7129
01WC 7130, 02WC 52556,
04WC 23916, 04WC 23917,
05WC 52366, 05WC 54352,
& 07WC 46355

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 medical expenses, credit, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 10, 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.

14IWCC0724

The party commencing 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:
o081814
MJB/bm
052

AUG 2 1 2014

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0724

COOPER, BILLIE
Employee/Petitioner

Case# **04WC048472**

01WC007130
02WC052556
04WC023916
04WC023917
01WC007129
05WC052366
05WC054352
07WC046355

CITY OF CHICAGO
Employer/Respondent

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:

0230 FITZ & TALLON LLC
PATRICK A TALLON
5338 MAIN ST
DOWNERS GROVE, IL 60517

0766 HENNESSY & ROACH PC
ERICA LEVIN
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

14IWCC0724

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

Billie Cooper
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **04** WC **48472**

Consolidated cases: 01 WC 07129, 01 WC 07130 02 WC 52556, 04 WC 23916, 04 WC 23917, 05 WC 52366 05 WC 54352, & 07 WC 46355

An *Application for Adjustment 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 **11/2/12 and 2/28/13**. 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 _____

14IWCC0724

FINDINGS

On **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.

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that Petitioner failed to prove a causal connection between the undisputed accident of September 23, 2004 and any claimed current condition of ill-being.

In the year preceding the injury, Petitioner earned **$51,214.80**; the average weekly wage was **$984.90**.

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

The parties agree Petitioner was temporarily totally disabled from September 23, 2004 through December 15, 2004, a period of 12 weeks, and that Respondent is entitled to credit for the $9,286.20 in benefits it paid during this period. Arb Exh 6.

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 **$9,286.20** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$9,286.20**.

ORDER

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that Petitioner failed to prove a causal connection between the undisputed work accident of September 23, 2004 and any claimed current condition of ill-being. Based on this finding, the Arbitrator awards no permanency in this case.

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that the treatment provided by Robert Gelles, D.P.M. in September and October of 2004 was unrelated to the September 23, 2004 work accident. The Arbitrator thus declines to award Petitioner any expenses associated with this treatment. The Arbitrator views the treatment rendered by MercyWorks and Dr. Stevens as related, reasonable and necessary. The bills from MercyWorks and Dr. Stevens reflect $0 balances so there are no outstanding medical expenses to award. PX 1.

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

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

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

Molly C Mason
Signature of Arbitrator

4/10/13
Date

Billie Cooper v. City of Chicago
04 WC 48472 (consolid. with 01 WC 7129-30, 02 WC 52556, 04 WC 23916-7,
05 WC 54352, 05 WC 52366 and 07 WC 46355)

Arbitrator's Findings of Fact Relative to 04 WC 48472 (D/A: 9/23/04)

Petitioner testified she began working for Respondent on April 17, 1998. T. 11/2/12 at 27.

Petitioner's accident of September 23, 2004 is not in dispute. Arb Exh 6. Records in evidence reflect that, three days prior to this accident, Petitioner went to the Christian Community Health Center and requested a referral to a podiatrist. A handwritten history dated September 20, 2004 states that Petitioner injured her right foot several years earlier. The history also states that, approximately one week earlier, Petitioner "removed a large piece of dead skin off the right lateral side of the 3rd metatarsal and heavy bleeding occurred." Petitioner complained of increased pain and an inability to bear weight on her right foot. On right foot examination, the provider at the Christian Community Health Center noted a lesion on the right lateral aspect of the third metatarsal, distal enlargement of the fifth metatarsal and pain with dorsiflexion. This provider gave Petitioner a "referral for podiatry." PX 6, pp. 15-16.

Petitioner testified that, at Respondent's direction, she underwent treatment at MercyWorks following the September 23, 2004 work accident. Petitioner saw Dr. Diadula at MercyWorks on September 23, 2004, with the doctor indicating that a garbage container fell off of a "flipper" that day, striking Petitioner's left knee and right foot. Dr. Diadula noted that Petitioner had undergone left knee surgery in March 1999 and March 2000. He also noted that Petitioner complained of left knee pain, rated 9/10, and pain "in all the toes," rated 5/10.

On left knee examination, Dr. Diadula noted swelling, "very little flexion" and tenderness in the infrapatellar, inferomedial and medial aspects. He noted no ecchymosis or abrasions. On examination of Petitioner's right foot, Dr. Diadula noted tenderness in the toes, including the metatarsophalangeal joints, but no ecchymosis or swelling. He indicated that left knee and right foot X-rays showed no fractures or dislocations on preliminary reading. He diagnosed contusions of the left knee and right foot. PX 2, p. 108. He prescribed Naproxen and instructed Petitioner to stay off work and apply ice to the affected areas. PX 2, p. 109.

Petitioner also saw Dr. Gelles, a podiatrist, on September 23, 2004. A history form in the doctor's chart (PX 15, p. 3) reflects a referral from the Christian Community Health Center. The form reflects complaints of pain in the right toes and bottom of the right foot. Another history form, also dated September 23, 2004, reflects that a 180-pound can fell on Petitioner's right foot four months earlier. This form also reflects that Petitioner reported being on her feet 8 to 10 hours per day. PX 15, p. 6. Neither form contains any mention of a work accident of that day, i.e., September 23, 2004.

Dr. Gelles' handwritten notes concerning his findings are somewhat difficult to read. It appears he diagnosed a neuroma in the third interspace of the right foot. He prescribed right foot X-rays and an injection. PX 15, p. 13.

Petitioner returned to MercyWorks on September 27, 2004 and again saw Dr. Diadula. Petitioner complained of 9/10 pain in her left knee and right foot. Dr. Diadula noted that the previous X-rays "officially" showed no fractures or dislocations. His examination findings were unchanged. He kept Petitioner off work and noted that Petitioner planned to see Dr. Wolin for her knee and Dr. Gelles, a podiatrist, for her foot. He described each of these providers as Petitioner's "choice." PX 2.

Petitioner returned to Dr. Gelles on October 7, 2004, with the doctor now noting a history of the September 23, 2004 work accident. Dr. Gelles administered an injection into the third interspace of the right foot. He discussed the possibility of foot surgery. PX 15, p. 14.

On October 11, 2004, Petitioner saw Dr. Stevens, Dr. Wolin's associate, at the Center for Athletic Medicine. T. 11/2/12 at 54. An undated history form (apparently completed by Petitioner) reflects that Petitioner was working on September 23, 2004 when a garbage can fell off of a truck, striking her left knee and right foot. Dr. Stevens described Petitioner's orthopedic history as "somewhat complicated." He indicated Petitioner improved but remained somewhat symptomatic following her March 1, 2000 left knee surgery and "underwent a subsequent arthroscopy by Dr. Wolin for a revision partial meniscectomy of a degenerative lateral meniscus and a chondroplasty."

When Dr. Stevens examined Petitioner's left knee on October 11, 2004, he noted a nearly full range of motion, from 3 to 130 degrees, a small effusion, a mild amount of patellofemoral crepitus, ligamentous stability, no pain or instability with varus/valgus stressing and some diffuse tenderness to palpation along the lateral aspect of the knee and at the proximal pole of the patella. He reviewed previous left knee X-rays with Petitioner, noting significant joint spurring and a "mild amount of lateral tracking of the patella." He indicated that Petitioner had "questions concerning the utility of a repeat arthroscopy versus a total knee arthroplasty." Because Petitioner was not experiencing meniscal symptoms, and in light of the two previous arthroscopies, he indicated he saw little utility in a third arthroscopy. Instead, he recommended therapy with quadriceps strengthening, oral anti-inflammatories and activity modification. He indicated that, if Petitioner's pain progressed to the point where it was interfering with her activities of daily life, she should consider a total knee arthroplasty. He did not make any findings or recommendations relative to the right foot. PX 4, p. 63.

Petitioner also saw Dr. Diadula on October 11, 2004, with the doctor noting a complaint of 8/10 left knee pain and indicating Dr. Stevens recommended a left knee MRI. Respondent pre-certified the MRI on October 12, 2004. PX 2 at 111. There is no evidence indicating Petitioner underwent the MRI.

Petitioner returned to Dr. Gelles on October 26, 2004, with the doctor indicating that the previous injection "helped a great deal." Dr. Gelles advised Petitioner that the neuroma could recur and that she could require another injection or surgical excision of the neuroma in the future. PX 15, p. 15.

Petitioner returned to MercyWorks on October 27, 2004 and saw Dr. Marino. On left knee examination, Dr. Marino noted minimal swelling below the medial joint line. He kept Petitioner off work and recommended she begin therapy. Petitioner began a course of therapy at MercyWorks on November 2, 2004. On November 11, 2004, Dr. Marino instructed Petitioner to continue therapy and stay off work. Petitioner continued attending therapy thereafter. On December 14, 2004, Petitioner returned to Dr. Marino and asked to be released to full duty. The doctor indicated Petitioner rated her left knee pain at 1/10 and stated her right foot was no longer sore. Dr. Marino recommended a home exercise program and discharged Petitioner from care. He released Petitioner to full duty as of December 16, 2004. PX 2, p. 113.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between her undisputed accident of September 23, 2004 and her current left knee and right foot conditions of ill-being?

Based on the evidence outlined above, the Arbitrator views the undisputed work accident of September 23, 2004 as temporarily aggravating Petitioner's underlying left knee condition and causing toe contusions which resolved within a short period of time. The Arbitrator finds that Petitioner failed to prove a causal relationship between the September 23, 2004 accident and the right foot neuroma Dr. Gelles treated because there is every indication the doctor diagnosed this condition before the accident occurred. Petitioner saw Dr. Gelles on the day of the accident but it appears she saw him before the accident occurred. It also appears she saw him at the referral of the provider she saw at the Christian Community Health Center on September 20, 2004. PX 6. It was not until October 7, 2004 that Dr. Gelles recorded a history of the accident. Dr. Gelles did not opine that the accident aggravated the neuroma or brought about the need for the injection he administered on October 7, 2004. He had prescribed this injection at the previous visit. Dr. Gelles noted improvement of Petitioner's right foot pain on October 26, 2004. On December 14, 2004, Dr. Marino noted a complaint of minimal left knee pain and no complaints referable to the right foot. He released Petitioner to full duty at her request.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner seeks an award of the expenses associated with the care Dr. Gelles provided on September 23, 2004, October 7, 2004 and October 26, 2004. PX 1. This care relates to a neuroma in the third interspace of Petitioner's right foot. Having found that Dr. Gelles diagnosed this neuroma prior to the September 23, 2004 accident, and with there being no evidence suggesting that the doctor viewed the accident as aggravating the neuroma or

contributing to the need for the October 7, 2004 injection, the Arbitrator declines to find Respondent liable for Dr. Gelles' charges of September 23, October 7 and October 26, 2004.

Petitioner also seeks an award of the expenses associated with Petitioner's October 11, 2004 visit to Dr. Stevens at the Center for Athletic Medicine. PX 1. The Arbitrator finds the care that Dr. Stevens rendered to be related to the undisputed work accident of September 23, 2004. The Arbitrator also finds Dr. Stevens' charges to be reasonable and necessary. PX 1 reflects that workers' compensation paid $114.00 toward those charges and that the balance of $188.00 was adjusted, leaving a zero balance.

Is Petitioner entitled to permanency?

Based on the foregoing causation finding, the Arbitrator awards no permanency benefits in this case.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BILLIE COOPER,

Petitioner,

vs.

14IWCC0725

NO: 04WC 23916
Consolidated cases: 01WC 7129, 01WC 7130, 02WC 52556, 04WC 23917, 04WC 48472, 05WC 52366, 05WC 54352, & 07WC 46355

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 medical expenses, credit, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 10, 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.

14IWCC0725

The party commencing 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:
o081814
MJB/bm
052

AUG 2 1 2014

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COOPER, BILLIE
Employee/Petitioner

CITY OF CHICAGO
Employer/Respondent

Case# **04WC023916**

01WC007130
02WC052556
01WC007129
04WC023917
04WC048472
05WC052366
05WC054352
07WC046355

14IWCC0725

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:

0230 FITZ & TALLON LLC
PATRICK A TALLON
5338 MAIN ST
DOWNERS GROVE, IL 60517

0766 HENNESSY & ROACH PC
ERICA LEVIN
140 S DEARBORN 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

Billie Cooper
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

14IWCC0725

Case # **04** WC **23916**

Consolidated cases: 01 WC 07129, 01 WC 07130 02 WC 52556, 04 WC 23917, 04 WC 48472, 05 WC 52366 05 WC 54352, & 07 WC 46355

An *Application for Adjustment 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 **11/2/12 and 2/28/13**. 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 **April 27, 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.

For the reasons set forth in the attached conclusions of law, Petitioner failed to establish a causal connection between the undisputed work accident of April 27, 2004 and any claimed current condition of ill-being.

In the year preceding the injury, Petitioner earned **$51,214.86**; the average weekly wage was **$984.90**.

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

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

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

Petitioner was temporarily totally disabled from April 28, 2004 through May 4, 2004, a period of 1 week but, pursuant to Section 8(b) of the Act, Respondent is only liable for benefits from May 1, 2004 through May 4, 2004, a period of 4 days.

Respondent shall be given a credit of **$187.60** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**. Arb Exh 4.

ORDER

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that the undisputed work accident of April 27, 2004, resulted in contusions of the right foot and right fifth toe that required treatment through May 27, 2004. Petitioner failed to establish a causal connection between the April 27, 2004 accident and any claimed current condition of ill-being. The Arbitrator awards no permanency in this case.

Respondent shall pay Petitioner temporary total disability benefits of $656.60/week for 4/7 weeks, commencing May 1, 2004 through May 4, 2004, as provided in Section 8(b) of the Act, with Respondent receiving credit for the $187.60 in benefits it paid prior to hearing. Arb Exh 4.

Based on the foregoing causation finding, the Arbitrator finds that the treatment rendered by MercyWorks and Dr. Westin between April 27, 2004 and May 27, 2004 was related, reasonable and necessary. Because the bills relating to this treatment reflect $0 balances (PX 1), there are no outstanding medical expenses to award.

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

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

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

Molly C Mason
Signature of Arbitrator

4/10/13
Date

APR 10 2013

Billie Cooper v. City of Chicago
04 WC 23916 (consolid. with 01 WC 7129-30, 02 WC 52556, 04 WC 23917, 04 WC 48472, 05 WC 54352, 05 WC 52366 and 07 WC 46355)

Petitioner testified she began working for Respondent on April 17, 1998. T. 11/2/12 at 27.

Petitioner's accident of April 27, 2004 is not in dispute. Arb Exh 4. Petitioner testified she was pulling a 100-pound garbage cart that day when the cart rolled over her right foot. T. 11/2/12 at 46.

Petitioner testified she notified her supervisor of the accident and went to MercyWorks Occupational Medicine Centers at Respondent's direction. T. 11/2/12 at 47.

The MercyWorks records reflect that Petitioner saw Dr. Diadula on April 27, 2004. The doctor noted that "while [Petitioner] was attempting to pull a garbage cart weighing approximately . . . 100 pounds off of concrete, the cart rolled over on her right foot and little toe." The doctor also noted that Petitioner complained of right foot swelling and pain, rated 6/10, "on the third to the fifth metatarsal and the fifth toe." Petitioner denied having any similar condition in the past.

On examination, Dr. Diadula noted slight swelling of the right foot, no abrasions or erythema and "tenderness in the third to fifth metatarsals distal half and also in the fifth toe." He obtained right foot X-rays, which showed a healed fracture of the distal shaft portion of the fifth metatarsal but no acute fractures or dislocations. PX 2, p. 76. Dr. Diadula diagnosed a right foot contusion. He prescribed Ibuprofen and instructed Petitioner to stay off work, apply ice, keep her leg elevated and return to MercyWorks on April 30, 2004. PX 2, p. 79.

Petitioner returned to MercyWorks on April 30, 2004, as directed, and again saw Dr. Diadula. Petitioner complained of right foot pain, rated 6/10, particularly in the fifth toe. On examination, Dr. Diadula noted swelling and tenderness of the right fifth toe. He also noted that Petitioner was able to wiggle her toes well. He again diagnosed a right foot contusion. He applied "buddy tape" and instructed Petitioner to keep her leg elevated and stay off work. PX 2, pp. 81-82.

At the next visit, on May 4, 2004, Dr. Diadula again noted complaints of pain and swelling in the right fifth toe. He referred Petitioner to Dr. Sclamberg. He released Petitioner to full duty as of May 5, 2004 and noted he was doing so at Petitioner's request. He instructed Petitioner to return to him after seeing Dr. Sclamberg. PX 2, pp. 83-84.

Petitioner saw Dr. Westin of Midwest Orthopaedics on May 10, 2004. T. 11/2/12 at 48. Dr. Westin wrote to Dr. Diadula the same day, acknowledging the referral "for consultation regarding [Petitioner's] right fifth toe. Dr. Westin's letter sets forth a consistent account of the April 27, 2004 work accident. Dr. Westin indicated he examined Petitioner and obtained repeat

X-rays. He informed Dr. Diadula that these X-rays "again showed no fracture." He taped Petitioner's toe and released Petitioner to full duty "using a firm-soled shoe with a wide toe box." He did not see any need for additional treatment. PX 13, p. 3.

In a separate treatment note, also dated May 10, 2004, Dr. Westin noted that Petitioner had undergone "multiple prior surgeries on the foot, but never on the small toe, though she did have one on the distal fifth metatarsal." He also noted that Petitioner had been "working in tennis shoes because it is more comfortable because of her prior lower extremity problems." PX 13, p. 2.

Petitioner testified she saw Dr. Westin only once in connection with the accident of April 27, 2004. T. 11/2/12 at 48.

Petitioner also saw Dr. Diadula on May 10, 2004, with the doctor noting Dr. Westin's recommendation and instructing Petitioner to continue full duty and return on May 27, 2004. PX 2, pp. 86-87, 107. Petitioner returned on May 27, 2004 and again complained of pain and swelling in her right fifth toe. On examination of the right fifth toe, Dr. Diadula noted swelling, tenderness and a full range of motion. He instructed Petitioner to perform toe exercises and take Ibuprofen as needed. He directed Petitioner to return on June 18, 2004. PX 2, pp. 93-94, 100. PX 2 contains no note dated June 18, 2004. A subsequent note, dated July 26, 2004, reflects that Petitioner had rescheduled several times but failed to keep appointments due to work. PX 2, p. 93. MercyWorks closed the case. PX 2, p. 95.

Petitioner testified that MercyWorks released her to full duty as of May 5, 2004. The parties agree Respondent paid Petitioner $187.60 for the time she lost from work due to the accident of April 27, 2004. Arb Exh 4. T. 11/2/12 at 47.

Arbitrator's Conclusions of Law

Did Petitioner establish causal connection?

Based on the records from MercyWorks (PX 2) and Dr. Westin (PX 13), the Arbitrator finds that the undisputed work accident of April 27, 2004 resulted in contusions of the right foot and right fifth toe that required treatment through May 27, 2004. Petitioner testified to some generalized right foot pain at the November 2, 2012 hearing but failed to establish any connection between the April 27, 2004 accident and that pain.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims temporary total disability benefits running from April 28, 2004 through May 4, 2004 while Respondent claims that Petitioner was temporarily totally disabled only on May 3 and 4, 2004. Arb Exh 4.

The records from MercyWorks reflect that Dr. Diadula took Petitioner off work on April 27, 2004 and released Petitioner to full duty, at her request, as of May 5, 2004. The Arbitrator finds that Petitioner was temporarily totally disabled from April 28, 2004 through May 4, 2004, a period of one week. Pursuant to Section 8(b) of the Act, Respondent is only liable for benefits from May 1 through May 4, 2004 since Petitioner's disability did not last for fourteen or more days from the date of accident. The Arbitrator awards temporary total disability at the rate of $656.60 per week (based on the stipulated average weekly wage of $984.90, Arb Exh 4) from May 1, 2004 through May 4, 2004, a period of four days, with Respondent receiving credit for the $187.60 in benefits it paid during this period. Arb Exh 4. This award is equivalent to $187.70 ($93.80/day TTD rate x 4 days =$375.20 - $187.50 = $187.70).

Is Petitioner entitled to reasonable and necessary medical expenses?

Based on the foregoing causation finding, the Arbitrator finds that the treatment rendered by MercyWorks and Dr. Westin was related, reasonable and necessary. Petitioner claims the expenses associated with this treatment but the bills from MercyWorks (for services rendered on April 27, April 30, May 4, May 10 and May 27, 2004) and Dr. Westin reflect $0 balances. PX 1. There are no outstanding medical expenses to award.

Is Petitioner entitled to permanent partial disability benefits?

Based on the foregoing causation finding, the Arbitrator awards no permanency in this case.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BILLIE COOPER,

Petitioner,

vs.

CITY OF CHICAGO,

Respondent,

14IWCC0726

NO: 04WC 23917
Consolidated cases: 01WC 7129, 01WC 7130, 02WC 52556, 04WC 23916, 04WC 48472, 05WC 52366, 05WC 54352, & 07WC 46355

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 10, 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.

14IWCC0726

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

DATED:
o081814
MJB/bm
052

AUG 2 1 2014

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

14IWCC0726

COOPER, BILLIE
Employee/Petitioner

Case# 04WC023917

01WC007130
02WC052556
04WC023916
01WC007129
04WC048472
05WC052366
05WC054352
07WC046355

CITY OF CHICAGO
Employer/Respondent

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:

0230 FITZ & TALLON LLC
PATRICK A TALLON
5338 MAIN ST
DOWNERS GROVE, IL 60517

0766 HENNESSY & ROACH PC
ERICA LEVIN
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

14IWCC0726

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

Billie Cooper
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 04 WC 23917

Consolidated cases: 01 WC 07129, 01 WC 07130, 02 WC 52556, 04 WC 23916, 04 WC 48472, 05 WC 52366, 05 WC 54352, & 07 WC 46355

An *Application for Adjustment 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 **11/2/12 and 2/28/13**. 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 _____

14IWCC0726

FINDINGS

On **May 11, 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.

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that Petitioner failed to establish a causal relationship between the left knee abrasions she sustained as a result of the accident of May 11, 2004 and her claimed current left knee condition of ill-being.

In the year preceding the injury, Petitioner earned $**51,214.86**; the average weekly wage was $**984.90**.

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

The parties stipulated Petitioner lost no time from work due to the accident of May 11, 2004. Arb Exh 5.

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**. Arb Exh 5.

ORDER

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that the undisputed work accident of May 11, 2004 resulted in left knee abrasions for which Petitioner required treatment through May 17, 2004. Petitioner failed to establish causation as to any claimed current left knee condition of ill-being. The Arbitrator awards no permanency in this case. The Arbitrator views the treatment rendered by MercyWorks on May 11 and 17, 2004 as related, reasonable and necessary but the MercyWorks bills relating to this treatment show $0 balances. There are no outstanding medical expenses to award. Respondent shall be given a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless against any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

Molly C Mason
Signature of Arbitrator

4/10/13
Date

APR 10 2013

Billie Cooper v. City of Chicago
04 WC 23917 (consolid. with 01 WC 7129-30, 02 WC 52556, 04 WC 23916, 04 WC 48472, 05 WC 54352, 05 WC 52366 and 07 WC 46355)

Arbitrator's Findings of Fact Relative to 04 WC 23917 (D/A 5/11/04)

Petitioner testified she began working for Respondent on April 17, 1998. T. 11/2/12 at 27.

Petitioner's accident of May 11, 2004 is not in dispute. Arb Exh 5. Petitioner testified she was performing her laborer duties on that date when she tripped on some broken wire and fell, injuring her left knee. T. 11/2/12 at 48-49. Petitioner testified she notified her supervisor of the accident and went to MercyWorks Occupational Medicine Centers at Respondent's direction. T. 11/2/12 at 49.

Records in PX 2 reflect that Petitioner went to MercyWorks on May 11, 2004 and indicated she "hurt her L knee on a broken wire fence." The examining physician, whose signature is not legible, noted multiple left knee abrasions in the patellar area. The physician obtained left knee X-rays. He described the results as negative. [PX 2 contains no left knee X-ray report dated May 11, 2004.] He released Petitioner to full duty and instructed her to apply ice and heat and return on May 17, 2004. PX 2, p. 91. Petitioner returned on May 17, 2004, as directed, and complained of "mild soreness" in her left knee. The examining physician noted no swelling. He discharged Petitioner from care. PX 2, p. 92. PX 2 contains no additional records concerning the accident of May 11, 2004.

The parties stipulated that Petitioner lost no time from work due to the accident of May 11, 2004. Arb Exh 5.

Arbitrator's Conclusions of Law

Did Petitioner establish causation?

Based on the MercyWorks records described above, the Arbitrator finds that the accident of May 11, 2004 resulted in left knee abrasions which required treatment through May 17, 2004. Petitioner failed to establish any connection between the abrasions and her current claimed left knee condition of ill-being.

Is Petitioner entitled to reasonable and necessary medical expenses?

Based on the foregoing causation-related finding, the Arbitrator views the treatment rendered by MercyWorks on May 11 and 17, 2004 as related, reasonable and necessary. Petitioner claims the expenses related to this treatment but the MercyWorks bills dated May 11 and 17, 2004 show $0 balances. PX 1. Thus, there are no unpaid medical expenses to award.

Is Petitioner entitled to permanency?

The Arbitrator has already found that Petitioner failed to establish a causal relationship between the left knee abrasions she sustained on May 11, 2004 and her claimed current left knee condition of ill-being. Accordingly, the Arbitrator awards no permanency in this case.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BILLIE COOPER,

Petitioner,

vs.

14IWCC0727

NO: 02WC 52556
Consolidated cases: 01WC 7129, 01WC 7130, 04WC 23916, 04WC 23917, 04WC 48472, 05WC 52366, 05WC 54352, & 07W46355

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 medical expenses, credit, permanent disability, temporary disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 10, 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:
o081814
MJB/bm
052

AUG 2 1 2014

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0727

COOPER, BILLIE
Employee/Petitioner

CITY OF CHICAGO
Employer/Respondent

Case# **02WC052556**

01WC007130
01WC007129
04WC023916
04WC023917
04WC048472
05WC052366
05WC054352
07WC046355

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:

0230 FITZ & TALLON LLC
PATRICK A TALLON
5338 MAIN ST
DOWNERS GROVE, IL 60517

0766 HENNESSY & ROACH PC
ERICA LEVIN
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

14IWCC0727

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

Billie Cooper
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 02 WC 52556

Consolidated cases: 01 WC 07129, 01 WC 07130, 04 WC 23916, 04 WC 23917, 04 WC 48472, 05 WC 52366, 05 WC 54352, & 07 WC 46355

An *Application for Adjustment 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 **11/2/12 and 2/28/13**. 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 _____

14IWCC0727

FINDINGS

On **September 30, 2002**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that Petitioner established a causal connection between the undisputed work accident of September 30, 2002 and her current urinary incontinence condition of ill-being.

In the year preceding the injury, Petitioner earned **$49,096.32**; the average weekly wage was **$944.16**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

Petitioner was temporarily totally disabled from October 1, 2002 through November 16, 2003, a period of 58 4/7 weeks, with Respondent receiving credit for the $35,489.91 in benefits it paid during this period. Arb Exh 3.

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 **$35,489.91** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$35,489.91**.

ORDER

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that Petitioner established a causal connection between the undisputed work accident of September 30, 2002 and her current urinary incontinence condition of ill-being.

Respondent shall pay Petitioner temporary totally disability benefits at the rate of $629.44 per week from October 1, 2002 through November 16, 2003, a period of 58 4/7 weeks, with Respondent receiving credit for the $35,489.91 in benefits it paid during this period.

The Arbitrator finds the treatment associated with the September 30, 2002 accident to be related, reasonable and necessary. The Arbitrator awards no medical benefits in this case, however, because PX 1 reflects $0 balances for four providers, Trinity Hospital, MercyWorks, Christian Community and St. Francis Hospital, and does not include any bills from the remaining providers, Dr. Beck (Prairie Medical) and Mercy Hospital.

Respondent shall be given a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless against 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 at the applicable maximum rate of $542.17/week for 37.5 weeks, because the injuries sustained caused the 7.5% 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.

Molly C Mason
Signature of Arbitrator

4/10/13
Date

APR 10 2013

Billie Cooper v. City of Chicago
02 WC 52556 (consolid. with 01 WC 7129-30, 04 WC 23916-7, 04 WC 48472, 05 WC 54352, 05 WC 52366 and 07 WC 46355)

Arbitrator's Findings of Fact Relative to 02 WC 52556 (D/A 9/30/02)

Petitioner testified she began working for Respondent on April 17, 1998. T. 11/2/12 at 27.

Petitioner's accident of September 30, 2002 is not in dispute. Arb Exh 3. Petitioner testified she was lifting some carpeting while working as a laborer when she experienced pain in her groin, left leg and left thigh. T. 11/2/12 at 41. Following this accident, she was transported to the Emergency Room at Trinity Hospital via ambulance. T. 11/2/12 at 41.

The Emergency Room records reflect that Petitioner "complained of left groin pain, left leg pain [and] left thigh pain after lifting carpet." Dr. Cambry, the Emergency Room physician, indicated there was "no history of fall." On examination, Dr. Cambry noted that straight leg raising testing was very painful and decreased. She also noted tenderness on palpation over the side of the leg, "although no gross deformity." X-rays of the pelvis, left femur and left tibia/fibula showed no abnormalities. PX 10, p. 7. Dr. Cambry administered an injection of Toradol. At discharge, she provided Petitioner with a four-prong cane and prescriptions for Flexeril and Motrin. PX 10, p. 3. She instructed Petitioner to follow up with Dr. Smith within forty-eight hours. PX 10, p. 4.

Petitioner went to MercyWorks the following day, October 1, 2002 and indicated she injured her "left pelvic region and both legs" while lifting a 100-pound roll of wet carpet the previous day. Dr. Diadula noted complaints of pain in the left lower quadrant of the abdomen, the left groin and both legs, rated 7/10. He also noted that Petitioner complained of difficulty walking, standing and sitting. He indicated that "later on," Petitioner complained of pain in the "muscles of her arms, the calves, the lower back and both feet."

On examination, Dr. Diadula noted tenderness in the left lower quadrant of the abdomen, the left groin, the lumbosacral spine and the thighs, calves and feet. Straight leg raising was limited to 50 degrees on the left.

Dr. Diadula diagnosed strains of the left lower quadrant of the abdomen, left groin and both legs. He prescribed Ibuprofen and Cyclobenzaprine. He instructed Petitioner to stay off work, apply heat to the affected areas and return to MercyWorks in one week. PX 2.

Subsequent MercyWorks notes, dated October 2 and 7, 2002, reflect that Respondent's Committee on Finance denied liability on October 4, 2002. PX 2.

On October 7, 2002, Petitioner sought treatment at Christian Community Health Center, reporting she had strained her abdominal muscles a week earlier. Petitioner also voiced

radicular complaints. Petitioner was released to light duty, with no lifting over ten pounds, and was instructed to undergo a lumbar spine MRI. The MRI, performed on October 11, 2002, showed degenerative changes and a small to moderate central to left lateral disc herniation at L5-S1. PX 24.

On March 17, 2003, MercyWorks "reopened" Petitioner's case "per COF." PX 2.

Petitioner returned to MercyWorks on March 18, 2003 and saw Dr. Diadula. The doctor noted Petitioner was "still complaining of lower abdominal pain, lower back pain and difficulty holding urine. Petitioner denied having bladder-related issues prior to her work accident.

On examination, Dr. Diadula noted positive direct tenderness in the hypogastrium and groins, left greater than right, tenderness of both anterior thighs and knees and tenderness in the lower back. Straight leg raising was positive on the left at 45 degrees. Petitioner had difficulty performing heel and toe walking. Dr. Diadula diagnosed strains of the lower back, groins and thighs with persistent pain and urinary incontinence. He took Petitioner off work and referred her to Dr. Beck. He also prescribed physical therapy. PX 2, p. 54.

Petitioner saw Dr. Beck on April 3, 2003 and complained of "urinary incontinence after lifting heavy load." On examination, Dr. Beck noted "moderate uterine prolapse." She prescribed a "UDE," or urodynamic evaluation. PX 12, p. 3.

Petitioner returned to MercyWorks on April 4, 2003 and saw Dr. Veits. Dr. Veits noted that Dr. Beck diagnosed a uterine prolapse and large cystocele. Dr. Veits indicated he "spoke to Dr. Beck, who feels both these problems could have been caused by the lifting incident of 9/30/03 [sic]." Dr. Veits noted that Petitioner was scheduled to undergo a "UD," or urodynamic evaluation. He instructed Petitioner to remain off work. PX 2, p. 54.

Petitioner underwent a urodynamic study at Mercy Hospital on April 30, 2003. A "urodynamic patient data sheet" dated April 30, 2003 reflects that Petitioner "picked up wet carpet and felt something snap – since has had stress incontinence." PX 3, p. 71. Dr. Beck interpreted the study as showing "stress urinary incontinence with a low Valsalva leak point pressure." PX 3, p. 70.

Following the urodynamic evaluation, Petitioner returned to Dr. Beck. Dr. Beck addressed causation as follows:

> "Prolapse and incontinence are the result of a work-related injury, given symptoms did not appear until pt. heard a 'pop.'"

PX 12, p. 4. Dr. Beck discussed treatment options and noted Petitioner opted for surgery.

On May 2, 2003, Dr. Diadula noted he "spoke with Dr. Beck and she said that the condition is work-related because, while lifting, [Petitioner] heard a 'pop'." He indicated that

surgery (a cystocele repair with pubo-vaginal sling) had been scheduled for July 7, 2003. He prescribed Naproxen and kept Petitioner off work. PX 2, p. 54.

A MercyWorks note dated July 10, 2003 reflects that Respondent pre-certified the proposed surgery. Due to Dr. Beck's schedule, the surgery did not take place until August 13, 2003, with MercyWorks physicians keeping Petitioner off work in the interim. PX 2, p. 66.

Dr. Beck admitted Petitioner to Mercy Hospital on August 13, 2003. That day, Dr. Beck performed a "cystoscopy and cystocele repair with pubo-vaginal sling using cadaveric fascia and bone anchor." PX 3, pp. 83-84. A pre-discharge nursing note dated August 15, 2003 reflects that Petitioner was doing well and experiencing no urinary leakage. PX 3, p. 128.

Following the surgery, Petitioner returned to Dr. Beck on August 21, 2003. The doctor noted that Petitioner was healing well and voiced no complaints. The doctor indicated Petitioner should avoid heavy lifting for three months following the surgery. PX 12, p. 6.

Petitioner returned to MercyWorks on August 21, 2003 and saw Dr. Marino. The doctor noted Petitioner was no longer experiencing urinary incontinence. Petitioner reported taking Bextra for pain. Dr. Marino kept Petitioner off work. PX 2, p. 71.

Petitioner returned to Dr. Beck on September 11, 2003. Dr. Beck again noted that Petitioner denied complaints. On examination, Dr. Beck noted "no cystocele." She also noted that the sling was "in good position." She described Petitioner as "doing well." PX 2, p. 7.

Petitioner also saw Dr. Diadula on September 11, 2003. Petitioner complained of a burning sensation in her pelvic area when carrying even a gallon of milk. Dr. Diadula continued to keep Petitioner off work. PX 2.

On October 30, 2003, Petitioner returned to Dr. Beck. The doctor again noted that Petitioner denied complaints. She described Petitioner's incisions as healed and indicated that the bladder and urethra were "well-supported." She released Petitioner to full duty as of November 15, 2003 but noted that the "nature of [Petitioner's] job puts her at increased risk for recurrence of pelvic prolapse." PX 12, p. 8.

Petitioner saw Dr. Diadula again on October 30 and November 13, 2003. On each of these dates, the doctor indicated that Petitioner denied urinary incontinence. He released Petitioner to full duty as of November 17, 2003 and instructed Petitioner to take Ibuprofen as needed. PX 2, p. 71.

Petitioner testified she was off work from September 30, 2002 through November 16, 2003. She acknowledged receiving temporary total disability benefits during this period. T. 11/2/12 at 42, 45. She resumed her regular laborer duties on November 17, 2003. T. 11/2/12 at 46.

Petitioner returned to Dr. Beck on January 29 and July 29, 2004. On each of these dates, the doctor indicated Petitioner was "dry" and "doing well." On July 29, 2004, she instructed Petitioner to follow up in six months. No subsequent note is in evidence.

At the hearing, Petitioner testified she experiences urinary incontinence and has to wear diapers. When she coughs, she loses urine. This is embarrassing. Sometimes she has to leave church because her clothes are wet. T. 11/2/12 at 87-88. Just thinking about the involuntary wetting gives her a headache. T. 11/2/12 at 95.

Arbitrator's Conclusions of Law

Did Petitioner establish causation?

The Arbitrator finds that Petitioner established a causal connection between her undisputed lifting-related accident of September 30, 2002 and the uterine prolapse and cystocele condition for which she underwent surgery in August of 2003. The Arbitrator further finds that Petitioner established causation as to the current urinary difficulties she testified to on November 2, 2012. Dr. Beck, who was not a physician of Petitioner's selection, found a causal relationship between Petitioner lifting a heavy roll of carpeting on September 30, 2002 and the prolapse and cystocele. While Dr. Beck released Petitioner to full duty postoperatively and noted no complaints in July of 2004, she warned Petitioner she was at risk for a recurring prolapse due to the heavy nature of her work duties. Petitioner credibly testified to ongoing urinary incontinence at the hearing.

Is Petitioner entitled to temporary total disability benefits?

Based on the records from MercyWorks and Dr. Beck, the Arbitrator finds that Petitioner was temporarily totally disabled from October 1, 2002, when Dr. Diadula took Petitioner off work, through November 16, 2003, the day Dr. Diadula released Petitioner to full duty. The awarded period is equivalent to 58 4/7 weeks. Respondent is to receive credit for the $35,489.91 in benefits it paid, pursuant to the parties' stipulation. Arb Exh 3.

Is Petitioner entitled to reasonable and necessary medical expenses?

As a result of the accident of September 30, 2002, Petitioner underwent treatment at Trinity Hospital, MercyWorks, Christian Community Health Center, Dr. Beck's office, St. Francis Hospital and Mercy Hospital. Petitioner claims the expenses relating to this treatment. The Arbitrator notes that PX 1, Petitioner's medical bill exhibit, reflects $0 balances for Trinity Hospital, MercyWorks, Christian Community Health Center and St. Francis Hospital and lists no bills from Dr. Beck (Prairie Medical) or Mercy Hospital. The Arbitrator awards no medical expenses in this case.

Is Petitioner entitled to permanent partial disability?

Based on the treatment records and Petitioner's credible testimony concerning her current urinary incontinence problem, the Arbitrator awards permanency equivalent to 7.5% loss of use of a person, or 37.5 weeks, pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCHENRY)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAIME QUINTANAL,

Petitioner,

vs.

NO: 11 WC 20184

ACTIVE FOAM SPECIALISTS,

14IWCC0728

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, and medical expenses both current and prospective and being advised of the facts and law, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The 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 there appear to be a few clerical errors in the Decision of the Arbitrator. In the "FINDINGS" section in the beginning of the decision, it is indicated that Petitioner was "3" years of age, when in reality he was 38 years of age at the time of the accident. Accordingly, the Commission changes the Decision of the Arbitrator to indicate that Petitioner was 38 years of age.

In addition, in the preamble section the Arbitrator notes that the hearing was held on "10/17/13." However, the transcript of proceedings indicates that the matter was heard on October 21, 2013. Also, in the body of the decision, the Arbitrator found that "Petitioner has been totally temporarily disabled since February 1, 2011 and remains so through the date of hearing on October 21, 2013, a period of 141 2/7 weeks." However, in the 'ORDER" section, the Arbitrator awarded temporary total disability from 2/1/11-10/21/11 for a total of 141 & 2/7 weeks. Accordingly, the Commission changes the reference of the date of hearing in the preamble from "10/17/13" to "10/21/13" and changes the reference in the ORDER section from "10/21/11" to "10/21/13."

The Commission also notes that according to the Future Date Calculator the period of temporary total disability from February 1, 2011 through October 21, 2013 is 141 & 4/7 weeks and not 141 & 2/7 weeks. In addition, the period spans the year 2012, which is a leap year. Therefore, the Commission adds a day to the temporary total disability award to 141 & 5/7 weeks.

Finally, in the "FINDINGS" section the Arbitrator noted that Respondent *has not* paid all reasonable and necessary charges for all reasonable and necessary medical services. However, in the "ORDER" section, the Arbitrator does not award any current medical expenses but awards only prospective medical treatment. Accordingly, the Commission awards current reasonable and necessary charges incurred to treat Petitioner's work-related condition of ill being of his lumbar spine.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $278.90 per week for a period of 141 & 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 Respondent pay to Petitioner all reasonable and necessary medical expenses incurred for the treatment of Petitioner's condition of ill being of his lumbar spine, pursuant to the appropriate medical fee schedule under §8(a) and §8.2 of the Act.

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

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: AUG 25 2014

Ruth W. White

Daniel R. Donohoo

Charles J. DeVriendt

RWW/dw
O-8/6/14
46

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

QUINTANAL, JAIME
Employee/Petitioner

Case# **11WC020184**

ACTIVE FOAM SPECIALISTS
Employer/Respondent

14IWCC0728

On 12/31/2013, 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:

2932 KUGIA & FORTE PC
MARTIN V KUGIA
711 W MAIN ST
WEST DUNDEE, IL 60118

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

14IWCC0728

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)

Jaime Quintanal
Employee/Petitioner

v.

Active Foam Specialist
Employer/Respondent

Case # 11 WC 020184

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 **ROCKFORD** , on **10/17/13**. 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 _____

14IWCC0728

FINDINGS

On the date of accident, **1/31/11**, 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 **$21,754.00**; the average weekly wage was **$418.35.**

On the date of accident, Petitioner was **3** 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 **$17,849.70** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$17,849.70.**

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

ORDER

THE ARBITRATOR FINDS THT THE PETITIONER HAS NOT REACHED MMI AND THAT THE BACK SURGERY IS REASONABLE AND NECESSARY. THE RESPONDENT IS ORDERD TO AUTHORIZE, APPROVE AND PAY FOR THE DECROMPRESSION AND FUSION BACK SURGERY RECOMMENED BY DR. GRAF.

THE ARBITRATOR ALSO ORDERS THE RESPONDENT TO PAY FOR TTD AT THE RATE OF 278.90 PER WEEK FOR THE PERIOD OF 2/1/11-10/21/11, A PERIOD OF 141 &2/7 WEEKS.

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

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

Grant Lee
Signature of Arbitrator

12/23/13
Date

ICArbDec19(b)

DEC 31 2013

14IWCC0728

FINDINGS OF FACT:

The Petitioner is 40 years old as of the date of trial. He speaks Spanish and testified through an interpreter. He injured his back while working for the Respondent on January 31, 2011 when he was carrying a ladder and twisted. He felt pain in his back and down his legs.

The Petitioner was seen at McHenry County Orthopedics by Dr. Basran on February 3, 2011. His records indicate the Petitioner's history of injuring his back at work while carrying a ladder and he noted the Petitioner's complaints of pain in his back and down his left leg. Dr. Basran's exam indicated positive SLR on the left side. He ordered an MRI, prescribed Norco for pain, and issued a five pound lifting restriction. The Petitioner had an MRI on February 7, 2011. He saw Dr. Basran again on February 10, 2011 and Dr. Basran reviewed the MRI, examined the Petitioner, and concluded that he had a herniated or protruding disc at L5-S1 with impingement. He recommended cortisone injections and referred him to a spine specialist, Dr. Graf.

The Petitioner was seen by Dr. Graf of Illinois Spine Institute on February 18, 2011. Dr. Graf recorded his history of back and leg pain. He examined the Petitioner and ordered physical therapy and issued an off work note. The Petitioner underwent physical therapy and chiropractic treatment with Dr. Spengel from January through May 2011, and also continued following up with Dr. Graf. On April 6, 2011 Dr. Graf noted his leg and back pain and recommended an epidural steroid injection and kept the Petitioner off work.

The Respondent did not authorize the injection at that time and instead sent the Petitioner for an independent medical exam with Dr. Bernstein. On May 19, 2011. Dr. Bernstein examined the Petitioner and opined that he needed a short course of physical therapy and a home exercise program and that the Petitioner could work full duty notwithstanding his complaints of back pain into his thighs.

The Petitioner continued to see Dr. Graf in June and July 2011 and Dr. Graf continued to recommend the epidural injection. The Petitioner was examined at the request of his attorney by Dr. Gregory Brebach, an orthopedic surgeon with Lake Cook Orthopedic on September 15, 2013. Dr. Brebach examined the Petitioner and reviewed the MRI. He opined that the Petitioner had a left sided herniated disc at L5-S1, and recommended an epidural steroid injection consistent with Dr. Graf. The Respondent subsequently authorized the injection which was done on January 10, 2012 by Dr. Bayran. The injection provided temporary relief to the Petitioner. The Petitioner underwent a second epidural steroid injection on January 24, 2012 which did not provide any relief. Dr. Bayran also prescribed Norco for pain.

The Petitioner continued to see Dr. Graf after his injections. On February 22, 2012, Dr. Graf examined the Petitioner and noted he continued to have leg symptoms in the distribution of the S1 nerve root, including decreased sensation in the sole of his left foot. Dr. Graf also noted that he continued to have positive SLR. Dr. Graf recommended a

discogram and issued a note keeping the Petitioner off work. The Respondent refused to authorize the discogram at that time and the Petitioner remained off work and continued to see Dr. Graf. Dr. Graf continued to prescribe medications, keep the Petitioner off work, and recommend the discogram.

The Respondent eventually authorized the discogram which was done on January 8, 2013. The discogram showed concordant low back pain and left leg pain at L5-S1, the same location where the MRI showed the herniated or protruding disc. It also showed a Dallas grade 5 tear at that level. The Petitioner saw Dr. Graf on January 23, 2013 and Dr. Graf examined the Petitioner and reviewed the discogram results and recommended back surgery. On April 8, 2013 Dr. Graf issued a note continuing the Petitioner off work and refilled his pain medications. On July 19, 2013 Dr. Graf noted the Petitioner's continued decreased sensation in the sole of his left foot, and recommended a decompression and fusion. Dr. Graf noted that the Petitioner's care continues to be delayed awaiting approval. On August 26, 2013 Dr. Graf indicated he is waiting to hear from workers' compensation to approve the back surgery and gave the Petitioner a restriction of sedentary work only, with only occasional lifting 10 pounds. The Petitioner testified that his job for the Respondent required frequent bending, pulling heavy insulation hoses and heavy lifting well in excess of his restrictions. His testimony was not rebutted.

The Petitioner testified that he continues to have severe back pain and pain into his left leg. He indicated that activities of daily living are difficult. He wants to have the surgery recommended by Dr. Graf.

CONCLUSIONS OF LAW:

The Findings of Fact as stated above are adopted herein.

With respect to issue (F), Is the Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

It is not disputed that the Petitioner had an accident at work on January 31, 2011 when he felt back and leg pain after carrying a ladder. The Petitioner testified that he was not having any trouble or pain performing his heavy job duties before his accident, and that he had not had any prior back problems except for several visits with a chiropractor named Dr. Chevere back in 2009. The records from Dr. Chevere indicate he was seen six times in 2009 and was released with no restrictions on January 19, 2009. Even Dr. Bernstein, the Respondent's examining doctor, agreed that his brief chiropractic treatment in 2009 were irrelevant to his opinions in the case (page 21 Bernstein dep.).

The Petitioner's testimony that he has had severe back pain and left leg pain since his accident is corroborated by the medical records. All of the doctors that have evaluated the Petitioner have recorded not only his history of accident, but his ongoing back and left

leg pain. No alternative accident histories have been suggested by the Respondent, which authorized most of the treatment that the Petitioner has had to date and paid TTD earlier in the case.

The Petitioner's subjective complaints are supported by the objective findings contained in the medical records. Dr. Graf continuously records that the Petitioner's left sided symptoms, including his leg pain and decreased sensation in the sole of his left foot, are in the S1 nerve root distribution. Said findings are consistent with the MRI findings of a protruding disc at L5-S1. These findings are also consistent with the frequent exam findings of positive straight leg raises. In addition, all of the foregoing findings are consistent with the positive discogram showing concordant pain at L5-S1.

Dr. Brebach confirmed these consistent findings in his deposition and Dr. Brebach testified that, after examining the Petitioner and reviewing the MRI, it was his opinion that the Petitioner was suffering from a herniated disc at L5-S1. This conclusion is consistent with the diagnoses of Dr. Graf. Dr. Brebach testified that based on a reasonable degree of medical and surgical certainty, the work accident is a causative factor in his diagnoses. (Brebach dep page 14). Dr. Brebach stated: "Certainly the cause of that diagnoses, given his history and the way he presented, would be the accident." (Brebach dep. Page 14).

Although Dr. Bernstein testified that he did not believe the Petitioner had a symptomatic herniated disc, his opinion is inconsistent with the findings on the MRI and discogram, and inconsistent with the clinical findings of decreased sensation in the S1 nerve distribution, the positive SLR findings, and the lumbar spasms noted by the treating doctors. Dr. Bernstein admitted that the foregoing findings and the results of the discogram are consistent with the Petitioner's complaints, but said he is choosing to ignore that evidence because he believed the Petitioner was exaggerating his symptoms when he examined him. (Bernstein dep. Page 19). None of the other five doctors that evaluated the Petitioner doubted the sincerity of his complaints (Dr. Basran, Dr. Bayran, Dr. Graf, Dr. Spengel, and Dr. Brebach).

As a result of the foregoing the Arbitrator finds the opinion of Dr. Bernstein is not credible and that the Petitioner's current condition of ill-being is causally related to his accident.

With respect to issue (K), whether the Petitioner is entitled to prospective medical care, the Arbitrator finds the following:

The Petitioner testified that he continues to have pain in his back and left leg and numbness in his foot. He also has testicular pain. Dr. Graf's and Dr. Brebach's opinion that he has compression of the S1 nerve root are consistent with the MRI, the discogram, and all the other foregoing clinical findings. He has failed conservative treatment including physical therapy, chiropractic care, injections and medications. When Dr. Brebach was asked if he agrees with Dr. Graf's recommendation for surgery he agreed and stated: "I am surprised it has taken this long to reach that conclusion." (Brebach dep page 13).

As a result of the foregoing, the Arbitrator finds that the decompression and fusion recommended by Dr. Graf is reasonable and necessary. The Arbitrator orders the Respondent to approve, authorize and pay for the surgery.

With respect to issue (L), what temporary total disability benefits are due, the Arbitrator finds the following:

The Respondent terminated the Petitioner's TTD notwithstanding the off work notes issued by Dr. Graf on 3/9/11, 4/6/11, 2/22/12 and 4/8/13. In addition, Dr. Bayran's records indicate he instructed the Petitioner to remain off work as of 1/15/13. The last visit with Dr. Graf was on 8/26/13 and at that time Dr. Graf indicated the Petitioner can work only sedentary duty, with lifting to a maximum of 10 pounds occasionally. It is not disputed that the Petitioner cannot perform his job duties within that restriction. The only doctor to release the Petitioner to work full duty is Dr. Bernstein who said there is nothing wrong with the Petitioner notwithstanding the L5-S1 protrusion on the MRI, the positive discogram at L5-S1, the decreased sensation in the S-1 nerve distribution, the lumbar spasms and the positive straight leg raises consistently recorded by Dr. Graf.

The Petitioner's testimony and the overwhelming majority of the medical records indicate that the Petitioner continues to suffer from back pain and left leg pain. The Petitioner has been unable to improve his condition because the Respondent has refused to authorize the treatment he needs.

As a result of the foregoing the Arbitrator finds that the Petitioner has been totally temporarily disabled since February 1, 2011 and remains so through the date of hearing on October 21, 2013, a period of 141 2/7 weeks. The Arbitrator orders the Respondent to pay TTD benefits for said period.

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Winters,

Petitioner,

vs.

NO: 10 WC 38523

14IWCC0729

Tennant Truck Lines,

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, extent of temporary total disability, nature and extent of permanent disability, medical expenses, intervening accident and termination of employment and being advised of the facts and law, corrects 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 on the face sheet of his Decision, the Arbitrator awarded permanency of 10% person as a whole. However, in the body of the Decision, the Arbitrator awarded 11.75% person as a whole. The Commission corrects the face sheet to reflect the permanency award of 11.75% person as a whole as indicated in the body of the Decision. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 19, 2013 is hereby affirmed and adopted with the above noted correction.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $587.38 per week for a period of 17-3/7 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 $528.64 per week for a period of 58.75 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 11.75%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner all reasonable and necessary medical expenses through April 8, 2011 under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit in the amount of $1,123.79 under §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury. The Commission notes that Respondent paid $35,410.20 in TTD benefits.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,900.00. 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: AUG 25 2014
MB/maw
o06/25/14
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WINTERS, JOHN
Employee/Petitioner

Case# **10WC038523**

14IWCC0729

TENNANT TRUCK LINES
Employer/Respondent

On 7/19/2013, 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 0.07% 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 M STROW
110 E MAIN ST POB 859
OTTAWA, IL 61350

1564 HINSHAW & CULBERTSON LLP
PETER H CARLSON
222 N LASALLE ST SUITE 300
CHICAGO, IL 60601

14IWCC0729

STATE OF ILLINOIS)
)SS.
COUNTY OF La Salle)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

John Winters
Employee/Petitioner

v.

Tennant Truck Lines
Employer/Respondent

Case # 10 WC 38523

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 George Andros, Arbitrator of the Commission, in the city of **Ottawa**, on 8/29/12 and 5/23/13. 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 **September 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$45,815.64**; the average weekly wage was **$881.07**.

On the date of accident, Petitioner was **65** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$35,410.20** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$35,410.20**.

Respondent is entitled to a credit of **$1,123.79** under Section 8(j) of the Act.

ORDER

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS OF $587.38/WEEK FOR 17 3/7 WEEKS FROM 1/22/11 TO 5/22/11 PURSUANT TO SECTION 8(B) OF THE ACT. .

RESPONDENT SHALL PAY PETITIONER PERMANENT PARTIAL DISABILITY BENEFITS OF $528.64 PER WEEK FOR 50 WEEKS, WHICH EQUATES TO 10% LOSS OF PERSON AS A WHOLE, AS PROVIDED IN SECTION 8(D)2 OF THE ACT.

AN INTERVENING EVENT IS FOUND TO HAVE OCCURRED ON APRIL 8, 2011. RESPONDENT'S LIABILITY FOR PETITIONER'S RELATED MEDICAL TREATMENT IS TERMINATED AS OF APRIL 8, 2011. RESPONDENT IS AWARDED A SECTION 8(J) CREDIT IN THE AMOUNT OF $1,123.79 FOR THE CONCENTRA MEDICAL BILL FOR DOS 9/21/10. RESPONDENT'S CREDIT FOR COMPENSATION PAID TO DATE CITED ABOVE IS $35,410.20

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

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

Signature of Arbitrator

July 16, 2013
Date

JUL 19 2013

FINDINGS OF FACT 10 WC 38523

The parties have stipulated to an average weekly wage of $881.07 and that proper notice of an alleged accident was given within the limits stated in the Act.

Petitioner, John Winters, is a truck driver for Respondent Tennant Truck Lines and has alleged an injury to his non-dominant left arm/shoulder on September 6, 2010. Petitioner was in Maryland at the time of the accident and continued driving his truck and did not seek medical treatment until September 21, 2010 at Concentra. On that date he was given restrictions with his left arm that allowed him to continue to drive a truck, with no lifting the left arm above the shoulder and no pushing/pulling with the left arm. Petitioner continued to drive his regular tractor assigned to him(owned by Respondent) after the accident with these restrictions with the only difference being he changed his trailer from a flatbed to a drive only box/van that did not involve securing the load with chains. Respondent has regular drive only truck driving jobs where only the box/van trailers are hauled. Then after driving several additional routes/loads, on September 24, 2010 he returned to the Respondent's terminal. Respondent testified that they inspected Petitioner's tractor on September 24, 2010 and that they discovered that Petitioner had caused his tractor to become filthy and unsanitary, including bottles with his urine all over the cab. Respondent testified that this cleanliness problem was a recurring problem with Petitioner. Petitioner testified that he was urinating in these bottles while on the road due to having a small bladder, because otherwise he would have to stop every hour to go to the bathroom and that is not feasible when driving over the road. Respondent confronted Petitioner regarding the cleanliness of the truck on September 24, 2010. Petitioner testified that he was terminated at that time, but that he was physically capable of continuing to drive that truck right up to the date of his first left shoulder surgery on January 22, 2011. Dr Gunderson performed the left shoulder surgery on January 22, 2011 consisting of a rotator cuff repair with anchors. Mr Aaron Tennant, CEO of Tennant Truck Lines testified that he told Mr Winters to clean up the tractor as required by the company employee handbook and that Mr Winters refused, walked out and threatened to sue Tennant Truck Lines. Petitioner denied this. Mr Tennant testified that his company is always looking for truck drivers and that there is a shortage of drivers in the industry and at Tennant Truck Lines.

Petitioner had the left shoulder surgery with Dr. Gunderson on January 22, 2011 and after the surgery he was doing well until he fell in his bathtub as noted in the treatment note of April 8, 2011. Petitioner was not at MMI at the time of the fall. After that the medical records reflect increased complaints. Petitioner denied increased pain complaints after this fall. Petitioner testified at trial that he slipped on soap in his bathtub at home. Petitioner had a second shoulder surgery with Dr. Gunderson on August 29, 2011. Ultimately, Petitioner had an FCE on April 16, 2012 placing him at the medium to heavy level, with difficulties with overhead lifting with his left upper extremity. Petitioner reached MMI on May 15, 2012 per the opinions of Dr. Gunderson that he could not climb into the cab of a semi-truck.

On June 13, 2012 the Respondent offered Petitioner a truck driving job that was drive only(no lifting)operating a tractor with the box/van trailer. This is a full time regular job with Respondent that Petitioner was doing previously and is at the same rate of pay or higher than before the accident. Petitioner refused this job on the grounds that he could not climb into the tractor based upon the opinion of Dr. Gunderson. Alternatively, Respondent offered Petitioner a job as a security guard earning $15 per hour. Petitioner accepted this job until he quit so he could get right shoulder surgery that was unrelated to this accident. Petitioner also testified that he did not like working nights even though it paid more than during the day and he did not like driving back and forth to the terminal. Petitioner also testified on page 75 of the trial transcript that he told Respondent that he would be available to work again after the right shoulder treatment in December 2012 because he hoped to be able to drive a truck again at that time. Petitioner has not looked into driving smaller trucks, which would be easier to get into and he doesn't know what those jobs would pay although he believes the pay would be less.

Mr Aaron Tennant testified(pg 118-119) that climbing into the Tennant Truck that would be assigned to Petitioner does not require overhead lifting/pulling with both arms, because of the location of the grab bar and that you can get into the cab utilizing one arm to pull. He also testified that he continues to need truck drivers to fill trucks for no-touch/no lift jobs and that there is a shortage of truck drivers in the industry. Also Mr Tennant testified that there are plenty of truck positions open in the industry driving smaller trucks. Lastly, he testified that he would work with Petitioner to help him return to the same type of semi-truck he was driving previously. The testimony of the Petitioner and Mr. Tennant differed about the dynamics of climbing into a cab and the location of the grab bar. A three point stance and a small step if needed was not discussed as I recall. However, Petitioner's explanation of his arm raising to grasp the grab bar seemed to flail at the issue of why he could not enter and drive. The proverbial verbal finger pointing ensued about how Tennant failed to provide any help in those mechanics. In comparison to the body habitus of the worker, his insistence he can drive a truck but does not want to drive to the yard, the expectancy of this worker to make a full faith effort to return to work all make the testimony of Mr. Tennant much more persuasive in all factual issues.

Respondent's IME, Dr Ram Aribindi, was deposed and he testified that the second surgery was necessitated by the Petitioner's fall in his bathtub that increased his symptoms on or about April 8, 2011 as Petitioner was doing well up to then and that he would have been MMI by May 22, 2011 if that fall had not occurred. He also testified that the anchors from the first surgery were not damaged in the fall and that the surgery would likely not have been done to repair what was ultimately found during the second surgery, i.e a minimal incidental tear and some scar tissue. The scar tissue could have been there as a result from the first surgery, the fall in April 2011 or from a degenerative condition. Dr Aribindi opined that the April 8, 2011 fall caused increased symptoms resulting in the second surgery of August 29, 2011 and that it would not be possible to determine whether the second surgery had a connection to the first surgery or the initial injury.

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

Petitioner's injury is limited exclusively to his non-dominant left shoulder. Dr. Aribindi confirmed that the first surgery of January 22, 2011 was the result of the work accident.

However, per the opinions of Dr. Aribindi the second surgery on August 29, 2011 was due to the increased symptoms from the fall in Petitioner's bathtub after slipping on soap at home on or about April 8, 2011. Both Dr. Gunderson and Dr. Aribindi confirm that there were minimal findings in the second surgery and that the first surgical repair was not damaged. The Arbitrator notes that Petitioner was doing well until the fall in his bathtub on soap and that the medical records reflect that he worsened immediately after that as noted in Dr. Gunderson's medical note of April 8, 2011 and beyond. The Arbitrator notes that the medical evidence is speculative to support Petitioner's claim that the second surgery of August 29, 2011 has sufficient legal connection to the work accident of September 6, 2010 and the first surgery of January 22, 2011. Accordingly, the Arbitrator finds that there was an intervening event on or about April 8, 2011 that breaks the causal chain in terms of Petitioner's work injury. Accordingly, Respondent is not responsible for medical benefits after April, 8, 2011.

K. What temporary benefits are in dispute: TTD?

Petitioner is claiming TTD from the date he stopped working i.e September 25, 2010, until he reached MMI on May 15, 2012. Respondent disputes the TTD period from September 25, 2010 until the date of the first surgery on January 22, 2011. Respondent also disputes TTD from May 22, 2011 until May 15, 2012.

Claimed TTD Period -September 25, 2010 to January 22, 2011

Respondent is not liable for TTD benefits from September 25, 2010 until the date of the first surgery on January 22, 2011. After the accident the Petitioner continued working, driving the same tractor and earning the same pay until he walked off the job on September 24, 2010 after a dispute with Respondent over cleaning his truck. While its true that he was hauling a different trailer than on the day of accident and he had restrictions, it was the same tractor that he was climbing into as on the date of accident, he was earning the same pay, it was a trailer type that he had hauled before and he was performing a regular full duty driving job as he had done before and as performed by many other drivers for Respondent. Petitioner also testified that he was physically capable of doing that job the entire time up until the date of his first shoulder surgery on January 22, 2011 and that he would have continued to do so if his employment had not ended on September 24, 2010. Petitioner claims he was fired on that date. However, the CEO of Respondent, Aaron Tennant, testified that Petitioner walked off the job, quit and threatened to sue Respondent after refusing to clean his truck on September 24, 2010. The Arbitrator finds the testimony of Aaron Tennant extremely persuasive on this issue. Further that Respondent needed truck drivers to fill their trucks. He is active in trucking associations and knowlegable of the market need for drivers.

Furthermore, the Arbitrator finds that the Petitioner is highly selective and almost sabotaging his efforts to return to work in light of the many inconsistencies in his testimony.The record as a whole demonstrates that Petitioner appears to come and go from his job at his convenience.

The Arbitrator finds instructive the Commission decision in *Lackscheide v. Help at Home*, 11 IWCC 0679 (2011), where Petitioner's employment included taking patients to the doctor or to do their housework. Petitioner would also do laundry, dusting, sweeping, mopping and vacuuming. Petitioner was injured on December 14, 2007 and continued working. Petitioner was later fired on February 14, 2008, for 'cause' for 'falsification of time cards". Petitioner was released light duty with no lifting over 10 pounds from February 12, 2008. On April 1, 2009, Petitioner's work restrictions increased to 30 pounds. Petitioner was not working during this period and was not at MMI. Petitioner found new employment within her restrictions in September of 2009. The Commission held that on April 1, 2009, a physician placed a lifting restriction on the Petitioner of 30 pounds and that it was clear that Petitioner's job with the Respondent was within that restriction. Therefore, the Commission found that Petitioner was not entitled to temporary total disability payments after April 1, 2009. The Commission analyzed the Interstate Scaffolding decision holding that "when Petitioner was initially discharged, it was clear that she was working "light" duty work for Respondent. A physician put her on a 10 pound restriction per the Physical Therapist Clinic initial evaluation on February 11, 2008. Testimony was given that at the time she was fired, she was not working her regular job for the Respondent. The record then shows that no doctor changed that 10 pound lifting restriction until April 1, 2009 when it was increased to 30 pounds. Petitioner's previous regular job did not require her to lift more than 30 pounds and therefore she could not show that she continues to be temporarily totally disabled. Thus, Interstate Scaffolding does not apply." *Id.*

In the instant case, Petitioner was working the regular truck driving job driving his same company tractor until the job ended on September 24, 2010 as a result of Petitioner's decision to walk off the job and quit over a dispute regarding the cleaning of his truck. Accordingly, no TTD is awarded for the period from September 25, 2010 to the date of the first surgery of January 22, 2011 as Petitioner agrees he could have physically continued in that regular truck driving job up until January 22, 2011.

Claimed TTD Period from May 22, 2011 to May 15, 2012

Dr. Aribindi testified that Petitioner would have been at MMI after the first surgery four months post-op on page 15 of his deposition. Based upon the intervening fall on or about April 8, 2011 the causal chain on the work accident was broken at that time. Accordingly, TTD is awarded through the expected MMI date for the work related injury and surgery, which per Dr. Aribindi is May 22, 2011.

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

Petitioner sustained a surgically repaired left shoulder rotator cuff injury to his non-dominant arm prior to an intervening injury to the same part of his body. Given the nature of the rotator cuff surgery on January 22, 2011, the Arbitrator finds that Petitioner is awarded permanent partial disability of 11.75 % of a person as a whole.

Alternatively, and without prejudice to the causation/intervening event dispute, the Arbitrator finds that Petitioner was ultimately able to return to truck driving after reaching MMI on May 15, 2012 from his second shoulder surgery. The Arbitrator notes that the findings and repair from the second surgery were relatively devoid of documented pathology in the surgical report plus the repair done at that time may even have been in hindsight insufficient for surgical intervention but for subjective symptoms. The Arbitrator does note that the surgery was justified on the basis that the pre-surgical MRI had incorrectly indicated that an anchor was loose, when in fact it was not . The truism that the doctor treats the patient not the test rings true here.

However, even with the second surgery the evidence supports the fact that Petitioner can return to truck driving with only minimal restrictions in overhead lifting with his non-dominant arm. The Arbitrator notes that Petitioner did not attempt to return to truck driving or to climb into the regular sized semi-tractor in the manner identified by Aaron Tennant when Respondent offered him his previous no touch/no lifting job driving a van/box trailer in June of 2012. Mr Tennant credibly testified that the dimensions of the Respondent's tractors allow for a driver to climb into them using only one arm pulling. Also, the Arbitrator notes that Petitioner was able to drive and get into the same tractor after the accident up until the employment ended on September 24, 2010 and that Petitioner testified that he planned to return to truck driving after surgery on his right arm by December 2012. This fact issue is also addressed above.

Relative to the concept of a reasonably stable job market, the Arbitrator finds compelling the knowledge, forthright testimony, position in the industry and content put forth by Mr. Tennant. His testimony was tested by insightful, focused & long cross examination over extended time to give each side due process. The Arbitrator adopts the testimony of Mr. Tennant in total both here and above and below . The material facts are thus deemed adopted as follows in the case at bar: there is a shortage of drivers in the trucking industry and that Petitioner could drive smaller trucks where the rate of pay was undetermined, the truck design in terms of the location/height of the vertical bar used to aid the entrance was not a barrier to entering his truck.

Many variables go into a judicial officer determining credibility. A number of those variables are rooted in and include observations, reasonable inferences from "facts" and perceived attitude/behavioral demeanor of witnesses. Added to that forceful word of credibility those factors do impact the determination of the tipping point of the preponderance of the evidence. In the case at bar, this Petitioner when it suited him had the proverbial "answer for everything" when being asked about each and every question as to his conduct or lack thereof.

That went from the testimony about trashing his cab time after time, his mechanics of entering a cab that he was practically defiant was the only way to step up to enter the cab, the lack of responsiveness of the employer to somehow provide aids or modifications, as the arbitrator recalls when the discussion turned to the height and location of gripping bars that being tied into some discussion about the employer possibly not providing some aid to alight to a higher level to prevent him reaching to a level over his shoulder in proceeding to enter the cab.

Notwithstanding, the Arbitrator also questions whether Petitioner is medically suited to be an over the road driver unrelated to this accident based upon his self stated "small bladder" that requires him to stop every hour for a rest break verse other inappropriate options. This alleged medical condition is foisted upon the employer seemingly as a rebuke why the worker trashed his cab(s) costing thousands of dollars to restore. The black and white page transcript will not release the almost palpable animus and negativity from the Petitioner on the stand in giving any consideration to the herculean return to work effort posited by Mr. Tennant. The Arbitrator also relies upon multiple instances in the record where Petitioner displayed a lack of credibility including his claim that he could "curl" Respondents attorney, that he was limited in casting with a fishing pole as a result of the injury, but then admitted he uses his right arm (not his injured left arm) to cast and that he hoped to return to truck driving in December of 2012 after quitting his security guard job to have right shoulder surgery.

M. Penalties are not awarded in light of the legitimate/good faith disputes at issue.

N. Is the Respondent due any credit?

The parties have stipulated that Respondent has paid $35,410.20 in TTD. TTD is awarded in this decision from the date of the first surgery of January 22, 2011 to the MMI date from the first surgery in light of the intervening event i.e May 22, 2011. This results in 17 3/7 weeks of TTD and a net credit to respondent of $25,131.05. Also, Petitioner's medical exhibit confirms that Respondent is entitled to an 8(j) credit for group medical payments in the amount of $1,123.79.

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angela Thomas,

Petitioner,

vs.

NO: 12 WC 2264

14IWCC0730

Pretium Packaging, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Respondent appeals the Decision of Arbitrator Falcioni finding that as a result of repetitive trauma accidental injuries arising out of and in the course of her employment manifesting on December 20, 2011, Petitioner was temporarily totally disabled from December 21, 2011 through January 17, 2013, a period of 55-6/7 weeks, that she is entitled to $127,765.64 in medical expenses and is permanently disabled to the extent of 10% person as a whole. The Arbitrator found that a causal relationship exists between those injuries and Petitioner's current condition of ill-being, that timely notice was given to Respondent and denied penalties and attorneys' fees. The issues on Review are whether Petitioner sustained repetitive trauma accidental injuries arising out of and in the course of her employment, whether timely notice was given to Respondent, whether a causal relationship exists between those injuries and Petitioner's current condition of ill-being and if so, the extent of temporary total disability, the amount of medical expenses and the nature and extent of permanent disability. The Commission, after reviewing the entire record, reverses the Decision of the Arbitrator finding that Petitioner failed to prove that a causal relationship exists and denies Petitioner's claim for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 53 year old general laborer, testified at the March 22, 2013 arbitration hearing that Respondent's business is making plastic bottles and other containers (Tr 8). Before being hired by Respondent, she worked for Respondent through a temporary agency called Safe-Rite Staffing (Tr 9). Petitioner did the same job duties as a temporary as she did later as an employee at Respondent (Tr 9). Through Safe-Rite Staffing, Petitioner began working at Respondent directly in April or May 2011 (Tr 9). She was hired on October 23, 2011 (Tr 9-10). Her job duties consisted of packed bottles onto pallets (Tr 11). Respondent provided a DVD that depicted two jobs; one where a machine emptied made bottles into a bin and the other the grind area. Petitioner worked at the grind more than at the machine (Tr 12). The machine produces plastic bottles that then run down a small ramp (Tr 14). Petitioner worked on this machine 2 or 3 times during her employment, including with Safe-Rite. She did the grinding job and others (Tr 15). Her job at Respondent was full-time at 12-hour shifts (Tr 15). For 6 hours out of 40, she worked in grinding (Tr 16).

The DVD depicts the grinding job she did (Tr 16). The bin was full of plastic bottles; some she had to empty from the bin half way and then she could bring the door down and grab bottles and put them into the grinder (Tr 16). She would empty the bin by manually pulling bottles out and putting them into the grinder (Tr 17). In the bin there are bottles that have something wrong with them; these bottles are reground and reproduced for plastic (Tr 17). Petitioner is 5'2" tall and had to reach in over the top of the wire bin/basket (Tr 18). She would reach in with both hands and empty the bin halfway down. The top of the bin was above her chest and below her chin (Tr 19). In order to reach in, her arms would be above her shoulders (Tr 19). When the bin was half empty, she could put the gate down to where she could bend over and get the bottles easier; this is seen on the DVD (Tr 19). She described that the other part of her job as plastic bottles would come out of a machine and onto a conveyor belt; she would reach up and grab however many bottles she could off the conveyor belt and then did the same with her other hand (Tr 20). Her arms would be extended straight out above her shoulders when doing this (Tr 21). Other bottles would go off the conveyor belt and into a bin; she would miss them or she was not fast enough to keep up with the line; the bin was at her chest level (Tr 21). She would keep up with the belt. As the bottles came off the belt, she would reach up and get them from the conveyor belt, inspect them, reach with her other hand and get bottles off the conveyor belt and inspect them, turn around and pack them into whatever they would go on to (Tr 21). She next stacked the bottles onto wooden pallets that have dividers in between the stacked layers (Tr 22). The bottles are not put into boxes; they are stacked directly onto pallets (Tr 22). Every layer stacked would have 50 plus bottles, but it would depend on the size of the bottles and it could be double that amount (Tr 23). Petitioner loved her job at Respondent.

During an entire shift, Petitioner would be pulling bottles, inspecting them and stacking those onto pallets, unless she was doing the grinding of defective bottles (Tr 25). The type of stacker seen on the DVD is called a manual palletizer (Tr 25). She would use the manual palletizer frequently (Tr 26). If stacking on a wooden pallet, she would put a divider on top of the pallet first and then begin stacking on the first level/layer in whatever diagram was depicted

for her to pack, however the customer wanted it packed (Tr 27). Each one of those bottles that made it to the pallet would be placed there by her (Tr 27). Depending on what the customer ordered, the height of the levels of the bottles on an individual pallet could be 4 to 8 levels (Tr 27). If each level was 100 bottles, 8 levels would be 800 bottles on that pallet (Tr 28). When she was doing one-gallon jugs, she was stacking 4 pallets per hour (Tr 28). The levels on each pallet were 8 plus. She did not remember how many gallon jugs were on one level (Tr 29). Fifty to 100 bottles stand for all the bottles she did (Tr 29). Each bottle is manually touched by her and put on the pallet by her (Tr 29). She used both hands. She would start with her thumb and grab 4 bottles in her left and then right hand, turn the bottles and look for anything that was not supposed to be there, made sure the mouths of the bottles were fine and put them on to the manual palletizer or the pallet, whichever they needed to go (Tr 30). After inspecting and stacking the bottles, Petitioner would then turn for another load and do the same (Tr 30). She would get a lunch and bathroom breaks (Tr 31).

Before being hired directly by Respondent, while she was employed with the temporary agency, Petitioner was involved in an altercation with her boyfriend on August 11, 2011 (Tr 31). He was drunk, yelling and screaming at her. During the altercation, she sustained bruising to her left arm. Petitioner identified Rx7 as a photograph of her left hand where car keys were taken out of her hand by her boyfriend (Tr 32). In the photograph, there are a number of birth marks. The photograph also shows her left biceps, which is bruised and this came about when her boyfriend grabbed hold of her (Tr 33). She did not seek medical attention for this (Tr 34). Petitioner did not know why Respondent's physician would say that this altercation is what caused her injury (Tr 34). She continued to work after this altercation (Tr 34).

On December 20, 2011, Petitioner went to Illinois Valley Community Hospital (IVCH) emergency room and reported she had severe left shoulder pain (Tr 35). She was having pain in the front of her left shoulder, in the joint and upwards at the top (Tr 35). She told ER personnel where she worked and she answered many questions about the nature of her work (Tr 36). Petitioner told them that initially in early to mid November 2011, she was having pain which was controllable with over-the-counter Ibuprofen (Tr 36). For the 3 weeks prior to this visit, the pain was uncontrollable (Tr 37). She had continued to work with the pain (Tr 37). Petitioner was authorized off work by ER personnel and was also given work restrictions (Tr 37-38). On this day or near that time, Petitioner reported her condition to Respondent's human resources Corey Sipes (Tr 38). Petitioner thinks Mr. Sipes told her that she was terminated as she was on the point system (Tr 39). Petitioner lost her job after December 20, 2011 (Tr 39). The conversation with Mr. Sipes took place a day or two after December 20, 2011, when Petitioner did not go to work and called in (Tr 39). That was the day she was authorized off work by the ER personnel (Tr 40). She had called in and spoke to Mike, a supervisor who has since passed away (Tr 40).

Petitioner returned to IVCH on December 22, 2011 and reported the same pain and her work issues (Tr 40). In the records that date, there is also mention of a fall. Petitioner testified this fall happened several months before this visit (Tr 41). The nurse was asking her questions and she mentioned that the grind floor was slick and she fell. She did not seek treatment for that

fall (Tr 41). She was treated and released that day (Tr 41). Petitioner then stated that the conversation with Corey Sipes occurred on December 22, 2011 on the telephone (Tr 42). Petitioner testified she told Mr. Sipes about her left shoulder and he told her that it did not matter, that he was sorry that he had to terminate her because of the point system and her missing work (Tr 42). Respondent had a point policy where if a person gets so many points in a period before, they have to let that person go; points are given for days that a person is not there and other events (Tr 43). Petitioner's employment was terminated on December 22, 2011 (Tr 43). Since that time, she has not received TTD benefits on a weekly basis (Tr 43). On December 22, 2011, IVCH staff referred her to Dr. Rhode, an orthopedic surgeon (Tr 44).

Petitioner testified she saw Dr. Rhode on January 5, 2012 (Tr 44). She described her job to Dr. Rhode and reported to him she was having swelling and horrendous non-stop left shoulder pain in the joint and shoulder blade (Tr 44-45). She also was having left elbow pain and left wrist pain, which she reported (Tr 45). She worked a 12-hour shift (Tr 45). Dr. Rhode injected her left shoulder, which provided temporary relief (Tr 45). Dr. Rhode authorized her off work and ordered a left shoulder MRI. On January 10, 2012, Petitioner saw her primary care physician Dr. Bailey and described her job the same as she had testified to (Tr 46). Dr. Bailey indicated she also had some left shoulder impingement issues (Tr 46). Petitioner underwent the MRI on February 6, 2012. She saw Dr. Bailey again and he diagnosed a rotator cuff tear and suggested she see an orthopedic surgeon (Tr 47). On March 1, 2012, Petitioner saw Dr. Rhode and discussed left shoulder surgery, which she decided to undergo (Tr 48). She had no past left shoulder or arm issues, other than the bruising done by her boyfriend at the time (Tr 48). She continued to be authorized off work by Dr. Bailey and Dr. Rhode awaiting authorization for the surgery (Tr 49).

On April 24, 2012, Petitioner underwent a subacromial decompression, distal clavicle excision and arthroscopic rotator cuff repair (Tr 49). She followed-up with Dr. Rhode, who removed sutures and prescribed pain medications. She still sometimes takes pain medications (Tr 50). Petitioner hurts more in the mornings when she wakes up and on wet days (Tr 50). She saw Dr. Rhode in May and June 2012. She saw Dr. Bailey and Dr. Rhode in July 2012. She attended post-operative physical therapy at St. Margaret's (Tr 50-51). Petitioner continued to follow-up with Dr. Rhode and Dr. Bailey through October 2012 (Tr 51). She has been released to return to work with restrictions of no lifting greater than 10 to 15 pounds (Tr 51). She was given these permanent restrictions on February 7, 2013 (Tr 52). Since being released, Petitioner has looked for employment (Tr 52). She searched for work from 9 to 12 places a week, as well as staffing services (Tr 52).

On cross-examination, Petitioner testified that the total time she worked for Respondent was from April or May 2011 until December 2011 (Tr 54). During that time, she worked on 5 or 6 different lines. She would come to work in the morning and the plant manager would assign her a line to work on (Tr 54). That was the case when she was a temporary worker and a full-time employee of Respondent (Tr 55). She was hired by Respondent directly on October 23, 2011 (Tr 55). From October 23, 2011 until December 22, 2011, Petitioner worked on 7 different

lines (Tr 55). In a week, she worked three 12-hour shifts, then she was off for 2 days, then back on for 2 days, then off (Tr 55). Petitioner worked on more lines that had conveyor belts than she did on the machine that had the bin (Tr 56). She worked more on the grinder than the machine with the bin (Tr 56). Between October 23, 2011 and December 22, 2011, she worked on the machine with the bin 2 or 3 times only (Tr 56-57). Every shift she had to grind waste bottles (Tr 57). Sometimes grinding would take 10 minutes, sometimes a half hour or 45 minutes, depending on if she wanted to be lazy throughout the day or not (Tr 57).

Petitioner on direct examination testified to 3 of the 7 lines she worked at (Tr 58). On the maple syrup line, her job was to stand where the syrup bottles come out and make sure they did not go farrow because the bottles had to go down a rail into the packing area. She made sure the bottles were going in straight on the conveyor belt (Tr 59). On the gallon jugs and restaurant style pickle jugs lines, when they came off a conveyor belt, generally she had a manual palletizer for them. She would pick them off the conveyor belt; the only time they dropped into the bin was when she was banding the pallets (Tr 59). Petitioner stated the relish jar line is depicted on the DVD. On the RX line, the bottles looked like fish bowls and came down a conveyor belt. As a bottle came off the conveyor belt, Petitioner checked it and packed it (Tr 60). On the STP line, bottles of different colors came out on that line on a conveyor belt, but it was bulk packed and she did not reach up to touch those bottles; so many of them spilled into the cage that she packed them from the cage (Tr 60). On any given day, Petitioner could be working on any of these different lines (Tr 61). The machines drop bottles onto a conveyor belt, which brings the bottles to the packer, her job (Tr 61). She took the bottles from the conveyor belt with her hands and would inspect them for imperfections and then stack the bottles (Tr 61). The conveyor belt was at her shoulder height (Tr 62).

Petitioner went to IVCH on December 20, 2011. Before that date, she had not gone to IVCH or any other facility for her left shoulder (Tr 62). She told IVCH personnel that she had been having left shoulder pain for 3 weeks that was uncontrollable. She had pain on and off for a week or two before that, but the pain was controllable (Tr 63). To her knowledge, nothing happened to make her pain more severe (Tr 63). She did not go to work on December 20, 2011 (Tr 63). She was also seen at IVCH on December 27, 2011 and the records reflect that she told the doctor her pain began 3 months before; Petitioner thought that was inaccurate on her part (Tr 64). Petitioner underwent surgery on April 24, 2012 and it helped. She had a lot of post-operative tenderness. She underwent another left shoulder MRI in November 2012 ordered by Dr. Bailey to see if what had been torn was repaired (Tr 65). After that MRI, Dr. Bailey told her she had bursitis (Tr 66).

Petitioner may have spoken with Mr. Sipes on December 20, 2011, but she believed their conversation occurred on December 22, 2011 (Tr 66). She did not recall whether she worked on December 20, 2011 (Tr 67). She did not work the next day or on December 22, 2011 (Tr 67-68). Petitioner was scheduled to work on December 22, 2011 and called in to Mike. She then called Corey Sykes on December 22, 2011 (Tr 68). In their conversation, Mr. Sipes informed her that

she had reached enough points to qualify for termination and she pleaded with him not to terminate her (Tr 68). The day after December 22, 2011, she had a further conversation with Mr. Sipes (Tr 69).

Petitioner first started looking for work in February 2013 (Tr 69). She denied that she had been convicted of a felony or a crime of dishonesty within the last 10 years (Tr 70). Petitioner testified that in July 2003, she was convicted of writing a bogus check (Tr 71). The boyfriend involved in the altercation with her on August 11, 2011 is not currently her boyfriend, but they are platonic friends (Tr 72). In that altercation, he grabbed her left arm and left a bruise (Tr 72). It is not true that he was holding her left arm so tight that she had to kick him in order to break free (Tr 72). The boyfriend's name is Randy (Tr 73). She had no further altercations with Randy (Tr 73). Petitioner reported the August 11, 2011 incident to police. She told the police officer she was involved in numerous prior verbal altercations with Randy, who drank frequently, but he did not put his hands on her until August 11, 2011 (Tr 74). She and Randy had been drinking on that day and their fight lasted 5 minutes (Tr 75-76). Petitioner may have told the police officer that Randy was holding onto her and that she attempted to kick him (Tr 76-77). Petitioner currently takes pain medication 7.5 Hydrocodone. She no longer takes Norco. She takes Aleve as well (Tr 77).

On re-direct examination, Petitioner testified she takes pain medication only as needed (Tr 77). She currently has left shoulder discomfort, which is much better than it was before surgery (Tr 78). She just watched on the syrup bottle line, but sometimes action was required (Tr 78-79). All the other jobs required her to physically stack things and pull things out. During her employment with Respondent, Petitioner worked the syrup line 5 or 6 times (Tr 79). On questioning from the Arbitrator, Petitioner testified that she worked the big pickle and mayo jar line 3 to 4 times a week (Tr 80). The majority of her work was on the gallon pickle and mayo line and the RX line (Tr 81). On re-cross examination, Petitioner testified that she worked the RX line approximately two times a week, maybe three, sometime the whole week (Tr 81). When she was assigned to a line every morning, her assignment could change during the day (Tr 81-82). On re-direct examination, Petitioner testified she was more likely to stay on a line than be switched (Tr 82).

2. At the May 7, 2013 arbitration hearing, Corey Sipes testified that he has been employed with Respondent since 1989. At that time he was hired as an inspector packer, the same kind of position Petitioner was hired as (Tr 6). He worked in that position for 3 years. After that he was promoted to quality control, inspecting the bottles that were packed to verify they met customer qualifications (Tr 6). He worked in that position for 2 years. He then was eventually hired as a salaried position in the job he currently has of business manager. He manages human resources, scheduling, customer service, warehouse and financial (Tr 7). He has been in this position for the last 6 years (Tr 7). He has come across Petitioner, who was with a temporary agency and was then hired full-time for Respondent on October 23, 2011 (Tr 8).

Mr. Sipes testified that on December 21, 2011, Petitioner called him to notify that she was calling off work for the day. He told her he would get back to her as he was not at his desk (Tr 9). At Respondent, there are points given for every attendance issue for an employee. For a person within their first 90 days of employment, that person gets a total of 4 points and then are considered done. For a full-time employee after their 90 days, it is 5 points for a 12 month period (Tr 9). In December 2011, Petitioner was still within her 90 days probation period (Tr 9). Mr. Sipes felt that when Petitioner was calling off work on December 21, 2011, she was close to that point and he would have to check on it (Tr 9). During their initial conversation, Petitioner did not advise him of any kind of injury or tell him she was at the doctor (Tr 9-10). Mr. Sipes checked the point system to determine whether or not Petitioner qualified for termination based on her attendance policy (Tr 10). This revealed she had 4 points and was qualified for termination (Tr 10).

Mr. Sipes testified he called Petitioner back on December 23, 2011 to advise her that she had been terminated (Tr 10). He told her that unfortunately, she was at 4 points within 90 days and following procedure she was being let go. Petitioner responded by telling him she injured herself. He reviewed his records and found she did not have an accident report and he had no idea there was ever an accident (Tr 10-11). At that point in the conversation, Petitioner did not tell him how she injured herself (Tr 11). Later that same day, Petitioner called Mr. Sipes and advised him that sometime in December 2011, she slipped in the grinding room and had reported that to James Law, the lead. Mr. Sipes went out and interviewed Mr. Law (Tr 12-13). Mr. Sipes reviewed Petitioner's file and did not find an accident report related to a September 2011 accident or any indication that there was a fall that occurred or was reported (Tr 13-14). Petitioner later called Mr. Sipes again and reported she fell a second time in the grind room and reported that to Harold Stanford, a lead tech (Tr 15). Respondent policy is that any incident or any injury that is reported to a lead requires that a report be filled out and then Mr. Sipes is contacted as well as the production manager and there is a formal investigation at the moment of the report (Tr 16). Mr. Sipes checked Petitioner's file again and found no report by Harold Stanford (Tr 16). Petitioner again called later that day and stated she slipped and fell out on the production area and that quality manager Shawn Wooten had witnessed it (Tr 16). The quality manager is also a person that an employee can report an accident to (Tr 17). The quality manager follows the same procedure that a lead would follow and fills out an accident report, contacts Mr. Sipes and the production manager and an immediate investigation is conducted (Tr 17). Mr. Sipes checked Petitioner's file again and found no accident report (Tr 18). Mr. Sipes also conferred with Mr. Stanford and Mr. Wooten and determined there were no accident reports filled out (Tr 18). Petitioner also called him multiple times that day to beg for her job back, that she was an excellent worker and if he could make exception to the rule and that she needed money (Tr 19). During those conversations on December 23, 2011, Petitioner reported that her arm was injured, but she could not be specific if it was her wrist, elbow or shoulder and she could not tell him exactly when or how she was injured (Tr 19). Mr. Sipes asked Petitioner to come in and fill out an accident report, but she never came in (Tr 20). Mr. Sipes left a voice mail telling Petitioner to come in the next week to get this all taken care of, but she never came in or called him after that (Tr 20).

Mr. Sipes testified that prior to December 23, 2011, Petitioner worked at Respondent for approximately 8 months (Tr 21). During that time, she never reported any pain to her arms (Tr 21). After this left arm pain that she did eventually report to him on December 23, 2011, Petitioner never provided him with any kind of off work notes (Tr 21). If an off work note is provided by an employee, it is turned over to him so he is aware of the human resources situation (Tr 22). During all the multiple conversations he had with Petitioner on December 23, 2011, Petitioner never told him why her arm hurt (Tr 22). It was only after he terminated Petitioner that she said it had to do with work (Tr 22-23). Mr. Sipes identified Rx1 as his statement on a phone conversation he had with Petitioner on December 23, 2011 about a statement she made to James Law reporting an accident to him about a fall in the grind room (Tr 23). Rx1 was created in the usual and customary nature of the investigation of a reported accident (Tr 24). Rx1 contains his statement and a written statement by Mr. Law, which he had asked Mr. Law to write (Tr 24). Rx1 was created on January 10, 2012 (Tr 24-25). Mr. Sipes did not recall the date that he received Petitioner's Application for Adjustment of Claim. The Commission notes that Petitioner's Application for Adjustment of Claim was filed on January 23, 2012. Mr. Sipes recognized Rx2 as a statement from Petitioner that she fell in the grind room sometime in September 2011 and she reported it to Harold Stanford (Tr 30). Rx2 was also created in the usual and customary nature of conducting an investigation of a reported claim (Tr 30). Regarding Rx2, Mr. Sipes also secured a witness statement from Harold Stanford (Tr 32). Mr. Sipes identified Rx3 as his typed statement regarding conversations Petitioner had with him about how she tripped on the production floor and it was written by Quality Manager Shawn Wooten sometime in December 2011 (Tr 32). Mr. Sipes signed and dated Rx3 on January 10, 2012 (Tr 33). Once Petitioner's Application was filed, Mr. Wooten spoke with the insurance company (Tr 34). The investigation of the 3 alleged falls is still open and Petitioner did not come in to fill out her portion. Mr. Sipes had found no substantial evidence that there was ever an accident in all 3 alleged falls (Tr 34).

Petitioner never told him that the arm pain she told him about on December 23, 2011 was related to repetitive work activities (Tr 35). He was unaware and repetitive was not mentioned until he talked to CNA (Tr 35). Petitioner was made aware of the accident reporting policy at Respondent and she was given a manual and he made her aware of this policy (Tr 37).

On cross-examination, Mr. Sipes testified that Rx1, Rx2 and Rx3 are all dated January 10, 2012 (Tr 37). January 10, 2012 was not the day he spoke with CNA about Petitioner's claimed injury (Tr 37). Mr. Sipes is familiar with the way CNA handles matters (Tr 38). Once CNA is notified of a claim, they contact the claimant and then contact him to inform him of what is going on (Tr 38). Mr. Sipes' reactions on January 10, 2012 were triggered by his communication with CNA about the claim Petitioner brought (Tr 39). Mr. Sipes identified Px8 as a letter from CNA to Petitioner dated January 10, 2012 (Tr 39-40). Mr. Sipes had contact with CNA regarding Petitioner's workers' compensation claim before January 10, 2012 (Tr 43-44). Mr. Sipes prepared Rx1, Rx2 and Rx3 as part of Respondent's procedure for all incidents (Tr 44). Mr. Sipes was shown Px9, the Application of Adjustment of Claim, and agreed that it alleges repetitive lifting and nowhere claims any falls as referenced in Rx1, Rx2

and Rx3 (Tr 46). Petitioner's last physical day worked was on December 18, 2011 (Tr 54). Petitioner's last day of employment was December 20, 2011 (Tr 54). He would expect Petitioner to come in and fill out an accident report even though she had been terminated (Tr 56).

On re-direct examination, Mr. Sipes was shown Px9, the Application for Adjustment of Claim, and stated it was file stamped January 23, 2012 (Tr 57). Petitioner had signed Px9 and dated it December 28, 2011 (Tr 57). It was received at the IWCC mailroom on January 17, 2012 at 2:43 p.m. (Tr 59). Mr. Sipes did not recall the date he saw Px9 (Tr 63). Mr. Sipes was shown Px8, a letter from CNA to Petitioner dated January 10, 2012, which he had not seen before (Tr 63). The statements from Shawn Wooten, James Law and Mr. Stafford were obtained by Mr. Sipes before January 10, 2012 (Tr 63). Petitioner reported 3 incidents on December 23, 2011 (Tr 64). Mr. Sipes spoke to Mr. Wooten, Mr. Law and Mr. Stafford on December 23, 2011 (Tr 65).

3. At the May 9, 2013 arbitration hearing, Martin Gropp testified that he began working for Respondent in November 2009 as a shift supervisor. Since mid 2011, he has been the production manager and maintenance manager at Respondent (Tr 6-7). He is responsible for getting together the labor needed to do the work, training new labor, making sure the production flows and manage any issues (Tr 7). Respondent makes plastic food containers for companies that package peanut butter, mayo, pickles, relish and things like that (Tr 8). He brought 6 samples and showed the Arbitrator same (Tr 8). The 1 gallon pickle container weighs 109 grams. The next tallest is an assorted nuts container which weighed 89 grams. The widest container looks like a fish bowl and is an air purifier and weighs 108 grams. The smallest is a 28 ounce peanut butter container. There is a 30 ounce almond container and a 67 ounce miscellaneous bottle (Tr 9-10). All the containers are packed in cardboard square trays. The only one packed from the floor is the 1 gallon container; a lot of times a pallet jack is used that will raise it up. There are 7 different lines that these containers run on (Tr 11). There are 2 lines that make 18-ounce peanut butter, 30-ounce mayo, 32-ounce mayo, 24-ounce syrup and 16-ounce salad dressing containers; the machines are almost fully automated and the packing of these is a little bit easier than the rest (Tr 12). The peanut butter packs into a unit that usually slides them out in rolls and layers and you pull them out in a bundle out of the machine. The syrup bottle is a bulk pack and all the bottles drop into a bulk box; all that is done is the lid is taped shut and the boxes are stacked into a tip bin, an articulated packing bin, which is 8-feet long and wide enough to hold a skid; it is tilted back 45 degrees and loaded from the short end until the pack is full, turn a switch and it raises the entire pack up to either onto a set of rollers or lifted onto a pallet jack, then you pull it out of there and push it onto the line (Tr 12-13). The tip bin is tipped to 45 degrees hydraulically. On the syrup line, the packer waits for the boxes to fill the machine, counts them, puts the amount into a box; the box slides down the conveyor; the lid is taped closed and stacked into a tip bin (Tr 13-14). There are 2 lines like that and are automatic; line 1 and line 2. Line 3 is where a variety of bottles are run; there is an arm that reaches out with suction cups and grabs all the bottles and sets them to an automatic conveyor and releases them; the conveyor feeds them to the packer and drops them to a cage at the end of the conveyor which the packer packs it out of the cage and puts it onto the tear sheets (Tr 14-15). The packer packs the bottles from the

cage where the bottles dropped into (Tr 15). The cage is 4 feet tall. The conveyor on Line 3 is chest height and he is 5'8". Line 3 and Line 4 are the same machine and operate the same (Tr 15). Line 5 is an older machine and does not have a bottle take away with suction cups; the bottles drop off into a chute into a basket; the bottles are loaded out of the basket (Tr 16). All baskets are roughly 4 feet tall; the packer packs the bottles out of the basket. Line 6 rarely operates and is an unmanned line; it bulk packs and runs 2 to 4 bottles a cycle and fills a basket; the packer will put the bottles into a bulk box, weigh them, tape the boxes and stack them; the packer is between 2 lines (Tr 16). There is no line 7. Line 8 packs the same as line 5; bottles drop from a chute into a basket (Tr 16-17).

Mr. Gropp agreed with Petitioner that most of her time was spent on the EX lines; Line 5 and Line 8 are EX lines. Petitioner also worked on the pickle jar line (Tr 17). Mr. Gropp identified Rx5 as labor report from May 2011 to September 2011 and Rx6 as labor reports from October 2, 2011 through December 3, 2011 (Tr 17-18). The top sheet of each show what line Petitioner packed on and what day (Tr 18). Labor reports are done daily by Mr. Gropp. He assigns the laborers to the lines (Tr 19). These reports are created in the usual and customary operation of Respondent's business (Tr 19).

Mr. Gropp knows Petitioner and has since early 2009. She was hired full time at Respondent on October 23, 2011. Before that she worked at Respondent from a temporary employment service. Petitioner worked at Respondent from April or May 2011 until December 2011. Mr. Gropp referred to Rx5 and stated that in the month of May 2011, Petitioner worked 7 days. She did not work a specific shift while she worked for the temporary service. From May 2011 through October 22, 2011, Petitioner did not have a specific shift that she worked. When she was hired on October 23, 2011, Petitioner was assigned to C shift, a day shift where a person works 2 days, is off for 2 days, works 3 days and the following week would be different (Tr 21). In any given week, Petitioner worked either 2 days or 3 days at most (Tr 22). In June 2011, Petitioner worked 7 days. In July 2011, she worked 14 days. In August 2011, she worked 11 days. In September 2011, she worked 13 days. In October 2011, she worked 10 days. In November 2011, she worked 8 days. In December 2011, she worked 5 days (Tr 22-23). The total days Petitioner worked from May 2011 to December 2011 was 68 days. Petitioner worked 12-hour shifts (Tr 24). She got a break every 2 hours for 10 minutes and a 20 minute lunch mid shift (Tr 24).

Mr. Gropp testified that in the labor reports: Line 1 is 101 and based on the reports, Petitioner worked this line twice early on. Line 2 is 102 and Petitioner worked that line 6 times. Line 1 has an automatic packing device that will grab 12 bottles, drop them into a box, the box then goes down the conveyor line to the packer, who looks in the box, folds two flaps in, takes the second box and stacks them either 6 or 8 high on a skid on the floor (Tr 27). Line 3 is 304 and Petitioner worked that line 10 times. That line had a conveyor that would bring the bottles and drop them into a cage (Tr 28). Mr. Gropp was Petitioner's direct supervisor and he observed her working on a regular basis (Tr 30). He stated that a person would not physically be able to take the bottles off the conveyor belt. The bottles are grabbed as the fall off the end of the

conveyor (Tr 31). Mr. Gropp identified Rx7 as a photograph he took showing the reach from the packer to the conveyor on Line 3; a gallon jug is also shown (Tr 32). The woman in the photograph is 5'4" tall and she was not able to reach the gallon jar off the conveyor belt (Tr 34). Line 4 is 306 and Petitioner worked this line 4 times; Line 4 is the same as Line 3 (Tr 34). Line 5 is 308 and Petitioner worked this line 6 times; the bottles drop into a basket (Tr 35). The DVD, Rx8, was viewed (Tr 35). Line 5 (308) is shown on the DVD (Tr 36). The bottles that fall into the basket are hand packed into a tray (Tr 36). The tray is sitting on a pallet jack; the jack can be raised up so the packer does not have to bend over (Tr 36). Petitioner did the floor pallet packing (Tr 37). The DVD also shows grinding bottles: the bottle is put into the box at the top of the grinder machine, the bottle falls down through and is ground up for recycling. When the line is down, packers do grinding. Petitioner would grind the defective bottles produced during her shift (Tr 39). A lot of times she would also grind others bottles (Tr 39). The basket holding the defective bottles is 4 feet high and there is a gate that allows a person to lower it and reach in, so a person is not reaching in over the 4 foot basket (Tr 40). Line 6 is 309 and she worked this line once steadily; this line runs 12-ounce syrup, 36-ounce syrup and 15 milliliter bottles (Tr 41). Line 8 is line 8 on the reports and Petitioner worked this line 12 times (Tr 41-42). Petitioner worked Line 5 and Line 8 the most (Tr 42). Both lines are viewed on the DVD. The bottles are stacked in rows on the pallet and with trays separating the rows (Tr 43). Taller bottles have less layers/rows (Tr 43). There are 6 layers for the gallon jars. Petitioner did not stack wooden pallets (Tr 45).

Mr. Gropp testified that Petitioner never complained to him about having pain in her arm (Tr 45). Petitioner never said to him that a job activity is causing pain to either arm (Tr 45). Petitioner did not report any kind of work accident to him (Tr 45-46). Petitioner also worked Line 2 (102) and Line 4 (306) did not require her to actually stack any bottles; she would tape up the boxes, stack the boxes, move to tip bin (Tr 46). The tip bin slides over automatically and is maneuvered so a person does not have to reach at all (Tr 46). In looking at the reports, Petitioner worked Line 2 (102) 6 times, Line 4 (306) 9 times, Line 3 (304) 13 times, Line 8 19 times, Line 7 (301) 24 times, Line 5 (308) 9 times (Tr 47-49). Petitioner worked most often on Line 5, Line 8 and Line 7; they all operate the same way as depicted in the DVD (Tr 49). Pulling skids off a stack is the heaviest thing Petitioner would have been doing on a consistent basis (Tr 51). He guessed a skid weighed 65 pounds (Tr 51). The skids are stacked 6 or 7 high. Petitioner would slid it off the top of the stack and the skid would fall to the floor; she was not actually lifting the skid (Tr 52). During a 12 hour shift, Petitioner would have done this 13 times (Tr 53).

On cross-examination, Mr. Gropp testified that the DVD shows a lady grabbing a number of multiple bottles in the stacking procedure (Tr 54). It is not unusual for a packer to grab 4 bottles in one hand, maybe 4 in the other hand, and inspect those bottles. It is not unusual for packers to be grabbing the bottles and pulling them out with both hands and twisting their wrists and arms in a variety of different motions so the bottles can be quickly examined (Tr 55). 18-ounce peanut butter jars are seen in the DVD (Tr 56). Once a pallet is full, the packer would use a pallet jack to move the full pallet to an area (Tr 56-57). A full pallet of gallon jugs might be 6 or 7 feet high (Tr 57). If the gate on a wire basket is up, a person has lesser ability to reach

forward versus when the gate is down (Tr 58-59). Mr. Gropp agreed that the shorter a person is, the more likely that somebody with the gate down is having to reach up towards those bottles before those bottles fall into the basket (Tr 60). In a 12 hour shift, a person would have stacked 15 to 18 bundles, 270 gallon bottles per bundle (4,050 to 4,860) (Tr 62). More for 20-ounce peanut butter jars. For 28-ounce peanut butter jars, 780 in a bundle, 13 to 14 bundles a shift (10,140 to 10,920) (Tr 64). The person who is at the receiving end or doing the packing is actually manually touching each one of those bottles (Tr 64). The gallon bottles are put on a pallet and stacked 6 layers high; this takes 15 minutes to make (Tr 67). Mr. Gropp was part of the hiring process of Petitioner (Tr 68). He noticed nothing physically wrong with her (Tr 68). The air bander, which wraps the product on the pallet in plastic, weighs 7 pounds and is moved and manipulated in the banding process (Tr 69). Mr. Gropp agreed that the banding process would require a person to reach above the head, especially a shorter person (Tr 69).

On re-direct examination, Mr. Gropp testified that the air bander is 8 inches wide and 12 inches long (Tr 70). The bander is on a rolling cart with an air hose attached; the cart is at waist level. He described the banding process (Tr 71-73). He has seen Petitioner grab 2 gallon bottles per hand (Tr 74). The labor reports reflect the amount of times Petitioner worked on a specific line (Tr 74). During a break, someone else comes and works the line (Tr 75). For a 12-hour shift there are six 10-minute breaks and a 20 minute lunch (Tr 75-76). Petitioner was trained to let the gallon bottles fall into the basket and pull from the basket (Tr 76).

On re-cross examination, Mr. Gropp acknowledged that it was commonplace that packers would try to catch the gallon bottles between the conveyor and the basket (Tr 78). No one was punished for doing that (Tr 78). It was possible to grab 5 gallon bottles with both hands at one time (Tr 79). On re-direct examination, Mr. Gropp acknowledged that Petitioner would grab bottles with both hands (Tr 79).

4. At the June 26, 2013 arbitration hearing, Denise Forrester testified that had worked for Respondent as a machine operator. Petitioner started working at Respondent a month before Ms. Forrester was let go (Tr 7-8). She is working elsewhere now. She worked directly with Petitioner, whose job was packing bottles. She worked with Petitioner for approximately a month (Tr 9). She socializes with Petitioner and the last time was 3 months before this hearing (Tr 10). Ms. Forrester described the packer job as constantly picking bottles up, looking at them and putting them into either a tippy bin or in boxes (Tr 10). Ms. Forrester watched the DVD, Rx8, earlier this day (Tr 10). The DVD shows a tippy bin. There is a pallet at the bottom of the tippy bin and a paper divider and on top of that the bottles go (Tr 11). The bottles come out of the machine 6 to 8 at a time and the packer picks them out of a bin, turns around and packs them into the tippy bin (Tr 11). Some people actually grab them by the openings and take them in the same fashion and put them into the tippy bin (Tr 11). The packer usually takes 3 or 4 in each hand and inspects them by moving the hands and then packs them in the tippy bin (Tr 12). Some bottles are packed 12 to a box and the boxes are put onto a pallet, 6 or 8 high (Tr 13). While viewing Rx8 DVD, Ms. Forrester could not believe how slow the machine was running and she audibly giggled while watching (Tr 14). The machine was running at not the speed it normally

ran during normal business hours (Tr 14). She thought Petitioner was capable of doing anything at Respondent's plant (Tr 15). Petitioner did not complain to her of any pain or discomfort (Tr 15).

On cross-examination, Ms. Forrester testified she started a new job in January 2011 and is pretty sure she worked with Petitioner in 2010. Boxes of product were moved by hand. Ms. Forrester has known Petitioner all her life (Tr 16). Petitioner went to school with her older sister. Ms. Forrester did not remember how many lines Respondent ran (Tr 17).

5. Also at the June 26, 2013 arbitration hearing, Gail Grady testified that she currently works at Clover Technologies. She worked at Respondent for 3½ years up to October 30, 2012 (Tr 19). She is relatively familiar with the operations at Respondent and was a packer there (Tr 20). She believed Respondent ran 8 to 9 lines. Over time, Ms. Grady worked all of the lines (Tr 21). She knew Petitioner briefly prior to her job there. They were not life-long friends, she just recognized her as she passed at work (Tr 21). Ms. Grady had viewed the DVD, Rx8, before this hearing. Her initial reaction to watching it was that the machine ran slow and funny (Tr 22). One of the slowest ways to pack is in a tilty bin. The titly bin does the stacking; you push back layer by layer; when it is full, it stands itself up and then with a pallet jack you pull your layers out of it (Tr 22). The packer takes the material off of that machine and then turns and puts it in the tilty bin (Tr 23). The DVD showing the loading from the machine to the tippy bin was slower that normally seen (Tr 24). Ms. Grady has done the job depicted in the DVD. A person can grab 3 or 4 in each hand, examine them and put the good ones into the bin (Tr 25-26). People can take the bottles off the conveyor belt instead of at the end (Tr 26). The bottles will fall into a bin at the end and the packer can take them from the bin and put them into the tippy bin (Tr 27). Petitioner worked at Respondent when Ms. Grady worked there (Tr 27). She had observed Petitioner doing her job and she did it real good (Tr 27-28).

At one point in time, Petitioner told Ms. Grady that she had pulled her shoulder and that it was hurting her bad and the job just contributes to irritating her shoulder more (Tr 28). Petitioner was doing her job and it was hurting her (Tr 28). Other than the job itself, Ms. Grady was not aware of anyplace Petitioner would have been hurt (Tr 28). Ms. Grady herself had experienced shoulder problems doing the same job as Petitioner (Tr 28). Ms. Grady would describe her activities at Respondent as repetitive (Tr 29). The repetitive activity of grabbing bottles and packaging them was 100% of her work day. The machine did not stop unless they break down and run 24 hours a day (Tr 29).

On cross-examination, Ms. Grady testified she was a packer her entire employment with Respondent (Tr 30). She was not Petitioner's supervisor and did not monitor her work (Tr 30). She occasionally sees Petitioner, but they live in different towns. The machine activity seen on the DVD seemed slower than normal. The bottles weighed ounces. She would have breaks during her shift. Petitioner told her she hurt her shoulder and that her job contributes to it (Tr 32). Ms. Grady was not sure when Petitioner told her that (Tr 32).

On re-direct examination, Ms. Grady testified she did not socialize with Petitioner (Tr 33). She left Respondent on October 30, 2012. Sometime prior to Petitioner leaving Respondent, she told Ms. Grady about her shoulder (Tr 34). Petitioner told Ms. Grady about it and then she was gone from Respondent a few days later (Tr 36). Petitioner never told her she got hurt outside of work (Tr 36). On questioning from the Arbitrator, Ms. Grady testified that she hurt her shoulder lifting up over her head and lifting up and the back and forth and up and down (Tr 36-37). Ms. Grady has the same problem in one of her shoulders (Tr 37).

On re-cross examination, Ms. Grady testified that Petitioner just said it was from working and her arm going up above her shoulder area. She asked Petitioner if she reported that and believes she told her she had reported it. Ms. Grady testified she told Petitioner she had to report it to the right people and not just talk about it (Tr 38). Their conversation occurred when Petitioner injured her shoulder and she did not know the exact date (Tr 38-39). It was probably in 2011 and could have been in the winter (Tr 39-40). She then stated she did not remember when this conversation occurred (Tr 40). No one else was around during their conversation (Tr 40). Petitioner just mentioned it briefly as Ms. Grady was passing by her (Tr 41).

6. Proofs were closed at the August 13, 2013 arbitration hearing. According to the records of Illinois Valley Community Hospital, Px2, Petitioner was seen at the emergency room on December 20, 2011 for complaints of her left shoulder. The following was noted under Mechanism of Injury: "Works in packing plant. Started 3 months ago." Petitioner reported that initially she had moderate pain and currently had constant moderate aching pain, which was alleviated with rest. Her pain was aggravated with movement, lifting and internal/external rotation. Petitioner was diagnosed with left shoulder pain. She was given Tordal IM and discharged. In the December 20, 2011 ER Assessment it is noted, "Left arm pain X 3 weeks. Progressively gotten worse." A provisional diagnosis of left shoulder bursitis was noted. Petitioner was to follow-up with Occupational Health. She was authorized off work until December 21, 2011. It was noted that she could work with restrictions of minimum work using her left arm and hand. Medications were prescribed.

Petitioner returned to the emergency room on December 22, 2011 complaining of left shoulder pain. Mechanism of Injury was noted as: "repetitive work at plant. Can't move 2-3 days." "Fell 2 months ago-was to see occupational health but didn't." X-rays were taken and it was the radiologist's impression that the left AC joint had an abnormal appearance consistent with degenerative osteoarthritis or chronic repetitive trauma. Petitioner was diagnosed with a left shoulder strain. Medications, a sling, ice and rest were prescribed. In the December 22, 2011 ER Assessment it is noted, "Pain in left shoulder getting worse. Feels like my shoulder has dropped. Repetitive work, 12-hour shifts. Recalls fall 2 months ago and landed on hands. Bruise noted to left humeral area. Holding arm next to body." Petitioner was to see Occupational Health for a post-accident screening.

On December 27, 2011, Petitioner was seen at Occupational Health for follow-up for left shoulder bursitis. The following history was noted: "The patient states approximately three months ago while working at Pretium she began to develop left shoulder pain. She noted on 12/20/11 she had an increase in swelling and decrease in movement. She denies specific injury and feels that the onset was gradual." The ER visits were noted. The following was found on examination: abduction and forward flexion were limited to 30 degrees due to complaints of extreme pain, tenderness to palpation over the deltoid, AC joint and left cervical musculature. Petitioner was to discontinue the left arm sling. She was to perform pendulum and progressive range of motion exercises. She was to continue over-the-counter pain relievers and apply ice. The x-rays were reviewed and were noted to be positive for degenerative osteoarthritis. Petitioner was diagnosed with left shoulder bursitis and degenerative osteoarthritis. It was noted that Petitioner may work with restrictions. She was referred to orthopedics.

7. According to Dr. Rhode's records, Px3, Petitioner was seen on January 5, 2012 for consultation for complaints of left shoulder pain, elbow pain and wrist pain. The Commission notes that this is the first mention of elbow and wrist in the medical records. The following history was noted: "Symptoms are secondary to an injury while at work." Other history was noted as: "The patient presents for evaluation of a work-related left shoulder, hand and elbow injury sustained December 19, 2011. She states that she worked as a Inspector/Packer since October. She performed a highly repetitive job 12 hours a day with 10 minute breaks every 2 hours. She states that she developed significant shoulder blade pain for which she presented to the emergency room twice over the span of a few days. Secondary to the fact that she left work to go to the emergency room, her employer terminated her." It was noted that Petitioner had been off work since December 20, 2011. Petitioner complained of superior left shoulder pain with numbness and tingling to the hand. She denied any prior left upper extremity injury. It was noted that Petitioner is right hand dominant and that her work involved reaching into a bin with her left hand and performed fine motor inspection with the right hand.

On examination, Dr. Rhode found range of motion 90/30 inhibitory with pain on end range motion, positive impingement sign, specifically with internal rotation representing the posterior infraspinatus rotator cuff, pain with palpation over the AC joint and pain referred to the AC joint with resisted straight arm abduction and cross-arm adduction. Dr. Rhode's impression was a rotator cuff strain. Dr. Rhode injected the left sub-acromial space. His assessment was left shoulder pain, elbow pain, wrist pain, rotator cuff strain and AC internal derangement. He noted that Petitioner demonstrated evidence of AC pain and rotator cuff tendinitis. X-rays were noted as demonstrating osteolysis at the level of the AC joint. Dr. Rhode ordered a left shoulder MRI and prescribed medications.

8. According to primary care physician Dr. Bailey's records, Px4, Petitioner was seen on January 10, 2012 and reported she had been having severe pain in her left shoulder for a couple months and could not work at that time. Dr. Bailey noted, "She thinks it was aggravated by work." No history of trauma was reported. Dr. Bailey noted that Petitioner had significant impingement signs and that she had received an injection.

Petitioner saw Dr. Bailey on January 24, 2012 and complained of severe left shoulder pain. Petitioner reported that the injection had helped for a couple days, but her left arm pain was back with terrible pain. On examination, Dr. Bailey found objective signs of a rotator cuff tear. Dr. Bailey prescribed medications, continued ice and ordered a left shoulder MRI. Dr. Bailey referred Petitioner to orthopedic Dr. Perona. In a slip that date, Dr. Bailey authorized Petitioner off work until further notice.

9. A left shoulder MRI was performed on February 6, 2012. The radiologist's impression was: 1) component of focal tendinosis versus partial thickness tearing of the bursal surface involving the anterior fibers of the supraspinatus moiety of the rotator cuff; 2) minimal subacromial/subdeltoid bursitis; 3) active acromioclavicular arthropathy with inferiorly projecting distal clavicular spur. (Px3).

10. Petitioner complained of severe left shoulder pain to Dr. Bailey on February 10, 2012. Dr. Bailey again referred Petitioner to Dr. Perona for her severe impingement syndrome. (Px4).

11. On March 1, 2012, Petitioner reported to Dr. Rhode that the injection gave her only temporary relief. Dr. Rhode reviewed the left shoulder MRI, which he felt demonstrated a partial thickness rotator cuff tear with acromioclavicular changes. His examination findings were the same, as was his assessment. Dr. Rhode discussed options with Petitioner and noted she wanted to proceed with arthroscopic subacromial decompression, distal clavicle excision and possible rotator cuff repair. Dr. Rhode noted she was currently off duty and prescribed medications. (Px3).

12. Dr. Bailey noted on March 13, 2012 that Petitioner's problem was left lateral epicondylitis and that she had a left shoulder problem that has not been approved by workers' compensation yet. Dr. Bailey noted, "These idiots are keeping her from getting care on her shoulder and, of course, are like shooting themselves in the foot. Of course, all insurance companies these days are idiots, especially this workman's comp carrier." Dr. Bailey gave Petitioner an injection, which gave her immediate relief. In a slip that date, Dr. Bailey authorized Petitioner off work until cleared by the orthopedic surgeon. (Px4). On March 29, 2012, Dr. Rhode noted that he would continue to await authorization for surgery and prescribed medications. (Px3).

13. At Respondent's request, Petitioner saw Dr. Marra on April 10, 2012 for a §12 evaluation. In his report of that date, Rx9, DepEx2, Dr. Marra noted that Petitioner reported a history of left shoulder pain. Dr. Marra noted that Petitioner is a packer and she reported that from May to December 2011, she was on assembly line involving packing plastic bottles and was required to lift up to 20 pounds. Petitioner reported performing repetitious work at a low shoulder height for 12 hour shifts, 5 days a week, and that during the course of this time she began to experience increased left shoulder pain. Dr. Marra noted her treatment to that date. Petitioner complained of diffuse superior lateral shoulder pain as well as numbness and tingling which radiated to her thumb, index and middle fingers. Left shoulder pain was localized over the

outer aspect and was sharp and reached a rating of 10/10. Petitioner displayed significant guarding. On examination, Petitioner had positive impingement signs. Dr. Marra reviewed the February 6, 2012 MRI report, but not the films. Dr. Marra reviewed the medical records. Dr. Marra also reviewed a DVD of job activity and opined it depicted a repetitious activity which was light and done anywhere from below to above shoulder height. Dr. Marra noted that he wanted to review the MRI scan.

14. Dr. Rhode performed surgery on April 24, 2012. In his Operative Report, Dr. Rhode noted a pre-operative diagnosis of left shoulder impingement, acromioclavicular pain and rotator cuff tear. Dr. Rhode performed a left shoulder video assisted subacromial decompression, distal clavicle excision, arthroscopic rotator cuff repair and application of cold therapy. On his May 10, 2012 examination, Dr. Rhode found range of motion at 130/30. His assessment was the same along with AC internal derangement. Dr. Rhode removed sutures, ordered physical therapy, prescribed medications and kept Petitioner off work. On May 24, 2012, Dr. Rhode found range of motion at 155/30. Dr. Rhode's assessment was the same and he continued physical therapy, off duty and prescribed medications. On June 7, 2012, Dr. Rhode found range of motion at 160/40 and all else was the same. On June 21, 2013, Dr. Rhode found range of motion at 170/55 and all else was the same. (Px3).

15. In a supplemental report dated June 27, 2012, Rx9, DepEx3, Dr. Marra noted that he had reviewed the Operative Report, Dr. Rhode's office notes and a Peru Police Report of a domestic battery incident indicating that on August 11, 2011, Petitioner alleged that her boyfriend had grabbed her left arm twice and left bruises. Dr. Marra opined that the police report describing an incident on August 11, 2011 is a competent cause of a rotator cuff tear. Dr. Marra opined that the DVD did not show any substantial overhead motion and opined it is unlikely to cause significant damage to the rotator cuff. Dr. Marra opined that the weight and arm position seen on the DVD would not cause enough strain on the rotator cuff to cause a tear the size documented in the Operative Report. Dr. Marra opined that the August 11, 2011 incident noted in the police report was a significant magnitude of force and there was a significant bruise noted on the left shoulder and given the size of the rotator cuff tear, this would be a competent cause of the tear. Dr. Marra recommended Petitioner continue physical therapy and opined she would reach maximum medical improvement 6 months post-op. Dr. Marra opined that the surgery performed by Dr. Rhode was reasonable and necessary treatment for Petitioner's condition. Dr. Marra opined Petitioner should have restrictions of no use of the left arm.

Respondent sought to admit the Peru Police Report of the August 11, 2011 domestic battery incident into evidence as Rx11, but the Arbitrator excluded same. However, the Commission notes that the Peru Police Report was attached to Dr. Marra's October 5, 2012 deposition admitted into evidence as Rx9, DepEx4.

16. Petitioner saw Dr. Bailey on July 6, 2012 for complaints of her left shoulder. Petitioner reported she had surgery on April 24, 2012 and since surgery the pain has not gotten any better. She could lift small things, but was unable to lift over her head. She reported physical therapy

was helping. Dr. Bailey's assessment was a full thickness rotator cuff tear and he prescribed medications. (Px4).

17. On July 19, 2012, Dr. Rhode noted that Petitioner continued to improve with a slight stiffness in the left shoulder. On examination, Dr. Rhode found range of motion at 165/55. All else was the same. On his August 12, 2012 examination, Dr. Rhode found range of motion at 155 and internal rotation to the pants pocket. Dr. Rhode noted he would consider manipulation under anesthesia if her internal rotation did not improve. Petitioner was to continue physical therapy and remain off duty. On August 16, 2012, range of motion was noted at 165/45. On August 30, 2012, range of motion was noted at 154/30. All else was the same. (Px3).

18. Petitioner saw Dr. Bailey on September 25, 2012 for complaints of left shoulder pain. Petitioner reported, "the surgeon Dr. Rhode manipulated it 2 months ago and I think it did more harm than good, because now I have a burning sensation inside my shoulder." Dr. Bailey prescribed medications. (Px4).

19. Dr. Rhode saw Petitioner on September 27, 2012 and noted she continued to experience moderate lateral shoulder pain. Petitioner reported she had difficulty with forward reach and overhead lift. On examination, Dr. Rhode found range of motion of 155/40. Dr. Rhode opined that Petitioner had plateaued. Dr. Rhode opined Petitioner would require permanent restrictions of light/medium with an overhead restriction of 5/10 pounds. Petitioner was to follow-up in 4 weeks to consider maximum medical improvement and she was prescribed medications.

20. In his October 5, 2012 deposition, Rx9, Dr. Marra testified that he is a board certified orthopedic surgeon. Dr. Marra recited from his reports, which are noted above. Dr. Marra opined that the level of repetitive packing Petitioner performed at Respondent would not cause a rotator cuff tear (Dp 25).

On cross-examination, Dr. Marra testified that if the DVD did not accurately depict what Petitioner did at work, that could potentially affect his opinions of no causation (Dp 28-29). Dr. Marra acknowledged he did not review the MRI films (Dp 29). Dr. Marra noted that in his Operative Report, Dr. Rhode noted a much larger size tear (Dp 29). Dr. Marra opined that if this tear occurred on August 11, 2011, Petitioner would have been working full duty for at least 90 days performing the job depicted on the DVD (Tr 32). Dr. Marra opined that it is possible she would have needed medical treatment closer to August 2011. Dr. Marra opined that Petitioner could have had a preexisting tear which got bigger over time (Dp 32). Dr. Marra opined that moving light bottles would not be sufficient enough to cause any more damage to her rotator cuff (Dp 33). He acknowledged that rotator cuff tears can enlarge by themselves (Dp 36). Dr. Marra opined that if a person has a rotator cuff tear and does something overhead, it can increase that person's pain (Dp 41). Dr. Marra opined that the activity seen in the DVD did not put a lot of stress on the rotator cuff to cause a tear to get bigger (Dp 42).

21. On his October 11, 2012 examination, Dr. Rhode found range of motion of 160/45. He noted Petitioner reported she had worsened symptoms. Dr. Rhode ordered physical therapy and subsequently ordered a left shoulder MRI.

A left shoulder MRI was performed on November 1, 2012. The radiologist's impression was: 1) status post acromioplasty, lateral clavicular resection and rotator cuff repair since prior MRI; 2) small to moderate amount of non-specific fluid in the subacromial/subdeltoid bursa which could be related to bursitis or adjacent rotator cuff pathology; 3) persistent heterogeneous signal within the rotator cuff consistent with tendenitis or partial tearing with some thinning and particularly increased signal in the anterolateral supraspinatus tendon near its insertion at the level of the repair.

On his November 8, 2012 examination, Dr. Rhode found range of motion of 160/45. Petitioner was to remain off duty. (Px3).

22. Petitioner saw Dr. Bailey on November 13, 2012, who noted she had some questions about her MRI and wanted to know if there was still a tear from her first rotator cuff repair. Petitioner reported she still had pain. She wanted to compare side by side the two MRIs, the second showing there was still a tear and she was wondering that it was never fixed. Dr. Bailey's assessment was rotator cuff syndrome and shoulder joint pain. (Px4).

23. Dr. Rhode examined Petitioner on November 20, 2012 and found range of motion of 160/45. Dr. Rhode reviewed the November 1, 2012 left shoulder MRI and noted it showed partial thickness tearing and no full thickness tear. Dr. Rhode injected the left sub-acromial space and prescribed medications.

On December 6, 2012, Dr. Rhode found range of motion of 160/45. Dr. Rhode noted that the MRI did not demonstrate a frank disruption. Dr. Rhode opined Petitioner had plateaued. Dr. Rhode ordered a functional capacity evaluation. On January 3, 2013, Petitioner's range of motion was 160/45 and Dr. Rhode noted that all else was the same. On January 17, 2013, Dr. Rhode found range of motion of 155/30 with pain on end ranges. Dr. Rhode noted Petitioner had the same left arm restrictions, which were permanent. Dr. Rhode opined Petitioner was at maximum medical improvement. Dr. Rhode noted that Petitioner would require prescribed medications in the future and that he would see her as needed.

Petitioner was seen on February 7, 2013 and on examination, Dr. Rhode found range of motion of 155/50 with pain on end ranges. Dr. Rhode noted Petitioner had a positive impingement sign, specifically with external rotation, representing the anterior (supraspinatus) rotator cuff. Dr. Rhode continued modified duty, discussed an injection and prescribed medications. (Px3).

24. Dr. Bailey noted on February 12, 2013 that Petitioner was there with chronic left shoulder pain from a work related injury in December 2011. Petitioner reported no improvement after surgery. Dr. Bailey noted that as time goes on, progressive pain continued to get worse. Her pain was interfering with her daily activities. Dr. Bailey's assessment was rotator cuff syndrome and shoulder joint pain. Dr. Bailey prescribed medications. (Px4).

25. Petitioner submitted medical bills and these were admitted into evidence as Px1, which show a total outstanding amount of $127,765.64. Petitioner submitted the physical therapy records of St. Margaret Hospital and these were admitted into evidence as Px5. Petitioner and Respondent submitted into evidence the Application for Adjustment of Claim and it was admitted as Px9 and Rx10.

Respondent submitted the January 10, 2012 written statement of James Law and this was admitted into evidence as Rx1. In this statement, Corey Sipes wrote the following: "On 12-23-11 Angela Thomas reported to me that she fell sometime in September of 2011 in the Grind Room. She stated she then reported the incident to James Law." In this statement, James Law wrote the following: "I was not informed that Angela Thomas fell in the grindroom. If she did I would have filled out a accident report. The only thing she told me was she almost fell on line 8."

Respondent submitted the January 10, 2012 written statement of Harold Stanford and this was admitted into evidence as Rx2. In this statement, Corey Sipes wrote the following: "On 12-23-11 Angela Thomas reported to me that she fell sometime in September of 2011 in the Grind Room. She stated she then reported the incident to Harold Stanford." In this statement, Harold Stanford wrote the following: "Angela Thomas never reported to me that she fell or had any injury."

Respondent submitted the January 10, 2012 written statement of Shawn Wooten and this was admitted into evidence as Rx3. In this statement, Corey Sipes wrote the following: "On 12-23-11 Angela Thomas reported to me that she tripped and fell sometime in December of 2011 in the Production area. She stated she that Shawn Wooten witnessed her injury." In this statement, Shawn Wooten wrote the following: "Given over the phone to CNA."

Respondent submitted a photograph of plastic containers manufactured by Respondent and this was admitted into evidence as Rx4. Respondent submitted Labor Reports from May 8, 2011 through October 22, 2011 and these were admitted into evidence as Rx5. Respondent submitted Labor Reports from October 23, 2011 through December 30, 2011 and these were admitted into evidence as Rx6. Respondent submitted the DVD of the various production lines at the plant Petitioner worked at and this was admitted into evidence as Rx8.

Based on the record as a whole, the Commission reverses the Decision of the Arbitrator finding that Petitioner failed to prove that a causal relationship exists and denies Petitioner's claim. In cases relying on the repetitive trauma concept, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability. "Although medical testimony as to causation is not necessarily required, where the question is one within the knowledge of experts only and not within the common knowledge of laypersons, expert testimony is necessary to show that claimant's work activities caused the condition complained of." *Nunn v. Illinois Industrial Commission*, 157 Ill.App.3d 470, 510 N.E.2d 502, 506 (1987).

The evidence shows that Petitioner's work was repetitive. The only causation opinion is that of §12 Dr. Marra, who opined that the level of repetitive packing Petitioner performed at Respondent would not cause a rotator cuff tear. There is no other opinion. The Commission also notes that Dr. Rhode in his treatment records does not specifically note what Petitioner did at Respondent. Dr. Rhode did not view the video and gave no opinion as to causation. Therefore, based on the no causation opinion of §12 Dr. Marra, Petitioner failed to prove that a causal relationship exists. All other issues are moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove that a causal relationship exists, her claim for compensation and medical expenses is hereby denied.

There is no bond as there is no award. The party commencing 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: AUG 2 5 2014
MB/maw
o06/26/14
43

Mario Basurto

Stephen J. Mathis

David L. Gore

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

Mark Bowers,
Petitioner,

vs.

NO: 10 WC 36315

14IWCC0731

State of Illinois,
Tamms Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW UNDER
SECTION 8(a) AND SECTION 19(h)

This cause comes before the Commission on Petitioner's Petition under Section 8(a) and Section 19(h) filed on May 14, 2012. The arbitration hearing was held on May 11, 2011 Arbitrator Nalefski issued a decision on June 10, 2011, awarding Petitioner 20% loss of use of the right leg for injury sustained on September 5, 2010 that arose out of and in the course of his employment by Respondent. The arbitration decision was not appealed and became the final decision of the Commission.

At hearing in May 2011, the parties stipulated that Petitioner was a correctional officer and sustained injury to his right leg that arose out of and in the course of his employment by Respondent on September 5, 2010. Petitioner had previously injured the same leg in a 2007 work injury filed as claim 07 WC 34736 and settled for 17.5% loss of the leg. At the time of the September 5, 2010 accident, Petitioner had been working full duty and was not under active treatment. Petitioner treated with Dr. Paletta after the September 5, 2010 accident and was diagnosed with a high grade partial tear of the distal quadriceps tendon. Petitioner had a right knee arthroscopy with repair of the tendon rupture on September 14, 2010. A closed manipulation was performed on February 1, 2011. Petitioner was released to full duty work on March 21, 2011. Petitioner testified at trial that he continued to have constant low level pain in the right knee which was aggravated with bending and straightening his leg and sitting for prolonged periods and medical records noted a decrease in his range of motion and quadriceps atrophy.

14IWCC0731

Petitioner filed his initial Petition for Review under Sections 19(h) and 8(a) of the Act on May 14, 2012. A hearing on Petitioner's Section 8(a) and Section 19(h) Petition was held before Commissioner Donohoo in Mt. Vernon, IL on February 13, 2014. Both parties were represented by counsel. Petitioner's counsel stated at the hearing that he was only proceeding on the Petition under Section 8(a) for surgery on the right knee.

The Commission, after having reviewed the entire record, hereby denies Petitioner's Section 8(a) and Section 19(h) Petition and finds that Petitioner failed to prove that his current condition of ill-being is causally related to his work accident of September 5, 2010. Petitioner has failed to meet his burden of proof that the treatment requested is reasonably required to cure or relieve him from the effects of the September 5, 2010 injury.

Petitioner, a 45 year old correctional officer, was working at Tamms Correctional Center on September 5, 2010 when he injured his right leg while walking down stairs. Prior to this accident, Petitioner sustained a traumatic knee dislocation on April 1, 2007 while playing basketball in the course of his duties. He underwent knee dislocation reconstruction surgery involving reconstruction of his ACL, PCL, MCL, and LCL, and the injury resulted in claim 07 WC 34736, which was settled pursuant to contract with closure of prospective medical benefits. Petitioner returned to work full duty after recovering from the 2007 work injury.

On September 5, 2010, Petitioner sustained a new right knee injury when he missed a step at work. Petitioner sustained a high grade partial thickness tear of his distal quadriceps tendon and required surgery to repair the tendon. He later underwent a closed manipulation of the right knee on February 1, 2011. He developed a suture granuloma, which was removed on August 16, 2011. Dr. Paletta determined Petitioner was at maximum medical improvement with excellent results on October 12, 2011 and he was returned to work full duty.

At arbitration hearing on May 11, 2011, Petitioner testified that since the September 5, 2010 accident and subsequent return to work at full duty, he experienced a low level of right knee pain at all times. He further testified that the pain is made worse with extensive bending, walking, stairs, and sitting. Petitioner testified he was able to perform his job satisfactorily despite his complaints.

After arbitration and issuance of a decision on this claim, Petitioner returned to Dr. Paletta on June 6, 2012 with complaints of pain in both knees, but left sided symptoms were worse than the right. Dr. Paletta noted that Petitioner had significant degenerative changes at the time of his 2010 quadriceps tendon rupture. X-ray imaging indicated very large hypertrophic osteophytes of the patellofemoral with advanced patellofemoral degenerative changes, as well as medial lateral compartment changes. Dr. Paletta diagnosed right knee healed quadriceps tendon repair and progressive degenerative changes. The doctor opined that the progression of Petitioner's osteoarthritis appeared consistent with the expected progression of posttraumatic arthritis following a knee dislocation, such as he suffered in 2007. Dr. Paletta recommended a right total knee replacement or conservative treatment and specifically stated that Petitioner was not a candidate for arthroscopy and debridement, as that would be highly unpredictable in this situation.

Petitioner first presented to Dr. Mall on March 29, 2013. At that visit, Dr. Mall recommended a right sided arthroscopy and left sided total knee replacement. Dr. Mall related the need for the left knee replacement back to the 2007 work injury and "the stress of the job." Petitioner's symptoms in the bilateral knees continued, and on May 31, 2013, Dr. Mall recommended left total knee arthroplasty and right knee arthroscopy, debridement, lysis of adhesions and removal of loose bodies. Dr. Mall opined that the right knee had some scar tissue and loose bodies secondary to prior procedures covered by workers' compensation, and therefore, the right knee condition and need for treatment was work related and aggravated by Petitioner's job.

During his October 8, 2013 deposition, Dr. Mall indicated that he has been a practicing orthopedic surgeon for just over a year and was not yet board certified. Dr. Mall disagreed with Dr. Paletta's diagnosis of severe tricompartmental osteoarthritis of the right knee and instead diagnosed Petitioner with insignificant tibiofemoral arthritis, patellofemoral arthritis, significant adhesions and medial joint line tenderness. Dr. Mall stated that, in his experience, he has been able to make range of motion significantly better with arthroscopy and lysis of adhesions and opined that the treatment would significantly improve Petitioner's right knee symptoms. He further opined that both of Petitioner's right knee injuries in 2007 and 2010 contributed to his current right knee condition. He opined the 2007 dislocation was likely the major factor in the generation of Petitioner's right knee arthritis but the 2010 quadriceps injury could have potentially caused some progression of that arthritis.

On July 25, 2013, Dr. Lehman, a board certified orthopedic surgeon specializing in sports medicine, examined Petitioner under Section 12 of the Act and issued a report. He diagnosed Petitioner with patellofemoral degenerative arthritis and some mild degenerative changes to the tibiofemoral joint and opined that there was no causal connection between Petitioner's 2010 right quadriceps injury and his current arthritic complaints. Dr. Lehman agreed with Dr. Paletta's June 2012 note which characterized the condition of Petitioner's right knee as consistent with the natural progression of post dislocation arthritis. He stated that once a knee is dislocated, the clock starts ticking; one is going to get arthritis and there is no way to avoid it. Dr. Lehman opined that Petitioner's 2010 quadriceps tear was far less severe than his 2007 injury and played no role in altering Petitioner's preexisting arthritis. Dr. Lehman opined that Dr. Mall's proposed surgery on Petitioner's right knee was not necessary as Petitioner had very few complaints and was capable of lifting weights and training physically at a high level, despite his arthritis. Further, Dr. Lehman stated that arthroscoping a knee to clean cartilage damage, as Dr. Mall suggests, has been summarily dismissed as not effective and arthroscopic surgery is absolutely not a treatment mechanism for degenerative arthritis. Dr. Lehman opined that Petitioner did not require any further treatment on the right knee, but the treatment to date had been reasonable and necessary in treating the degenerative changes which were the result of the 2007 injury. Dr. Lehman opined Petitioner was at maximum medical improvement regarding the right knee and was able to work full duty.

Petitioner argued that the treatment as recommended by Dr. Mall for the right knee is reasonable, necessary, and related to the September 5, 2010 accident. Petitioner conceded in his brief that Dr. Mall opined that the 2007 dislocation injury was likely a major factor contributing to the right knee condition, but that the 2010 accident contributed as well. Petitioner argues the surgery recommended by Dr. Mall would benefit Petitioner and help him regain range of motion in the right knee and clean up loose cartilage in the knee.

14IWCC0731

Respondent argues the surgery recommended by Dr. Mall is not reasonable or necessary and is further a direct result of the 2007 accident. The records in evidence show that Petitioner had a prior knee dislocation in 2007 with extensive reconstructive surgery, and any treatment recommended for the right knee is related to the 2007 accident. Respondent argues the opinions of Dr. Lehman are more credible than those of Dr. Mall.

The Commission finds the opinions of Dr. Lehman and Dr. Paletta credible. Dr. Paletta is a veteran board certified orthopedic surgeon and was Petitioner's treating doctor. He opined the arthroscopy recommended by Dr. Mall was not appropriate for Petitioner's right knee condition and, further, that the right knee condition stemmed from the 2007 accident. Dr. Lehman is also a seasoned board certified orthopedic surgeon and opined that the treatment recommended by Dr. Mall was against the medical literature and would actually weaken the quadriceps and would not improve range of motion. Dr. Lehman also opined that the right knee condition was not related to the 2010 accident. Dr. Mall repeatedly opined that the 2007 accident was the major factor in the current condition of the right knee but that the 2010 injury potentially could have caused some progression of symptoms. Dr. Mall opined that a knee arthroscopy would significantly improve the right knee symptoms and improve range of motion. The Commission notes that Dr. Lehman, Dr. Paletta and Dr. Choi all found good range of motion, and the physical therapy records from 2012 and 2013 do not note any deficit.

For the foregoing reasons, the Commission finds Petitioner's right knee condition is not causally connected to his September 5, 2010 work injury. The Commission further finds that Petitioner has not met his burden of proof that the treatment requested, arthroscopy of the right knee, is reasonably required to cure or relieve him from the effects of the 2010 work injury. Petitioner's Section 8(a) Petition for additional treatment as recommended by Dr. Mall is hereby denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under Section 8(a) and Section 19(h) is hereby denied.

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.

As Respondent in this claim is the State of Illinois, no further appeal may be taken from this Decision pursuant to Section 19(f)(1) of the Act.

DATED: AUG 25 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-06/24/14
drd/adc
68

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 Causal connection & to award benefits	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Pamela Hatfield,

Petitioner,

14IWCC0732

vs.

NO: 12 WC 20496

Maxim Healthcare Services,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b)/8(a) 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 (TTD), medical expenses, and prospective medical care 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 medical 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 is a 52 year old employee of Respondent, who described her job as a private duty nurse for special needs children. Petitioner performed her job by traveling to the homes of special needs children to provide care in their home setting. On the date of accident, May 2, 2012, Petitioner testified that she was getting supplies together to take her patient to school. Petitioner stated that the patient went to school and Petitioner went

with him every day. Petitioner stated that as she went from the living room to the patient's room to get a suction bag, the patient started to go with Petitioner and Petitioner stepped on his hand. Petitioner stated that in order to keep from hurting the patient she threw herself off balance and she did not fall, but she bounced from pieces of furniture back and forth until she caught her balance.

- Petitioner testified that prior to this accident she did have treatment for her low back with Dr. Meinders (chiropractor) in Belleville. Petitioner had read the deposition transcript of Dr. Meinders and she agreed with the doctor's statements about the type and nature of her visits prior to this accident. Petitioner testified that prior to the accident she did have an MRI of her low back; there had not been any recommendations for injections to her low back prior to this injury and there had been no prior recommendations for low back surgery. Petitioner testified that prior to this accident she had been able to work without restrictions; there had been no prior restrictions as to lifting, bending, stooping, pushing, or pulling. Petitioner testified that prior to this accident she was not taking any sort of narcotic pain medications for her low back symptoms and she would only occasionally before take over-the-counter medications for low back pain. Petitioner did not recall missing work previously because of her back.

- Petitioner testified that after this accident she had a lot of pain and stiffness. Petitioner testified that she returned to Dr. Meinders after this accident and she agreed with his records and deposition testimony of the treatment he provided to her. Petitioner was ultimately referred to Dr. Raskas for further work up, care and treatment. Dr. Raskas had first recommended some steroid injections which Petitioner stated that she did not get because she was "chicken." Petitioner testified that the doctor was now recommending very intensive surgery. Petitioner testified that her symptoms from the date of the accident to present have not gotten any better. Petitioner stated she has low back pain, some days it is worse than others, stiffness, and an increase in pain when she first stands up. Petitioner stated that she had resorted to using a cane because her gait is so bad because she cannot feel where her left leg is most of the time. Petitioner had previously used a cane for a short period of time during her rehabilitation after her hip replacement in 2009 but had not since then. Regarding the proposed low back surgery, Petitioner stated that she wanted to do whatever needed to be done to fix her back. Petitioner did not have the previously prescribed injections because she was afraid. Petitioner also stated that she had turned the injections down because she knows as a nurse that it is not a fix. She stated the injections are just a mask that was not going to fix the problem and the possibility of side effects was too scary. Petitioner stated that if the doctor said surgery would help, that if that was the only option, and that sounded like it was, then she guessed she did not have a choice because at 52 years old she cannot go on like that; she just wanted it fixed. Petitioner indicated her goal was to return to work as she missed her kids.

- Petitioner testified that the last little boy she cared for was a micro-preemie that she had for three years. She stated that he was only 5 ounces when he was born and she got him the first day he got home at 6 months old. Petitioner stated the boy was vent dependent with a trach and feeding tube. Petitioner stated when she was hurt, everything was gone except that the boy still has the trach and he was going to school every day and starting to walk with a walker and was progressing very well. Petitioner stated that it was really rewarding to see the little one progress and know that she had a lot to do with it because she was there 5-6 days per week with him. Petitioner has been a licensed practical nurse for 33 years.

- It was noted as referenced in the depositions regarding Petitioner's current weight. Petitioner testified she had been her current weight for years; it fluctuated up and down in the prior 15-20 years, but she had always been heavy. Petitioner testified that she had always been able to function regarding her back at her current weight, up until the time of this accident.

- Petitioner did not have a follow-up appointment with Dr. Raskas as she does not have insurance and she was waiting approval from the workers' compensation carrier. Petitioner agreed she had seen Dr. Taylor at Respondent carrier's request and she had been cooperative with that examination. It was noted from Dr. Taylor's deposition regarding Petitioner having sustained new or aggravating accidents from the time of this accident. Petitioner testified that she did have a fall in about the late summer. Petitioner testified that she is very unsteady on her feet and she was trying to fold up a lawn chair and it folded quickly and like pulled her down to the ground with it. Petitioner stated she was unsteady on her feet because of her back and the pain going down her leg. Petitioner did not think that fall from her unsteadiness caused her any additional problems or anything else. Petitioner testified that she does stumble a lot because of her leg giving out but she had not fallen to the ground otherwise. Petitioner testified she stumbles because her gait is so unsteady. Petitioner testified that she did not have a gait problem prior to her May 2012 incident. Petitioner had reviewed the medical bills and records in this matter and stated those were incurred and generated as a result of her care and treatment from this accident.

- On cross examination, Petitioner agreed that she did not actually fall to the ground from the May 2, 2012 accident. Her August 2012 incident was actually a fall to the ground at that time. Petitioner agreed per the records and testimony that prior to this accident she had sought treatment for low back pain. She agreed Respondent attorney also had additional records of Dr. Meinders and Dr. Jay Picket (family doctor) regarding back pain treatment in 2008-2009. Petitioner agreed that she had a hip replacement also in 2009. Petitioner had also seen Dr. Meinders for chiropractic treatment before this claimed accident. Petitioner agreed she first saw Dr. Meinders in March 2012, about 2 months prior to this accident. Petitioner agreed (per Dr. Taylor's report notes) that in the months leading to this accident Petitioner's father had been hospitalized and she had spent a lot

of time in the hospital with him (he had been in the intensive care for several months at Missouri Baptist, about 60 miles from Petitioner's home). Petitioner agreed that a few times she had slept in hospital chairs when she was there for several hours.

- Numerous treating medical records, and other reports, as well as the Form 45, and the deposition transcripts of treating doctors, Dr. Raskas and Dr. Meinders (chiropractor) and Respondent's §12 examiner, Dr. Taylor were admitted into evidence.

The Commission notes that the Arbitrator found Petitioner's current condition of ill-being NOT to be causally related to the injury. Accordingly, as the Arbitrator found Petitioner's current condition of ill-being not causally related to the accident, no benefits were awarded.

The Commission finds that Petitioner's testimony is unrebutted as to her condition and symptoms since the accident versus her prior condition. There is no question Petitioner had prior back symptoms and that she in fact had treated in the months immediately prior to this incident for the worsening problem. It is also clear; however, that the prior treatment had been of benefit and those treatments with the chiropractor documented her improvement until after this accident. After this accident, Petitioner then never appeared to have returned to her pre-injury baseline and treatment then did not seem to be of much benefit. At no time before this incident is there any indication of restrictions or off work authorizations and there was no prior recommendations for epidural steroid injections (ESI) or surgical recommendations. The Commission notes the MRI's of before and after the accident did not evidence any significant structural difference, but none the less, Petitioner has remained symptomatic since this accident and she has not been able to return to her prior private duty nursing responsibilities. While Respondent's Dr. Taylor opined of only a temporary exacerbation that would not have required treatment, the treating records support Petitioner's unrebutted testimony of her worsened condition since this accident May 2, 2012. Dr. Taylor's opinion of a temporary exacerbation appears speculative given the medical treatment records and Petitioner's unrebutted testimony. It is evident that Petitioner is noted as obese and that she had a significant pre-existing condition and likely (albeit speculative) would have needed medical attention to address her natural deterioration of the degenerative condition, but for the fact that this accident appears to have been a significant catalyst to push the need for the medical attention to sooner than later (with a permanent aggravation as indicated by the treating doctors). The evidence and testimony finds an unbroken causal relationship chain of events between this claimed accident and her current condition of ill-being. The evidence in this record, Petitioner's unrebutted testimony and the deposition testimony of the various doctors supports Petitioner to find that Petitioner met her burden of proving a causal connection to her current condition of ill-being. The Commission finds, therefore, the decision of the Arbitrator as contrary to the weight of the evidence, and reverses the Arbitrator to find that Petitioner met the burden of proving a causal connection between the accident and her current condition of ill-being.

14IWCC0732

The Commission, with the above finding of a proven causal connection to Petitioner's current condition of ill-being, further finds with Petitioner having been on restrictions or authorized off work and with Petitioner's need for ongoing treatment that she has not yet reached maximum medical improvement. The Commission finds the above proving of causal connection to her current condition of ill-being warrants reversal of the Arbitrator's denial of benefits. Accordingly, the Commission awards temporary total disability (TTD) benefits from May 17, 2012 through the date of hearing, May 17, 2013 (52-1/7 weeks). The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence and, herein, reverses the Arbitrator's finding and awards total temporary disability benefits as noted above.
(Note credit given for $6,277.44 of TTD benefits paid and §8(j) disability credit of $2,292.64)

The Commission notes that Petitioner argued Petitioner's condition worsened after this accident and the record demonstrates an aggravation. Petitioner argued the accident created the need for more aggressive treatment and created a causal chain between the accident and her current condition. Petitioner argued medical testimony of all physicians demonstrate Petitioner met the burden proving causation and even Respondent's examiner would not have an explanation for her subjective complaints beyond the reported event. Petitioner argued the medical treatment rendered was reasonable and necessary and that Petitioner is entitled to prospective medical care as prescribed. The Commission, with the above finding of a proven causal connection to Petitioner's current condition of ill-being, further finds with Petitioner having been on restrictions or authorized off work and with Petitioner's need for ongoing treatment that she has not yet reached maximum medical improvement. The treating doctors opined Petitioner to be a surgical candidate as she had not responded to conservative treatment; Petitioner's ongoing condition of ill-being since this accident is clearly evidenced here. Respondent's own examiner, Dr. Taylor, indicated that while he found no causal connection, Petitioner was potentially a surgical candidate with her diagnosis and lack of response to conservative care. The Commission finds the above proving of causal connection to her current condition of ill-being warrants reversal of the Arbitrator's denial of benefits to award medical expenses incurred, as well as prospective medical care in the form of the surgery per the treating doctors. The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence and, herein, reverses the Arbitrator's finding and awards the claimed medical expenses and the prospective medical care benefits as prescribed by the treating physicians. (Note §8(j) medical credit of $4,644.56).

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $636.85 per week for a period of 52-1/7 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.

14IWCC0732

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $5,390.71 (as evidenced in PX 1) for medical expenses under §8(a) of the Act. Further, Respondent shall authorize and pay for the prospective treatment prescribed by Petitioner's treating doctors, including but not limited to the prescribed surgery.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. Respondent shall further hold Petitioner harmless for any claims from providers for which Respondent is receiving credit herein.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $55,500.00. 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: AUG 26 2014
o-6/26/14
DLG/jsf
45

David L. Gore

Stephen Mathis

Mario Basurto

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 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 Chambers,

Petitioner,

vs.

NO: 09 WC 51208

14IWCC0733

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 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.

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

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

14IWCC0733

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: AUG 26 2014
TJT:yl
o 8/19/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CHAMBERS, MARY
Employee/Petitioner

Case# **09WC051208**

ST OF IL DOC STATEVILLE ET AL
Employer/Respondent

14IWCC0733

On 9/17/2013, 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 0.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

5165 ASSISTANT ATTORNEY GENERAL
JEANNINE D 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

SEP 17 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS
COUNTY OF WILL

14IWCC0733

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARY CHAMBERS
Employee/Petitioner

v.

STATE OF IL DOC STATEVILLE, ET AL.
Employer/Respondent

Case # **09** WC **51208**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Geneva, Illinois**, on **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. [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 **05/07/2008**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$40,372.80**; the average weekly wage was **$776.40**.

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

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

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

Respondent shall be given a credit of **$92,135.71** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$92,135.71**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$517.60**/week for **178 6/7** weeks, commencing **05/28/08 through 10/31/11**, as provided in Section 8(b) of the Act. Per the stipulation of the parties there are no claims for overpayment or underpayment of benefits.

Respondent shall be given a credit of **$92,135.71** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of **$221,158.61**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of **$179,835.54** for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of **$517.60**/week for life, commencing **11/01/2011**, as provided in Section 8(f) of the Act.

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

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

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

Signature of Arbitrator

9/16/13
Date

SEP 17 2013

FINDINGS OF FACT:

Petitioner, a 57 year old human resources associate-benefits coordinator at Stateville, testified that she had a high school diploma, some secretarial type classes at a career center, and some general junior college classes. Her previous experience was in retail, some secretarial and clerical, including for a temp agency, and factory work for Ecolab and Caterpillar. She had worked for the Department of Corrections since November 1991.

Petitioner testified that she hurt herself on May 27, 2008. Petitioner testified that she was in the office and walked to a file cabinet in the timekeeping office to retrieve a file. On her way back to her desk, she tripped on a phone cord hanging from another employee's desk. Petitioner testified that she caught herself from falling completely and landed on some boxes. Petitioner indicated that she injured her right ankle, right knee, right wrist, right elbow, right shoulder and neck.

Petitioner was taken to Provena St. Joseph Medical Center where they treated her right shoulder, elbow, wrist and knee. Petitioner was diagnosed with a sprain and contusion of the right knee and wrist. (Pet's. Ex. 1(a) pp. 17-18) On June 9, 2008 an MRI of the right knee was performed revealing a small area of abnormality involving the free edge of the body of the lateral meniscus with subchondral cyst formation and early degenerative change of the lateral compartment and chondromalacia patella. (Pet's. Ex. 1(a) p. 29)

On June 26, 2008, Petitioner presented to Dr. Dworsky complaining of shoulder soreness as well as mild swelling in her right knee. Petitioner informed the doctor that she experienced difficulty when reaching overhead or to her side and while laying on it at night. She also provided that she experienced pain in her knee while getting up, bending or twisting. X-rays of the right shoulder showed a type II acromion with AC joint arthrosis. X-rays of the right knee showed mild degenerative changes. Dr. Dworsky diagnosed 1.) right knee sprain, possible lateral meniscal tear and 2.) right rotator cuff strain. The doctor recommended a non-operative course for the right shoulder and conservative care for the right knee. (Pet's. Ex. 2(a) pp. 4-5)

At Dr. Dworsky's request, Petitioner underwent a cervical MRI on July 25, 2008. The impression was mild cervical spondylosis with scattered disk bulges and bony spondylotic changes. There was moderate right and mild left foraminal stenosis at C4-C5. (Pet's. Ex. 2(a) p. 6) Petitioner also underwent an EMG on August 13, 2008. Same revealed no evidence of cervical radiculopathy and no evidence of median or ulnar neuropathy. (Pet's. Ex. 1A (a) p. 32)

Because of Petitioner's cervical and right arm complaints, Dr. Dworsky referred Petitioner to Dr. Cary Templin. Petitioner presented to Dr. Templin on August 15, 2008. Dr. Templin reviewed the MRI indicating same revealed no frank disc herniation. He noted that C4-5 showed facet arthropathy with mild left and moderate right foraminal narrowing. At C5-6 and C6-7 there was very minimal disc bulge with patent foramina. The doctor noted that Petitioner had an injury that occurred at work when she fell. He felt she had some foraminal stenosis at C4-5 on the right that was moderate which he indicated she could be having some symptomatology from this with pain radiating into the shoulder. Dr. Templin felt Petitioner could benefit from an epidural steroid injection at C5. He ordered physical therapy and felt that she may warrant a MRI to the right shoulder. (Pet's. Ex. 1(a) p. 7-8)

Petitioner continued treating conservatively for her right knee. Because of her continual complaints and results from the MRI, Dr. Dworsky recommended surgery. On August 19, 2008, Dr. Dworksy performed an

arthroscopic partial lateral meniscectomy and chondroplasty of the patella, right knee. The post operative diagnosis was lateral meniscal tear, right knee and chondromalacia patella. (Pet's. Ex. 4)

At Dr. Dworsky's request Petitioner underwent a right shoulder MRI on September 5, 2008. The results showed mild to moderate supraspinatus tendinopathy with minimal inflammatory type change in the overlying subacromial/subdeltoid bursa. No discrete rotator cuff tear was identified. Also noted were mild degenerative changes. (Pet's. Ex. 14 p. 9)

On September 18, 2008, Dr. Templin noted Petitioner underwent a C5 transforaminal injection and that Petitioner had no relief from same. Dr. Templin felt the majority of Petitioner's symptoms were coming from her shoulder. Physical therapy was continued. (Pet's. Ex. 2 p. 9)

At the behest of Dr. Dworsky, Petitioner presented to Provena St. Joseph Medical Care for an urgent Doppler Scan of her leg on October 6, 2008. Records show Petitioner was admitted for right leg pain and swelling. Petitioner noted pain in her right leg the prior week which had been continuing with physical therapy. It was noted that Petitioner could barely stand on her leg. (Pet's. Ex. 1A p. 94) Petitioner underwent a Venus Doppler Scan of her leg which showed extensive thrombus beginning in the mid to distal right superficial femoral vein, extending through the popliteal vein and into the peroneal and posterior tibial veins. There was also thrombus noted in the right gastrocnemius vein and in the lessor saphenous vein posteriorly as well. The changes all appeared to be quite acute. (Pet's. Ex. 1A p. 103) Petitioner was discharged October 9, 2008 and diagnosed as having a deep vein thrombosis (DVT). She was prescribed Coumadin and Lovenox. (Pet's. Ex. 1A p. 88)

Petitioner continued to see Dr. Dworsky throughout the fall of 2008 and continued to complain of shoulder discomfort and problems with her knee. On October 28, 2008, Dr. Dworsky noted Petitioner was still having significant pain in her lower extremity secondary to her DVT. On November 5, 2008, the doctor noted Petitioner continued with complaints of shoulder pain. She reported difficulty with reaching and overhead use. An epidural injection was administered. Dr. Dworsky also recommended additional physical therapy for Petitioner's right knee, but due to Petitioner's ongoing treatment for the DVT all strength and conditioning programs were placed on hold until Petitioner first received medical clearance. (Pet's. Ex. 2 p.11-14)

On November 12, 2008, Petitioner started treating with a hematologist, Dr. Ellen Gustafson, with whom she treats through the present time (Pet's. Exs. 9 – 13). She was also referred to Dr. Sankari of Heartland Cardiology (Pet's. Ex. 15) for vascular workup to rule out genetic or predisposing factors to blood clots. (Pet's. Ex. 15, Pet's. Ex. 9 p. 33, Resp. Ex. 8, p. 2 Par. 4).

During the first few months of 2009, Petitioner continued to complain of knee and shoulder issues while Dr. Gustafson, Petitioner's hematologist, continued treatment for Petitioner's blood clot issues. On January 29, 2009, a venous duplex scan was deemed to show chronic DVT involving the right superficial femoral and popliteal veins. (Pet's. Ex. 9, p. 61) Petitioner continued taking anticoagulants.

Petitioner underwent a venus Doppler on April 23, 2009. When Petitioner saw Dr. Gustafson on April 28, 2009, the doctor felt the scan showed that the popliteal and superficial viens were irregular consistent with old, chronic changes, but no evidence of acute deep venous thrombosis. The doctor discontinued the use of Coumadin. (Pet's. Ex. 9, p. 32)

On April 30, 2009, Dr. Sankari, felt Petitioner was in a chronic phase of deep vein thrombosis (Pet's. Ex. 15, p. 11).

Petitioner returned to Dr. Dworsky on May 7, 2009. Dr. Dworsky noted Petitioner continued to complain of knee problems. Petitioner also complained of worsening shoulder pain. The doctor recommended a right shoulder MRI arthrogram for a possible small tear. (Pet's. Ex. 2, p. 27)

Petitioner returned to Dr. Gustafson on June 2, 2009. The doctor's records show that Petitioner "... was doing her physical therapy and noted last Friday that her leg was more painful and swollen. She went to the emergency room, where they did, indeed, find that there was a clot in her peroneal vien in her right lower extremity. They put her on Lovenox and Coumadin." Dr. Gustafson continued Petitioner's use of Lovenox and Coumadin. (Pet's. Ex. 9, p. 29-30)

On May 21, 2009, Petitioner underwent a MRI arthrogram of her right shoulder which revealed components of both full and partial thickness tearing noted along the supraspinatus tendon laterally. (Pet's. Ex. 2, p. 59) On July 14, 2009, Dr. Dworsky performed right shoulder surgery at Provena St. Joseph Medical Center consisting of an arthroscopic rotator cuff repair with subacromial decompression and labral debridement. (Pet's. Ex. 5) The surgery was followed by physical therapy.

On June 5, 2009, Dr. Sankari opined that Petitioner would continue on Coumadin indefinitely. (Pet's. Ex. 15, p. 13).

Petitioner continued with right extremity complaints. Dr. Dworsky ordered a right upper extremity EMG/NCV. Same was performed in September 2009. The results were negative for mononeuropathy, peripheral neuropathy, or plexopathy. There was slight right carpal tunnel which the evaluator felt was possible because of borderline changes compared with the ulnar nerve. (Pet's. Ex. 2, p. 45)

On October 12, 2009 Dr. Dworsky noted Petitioner was making slow steady progress with her shoulder. He indicated that her biggest problem was her knee which was significant. Dr. Dworsky indicated that it appeared that no further intervention could be done other than localized treatment. On December 9, 2009, the doctor again noted that Petitioner was making slow steady progress with her right shoulder. At that time, Dr. Dworsky felt Petitioner's right knee was going to be problem that "will not resolve." He recommended that she continue on her own in a light exercise program. (Pet's. Ex. 2, p. 46-50)

Petitioner testified that on February 1, 2010, she saw Dr. Bardfield, a physiatrist at Hinsdale Orthopedics for her neck. At that time, Dr. Bardfield referred her to a hand specialist in his group, Dr. Leah Urbanosky. On February 5, 2010, Petitioner presented to Dr. Leah Urbanosky. After performing an examination and reviewing the September 2009 EMG/NCV, Dr. Urbanosky assessed cubital tunnel syndrome greater than carpal tunnel syndrome. (Pet's. Ex. 3, p. 8) Ultimately, on April 13, 2010, Dr. Urbanosky performed a right carpal tunnel release and right thumb trapezial incision, liamentous reconstruction using autogenous flexor carpi radialis tendon transfer as interposition grafting material and pinning of the thumb to the index metacarpal (Pet's Ex. 6).

On February 8, 2010, Petitioner presented to Dr. Dworsky with continued right knee complaints. The doctor ordered an MRI. On February 15, 2010, Dr. Dworsky noted the MRI had been performed which showed increasing changes within the medial compartment consistent with further degeneration. Dr. Dworsky wrote, "I do feel that this is a progressive problem for Mary which she is not able to overcome due to the fact that she cannot work on strength and conditioning of that leg. I do feel that this will continue to be a source of problem for her that will progress over a slow period of time and may need further intervention from injections as well as possible surgical intervention if the progressive degeneration continues." Dr. Dworsky recommended limited ambulation, climbing, bending and lifting position. The doctor felt that any increasing activities would increase the amount of problems and discomfort. (Pet's. Ex. 3, p. 12)

On March 19, 2010, Dr. Gustafson wrote, "[Petitioner] has chronic venus embolism and thrombosis of deep vessels of right distal lower extremity. This condition will remain unchanged indefinitely. She is on therapeutic Coumadin for this chronic condition. She is unable to stand, walk, sit, climb, and bend...She has severe limitation of the above functional capacity greater than 75%. This is a chronic condition and the only treatment available is Coumadin therapy which will be lifelong...there is nothing more than can be done. Due to her chronic condition, Mary Chambers is unable to work indefinitely." (Pet's. Ex. 10, p. 64)

On March 25, 2010, Dr. Dworsky authored a letter. In the letter Dr. Dworsky noted Petitioner continued to have problems involving her right knee secondary to an injury. He wrote that she developed a complication of a chronic DVT, which in combination with her significant degeneration of the leg has placed her in a situation where she had not been able to rehab completely and no further surgical intervention had been recommended due to the risk of further complication due to that chronic DVT. Dr. Dworsky determined Petitioner did not meet the requirements of her job. She would be limited to the amount of time she could be on her feet to less than one hour at a time; limited to ambulating distances of no more than 100 feet at a time; and limited to the ability to change positions such as stair climbing, bending, climbing and carrying. Dr. Dworsky also noted Petitioner had good results from her shoulder surgery and would have limitations in reaching above shoulder level; limited to no lifting at or above shoulder height; no repetitive reacing, pushing or pulling. (Pet's. Ex. 3, p. 19-20)

On April 26, 2010, Petitioner saw Dr. Bardfield complaining of a flair up in the soft tissue areas of the neck, particularly on the left side. Dr. Bardfield assessed cervical myofascial pain with underlying C4-5 disc bulge. Physical therapy was reinitiated. (Pet's. Ex. 3, p. 22)

On June 14, 2010 Dr. Bardfield noted that Petitioner's cervical spine complaints had improved with physical therapy and traction, but Petitioner still complained of experiencing some cervical pain. Dr. Bardfield provided that Petitioner had done well enough to transition into self-directed exercises and stretching program. Petitioner was also encouraged to continue with her home traction when necessary. Petitioner was released from care. (Pet's. Ex. 3, p. 32)

On June 21, 2010, Dr. Dworsky saw Petitioner with a history that she had a 15 minute walking tolerance, was not able to utilize a brace due to her clot, and had a very poor response to injections. Dr. Dworsky found Petitioner at maximum medical improvement regarding the knee, and noted: "I do feel that her only alternative at this point is a total knee arthroplasty, which I do not feel she is ready for and I would expect there would be quite a lot of pre-operative planning necessary for this" (Pet's. Ex. 3, p. 33).

Petitioner continued treating with Dr. Urbanosky. On September 22, 2010 Dr. Urbanosky prescribed a trial of Lyrica to help manage Petitioner's continued complaints of pain. (Pet's. Ex. 3, p. 44) By April 6, 2011, Dr. Urbanosky noted that Petitioner reported that she was gradually improving relative to decreased pain and increased use. Petitioner provided that she was satisfied with her results, although with residual pain. At that time, Dr. Urbanosky released Petitioner from care with a recommendation she continue her home exercise program. (Pet's. Ex. 3, p. 52)

At Petitioner's request, on November 1, 2011, she saw Dr. Jeffrey Coe, an Occupational Medicine Specialist, who gave evidence by report (Pet's. Ex. 18) and deposition (Pet's. Ex. 20). Dr. Coe did a medical record review. The doctor noted that Petitioner suffered injuries to her right knee, right hand and wrist, right shoulder, and neck, causing internal derangement of the right knee with right knee lateral meniscal tearing, chondromalacia of the patellofemoral joint and synovitis, a post operative complication of deep vein thrombosis, and internal derangement of the right shoulder with rotator cuff and glenoid labral tearing and impingement, aggravation of degenerative arthritis at the base of the right thumb and direct injury to the right

palm as a cause of carpal tunnel syndrome (due to the accident and prolonged need for crutch use post surgical), and cervical strain with chronic cervical myofascial pain (Pet's. Ex. 18, p. 16)

Dr. Coe testified that prevention of falling is particularly important for Ms. Chambers because she is being chronically anti-coagulated, maintained forever on blood thinning medication. If she does fall, there would be major concern if she hit her head, because she is at increased risk for bleeding with any fall or contusion, which puts her at increased risk for either brain injury or fatality (Pet's. Ex. 20, pp. 50 – 51). Dr. Coe testified that he would not pass her for any type of pre-employment or job placement physical, as he would have concerns about allowing her into a work place with the totality of her post-traumatic medical problems (id. p. 51). The doctor also testified that in winter he would not want her out on ice or risk her slipping or falling (id. P. 53). Dr. Coe found Petitioner to be medically, permanently and totally disabled (Pet's. Ex. 18, p. 17; Pet's. Ex. 20, pp. 51 – 53, 84)

Respondent offered into evidence two Exhibits regarding medical opinions. Respondent's Exhibit 7 is a Section 12 Exam of Dr. Nikhil Verma, an Orthopedist, of October 15, 2012, who limited his opinions to the right shoulder and knee from an orthopedic perspective. Dr. Verma opined that Petitioner right shoulder surgery and treatment was medically necessary and related to the May 2008 injury. Dr. Verma felt Petitioner sustained an exacerbation of her right knee osteoarthritis with small lateral meniscal tear as a result of the May 2008 accident. He felt and that her current condition and ongoing pain is directly related to her progression of underlying degenerative arthritis and unrelated to her work injury. He further opined that Petitioner's degenerative knee progression of symptoms with persistent pain and swelling is consistent with Petitioner's underlying degenerative arthritis and is further consistent with the natural history of degenerative arthritis "which is one of symptomatic progression." The doctor opined that Petitioner was able to perform her normal duties, "based on the sedentary nature of her job description work and objective findings..." (Resp. Ex. 7)

Dr. Lisa Boggio, a board certified hematologist at Rush University Medical Center, conducted an independent medical examination on Respondent's behalf in May, 2013. Based on her review, Dr. Boggio opined that Petitioner is required to take anticoagulant medication for an indefinite period of time. Dr. Boggio felt the need for long term anticoagulation was due to her recurrent thrombosis which was indirectly due to the DVT which occurred after the injury in May 2008. Dr. Boggio opined that there is no contraindication to anticoagulation and working. The doctor indicated that the only exception would be for police officers and firefighters. Dr. Boggio indicated that people with thrombosis can continue to work, but they might require workplace modifications. The doctor noted that it is recommended that people with a history of blood clot should get up and move every hour for at least 5-10 minutes and if they develop leg swelling, the leg should be elevated which may require a footstool under the desk. The doctor noted graduated compression stockings were also recommended to decrease the swelling. Dr. Boggio further noted that prolonged standing was not recommended and rest was indicated depending on the individual symptoms. Dr. Boggio recommends that Petitioner maintain a healthy diet and exercise routine. Dr. Boggio noted that other than the anticoagulation medication Coumadin and the need to wear compression stockings, there are no other interventions for this chronic condition. (Resp. Ex. 8)

On July 3, 2012, Dr. Gustafson authored a letter stating that Petitioner has had lower extremity thromboembolism and because of immobility secondary to orthopedic conditions, she is at a high risk of recurrent clotting. The doctor reiterated that Petitioner will always have some form of anticoagulation to prevent recurrent disease. The doctor also felt that Petitioner was permanently disabled from gainful employment. (Pet's. Ex. 12)

Petitioner testified she has to elevate her leg, and the blood collects and doesn't always flow. She has pain and swelling, and it will wake her at night. She can only ambulate up and down the stairs of her house very slowly, and goes downstairs once in the morning with everything she will need for the day, as she can only

go up once at night, and sometimes has to remain downstairs at night and sleep on the couch. She testified that she owned the equipment for and had a retail hat store, which she closed to devote full time to her duties at Stateville, and was planning to reopen when she retired from Stateville. She was no longer able to work on hats both because of her leg and because of symptoms in her hand and fingers. She testified that when it snows or when there is ice, she cannot go out of the house for risk of injury and bleeding. She would have to wait and make sure the snow is cleared before making short trips for groceries and the like. On occasion she will require a cane, and in airports a wheelchair. On bad days her pain will be 8/10. She testified she is taking high doses of Coumadin. She has to be careful taking antibiotics as they are a blood thinner, and she must maintain strict blood levels.

Regarding her shoulder, she has loss of motion and has difficulty reaching behind her to fasten or unfasten female garments. She also has loss of strength, particularly overhead and she cannot reach behind.

Regarding the wrist and hand, her ring and little fingers are always cold, the wrist clicks, and she doesn't have the strength to grip. At one stage she reported improvement to her doctor that she could finally clap in church. She has learned to write left handed.

In Support of the Arbitrator's Decision regarding "L" (Nature and Extent of the Injury), the Arbitrator finds as follows:

All three doctors opining on the issue, Dr. Gustafson, Dr. Coe and Dr. Boggio all agree that Petitioner is permanently and totally disabled, at least the absence of significant modifications, if not completely. In *ABB C-E series v. Industrial Commission*, 316 Ill. App. 3d 745, 737 NE 2d 682 (2000), the Appellate Court, following Supreme Court precedent, held there were three ways to prove permanent and total disability, either 1) by a preponderance of medical evidence; 2) by diligent yet unsuccessful job search, or; 3) because of age, training, education, experience and condition, no jobs are available (odd-lot). Based on the medical condition and risks to health, the Arbitrator is persuaded by the opinions of Drs. Gustafson and Coe that Petitioner is medically permanently and totally disabled by the first method. There was no evidence regarding the second method.

Regarding the third method, in *Ceco Corp. v. Industrial Commission*, 95 Ill 2d 278, 447 NE 2d 842 (1983), the Supreme Court held that a claimant need not be reduced to total physical incapacity before permanent total disability may be granted; rather, the question is whether she is incapable of performing services except those for which there is no reasonably stable market. Where medical evidence, even if conflicting, establishes total disability, the burden shifts to the employer to establish that suitable employment is reasonably available.

The Court further held if employment would involve serious risk of health or life, an award of permanent total disability is appropriate. In *Steve Foley Cadillac v. Industrial Commission*, 283, Ill App. 3d 670 NE 2d 885 (1996), the Appellate Court affirmed a finding of permanent and total disability where claimant was working part time, holding the fact that he can earn occasional wages or perform certain useful services does not preclude a finding of total permanent disability. Here there has been no showing herein that Petitioner can ever earn occasional wages, as she had planned to do with a hat shop.

In the case at bar, requiring Petitioner to work would pose serious risks to health and life. Dr. Gustafson found that due to immobility secondary to orthopedic conditions, she is at high risk for recurrent clotting (Pet's. Ex. 12). Dr. Coe testified to the serious risks involved, noting her at "increased risk for catastrophic change from a fall because of her anti-coagulant status" She has significant limitations, something both Drs. Coe and Boggio agreed with. The is no evidence Vocational counseling has been offered, which in and of itself is

sufficient evidence and, if appropriate should have been offered without request, *Mattea v. Roadway Express*, 11 IWCC 1009; *Roper v. Industrial Commission*, 349 Ill App. 3d 500, 812 NE 2nd 65 (2004); Commission Rule 7110.10(a). Thus permanent and total disability has also been proved by the third method.

Petitioner has had a uncontested on the job injury which has resulted in knee surgery, development of chronic DVT's following the knee surgery, shoulder surgery, hand and wrist surgery, and soft tissue injuries to the neck, all of which are still symptomatic. She will require indefinite anti-coagulation, and currently takes Coumadin at high doses to control her vascular condition.

The Arbitrator adopts the findings, opinions and conclusions of Drs. Gustafson and Coe. These are the only doctors who assessed both the orthopedic and vascular conditions together (Pet's. Exs., 12 and 18) Petitioner is not physically able to perform even sedentary duties in a stable, competitive labor market and to do so would put her at significant increased risk to her health. Dr. Boggio's opinions are not inapposite, but confirmatory. Accordingly, the Arbitrator finds Petitioner permanently and totally disabled as of November 1, 2011, Temporary Total Disability having ceased by stipulation on October 31, 2011, and Dr. Coe finding total permanent disability on November 1, 2011.

In Support of the Arbitrator's Decision regarding "J" (Medical Expenses), the Arbitrator finds as follows:

Petitioner's Exhibit 21 through 44 was admitted without objection with the agreement that Respondent could pay the providers directly. The unpaid medical bills total $40,956.41, and the bills paid by group total $179,835.54, for a combined total of $221,158.61 for which the bills are awarded to Petitioner, with the proviso that Respondent may avail of the fee schedule or any agreements and pay the bills directly to providers. Respondent shall have a credit of $179,835.54 and shall further hold Petitioner harmless for group payments as provided by Statute.

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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Conchas,

Petitioner,

vs.

NO: 07 WC 39404

14IWCC0734

Aramark,

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, 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 6, 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.

14IWCC0734

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 $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: AUG 26 2014
TJT:yl
o 8/18/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CONCHAS, MARIA
Employee/Petitioner

Case# **07WC039404**

ARAMARK
Employer/Respondent

14IWCC0734

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 OFFICES OF JIM BLACK
BRAD A REYNOLDS
308 W STATE STSUITE 300
ROCKFORD, IL 61101

2337 INMAN & FITZGIBBONS LTD
TERRY DONOHUE
33 N DEARBORN SUITE 1825
CHICAGO, IL 60602

STATE OF ILLINOIS)
) **14IWCC0734**
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

Maria Conchas
Employee/Petitioner

Case # **07** WC **39404**

v.

Rockford

Aramark
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, arbitrator of the Commission, in the city of **Rockford**, on **January 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 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 **Prospective Medical Care**

14IWCC0734

FINDINGS

- On **August 29, 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 $ **26,065.49** ; the average weekly wage was $ **501.25** .
- At the time of injury, the petitioner was **42** years of age, ***single*** with **2** 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 $ **N/A**/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 $ **458.00** 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.

The Respondent is Ordered to authorize bilateral CTS releases and treatment for de Quervain's syndrome.

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

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

3/5/13
Date

MAR 6 - 2013

IN AND BEFORE THE ILLINOIS
WORKERS' COMPENSATION COMMISSION

Maria Conchas, Employee/Petitioner, v. Aramark, Employer/Respondent.	)	Case No. 07 WC 39404

DISPUTED ISSUES

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

Petitioner Maria Conchas has worked for Respondent Aramark, for more than 15 years. Ms. Conchas is employed full-time by Respondent as a garment hanger. Petitioner works on the tunnel line. Petitioner described her work duties in great detail at the time of the hearing. Petitioner's job required that she remove laundered clothing (pants, shirts, jackets, and robes) from tubs onto hangers. Once the clothes were placed on hangers, they were placed on moving conveyors on the tunnel line. Most of the items hung were collared shirts or pants. With regards to shirts, Ms. Conchas hung a shirt on the hanger, and then she was required to button the top button of the shirt using both of her hands and pinching with her thumbs. Rate was fast-paced. Ms. Conchas testified that she hung 300 or more pieces of clothing per hour. In an eight hour day, she would hang 2,400 items or more. Ms. Conchas testified that she grabbed garments from tubs and hung them on the line all day long for eight hours, other than her breaks and lunch.

Respondent called Debbie Prebula in their case in chief. Ms. Prebula is Respondent's production manager and has held that position for the last 11 years. Ms. Prebula testified she was familiar with all operations in the plant, including the garment hanger job done by Ms. Conchas. On cross examination, Ms. Prebula admitted that Petitioner's description of her work activity was accurate. She testified that Petitioner described her job duties correctly and she further confirmed that Petitioner did the job in the manner described, all day long without variation in her job duties. Ms. Prebula agreed that Petitioner did her job well and there were no issues with her meeting performance standards or quotas.

Respondent also offered a video job analysis as well as a written job analysis. The written job analysis confirms that Petitioner was to take garments out of bins and then was to hang, button, and place them on a conveyer. **Respondent's written job description indicates that repetitive movement with the hands was constant**. The Arbitrator reviewed Respondent's DVD-ROM video job analysis. After review the

Arbitrator confirms that the video is consistent with both the written job analysis submitted by Respondent and Petitioner's description of her work activity.

Petitioner testified that she began to experience pain, numbness, and tingling in her hands beginning early in 2007. Petitioner testified that when her symptoms did not improve, she sought medical treatment with her primary care physician.

To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. Sisbro v. Industrial Commission, 207 Ill. 2d 193, 203, 797 N.E. 2d 665, 671-672 (2003). An injury occurs within the course of an employee's employment if the injury occurs within the time and space boundaries of the employment. Id. An injury "arises out" of an employee's employment when the employee was performing acts he was instructed to perform by his employer, acts which the employee might reasonably be expected to perform relating to his assigned duties. Id.

For an injury to arise out of the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. Caterpillar Trucker Company v. Industrial Commission, 129 Ill. 2d 52 (1989). A risk is incidental to employment where it belongs to or it is connected with what an employee has to do in fulfilling his duties. Id. If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is said to arise out of this employment. Id.

The Arbitrator finds that Petitioner sustained her burden of proving an accident arising out of her employment on August 28, 2007. Certainly Petitioner was performing acts, namely hanging garments from tubs onto a conveyor, as instructed by her employer-acts which an employee might reasonably be expected to perform relating to her assigned duties. A risk is incidental to employment where it belongs to or is connected with what an employee has to do in fulfilling her duties. If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is said to arise out of employment. Here, Petitioner was hanging garments and buttoning the top button of collared shirts at the rate of 2,400 or more pieces per eight hour shift. This activity, and the rate at which she did it, were done to a greater degree than persons in the general public and can thus be said to arise out of her employment.

The Arbitrator amends the accident date to conform to proof. Petitioner's EMG which diagnosed CTS is dated 8-29-07. The arbitrator amends the DOI from 8-28-07 to 8-29-07. See Wages v. Hampton Properties LLC, 7 IWCC 521 (2007) (reversing Arbitrator and amending accident date to conform to proof in the record where no prejudice is demonstrated to the Respondent). This amendment is also consistent with principles articulated by our Supreme Court in Durand.

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

Petitioner was seen by her primary care physician, Dr. Jorge Villacorta, on March 23, 2007. At that time, she reported history of feeling numbness in both of her hands. PX 1. The Arbitrator notes Petitioner was also treating with Dr. Villacorta concerning Case No. 07 WC 25768, which is the subject of a separate Arbitration Decision, in these consolidated matters. The Arbitrator notes that Petitioner was referred by Dr. Villacorta to Dr. Rozman for EMG, regarding her complaints of numbness and tingling in both of her hands. PX 1. Petitioner was seen by neurologist, Dr. Rozman, on August 29, 2007. PX 1. Dr. Rozman noted bilateral numbness and tingling in both hands on August 29, 2007. Petitioner gave a history of manual work at Aramark doing a lot of fine manipulation and movements with her hands. Physical exam revealed positive Phalen's test on both sides. PX 1. There was decreased sensation in the area of the distribution of the median nerves, bilaterally. There was also positive Finkelstein's test, bilaterally. PX 1. EMG revealed right sensory motor median nerve entrapment neuropathy at the wrist with signs of focal demyelination with mild carpal tunnel syndrome. PX 1. EMG also noted left sensory median nerve entrapment neuropathy at the wrist with signs of focal demyelination- moderate carpal tunnel syndrome. Dr. Rozman recommended a trial of conservative treatment. PX 1. Dr. Roman noted that if further progression of signs or symptoms was apparent, that she could consider orthopedic surgery consult. Dr. Rozman also recommended treatment of mild De Quervain's tenosynovitis, bilaterally. PX 1.

Subsequent to the EMG, Petitioner testified that she continued working for Respondent full-duty and unrestricted. Petitioner testified that her symptoms did not change following her EMG. Petitioner was seen for an IME by Dr. Jeffrey Coe on December 2, 2009. Dr. Coe received a history consistent with Petitioner's testimony that she worked as a garment hanger for Respondent and had done so for more than 12 years at the time of the IME. Rate was identified at 300 pieces of clothing per hour, and that she would remove clothing from a tub and place it on a hanger. She also fastened buttons or at least the top button in clothing on a shirt when the shirt was on a hanger, and placed the garments on the conveyor; she carried out these activities throughout her work shift. PX 5; Deposition transcript pages 11-12.

Dr. Coe reviewed treatment records from Dr. Villacorta and Dr. Rozman. PX 5; Deposition transcript pages 12-15. Dr. Coe recorded that on the date of his visit, Petitioner continued to have numbness, tingling, burning, and pain in her bilateral wrists, as well as pain radiating up into her upper extremities. PX 5; Deposition transcript page 16. Dr. Coe testified that Petitioner did not have any risk factors for carpal tunnel syndrome, including diabetes mellitus, thyroid disease, collagen and vascular diseases, nor direct injuries to her hands or wrists. PX 5; Deposition transcript page 16. Dr. Coe diagnosed bilateral carpal tunnel syndrome and offered the opinion that Petitioner's diagnosis was causally related to her work activities as a garment hanger for Respondent. PX 5; Deposition transcript pages 20-21. Dr. Coe recommended physician follow-up and conservative treatment for the CTS. Dr. Coe opined that if invasive treatments, including steroid injections, did not work that surgery could be considered. PX 5; Deposition transcript page 23.

Respondent then arranged for Petitioner to be examined for an IME by Dr. Charles Carroll. Dr. Carroll performed his IME exam regarding Petitioner on May 17, 2010. Dr. Carroll recorded a history of a tunnel operator who presented with bilateral wrist complaints and pain over the radial side of each thumb and wrist, somewhat worse on the left than the right. There was some radiation of pain into the index finger and thumb. There was some volar radiation of pain into the thumb musculature called the thenar eminence. Ms. Conchas noted night discomfort to Dr. Carroll. She reported difficulty with some of her gripping and grasping activities. Symptoms were reportedly getting worse rather than better and she had some radiation of the left shoulder. RX 1; Deposition transcript pages 7-8. Physical exam was positive for De Quervain's tenosynovitis, bilaterally. Grip strength was 40 pounds on the right and twenty pounds on the left. Dr. Carroll's most prominent finding on physical exam was a positive Finkelstein's sign in each wrist for De Quervain's tenosynovitis. RX 1; Deposition transcript pages 8-9. Physical exam also revealed that Ms. Conchas demonstrated some pain in the impingement arc regarding her left shoulder. RX 1; Deposition transcript page 21. Dr. Carroll also noted some mild lateral epicondylar pain, worse on the right than on the left, as well as a positive Finkelstein's test bilaterally. RX 1; Deposition transcript page 22.

With regards to work activities, Dr. Carroll received a history that she was working on a clothing line. She had to take clothes off of the line and place them on hangers. She worked eight hours a day. Job video and analysis reported taking material, hanging material, and buttoning material. Dr. Carroll reported the work was repetitive, but not heavy. Fingering/use of the fingers was chronic throughout the day because she used her hands to do the assembling of the clothes and hanging them up. RX 1; Deposition transcript pages 9-10.

Dr. Carroll's opinion was that Petitioner had bilateral de Quervain's tenosynovitis. Dr. Carroll felt Petitioner needed additional treatment for this diagnosis, including a corticosteroid injection into her wrist. He further recommended stretching exercises and a soft thumb spica. Dr. Carroll testified if the injection was not successful, she should consider a hard splint. Dr. Carroll felt she could continue to work without work restriction. RX 1; Deposition transcript pages 10-13.

With regards to his diagnosis of bilateral de Quervain's tenosynovitis, Dr. Carroll testified that this diagnosis can be found in an occupational setting. RX 1; Deposition transcript page 23. Dr. Carroll testified with regards to causation that he would look for a combination of repetition and force, as well as awkward posturing of the hand in a more deviated position toward the pinky finger and away from the thumb. RX 1; Deposition transcript pages 23-24. On direct exam Dr. Carroll opined that Petitioner's work was certainly repetitive but he testified it was not forceful and therefore not causally related to her job for Respondent. RX1.

On cross examination, Dr. Carroll testified that Petitioner's work was certainly repetitive. RX 1; Deposition transcript page 17. **Dr. Carroll testified that at the time he offered his opinions, that he was provided no medical records by Respondent.** RX 1;

Deposition transcript pages 18-19. Dr. Carroll testified he was not provided with Dr. Villacorta's records, nor was he provided with a copy of the EMG dated August 29, 2007. RX 1; Deposition transcript pages 19-20. Dr. Carroll agreed that this information was important and that he would have liked to review it before offering opinions on the subjects of medical diagnosis and causal connection. RX 1; Deposition transcript pages 20-21.

Dr. Carroll agreed that evidence that Petitioner buttoned the top button of shirts before hanging them on the conveyor involved use of both of her hands. RX 1; Deposition transcript page 24. Dr. Carroll further testified that the act of buttoning the top button of each shirt involved fine manipulation. On cross examination, Dr. Carroll agreed that buttoning the top button of the shirt required contraction of the flexor tendons in both of her thumbs. RX 1; Deposition transcript page 24.

With regards to carpal tunnel, Dr. Carroll testified in general that he is looking for a combination of repetitive activities along with force. RX 1; Deposition transcript page 25. Dr. Carroll agreed that there was evidence of highly repetitive work done by Ms. Conchas. RX 1; Deposition transcript pages 25. **Furthermore, Dr. Carroll testified to a reasonable degree of medical and surgical certainty that the more repetitive the work is, the less force is needed in order for the work to be occupational.** Dr. Carroll further testified that in addition to the act of buttoning the top button of the shirts, that the act of gripping clothes from the laundry tubs and hanging them would require that Petitioner contract her flexor tendons in both hands. Dr. Carroll explained that the tendons move in the course of this activity and that it is correct, that if it is done repetitively, the flexor tendons can become inflamed. RX 1; Deposition transcript pages 25-26. Dr. Carroll further agreed on cross examination that if the flexor tendons become inflamed, that can lead to the development of carpal tunnel syndrome. RX 1; Deposition transcript page 26.

Dr. Carroll testified that synovium is the lining of a joint or the lining of a tendon. Dr. Carroll explained that synovium is the coating that enables a tendon to glide or move. Dr. Carroll testified that increased pressure on the median nerve can lead to median nerve entrapment if there is inflammation in the synovium. RX 1; Deposition transcript pages 26-27. Lastly, on cross examination, Dr. Carroll testified that in the act of gripping clothes if force is involved and done on a repetitive basis, the contraction of flexor tendons which would lead to inflammation can set into motion the development of de Quervain's tenosynovitis. RX 1; Deposition transcript page 26.

Petitioner testified that she continued to experience bilateral numbness and tingling in her hands following Dr. Carroll's exam in May of 2010. She was referred by her primary care physician to orthopedic surgeon, Dr. Scott Nyquist, who saw her on April 25, 2011. PX 4. Dr. Nyquist noted Petitioner's bilateral numbness and tingling in her hands for the past four years. He noted her history of working at Aramark, which involved folding and hanging of clothes. PX 4. He noted her symptoms came on gradually and that her right hand was worse than her left. He further noted that she had

not missed any work. He stated that she wakes up at night. PX 4. Physical exam revealed positive Tinel's and Phalen's signs, bilaterally. X-rays taken of both of her hands were unremarkable. Dr. Nyquist diagnosed bilateral carpal tunnel syndrome. He recommended consideration of release of her carpal tunnels at that time and indicated that he would request her prior EMG for review. PX 4. When seen in follow-up on June 13, 2011, Dr. Nyquist reviewed her prior EMG. Dr. Nyquist noted her continued numbness and tingling and that her symptoms were worse. He noted it continues to wake her up at night. The diagnosis continued to be bilateral carpal tunnel syndrome. PX 4. Petitioner was allowed to continue working without restrictions at that time. Dr. Nyquist stated surgery would be scheduled when it was authorized by the workers' compensation carrier. PX 4.

Petitioner testified at the time of hearing that she had not yet had surgery for her bilateral carpal tunnel syndrome, as it had not been authorized by Respondent. Petitioner testified that she continues to experience numbness and tingling in her hands, as well as night pain. Petitioner testified she desired to proceed with surgery, so long as it would be approved.

With regards to causal connection, the Arbitrator finds that Petitioner sustained her burden of proving her condition of ill-being regarding her bilateral CTS and de Quervain's tenosynovitis are work-related. Several factors lead the Arbitrator to this conclusion.

First, it is undisputed that Petitioner did repetitive work. The production manager for Respondent confirmed that Petitioner's description of her work activities was accurate. Petitioner's testimony was further corroborated by the written job analysis, as well as the CD-ROM. Respondent's expert witness, Dr. Carroll, confirmed that Petitioner's work was absolutely repetitive. Even if Petitioner's job was not forceful, the hand intensive work done by Petitioner on a continuous basis throughout her day (other than her breaks and lunch) are considered by the Commission to be the type of activities that can be causative of her bilateral CTS and de Quervain's tenosynovitis. In Baughman v. Peoria Starcrest, (Ill. W.C. Comm. 2008), the Commission affirmed the Arbitrator's Decision finding claimant sustained a compensable carpal tunnel syndrome injury to her left hand as a result of purely repetitive hand intensive work. In Baughman v. Peoria Starcrest, the claimant pressed almost 200 pants per day. She hung the pants on hangers and also pressed coats and silk products throughout her work day. See also Johnson v. Caseys General Store, (Ill. W.C. Comm. 2008), where the Commission once again confirmed that hand intensive work duties constitute sufficient evidence to support an award of a repetitive stress claim involving the hands.

Second, Respondent's assertion that work activities must be both repetitive and forceful to cause carpal tunnel syndrome has never been adopted by the Commission. Keyboarding, which is highly repetitive but not forceful, has long been determined to be a causative factor in the development of carpal tunnel syndrome. See Pold v. United Airlines, 03 IIC 0141 (2003); Wartz v. Illinois Mutual Insurance, 03 IIC 0810 (2003); Miller v. Metropolitan Water Reclamation District, 03 IIC 0199 (2003); Dagit v. Midwest Kidney Centers, 03 IIC 0812 (2003); Pickins v. MetraHealth and United Health Care

Core, 99 IIC 0182 (1999); Barker v. Caterpillar, Inc., 00 IIC 0449 (2000); Peterson v. McKinney and Company, 99 IIC 1179 (1999); Zalewa v. Appollo Colors, 02 IIC 0369 (2002); Wallingford v. Self-Help Enterprises, Inc., 02 IIC 01966 (2002); Boettcher v. Spectrum Property Group, 99 IIC 0961 (1999).

Third, the Arbitrator finds persuasive the Commission's decision in Rivera v. Aramark 06 WC 018593 (2009). There the Arbitrator found claimant's bilateral carpal tunnel syndrome to be work related. Claimant in Rivera v. Aramark, performed the same job on the line in the tunnel as was performed by Ms. Conchas.

Fourth, Dr. Carroll's entire testimony on cross examination is supportive that petitioner's CTS and de Quervains are work related. Dr. Carroll agreed that the act of grasping clothes from bins and placing them on hangers, as well as the act of buttoning the top button of shirts, involved activation of Petitioner's flexor tendons. Dr. Carroll conceded during cross examination that if the flexor tendons are contracted on a repetitive basis, this can cause inflammation within the tendons, which can lead to carpal tunnel syndrome.

Fifth, Petitioner's treating orthopedic surgeon, Dr. Nyquist's records indicate that the treating physician finds a causal relationship between Petitioners's bilateral CTS and her work activities for Respondent. This causation opinion was also echoed by Dr. Jeffrey Coe.

In sum, the totality of the evidence supports a finding that Petitioner's bilateral CTS and de Quervain's tenosynovitis are work-related.

J. Were 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, having considered the evidence, finds that medical services provided to Petitioner to the date of the hearing were reasonable and necessary. No opinion by Respondent was offered to the contrary. Respondent has not paid all appropriate charges for reasonable and necessary medical services. Respondent is ordered to pay the following medical bills, pursuant to the Illinois Fee Schedule:

Medical Provider	Date of Service	Total Outstanding Balance
Lundholm SAMG	4/2/2011	$382.00
Lundholm SAMG	6/13/2011	$76.00

K. Is Petitioner entitled to any prospective medical care?

Petitioner was last seen in June of 2011 by her orthopedic surgeon, Dr. Nyquist, who recommended bilateral CTS releases. Petitioner has a positive EMG. At the time of her visit with Dr. Nyquist in 2011, she continued to show positive Tinel's and Phalen's signs bilaterally. At the date of the hearing, Petitioner testified she continued to remain

symptomatic with her hands and that her symptoms included awakening at night time. The Arbitrator finds that Petitioner is entitled to bilateral CTS releases, as recommended by Dr. Nyquist. The Arbitrator further finds Petitioner is entitled to the additional medical care described by Dr. Carroll concerning her bilateral de Quervain's tenosynovitis. Respondent is Ordered to authorize this treatment.

Date

Arbitrator Edward Lee

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

John Manning,

Petitioner,

vs.

NO: 11 WC 48855

Great Lakes Elevator Services Inc.,

14IWCC0735

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, vocational rehabilitation, temporary total disability, maintenance, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 4, 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.

14IWCC0735

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 $24,900.00. 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: AUG 26 2014
TJT:yl
o 8/18/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

MANNING, JOHN
Employee/Petitioner

Case# **11WC048855**

GREAT LAKES ELEVATOR SERVICES INC
Employer/Respondent

14IWCC0735

On 10/4/2013, 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 0.04% 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:

0320 LANNON LANNON & BARR LTD
PATRICIA LANNON KUS
180 N LASALLE ST SUITE 3050
CHICAGO, IL 60601

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
THOMAS CROWLEY
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS
COUNTY OF COOK

14IWCC0735

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

John Manning
Employee/Petitioner

v.

Great Lakes Elevator Services, Inc.
Employer/Respondent

Case # **11** WC **48855**

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 **8/22/13**. 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 **Should Respondent provide vocational rehabilitation to the Petitioner pursuant to Section 8(a) of the Act. Deferred Evidentiary Ruling**

FINDINGS

14IWCC0735

On the date of accident, **12/20/11**, 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 right knee condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**126,256.00**; the average weekly wage was $**2,428.00**.

On the date of accident, Petitioner was **50** 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 $**88,298.73** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**88,298.73**.

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 $**1,261.41**/week for **72 1/7** weeks, commencing **12/22/11** through **5/9/13**, as provided in Section 8(b) of the Act.

Maintenance

Respondent shall pay Petitioner maintenance benefits of $**1,261.41**/week for **15** weeks, commencing **5/10/13** through **8/22/13**, as provided in Section 8(a) of the Act.

Medical Benefits

Respondent shall pay reasonable and necessary medical services of $**3,149.30**, as provided in Sections 8(a) and 8.2 of the Act. PX 6-7.

Vocational Rehabilitation

Respondent shall prepare a vocational assessment and shall provide vocational rehabilitation services pursuant to Section 8(a) of the Act.

Penalties/Fees

For the reasons set forth in the attached conclusions of law, the Arbitrator declines to award Section 19(l) penalties and fees, as requested by Petitioner.

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

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

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

Molly C Mason
Signature of Arbitrator

10/4/13
Date

OCT 4 - 2013

John Manning v. Great Lakes
11 WC 48855

14IWCC0735

Deferred Evidentiary Ruling

Causation is the primary disputed issue in this case. The case is somewhat unusual in that Petitioner relies largely on causation opinions expressed by Respondent's first Section 12 examiner, Dr. Ira Kornblatt. Dr. Kornblatt examined Petitioner on three occasions. Petitioner secured Dr. Kornblatt's deposition on August 7, 2013, well after Respondent's second Section 12 examiner, Dr. Karlsson, issued his report. PX 3. RX 1. At the deposition, Dr. Kornblatt relied on his reports while testifying. PX 3 at 6. Respondent's counsel questioned the doctor about the reports during cross-examination.

It was not until the August 22, 2013 hearing that Petitioner offered Dr. Kornblatt's reports into evidence. Petitioner obtained those reports, along with the doctor's "quick reports," history forms and bill, via subpoena. PX 3A. Respondent objected to the admission of PX 3A on the basis of hearsay. The Arbitrator reserved ruling on this objection. Respondent did not renew the objection in its proposed decision.

The Arbitrator overrules Respondent's hearsay objection and admits PX 3A into evidence. Respondent solicited the reports from Dr. Kornblatt, solicited other opinions from a different examiner in April of 2013 and had ample opportunity to cross-examine Dr. Kornblatt at his August 7, 2013 deposition.

Arbitrator's Findings of Fact

Petitioner testified he has worked as an elevator repairman for 33 years. He is a member of Local 2. He specializes in "rehab demolition," which involves ripping out old elevator cabs and machinery and installing new equipment.

Petitioner testified his activities as an elevator repairman include climbing stairs and ladders, crawling, walking on open beams at heights and carrying various items such as chain falls. Petitioner testified that chain falls come in different sizes. They vary in weight between 125 and 600 pounds. Each chain fall is labeled so as to reflect its weight. In his trade, a worker is expected to lift and carry 100 pounds on his own.

The parties agree Petitioner sustained an accident while working for Respondent on December 20, 2011. Petitioner was descending a "pull-down" ladder. Petitioner indicated this ladder folded down from the ceiling. Petitioner was stepping down with his left foot, with his right foot still up on a rung, when the ladder shifted, causing his left foot to slip. His right foot stayed up on the rung but his right knee twisted as he fell.

Petitioner acknowledged having undergone some knee-related treatment with his internist, Dr. Pettigrew, before the accident. He had undergone MRI scanning but only of his

left knee. The left knee MRI, performed on May 12, 2010, showed Grade III/IV chondromalacia of the patellofemoral compartment, some fraying of the medial meniscus and what was thought to be a Grade 1 sprain of the superficial portion of the medial collateral ligament. RX 2. Petitioner testified that Dr. Pettigrew injected his left knee with cortisone following the MRI. His left knee was "okay" after this injection.

Petitioner testified he saw Dr. Pettigrew for right knee pain about a month before the accident, with the doctor ordering right knee X-rays. Records in RX 2 reflect that Dr. Pettigrew ordered right knee X-rays on November 22, 2011. Petitioner testified he did not undergo these X-rays until December 17, 2011 because that was "the first date he could get in." The X-rays showed "mild narrowing of the medial tibiofemoral compartment," no significant effusion and no acute fracture, dislocation or destructive lesions. The clinical history states: "knee derangement." A separate note, also dated December 17, 2011, states: "pt has torn meniscus to rt knee. Pt states pain got worse over the last couple days."

Petitioner testified he underwent emergency room treatment at "Northwest Hospital" after the December 20, 2011 accident. Neither party offered any emergency room records into evidence. Petitioner testified he underwent X-rays at the emergency room and was given pain medication.

On December 22, 2011, Petitioner saw Dr. Paik of the Midwest Bone & Joint Institute at Dr. Pettigrew's referral. Petitioner denied seeing Dr. Paik at any time prior to December 22, 2011. Dr. Paik's initial note reflects that Petitioner presented "for bilateral knee pain" of eight months' duration and a right knee "re-injury" on December 20, 2011. Dr. Paik indicated Petitioner was "coming down a ladder" on December 20, 2011 when he "heard a snap." Dr. Paik also indicated that Petitioner described his right knee as "worse than left."

On right knee examination, Dr. Paik noted tenderness to palpation of the medial collateral ligament and medial parapatellar area, along with positive valgus stress testing. McMurray's meniscal testing was negative. The doctor interpreted X-rays as showing mild degenerative joint disease. Dr. Paik's impression was "possible acute MCL injury, unclear etiology of medial parapatellar pain and mild djd." He took Petitioner off work, placed Petitioner's right knee in a hinged brace and ordered a right knee MRI. He instructed Petitioner to return to him following the MRI. PX 1.

At the hearing, Petitioner denied telling Dr. Paik he had been experiencing right knee pain for eight months.

The right knee MRI, performed without contrast on December 28, 2011, showed moderate degenerative changes in the medial and patellofemoral compartments, with "subchondral degenerative marrow signal changes as well as chondromalacia," a tibial surface defect in the small posterior horn of the medial meniscus, consistent with a tear, and a 5 millimeter cyst posterior to the tibial PCL insertion. The interpreting radiologist described the images as sub-optimal but indicated the overall quality was diagnostic. PX 2.

There is no evidence indicating Petitioner underwent, or was told to undergo, a right knee MRI at any point prior to December 28, 2011. RX 2, which consists of extensive records from Adventist Bolingbrook Hospital, contains only a left knee MRI report.

Petitioner returned to Dr. Paik on January 3, 2012. Dr. Paik again noted that Petitioner sustained a right knee trauma on December 20, 2011. He also noted that Petitioner described his right knee pain as constant and aggravated by using stairs. Dr. Paik described Petitioner's gait as antalgic. He noted medial joint line tenderness, negative valgus/varus stress testing and negative McMurray's on re-examination. Based on the MRI, he considered the medial meniscus tear to be the "main acute issue." He indicated the MRI also showed "baseline medial and patellofemoral djd." He gave Petitioner three treatment options: "injection vs. scope vs. observation." He noted that Petitioner opted to undergo scoping. He advised Petitioner that an arthscopcy might provide "incomplete relief" due to the degenerative joint disease but that it was "likely to help" the meniscal tear. He prescribed Tramadol and indicated Petitioner would need medical clearance and "WC approval." He released Petitioner to light duty with no climbing and walking/standing limited to ten minutes per hour. PX 1.

At Respondent's request, Petitioner saw Dr. Kornblatt for a Section 12 examination on February 22, 2012. Records in PX 3A reflect that Petitioner completed a medical history form at Dr. Kornblatt's office. On this form, Petitioner indicated he had some right knee symptoms with weather changes before the work accident. He described these symptoms as "nothing like" the symptoms he experienced after the accident.

Dr. Kornblatt is a fellowship-trained orthopedic surgeon. He obtained board certification in 1984 and was re-certified in 1996. PX 3, Dep Exh 1. At his deposition, taken by Petitioner on August 7, 2013, Dr. Kornblatt testified he sub-specializes in sports medicine, which mainly involves the knees and shoulders. PX 3 at 5. He had "minimal" independent recollection of Petitioner and thus needed to rely on his notes while testifying. PX 3 at 6.

Dr. Kornblatt testified that, when he first examined Petitioner on February 22, 2012, Petitioner told him he "jammed his left knee" and twisted and injured his right knee when his left foot slipped off a rung while he was descending a ladder. Petitioner related that he had been off work since the accident and was taking Tramadol for pain.

Dr. Kornblatt testified he asked Petitioner about previous knee problems, with Petitioner denying any "previous significant problem with either knee." Petitioner acknowledged having "some aching in his knees" before the accident and "did have an X-ray by his internist sometime prior to the injury. Dr. Kornblatt indicated that Petitioner described the X-ray as "nondiagnostic" and denied undergoing any right knee treatment before the accident. PX 3 at 7.

Dr. Kornblatt described Petitioner as a "very large man" who was 6 feet, 1 inch tall and weighed 340 pounds. He noted that Petitioner walked with a "slight right-sided limp" on February 22, 2012. He noted "evidence of muscle atrophy of the thighs." On right knee

examination, Dr. Kornblatt noted a normal range of motion, pain on full flexion, medial joint line tenderness and an equivocal McMurray test. The doctor noted no abnormalities on left knee examination. PX 3 at 8. Dr. Kornblatt was unable to open the disc pertaining to Petitioner's right knee MRI but he did review the MRI report. He testified that the "subchondral degenerative marrow signal changes" shown on the MRI were consistent with developing arthritis.

Dr. Kornblatt testified he obtained X-rays on February 22, 2012. He wanted to see how far advanced Petitioner's arthritis was. The "arthritis was obviously early because the X-rays were basically normal." [The X-rays, including the standing views, showed Petitioner's joint spaces to be "smooth and well maintained throughout." PX 3A.]

Dr. Kornblatt testified that, with respect to the right knee, he felt Petitioner had a "medial meniscal tear with minor pre-existing degenerative arthritis." PX 3 at 9. He agreed with Dr. Paik's surgical recommendation and with the need for post-surgical physical therapy. He found the treatment to date to be reasonable and necessary. He found a causal relationship between Petitioner's work accident and his knee condition. PX 3 at 10. He found that Petitioner was not at maximum medical improvement and could perform only a seated job. PX 3 at 11.

On March 1, 2012, Petitioner saw Dr. Pettigrew for a pre-operative evaluation. Dr. Pettigrew noted that Petitioner was scheduled to under right knee surgery on March 12th. He noted a history of diabetes dating back to 2006, controlled by diet and oral medication. He described Petitioner as having an onset of right knee pain "two months ago." He described this pain as worsening and associated with instability and popping. On right knee examination, he noted medial tenderness and mild pain with motion. He cleared Petitioner for surgery.

On March 12, 2012, Dr. Paik operated on Petitioner's right knee at Adventist Bolingbrook Hospital. He performed a right knee arthroscopy, a medial and lateral meniscectomy, a chondroplasty of all three compartments and a synovectomy of the suprapatellar pouch. In his operative report, he described Petitioner as having "right knee pain of the medial joint after an injury at work." He described the anterior cruciate ligament as intact. He noted a "significant posterior medial meniscus horn tear" and a tear in the "very posterior medial corner" of the lateral meniscus. He described the chondromalacia as "significant." He noted a "significant amount of synovitis and murky fluid within the joint space." RX 2.

Petitioner saw Dr. Paik post-operatively on March 15, 2012. Petitioner complained of sharp pain in the back of his right knee. Dr. Paik prescribed Vicodin for pain and instructed Petitioner to start physical therapy and return to him in two weeks for suture removal. PX 1.

On March 29, 2012, Petitioner began a course of therapy at ATI. The therapy evaluation note of March 29, 2012 sets forth a consistent account of the work accident, with the therapist indicating Petitioner was on a ladder when his "left leg slipped out and right leg stayed on rung, twisting." PX 4.

On March 29, 2012, Petitioner returned to Dr. Paik and complained of occasional right knee pain, rated 6/10. The doctor noted he was "full weight bearing" and performing home exercises. He removed the sutures and noted an acceptable range of right knee motion. He instructed Petitioner to continue therapy and return to him in two weeks. PX 1.

At the next visit, on April 19, 2012, Petitioner again complained of 6/10 right knee pain. Dr. Paik administered a steroid injection, prescribed Tramadol for pain and instructed Petitioner to continue therapy and return to him in two weeks. PX 1.

On May 17, 2012, Petitioner returned to Dr. Paik and reported that the injection helped but that he was still experiencing anterior knee pain when descending stairs. The doctor noted a good range of motion on right knee examination. He instructed Petitioner to continue therapy for one more week and then begin work conditioning. He instructed Petitioner to return to him in two weeks. PX 1.

Petitioner began a course of work conditioning at ATI on May 21, 2012. In a progress note dated May 25, 2012, therapist Alex Kichakov, ATC [hereafter "Kichakov"] indicated Petitioner was functioning at what appeared to be light to medium physical demand level. Kichakov also indicated Petitioner had reported increased right knee soreness that week "due to the increased intensity of his workouts." On June 5, 2012, Kichakov noted that Petitioner was complaining of right knee soreness and swelling, which was being addressed with ice and electrical stimulation. PX 4.

On June 6, 2012, Petitioner returned to Dr. Paik and complained of "lots of pain and swelling since he started work conditioning." Dr. Paik noted that Petitioner was limping. He also noted that Petitioner had "backed off" the work conditioning a little due to his pain. He described the right knee range of motion as good. He prescribed Diclofenac and instructed Petitioner to continue the work conditioning. PX 1.

On June 12, 2012, Kichakov reported that Petitioner was continuing to complain of "constant increased pain in his R knee while participating in" work conditioning. Kichakov indicated he had attempted to address this by modifying activities, eliminating stepping and squatting, and applying ice and electrical stimulation following the workouts. On June 22, 2012, Kichakov reported that Petitioner described his right knee pain as "progressively worsening" despite the use of ice and electrical stimulation. PX 4.

Documents in PX 4 reflect that, on June 25, 2012, Kenneth Garst of Respondent sent Berkley Net Insurance a lengthy letter outlining Petitioner's elevator mechanic job duties. In the letter, Garst indicated that Petitioner "is required to lift many heavy and awkward items," with those items varying in weight from fifty to several hundred pounds. Garst also indicated that "the average toolbox" of an elevator repairman such as Petitioner weighs over fifty pounds and that Petitioner may have to carry items up stairs or ladders. Garst stated that Petitioner may also have to push loaded carts weighing several hundred pounds and push/pull heavy elevator components. Respondent raised no objection to PX 4 at the hearing.

On June 26, 2012, Kichakov reported that Petitioner rated his right knee pain at 9/10 and was continuing to have difficulty with squatting and using stairs. Kichakov noted that, "per his employer's job description, [Petitioner] is required to constantly lift/carry over 50 pounds." Kichakov indicated that, based on the employer's description, Petitioner's job fell in the "very heavy" physical demand level. PX 4.

When Petitioner next saw Dr. Paik, on June 27, 2012, he indicated his right knee felt the same as it had just before the surgery. He reported that, a week or two into work conditioning, he had a "substitute therapist who pushed too hard and had an event of increased pain with knee." He expressed frustration with his lack of progress. He requested an MRI. Dr. Paik noted that the work conditioning notes documented "significant pain" and difficulty walking. He placed work conditioning on hold and ordered an MRI. He instructed Petitioner to return to him following the MRI. PX 1.

Petitioner underwent the repeat right knee MRI on July 2, 2012. The radiologist who interpreted the MRI compared the scan with the earlier MRI performed on December 28, 2011. He noted a small joint effusion, "increased from the prior exam," slight progression of moderate degenerative changes involving the medial and patellofemoral joint compartments, "slight progression of a medial meniscal tear," with no other evidence of meniscal or ligament tearing, and a small 5 mm stable ganglion cyst posterior to the posterior cruciate ligament. PX 2.

On July 6, 2012, Petitioner returned to Dr. Paik and indicated he was "still having a lot of pain." Dr. Paik reviewed the recent MRI with Petitioner. In his note, Dr. Paik indicated the MRI shows a "possible new medial meniscus tear but more likely post-op changes." He also indicated that Petitioner's pain may be due to a bone bruise, "which may be very slow to resolve." He prescribed Diclofenac and recommended a consultation with his associate, Dr. Lee. PX 1.

Petitioner saw Dr. Lee on July 20, 2012. At the hearing, Petitioner denied having seen Dr. Lee at any point prior to that date. Dr. Lee noted a possible re-injury during work conditioning, with worsening right knee pain. On right knee examination, he noted medial joint tenderness and tenderness in the quadriceps tendon. He described lateral McMurray's testing as negative and medial McMurray's testing as "guarded." He described the right knee range of motion as normal. He noted no swelling. He described the recent MRI as "inconclusive due to surgical changes." He recommended that Petitioner stay off work and undergo a diagnostic arthroscopy. PX 1.

At Respondent's request, Dr. Kornblatt re-examined Petitioner on September 27, 2012. At his deposition, Dr. Kornblatt testified that, at the re-examination, Petitioner told him he felt significantly better after the March 2012 surgery until his knee flared during work conditioning. Dr. Kornblatt also testified that Petitioner reported he had remained off work since no light duty was available. Petitioner again denied any previous problem with either knee "except for some aching." PX 3 at 12.

Dr. Kornblatt testified he is familiar with the activities that go on during work conditioning. Based on this familiarity and Petitioner's history, Petitioner's knee could have flared up during work conditioning. When he re-examined Petitioner's right knee, he noted no local swelling or joint line tenderness, negative McMurray's, stability to stress testing and "soft patellofemoral crepitus," meaning that, as he bent Petitioner's knee up and down, he "could feel like a rubbing feeling around the kneecap." PX 3 at 14.

Dr. Kornblatt testified he interpreted the repeat right knee MRI as showing "post-surgical changes of the meniscus with a small joint effusion and slight progression of the degenerative changes." He obtained repeat right knee X-rays to determine whether there was any progressive narrowing. He testified these X-rays showed "just minor progression of the medial and patellofemoral compartment." The "joint space was still well-maintained." PX 3 at 14-15.

Dr. Kornblatt testified that, in his re-examination report, he opined that Petitioner experienced an exacerbation of his arthritis during work conditioning. He described Petitioner's prognosis as guarded due to his morbid obesity. He again found causation based on what he had been told, i.e., that Petitioner was asymptomatic before the work accident. He characterized the treatment to date as reasonable and necessary. He found Petitioner "capable of carrying out a job which involved no squatting, kneeling or climbing." He indicated it was too early to say whether those restrictions would be temporary or permanent. He opined that Petitioner was at maximum medical improvement, assuming he underwent no additional treatment. Because Petitioner's right knee had calmed down with rest, he suggested that therapy be reinstituted "in an attempt to obtain rehabilitation to the point where [Petitioner] was capable of carrying out his previous job activities." He indicated that a functional capacity evaluation would be needed once Petitioner reached a plateau in this therapy. PX 3 at 18.

Petitioner returned to Dr. Paik on October 16, 2012, with the doctor noting that Dr. Lee recommended a "diagnostic knee scope" while the "IME rec[ommended] PT." Dr. Paik indicated he "would still recommend a diagnostic knee scope per Dr. Lee." He went on to state that the scope would be definitive, unlike the MRI, "and possibly therapeutic." PX 1.

In a subsequent note, dated November 27, 2012, Dr. Paik indicated that "PT was restarted," with Petitioner reporting some plateauing and difficulty with strengthening due to pain. [No additional therapy records are in evidence.] Dr. Paik also indicated that Petitioner wanted to discontinue therapy and that he planned to pursue an MR arthrogram per Dr. Lee's recommendation.

On January 17, 2013 Petitioner returned to Midwest Bone & Joint Institute and saw Dr. Lee. Petitioner complained of constant right knee pain aggravated by activity. The doctor noted that Petitioner underwent nine weeks of therapy and "pain has become worse." He also noted that the carrier declined to authorize the MR arthrogram.

Dr. Lee indicated that Petitioner "may have reinjured his knee during WC." He again recommended an MR arthrogram. He released Petitioner to light duty until further notice. PX 1.

At Respondent's request, Dr. Kornblatt examined Petitioner a third time on February 7, 2013. At his deposition, Dr. Kornblatt testified that, on February 7, 2013, Petitioner was limping and unable to squat. PX 3 at 19. On right knee re-examination, the doctor noted a new finding, i.e., a moderate effusion. He also noted equivocal meniscal signs, stability to stress testing and soft patellofemoral crepitus. PX 3 at 19. He noted no abnormalities on left knee examination. PX 3 at 19. The effusion was an indication that "the lining of the [right] knee was making more fluid than the knee was absorbing."

Dr. Kornblatt testified he diagnosed "post-traumatic synovitis of the right knee status post arthroscopic meniscectomy" on February 7, 2013. He viewed the prognosis as guarded, given the recurrent synovitis and Petitioner's morbid obesity. PX 3 at 20. He found Petitioner "capable only of working at a sitting job." PX 3 at 21. He viewed Petitioner's symptoms as worsening and agreed with the treating physician's recommendation of an MR arthrogram. PX 3 at 21.

Dr. Kornblatt testified he is familiar with the duties of an elevator repairman "to a certain degree." Based on Petitioner's presentation on February 7, 2013, he felt Petitioner was not capable of resuming his elevator repairman trade. PX 3 at 22. He has not seen Petitioner since February 7, 2013.

Dr. Kornblatt testified he performs about five examinations per week, all of which are for insurance carriers. PX 3 at 23.

Under cross-examination, Dr. Kornblatt testified it was his understanding that Petitioner had some right knee "aching" before the work accident and had undergone an X-ray. PX 3 at 24. He did not recall previously reviewing Dr. Paik's first note, which showed an onset of right knee pain eight months earlier. PX 3 at 25. He opined that Petitioner most likely had chondromalacia in his right knee before the accident. That condition could have been aggravated by Petitioner's weight. PX 3 at 29. It is his understanding that Petitioner's right knee flared up during post-operative work conditioning. PX 3 at 29. As of February 7, 2013, Petitioner was taking pain medication but not otherwise undergoing active care. PX 3 at 29-30. The post-operative MRI showed that Petitioner's chondromalacia had progressed but "you can't stop arthritis." The "main reason" for the surgery was the meniscal tear, not the chondromalacia. Dr. Paik tried to take care of the chondromalacia during the surgery because that is what orthopedic surgeons are supposed to do. PX 3 at 31.

Dr. Kornblatt testified Petitioner "seemed to be a very nice man" and "was very frustrated" about not being under active care. He cannot say that Petitioner's degenerative condition was such that any activity of daily life could have aggravated that condition. PX 3 at 32. It was his impression, based on his examination findings of February 7, 2013, that Petitioner "just couldn't

tolerate" the attempted work hardening. There is no way for him to know whether that inability to tolerate stemmed from the meniscal condition or the degenerative condition. PX 3 at 35. It is possible Petitioner had a recurrent meniscal tear. It is also possible, due to Petitioner's size, that the injury started Petitioner on a downward cycle that might lead to the need for knee replacement surgery. PX 3 at 36. He did not feel Petitioner needed surgery as of his second examination but his opinion "obviously changed the third time." PX 3 at 36. The synovitis he noted in February 2013 is due to the work accident. PX 3 at 38. It is anticipated that a patient will reach MMI three to four months after an arthroscopy but "not everybody gets well." PX 3 at 38-39. A recurrent tear is not always symptomatic. Dr. Paik recommended the MR arthrogram to check for a recurrent tear. PX 3 at 39.

On redirect, Dr. Kornblatt testified that, other than the MRI disc provided by Petitioner, all the records he reviewed are records he received from the carrier or GENEX. At no time did he review any records pre-dating the work accident. Chondromalacia can be aggravated by the kind of accident Petitioner sustained. PX 3 at 41.

Petitioner underwent the recommended MR arthrogram on February 15, 2013. The radiologist who interpreted this study noted the following: 1) a medial meniscal tear, especially along the tip of the posterior horn; 2) advanced osteoarthritic changes, especially in the medial compartment; 3) moderate chondromalacia of the patella; and 4) a Baker's cyst with debris and edema surrounding the cyst. Karlsson Dep Exh 4.

On March 14, 2011, Dr. Lee reviewed the MR arthrogram and noted the meniscal tear. He gave Petitioner the option of "activity modification versus" another arthroscopy. He indicated he told Petitioner that an arthroscopy would not relieve his pain due to his degenerative arthritis. He noted that Petitioner "agreed to non-surgical treatment." He recommended a functional capacity evaluation and directed Petitioner to return to him after the evaluation. PX 1.

At Respondent's request, Petitioner saw a second Section 12 examiner, Dr. Karlsson, on April 22, 2013. Petitioner testified that Respondent scheduled this examination just before he was to undergo a functional capacity evaluation.

Dr. Karlsson's report of April 24, 2013 (Karlsson Dep Exh 6) sets forth a consistent history of the December 20, 2011 work accident, with the doctor indicating Petitioner was about six feet above ground level when he fell off the ladder. The report also reflects that Petitioner derived benefit from the March 12, 2012 surgery but "twisted the right knee again" in late April 2012, while pulling a loaded sled during work hardening.

With respect to Petitioner's past medical history, Dr. Karlsson noted that Petitioner acknowledged having undergone a right knee X-ray per Dr. Pettigrew "about a week before" the work accident. Dr. Karlsson also noted that Petitioner reported having had "some discomfort in the back of the [right] knee for a couple of years."

Dr. Karlsson noted that Petitioner complained of constant right knee pain, aggravated by walking, driving or using stairs. The pain was "primarily at the medial aspect of the knee."

On bilateral knee examination, Dr. Karlsson noted no abnormalities other than 1+ medial joint line tenderness and trace lateral joint line tenderness in the right knee.

Dr. Karlsson indicated he reviewed the films and reports concerning the MRIs and MR arthrogram. Dr. Karlsson also indicated he reviewed records from Drs. Lee and Paik, therapy and work hardening records from ATI and Dr. Paik's operative report.

Dr. Karlsson diagnosed Petitioner's current problems as "degenerative osteoarthritis of the knee and morbid obesity." He noted that Petitioner "previously also had the diagnosis of medial and lateral meniscal tears."

Dr. Karlsson found the changes seen on the July 2, 2012 and February 15, 2013 MRI as "consistent with the prior meniscectomy and not a new meniscal tear." He indicated that the "radiologist who read of [sic] a new meniscal tear [in the February 15, 2013 MRI report] did not have the history of a prior meniscectomy."

Dr. Karlsson described Petitioner's ongoing condition as "completely unrelated to the accident of December 20, 2011." He attributed the need for further treatment solely to the "natural progression" of Petitioner's tri-compartmental osteoarthritis, which was documented on the first MRI.

Based on a work hardening report dated July 2, 2012, Dr. Karlsson found Petitioner capable of returning to work, with the "only limitation [being] for his subjective complaints of pain relative to his pre-existing osteoarthritis compounded by his weight." He indicated that, at the very least, Petitioner could be performing a medium heavy job, lifting 90 pounds.

Dr. Karlsson opined that Petitioner reached maximum medical improvement in July 2012.

Near the end of his report, Dr. Karlsson indicated he had received a cover letter that "referred to some prior records from Dr. Pettigrew regarding left knee medial meniscal tear." [emphasis added]. Dr. Karlsson indicated that "if there was documentation of significant ongoing problems with his knee and suspicion of a meniscal tear combined with any questions about the actual occurrence of December 20, 2011," his opinions concerning causation "would be changed."

In a separate report, also dated April 24, 2013 (Karlsson Dep Exh 7), Dr. Karlsson provided a rating of "10% lower extremity impairment," which converted to a 4% whole person impairment based on Table 16-10 of the AMA Guides, Sixth Edition.

Petitioner underwent a functional capacity evaluation at ATI on May 1, 2013. The evaluator, David McInnis, ATC, LAT, rated the evaluation as valid.

McInnis found that Petitioner demonstrated capabilities most consistent with the very heavy physical demand level, meaning that Petitioner was able to occasionally lift 107.8 pounds chair to floor, desk to chair and above shoulder. He noted, however, that Petitioner "reported increased right knee pain with stairs, prolonged standing, functional squatting and lifting activities" during the evaluation.

McInnis noted that he was not provided with a specific job description. He relied on the Dictionary of Occupational Titles in rating Petitioner's elevator mechanic job as a heavy physical demand level position requiring occasional lifting up to 100 pounds. He went on to comment: "Based on weights lifted, [Petitioner] appears to exceed his job physical demand level. However, due to limitations with squatting, crouching, prolonged standing and climbing, he may have difficulty successfully performing his essential job tasks." In his attached "whole body assessment," he noted that Petitioner could only "minimally occasionally" (i.e., 1-5% of an 8-hour workday) bend/stoop, climb stairs, crouch, kneel and squat. During a carrying-related portion of the evaluation, McInnis noted that Petitioner was "starting to limp" when he carried 75.2 pounds. During the "tolerance component" of the evaluation, McInnis noted that Petitioner complained of burning in his right knee after standing for 28 minutes while performing assembly activities. He also noted that Petitioner reported being unable to tolerate his right knee burning at the 48-minute point. PX 5.

On May 7, 2013, Petitioner filed a petition for penalties and fees (PX 9) and Respondent filed a response to Petitioner's Section 8(a) petition. RX 4. Respondent filed a response to the penalties/fees petition on May 14, 2013.

Petitioner returned to Dr. Lee on May 9, 2013 and complained of constant right knee pain, aggravated by activity. Petitioner reported having undergone a functional capacity evaluation.

Dr. Lee described Petitioner's gait as antalgic. On right knee examination, he noted medial joint line tenderness and positive McMurray's testing. He noted that the functional capacity evaluation showed Petitioner "has difficulty with prolonged squatting, crouching, climbing which apparently is required as an elevator constructor mechanic." He opined that Petitioner "will have difficulty performing his regular duty due to his knee symptoms." He found Petitioner to be at maximum medical improvement and released Petitioner to mainly seated work. PX 1.

Dr. Karlsson's evidence deposition took place on August 19, 2013. Dr. Karlsson testified he obtained board certification in orthopedic surgery in 1995. He is also certified in the evaluation of disability and impairment ratings. RX 1 at 5. At Respondent's request, he examined Petitioner on April 22, 2013. RX 1 at 5.

Dr. Karlsson's testimony concerning Petitioner's history and his examination findings is consistent with his report of April 24, 2013. He reviewed both the reports and the discs concerning the MRIs and MR arthrogram. RX 1 at 10, 13, 15.

Dr. Karlsson testified that Dr. Paik's operative report was significant in that he noted tearing of the medial meniscus and lateral meniscus as well as chondromalacia in all three compartments of the knee. In some areas, the chondromalacia was Grade IV, or fairly advanced. RX 1 at 11. Grade 14 means that there is "complete loss of cartilage down to bare bone." RX 1 at 12.

Dr. Karlsson opined that the chondromalacia would have pre-existed the work accident but that, based on Petitioner's history, the meniscal tears were "most likely" related to the accident. RX 1 at 19.

Dr. Karlsson opined that the post-operative findings on the July 2012 MRI and the February 2013 arthrogram were most likely related to the surgery. He could not rule out the possibility of some new meniscal tearing but there was certainly no large tear or large piece. RX 1 at 16.

Dr. Karlsson characterized Dr. Paik's initial history as different from Petitioner's in that Dr. Paik noted an onset of bilateral knee pain eight months earlier. RX 1 at 18.

Dr. Karlsson opined that Petitioner's ongoing complaints are due solely to his rather advanced degenerative changes. RX 1 at 19. Petitioner could have pain with activities of daily living due to his advanced degenerative changes. RX 1 at 20. Petitioner reached maximum medical improvement as of July 2012, when an MRI showed no new meniscal tears. Petitioner does not require any additional care as a result of the work accident. RX 1 at 21.

Under cross-examination, Dr. Karlsson testified he conducts between zero and five Section 12 examinations per week. In general, he conducts these examinations on behalf of insurance carriers. RX 1 at 24. He typically charges $1,200 for an examination. He charged either $300 or $600 for the impairment rating. RX 1 at 24-25. He probably spent about twenty minutes with Petitioner. RX 1 at 25. He did not question Petitioner as to why his history was different than Dr. Paik's. He was not given any records pre-dating the work accident. RX 1 at 26. He does not know whether Petitioner was working full-time as of the work accident. RX 1 at 26. He did not see the right knee X-ray that Petitioner underwent before the work accident. RX 1 at 27. It is his understanding that Petitioner, as an elevator mechanic, would have to work with large tools in tight spaces repairing pulleys, motors, etc. Squatting, bending and climbing would be regular work activities for Petitioner. RX 1 at 27. He did not receive a formal job description. RX 1 at 29. He does not know how much Petitioner weighed before the work accident but it is likely Petitioner was obese. RX 1 at 28. He did not review any of Dr. Kornblatt's reports. RX 1 at 30-31.

Dr. Karlsson acknowledged that trauma to the knee can cause osteoarthritis to worsen. Chondromalacia can also be aggravated by trauma. A surgical removal of a large piece of meniscus can aggravate arthritis over a long period. The radiologist who read the February 15, 2013 arthrogram documented a medial meniscus tear. It is "certainly possible" Petitioner re-tore his meniscus but he is not sure whether the radiologist had Petitioner's entire history. RX 1 at 33, 46. He did not discuss Petitioner's case with the radiologist. RX 1 at 34-35. When he examined Petitioner, he noted a negative McMurray's but it would not surprise him if Dr. Paik noted a positive McMurray's in May 2012. McMurray's test results are variable. The test is neither 100% sensitive nor 100% specific for a meniscal tear. RX 1 at 36. When he performed the impairment rating, he did not factor in the osteoarthritis. An impairment rating does not measure disability. It is independent of the person's job duties. RX 1 at 38. He is not certain that a functional capacity evaluation was needed but there is no down side to having such an evaluation. RX 1 at 39. He has no strong objections to the findings of the evaluator. RX 1 at 41. It is "certainly possible" and "more likely than not" that Petitioner will require additional treatment for his osteoarthritic condition. RX 1 at 41. Such treatment could include bracing, ice, medications, injections, therapy and possibly knee replacement. RX 1 at 41. The work hardening could have temporarily aggravated Petitioner's right knee condition. RX 1 at 42. He is not sure whether Petitioner will ever be symptom-free. RX 1 at 42. He is aware Petitioner was performing his regular duties as of the accident. RX 1 at 43. If Petitioner in fact sustained a new tear, he does not believe more surgery would be helpful. RX 1 at 48. The Baker's cyst documented on the arthrogram "could be due to the meniscal tears."

On redirect, Dr. Karlsson testified the limitations documented by the functional capacity evaluator are related to Petitioner's degenerative osteoarthritis, not the work accident. RX 1 at 50. A positive McMurray's does not necessarily mean the patient has a meniscal tear. RX 1 at 52.

Petitioner testified he received temporary total disability benefits up until Dr. Karlsson's examination. No doctor released him to full duty before this examination. When he last saw Dr. Lee, on May 19, 2013, the doctor released him to mostly seated duty. He is limping due to right knee pain. The pain affects his hips. He is not taking any prescription medication for pain. To his knowledge, bills from Dr. Paik and ATI remain unpaid. PX 6-7. He weighs 342 pounds now. He weighed the same amount before the accident.

Petitioner testified he attended high school but did not graduate. He worked at a gas station during high school, before he became an elevator repairman. He has never worked in an office. He does not know how to operate a computer.

Under cross-examination, Petitioner testified that, per Respondent's rules, he could carry up to 100 pounds on his own but was supposed to get assistance with lifting an object that weighed over 100 pounds. The left knee MRI he underwent in May 2010 showed a meniscus problem but surgery was not recommended. He was honest with his treating physicians. He understands the importance of providing an accurate history to a doctor. He underwent right knee X-rays on December 17, 2011, at Dr. Pettigrew's recommendation. He

has no recollection of being told he had a right meniscal tear before the work accident. He was experiencing intermittent right knee pain as of December 17, 2011. The pain increased with stair usage. He has stairs at home and was using those stairs as of December 17, 2011. He was honest with Drs. Kornblatt and Karlsson. After the functional capacity evaluation, he did not report to Respondent or communicate with anyone from Respondent. He has no upcoming appointments with Dr. Paik or Dr. Lee. In his trade, apprenticeships last six months. In the last four to five years, he has trained eleven to twelve apprentices, all of whom went on to be journeymen.

On redirect, Petitioner testified he did not have the opportunity to review the histories taken by the physicians he saw. Dr. Pettigrew did not use the term "meniscal tear" in December 2011. Before the work accident, the pain he was experiencing in his right knee was behind the knee. After the accident, he felt pain in the left side and top of his right knee. He has about eight stairs at home. When he was working, he climbed stairs more frequently at work than at home. When he trained apprentices, the trainees mostly ran errands and watched him perform various tasks. He had to build elevators when he was training apprentices. It was only when some big repair job came in that apprentices were actually given the chance to work on elevators.

Daniel Baumann testified on behalf of Petitioner, pursuant to subpoena. Baumann testified he has been the business manager of Petitioner's local since September 2012. Prior to that, he was a member of Petitioner's union for almost thirty years. He is familiar with Petitioner. Petitioner is a mechanic. The union has a 4-year apprenticeship program. Before an apprentice enters the program, he has to work as a "helper" for six months. Apprentices attend classes covering subjects such as safety.

Baumann identified PX 8 as a NEIEP [National Elevator Industry Educational Program] pamphlet that describes the duties of an elevator constructor apprentice. Baumann testified that NEIEP is a trust agreement running between contractors, including Respondent, and the international. PX 8 sets forth the following required physical duties: 1) the ability to walk or stand approximately 90% of the time; 2) the ability to lift up to 100 pounds approximately 75% of the time; 3) the ability to perform repetitive stooping, forward bending and crouching approximately 70% of the time; and 4) the ability and willingness to travel up to 95% of the time.

Baumann testified that Petitioner was involved in the repair aspect of the elevator construction trade. As such, he was required to perform more bending and stooping than others in the trade. He indicated it would be difficult for Petitioner to do his job with restrictions. In his opinion, no light duty is available. There is no such thing as an elevator repair job that allows a worker to primarily sit. Of the 1,400 tradesmen he represents, 44 mechanics are out of work and 14 apprentices are out of work. Local 2 is a referral hall, not a hiring hall. A member "gets on the list" for jobs by coming in to the local office and signing a book. In accordance with ADA regulations, he does not instruct members not to sign the book but employers have the right of rejection.

Under cross-examination, Baumann testified that maintenance men in his trade have to climb into pits and walk on roofs. Construction workers in his trade have to build elevators. This involves bending. He is in regular communication with Respondent. He talked with Tom Paskey, one of Respondent's owners, a week before the hearing.

On redirect, Baumann testified that construction workers in his trade have to use stairs very frequently. They take the stairs rather than waiting for the "skip" [elevator]. He is not aware of any local member who is working with a "mostly seated work" restriction.

Respondent did not call any witnesses at the hearing.

[CONT'D]

Arbitrator's Credibility Assessment

Petitioner came across as a hard-working, honest individual. His functional capacity evaluation was valid and neither of Respondent's Section 12 physicians noted any inconsistencies on examination.

The Arbitrator acknowledges there are some inconsistencies between Petitioner's testimony concerning his pre-accident right knee complaints and the histories set forth in Dr. Paik's initial note and Dr. Karlsson's IME report. The Arbitrator found Petitioner credible overall. There is no evidence indicating that Petitioner's pre-accident complaints were disabling. Petitioner was performing his regular strenuous duties when the accident occurred.

Did Petitioner establish a causal connection as to his current right knee condition of ill-being?

The Arbitrator finds that Petitioner established a causal connection between his undisputed work accident of December 20, 2011 and his current right knee condition of ill-being. In so finding, the Arbitrator relies on the following: 1) Petitioner's testimony concerning the extent of his pre-accident right knee complaints; 2) the fact that Petitioner was performing his usual physically strenuous duties as of the accident; 3) the mechanism of injury Petitioner described, i.e., a twisting of the right knee followed by a fall from a height; 4) the various causation-related opinions voiced by Dr. Kornblatt; 5) the fact that Dr. Kornblatt did not revise any of those opinions after reviewing Dr. Paik's initial note at his deposition; 6) Dr. Karlsson's finding of causation as to the meniscal tears; 7) Petitioner's testimony that he experienced right knee pain while pulling a loaded sled during post-operative work hardening; 8) the work hardening notes from ATI; 9) the post-operative MR arthrogram, which showed a meniscal tear; and 10) Dr. Karlsson's concession that Petitioner could have re-torn his meniscus during work hardening.

Overall, the Arbitrator finds Dr. Kornblatt more persuasive than Dr. Karlsson. Dr. Kornblatt examined Petitioner on three occasions. Dr. Karlsson, in contrast, saw Petitioner once. He was not provided with Dr. Kornblatt's reports. He conceded that the work accident likely caused the meniscal tears. This is a significant concession since the tears brought about the need for surgery and post-operative rehabilitation. In Petitioner's case, given the demands of his job, rehabilitation consisted of vigorous work hardening. The credible evidence reflects that Petitioner suffered a re-tear and aggravation of his chondromalacia as a result of that work hardening. When pressed, Dr. Karlsson could not rule out the possibility of a re-tear.

Is Petitioner entitled to medical expenses?

Petitioner seeks an award of the following medical bills: 1) Midwest Bone and Joint Specialists (Dr. Lee), 2/28/13, $235.00 and 5/9/13, $235.00; and 2) ATI, 5/1/13, functional capacity evaluation, $2,679.30. PX 6-7.

Respondent objected to these bills solely on the basis of liability. Having found in Petitioner's favor on the issue of causation, the Arbitrator awards Petitioner the aforementioned medical expenses subject to the fee schedule. The Arbitrator notes that Respondent's first examiner, Dr. Kornblatt, recommended a functional capacity evaluation.

Is Petitioner entitled to temporary total disability benefits? Is Petitioner entitled to maintenance? Is Petitioner entitled to vocational rehabilitation?

At the hearing, Petitioner claimed temporary total disability benefits from December 21, 2011 through August 22, 2013 while Respondent maintained Petitioner was not entitled to any temporary total disability benefits. Arb Exh 1.

The parties changed their positions somewhat after the hearing. In his proposed decision, Petitioner seeks temporary total disability benefits from December 21, 2011 (the day after the accident) through May 9, 2013 (the date on which Dr. Lee found Petitioner to be at maximum medical improvement and released him to primarily seated work) and maintenance from May 10, 2013 through August 22, 2013. In reliance on Dr. Karlsson, Respondent maintains Petitioner is entitled to temporary total disability benefits only through July 2, 2012.

The Arbitrator has previously found that Petitioner established causation as to his current right knee condition. The Arbitrator further finds that Petitioner was temporarily totally disabled from December 22, 2011 (the date on which Dr. Paik first saw Petitioner and took Petitioner off work) through May 9, 2013, a period of 72 1/7 weeks. The Arbitrator views Petitioner's causally related right knee condition as having stabilized as of May 9, 2013. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010).

The Arbitrator also finds that Petitioner is entitled to maintenance benefits from May 10, 2013 through August 22, 2013, a period of 15 weeks. In so finding, the Arbitrator relies on Petitioner's testimony concerning the demands of his job and his current complaints, Baumann's testimony, Kenneth Garst's letter of June 25, 2012 (PX 4), the physical requirements set forth in the NEIEP job description (PX 8), the observations of the functional capacity evaluator as to Petitioner's limitations with squatting, crouching, prolonged standing and climbing (PX 5), Dr. Kornblatt's testimony (PX 3) and Dr. Lee's release to primarily seated work (PX 1). The Arbitrator views Petitioner's current right knee condition, as documented on the MR arthrogram, as wholly incompatible with the physical demands of his trade.

The Arbitrator further finds that Petitioner is entitled to a vocational assessment and rehabilitation services. In so finding, the Arbitrator relies on the long duration of Petitioner's employment in his trade, Petitioner's limited education and lack of computer skills, Petitioner's

relatively young age (50 at the time of the accident) and the wording of Rule 7110.10 of the Rules Governing Practice Before the Workers' Compensation Commission. In Ameritech Services, Inc. v. IWCC, 389 Ill.App.3d 191, 207 (1st Dist. 2009), the Appellate Court held that this rule requires the preparation of a written vocational assessment "even in circumstances where no plan or program of vocational rehabilitation is necessary or appropriate."

Is Respondent liable for penalties and fees?

Petitioner seeks an award of Section 19(l) penalties and fees, citing Respondent's decision to change Section 12 examiners, Respondent's reliance on the opinions of its second examiner in terminating benefits, the fact that the functional capacity bill remained unpaid as of the hearing and Respondent's acknowledged failure to perform a vocational rehabilitation assessment.

The Arbitrator has considered both the factors cited by Petitioner and the inconsistencies addressed above (see the foregoing credibility assessment). In the Arbitrator's view, Respondent's conduct has to be viewed in the context of all of the existing circumstances. On this record, the Arbitrator declines to award penalties and fees.

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

Don Smith,

Petitioner,

14IWCC0736

vs.

NO: 11 WC 18885

Orput Commpanies,

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 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 September 19, 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: AUG 2 9 2014
KWL/vf
O-8/18/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

14IWCC0736

SMITH, DON
Employee/Petitioner

Case# **11WC018885**

ORPUT COMPANIES
Employer/Respondent

On 9/19/2013, 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 0.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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

0560 WIEDNER & MCAULIFFE LTD
MARGARET McGARRY
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC0736

Case # 11 WC 18885

Consolidated cases: _____

Don Smith
Employee/Petitioner

v.

Orput Companies
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 **7/19/2013**. 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 _____

FINDINGS

On the date of accident, **2/21/2011**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$35,501.44**; the average weekly wage was **$682.72**.

On the date of accident, Petitioner was **59** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of **$8,192.70** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$8,192.70**.

Respondent is entitled to a credit of **$650.92** under Section 8(j) of the Act.

ORDER

Respondent shall be given a credit of $8,192.70 for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner temporary total disability benefits of $455.15/week for 18 weeks, commencing 2/22/2011 through 6/27/2011, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $650.92 under Section 8(j) of the Act.

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

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

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

Signature of Arbitrator

9/18/13
Date

ICArbDec19(b)

SEP 19 2013

14IWCC0736

FINDINGS OF FACT

On February 21, 2011, the petitioner was employed as a maintenance supervisor for the respondent. The petitioner testified that on the date of accident, he slipped on ice while moving a dumpster at work. He was able to catch himself and did not fall to the ground; however, he noticed pain in his neck and down his shoulders. The petitioner was able to complete his shift. When he returned to work on February 22, 2011 he again felt pain in his neck and into his right arm when he picked up a 50 pound bag of salt. The petitioner has a prior history of treatment for cervical degenerative disc disease and radiculopathy and has continued to treat in this regard since the February 21, 2011 injury.

Treatment Prior to February 21, 2011:

Based on the medical records entered into evidence, the petitioner first presented to Dr. Sliva on November 11, 2006, complaining of a three year history of neck pain. An examination revealed restricted cervical range of motion on flexion, extension, and lateral bending. X-rays showed degenerative disc disease, most prominent at C5-6, but also to a lesser extent at C6-7 and C3-4. An MRI from Forest City Open MRI showed degenerative disc disease, most prominent at C5-6 with a broad-based disc osteophyte complex and bilateral neuroforaminal narrowing. Dr. Sliva diagnosed the petitioner with C5-6 disc osteophyte complex and bilateral foraminal stenosis with predominant neck pain and some C6 nerve root irritation. He recommended that the petitioner undergo physical therapy followed by possible epidural steroid injections. (RX 3, p.32).

The petitioner attended physical therapy from December 8, 2006 through January 5, 2007 with very little progression. He was discharged from therapy a referred back to Dr. Sliva, who recommended cervical epidural steroid injections. (RX 3).

On January 10, 2007 the petitioner presented to Dr. James Sturm at Rockford Memorial Hospital for a pain management evaluation. The petitioner reported a four year history of significant neck pain which recently had been associated with dizziness and feeling lightheaded with certain arm movements. Dr. Sturm diagnosed the petitioner with C5-6 osteophyte complex, cervical radicular pain of a C6-type distribution, and several levels of spinal spondylosis. He administered a C6-7 epidural steroid injection under fluoroscopic guidance. (RX 2, p. 49-51).

The petitioner returned to Dr. Sturm for a second injection on January 24, 2007. He reported no significant change in his symptoms following the first injection. The petitioner's complaints included left and right arm pain with tingling in the right thumb. Dr. Sturm performed a C6-C7 epidural steroid injection. (RX 2, p.64). Immediately after the injection was performed, the petitioner reported pain in his neck as well as in his left and right armpits. (RX 2, p.68).

On February 14, 2007, Dr. Sturm performed a C6 selective nerve block. Following the nerve block, the petitioner returned to Dr. Sturm on February 28, 2007 with persistent complaints of pain. The petitioner noted pain in both his left and right upper extremities as well as numbness in both the left and right thumbs. In addition, the petitioner reported shooting pain into his neck, bilateral arms, and bilateral armpit areas with flexion of the neck. Dr. Sturm noted decreased

reflexes in both upper extremities and a possible L'hermitte's sign. Because the injections failed to provide relief, Dr. Sturm referred the petitioner back to Dr. Sliva. (RX 2, p.84).

The petitioner returned to Dr. Sliva on March 21, 2007. Upon examination, Dr. Sliva noted unrestricted range of motion, mildly positive Spurling's test with reproduction of shoulder and neck pain, and diminished biceps and triceps on the left. The petitioner was diagnosed with C5-6 disc osteophyte complex with foraminal stenosis Dr. Sliva recommended an EMG to evaluate for evidence of active radiculopathy.

On April 16, 2007 Mr. Smith underwent an EMG and nerve conduction study of the left upper extremity with Dr. Marie Walker. The nerve conduction study showed low amplitude left median sensory response, but the NCV/EMG was otherwise normal. With these results, Dr. Sliva recommended a RS muscle stimulator to address cervicalgia with radicular features.

The petitioner received the RS muscle stimulator in May 2007. After using the devise, he called Dr. Sliva's office reporting no improvement. Accordingly, the petitioner requested further treatment, or in the alternative, asked to be referred to another physician. (RX 3, p.6).

On June 11, 2007, the petitioner returned to Dr. Sturm. (RX 2). He described a worsening of pain with left shoulder abduction, left side bending of the neck, cervical extension and left cervical rotation. He also described muscle spasms of the neck. Dr. Sturm then referred the petitioner to the University of Wisconsin Madison Spine Center. In the interim, he recommended Ultram and Skelaxin. (RX 2, p.88).

The petitioner called Dr. Sliva's office on August 13, 2007 requesting an authorization off of work due to significant pain and an inability to function at work. (RX 3, p.5). The petitioner reported pain in both the left and right side of his neck with pain extending down the neck into the right arm and left elbow. (RX 2, p.5). Dr. Sliva referred the petitioner back to Dr. Sturm. On August 13, 2007, Dr. Sturm authorized the petitioner off of work, noting that he was scheduled to be evaluated at the University of Wisconsin on August 29, 2007. (RX 2, p.108).

As per the referral of Dr. Sturm, on August 29, 2007, the petitioner was evaluated by Dr. Weigert of the University of Wisconsin-Madison Spine Center. (RX 4, p.3) The petitioner presented with complaints of constant pain in his neck with stiffness and sometimes sharp, stabbing, severe pain. The pain was aggravated with certain positions, and the petitioner indicated that he could reproduce the symptoms with body movements. The petitioner described significant difficulty sleeping, riding in a car, looking up, turning his head sideways, and with overhead activity at work.

Dr. Weigert reviewed an October 26, 2006 cervical MRI, which she found to be consistent with a disc protrusion at C5-C6 with contact of the cord and moderate bilateral neuroforaminal stenosis, as well as C4-C5 facet changes and abnormality of the neural signal intensity in the T1 vertebral body. (RX 3, p.43; RX 4, p.4). On exam, Dr. Weigert noted extremely limited cervical range of motion in a seated position with extension to less than 10 degrees with pain. The petitioner was able to laterally bend to about 20 degrees with a "pinch" particularly on the left side, also produced on rotation at about 30 degrees. There was also a

decreased shoulder range of motion bilaterally. Dr. Weigert felt that the petitioner had underlying cervical degenerative disc disease and recommended an additional cervical MRI scan and a course of physical therapy. (RX 4, p.5). In the interim, the petitioner was authorized off of work. (RX 4, p.9).

Physical therapy began and the petitioner returned to Dr. Weigert on October 29, 2007, describing continued, relatively constant neck pain. The petitioner described continued radiating pain into the left arm all the way down to the thumb with C6 radicular symptoms. On exam, sensation was normal to light touch, but the petitioner had a positive Spurling's sign. Dr. Weigert recommended continued physical therapy and an MRI scan as well as a surgical consultation. (RX 4, p.6).

The cervical MRI scan was performed on November 8, 2007 and on November 20, 2007 the petitioner was evaluated by Dr. Thomas Zdeblick, an orthopedic surgeon at the University of Wisconsin-Madison Spine Center. (RX 4). The petitioner reported that he injured his neck approximately one year ago when he was moving a heavy item at work. The initial patient questionnaire indicates that the petitioner noted pain in both the left and right armpit areas as well as in the neck. (RX 4, p.13). The petitioner advised Dr. Zdeblick that he was no longer working due to the severity of his complaints. (RX 4, p.8)

On exam, Dr. Zdeblick noted tenderness of the paraspinal muscles on both the left and right side with diminished fine touch sensation in the C6 nerve distribution. X-rays of the cervical spine were taken which showed significant loss of disc height at C5-C6 with degenerative osteophyte formation. Dr. Zdeblick reviewed the November 8, 2007 MRI scan noting degenerative changes at C5-C6, C6-C7, and C3-C4. Dr. Zdeblick diagnosed C5-C6 degenerative disc disease and foraminal stenosis. The doctor recommended surgical decompression of the C5-C6 foramen with an anterior cervical discectomy and arthroplasty. Because the treatment was noted to be related to a work injury, the petitioner was advised that he would need to go through the proper procedures for surgical clearance. (RX 4, p.8).

The records indicate that the petitioner was scheduled for cervical spine surgery on January 10, 2008 with Dr. Zdeblick, but he had to cancel the surgery due to a denial of insurance coverage. (RX 4, p.2). On November 12, 2008, the petitioner called Dr. Zdeblick's office to advise that he was looking to have the surgery performed elsewhere due however, needed to know the kind of surgery recommended so as to obtain a price estimate for the treatment. (RX 4, p.2).

Approximately three weeks before the February 21, 2011 accident, on January 28, 2011 the petitioner presented to Dr. Jennifer Guffey of Swedish American Medical Group for complaints of dizziness. The petitioner reported "significant" neck pain and right hand numbness with loss of grip strength. The petitioner advised Dr. Guffey that he had a prior workers' compensation injury in 2007 and that he continued to experience ongoing pain symptoms which affected his ability to sleep. In addition, the petitioner reported anxiety issues and feeling as though management at work was "out to get him fired." (PX2). Dr. Guffey diagnosed hypertension, cervicalgia, and osteoarthritis. To further evaluate the petitioner's neck and right hand complaints, Dr. Guffey requested the medical records of Rockford Memorial Hospital,

where the petitioner had undergone an MRI and EMG in the past. (RX 2). In the interim, the petitioner was given Celebrex.

Treatment incurred after February 21, 2011:

On February 22, 2011, the petitioner presented to Swedish American Medical Group where, in the absence of Dr. Guffey, he was seen by Dr. Bruce Stiles. (PX 2) The corresponding report of Dr. Stiles lists the "Reason for Visit" as "Pain" and notes that the petitioner saw Dr. Guffey three weeks earlier stating "last 3 weeks neck hurts on right side and fingers in right hand become tingling." (PX 2). Dr. Stiles' record notes that the petitioner reported worsening right neck, arm, and hand pain for the "past several months." (PX 2). The petitioner reported numbness and tingling in the right hand and it is indicated that he had a known history of degenerative disc disease. It was also noted that the petitioner had severe pain at work earlier that day while pouring a 50 pound bag of salt. The Celebrex given to him by Dr. Guffey had not been helping his symptoms. (PX 2). Dr. Stiles recommended that the petitioner obtain a cervical MRI scan and authorized the petitioner off of work for two days. (PX 2).

The recommended cervical MRI scan was done on February 24, 2011 at Forest City Diagnostic Imaging. The MRI report indicates that the petitioner underwent a previous cervical MRI scan at Forest City Imaging on October 26, 2006. In regard to the February 24, 2011 cervical MRI scan, the radiologist noted "Essentially stable MR cervical spine" in comparison to the 2006 scan.

Following the MRI scan, the petitioner returned to Rockford Spine Center where he was again seen by Dr. Sliva. The petitioner reported having injured himself at work on February 21, 2011 when he slipped on ice in a parking lot. The petitioner reported neck pain radiating into his right shoulder and arm with weakness in the right hand. The petitioner also reported episodes of left –sided pain radiating into the left shoulder and forearm. (RX 3, p.13). Upon examination and review of the petitioner's February 24, 2011 cervical MRI scan, Dr. Sliva diagnosed multilevel cervical radiculopathy. Dr. Sliva suggested cervical epidural steroids; however, the petitioner advised that he had not experienced relief in the past with such treatment.

Dr. Sliva explained to the petitioner that the "natural history" of cervical radiculopathy was favorable, indicating that the petitioner would likely respond to conservative treatment. The petitioner was authorized off of work for one month and referred for physical therapy. (RX 3, p 14). The medical record indicates that after Dr. Sliva recommenced conservative treatment, the petitioner asked if surgery would be an option. Dr. Sliva than addressed a potential cervical decompression and fusion recommendations were given, the petitioner asked Dr. Sliva about potential surgery. (RX 3, p.15).

Physical therapy began at Rockford Spine Center on April 6, 2011. (PX 3). The petitioner reported neck pain and right shoulder/arm pain with tingling in the right hand depending upon the position of his neck. The petitioner also reported symptoms in the left shoulder and arm depending upon his head position. It was recommended that the petitioner undergo therapy twice per week for four weeks. (PX 3).

On May 3, 2011, the petitioner returned to Dr. Sliva. The report indicates that the petitioner had undergone one month of therapy without relief. The corresponding therapy reports are not provided in the subpoenaed records of Rockford Spine Center. (PX 3). Dr. Sliva's diagnosis remained multilevel cervical radiculopathy and neuroforaminal stenosis. It was recommended that the petitioner continue with a home exercise program and surgical v. non-surgical options were discussed. Dr. Sliva released the petitioner to return to work with 30 pound lifting restrictions and recommendations for the avoidance of overhead work and limited pushing and pulling. The petitioner was advised to return in six weeks for a re-evaluation. (PX 3).

At the request of the respondent, the petitioner was examined by Dr. Sean Salehi on May 26, 2010. The petitioner reported that he had been involved in a work accident on February 22, 2011 when he slipped while pushing a dumpster. Following that incident, the petitioner reported feeling pain in his neck and right arm. The petitioner admitted to having experienced pain in his neck in 2007 following a work accident, but denied any right arm symptoms until after the February 22, 2011 incident. (RX 1, p.13). Following a physical examination and review of the petitioner's February 24, 2011 cervical MRI scan, Dr. Salehi diagnosed cervical degenerative disc disease. (RX 1, p. 22).

In relation to the February 2011 work injury, Dr. Salehi opined that the petitioner had sustained a cervical strain, or temporary exacerbation of the pre-existing degenerative condition. Dr. Salehi testified that the radicular arm complaints were not related to the work accident as the petitioner had a history of both left and right arm radicular symptoms. In support of this opinion, Dr. Salehi pointed to the January 28, 2011 report of Dr. Guffey which notes neck pain and right arm radicular symptoms including hand numbness and loss of grip strength. In addition, Dr. Salehi cited the February 22, 2011 report of Dr. Stiles which notes that the petitioner reported several month of developing right neck, arm and hand pain. (RX 1, p. 29). The doctor testified that within three months of the work accident the petitioner's degenerative condition would have stabilized and returned to baseline. (RX 1, p.18).

Dr. Salehi agreed with the need for work restrictions; however, opined that the need for the restrictions was not related to the work accident. Rather, based on the documented existence of right upper extremity symptoms before the accident- in the January 28, 2011 office visit note of Dr. Guffey- the petitioner's pre- existing condition was symptomatic before the February 21, 2011 accident. Dr. Salehi testified that because the degenerative condition was symptomatic before the February 21, 2011 accident, any need for restrictions or further treatment would therefore not be related to the 2011 accident. (RX 1, p.19, 23, 32).

The petitioner last underwent medical treatment for the cervical spine on June 21, 2011 when he presented to Dr. Sliva on June 21, 2011. At that time, Dr. Sliva's diagnosis remained multilevel cervical radiculopathy, for which the petitioner wished to undergo surgical treatment. (RX 3, p.11). In the interim, the petitioner was released to work with 30 pound restrictions.

At the request of his attorney, the petitioner underwent an independent medical evaluation with Dr. Jeffrey Coe on March 6, 2012. (PX 4). Upon presentation, the petitioner reported having been injured at work on February 21, 2011 when he slipped on ice while pushing a dumpster. He then lifted a bag of salt and noticed an electric pain in his upper extremities,

which Dr. Coe referred to as a L'hermitte's phenomenon. (PX 4, p. 9). Dr. Coe testified that the petitioner admitted to a prior history of a cervical injury in 2007, but that the petitioner had indicated that after several cervical epidural steroid injections he had enough improvement to return to work at full duty until February 21, 2011. (PX 4, p.19). After the treatment in 2007, the petitioner experienced neck stiffness and pain. Dr. Coe testified that the petitioner reported that the symptoms following the 2011 accident were different from those experienced in 2007 as he did not have any right arm involvement in 2007. (PX 4, p.21). The petitioner advised that the right hand symptoms noted to Dr. Guffey on January 28, 2011 were in relation to right thumb arthritis. (PX 4, p.20-21).

Following a physical examination and review of the petitioner's medical records, Dr. Coe diagnosed degenerative disc disease and degenerative arthritis of the cervical spine. Dr. Coe opined that the February 21, 2011 accident aggravated the pre-existing condition causing both acute and chronic cervical pain. (PX 4, p. 27). In regard to further treatment, Dr. Coe agreed with the need for a cervical decompression and fusion. Dr. Coe testified that in his opinion, the petitioner was unable to work as the result of the February 21, 2011 accident. (PX 4, p.29). Dr. Coe also testified that his opinions were based on the March 6, 2012 examination and the petitioner's 2011 medical records; Dr. Coe had not reviewed any medical records from 2006, 2007, or 2008. He was unaware of the petitioner's prior right arm symptoms and was not aware that surgical decompression had been scheduled in 2008. (PX 4, p.31-32).

The petitioner testified that he has not undergone any treatment for his cervical spine since June 21, 2011. Dr. Sliva recommended 30 pound lifting restrictions; however, the petitioner was not working at the time of trial.

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material facts in support of the following conclusions of law:

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

The petitioner has a significant history of pre-existing neck and upper extremity pain. As per the petitioner's testimony, he initially sustained an injury to his cervical spine in 2006. After that injury, the petitioner treated consistently through 2008, when cervical decompression surgery was recommended. At the time of trial, however, the petitioner testified that before 2011 he treated only for neck "stiffness" and occasional tingle in the fingers, stating that the symptoms in 2007 "didn't bother me too much." (TX 12). The petitioner also testified that he did not lose any time from work after the 2006 injury. (TX 12). The records in evidence do not support the petitioner's testimony.

The medical records of Rockford Spine Center, Rockford Memorial Hospital and Dr. Strum, and the University of Wisconsin directly contradict the petitioner's testimony. The petitioner testified at the time of trial that he did not experience shooting pain or pain in his armpits prior to the 2011 accident. (TX 14-15, 20). The records, however, indicate that as early as January 2007, the petitioner complained of symptoms involving shooting pain in the right upper extremity and armpit area. On February 28, 2007, the petitioner advised Dr. Strum that following cervical injections, his symptoms had worsened and that he had developed pain and bilateral numbness in his arms and bilateral armpit areas. (RX 2, p.84). The February 28, 2007 report of Dr. Sturm indicates that the petitioner reported significant shooting pain when flexing his neck, which radiated into the upper extremities bilaterally. (RX 2, p. 84). At that point in 2007, Dr. Strum noted a L'hermitte's sign, just as Dr. Coe noted when evaluating the petitioner in 2012. (RX 2, p. 84).

These symptoms worsened and in August 2007, the petitioner advised Dr. Sliva that the pain in his right upper extremity and neck were so great that he could not function at work. (RX 3, p.5). While the petitioner testified that he did not miss any time from work after the 2006 injury, the records indicate Dr. Strum authorized the petitioner off of work completely beginning in August 2007. (RX 2, p. 108). These restrictions were confirmed by Dr. Weigert following the August 29, 2007 evaluation, and again by Dr. Zdeblick following his November 20, 2007 evaluation. (RX 4). The records do not indicate that the petitioner was released to return to work in any capacity by any of the treating physician at any point after the November 20, 2007 evaluation.

The petitioner testified that his symptoms prior to the February 21, 2011 accident differed from those he experienced after February 21, 2011. At the time of trial, the petitioner reported that following the February 21, 2011 accident, he developed difficulty sleeping and driving which had not occurred in the past. (TX 14-15). This testimony is also contradicted by the medical records. The petitioner reported issues with sleeping and driving due to neck and upper extremity pain throughout 2007. In August 2007 he advised Dr. Strum that he could not sleep and that he count not drive due to significant pain. (RX 2, p.97). On August 29, 2007, the

petitioner advised Dr. Weigert that he was only able to sleep for approximately two hours at a time because of pain and that he had difficulty looking up and riding in a car. (RX 4, p.3).

Presumably the issues with sleep continued as on January 28, 2011, three weeks before the February 21, 2011 accident, the petitioner reported difficulty sleeping due to pain in his neck when seeing Dr. Guffey. (PX 2). The petitioner testified that the right upper extremity complaints noted in Dr. Guffey's January 28, 2011 report were related to issues with his thumb which he thought may have been related to a prior surgery he had on his right hand; however, all prior medical records indicate that the petitioner had prior surgery on the left hand- not the right. (TX 24).

The petitioner then testified that the mention of right hand symptoms on January 28, 2011 was in relation to "calcium deposits" in the right thumb. (TX 30). The records of Dr. Guffey do not indicate any such diagnoses involving calcium deposits in the right thumb. (PX 2). The petitioner also testified that he told Dr. Guffey on January 28, 2011 that his neck was "stiff." (TX 22). This testimony is contradicted by the records, which indicate that the petitioner was having "significant problems" with his neck and complained of right hand numbness and loss of grip strength. Dr. Guffey found the petitioner's pain and neurologic complaints significant enough to warrant a request for the medical from Rockford Memorial Hospital so as to review the prior cervical MRI scans.

The petitioner's testimony is further contradicted by the February 22, 2011 report of Dr. Stiles. While Dr. Stiles' report does note that the petitioner experienced pain while lifting a bag of salt at work, the record states that the petitioner had worsening symptoms of right neck, arm, and hand pain "over the past several months." The record notes that the petitioner had been seen three weeks before for complaints of right neck, right arm, and right hand pain with tingling in the right hand. (PX 2).

At the time of trial, the petitioner testified that his symptoms were "moderate." (TX 14). The petitioner has not undergone medical treatment for his neck since June 21, 2011. The petitioner testified that he did not experience "shooting" pain constantly, but could reproduce the symptoms with certain movements. (TX 15). Specifically, the petitioner testified "if I lean over and put my shoulders up and then look up with my head, then I'll get the symptoms. Certain twisting movements with my arms up, my shoulder blades seem when they go up seem to want to – if I tilt and look up a certain way, I can find the spot." (TX 15). The petitioner reported the same movements- including looking up, leaning forward, and arm abduction or overhead placement- reproduced his symptoms beginning in physical therapy in 2006 and throughout treatment in 2007. The petitioner testified that it is only with these deliberate body movements that he feels shooting pain. (TX 15).

The Arbitrator finds as a matter of fact and conclusion of law that the petitioner's current condition of ill-being is not related to the work accident. Rather, the current condition is the result of the petitioner's pre-existing underlying degenerative condition. The petitioner's symptoms at the time of trial were indistinguishable from those noted throughout the 2007 treatment records. Three weeks before the February 21, 2011 accident, the petitioner reported significant neck and right upper extremity symptoms. As such, the Arbitrator finds that the

petitioner sustained a temporary aggravation of a pre-existing cervical degenerative condition on February 21, 2011. The petitioner's condition has since returned to its baseline. This is supported by the symptoms noted at the time of the January 28, 2011 evaluation with Dr. Guffey which mirror the current symptoms noted in the petitioner's testimony.

Based on the foregoing, the Arbitrator finds that petitioner's current condition of ill-being is not causally related to the injury of February 21, 2011.

L. What amount of compensation is due for temporary total disability?

The Arbitrator finds that the petitioner sustained a temporary aggravation of a pre-existing degenerative condition. As per the opinion of Dr. Salehi, the petitioner reached maximum medical improvement with regard to the work injury within three months of the February 21, 2011 accident.

Following the February 21, 2011 accident, the petitioner was released to work with restrictions by Dr. Sliva in May of 2011. Dr. Salehi opined that he would have recommended work restrictions for the petitioner before the February 21, 2011 work accident even occurred. Dr. Salehi testified that based on the MRI findings, in conjunction with the fact that the petitioner's condition was symptomatic in January 28, 2011- before the work accident- the need for restrictions is related to the pre-existing condition.

The opinion of Dr. Salehi is further supported by the 2007 medical treatment records. As per the pre-injury records, the petitioner was taken off of work due to this cervical condition in August 2007. On November 2007 cervical decompression surgery was recommended and in the interim, the petitioner was authorized to remain off of work. The petitioner was not released to return to work in a full duty capacity by any of the treating physicians after November 2007.

The Arbitrator finds that the petitioner reached maximum medical improvement in regard to the work accident when he was released to work with restrictions by Dr. Sliva in May of 2011. The petitioner's condition had returned to its pre-injury state as of that time. As per Dr. Salehi's testimony, these restrictions were needed before the February 21, 2011 accident due to the petitioner's pre-existing condition. Based on the medical records in conjunction with the petitioner's testimony at trial the petitioner is currently able to function in the same capacity in which he was capable of functioning, and working, before the accident. As such, the work restrictions in place at the time of trial are not related to the work accident and Arbitrator denies temporary total disability benefits incurred after the date of Dr. Salahi's independent medical examination of the petitioner.

Based on the foregoing, the Arbitrator finds petitioner entitled to temporary total disability from February 22, 2011 through June 27, 2011. TTD benefits subsequent to June 27, 2011 are denied. Respondent shall have a credit for all TTD benefits previously paid.

K: Is the petitioner entitled to prospective medical care?

With regard to the recommendations for further treating including cervical surgery, the

Arbitrator finds the opinion of Dr. Sean Salehi more persuasive that that of Dr. Jeffery Coe. The petitioner was a surgical candidate before the February 21, 2011 accident. His symptoms at that time of trial are indistinguishable from those contained in the 2007 records, at which point surgical decompression was recommended. Thus, because the current symptoms pre-date the work accident, the need for any further treatment relates to the pre-existing condition.

Dr. Coe's opinion causally connecting the need for surgery and the February 21, 2011 accident is based on incomplete medical records and inaccurate information. Dr. Coe testified that his opinion regarding the causal connection between the need for surgery and the work accident was based on his understanding that cervical surgical treatment had never been recommended prior to the February 21, 2011 accident. (PX4, p.29).

Dr. Coe testified that was unaware that the petitioner had any right arm symptoms prior to February 21, 2011 and that he was unaware that the petitioner had been authorized off of work in 2007 due to the cervical condition. The petitioner told Dr. Coe that his symptoms had improved in 2007 following epidural steroid injections. The petitioner also advised Dr. Coe that the right hand complaints noted in Dr. Guffey's January 28, 2011 report were in relation to arthritic pain at the base of the petitioner's right thumb joint. (PX 4, p.19-20). Dr. Coe testified that he did not see any other mention of the neck in Dr. Guffey's records and did not believe that Dr. Guffey had recommended any further treatment for the neck after January 28, 2011.

Dr. Coe's opinions and testimony are not supported by the medical evidence. The January 28, 2011 report of Dr. Guffey contains no mention of right thumb joint arthritis. Further, Dr. Guffey requested the petitioner's prior medical records from Rockford Memorial Hospital to further evaluate the neck/ upper extremity symptoms and recommended that the petitioner return for re-evaluation upon review thereof. The records from Rockford Memorial Hospital and Dr. Strum indicate that the petitioner complained of right upper extremity symptoms as early as January 2007 and that the petitioner's symptoms actually worsened after cervical injections in 2007. Finally, and most importantly, based on the records of the University of Wisconsin physicians, the petitioner was scheduled to undergo cervical decompression surgery in 2008. Thus, Dr. Coe's opinion causally connecting the need for surgery to the work accident because surgery had never been recommended in the past is invalid.

Based upon the medical records in evidence, the Arbitrator finds that any current or future need for treatment is not related to the work accident. The petitioner sustained a temporary aggravation of a pre-existing cervical degenerative condition on February 21, 2011. The petitioner reached maximum medical improvement in regard to that work injury as of the May 26, 2011 examination of Dr. Salehi. The petitioner's symptoms at the time of trial were indistinguishable from those outlined in the medical records corresponding with prior treatment throughout 2007. The petitioner's degenerative condition has since returned to its pre-injury baseline and any need for further treatment is related to that pre-injury condition.

Based on the foregoing, the Arbitrator denies petitioner's claim for further medical benefits.

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

Barbara Peterson,
Petitioner,
vs.

United Airlines,
Respondent.

14IWCC0737

NO: 10 WC 14950
11WC 45662

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, permanent partial disabilityand 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 18, 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: AUG 29 2014
KWL/vf
O-8/19/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0737

PETERSON, BARBARA
Employee/Petitioner

Case# **10WC014950**

11WC045662

UNITED AIRLINES
Employer/Respondent

On 12/18/2013, 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 0.09% 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:

0147 CULLEN HASKINS NICHOLSON ET AL
DAVID B MENCHETTI
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0560 WIEDNER & McAULIFFE LTD
MARK MATRANGA
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

14IWCC0737

Barbara Peterson
Employee/Petitioner

Case # **10WC014950**

v.

Consolidated case: **11WC045662**

United Airlines
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **September 26, 2013 & November 26, 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 **09/03/2009 and 09/09/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

On those dates, 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 of September 3, 2009.

In the year preceding the injury, Petitioner earned $**$40,969.76**; the average weekly wage was $**$787.88**.

On the dates of accident, Petitioner was **50 & 52** years of age respectively, *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 $**47,422.57 + $13,881.61 (Total $61,304.18)** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**61,304.18**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**525.25** per week for **90-5/7** weeks, commencing September 10, 2009 through June 6, 2011, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $47,422.57 for temporary total disability benefits that have been paid for this period.

In addition, Respondent shall pay Petitioner temporary total disability benefits of $**525.25** per week for **57-3/7** weeks, commencing September 10, 2011 through October 15, 2012, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $13,881.61 for temporary total disability benefits that have been paid for part of this period.

Respondent shall pay Petitioner permanent partial disability benefits of $**472.73**/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.

David A. Kane
Signature of Arbitrator

December 18, 2013
Date

DEC 18 2013

14IWCC0737

Attachment to Arbitration Decision
Barbara Peterson v. United Airlines
10WC014950 & 11WC045662

On September 3, 2009, Petitioner Barbara Peterson was a 50 year old flight attendant for Respondent United Airlines. Petitioner's job duties required her to lift, push heavy carts, kneel, stow bags and walk stairs. Petitioner worked long flights that sometimes required 16 hour flight duty.

It was stipulated by the parties that on September 3, 2009 Petitioner sustained accidental injuries that arose out of and in the course of her employment. At that time she reached over to serve a heavy tray and it jarred her when she went to grab it and she injured her back and neck. She felt a strain in her neck and low back and heard a little pop or crack.

Petitioner saw Dr. Zinis for the first time on September 15, 2009. Dr. Zinis diagnosed discogenic low back and cervical strain, described Petitioner's symptoms as a new injury and prescribed an MRI. (PX1, pg. 162). MRI showed L4-5 anular tear and Dr. Zinis prescribed physical therapy and possible epidural steroid injections (ESI). (PX 1, pg. 160).

Petitioner underwent ESI at L4-5 at Rose Surgical Center on November 20, 2009 (PX 3, pg. 6). Petitioner reported some relief to Dr. Zinis on December 21, 2009. (PX1, pg. 156). Petitioner underwent another ESI on January 15, 2010. (PX 3, pg. 9). Dr. Zinis noted some improvement in Petitioner's symptoms on March 2, 2010.

(PX 1, pg. 154). EMG performed by Dr. Zinis on May 12, 2010 was relatively normal. (PX 1, pg. 152).

On May 7, 2010, Petitioner saw the neurosurgeon Dr. Shogan at the recommendation of Dr. Zinis. (PX 9, pg. 1). Dr. Shogan diagnosed spinal stenosis in the cervical region and reported that surgery to the cervical region would be reasonable. (PX 9, pg. 2).

On June 30, 2010, Petitioner reported to Dr. Zinis increasing and rather severe pain in the right side of the neck and upper back and Dr. Zinis noted changes in the previous MRI at the level of C6-7. (PX1, pg. 150). Petitioner underwent cervical ESI at C6-7 at Rose Surgery Center on July 23, 2010; on October 1, 2010; and again on December 17, 2010. (PX 3, pgs.12, 16 & 19). Petitioner continued to follow up with Dr. Zinis during this period of time. (PX1, pg. 140).

On January 3, 2011, Dr. Zinis reported that if Petitioner were not able to sustain improvement from the cervical ESI treatment that he would refer her back to neurosurgeon Dr. Shogan for surgical consideration (PX 1, pg. 141). Petitioner continued to treat with Dr. Zinis, who prescribed additional physical therapy (PX 1, pg. 14) and noted on July 19, 2011 that Petitioner had returned to work. (PX 1, pg. 133).

Petitioner was examined by Dr. Theodore Fisher at the request of the Respondent on: January 6, 2010; May 5, 2010; October 22, 2010; and April 15, 2011. (PX 7). Dr. Fisher diagnosed Petitioner with: herniated disc at L5-S1 resulting in moderate left L5-S1 foraminal stenosis; L4-5 annular disk tear; left lower extremity radicular

symptoms; cervical and lumbar strains; and cervical stenosis at C6-7and C7-T1. (PX7, pg. 4). Dr. Fisher reported that within a reasonable degree of medical certainty, the condition of Petitioner's neck and low back was an exacerbation of pre-existing condition and that the exacerbation was due to her work injury of September 3, 2009. (PX7, pgs. 5 & 15). Dr. Fisher reported and then confirmed that treatment had been reasonable and necessary, but indicated that if Petitioner failed to improve she would be a candidate for C6-7 cervical discectomy and fusion. (PX 7, pgs. 11 & 15).

On May 18, 2011, Dr. Fisher released Petitioner to return to work and Petitioner did so on June 6, 2011. (PX 7, pg. 17). The parties stipulated that Petitioner was temporarily and totally disabled (TTD) from September 10, 2009 through June 6, 2011 and that all TTD benefits for that period were paid to the Petitioner by the Respondent. ARBX 1.

After she returned to work as a flight attendant Petitioner in June 2011, Petitioner still did not feel right in her neck and low back. On July 19, 2011, Dr. Zinis reported that Petitioner was still experiencing pain in her neck and low back and that Petitioner should consider additional ESI. (PX1, pg. 133).

It was stipulated by the parties that on September 9, 2011, Petitioner sustained accidental injuries that arose out of and in the course of her employment. At that time, Petitioner was pulling out oven racks and noticed a strain in her neck. Petitioner sought medical treatment at Concentra in Colorado and diagnosis was cervical strain with right cervical radiculitis and lumbar strain. (PX 2, pgs. 10 &

15). Petitioner received trigger point injections and physical therapy at Concentra through January 5, 2012. (PX2, pg. 22).

Petitioner continued to treat with Dr. Zinis after the injury of September 9, 2011 and on November 14, 2011 Dr. Zinis assessed neck and upper back pain due to work-related injury. (PX1, pg. 132). On January 17, 2012, Dr. Zinis recommended evaluation with the neurosurgeon Dr. Shogan. (PX 1, pg. 128). On January 23, 2012, Petitioner was seen by the neurosurgeon Dr. Shogan who diagnosed stenosis at C6-7 and left-sided disc spur at C7-T1 and offered Petitioner surgical intervention. (PX 9, pg. 4). On February 2, 2012, Dr. Shogan assessed neck and upper back pain with acute cervical radiculopathy due to a second work-related injury. (PX 1, pg. 126).

Petitioner was evaluated by Dr. Lami at the Respondent's request on February 1, 2012. (RX 1). Dr. Lami noted that the MRI of January 9, 2012 showed disc protrusions at C6-7 and C7-T1. (RX 1, pg. 6). On March 15, 2012, Dr. Lami issued an addendum report in which he could not support any injury or aggravation of injury and did not recommend any cervical surgery. (RX 1, addendum pg. 1). Dr. Lami did not review any records from the injury of September 3, 2009 and did not review the reports of Respondent's previous evaluating physician Dr. Fisher.

Petitioner was evaluated by Dr. Heller at the Respondent's request on February 10, 2012. (RX 2). Dr. Heller diagnosed a right shoulder strain injury sustained on Septmber 9, 2011. (RX 2, pg. 3). Dr. Heller reported that Petitioner's current findings and complaints were more consistent with cervical spine pathology. (RX 2, pg.3).

On March 6, 2012, Dr. Zinis noted that Petitioner continued to suffer from cervical radiculopathy that had been persistent since the initial work-related injury of September 2009 and had been re-aggravated in September 2011. (PX 1, pg. 123). Dr. Zinis recommended that petitioner proceed with surgical intervention for the neck. (PX 1, pg. 124). On March 7, 2012, Petitioner underwent: anterior cervical disk and spur removal with fusion and mosaic plating at C7-T1; and anterior cervical disk and spur removal with fusion with trabecular metal at C6-7 by Dr. Shogan at Healthone Rose Medical Center; post-operative diagnosis was cervical disk and spur disease at C6-7 and C7-T1. (PX 8, pg. 1). After the surgery, Petitioner continued to follow up with Dr. Shogan who released Petitioner to the conservative care of Dr. Zinis on May 17, 2012. (PX 9, pg. 12). Dr. Zinis reported that petitioner would need physical therapy and would be expected to be able to return to work within six months. (PX 1, pg. 120).

Petitioner returned to work as a flight attendant for Respondent on October 15, 2012. The Respondent stipulated that Petitioner was temporarily and totally disabled (TTD) from September 10, 2011 through at least March 15, 2011 when Respondent last paid TTD.

The parties stipulated that Respondent that all reasonable, necessary and related medical bills have been paid or paid pursuant to Section 8(j) for which Respondent is entitled to credit and Petitioner entitled to be held harmless.

Petitioner continues to experience everyday pain and aches and pains while doing her job. Petitioner avoids flying longer international flights, but continues to

experience pain and soreness when she lifts, kneels, bends, pulls and pushes at work. She experiences difficulty with fine motor skills and notices pain in her shoulders and neck when driving. Petitioner notices lack of mobility in her neck. Petitioner had previously had neck surgery in 1999 consisting of fusion of C5-6. (PX1, pg. 161). For the ten years from 199 through 2009, Petitioner worked full duty as a flight attendant and was not under any medical treatment for her neck.

CONCLUSIONS

In case 10WC014950, Respondent stipulated to every issue, including causal connection, except nature and extent of the injury. In case 11WC045662, the disputed issues are causal connection, TTD and nature and extent of the injury.

Regarding **Causal Connection**, the Arbitrator concludes that the Petitioner's current condition of ill-being and the need for the surgery March 7, 2012 are causally related to the accidental injuries of September 3, 2009 (10WC014950). The Arbitrator bases this conclusion on the records and reports of Dr. Zinis and Dr. Shogan who as early May 2010 were considering surgery to Petitioner's cervical spine as an option. According to those treating records, Petitioner's symptomatology relating to her neck and low back were consistent since the accidental injuries of September 3, 2009. Dr. Zinis and Dr. Shogan consistently reported that Petitioner's condition was due to her accidental injuries. Additionally, in 2010 before the second injury date of September 9, 2011 (11WC045662), the Respondent's own evaluating physician Dr. Fisher reported that the condition of Petitioner's neck and low back were causally connected to the work injury of September 3, 2009 (10WC014950) within a reasonable degree of medical certainty and due to an aggravation or exacerbation of her previous condition and that

cervical surgery would be an option. In 2012, after the second injury of September 9, 2011 (11WC045662), Respondent's other evaluating Dr. Lami failed to address the Petitioner's injury of September 3, 2009 (10WC014950) in his report and failed to consider the opinion of Dr. Fisher. In 2012, the Respondent's last evaluating physician Dr. Heller noted that Petitioner's condition at that time was due to cervical spine pathology and declined to give any opinion on causality related to the cervical spine.

Regarding **Temporary Total Disability** benefits, based on the conclusion regarding causal connection above, the Arbitrator concludes that the Petitioner was temporarily and totally disabled from March 15, 2012 through October 15, 2012. The additional period of TTD above is based on the last date the respondent paid TTD through the date of return to work after surgery and recuperation from surgery, which the Arbitrator has concluded is causally connected to the accidental injuries of September 3, 2009 (10WC014950).

Regarding **Nature & Extent of the Injury**, the Arbitrator concludes that Petitioner sustained accidental injuries on September 3, 2009 that resulted in the loss of use of the whole person to the extent of 25%f thereof. This conclusion is based on the conclusion relating to causal connection above. In addition, this conclusion is based on the diagnoses by Respondent's own evaluator Dr. Fisher of: herniated disc at L5-S1 resulting in moderate left L5-S1 foraminal stenosis; L4-5 annular disk tear; left lower extremity radicular symptoms; cervical and lumbar strains; and cervical stenosis at C6-7and C7-T1, which required surgery including fusion. The Petitioner credibly testified to pain and loss of mobility in her neck.

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

14IWCC0738

Wanda Winston,
Petitioner,

vs.

NO: 10 WC 27051

Total Facility Maintenance,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 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.

The party commencing 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: AUG 2 9 2014
KWL/vf
O-8/18/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0738

WINSTON, WANDA
Employee/Petitioner

Case# **10WC027051**

TOTAL FACILITY MAINT INC
Employer/Respondent

On 11/19/2013, 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 0.10% 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:

4998 LAW OFFICE HUGO A ORTIZ PC
4440 S ASHLAND AVE
CHICAGO, IL 60609

0210 GANAN & SHAPIRO PC
MICHELLE L LaFAYETTE
210 W ILLINOIS ST
CHICAGO, IL 60654

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 14IWCC0738

Wanda Winston
Employee/Petitioner

v.

Total Facility Maintenance
Employer/Respondent

Case # **10WC 27051**

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 **October 11, 2011**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 **Future medical**

FINDINGS

On 3/3/2008, 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 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 $30,784.00; the average weekly wage was $592.00.

On the date of accident, Petitioner was 46 years of age, *single* with 0 dependent children.

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

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

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

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

ORDER

Claim for compensation denied. Petitioner failed to prove that she sustained accidental injuries, arising out of and in the course of her employment by Respondent on the claimed accident date and failed to prove a causal connection between the alleged accidental injuries and her current condition of ill being with respect to her hands. Further, Petitioner failed to prove that she gave timely notice of the claimed injuries.

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

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

Signature of Arbitrator

Jeffrey B. Huebsch

11/19/2013
Date

NOV 19 2013

ICArbDec p. 2

14IWCC0738

STATEMENT OF FACTS

The matter was heard by Arbitrator Brian Cronin on October 11, 2013. Arbitrator Cronin was recused for cause and the Parties later stipulated to the admission of Petitioner's Exhibits 1, 2, 2A, 2B and 3 and Respondent's Exhibits 1 and 2. The matter was assigned to Arbitrator Jeffrey B. Huebsch for decision.

In February of 1999, Petitioner began her employment as a custodian for Respondent, Total Facility Maintenance. Petitioner testified she worked from 10:00 a.m. to 7:30 p.m., Monday through Friday. She worked at Taylor Elementary School. Her duties included sweeping, mopping, vacuuming, cleaning bathrooms, lifting books from the first to the third floor of the building, lifting tables, using a wet vac, and hanging letters on the marquee sign outside the building.

Petitioner is right handed.

Petitioner testified she was assigned to the first floor. The first floor included 8 to 10 classrooms, the auditorium, lunch room, a hallway and two offices. Petitioner testified she swept, mopped and vacuumed classroom floors. She cleaned windows, wiped down desks and cleaned chalkboards. Petitioner testified she used her hands when performing each activity. If needed, she would move furniture in order to clean a classroom, estimating she moved on average 10 desks in a classroom.

In the lunchroom, Petitioner emptied the garbage, mopped, swept, lifted tables, wiped down the walls and cleaned parts of the kitchen. She testified the garbage weighed about 30 lbs. She estimated she moved nine to twelve bags of garbage over the three lunch periods. At the end of the three lunch periods, she estimated she moved about twelve tables.

In the bathrooms, Petitioner cleaned the walls, removed tissue from the walls, mopped, swept and cleaned the stalls. She testified she performed similar duties in each of the offices. Petitioner testified she used her hands to push, occasionally squeeze out a mop or a rag and for lifting. She testified she had pain in her hands, legs and back at the end of the work day.

Petitioner testified that while working on March 3, 2008, she experienced pain in her hands. She testified she was having difficulty working and it took her longer to complete her tasks. She testified before she went to work for Respondent in 1999 she had no pain.

Petitioner testified she reported her condition and the pain to her supervisor, Pat, and the engineer, Sam. Petitioner initially testified she reported the symptoms and her condition to Pat and Sam at the beginning of 2009, but when asked again when she reported it by her attorney, Petitioner testified she reported the symptoms to Pat and

Sam sometime during the first part of 2008. Petitioner did not testify as to exactly when and where she reported the condition/symptoms to Respondent. She testified she was just letting them know she had pain in her hands.

Petitioner's medical history before March 3, 2008 was extensive. In 2005, Petitioner was diagnosed with an enlarged thyroid and was noted to be significantly overweight. Petitioner received treatment for thyroid disease, and she was repeatedly counseled to lose weight. The records from Union Health indicate Petitioner presented for treatment on November 3, 2007 with complaints of finger numbness for approximately one week to several months with discomfort noted in both hands. The physician suspected carpal tunnel syndrome, provided wrist braces and recommended weight loss. On December 31, 2007, numbness in both hands was again noted. The diagnosis was carpal tunnel syndrome, and Petitioner was advised to follow-up with the endocrinologist for further evaluation of the hypothyroid condition. The physician again recommended weight loss, and he advised Petitioner to not lift small children until after an EMG/NCV. (Pet. Ex. No. 1)

An EMG/NCV of January 30, 2008 showed moderately severe bilateral carpal tunnel syndrome and an underlying sensory peripheral neuropathy. It was recommended diabetes be ruled-out as a cause due to family history. On March 3, 2008, Petitioner saw Dr. Edward Abraham, an orthopedist, at Union Health. Dr. Abraham noted Petitioner had hypothyroidism and was under treatment, she had complaints of bilateral numbness in her fingers with pain and an MRI showed moderate to severe carpal tunnel syndrome. He discussed alternative treatment options with Petitioner with Petitioner indicating she would consider the options and get back to him with a decision. Dr. Abraham makes no mention of Petitioner's job activities, and he did not indicate Petitioner's condition was work related. (Pet. Ex. No. 1)

Petitioner did not follow up with Dr. Abraham and continued to treat for the thyroid condition. On May 1, 2008, she reported a funny feeling in her neck, difficulty swallowing and an occasional choking sensation on recumbency. Significant changes to the thyroid were noted on May 27, 2008 when compared to a study from 2005. On July 10, 2008, the physician recommended Petitioner undergo a total thyroidectomy for definitive malignancy determination and her failure to respond to suppression measures. Petitioner never underwent the procedure. On September 9, 2008, the physician noted Petitioner failed to respond to suppression treatment measures and had compression symptoms due to thyroid disease. (Pet. Ex. No. 1)

The condition of carpal tunnel syndrome is not again mentioned in the chart from Union Health until February 4, 2009 when she presented with complaints of bilateral carpal tunnel syndrome, left worse than right. Petitioner indicated she would undergo a sub-total thryoidectomy at some point. It was noted she did not respond to medication management and had an enlarged thyroid with no swelling noted elsewhere. By August of 2009, Petitioner was deemed an "extremely noncompliant" patient. She weighed

254 lbs with no effort to lose weight. She would not have the thyroid surgery, and she refused to stop smoking. She then presented to Union Health on September 12, 2009 with complaints of left arm and low back pain for one week. She was noted to work in school maintenance for 10 years with heavy lifting. She was restricted to light-duty work. When she returned to the clinic on September 17, 2009, Petitioner reported at the end of the day she could hardly walk because she was so stiff. She indicated she could not continue to work or to live with the symptoms. (Pet. Ex. No. 1) Petitioner then stopped working.

Petitioner underwent a left carpal tunnel release in March of 2010. (Pet. Ex. No. 1 & 3) After the surgery, Petitioner reported improvement, but not a complete resolution of her symptoms. She gained an additional 15 lbs. despite having been placed on a diet and having been advised on multiple occasions to lose weight. She was unable to undergo the thyroid surgery because her neck was too short due to the added weight and there was no distance between her chin and sternum to allow for a reasonable approach to the neck. (Pet. Ex. No. 1)

On July 14, 2011, Petitioner presented to Dr. Riera. He noted she was diagnosed with bilateral carpal tunnel syndrome in 2008. Petitioner complained of pain and numbness in both hands. She was overweight at 270 lbs., demonstrated good range of motion in both hands and demonstrated diminished sensation in the palm and fingers of both hands. An EMG was ordered. Dr. Bassam Osman performed the EMG on July 26, 2011. It was compatible with bilateral carpal tunnel syndrome, right worse than left. (Pet. Ex. No. 2)

Dr. Jeffrey Weinzweig examined Petitioner on August 26, 2011. He noted she worked as a custodian and had a three-year history of numbness, tingling and pain with nighttime symptoms involving the hands. He diagnosed recurrent left carpal tunnel syndrome and persistent right carpal tunnel syndrome. He recommended surgery. In a report dated October 21, 2011, Dr. Weinzweig indicated Petitioner's condition of ill-being was causally related to repetitive work activities over the last number of years. (Pet. Ex. No. 2) There is no mention of Petitioner's actual job activities, and no mention of the thyroid disease or other co-morbidities.

On direct examination, Petitioner testified she first experienced pain and numbness to the hands/wrists in February of 2008. On cross-examination, she admitted her symptoms began before 2008 and were documented in the records from Union Health in 2007. Petitioner admitted she was diagnosed with an enlarged thyroid in 2005, and said that she had no complaints regarding her hands or wrists before the diagnosis, even though she worked as a custodian from 1999 to 2005.

Petitioner testified her symptoms of bilateral hand pain and numbness persist. She testified she wanted to undergo surgery.

At Respondent's request, Dr. Michael Vendor of Hand Surgery Associates performed a Section 12 examination on January 27, 2012. Dr. Vendor noted Petitioner's medical history was positive for a number of risk factors for the development of carpal tunnel syndrome, including, her gender, age, significant increased body mass index and hypothyroidism. He noted she was on medication for the thyroid. In terms of her work activities, Dr. Vendor noted she worked as a custodian and her duties included sweeping, mopping, vacuuming, cleaning classrooms and washrooms and working on tables in the lunchroom. He considered the activities she performed to be varied, requiring a routine use of the hands, with limited exposure to potential forceful activities. Dr. Vendor therefore concluded that Petitioner's work activities did not cause, aggravate or accelerate the condition of carpal tunnel syndrome. (Res. Ex. No. 1)

CONCLUSIONS OF LAW

In support of the Arbitrator's Decision relating to C, whether Petitioner sustained accidental injuries arising out of and in the course of her employment by Respondent and F, whether Petitioner's current condition of ill-being is causally related to the accident, the Arbitrator finds the following:

Petitioner alleges she sustained an accidental injury arising out of and in the course of her employment on March 3, 2008 due to repetitive work activities. For a repetitive trauma claim to be successful , Petitioner must still prove a date of injury and she must also prove she sustained an injury caused by the performance of her job activities that developed gradually over a period of time. *See*, Peoria County Belwood Nursing Home v. Industrial Commission, 115 Ill.2d 524, 505 N.E.2d 1026, 106 Ill.Dec. 235 (1987). A claimant alleging an injury due to repetitive trauma must meet the same burden of proof as a claimant alleging injury from a single, definable event. *See,* Nunn v. Industrial Commission, 157 Ill.App.3d 470, 510 N.E.2d 502, 508, 109 Ill.Dec. 634 (4th Dist. 1987). In the present case, Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment by Respondent from repetitive trauma.

The chronology of events is clear from the evidence. Petitioner began working for Respondent in 1999, and she was diagnosed with thyroid disease in 2005. Before she was diagnosed with thyroid disease, Petitioner had no problems with her hands and she worked for years as a custodian with no problems. In 2007, Petitioner sought treatment for bilateral hand pain, numbness and tingling.

The facts are similar to those in Cheri Hagaman v. Methodist Medical Center, 12 I.W.C.C. 0365, 2012 WL 1902190 (2012). In Hagaman, the claimant worked as a document technician. She alleged the diagnosis of bilateral carpal tunnel syndrome was work-related. However, the job description provided revealed the claimant performed a wide variety of hand activities and no one could therefore conclude the activities were repetitive. Key to the denial of benefits, though, was the diagnosis of thyroid disease and that the carpal tunnel syndrome did not occur until after the thyroid diagnosis. It was clear the thyroid disease substantially increased the risk claimant would develop carpal tunnel syndrome.

In the present case, as in Hagaman, the evidence established Petitioner performed a wide variety of activities. While the activities included the use of the hands, the use of her hands was of a normal, routine nature and not of a repetitive nature. Petitioner provided no evidence that she performed a specific activity repeatedly or of an exposure to forceful activities. She therefore did not establish her job activities were repetitive and the cause of the bilateral carpal tunnel syndrome. *See also*, Susan K. McGuire v. St. Clair County, 11 I.W.C.C. 1241, 2011 WL 7024843 (2011) (*finding no causation when the job activities were varied, there was no testimony as to what portion*

of the day was spent performing specific activities and there was no evidence the claimant performed activities of a forceful nature).

The medical evidence also supports the Arbitrator's determination there is not a causal connection between the bilateral carpal tunnel syndrome condition and Petitioner's employment. The carpal tunnel syndrome was diagnosed in late 2007 and the thyroid condition was first diagnosed in 2005. Before the thyroid diagnosis, Petitioner had no complaints of hand pain and numbness, even though she performed the activities of a custodian in the prior years. The Arbitrator also notes that Dr. Abraham, the orthopedic physician who discussed treatment options with Petitioner on March 3, 2008 did not relate the carpal tunnel syndrome to Petitioner's employment. In fact, Dr. Abraham made no mention of Petitioner's employment. Instead, he noted the thyroid disease and efforts to control the condition medically had failed, suggesting he considered the carpal tunnel syndrome to be a sequela of the thyroid disease.

As the thyroid condition remained uncontrolled and her weight increased, Petitioner's symptoms of pain and numbness gradually worsened. Thyroid surgery was recommended, but Petitioner was non-compliant with a weight loss program making it impossible for the surgery to be performed. In the meantime, the physician commented that Petitioner failed to respond to suppression measures and she had compression symptoms. The chart from Union Health supports the thyroid condition as the cause of the carpal tunnel syndrome, not Petitioner's employment.

Regarding the issue of causal connection, the Arbitrator finds the opinion of Dr. Vendor more credible than the opinion of Dr. Weinzweig. Dr. Vendor described in his report the job activities performed by Petitioner and discussed whether the activities were varied and/or of a forceful nature. He concluded the activities were varied with Petitioner performing a number of different tasks throughout the day, a conclusion with which the Arbitrator agrees. Dr. Vendor also concluded the activities were not forceful, with which the Arbitrator also agrees. Finally, Petitioner's use of her hands was done in a normal, routine fashion. Dr. Vendor also recognized Petitioner's weight (she was noted to be significantly overweight) and the thyroid disease greatly increased her risk to develop carpal tunnel syndrome. Dr. Vendor's opinion that Petitioner's work activities did not cause, aggravate or accelerate her carpal tunnel condition is persuasive and most comports with the evidence adduced.

In contrast, Dr. Weinzweig only indicated Petitioner worked in maintenance. He suggested there was a causal connection between her work activities and the bilateral carpal tunnel syndrome due to "repetitive work activities over the last number of years." By the time Petitioner began treating with Dr. Weinzweig in August of 2011, she had not been working for almost two full years. Dr. Weinzweig made no mention of the thyroid disease or Petitioner's weight or of any details regarding Petitioner's work duties. Accordingly, the Arbitrator finds Dr. Weinzweig's causal connection opinion to be not credible.

Based upon the foregoing, the Arbitrator finds Petitioner failed to prove that she sustained accidental injuries, arising out of and in the course of her employment by Respondent and has failed to prove a causal connection between her employment and her current condition of ill-being with respect to her hands. The claim for compensation is therefore denied.

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

Section 6(c) of the Act provides, in part, "Notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident." 820 ILCS 305/6(c). Petitioner's testimony established she failed to give notice to Respondent. The failure to give notice is a complete bar to the claim. *See*, Gano Electric v. Industrial Commission, 260 Ill.App.3d 92, 631 N.E.2d 724, 197 Ill.Dec. 502 (4th Dist. 1994).

Petitioner claimed and testified to an accident date of March 3, 2008. It is her burden to show when and how she gave notice. She did neither. First, she testified she gave notice her hands hurt in the first part of 2009. When questioned further, she changed this to the first part of 2008. She never identified the exact date and time after March 3, 2008 when she gave notice. Petitioner's testimony does not establish that she gave notice in accordance with Sec. 6 (c) of the Act. The claim for compensation is, therefore, denied.

In support of the Arbitrator's decision relating to L, what is the nature and extent of the injuries; J and O, liability for incurred and prospective medical expenses and K, TTD, the Arbitrator finds the following:

The Request for Hearing Form (Arb. Ex. 1) indicates that the nature and extent of the injuries is in dispute. The Parties did not state this when the Arbitrator confirmed the issues in dispute on the Record at the beginning of the trial.

As the Arbitrator has found that the claim for compensation is denied, the Arbitrator needs not decide the above 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

Angelo Milano,
Petitioner,

vs.

City of Elmhurst,
Respondent.

14IWCC0739

NO: 11 WC 39118

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, accural date 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 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.

The party commencing 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: AUG 29 2014
KWL/vf
O-8/19/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0739

MILANO, ANGELO
Employee/Petitioner

Case# 11WC039118

CITY OF ELMHURST
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:

4036 MILLON & PESKIN LTD
MITCHELL PESKIN
2100 MANCHESTER RD SUITE 1060
WHEATON, IL 60187

0445 RODDY LEAHY GUILL & ZIMA LTD
RICHARD ZENZ
303 W MADISON ST SUITE 1500
CHICAGO, IL 60606

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
NATURE AND EXTENT ONLY

14IWCC0739

Angelo Milano,
Employee/Petitioner

v.

City of Elmhurst,
Employer/Respondent

Case # **11** WC **39118**

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 **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Wheaton**, on **5/13/13**. By stipulation, the parties agree:

On the date of accident, **9/23/11**, 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 $**66,237.08**, and the average weekly wage was $**1,273.79**.

At the time of injury, Petitioner was **50** years of age, ***married*** with **2** dependent children.

The parties agreed that necessary medical services and temporary compensation benefits have been or will be provided by Respondent. Specifically, Respondent agreed to pay any outstanding medical bills pursuant to §8(a) and the fee schedule provisions of §8.2 as well as any underpayment of TTD benefits at a rate of $849.19 per week from 9/24/11 through 11/22/11 and from 1/31/12 through 3/6/12, for a period of 13-5/7 weeks.

Respondent shall be given a credit of $**10,863.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**10,863.00**.

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

Respondent shall pay Petitioner the sum of **$695.78** per week for a further period of **125** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **the permanent partial loss of use of 25% person-as-a-whole.**

Respondent shall pay Petitioner compensation that has accrued from **9/24/11** through **5/13/13**, 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.

Signature of Arbitrator

6/20/13
Date

ICArbDecN&E p.2

JUN 25 2013

STATEMENT OF FACTS:

Petitioner works in the equipment maintenance department for the Respondent as a mechanic. He has been employed with the Respondent for over twelve years. Petitioner characterizes his job as being in the heavy category. He uses power tools, air tools and manual tools. He performs preventative maintenance and repairs on police cars, park district equipment, city hall equipment and anything that has mechanical parts. Petitioner testified that approximately 45 percent of his job involves lifting. He lifts tires and exhaust systems on cars. He rotates tires and torques tires. When he torques tires he is on his knees and has to push with 120 pounds of torque. He also uses a machine to balance tires which requires him to bend over, pick up a tire, and to place it on a machine. Petitioner does a lot bending over, pushing and pulling. Petitioner estimated about fifty-percent of his work requires his arms to be lifted overhead. Petitioner is 52 years old. He testified that he anticipates working to the age of 68 to 70 years old. Petitioner presently works for the Respondent five days a week; Monday through Friday. His typical shift is from 7:00 a.m. through 3:30 p.m.

On September 23, 2011 Petitioner was performing work on one of the Respondent's Ford Expedition SUVs. Specifically, he was doing preventive maintenance, which included an oil change, tire rotation and a brake check. At approximately 10:30 a.m. Petitioner bent over and picked up a tire off the floor to put it on the vehicle. He testified as he was doing so he went to turn and twist toward the front of the vehicle where he was going to place the tire. At that moment he felt a sharp pain in his right shoulder blade. Approximately five minutes later Petitioner noticed that he could not turn his neck all the way to his left. He estimated the weight of the tire to be 40 to 60 pounds. Petitioner did not complete his shift and instead was taken by his superintendent to the Elmhurst Memorial Occupational Health Clinic. At the clinic, he was diagnosed with a cervical and right shoulder strain, prescribed medication and taken off work until September 26, 2011.

The following day when Petitioner awoke his right arm was paralyzed. He went to Elmhurst Memorial Hospital on September 24, 2011. He was noted to have a sharp pain which was worse with palpation and movement just to the right of the lower cervical spine that radiated into his right upper extremity. (PX1). It was also noted that he had complaints of circumferential numbness of the whole right arm. An MRI was performed the same day and revealed a soft disc herniation at C5-C6 with significant impact on the spinal canal and spinal cord with bilateral stenosis. (PX1). Petitioner was subsequently admitted into the hospital and on September 25, 2011 underwent an anterior cervical discectomy at C5-C6, placement of interbody cage after arthrodesis of the C5 and C6 endplate and placement of anterior instrumentation. (PX1). The surgery was performed by Dr. Sean Salehi. (PX1). Petitioner was discharged from Elmhurst Memorial Hospital on September 26, 2011. (PX1). He subsequently followed up with Dr. Salehi on October 11, 2011. (PX2). Dr. Salehi recommended continuation of Norco and Robaxin and started Petitioner on a course of physical therapy. (PX2). He also prescribed off work restrictions. (PX2).

Petitioner attended physical therapy at ATI from October 12, 2011 through November 21, 2011. (PX4). He then attended work hardening at ATI from January 30, 2012 through March 2, 2012. (PX4). Petitioner returned thereafter to Dr. Salehi on March 6, 2012. Dr. Salehi found that he had minimal pain in the neck without radiation into the arm and had no weakness or paresthesias. (PX2). Dr. Salehi declared Petitioner at MMI and released him to return to work full duty without restrictions. (PX2). Petitioner last saw Dr. Salehi on September 25, 2012. (PX2). Dr. Salehi noted that Petitioner was having a lot of stiffness associated with pain in his neck especially when working overhead. (PX2). It was also noted that Petitioner was taking Norco for his lower back. (PX2). Dr. Salehi encouraged Petitioner to quit smoking and indicated he did not need to see him anymore. (PX2).

Petitioner was off work during the periods of September 24, 2011 through November 22, 2011. He then worked light duty for the Respondent up through January 30, 2012. He was thereafter off work while attending work conditioning from January 31, 2012 through March 6, 2012. He subsequently returned to work without restrictions after March 6, 2012 and has been working for the Respondent since.

Petitioner testified that he currently has a hard time doing overhead work when he has his arms up in the air. His arms get numb and it becomes difficult for him to hold wrenches. As a result, Petitioner has to bring his arms down and rest them before he can continue working. Petitioner also has problems turning his head all the way to the left or right. When he tilts his head back it hurts him. He testified that his arms feel heavy at night when he tries to fall asleep. Petitioner does not have pain in his arms but says he has a feeling of numbness and stiffness in them. He testified that at the end of the day his arms feel sore and stiff. He also testified that he has a lot of stiffness in his shoulder blades. Petitioner takes Norco for his complaints. He testified that he takes one pill in the morning and one when he gets home. He also takes Norco to help him fall asleep.

WITH RESPECT TO THE ISSUE OF THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner was credible and that his testimony was corroborated by the medical records. Section 8.1 (b) of the Act states that five factors must be considered in determining the extent of permanent partial disability, for accidents occurring on or after September 1, 2011. The factors include a permanent partial disability report prepared by a physician using the AMA guides rating the level of impairment, the occupation of the injured employee, his or her age on the date of accident, the employee's future earning capacity and evidence of disability corroborated by the medical records of the treating physicians. No single factor shall be the sole determinant of disability and the Arbitrator's decision should explain each factor and its weight.

The Arbitrator notes that Petitioner has returned to his usual employment but does have difficulty performing some of his job tasks, including performing overhead tasks.

Although the Petitioner is presently 52 years old, he testified that he plans on working at least to age 68. Accordingly, he still has a work life of an additional 16 years which is significant.

Petitioner continues to work in the position of a mechanic making essentially the same rate of pay so his future earning capacity is relatively undiminished.

Although there is no AMA report there are treatment records from Elmhurst Memorial Hospital and Dr. Salehi showing treatment from September 23, 2011 through September 25, 2012. The Arbitrator notes that Petitioner suffered a disc herniation at C5-C6 and underwent a one level fusion surgery at this level. Further, while the Petitioner was able to return to his job, his testimony and the medical records show that he continues to experience difficulties with his neck and arms. He has limited range of motion with his neck, difficulty sleeping without the aid of medication and stiffness in his neck, arms and shoulders. He also develops numbness in his arms while doing overhead work. His complaints are more prominent at the end of his work day.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner suffered the permanent partial loss of use of 25% person-as-a-whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Murlena Williams,
Petitioner,
vs.

The Methodist Home,
Respondent.

14IWCC0740
NO: 10 WC 12265

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of reinstatement and being advised of the facts and law, affirms and adopts the 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 9, 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: AUG 29 2014
KWL/vf
O-8/19/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF MOTION AND ORDER

ATTENTION. You must attach the motion form to this notice. If the motion is not attached, this form may not be processed.
Upon filing of a motion before a Commissioner on review, the moving party is responsible for payment for preparation of the transcript.

Oral Argument 7/2/13.

FILED
2014 APR 26 PM 12:18
ILLINOIS WORKERS' COMPENSATION COMMISSION

Murlena Williams
Employee/Petitioner
v.

Case # 10 WC 12265

14IWCC0710

The Methodist Home
Employer/Respondent

To: Derek Storm
Garofalo, Schreiber, Hart & Storm
55 West Wacker Drive, 10th Floor
Chicago, IL 60601

On 5 / 15 / 13, at 2 : 00 AM/PM, or as soon thereafter as possible, I shall appear before the Honorable Lynette Thompson-Smith, or any arbitrator or commissioner appearing in his or her place at 100 W. Randolph, 8th Floor, Chicago, Illinois, and present the attached motion for:

- ___ Change of venue (#3072)
- ___ Consolidation of cases (#3071) (list cases)
- ___ Dismissal of attorney (#3052)
- ___ Dismissal of review (#3085)
- ___ Fees under Section 16 (#1600)
- ___ Fees under Section 16a (#1645)
- ___ Hearing under Sect. 19(b) (#1902)
- ___ Penalties under Sect. 19(k) (#1911)
- ___ Penalties under Sect. 19(l) (#1912)
- X Reinstatement of case (#3074)
- ___ Request for hearing (#R33)
- ___ Withdrawal of attorney (#3073)
- ___ Other (explain) _____

Domenic Maciariello
Signature Petitioner X Respondent ___

Domenic Maciariello #1315
Attorney's name and IC code # (please print)

DWORKIN & MACIARIELLO
Name of law firm, if applicable

134 N. LaSalle #1515
Street address

Chicago IL. 60602
City State Zip code

312-857-7777 ChicagoWorkInjury@yahoo.com
Telephone number Email

ORDER

The motion is set for hearing on 30

Signature of arbitrator or commissioner

Date

ORDER

The motion is ___ Granted ___ Withdrawn ___ Continued to _____
___ Denied ___ Dismissed ___ Set for trial (date certain) on _____

Signature of arbitrator or commissioner

7-2-13
Date

14IWCC0740

PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.

I, Domenic Maciariello, affirm that I ____ delivered

X mailed with proper postage in the city of CHICAGO a copy of this form at

4:30 PM on April 26 2013 to each party at the address listed below.

Derek Storm
Garofalo, Schreiber, Hart & Storm
55 West Wacker Drive, 10th Floor
Chicago, IL 60601

Domenic Maciariello
Signature of person completing *Proof of Service*

Signed and sworn to before me ____/____/____

Notary Public

[1] The Workers' Compensation Commission assigns code numbers to attorneys who regularly practice before it. To obtain or look up a code number, contact the Information Unit in Chicago or any of the downstate offices at the telephone numbers listed on this form.

STATE OF ILLINOIS)
) SS.
COUNTY OF 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

Scott Webb,

Petitioner,

Vs.

NO: 09 WC 39712

The American Coal Company,

14IWCC0741

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, evidentiary rulings 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 20, 2013 is hereby affirmed and adopted.

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

DATED: AUG 2 9 2014

MB/mam
o:7/31/14
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WEBB, SCOTT
Employee/Petitioner

Case# **09WC039712**

14IWCC0741

THE AMERICAN COAL COMPANY
Employer/Respondent

On 2/20/2013, 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 0.13% 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:

0536 RON D COFFEL & ASSOC
502 W PUBLIC SQUARE
P O BOX 366
BENTON, IL 62812

0299 KEEFE & DEPAULI PC
GREG KELTNER
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

14IWCC0741

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

Scott Webb
Employee/Petitioner

v.

The American Coal Company
Employer/Respondent

Case # 09 WC 39712

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 December 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 January 14, 2008, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $39,868.00; the average weekly wage was $766.69.

On the date of accident, Petitioner was 39 years of age, married with 1 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $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

February 15, 2013
Date

FEB 20 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 January 14, 2008. According to the Application, Petitioner sustained a low back injury when he bent and twisted while putting paper in a copy machine. There was no dispute that Petitioner did sustain a work-related injury; however, Respondent disputed liability on the basis of causal relationship. This case was consolidated with two other workers' compensation claims (08 WC 50894 and 09 WC 19079) which involved alleged repetitive trauma injuries to the right hand.

Petitioner testified that on January 14, 2008, he worked for Respondent as a mine control operator. As Petitioner was in the process of picking up a box of copy paper, which he estimated weighed 50 pounds, Petitioner experienced low back pain with some radiation and numbness in the right leg. The following day Petitioner was seen by Dr. Mark Smith who noted some pain at the L3–L4 level. Petitioner complained of an inability to stand up straight and Dr. Smith prescribed some medication and referred Petitioner to physical therapy. Petitioner received physical therapy from January 17, 2008, through February 6, 2008, and he was discharged from physical therapy after he failed to keep an appointment on February 8, 2008. Dr. Smith saw Petitioner on January 22, 2008, and February 1, 2008, and Petitioner's condition was improved. Petitioner did not lose any time from work as a result of this injury.

At trial, Petitioner testified that he still experiences low back pain with occasional right leg numbness. Petitioner stated that he periodically obtains chiropractic care for this condition; however, no records of this treatment were tendered into evidence at the time of the trial.

Conclusions of Law

In regard to disputed issues (F) and (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner sustained a soft tissue low back injury as a result of the accident of January 14, 2008, but that Petitioner's current condition of ill–being is not related to that accident.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained a low back injury on January 14, 2008; however, the amount of medical treatment received by Petitioner as a result of this accident was minimal and Petitioner lost no time from work as a result thereof. While Petitioner testified that he still has some complaints and has periodically been seen and treated by a chiropractor, no treatment records were submitted into evidence regarding said treatment.

The Arbitrator thereby concludes that Petitioner did not sustain any permanent partial disability as a result of the accident of January 14, 2008.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Scott Webb,

Petitioner,

vs.

NO: 08 WC 50894
09 WC 19079

The American Coal Company,

14IWCC0742

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, evidentiary rulings 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 20, 2013 is hereby affirmed and adopted.

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

DATED: AUG 2 9 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:7/31/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WEBB, SCOTT
Employee/Petitioner

Case# **08WC050894**
09WC019079

THE AMERICAN COAL COMPANY
Employer/Respondent

14IWCC0742

On 2/20/2013, 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 0.13% 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:

0536 RON D COFFEL & ASSOC
502 W PUBLIC SQUARE
P O BOX 366
BENTON, IL 62812

0299 KEEFE & DEPAULI PC
GREG KELTNER
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

14IWCC0742

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

Scott Webb
Employee/Petitioner

v.

The American Coal Company
Employer/Respondent

Case # 08 WC 50894

Consolidated cases: 09 WC 19079

An *Application for Adjustment 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 December 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 15, 2007, and December 10, 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 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 injuries, Petitioner earned $48,000.00 and $40,000.00, respectively; the average weekly wages were $923.07 and $769.23, respectively.

On the date of accident, Petitioner was 37 years of age, married with 1 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $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

February 15, 2013
Date

FEB 20 2013

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim both of which alleged that Petitioner sustained injuries to his right hand arising out of and in the course of his employment for Respondent. In case number 09 WC 19079, Petitioner alleged a date of accident of December 10, 2006, and stated that Petitioner sustained a right hand injury "during course of employment." In case number 08 WC 50894 Petitioner alleged a date of accident (manifestation) of February 15, 2007, and that he sustained an injury to his right hand as a result of "repetitive motion." These two cases were consolidated for the purposes of trial along with another work-related claim involving a back injury (09 WC 39712).

Petitioner began working for Respondent in August, 1999, and worked as a roof bolter operator from that time until February 29, 2004. At that time, Petitioner sustained an accident which caused him to be off work for almost a year. When Petitioner returned to work on February 14, 2005, he worked as a mine control operator and worked in that capacity until he left the employment of Respondent on November 26, 2008. At that time, Petitioner went to work for another coal company, Nighthawk Coal, as a roof bolter where he has continued to work.

Petitioner claimed that he sustained a repetitive trauma injury to his right hand as a result of his working as a roof bolter because the roof bolting machine had various levers which required repetitive gripping in its operation. Petitioner testified that as a roof bolter operator, he used his dominant right hand to manipulate the levers of the machine. In addition to his oral testimony describing the duties of a roof bolter operator, Petitioner submitted into evidence a job description which he prepared along with a diagram showing the configuration of the levers on the roof bolter machine.

During his time as a roof bolter, Petitioner worked 40 hours per week and estimated that he installed 100 to 200 roof bolts per shift. The levers controlled various operations of the roof bolter. These levers were spring–loaded and required the operator to grasp the lever and push or pull it until the desired operation was complete. All of the levers on the machine functioned in this manner and Petitioner testified that the length of time he spent pushing or pulling on the levers varied based upon the mining conditions and the size of the roof bolts being installed, most of which were eight feet in length but occasionally were up to 22 feet in length. Petitioner testified that the time required to install a roof bolt ranged between three and 30 minutes. Petitioner also testified that the amount of force required to manipulate the levers varied from one machine to another with some levers requiring more force to manipulate than others.

Steve Matyi testified on behalf of the Respondent and is presently manager of training for the Respondent. Matyi disagreed with Petitioner's estimate as to the number of bolts installed per shift testifying that the number of bolts installed per shift was between 50 and 60. He explained that his estimate was based on the number of "cuts" per day, with five cuts representing optimal productivity. Matyi testified that 40 bolts are installed per cut resulting in the installation of 200 bolts installed by the four roof bolter operators that average 50 or 60 bolts per day per operator. Matyi also estimated that Petitioner actually only spent 50 to 60% of his time roof bolting because of the alternating manner in which the two roof bolters on the crew work. Matyi did

agree that Petitioner would have been using his right hand throughout the shift not only to operate the roof bolter but also to use a pry bar and to assemble bolts.

Petitioner testified that while working as a roof bolter, he began to experience pain in the palm of his right hand and thereafter noticed the formation of a small knot which increased in size over time. Petitioner testified that the knot developed prior to February 29, 2004, and that subsequent to his return in February, 2005, that the knot increased in size. When Petitioner returned to work in February, 2005, as a mine control operator, he did a substantial amount of paperwork, inputting data into a computer, making copies, answering the telephone, etc.

Petitioner first sought medical treatment for his right hand on November 20, 2006, when he was seen by Dr. Mark Smith, his primary care physician. Dr. Smith diagnosed Petitioner with Dupuytren's contracture and referred him to Dr. Michael Davis, an orthopedic surgeon. On December 6, 2006, Petitioner was examined by Dr. Davis who diagnosed Dupuytren's contracture of the right ring finger. On January 9, 2007, Dr. Davis performed a partial palmar fasciectomy and Dupuytren's release of the right ring finger. He authorized Petitioner to be off work and when seen by Dr. Davis on January 24, 2007, Dr. Davis continued to authorize the Petitioner to be off work through January 31, 2007. Petitioner was directed to return in one month's time; however, he did not returned to see Dr. Davis until April 26, 2010, at the direction of his attorney. The purpose of this visit was to determine Dr. Davis' opinion as to whether there was a causal relationship between the Petitioner's activities as a roof bolter and the development of the Dupuytren's contracture that required surgery. At that time, Dr. Davis noted that the Petitioner was doing well and had no complaints of pain or discomfort.

Dr. Davis was deposed on July 19, 2012, and his deposition testimony was received into evidence at trial. Dr. Davis testified that based on his experience of treating coal miners, including roof bolters, and his understanding of Petitioner's job duties as a roof bolter that those duties were a contributing factor to the development of the Dupuytren's contracture. It should be noted that in December, 2006, Dr. Davis was of the understanding that Petitioner had continued to work as a roof bolter even though he had not worked in that capacity since February 29, 2004. Dr. Davis explained that repetitive and prolonged compression forces applied to the palm where the primary factors that contributed to the contracture. Dr. Davis did agree that this disease is complex and multifactorial and that there is a conflict in the medical literature regarding causation.

At the direction of the Respondent, Petitioner was examined by Dr. David Brown on November 11, 2009. Dr. Brown examined the Petitioner and obtained a history from him as well as reviewing the various treatment records that were provided to him. Dr. Brown opined that the Dupuytren's contracture was not related to Petitioner's work activities because it is not a condition that has been associated with repetitive or hand intensive activities. Dr. Brown was deposed on August 6, 2012, and his deposition testimony was received into evidence at trial. Dr. Brown restated his opinion that Petitioner's Dupuytren's contracture was not related to his work activities and referenced several medical articles that supported his position. Further, Dr. Brown opined that even if repetitive and forceful hand activities were a cause of Dupuytren's contracture, the roof bolting activities would not have been such a causative factor because Petitioner had ceased working as a roof bolter in February, 2004.

At trial Petitioner testified that subsequent to the surgery, his right hand was fully functional and his fingers no longer drew up. Petitioner further testified that he had no complaints at all in respect to his right hand and that it was "perfect."

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain a repetitive trauma injuries to his right hand because the Dupuytren's contracture is not causally related to Petitioner's work activities as a roof bolter.

In support of this conclusion the Arbitrator notes the following:

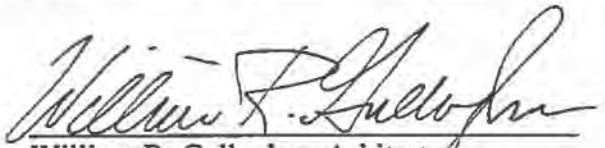
The Arbitrator notes that Petitioner last worked as a roof bolter on February 29, 2004, but did not seek medical treatment until November 20, 2006.

When Dr. Davis first saw Petitioner in December, 2006, it was his understanding that Petitioner had continued to work as a roof bolter. While Dr. Davis still opined that there was a causal relationship between Petitioner's work activities and the Dupuytren's contracture in his right hand, the fact that the Petitioner had ceased work as a roof bolter on February 29, 2004, indicates that Dr. Davis' opinion as to causality is flawed.

The Arbitrator thereby finds the opinion of regarding causal relationship of Dr. Brown to be more credible than that of Dr. Davis.

In regard to disputed issues (J), (K) and (L) the Arbitrator makes the following conclusions of law:

Because of the Arbitrator's conclusion in disputed issues (C) and (F) the Arbitrator hereby finds Petitioner is not entitled to payment of medical bills, temporary total disability benefits or permanent partial disability benefits.



William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lawrence Taylor,
Petitioner,

vs.

Dow Jones & Co., Inc.,
Respondent,

NO: 12 WC 18159

14IWCC0743

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, 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 September 4, 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 $46,600.00. 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: AUG 2 9 2014

Marjo Basurto

David L. Gore

Stephen Mathis

MB/mam
O:7/31/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TAYLOR, LAWRENCE
Employee/Petitioner

Case# **12WC018159**

14IWCC0743

DOW JONES & CO INC
Employer/Respondent

On 9/4/2013, 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 0.05% 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:

1956 JUNCKER, DANIEL K PC
1803 N BELT WEST
BELLEVILLE, IL 62226

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
THEODORE J POWERS
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

14IWCC0743

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

Lawrence Taylor
Employee/Petitioner

v.

Dow Jones & Co., Inc.
Employer/Respondent

Case # 12 WC 18159

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 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On March 31, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $n/a; the average weekly wage was $1,226.25.

On the date of accident, Petitioner was 55 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

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 $817.50 per week for eight and two-sevenths (8 2/7) weeks commencing March 15, 2012, through May 12, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $695.78 per week for 57 weeks because the injury sustained caused the 15% loss of use of the right hand and the 15% loss of use 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.

William R. Gallagher, Arbitrator

August 30, 2013
Date

SEP 4 - 2013

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 that was initially filed in this case alleged a date of accident (manifestation) of April 5, 2012. At trial, Petitioner's counsel filed an Amended Application which alleged a date of accident (manifestation) of approximately February 27, 2012, and that Petitioner sustained a repetitive trauma to both upper extremities. Respondent disputed liability on the basis of employee/employer relationship, accident, notice and causal relationship.

Petitioner worked for Respondent as a pressman at their Highland facility and worked as a full-time employee for Respondent from September 24, 2006, until November 8, 2011, when his job was terminated due to lack of work. Petitioner was subsequently called back to work for Respondent but only on an as needed basis. Petitioner testified that he worked intermittently for Respondent for the remainder of 2011 and 2012.

Petitioner testified that a pressman had to perform numerous hand intensive tasks. Petitioner's job duties included plating the press, loading rolls, gripping and grasping of the plates, using a wrench to both lock the plates in place and remove them, wash blankets and perform other maintenance tasks as required. Removal of the plates required Petitioner to forcefully use his hands in an upward/forward motion which he would do approximately 100 to 200 times per night.

Petitioner testified that sometime in 2010 he began to develop numbness/tingling in both of his hands. He did not experience these symptoms to any significant degree while at work; however, he did have a significant number of instances in which he experienced numbness/tingling at night which caused sleep disruption. While at work, Petitioner did notice that his right hand became weak and that he would drop wrenches. Petitioner stated that he did not initially associate his hand symptoms with his work and thought that they may have been due to a circulation problem or arthritic changes in his hands.

Petitioner initially sought medical treatment from his family physician, Dr. Jay Pickett; however, on January 25, 2012, Petitioner was evaluated by Rachel Green, a PA associated with Dr. Pickett. At that time, Petitioner complained of bilateral hand numbness of six months duration more in the right than left and occurring primarily at night. There was no reference in the medical record to Petitioner's work activities or any other trauma of the hands. Petitioner testified that he did not discuss his work activities at that time. The record indicated an assessment of "CTS bilateral." PA Green recommended that Petitioner to be seen by a specialist.

On February 20, 2012, Petitioner was evaluated by Dr. Bruce Schlafly, a hand surgeon. At that time, Petitioner complained of numbness/tingling in his hands, right greater than the left, primarily at night, and that the symptoms had been present for several months but were getting worse. There was no reference to Petitioner's work activities and Petitioner testified that he did not have any discussions with Dr. Schlafly regarding them. Dr. Schlafly examined Petitioner and has findings were positive for carpal tunnel syndrome; however, Dr. Schlafly recommended that Petitioner undergo nerve conduction studies. On February 27, 2012, Petitioner had nerve

conduction studies performed by Dr. Richard Head and the studies were consistent with bilateral carpal tunnel syndrome. Dr. Schlafly performed right and left carpal tunnel release surgeries on March 15, and April 5, 2012, respectively. Petitioner remained under Dr. Schlafly's care following the surgeries and was authorized to be off work from March 15, 2012, through May 12, 2012.

Petitioner testified that he did not know that the condition regarding his hands was work-related until sometime in late March, 2012, when he had a conversation with a retired St. Louis Post-Dispatch pressman. It was subsequent to this conversation that Petitioner decided to inform the Respondent that he had a work-related condition.

Petitioner testified that on April 5, 2012, (the date he had surgery on his left hand) he telephoned the Respondent's human resources department. Petitioner testified that he was informed that he had to speak to his supervisor, Andy Hempkin. Petitioner testified that the next day he telephoned Hempkin and was referred back to human resources. On April 8, 2012, Petitioner contacted human resources and was again told to speak to Hempkin. Petitioner testified that on either April 8, or April 9, 2012, he spoke to Hempkin again and informed him that he had to report a work-related injury to his hands.

At the direction of the Respondent, Petitioner was examined by Dr. William Strecker, an orthopedic surgeon, on March 11, 2013. Dr. Strecker reviewed medical records provided to him by Respondent, obtained a work history from Petitioner and examined him. Dr. Strecker opined that Petitioner's job duties as a pressman were a contributing factor to the bilateral carpal tunnel syndrome. At the request of Respondent's counsel, Dr. Strecker prepared a supplemental report dated April 22, 2013, in which he opined that Petitioner had five percent (5%) permanent partial disability to each wrist. This report contains no reference to the AMA Guides for Evaluation of Impairment so it is not clear if this is, in fact, an AMA impairment rating.

Gerald Gowman, Respondent's plant manager testified at trial and stated that Respondent trained the employees about repetitive motion, safety and the procedures for reporting work-related injuries. Gowman testified he had no knowledge of what was discussed by Petitioner and Hempkin but stated that he did speak to Petitioner on April 16, 2012, and completed an injury investigation report.

Petitioner testified that the surgeries relieved and numbness/tingling in both hands and he thought he had a good result. Petitioner did complain of decreased grip strength in both hands as compared to what they were prior to his developing carpal tunnel syndrome. He also complained of an occasional twinging sensation in the area of the surgical scars.

Conclusions of Law

In regard to disputed issues (B), (C), (D) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that on March 31, 2012, an employee-employer relationship existed between Petitioner and Respondent; Petitioner sustained a repetitive trauma injury to both hands

that manifested itself on that date, and that his current condition of ill-being is causally related to said repetitive trauma injury.

In support of this conclusion the Arbitrator notes the following:

As stated herein, Petitioner initially alleged the manifestation date to be April 5, 2012, the date of surgery on the left hand and, at trial, Petitioner filed an Amended Application alleging the manifestation date to be February 27, 2012, the date that the nerve conduction studies were performed that confirmed the diagnosis of bilateral carpal tunnel syndrome.

The date of manifestation in a repetitive trauma case has been defined as "...the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person." Durand v. Industrial Commission, 862 N.E.2d 918, 926 (Ill. 2006).

Determination of a manifestation date in a repetitive trauma case is dependent on various factors and the date can be when the employee requires medical treatment or the date on which the employee can no longer work. General Electric v. Industrial Commission, 546 N.E.2d 987 (Ill. App. 4th Dist. 1989). The peculiar facts of each case must be closely analyzed in repetitive trauma cases in the interest of fairness to the employee, the employer and the employer's compensation carrier. Three "D" Discount Stores v. Industrial Commission, 556 N.E. 2d 261 (Ill. App. 4th Dist. 1990).

In Durand, the Illinois Supreme Court noted that "...because repetitive trauma injuries are progressive, the employee's medical treatment, as well as the severity of the injury and particularly how it affects the employee's performance, are relevant in determining objectively when a reasonable person would have plainly recognized the injury and its relation to work." Durand at 929.

In the instant case, determination of the manifestation date is complicated by the fact that the Petitioner did not initially believe that he had carpal tunnel syndrome and, even when it was diagnosed, he did not associate it with his work activities until sometime in March, 2012, when he had the conversation with the retired Post-Dispatch pressman. Further, Petitioner was no longer working full time for Respondent as of November 8, 2011, so there was no cessation of work because of the condition.

In the proposed decision filed by Petitioner's counsel, the manifestation date was February 27, 2012, (the date alleged in the Amended Application) which is the date the nerve conduction studies were performed that confirmed the diagnosis of carpal tunnel syndrome. In the proposed decision filed by Respondent's counsel, the manifestation date was January 25, 2012, the date that Petitioner initially sought medical treatment and was given a preliminary diagnosis of carpal tunnel syndrome. In the medical records for both of these dates, there was no reference to Petitioner's work activities or any opinion relating the carpal tunnel syndrome to them. Petitioner testified that he did not associate his hand symptoms to his work activities until he spoke to the retired Post-Dispatch pressman sometime in late March, 2012. Applying the "reasonable person" test to the facts in the instant case, the Arbitrator finds that neither February 27, 2012, nor

January 25, 2012, are the date of manifestation. The date of manifestation is when Petitioner first learned of a possible association of his carpal tunnel syndrome and has work activities when he spoke to the retired Post-Dispatch Pressman, sometime in late March, 2012. Accordingly, the Arbitrator finds the date of manifestation to be March 31, 2012, and the Amended Application for Adjustment of Claim is so modified. See Warren v. A.T.&T, 10 IWCC 0801.

The fact that Petitioner's full time employment ceased with Respondent on November 8, 2011, is not of any significance because it is well established that a manifestation date can occur outside the date of employment. A.C. & S. v. Industrial Commission, 710 N.E.2d 837 (Ill. App. 1st Dist. 1999).

There is no dispute that Petitioner's condition of ill-being is causally related to Petitioner's work activities because Respondent's Section 12 examiner, Dr. Strecker, opined that there was a causal relationship. There was no medical opinion to the contrary.

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

The Arbitrator finds that Petitioner gave notice to Respondent within the time prescribed by the Act.

In support of this conclusion the Arbitrator notes the following:

As stated herein, the Arbitrator has determined the manifestation date to be March 31, 2012. Petitioner testified that he had multiple conversations with both human resources and Andy Hempkin, his supervisor, between April 5, and April 9, 2012. Hempkin did not testify at trial so there is no evidence to the contrary. Further, Respondent's witness, Gerald Gowman, testified that he spoke to Petitioner on April 16, 2012, and became aware of Petitioner's claim to have sustained a work-related injury. All of the preceding occurred within the time limit prescribed by the Act for Petitioner to provide notice to Respondent.

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 incurred therewith.

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.

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 eight and two-sevenths (8 2/7) weeks commencing March 15, 2012, through May 12, 2012.

In support of this conclusion the Arbitrator notes the following:

Petitioner's treating physician, Dr. Schlafly, authorized Petitioner to be off work for the aforestated period of time and there was no opinion to the contrary.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 15% loss of use of the right hand and 15% loss of use of the left hand.

In support of this conclusion the Arbitrator notes the following:

As stated herein, Respondent's Section 12 examiner, Dr. Strecker, opined that Petitioner had 5% permanent partial disability to each wrist. There was no reference to the AMA Guides for the Evaluation of Impairment and this is a rating of permanent partial disability, not an AMA rating of impairment. Accordingly, the Arbitrator gives this evidence no weight.

Petitioner's occupation of a pressman requires the active and repetitive use of both upper extremities.

Petitioner was 55 years of age at the time of the manifestation so he will have to live with the effects of this injury the remainder of his working and natural life.

There was no evidence that this injury will have any effect on Petitioner's future earning capacity.

Petitioner was diagnosed with bilateral carpal tunnel syndrome and surgery was required on both wrists/hands. Petitioner still has residual complaints consistent with the injury he sustained.

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

William J. Vickers,
Petitioner,
vs.
UTI Logistics,
Respondent,

NO: 11 WC 00115

14IWCC0744

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, permanent partial disability, medical expenses, 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 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $68,800.00. 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: AUG 2 9 2014

MB/mam
o:7/17/14
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

VICKERS, WILLIAM J
Employee/Petitioner

Case# **11WC000115**

14IWCC0744

UTI LOGISTICS
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:

4084 LAW OFFICE OF TIMOTHY J DEFFET
PO BOX 180335
CHICAGO, IL 60618

1296 CHILTON YAMBERT & PORTER LLP
DANIEL T CROWE
150 S WACKER DR SUITE 2400
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

14IWCC0744

☐ 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
CORRECTED

William J. Vickers
Employee/Petitioner

v.

UTI Logistics
Employer/Respondent

Case # 11 WC 115

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Geneva, Illinois**, on **2/1/13**. 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. X Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. X Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. X What is the nature and extent of the injury?
M. X Should penalties or fees be imposed upon Respondent?
N. X Is Respondent due any credit?
O. Other

FINDINGS

On **10/15/10**, 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 **$34,897.20**; the average weekly wage was **$671.10**

On the date of accident, Petitioner was 36 years of age, ***single*** with 2 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 **$11,339.14** for TTD, **$0** for TPD, **$0** for maintenance, and **$32,327.31** for other benefits, for a total credit of **$43,666**.45

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

ORDER

Respondent shall pay reasonable and necessary medical services in the amount of $60,476.02. As provided in Sections 8(a) and 8.2 of the Act, said services are to be paid pursuant to medical fee schedule. Consistent with the stipulation of the parties, Respondent shall receive a credit for all bills paid.

Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits of $402.66 per week for 128.8 weeks because the injuries sustained caused 5% loss of use of the right thumb (3.8 weeks) and 25% loss to the Person as a Whole (125 weeks) 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 — Date: 7/05/13

JUL 15 2013

Attachment to Arbitrator Decision
(11 WC 115)

Statement of Facts

Petitioner testified that on May 31, 2010 he was hired by Respondent UTI as a material handler. He continued to work for them until being terminated on March 10, 2011. His job duties consisted of working at the Michelin tire warehouse largely by himself. Petitioner 5'9" and weighs approximately 180 pounds. Petitioner normally worked 57.5 hours a week. He was required to use a standup forklift and move pallets of tires to a different location. He then was required to personally physically stack a minimum of 300-400 tires a day onto pallets. These tires varied in weight from 35-75 pounds. Each pallet contained 4 stacks of tires which were chest high at least in height (at least 5 feet high) on each pallet. Each pallet had 5 foot tall cardboard cylinder cones that these tires were placed upon by Petitioner. He also had to move the cones at times which weighed 40-50 pounds apiece.

Petitioner testified that on October 15, 2010, he was scheduled to work the 4:30 A.M. to 3:00 P.M. shift for Respondent. Petitioner provided that while working that day, he felt a pulled muscle with shooting pain up and down his arm, which was sharp, constant and throbbing. Petitioner also indicated that he noticed "a lot of pain in the lower right shoulder blade for 2 or 3 days." Petitioner testified that he "kept working hoping it was a pulled muscle," however; the pain became so severe he sought treatment.

On October 17, 2010, Petitioner went to St. James/Olympia Fields Hospital ER where he reported pain in the right shoulder and neck for two days after lifting tires at work. At St. James his right shoulder was x-rayed, which was negative for fracture or any bony abnormalities. He was prescribed medication and instructed to follow-up with occupational health. (PX 7)

Petitioner testified and the records show that he had been to St. James/Olympia Fields previously on January 6, 2010 for a right shoulder pain. (RX 2) Petitioner stated that he was treated and released and the pain resolved within 1-2 days. He did not get any further treatment.

Petitioner testified that on his October 17, 2010 visit to St. James he had different complaints of pain in his right shoulder blade and neck than on January 6, 2010. He provided that the pain in October 2010 was much more severe than the pain he experienced in January 2010 .

Petitioner sought treatment with Dr. Clay Canaday of Bone and Joint Surgeons, Ltd., on October 18, 2010. Dr. Canaday recorded that Petitioner reported "...that last Friday, October 15, 2010 he developed pain in his shoulder, triceps, and shoulder blades." He reported that the pain radiated all the way down to his forearm and that the tip of his thumb was numb. Dr. Canady noted that Petitioner couldn't recall any antecedent neck trauma or trauma to his shoulders. The doctor also recorded that Petitioner was a material handler performing a lot of heavy lifting and running a forklift. Cervical x-rays were taken showing mild disc narrowing and endplate degenerate C5-6. After performing examination, Dr. Canaday's impression was cervical radiculopathy. The doctor offered a Medrol Dosepak, ordered a MRI and took Petitioner off work. The doctor also felt epidural steroid injections were possible. (PX 7)

Petitioner testified that on October 20, 2012 he saw his primary care physician, Dr. Neilesh Shah who also took him off work. Petitioner provided that although he supplied his off work slip to Respondent, he was not paid TTD at this time.

On October 22, 2010 Petitioner filled out an accident report. The report titled "Employee's Report of Injury" states the time of accident (2:00 – 3:00 P.M.), date of accident (10/15/10) and the date reported (10/17/10). Petitioner provided that he "left messages on answering machines, Raury Calhoun, Cindy, etc." It also states in numbered section 10 entitled "Describe fully what you were doing and how injury occurred" that the job "requires consistent and repetitious lifting of various weight and size of tires…" and in numbered section 11 "Nature and location of injury" Petitioner wrote, "right side of neck branching towards upper shoulder neck." (PX 6)

Petitioner underwent the MRI of his cervical spine at High Tech Medical Park South on November 2, 2010. The examining radiologist stated the following impressions: 1.) At C5-C6, moderate central and moderate bilateral foraminal stenosis secondary to diffuse disc bulge with endplate osteophytes, uncovertebral osteophytes and a subtle broad based right paracentral protrusion with endplate osteophytes; 2.) C6-C7 small central left paracentral disc protrusion effaces the adjacent thecal sac without secondary stenosis; and 3.) C4-C5 mild foraminal stenosis secondary to bilateral degenerative uncovertebral osteophytes, left greater than right. (PX 3)

On November 5, 2010, Petitioner returned to Dr. Canady who reviewed the cervical MRI with him, gave him another off work slip and referred him to pain treater, Dr. Scot Glaser of Pain Specialists of Greater Chicago-Orland Park office. (PX 7)

On November 12, 2010 Petitioner saw Dr. Glaser for the first time with complaints of neck pain and upper extremity pain. Dr. Glaser noted Petitioner's onset of his complaints were gradual and that "[t]he precipitating event was a work related accident. The pain began 1 month ago…He noted starting on a Friday, 10/15…Primarily he picks up tires and puts them on pallets. He originally thought he had a pulled muscle and noted symptoms in his shoulder blade and it became severe by Sunday…" Petitioner reported a pain intensity level at 8/10. Dr. Glaser rendered a diagnosis of cervical radiculopathy and facet syndrome without myelopathy, cervical. Dr. Glaser recommended epidural steroid injections, three injections, one every two weeks. He authorized Petitioner off work. Subsequently, Dr. Glaser performed epidural steroid injections on November 17, 2010, December 8, 2010 and December 22, 2010 at Hinsdale Surgical Center. (PX 1) Petitioner testified that the injections only helped temporarily.

On November 16, 2010 x-rays were performed of Petitioner's right hand which showed no evidence of acute traumatic injury with mild degenerative changes. (PX 1)

On December 21, 2010, Petitioner returned to Dr. Glaser. The doctor provided the following diagnoses:1.) carpal tunnel syndrome;2.) osteoarthrosis, hand; 3.)facet syndrome without myelopathy, cervical; and 4.) cervical radiculopathy. Dr. Glaser expressed a concern that Petitioner had severe degenerative joint disease in the distal thumb or carpal tunnel syndrome. The doctor referred Petitioner to Dr. Manischa Saraf Khanna for EMG/NCS testing at Suburban Pain Care Center. (PX 1)

On January 4, 2011, Petitioner saw Dr. Khanna. The doctor recommended that Petitioner undergo electrodiagnostic testing to evaluate for cervical radiculopathy versus anterior interosseus neuropathy. As a result, Dr. Khanna then performed an EMG and NCV. The doctor provided the following impressions; 1.)The electrical study shows some subtle abnormalities of the right brachioradialis muscle which does receive some C5-6 innervation; these abnormalities are not diagnostic of radiculopathy or other process; 2.) The study is consistent with a bilateral mild median neuropathy of the wrist/carpal tunnel syndrome; and 3.) There is no electrical evidence of right sided anterior interosseus neuropathy. (PX 1)

On January 11, 2011, Petitioner again followed up with Dr. Glaser who recommended another cervical epidural and right thumb injection. (PX 1) Petitioner testified that he declined the recommendation as he wanted a second opinion.

On January 12, 2011, Petitioner sought the services of Dr. Daniel Troy of Midwest Orthopedics. Dr. Troy performed a physical exam, reviewed diagnostic studies and assessed 1.) C5-6 nucleus pulposus, secondary osteophyte causing right C6 radiculopathy; and 2.) right trigger thumb. Dr. Troy administered an injection into Petitioner's right thumb. The doctor also recommended physical therapy for the neck. (PX 2)

On January 24, 2011, Dr. Glaser authored a letter "[t]o whom it concern." The doctor wrote that Petitioner was under his care for carpal tunnel syndrome, osteoarthrosis, facet syndrome, and cervical radiculopathy. Dr. Glaser also indicated that Petitioner was unable to work. (PX 1)

On January 26, 2011, Dr. Troy discussed with Petitioner various surgical procedures, i.e. C5-6 anterior cervical discectomy, bilateral foraminotomy and spinal cord decompression, cervical disc replacement, and/or fusion. Petitioner elected to undergo cervical disc arthroplasty. Dr. Troy also kept Petitioner off work until further notice. (PX 2)

On February 8, 2011, Petitioner was seen by Dr. Glaser on February 8, 2011. Dr. Glaser reported that Petitioner's neck pain and upper extremity pain had increased since he last examined. Dr. Glaser's report does not discuss the surgical procedure that was ordered by Dr. Troy. Dr. Glaser ordered a right facet joint injection at C5-6, C6-7, and C7-T1. The doctor indicated Petitioner was disabled. (PX 2)

On February 24, 2011, Dr. Troy performed a C5-C6 anterior cervical discectomy, bilateral foraminotomies, C5-C6 and spinal cord decompression, C5-C6 cervical disk arthroplasty, which took place at Advocate Christ Medical Center. The pre-operative and post-operative diagnoses were: C5-6 right sided herniated nucleus pulposus with underlying spinal canal compromise. (PX 4)

On March 9, 2011, Petitioner had his first post-op visit with Dr. Troy. Petitioner reported that he was "doing overall fantastic. He had absolutely no pain. Petitioner underwent x-rays, was kept off work and told to come back on March 30, 2011. On that date, Petitioner returned and Dr. Troy recommended independent home exercises and stretching for the neck and forearm. On June 3, 2011 Dr. Troy saw him again. Petitioner was found neurologically intact both from a sensory and motor standpoint. Petitioner had no new complaints. Petitioner was instructed to follow-up in six to eight months. He was otherwise advised to return on as-needed-basis. (PX 5, pgs14-17)

Petitioner returned to Dr. Troy on March 13, 2012 when he had complaints of catching and popping in his neck occasionally and triggering in his right thumb. Dr. Troy performed a right thumb injection at that time. He was advised to return on as-needed-basis. (PX 2 and PX 5, pg. 18)

Dr. Troy testified in this matter via deposition on June 26, 2012. Dr. Troy opined that there was a causal relationship between the alleged occurrence of October 15, 2010 and the condition of Petitioner's cervical spine for which he provided treatment. Dr. Troy provided that his opinion was based on the history provided to him by Petitioner including Petitioner's description of the type of work he performed. Dr. Troy also provided that Petitioner's right thumb condition was causally related. The doctor stated, " ...I mean stenosing tenosynovitis, otherwise known as triggering of the thumb, is associated to repetitive trauma, and therefore that's where the causation would come from." (PX 5, pgs 20-22) Dr. Troy further testified that Petitioner, from a surgical standpoint with a cervical disc replacement, had no limitations nor was he susceptible, "theoretically," to further

injury due to the presence of the prosthesis in his spine. (PX 5, pg. 25) On cross-examination, Dr. Troy testified that his causal connection opinion could change if the history provided was not true. (PX 5, pg 28)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Ghanayem on June 8, 2011. Dr. Ghanayem testified via deposition on August 15, 2012. Dr. Ghanayem testified that there was a causal connection between the alleged occurrence of October 15, 2010 and the injury to Petitioner's cervical spine. The doctor stated, "I believe that he either sustained or aggravated the disk herniation when he was picking up tires and loading them in the pallet." When asked what's the basis of that, Dr. Ghanayem replied, "[m]echanism of injury, onset of symptoms, temporal sequencing, nature of the disease process in question, and the diagnostic studies." Dr. Ghanayem also provided that his physical examination of Petitioner was completely normal. Dr. Ghanayem further opined that Petitioner had achieved maximum medical improvement, that he was capable of returning to his pre-occurrence employment, full duty, and that he did not sustain any permanent disability as a result. (RX 1, pgs 12-16)

Petitioner testified that he provided his off work slips to Respondent. He did not receive any TTD from his employer until Respondent eventually paid all his TTD in a lump sum after he was seen by Section 12 defense examiner Dr. Alexander Ghanayem.

Petitioner testified he called Saborah Howell at work on Thursday March 10, 2011 to report to work. Petitioner indicated that he was told to come in by Ms. Howell and in fact did so later that afternoon at 1:00 P.M. Petitioner indicated he spoke to her at the HR office. She informed him that she would get in touch with him later in the day. Petitioner stated that she called him two hours later and informed him that he was terminated via February 9, 2011 letter. Petitioner testified that he informed Ms. Howell that he had not received this letter. Petitioner returned wherein she gave him a copy and told him he was terminated for attendance issues.

Petitioner testified that since being terminated, he had applied for numerous jobs. (PX 27) Petitioner indicated that he was on unemployment since approximately April 2011 until being re-employed in December of 2012. On said date, Petitioner began working as a material handler for ITW Tekfast (Frankfort, Il). Petitioner stated that he works on a rotating shift at 5 days one week, 2 days the next week, at $10.50 an hour, 12.5 hours for each day worked.

Petitioner testified that in his current position, he does heavy lifting at work. As a result, he experiences neck and right thumb pain on a daily basis.

Mr. Ivy Anderson testified on behalf of Respondent. A co-worker of Petitioner, Mr. Anderson, testified that he is a material handler who has been in the employ of Respondent for six years. He stated that prior to October 15, 2010, in the break room on Respondent's premises, he had a conversation with Petitioner. Mr. Anderson testified that in that conversation Petitioner told him that he had hurt his right shoulder and neck while working on a car at home. Mr. Anderson testified that Petitioner told him that he (Petitioner) intended to report the injury as a workers' compensation injury.

On cross-examination, Mr. Anderson testified that he didn't know the exact date when Petitioner told him about his neck and shoulder complaints. Mr. Anderson stated that he informed Respondent about the statement. He "prepared a statement [and] gave it to Safety."

On rebuttal testimony, Petitioner denied that he said this to Mr. Anderson. Petitioner provided that he didn't know Mr. Anderson, but had seen him on Respondent's premise. Petitioner also testified that he did not own a car in October 2010.

Mr. George Nichols, Petitioner's supervisor, testified on behalf of Respondent. Mr. Nichols testified that during the week leading up to October 15, 2010, on each and every day before work began, he conducted a toolbox meeting with the employees who worked for him. Mr. Nichols testified that at each of these meetings he stressed safety and the immediate reporting of accidents, no matter how slight the employee perceived the accident to be. Mr. Nichols stated that Petitioner did not provide notice of having experienced an injury to him. Rather, Petitioner gave notice of his alleged injuries to his right shoulder and neck via voicemail to the Respondent on Sunday, October 17, 2010.

Mr. Nichols testified that he did not have any work issues with Petitioner. He felt Petitioner was a hard work, "for the most part." Mr. Nichols also testified that workers regularly have to lift tires of 75 pounds or below. If it weighs more than 75 pounds then they have to use the clamp truck.

With respect to (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:

Based on the preponderance of evidence, the Arbitrator finds that Petitioner sustained an accidental injury that arose out of and in the course of his employment with Respondent on October 15, 2010. The Arbitrator relies on Petitioner's testimony and the consistent histories provided to his treating physicians. The Arbitrator is not persuaded by the testimony of Mr. Ivy Anderson, Respondent's witness. Mr. Anderson testified that prior to October 15, 2010 Petitioner told him that he had hurt his right shoulder and neck while working on a car at home. Mr. Anderson testified that Petitioner told him that he (Petitioner) intended to report the injury as a workers' compensation injury. Mr. Anderson testified that he didn't know the exact date when Petitioner told him but stated that he informed Respondent and "prepared a statement [and] gave it to Safety." The Arbitrator is of the belief that if a "statement" was prepared, Respondent would have produced same at trial. No such "statement" was submitted as evidence. Lastly, Petitioner unrebutted testimony was that he did not own a car in October 2010.

With respect to (F.) Is the petitioner's present condition of ill-being casually related to the injury, the Arbitrator finds as follows:

Relying on Petitioner's treating physician, Dr. Troy, and Respondent Section 12 examiner, Dr. Ghanayem, the Arbitrator finds that Petitioner's right thumb and neck conditions of ill-being are causally related to the October 15, 2010 accident.

With respect to (J.) Were the medical services that were provided to petitioner reasonably and necessary, the Arbitrator finds as follows:

Having found the requisite causal relationship, relying on Dr. Troy and Dr. Ghanayem, the Arbitrator finds the medical bills submitted as Petitioner's exhibits 11-23 were reasonably and necessary.

Respondent paid for the following medical services pursuant to the Illinois Workers' Compensation Fee Schedule:

PROVIDER	DATE OF SERVICE	AMOUNT BILLED	AMOUNT PAID
Pain Specialists of Greater Chicago	11/17/10, 12/8/10,	$4,896.00	$2,855.55

	12/22/10		
Pain Specialists of Greater Chicago	11/12/10, 12/21/10, 1/11/11, 2/8/11	$708.00	$437.83
Pain Specialists of Greater Chicago	1/11/11	$759.00	$645.15
Midwest Orthopaedics	2/24/11	$35,967.00	$22,925.62
Midwest Orthopaedics	2/24/11	$5,755.00	$3,438.84
Midwest Orthopaedics	1/21/11, 1/26/11	$2,398.00	$2,024.32

Petitioner entered the following bills into evidence:

Ex. 11-6/26/11 itemized bill from Advocate Christ Medical Center for 2/24/11 cervical surgery by treating surgeon Dr. Daniel Troy - $38,858.14 is owed by Respondent according to fee schedule on ($46,309 billed);

Ex. 12- St. James Hospital-Olympia Fields itemized bill for 10/17/10, 10/19/10 , as well as 2/2/11 collection agency letter from MRA regarding same - $825.88 owed by Respondent;

Ex. 13- Suburban Paincare Center (Dr. Manisha Saraf Khanna) itemized bill for 1/4/11 pain care and NCS studies including EMG - $3,358.00 owed by Respondent;

Ex. 14- HLG Anesthesia Associates, Limited anesthesia/pain management (5/9/11 itemized statement) for 11/17/10, 12/8/10 and 12/22/10 injections - $2,000.00 owed by Respondent;

Ex. 15- Hinsdale Surgery Center (3/8/11 itemized statement) itemized billing for 11/17/10, 12/8/10 and 12/22/10 injections - $13,068.00 owed by Respondent;

Ex. 16- Itemized bill of Dr. Clay Canady/IL Bone & Joint Physicians for treatment from 10/18/10 through 11/5/10 - $545.00 owed by Respondent;

Ex. 17- 7/14/11 itemized bill for 2/17/11 treatment with Dr. John J. Arrotti Heart Care Centers of Illinois in preparation for 2/24/11 surgery - $341.00 owed by Respondent;

Ex. 18- 7/23/11 itemized bill for 2/24/11 services from Midwest Diagnostic Pathology-$221.00 owed by Respondent;

Ex. 19- 4/8/11 itemized bill for Dr. Flynn Midwest Anethesiologists, Ltd. For 2/24/11 service - $1216.00 owed by Respondent;

Ex. 20- 4/7/11 itemized bill forDr. Daniel Troy/Midwest Orthopedic Consultants, S.C. treatment from 1/12/11 to 3/12/12 - appears to be paid in full by Respondent according to fee schedule;

Ex. 21- 5/9/11 itemized bill for Dr. Neilesh Shah/Advocate Medical Group for 2/14/11 service for ECG and exam - $243.00 appears to be paid by Respondent;

Ex. 22- 7/19/11 itemized bill for Dr. J. Mamon/Oaklawn Radiology Imaging Consultants, for 2/24/11 Cervical Xray - $43.00 owed by Respondent;

Ex. 23- Itemized bill for Dr. Scot E. Glaser/Pain Specialists of Greater Chicago for pain management treatment from 11/12/10 through 2/8/11 - appears to be paid in full by Respondent according to fee schedule.

TOTAL BILLS NOT PAID BY RESPONDENT: $60,476.02.

With respect to (L.) What is the nature and extent of the injury, the Arbitrator finds as follows:

Petitioner underwent surgery consisting of a C5-C6 anterior cervical discectomy, bilateral foraminotomies, C5-C6 and spinal cord decompression, C5-C6 cervical disk arthroplasty. Postoperatively, he treated until June 3, 2011 when Dr. Troy advised to return on as-needed-basis. Petitioner returned to Dr. Troy on March 13, 2012 when he had complaints of catching and popping in his neck occasionally and triggering in his right thumb. Dr. Troy performed a right thumb injection and again advised to return on as-needed-basis. Dr. Troy testified that Petitioner, from a surgical standpoint with a cervical disc replacement, had no limitations nor was he susceptible, "theoretically," to further injury due to the presence of the prosthesis in his spine.

Respondent's Section 12 examiner, Dr. Ghanayem, performed an examination on June 8, 2011. Dr. Ghanayem provided that his physical examination of Petitioner was completely normal. Dr. Ghanayem further opined Petitioner was capable of returning to his pre-occurrence employment, full duty, and that he did not sustain any permanent disability as a result.

Petitioner testified that at the time of the hearing he had pain every day in his right thumb and neck. He has problems doing things around the house that used to be no problem such as cleaning the garage out. Petitioner is a young man at 38 years old and although released full duty he still encounters pain and some limitation in his activities in and outside of work.

Based on the above the Arbitrator finds that Petitioner sustained 5% loss of use of the right thumb under Section 8(e) and is permanently disabled to the extent of 25% under Section 8(d)2 of the Act.

With respect to (M.) Should penalties or fees be imposed upon the respondent, the Arbitrator finds as follows:

While Respondent's conduct in this matter is suspect, same does not rise to the level contemplated under Section 19(k) of the Act. As such, Petitioner's request for penalties and attorney's fees are hereby 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

Rodney D. Lytle,
Petitioner,
vs.
State Of Illinois,
Respondent,

NO: 11 WC 06726

14IWCC0745

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 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 or summons for State of Illinois cases.

DATED: AUG 2 9 2014

MB/mam
o:7/31/14
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LYTLE, RODNEY D
Employee/Petitioner

Case# **11WC006726**

14IWCC0745

STATE OF ILLINOIS
Employer/Respondent

On 11/19/2013, 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 0.10% 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:

1465 DOC HALLIDAY ATTORNEY AT LAW
RONALD E HALLIDAY
5901 N PROSPECT RD SUITE #7A
PEORIA, IL 61614

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

5116 ASSISTANT ATTORNEY GENERAL
GABIREL CASEY
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

NOV 19 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0745

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RODNEY D. LYTLE,
Employee/Petitioner

v.

STATE OF ILLINOIS,
Employer/Respondent

Case # **11** WC **6726**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Peoria**, on **10/29/13**. 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **1/1/10**, 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.

In the year preceding the injury, Petitioner earned **$63,733.00**; the average weekly wage was **$1,225.63**.

On the date of accident, Petitioner was **47** 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 **$71,088.71** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$71,088.71**.

Respondent is entitled to a credit of **$33,458.14** under Section 8(j) of the Act.

ORDER

The petitioner's claim for compensation is denied. The petitioner has failed to prove by a preponderance of the credible evidence that he sustained an injury to his bilateral hands due to repetitive work activities that arose out of and in the course of his employment by respondent and manifested itself on 1/1/10.

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

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

11/14/13
Date

NOV 19 2013

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 47 year old correctional sergeant, alleges he sustained an accidental injury to his bilateral hands due to repetitive work activities that arose out of and in the course of his employment by respondent on 1/1/10. Petitioner was a correctional sergeant for over 25 years, with most of the time spent as a supervisor in the cell house. Petitioner testified that over the past ten years, as staff was reduced, he became more of a working supervisor. Petitioner mostly worked third shift.

From 2000 on petitioner worked in the cell house. Petitioner testified that his duties prior to that time included working in the sally port and segregation unit. However, after 2000 petitioner did not work in these units. He was assigned to the cell house thereafter, with a small period spent at the main gate, if he was filling in for someone that was sick or on vacation.

Petitioner testified that prior to working primarily in the cell house beginning in 2000, he worked in the sally port and segregation unit. Petitioner testified that in the sally port he would search all the vehicles coming in and going out. In segregation he and his staff would move on average 70 inmates in and out of segregation, and on a busy day they would move 130 inmates. This process included taking the inmates to the yard or to showers three times a week. Each inmate would be cuffed before the officer unbolted and opened the door with a key. Once the inmate was out of the cell the officer would put waist chains on the inmate and then place a padlock on the chains. The officer would reverse this process when they were returned to the cell. Petitioner did not work in the sally port or segregation after 2000.

As a sergeant on the midnight shift from 2000 to 2010 petitioner spent half of that time telling other officers what to do and the other half helping out due to the decrease in staffing. From 2000 to 2004 petitioner and the other staff would feed the inmates breakfast in their cells. This required petitioner, other officers and the feed crew to open and close the chuck holes of all inmates in the cell house. He testified that they had 336 inmates in his cell house. The chuck holes were opened and closed using a small key. He stated that the small keys were harder to get hold of. He stated that he performed this task 2-4 hours a day. He testified that he would alternate between his hands if they got tired. Petitioner testified that it affected his right hand immediately. He testified that in mid 2000s he had problems with his hands that included numbness, tingling, waking up at night, and loss of grip. When petitioner was not feeding the inmates breakfast he had other administrative tasks that were not repetitive in nature.

From 2005-2010 the inmates were not fed breakfast in their cells. The only time this would happen was when they were on lockdown. He testified that lockdown occurred 10-15 times a year, and would last from a week to 3 weeks. He admitted that the areas locked down depended on the severity of the infraction and may be

limited only to a specific cell house. Major Steele testified that the lockdowns lasted on average from 1-3 days and could be confined to one cell house.

From 2005 to 2010, when the cell house was not on lockdown, the inmates would have their breakfast in the dining room. In this instance the petitioner and other officers would be standing chow and watching the inmates eat, as well as enter and exit the dining room. On occasion the petitioner would also need to carry the mail bag. Petitioner could not testify to the weight of the bag. He also could not testify to the frequency with which he did this.

Petitioner first sought treatment for his hands in December of 2009. He stated that he had treatment at that time because the pain had gotten so bad he could not take it anymore. On 1/13/10 petitioner completed an incident report. He also reported his alleged injury to Major Gossett. He claimed that his daily job function involved using his hands for opening doors, locks, and trailers; carrying and using mirror for inspection under vehicles; constant use of hands, wrists, and elbows for repetitive motion. Petitioner claimed that on 1/13/10 he experienced extreme pain in his right and left hands; a noticeable difference in the range of motion; and constant numbness in his fingers and hands from constant use while opening doors, locks, hoods, and trailer doors. He complained of extreme pain while working in segregation using chuck hole doors, locks, handcuffs, waist chains, and slide bolts during the daily use of hands at his job. Petitioner claimed that while assigned to cell houses, the operation of the control panels and cell doors also aggravated the pain.

On 2/15/10 petitioner presented to Dr. Anane-Sefah at Great Plains Orthopedics. Petitioner was referred there by Dr. Enoch. Petitioner gave a 5 year history of bilateral hand numbness and tingling right greater than left, pain, and decreased strength. Petitioner also complained of night symptoms including burning, numbness, and tingling which awakens him throughout the night. He stated that he can only grip things for short periods of time. Petitioner reported difficulty manipulating fine objects such as coins, paperclips and buttons. Petitioner gave a history of high blood pressure and high cholesterol. Petitioner takes medication for his high blood pressure. Petitioner also reported that he has smoked on average 1 pack of cigarettes a day for 20 years.

Following an examination and record review that included an EMG with findings consistent with carpal tunnel syndrome of both of his hands, Dr. Anane-Sefah discussed carpal tunnel releases. Petitioner underwent a left carpal tunnel release on 2/23/10, and a right carpal tunnel release on 3/16/10.

On 7/21/10 petitioner was given a scar desensitization injection bilaterally. His diagnosis was status post bilateral carpal tunnel releases and bilateral sensitive hypertrophic scar secondary to the releases. On 8/9/10

petitioner underwent a second injection. On 8/23/10 petitioner underwent a third injection on the right side only. Petitioner's left hand was better following the second injection.

On 10/18/10 petitioner returned to Dr. Anane-Sefah complaining of residual hypersensitivity along the right-hand incision. Dr. Anane-Sefah reviewed the MRI and agreed that there was a small soft tissue structure, most consistent with synovium deep to the flexor tendons within the carpal tunnel. His impression was status post right open carpal tunnel release with residual pain. He referred petitioner to Dr. Garst.

On 11/30/10 petitioner presented to Dr. Garst for his ongoing pain in his right hand following a previous right carpal tunnel release. Petitioner reported that the numbness had improved but the pain around the scar and surgical site often radiates up into the fingers and back into the forearm. Petitioner reported that this inhibits his activities, including regular activities in his work. Dr. Garst reviewed an MRI of the right wrist that showed 3x7x16mm soft tissue structure deep into the flexor tendons within the carpal tunnel, possibly representing inflamed synovium. Dr. Garst's diagnoses were continued. Dr. Garst recommended a contrast enhanced MRI and repeat EMG/NCV test.

On 12/20/10 petitioner returned to Dr. Garst. Dr. Garst noted that petitioner's symptoms on exam were essentially unchanged. He noted that the EMG showed mild dysfunction of the right median nerve compatible with residual from previous carpal tunnel syndrome and surgery. There was no clear evidence of a recurrent carpal tunnel. The MRI showed evidence of possibly inflamed synovium or scar, but no true mass. Dr. Garst's diagnosis was continued.. Dr. Garst offered petitioner reexploration where he would look for inflamed synovium or possibly some hypertrophic scar pressing on the nerve. Dr. Garst could not guarantee petitioner great results.

On 1/3/11 petitioner's Application for Adjustment of Claim was filed. Petitioner alleged injuries to his right and left hands due to repetitive trauma. He alleged an accident date of 1/1/10.

On 1/27/11 petitioner underwent surgery for a recurrent right carpal tunnel syndrome. Petitioner followed-up postoperatively with Dr. Garst. On 3/8/11 Dr. Garst noted that petitioner's grip was a mildly improved compared to pre-operative. He noted better strength on the left side. Petitioner underwent a course of physical therapy for further range of motion strengthening. On 3/29/11 petitioner told Dr. Garst that he was still having problems and his condition was about the same as it was before his second surgery. On 4/25/11 petitioner returned to Dr. Garst complaining of a lot of pain and weak grip.

On 5/6/11 petitioner presented to Dr. Cohen. Dr. Cohen had no good explanation for the petitioner's continued problems. He did not recommend any more surgery. Dr. Cohen was of the opinion that the etiology was not entirely clear.

On 5/31/11 Dr. Garst referred petitioner to pain clinic. Petitioner underwent an injection and it did help, but he was not pain-free. Dr. Garst recommended continued pain clinic injections. Petitioner underwent injections on 7/511, 7/18/11, 8/19/11, and 9/22/11. On 8/16/11 Dr. Garst noted that petitioner's condition was essentially unchanged.

On 9/13/11 petitioner followed up with Dr. Garst still complaining of some excess scar on the carpal tunnel release site, especially on the radial side. Petitioner demonstrated full range of motion of the fingers, and good wrist range of motion to about 70° of volar flexion and dorsiflexion. Petitioner reported that the pain clinic injections had been helping and that he wanted to return to work even though he was still having pain. Dr. Garst was of the opinion that petitioner was getting better function, and still needed to work on his grip strengthening. He was also the opinion that petitioner may need another injection or two. He continued petitioner off work.

On 10/11/11 Dr. Garst was of the opinion that petitioner was almost at maximum medical improvement. He was of the opinion that petitioner needed a little more time to get stronger. He had no further suggestions for petitioner at the time. He recommended no further treatment. He released petitioner to full duty work as of 11/1/11.

On 11/21/12 petitioner underwent a section 12 examination performed by Dr. James Williams at the request of the petitioner. Petitioner gave a history of usually working the third shift. He reported that his job involved cuffing and uncuffing, opening cell doors, screening trucks, using mirrors for trucks, and working the sally port gate for seven years. Petitioner also reported that he was involved in picking up mailbags. He reported that most doors, except in segregation, were opened with small keys. He reported that there are 2 feed times in segregation, and the officer opens up the chuck hole. Petitioner denied any problems with his left hand following his left carpal tunnel release. However on the right he complained of constant numbness and tingling, his hand falling asleep at night, grip loss, weakness, dropping things, and treating numbness for pain. He rated his pain at rest on the right side 2 to 3 out of 10, and with activities 8 to 9 out of 10.

Following an examination and record review Dr. Williams impression was that petitioner appeared to have had right and left carpal tunnel syndrome with the successful carpal tunnel release on the left and continued problems of pain on the right without any further evidence of carpal tunnel. Dr. Williams was of the opinion

that petitioner had reached maximum medical improvement. He was also the opinion that petitioner has had appropriate treatment for his condition. He noted that petitioner was currently working regular duty.

Dr. Williams did not believe that petitioner's job duties would either have been aggravated or causative to his problems of right and left carpal tunnel syndrome for which he originally sought treatment. He opined a causal connection between petitioner's condition and his hypertension; smoking for 25+ years, one pack per day; his weightlifting hobby; riding a motorcycle; use of chainsaws; and outside work. Dr. Williams opined that petitioner's duties obviously are intermittent, and involve pinching and gripping. He further opined that petitioner's hobbies include significant impact to the palms with weightlifting, and involve vibration with the use of chainsaws, as well as motorcycle riding. He opined that petitioner's smoking and hypertension would be more aggravating to his condition than would be his work activities.

On 5/1/13 petitioner retired. Petitioner testified that when he grips things now he does not have the grip strength that he had before. He complained of pain and swelling, and a slight numbness in his ring finger. He stated that if he bumps it, hits it, or works with it for very long it hurts. Petitioner testified that he began having trouble with his hypertension in December 2009, and that is when he began taking medication for the problem.

On 7/31/13 the evidence deposition of Dr. Garst was taken on behalf of the petitioner. Dr. Garst was of the opinion that petitioner was probably going to always have some pain with his right hand. Dr. Garst opined that petitioner's job could or might have been a contributor factor to the carpal tunnel syndrome for which he was treating. He further opined that if petitioner's condition was pre-existing his work duties could or might have aggravated it. On cross-examination Dr. Garst testified that petitioner did not give him much detail about his job duties, but he was somewhat familiar with what the officers do at the prison. Dr. Garst did not discuss any of petitioner's home activities with him.

Major Wayne Steele was called as a witness on behalf of respondent. He testified that from 2005 to 2010 the third shift sergeant did inspections and the chow line in the morning. He stated that the sergeants just watched those that came out of their cells for breakfast, unless additional intervention was needed. Major Steele testified that third shift officers could, but are not usually involved with the mail. Major Steele testified that the shift commander assigned extra staff for the feed crew. Petitioner testified that after the jail changed from medium security to level II security that the class of prisoners had gotten worse. Major Steele testified that level II was still medium security. Major Steele testified that the third shift sergeant duties today are the same as they were before.

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?

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 his bilateral hands 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.

Petitioner is alleging that he sustained an accidental injury to his bilateral hands as a result of his repetitive work activities that arose out of and in the course of her employment by respondent that manifested itself on 1/1/11. Petitioner has been employed by respondent for 25 years. Petitioner testified that he worked in segregation and the sally port prior to 2000. After this date, petitioner did not work in these areas, but worked primarily in the cell house.

Many of the activities petitioner described as being repetitive in nature and causing his condition were cuff and uncuffing the inmates; placing chains on inmates and then securing them with a padlock; carrying and using mirrors for inspection under vehicles; and opening, doors, locks and trailers. The arbitrator notes that all these duties were performed by respondent while he was in the sally port and in segregation, places he did not work after 2000. Additionally, the arbitrator finds it significant that petitioner did not have any symptoms in his hands until 2005, and did not report them until December of 2009.

From 2000-2010 petitioner was primarily assigned to the cell house. In this capacity, from 2000 to 2004 petitioner would help feed the inmates breakfast in their cells. This task required petitioner, other officers and the feed crew to open and close the chuck holes of all inmates in the cell house. There were 336 inmates in his cell house. Petitioner opened and closed the chuck holes using a small key. He testified that he would alternate which hand he opened the lock with when his hands got tired. The feeding of the inmates took 2-4 hours. When petitioner was not feeding the inmates he would perform other administrative tasks that were not repetitive in nature. Petitioner did not perform this task after 2004 unless the cell house was on lockdown.

Petitioner testified that from 2005-2010 the inmates were no longer fed breakfast in their cells. He testified that during this period the only time the prisoners were fed breakfast in their cells was when the cell house was on lockdown. Petitioner testified that the prison had 10-15 lockdowns a year. However, which cell houses were locked down and for how long was not agreed on by petitioner and Steele. Steele testified that the lockdowns lasted 1-3 days. Alternatively, petitioner testified that they lasted from 1-3 weeks.

On occasion the petitioner would carry the mail bag. Petitioner could not testify how often he performed this task.

When petitioner first sought treatment for his hands in December of 2009 he gave a history of daily job functions that involved using his hands opening doors, locks, and trailers; carrying and using mirror for inspection under vehicles; constant use of hands, wrists, and elbows for repetitive motion. The arbitrator notes that opening trailers and carrying and using a mirror for inspection under vehicles were activities that petitioner had not performed since before 2000. Petitioner reported that he experienced extreme pain in his right and left hands, a noticeable difference in the range of motion of his hands, and constant numbness in his fingers and hands from his constant use while opening doors, locks, hoods, and trailer doors. He also complained of extreme pain while working segregation. The arbitrator notes that opening hood and trailer doors, and working segregation were activities petitioner had not done after the year 2000. The arbitrator also notes that after 2004 the opening and closing of chuck holes to feed the inmates breakfast was only performed intermittently when the inmates were on lockdown. In addition to his work activities, petitioner reported that he has smoked on

average one pack of cigarettes a day for 20 years. Petitioner testified that when he had presented for treatment in December 2009 he was having trouble with his hypertension and that is when he began taking medication for this problem.

In addition to his work activities petitioner testified that he did weightlifting as a hobby and rode motorcycles outside work. Dr. Williams notes also include a history of using chainsaws outside of work.

Both Dr. Williams and Dr. Garst offered causal connection opinions with respect to petitioner's bilateral carpal tunnel syndrome. However, the arbitrator notes that the work activities that petitioner provided them as the cause of his bilateral carpal tunnel were activities that he did not do after the year 2000, or were only intermittent after 2004. The arbitrator finds the work activities provided by petitioner were not specific or detailed as they relate to his work activities after 2004, which is when his actual symptomatology began and worsened over the next 5 years. As such, the arbitrator finds their opinions were not based on an accurate understanding of petitioner's work activities from the time he began experiencing symptoms.

Dr. Williams also noted that in addition to his alleged work activities the petitioner had other factors that could contribute to carpal tunnel syndrome. These activities included weightlifting, use of chainsaws, and motorcycle riding. He also opined that petitioner's smoking and hypertension would be more so aggravating to his condition than would be his work activities.

The arbitrator finds it significant that when petitioner's symptomatology began petitioner was not feeding the inmates breakfast daily. The arbitrator further finds it significant that when petitioner's symptoms were so bad he needed treatment, was the time petitioner was diagnosed with hypertension and placed on medication for that condition.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an injury to his bilateral hands due to repetitive work activities that arose out of and in the course of his employment by respondent and manifested itself on 1/1/10, and failed to prove that his current condition of ill-being as it relates to his bilateral hands is causally related to his 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?
K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?
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 he sustained an accidental injury due to repetitive trauma that arose out of and in the course of his employment by respondent, and manifested itself on 1/1/10, and failed to prove that his current condition of ill-being as it relates to his bilateral hands is causally related to his alleged accident, the arbitrator finds these remaining issues 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

Vern Smart,

Petitioner,

vs.

NO: 12 WC 17621

14IWCC0746

Champaign-Urbana Mass Transit District,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total 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 January 15, 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.

The party commencing 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: AUG 2 9 2014

MB/mam
o:7/31/14
43

Mario Basurto

David L. Gore

Stephen Mathis

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

SMART, VERN
Employee/Petitioner

Case# **12WC017621**

14IWCC0746

CHAMPAIGN-URBANA MASS TRANSIT DISTRICT
Employer/Respondent

On 1/15/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0874 FREDERICK HAGLE FRANK & WALSH
PHILIP W PEAK
129 W MAIN ST
URBANA, IL 61801

0522 THOMAS MAMER & HAUGHEY LLP
BRUCE E WARREN
30 MAIN ST SUITE 500
CHAMPAIGN, IL 61820

14IWCC0746

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)

Vern Smart
Employee/Petitioner

v.

Champaign-Urbana Mass Transit District
Employer/Respondent

Case # **12** WC **17621**

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 **McCarthy**, Arbitrator of the Commission, in the city of **Urbana**, on **12/20/13**. 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 **vocational rehabilitation**

FINDINGS

On the date of accident, **4/23/12**, 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 **$43,867.20**; the average weekly wage was **$843.60**.

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

Respondent is entitled to a credit of **$37,900.58** under Section 8(j) of the Act.

ORDER

Respondent shall pay the medical bills set forth in Petitioner's exhibits 16 through 21 pursuant to the Fee Schedule.

Respondent shall be given a credit of **$37,900.58** 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 **$562.40**/week for 40 2/**7** weeks, commencing **4/25/12** through 1/31/13, as provided in Section 8(b) of the Act.

Petitioner is not entitled to vocational rehabilitation and maintenance benefits.

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. Dale McGrath
Signature of Arbitrator

Jan 8, 2014
Date

ICArbDec19(b)

JAN 15 2014

Vern Smart v. Champaign-Urbana Mass Transit District
12-WC-17621

FINDINGS OF FACT

The Petitioner, Vernon Smart, testified that he was employed by the Respondent as a bus operator. His job duties involved the operation of the Respondent's passenger buses on various routes in the Champaign-Urbana area. On April 23, 2012, the Petitioner was making a 90° right turn near the Illinois terminal when he felt a pop in his left shoulder. The Petitioner testified that he was turning onto a narrow side street and was watching for traffic and pedestrians. He testified that his left arm was fully extended at the moment it popped, and was in the 11:00 position.

The Petitioner also testified that he was driving a hybrid bus, and that driving such a bus is quite a bit different than driving a normal passenger vehicle. Those differences included: that the steering wheel in the bus is larger than that in a car; that the steering wheels can be angled so that they are almost flat; that he did not have any armrests in the bus; that it can be harder to maintain control of a 40' bus during a turn; that he had to also pay attention to traffic, pedestrians, and his passengers while making the turn on the bus; that he couldn't sit still in the bus; that he wasn't able to bring the steering wheel as close to himself in the bus as he would in a normal vehicle; and that his chair sat upright. He described the turn as a full force turn.

The Respondent called their Director of Maintenance, David Moore, to testify at the hearing. Mr. Moore testified that the hybrid buses had power steering, and that the force needed to turn the steering wheel on the bus took no more effort than to turn the wheel in a normal vehicle. However, he also testified that the steering wheel on the hybrid buses are larger than those on normal vehicles (although not as large as the Petitioner described), that there are no armrests, that the steering wheel can be angled to 45°, that the chairs sit upright, and that a bus driver making a right turn may have their left arm completely extended, though he didn't recall seeing a driver with his arms fully extended. He further said that driver's are required to keep both of their hands on the wheel when they drive.

The Petitioner testified that after feeling the pop in his left shoulder, he continued to work and finished out his shift. However, he felt pain in the shoulder while continuing to drive the bus. He reported the accident through the Respondent's electronic terminal after finishing his shift.

Prior to the April 23, 2012 work accident, the Petitioner had been treated by Dr. Joseph Norris for a left shoulder rotator cuff tear. (PX 9). He had arthroscopic surgery performed by Dr. Norris on October 13, 2011. (PX 11). That procedure involved subacromial decompression, distal clavicle excision, biceps tenotomy, rotator cuff tendon repair, microfracture of the humeral head, and limited interarticular debridement. After surgery, the Petitioner attended physical therapy through Accelerated Rehabilitation Centers from November 16, 2011 through February 15, 2012. (PX 13). He was released by Dr. Norris without restrictions on February 16, 2012. (PX 9). Dr. Norris testified that the Petitioner's postoperative course was essentially routine and without complication to the point where he had essentially no pain and returned to full function. (PX 25, p. 10-11). Dr. Norris did not order an FCE after the October, 2011 surgery because at the time of his release post-surgery, the Petitioner had zero limitations. (PX 25, p. 37). The

Petitioner testified that he had no problems with his left shoulder again until he had the work accident on April 23, 2012. The Petitioner testified that he was seen by Dr. Steven Thatcher at Christie Clinic on April 13, 2012 for hand and wrist pain, but did not have any complaints relating to his left shoulder. (PX 14).

The first visit after the April 23, 2012 accident was to Safeworks Illinois on April 25, 2012. (PX 1). He was seen by Dr. David Fletcher. Dr. Fletcher's note indicated, "He reports a new injury to his left shoulder from a few days ago when his shoulder popped." He noted that the Petitioner had undergone a previous surgery to the left shoulder in October, 2011. The assessment was, "Status post 10/2011 left shoulder rotator cuff repair which was performed by Dr. Norris. Rule out recurrent tear." The doctor indicated that his opinion was that the Petitioner's condition was work related. The Petitioner was referred to physical therapy and restricted from work. The Petitioner was also seen for bilateral wrist and hand pain, although the Petitioner is not claiming injuries to his wrists or hands as a result of the April 23, 2012 accident.

Physical therapy was completed at 217 Rehab from April 30, 2012 through May 22, 2012. (PX 8). He received care for left shoulder pain, as well as the bilateral wrist and hand pain.

On May 7, 2012, Dr. Fletcher recommended an MRI/arthrogram of the left shoulder. The MRI/arthrogram was completed on May 21, 2012. (PX 2). Dr. Fletcher reviewed the results of the MRI in his May 23, 2012 visit with the Petitioner. His assessment was that the Petitioner had recurrent left shoulder rotator cuff pathology, and referred him to Dr. Norris. (PX 1). Physical therapy was also put on hold.

Dr. Norris saw the Petitioner on May 24, 2012. (PX 4). Dr. Norris indicated that the Petitioner had been doing well after a left rotator cuff repair, and was back to all work activities. The Petitioner indicated that he heard and felt a pop in his left shoulder while turning a corner while operating a bus, and had pain in his left shoulder ever since. Dr. Norris initially opined that the Petitioner may have dislodged his biceps tendon from the bicipital groove, and that he may have had inflammation around the rotator cuff tendon. Dr. Norris then proceeded with a subacromial injection. The Petitioner returned to see Dr. Norris on June 21, 2012 and reported that the injection provided no benefit. Dr. Norris recommended a left shoulder arthroscopy with revision rotator cuff tendon repair based upon the MRI findings of a possible re-tear of the rotator cuff tendon, and the failure of conservative management.

Surgery was performed by Dr. Norris on July 5, 2012. (PX 5). Dr. Norris performed a left shoulder arthroscopy with limited intra-articular debridement and rotator cuff tendon revision repair. Dr. Norris testified by way of evidence deposition. (PX 25). Dr. Norris testified that during the surgery he found an almost complete tear of the front edge of the supraspinatus tendon. (PX 25, p. 26). This tear was partially in the same area where the previous surgery had been performed. (PX 25, p. 26-27). The first surgery involved the majority of the supraspinatus and part of the infraspinatus, and the re-tear involved just one portion of the supraspinatus. (PX 25., p. 26-27). The majority of the initial repair had healed. (PX 25, p. 27). The tear was in a different location from where the anchor was placed in the first surgery. (PX 25, p. 28). That anchor did not need to be replaced; rather, the July 5, 2012 surgery involved new anchors and new repairs of the rotator cuff tendons. (PX 25, p. 29).

Dr. Norris testified that the only logical conclusion is that the work accident described by the Petitioner had either some aggravation or direct cause of the symptoms that followed the event. (PX 25, p. 29-30). He conceded that it is impossible to say with 100% certainty that the work accident caused the re-tear of the rotator cuff tendons, but his opinion is that the event had something to do with the symptoms that Petitioner had afterward. (PX 25, p. 30). He testified that force matters, and the force at which any repaired tendon is stretched has an impact on what can happen to that tendon with an injury or re-tear. (PX 25, p. 31). Based upon his everyday observations, a person has a more extended arm with more dramatic motion to steer a bus than a car. (PX 25, p. 33-34). As Dr. Norris testified, "If anyone is providing an action of their shoulder with an extended arm there is more force across the muscle that has to perform that action due to simple physics of lever arms." (PX 25, p. 34). He continued, "And if there is more force across the tendon it has a higher risk of re-tearing." (PX 25, p. 35).

The Respondent had the Petitioner seen for an independent medical evaluation with Dr. Stephen Weiss on December 3, 2012. (RX 2). Dr. Weiss was provided with a cover letter that indicated the steering wheel could be turned with one finger. (RX 1, p. 9). Dr. Weiss testified that turning the steering wheel was simply too trivial to cause any problems. (RX 1, p. 11-12). Since it was represented to him that one finger can turn the wheel, then this was simply a failure of the prior rotator cuff repair. (RX 1, p. 12). He testified that if the Petitioner had been doing something significant like lifting 20 pounds, or 10 pounds overhead, then he would have testified that it was related. (RX 1, p. 16). He did not recall where the re-tear was, but thought it was at the original site, and felt that there was a failure to heal. (RX 1, p. 17). His opinion is completely dependent upon the description provided to him by the Respondent in their cover letter. (RX 1, p. 24). The information provided by the Respondent indicated, "The steering is completely powered and can be turned with one finger. The seat of the steering wheel are adjustable to any height or configuration that the driver wishes. The hybrid bus is at a much higher hydraulic pressure on the steering mechanism than due to standard busses making them even easier to turn." (RX 1, p. 23). He has no personal knowledge of the bus in question. (RX 1, p. 24).

Dr. Norris continued to see the Petitioner after the July 5, 2012 surgery. He completed post-surgical physical therapy through Accelerated Rehabilitation Centers from July 24, 2012 through December 11, 2012. (PX 7). At the time of discharge on December 11, 2012, the Petitioner still had pain rated 3 out of 10 with reaching overhead to do twisting type motions. He reported difficulty folding laundry, was unable to push a lawnmower, and reported aching after driving to Bloomington for an IME examination. He was also noted to have diminished strength on examination, with measurements in flexion and abduction to be 4/5, left versus right. He was felt to have plateaued. When last examined by Dr. Norris on January 13, 2013, the Petitioner had full motion, pain with the Hawkin's sign and 4+/5 muscle strength throughout. (PX 4)

Dr. Norris ordered a functional capacity evaluation (FCE), which was performed on January 15, 2013 through Accelerated Rehabilitation Centers. (PX 6). Dr. Norris testified that he ordered the FCE because he was not sure what the shoulder would allow him to do, and he wanted to get a formal evaluation of his limitations before releasing him back to work. (PX 25, p. 37). Dr. Norris testified that the FCE revealed that the Petitioner could not turn the wheel on a consistent basis, but only on an occasional basis. (PX 25, p. 39). Dr. Norris released the Petitioner with permanent restrictions that mirrored the FCE, and that the Petitioner was limited to only occasional turning. (PX 25, p. 39).

The Petitioner testified that the steering wheel used to simulate his capabilities during the FCE was about the same size as the one he used to drive his bus. The FCE report noted that he was tested with steering over 65 minutes. He was asked to do turns of 90 degrees to the right and left, per his description of his job duties. The examiner found a limited range of motion with steering with the left arm across the mid-line during right hand turns. (PX 6) It was determined that he could perform his steering on an occasional basis. (Id)

On February 19, 2013, the Respondent sent the Petitioner a letter indicating that he would be terminated since he was unable to return to the position of a bus driver. (PX 22). The Petitioner testified that he was terminated by the Respondent, and has not driven a bus since his accident of April 23, 2012. The Petitioner was held off of work by Dr. Fletcher at Safeworks, and then Dr. Norris, from April 25, 2012 until he was released with permanent restrictions on January 31, 2013.

The Petitioner testified that since his termination he has continued to look for work elsewhere. He was awarded Social Security Disability benefits and received a Notice of Award dated February 5, 2013. (PX 23)

The Petitioner testified that he looked for work on his own, and was able to find employment through Rural King. He testified that he worked for Rural King from approximately July 18, 2013 through September 30, 2013. This is a period of 10 5/7ths weeks. He testified that during that time period he missed 3 weeks of work due to an unrelated knee issue, and was able to work 8 weeks. The Petitioner presented one pay stub for the time period of July 18, 2013 through July 31, 2013 with gross earnings of $439.02. He testified that this represented his typical pay for a two week time period through Rural King.

The Petitioner also testified that he had left Rural King due to the unrelated knee issue and being unable to stand on his feet. However, he has continued to look for work and testified to filing out approximately 10 applications since he left Rural King, mostly online. He testified to having applied at Pawn King, Wal-Mart, Lowe's and Menard's, as examples. However, he has been unable to find work since he left Rural King. The Petitioner did not offer any documentation concerning his job search. The Petitioner has been offered no assistance by the Respondent in terms of finding alternative work within his restrictions.

The Petitioner testified that he has received no temporary total disability benefits, and his medical bills were paid through his health insurance, which was provided by the Respondent. He further testified that the balances on his medical bills remain unpaid.

CONCLUSIONS OF LAW

There is no dispute that the Petitioner sustained the re-tear of the rotator cuff in his left shoulder while turning the steering wheel during a right turn while driving a bus in the course of his employment with the Respondent. The dispute is whether the action of merely turning the steering wheel was the cause of the Petitioner's re-tear.

To satisfy the requirement that an accident arise out of the employment, it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as

to create a causal connection between the employment and the accidental injury. Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193, 203 (2003). An injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer. Id. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. Id.

It is axiomatic that employers take their employees as they find them. Id at 205. Even though an employee has a preexisting condition which may make her more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. Id.

In this case, the Petitioner's employment was a causative factor in the left shoulder rotator cuff re-tear. The Petitioner testified that driving the Respondent's bus is much different than driving a normal truck or car. The steering wheel is bigger, which means that his arm will be extended further while making a turn. In addition, there are no arm rests in the bus, which means that the Petitioner was unable to rest his arms while driving like one would be able to in a normal vehicle. In addition, the act of driving a bus is different and more stressful than driving a normal vehicle. The Petitioner testified that it is harder to maintain control of a 40' bus, particularly during a 90° right turn. He has to be mindful of other vehicles, pedestrians, the curb, and his own passengers. He described this particular turn as a full force turn.

The testimony of David Moore, the Respondent's Director of Operations, corroborated the Petitioner's testimony. Although Mr. Moore testified that actually turning the steering wheel was relatively easy on these hybrid buses, he did confirm that the steering wheels are larger than normal vehicles, that the driver's seat sits upright, that there are no arm rests, and that the driver's arm could be fully extended while making a turn.

Dr. Norris testified that there was a causal connection between the action of turning the steering wheel and the resulting re-tear of the rotator cuff tendons. There is a strong temporal relationship between the work accident and the onset of symptoms. He conceded that it was impossible to tell with 100% certainty that the work accident caused the re-tear. However, his explanation for why the mere act of turning the bus steering wheel could result in a re-tear is compelling. As he opined, a person has a more extended arm with more dramatic motion to steer a bus than a car, and if anyone is providing an action of their shoulder with an extended arm there is more force across the muscle that has to perform that action due to simple physics of lever arms, and if there is more force across the tendon it has a higher risk of re-tearing.

Dr. Weiss testified that turning the steering wheel was simply too trivial to cause any problems. However, his opinion is flawed in that he relied upon incomplete facts regarding the operation of the bus. His opinion is completely dependent upon the description provided to him by the Respondent in their cover letter which indicated that the steering is completely powered and can be turned with one finger, and that the hybrid bus is at a much higher hydraulic pressure on the steering mechanism making them even easier to turn. That description was not borne out by the testimony of David Moore. Mr. Moore testified that the steering wheel is easy to turn, but he did not testify that it could be turned with one finger. More importantly, critical details to understanding the forces applied during a turn were not given to Dr. Weiss, including the size of the steering wheel, the lack of arm rests, and the extension of the arms during a turn. As Dr.

Norris testified, force matters, and Dr. Weiss' opinion is based upon a flawed understanding of the forces involved.

On the issue of causation, the Arbitrator gives greater weight to Dr. Norris' testimony than that of Dr. Weiss. As such, the Arbitrator finds that the Petitioner suffered a left shoulder rotator cuff re-tear as a result of the work accident of April 23, 2012, and that the work accident arose out of and in the course of the Petitioner's employment with the Respondent.

The Arbitrator incorporates his findings on causation into the issue on medical bills, finding that the bills represent services for treatment both reasonable and necessary. The Respondent is ordered to pay the bills contained in Petitioner's Exhibits 16 through 21 pursuant to the Fee Schedule. Respondent is entitled to any credit for any payments which it made on said bills through their health insurance plan.

Similarly, the period of temporary total disability is also payable. The Petitioner was completely restricted from work from April 25, 2012 until the Petitioner was released by Dr. Norris on January 31, 2013. The evidence indicates that he was at a point of maximum medical improvement.

On the issue of entitlement to vocational rehabilitation and maintenance, the Arbitrator looks to the Supreme Court decision in National Tea. See 97 Ill. 2d 424 (1983)

The Court outlined the many factors to be considered on the issue, including whether the Petitioner had proven that vocational rehab would likely increase his earning capacity and whether it was required in order for him to secure work. The Arbitrator believes the Petitioner's proof was lacking on those factors.

The Petitioner clearly has some residuals from his injury. He does not, however, have much by way of permanent restrictions which would prevent him from finding many jobs. Dr. Norris testified that the only thing he should not do is perform a job where he is steering on a constant basis. With that restriction, the Petitioner was able to find a job at Rural King, which he held for two months. He testified that his shoulder did not prevent him from doing all of his job duties. While he testified that he looked for other work after Rural King, he produced no documentation or detail as to the positions sought, when he made the applications, how he made them, and what responses he received. Additionally, he has other medical conditions and is receiving social security disability benefits. At age 57, the Arbitrator questions whether the Petitioner would have the motivation to participate in a vocational program if one were ordered.

The Commission recently said in the case of Borak v. Associated Glaziers, 13 IWCC 998, that the Petitioner has the burden of proving entitlement to vocational rehabilitation, referencing the factors set forth in National Tea. In this case, the Arbitrator does not believe the Petitioner has met his burden, and as such, vocational rehabilitation and maintenance is denied.

Dated and entered _____, 2014

D. Douglas McCarthy, Arbitrator

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

Ed Bruck,

Petitioner,

vs.

NO: 05 WC 45483

Vactor Manufacturing,

14IWCC0747

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

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 31, 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.

14IWCC0747

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: AUG 2 9 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:7/10/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRUCK, ED
Employee/Petitioner

Case# **05WC045483**

10WC014835

VACTOR MANUFACTURING
Employer/Respondent

14IWCC0747

On 5/31/2013, 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:

0190 LAW OFFICES OF PETER F FERRACUTI
THOMAS STROW
110 E MAIN ST PO BOX 859
OTTAWA, IL 61350

1120 BRADY CONNOLLY & MASUDA PC
MARK F VIZZA
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

14IWCC0747

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ed Bruck
Employee/Petitioner

v.

Vactor Manufacturing
Employer/Respondent

Case # **05** WC **45483**

Consolidated cases: **10 WC 14835**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **Ottawa, Geneva, and New Lenox**, on **9/27/12, 4/5/13, and 5/9/13**. 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 **3/19/99**, Respondent ***was*** 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 **$31,298.28**; the average weekly wage was **$601.89**.

On the date of accident, Petitioner was **56** 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** for TTD, **$0** for TPD, **$0** for maintenance, and **$17,981.36** for other benefits, for a total credit of **$17,981.36**.

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 **$319,673.30**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of **$401.26**/week for life, commencing **5/8/2003**, as provided in Section 8(f) of the Act.

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

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

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

Signature of Arbitrator

May 28, 2013
Date

MAY 31 2013

FINDINGS OF FACT

Petitioner Ed Bruck testified via evidence deposition on January 4, 2010 from his home and further testified briefly in court on September 27, 2012. (PX18, PX15) Petitioner testified that following high school he attended one year of college and then began working for Owens-Illinois Glass Company in the shipping department for about three to four years. He then worked for Chrysler Corporation for about four years. (PX18 at 11-12) After Chrysler, he became employed with Streator Dependable for thirteen years in maintenance where he was responsible for the maintenance of the fork trucks and the ventilation equipment. (PX18 at 13-14)

Mr. Bruck began smoking around age 18 and would smoke about two packs per day. He did not notice any problems with breathing while working for Streator Dependable. (PX18 at 15) Following Streator Dependable he worked for a company that made automotive lifts as a painter. At that position, he had a painting hood with a direct oxygen line. He worked there approximately three to four years. (P18X at 16-18) He then worked as a janitor at Northlawn High School for approximately one year. Other than that he recalled no other employment other than odd jobs at homes for people. (PX18 at 18)

During the Streator Dependable strike, he did paint about 100 cars at home in his garage but he had painters' masks as well as an exhaust fan on the ceiling in his garage. (PX18 at 21)

Prior to his employment with Respondent, on April 30, 1991, Petitioner underwent chest xrays ordered by his treating general physician, Dr. John Podzamsky to rule out pneumonia. His lungs were clear and his pulmonary vascular levels were normal. (RX2 at 6) An April 26, 1991 Emergency Room record regarding chest pain apparently referred to "COPD" but Petitioner testified that he had never heard of that diagnosis prior to 1999 and never treated for it prior to that date. (PX18 at 93)

Petitioner testified that he began his employment for Respondent Vactor Manufacturing Company in 1993 following a pre-employment physical with Dr. Podzamsky at St. Mary's Hospital. Petitioner testified that Dr. Podzamsky was his own general physician but also the company doctor for Vactor Manufacturing at the time. Petitioner continued to smoke but testified that he had no difficulty breathing at this time. (PX18 at 20)

Mr. Bruck's first job for Respondent was a painter's job and he worked his first 90 days in the painter's shop. (PX18 at 22) He then was moved to general assembly. Vactor Manufacturing makes vacuuming equipment and street cleaner trucks. They construct the entire truck from the frame up. (PX18 at 23) The general assembly area would include several different workers including welders, electrical workers, hydraulic workers, and painters. (PX18 at 24-26)

Mr. Bruck would use grinders and sanders as needed to perform his assembly job as well as basic mechanic tools. He was not issued any type of mask or protection for his face and mouth while working in this area. He is not aware of anyone other than the welders having any type of protection. (PX18 at 27-28)

He worked in general assembly approximately two years and did continue to smoke while he worked in that department. He noticed no difficulty with breathing. (PX18 at 27-28)

He was then moved to the subassembly department where they put together different parts that would go onto the truck. (PX18 at 29) He testified that the subassembly area was maybe 40 by 60 feet big and that the ceiling was probably 20 to 25 feet high. (PX18 at 31) He testified that the main weld shop was next to subassembly and that they were separated by a corrugated wall which went up to maybe 4 to 5 foot from the ceiling. On the south side of the subassembly area was outside of the building. (PX18 at 32) In the wintertime, the doors were not open in this area. In the summertime, the doors would be open and Petitioner testified that it would "almost make like a suction and actually like bring the smoke and stuff over more I think." (PX18 at 59)

Just north of where Petitioner and another worker were located in subassembly, there were approximately six subassembly welders. The nearest welder to him would be approximately 5 feet or so. The only thing separating him and the welders would be open shelving for parts about six feet high. (PX18 at 34-35)

Mr. Bruck testified that there was no ventilation in the subassembly department when he worked there and there were no ceiling fans at the time. (PX18 at 36) He began working in subassembly roughly in 1995 or 1996 and at the time they may work up to 58 hours per week due to the amount of orders at the company. (PX18 at 37-38)

When Petitioner started working in subassembly, he testified that there was a lot of weld smoke and weld fumes. It was a dirty area and there was a lot of "dust, dirt, whatever in the air." He testified that he would get completely filthy working in the area and he would go to wash his hands and face over break to get the filth off of him. He said that he could "taste it and smell it." His nostrils would get full of it from breathing. His face would look terrible and dirty enough to wash multiple times per day. (PX18 at 39)

Petitioner testified that the workers were allowed to have anything that they wanted to drink in the work area to clear their throat and wash their mouth out a little bit. (PX18 at 40) Petitioner also noticed that his car was filthy from the soot and that his co-worker that he worked with in his exact area was filthy as well. (PX18 at 40-41) The same things that were on his clothes would get ground into his car seats and he testified that he could not get it out of the seats with any kind of seat cleaner that he would use. The first thing he would do when he came home is take a shower and he stated that you could see the black and grey stuff go down the drain. This was the condition of subassembly the entire time he was in that department. (PX18 at 42) If he sneezed or spit at work, he would notice that it would be dirty. (PX18 at 64)

Mr. Bruck began to notice that he was sleeping and resting constantly while at home and that his breathing was getting steadily worse. (PX18 at 43)

Petitioner testified that as early as 1994 he would have gone to his foreman Rick Pence and requested face masks. For a while, his foreman would give him dust masks but eventually he would put him off and refer to him as a "wimp" when he requested one. He testified that then he would get assigned all of the dirty jobs and his partner would get the jobs of stacking parts and he felt it was retaliation for requesting the mask so he quit asking for it. (PX18 at 40, 45)

On February 20, 1999, Petitioner was admitted to St. Mary's Hospital, complaining of fever, cough, and lack of appetite for one week. (PX7). He was found to have chronic obstructive pulmonary disease, bronchitis, a questionable nodule in the left lower lung, and pneumonia. A chest scan revealed moderate emphysematous changes of both lungs with interstitial changes and an indeterminate nearly 1 cm soft nodular density in left lower chest. He was discharged on February 23, 1999. (PX7)

Dr. Podzamsky saw Petitioner on March 2, 1999, and at that time Petitioner was complaining of difficulty breathing. Petitioner was diagnosed with chronic obstructive pulmonary disease ("COPD"). (PX7)

Mr. Bruck testified that he noticed trouble breathing at work and would have to sit down from time to time until he caught his breath. (PX18 at 46)

A pulmonary function test was done at St. Mary's Hospital on March 15, 1999. (PX7). This revealed severe obstruction with air trapping, suggesting significant reactive airway distress present in addition to some possible emphysema. (PX7)

A pulmonary function test was ordered by Dr. Podzamsky on March 19, 1999, which revealed severe COPD. Petitioner returned to Dr. Podzamsky on April 16, 1999. On that date, an electrocardiogram was done, which showed a condition called P-pulmonale. Dr. Podzamsky testified that this can be related to the pulmonary problem. (PX9 at 9). Petitioner was started on an inhaled steroid and was prescribed a long-acting bronchodilator, medication that opens up the breathing tubes so the oxygen can get in more easily. (PX9 at 10).

A test was done at St. Mary's Hospital on April 20, 1999 to rule out myocardial ischemia. (PX7).

Petitioner was next seen by Dr. Podzamsky on April 30, 1999. He was breathing better at that time, but the COPD diagnosis remained the same. Dr. Podzamsky testified that treatment of Mr. Bruck involved the use of steroids and bronchodilators to maximize his breathing capacity. (PX9 at 11). Dr. Podzamsky testified that he treats patients exposed to welding fumes at least monthly and that Mr. Bruck's prognosis for recovery is

poor, meaning the damage to his lungs is so extensive that it will not recover and will probably steadily deteriorate. (PX9 at 18-19).

Sometime in 1999, Petitioner quit smoking. He testified that it was following his stay in the hospital. (PX18 at 58, 104)

Petitioner testified that Dr. Podzamsky issued him work restrictions regarding not working on Saturdays so that he could rest. He testified that he gave those restrictions to Rick Pence, his foreman, and that the company allowed them for some time but requested that he continue to get updated restrictions. (PX18 at 48-49) He continued to work restricted hours through May 7. 2003. (PX18 at 50)

On May 7, 2003, Petitioner reported to his regular work in the subassembly department. He testified that he worked for a little bit and his breathing got worse and he went to see his foreman to report to him that he could not breathe. He stated that he was then taken to the assembly shop and the head foreman sat him down and called for an ambulance. (PX18 at 51)

On May 7, 2003, Petitioner was admitted to St. Mary's Hospital after reporting a history that on that day, while working at Vactor, he became very short of breath with very minimal exertion. (PX7). He was diagnosed with COPD with exacerbation by Dr. Podzamsky. He was discharged on May 8, 2003. (PX7)

Since May 7, 2003, Petitioner has not returned to employment at Vactor Manufacturing and has not performed employment of any kind. (PX18 at 52-53)

A persantine cardiolite examination was performed on May 20, 2003 to rule out associated coronary artery disease for Petitioner's complaints of hypertension and shortness of breath. (PX13).

Petitioner did receive short and long term disability benefits through Cigna. He testified that he did not recall filling out any forms and that he believed that any forms would have been prepared by Rene Barr in Human Resources for Respondent. Mr. Bruck is not able to type. (PX18 at 97-100). He is sure that he never told Rene Barr that his condition was not work-related. (PX18 at 100)

Dr. Podzamsky referred Petitioner to Dr. Karamchandani at Peoria Pulmonary Associates, and he was seen on September 17, 2003. (PX2). The personal history provided included that Petitioner quit smoking in 1999 and had about a 50-pack-year history of smoking and that he works as a manual laborer and is exposed to nonspecific dust and fumes. A pulmonary function test was performed showing a FEV_1 of 0.92 and an FVC of 1.59 with a ratio of 57%. This is consistent with a severe obstruction pattern.' Dr. Karamchandani indicates in his notes, "There is no question based on his history, chest x-ray, and the pulmonary function test, he has chronic obstructive pulmonary disease." He was prescribed Xopenex, Atrovent, and Pulmicort nebulizers along with

Foradil. Dr. Karamchandani indicated he did not require home oxygen at the current time. (PX2)

Petitioner was granted Social Security Disability on October 31, 2003 with a finding that he became disabled on May 7, 2003. (PX16, PX17, PX18)

Petitioner next saw Dr. Karamchandani on November 18, 2003. (PX2). A recent pulmonary function test showed an FEV_1 of 1.28 which has gone up from 0.92 and an FVC of 2.75 which has gone up from 1.59. The plan was to continue current bronchodilators as previously prescribed. (PX2)

Petitioner was seen by Dr. Karamchandani on February 3, 2004. (PX2). He indicated that Petitioner was doing better and was participating in a rehabilitation program three times a week. His effort tolerance on flat ground seems to be fairly unrestricted, but when he has to do anything more intense, he has problems. The plan was to continue current medications. (PX2)

Petitioner saw Dr. Karamchandani on November 16, 2004. (PX2). He indicated Petitioner was doing well from a pulmonary standpoint. The plan was to continue his current bronchodilator regimen and go back to his pulmonary rehabilitation. (PX2)

Another pulmonary function test was performed on November 22, 2004. (PX2). This showed a severe obstructive defect with gas trapping and mild diffusion defect. As compared to the previous pulmonary function test, there has been a significant decline in the spirometry values and diffusion capacity. (PX2)

Petitioner saw Dr. Karamchandani on April 19, 2005. (PX2). He indicated that Petitioner was maintaining good oxygen saturation at 95% on room air and dropped down to 93% on walking about 300 feet. The plan was to continue the Advair, Xopenex, and Atrovent medications. (PX2)

Petitioner was evaluated for an Independent Medical Evaluation on January 18, 2006 by Dr. Robert Eilers. (PX5). He indicated that Petitioner's treatment and management to date are certainly reasonable and appropriate and necessary for his COPD. Dr. Eilers indicated that Petitioner's COPD has two underlying causes: first his history of tobacco use, and secondly environmental work hazards to which he was exposed. He indicated that the COPD is significantly aggravated by work environments in which there is heavy dust or dust within the air that would aggravate the pulmonary status, increasing his respiratory needs. Dr. Eilers indicated that Petitioner's condition is permanent as there is nothing that could be done to ameliorate his condition. Petitioner stopped smoking in 1999, which was an appropriate step, and his condition continued to worsen. Petitioner continued with his environmental exposures until 2003 when he ended his occupational activities. Dr. Eilers wrote that certainly the continued dust exposure at Petitioner's job would profoundly aggravate his underlying condition.

Dr. Eilers testified via evidence deposition on June 6, 2006. Dr. Eilers testified that Petitioner had a history of COPD with shortness of breath aggravated by physical activity. He reported that he had a history that Mr. Bruck worked in a number of positions and had worked as an assembler of parts of vacuum trucks near the back doors of the plant. He also reported that he had used spray cans to touch up parts and worked on the truck assembly and indicated that they didn't have masks or ventilation and were in a basically closed area. Dr. Eilers reported that there are welders, smoke from the welders, no ventilation systems, and the welding department was within ten feet of his assembly and work area. He stated that there were about eight welders and that Mr. Bruck was exposed to welding smoke, dust, grime and soot, which would settle overnight and clean off his tools and that he had been treated for seborrheic dermatitis. The doors of the plant were often closed in the cold weather. (PX6 at 6)

Dr. Eilers testified that it is not possible to determine whether the work exposure or the smoking caused the actual COPD or both. (PX6 at 19-20). However, he further testified as to causation:

> "If an individual with COPD is placed in an environment where you have more dust, toxic exposure, basically they're compromised from a pulmonary perspective. It's going to aggravate that condition, and that's certainly going to require further treatment. If you have COPD, you don't want to be exposed to additional substances that will cause airway aggravation, and certainly when they have basically retention because of that inhalation, those are – those particles are delayed more than they would be in the average person." (PX6 at 21)

Dr. Eilers further testified that the condition is permanent. (PX6 at 23)

On October 30, 2006, Dr. David Cugell authored a report based upon review of materials at the request of the Respondent. He also testified in this matter and his testimony is set forth below.

Dr. John Podzamsky, treating board certified family physician, testified via evidence deposition on January 24, 2008. (PX9) Dr. Podzamsky testified that he believes that the welding fume exposure contributed to Mr. Bruck's COPD and that there is scientific evidence to demonstrate that fumes from welding are injurious to the lung tissue. He further testified that he is familiar with the condition and that he treats patients who have been exposed to welding fumes on probably at least a monthly basis. (PX9 at 18)

Dr. Podzamsky testified that his opinion was that the welding fumes at Vactor Manufacturing did contribute to Petitioner's COPD. (PX9 at 18) His opinion was based on scientific evidence demonstrating that fumes from welding are injurious to the lung tissue. (PX9 at 18) He further testified that the exposure would cause permanent damage to the Petitioner because of the density of the welding fumes. (PX9 at 21)

Dr. Podzamsky further testified that the damage to Mr. Bruck's lungs is so extensive that he will not recover and will probably steadily deteriorate. (PX9 at 19)

Dr. Cugell testified via evidence deposition on August 21, 2008. He testified that based upon his review of the medical records and his visit to the plant in 2006, he did not believe that the workplace in any way contributed to Mr. Bruck's disease. (p.10) He testified that assuming the plant conditions at the time of employment were similar to those that he witnessed he did not observe any reason for paint fumes to be a factor in any ailments. He further testified that welding fumes could cause or aggravate COPD. However, he concluded that his proximity to where welding was in progress was irregular and that he could see no reason to assume welding fume exposure was related to his COPD. (p.11)

Dr. Cugell never met and did not speak with the Petitioner. He visited the plant on July 18, 2006 and spent an hour to an hour and a half at the plant for a scheduled visit. (p.16) He admitted that he had no direct knowledge of the conditions of the plant in the 1990s. (p.17)

Petitioner was taken by ambulance to the St. Mary's ER on February 20, 2009, complaining of shortness of breath and wheezing for the past week. (PX13). He was diagnosed with exacerbation of COPD secondary to cough, chest congestion, and fever. He was discharged from the hospital on February 25, 2009.

Petitioner was evaluated at the Prairie State Pulmonary & Sleep Consultants by Dr. Ravi Sundaram on April 24, 2009. (PX20 at 14). He indicated that Petitioner had been on home oxygen for about a year. He indicated that Petitioner becomes very dyspneic just from going from one room to the next, but improves after sitting down for quite some time. He was diagnosed with severe COPD with emphysematous changes reported on a chest x-ray report and some scarring notes and chronic hypercapneic hypoxemia respiratory failure, secondary to the COPD. Dr. Sundaram indicated that although Adair and Spiriva would be ideal to treat COPD, he did not think Petitioner has the ability to generate negative inspiratory force long enough or hold his breath long enough to benefit from inhalers and he thought they should treat his COPD primarily with nebulizers.

A pulmonary function report done on May 22, 2009 showed severe obstructive ventilatory defect without significant response to inhaled bronchodilator. (PX11). The results were consistent with severe emphysema with hyperinflation and air trapping.

Petitioner was next seen by Dr. Sundaram on August 21, 2009. (PX20 at 12). Dr. Sundaram wrote in his history, "He gets short of breath with exertion. He uses 2 liters when he is at rest and up to 3 liters when he is exerting himself. He is on continuous O2 and does not have a conserving device. He has been hospitalized twice for COPD." The x-ray Petitioner had showed hyperinflated lung fields, pleural apical scarring, no masses, no infiltrates. His full PFT's showed very severe COPD with severe airway obstruction,

with an FEV_1 of 0.61 and an FVC of 1.85 with a ratio of 33. His medications were continued with the addition of Brovana.

Petitioner was taken by ambulance to St. Mary's and admitted on September 26, 2009, with the chief complaint of respiratory difficulty. (PX13). He had to be intubated due to respiratory arrest, and it was found he had a large pneumothorax on the right side. An emergent chest tube was placed by Dr. Celeboglu, and Petitioner was admitted to the ICU. Dr. Nomani indicated in the report that it is likely his respiratory failure is due to his underlying lung disease. He was transferred to St. James Hospital on September 30, 2009 to see a pulmonologist.

Petitioner was discharged on October 19, 2009 by Dr. Bradley Coolidge at St. James Hospital in Olympia Fields, Illinois. (PX14). Dr. Coolidge summarized Petitioner's stay at St. James as follows:

> He was transferred to St. James in Olympia Fields because of severe chronic obstructive pulmonary disease with a persistent pneumothorax. On arrival he was on mechanical ventilation. He was felt to require surgical correction of his blebs and pneumothorax so he was seen by Dr. Barksdale from the thoracic surgery service because the need for surgery was seen by Dr. Martini from the cardiology service. He underwent a cardiac catherization on October 2nd which showed nonobstructing coronary disease. He underwent right video assisted thoracoscopic surgery after getting the okay from the cardiologist on October 5th. Postoperatively he was successfully weaned from the ventilator. He had a right chest tube in place which had continuous air leak throughout his hospital course. He had a pleural vent placed by the cardiovascular surgery service. He got nebulizer treatments, high dose Solu-Medrol, as well as antibiotics for much of his hospital stay. Because of his prolonged mechanical ventilation he developed severe deconditioning and was getting physical and occupational therapy. He eventually improved to the point where he was able to walk as far as 120 feet with assistance. He is being discharged to a skilled nursing facility in Streator, Illinois in fair condition.

Petitioner was admitted to the extended care facility at St. Mary's Hospital on October 19, 2009. (PX13). He was seen by Dr. Muhammad Zufar who recommended complete blood county, chem-13, and chest x-ray. Platelet count was okay and chest x-ray showed no pneumonia. He had rhonchi because of his advanced emphysema. Petitioner was discharged on October 30, 2009.

On November 20, 2009, Petitioner saw Dr. Sundaram. (PX20 at 10). The plan was to continue his oxygen and some of his medications were changed.

Petitioner saw Dr. Sundaram on February 19, 2010. (PX20 at 8). A chest x-ray was done, which showed bilateral apical scarring and bullous changes in both apices, no acute infiltrates, and some right pleural thickening. (PX12).

Petitioner next saw Dr. Sundaram on June 4, 2010. (PX20 at 6). He indicated that Petitioner was doing well since he was last seen in February. He was stable and had not had any worsening of his exercise tolerance.

Petitioner had a follow up visit with Dr. Sundaram on October 14, 2010. (PX20 at 4). He continued Petitioner's current regimen.

Petitioner saw Dr. Sundaram on January 7, 2011. (PX20 at 2). Lung transplant was discussed but Petitioner was not interested. Petitioner had previously declined cardiopulmonary rehabilitation, but he was now interested in trying it when it warms up outside.

Petitioner next saw Dr. Sundaram on April 29, 2011. (PX26). Medications were continued at that time.

Petitioner was seen by Dr. Sundaram on September 2, 2011. (PX26). At that time, Petitioner was placed on a long acting bronchodilator.

On September 17, 2012, Petitioner and his wife testified at hearing in front of this Arbitrator. Mr. Bruck testified from his wheelchair and was utilizing an oxygen machine. He testified that he recalled testifying via evidence deposition on January 4, 2010. Since that time he had continued to see Dr. Sundaram on a regular basis and continued on medications as well as oxygen at all times. He testified he cannot walk more than 15 to 20 feet without needing the wheelchair for assistance.

Paula Bruck, Petitioner's wife, also testified at this hearing date. She testified that she is the Vice-President of Sales for U.S. Foods and has been married to Petitioner for 30 years. She testified that when he worked for Respondent he would come home with grungy and dusty clothing and that their daughter would joke that he had a raccoon face since his face was dirty and his eyes were white from the area covered by glasses.

She testified that in a typical day she is responsible for Petitioner's caregiving. She prepares his meals and puts his lunch in the refrigerator so that all he has to do is obtain the meal and sit down to eat it. She washes his clothing and hair. He is able to bathe and dress himself with minor assistance. She does drive him to all of his doctors' appointments.

A letter from Chris Palicke, NP, dated January 22, 2013, indicates that Petitioner was last seen in the Pulmonary Clinic on August 14, 2012 by Dr. Aronson for end-stage COPD. (PX26). On August 14, 2012, a spirometry test was done, which showed FEV_1 of 0.47 and an FVC of 1.37 with a ratio of 34%. He was doing about the same.

Petitioner Ed Bruck testified via evidence deposition from his home on January 4, 2010. (PX18) Petitioner testified that in March 2009 Petitioner and his wife relocated to

a new home which they had built due to his difficulty in ascending and descending stairs. (PX18 at 7) At the time of his deposition, he had to wear oxygen 24/7. (PX18 at 9) He has noticed difficulty in his memory since 2003 in connection with his breathing problems and need for oxygen. (PX18 at 10)

Dr. Theodore Hogan, Ph.D., testified via evidence deposition on January 30, 2013. (PX22). Dr. Hogan is an assistant professor at Northern Illinois University who does consulting work separate from his employment at NIU in the area of environmental occupational health and safety. (PX22 at 3) Dr. Hogan has been consulting since 1990 and has a bachelor's degree in chemistry, a master's and doctorate degree in public health and concentration in environmental occupational health sciences, specifically industrial hygiene. (PX22 at 4) His testimony is balanced between plaintiff and defense. (PX22 at 4-5) He had never done consulting work previously on behalf of the Petitioner's law firm. (PX22 at 29)

In preparation for his testimony, Dr. Hogan reviewed medical records, depositions, workers' statements, the reports of Mr. David Duffy Respondent's expert and documents that he gathered, and scientific literature. (PX22 at 5-6) Dr. Hogan testified that the type of exposure that Mr. Bruck was exposed to is multiple exposures, dust, fumes, gases and vapors. (PX22 at 6)

Dr. Hogan testified that he did not inspect the job site and an inspection would not have affected his opinion because the job site had significantly changed since when Mr. Bruck was employed for the Respondent. He pointed out Dr. Cugell's deposition contained descriptions of the job site that had changed since the time of Mr. Bruck's employment. (PX22 at 6-7) Dr. Hogan felt that the inconsistencies regarding the positioning of the welding operations could have had some bearing on the opinions given in the case. (PX22 at 7)

Dr. Hogan testified that he disagreed with some of the conclusions expressed by Mr. Duffy, Respondent's expert. He testified that he incorrectly stated that emphysema was a restrictive lung disease. He further stated that Mr. Duffy's reliance on the fact that exposures were below exposure limits as an indication that the exposures were not a risk was an incorrect conclusion. (PX22 at 8-9) Dr. Hogan testified that he is a member candidate for the Threshold Limit Value Committee from ACGIH that sets the actual threshold limits and that the preamble of the ACGIH states that the exposure limits cannot be used as a basis for determining the presence or absence of a disease or as a causation factor. He further testified:

> "So just because something is below an exposure limit, either the OSHA or TLVs, does not mean that a disease is not occurring or has occurred from exposure to that particular material." (PX22 at 9)

Dr. Hogan testified that Mr. Bruck was exposed to welding fumes including both metals and gases and also to dust in the air, chemicals in the air, and some vapors. (PX22 at 9-10) Dr. Hogan has experience by working in this type of exposure in the 1970s and by participating in air sampling of these types of exposure environments since the 1980s.

(PX at 10) Dr. Hogan further has experience with the effects of cigarette smoking as he has done work on behalf of tobacco companies for workers who also have occupational exposures and he has a degree in public health so he is familiar with the health effects of both cigarette smoking and occupational exposure. (PX at 11)

Dr. Hogan testified that at no time during the contact from petitioner attorney firm was he ever advised as to what type of opinion was expected from him to give regarding Mr. Bruck's exposure. In his consulting experience, he has expressed opinions in cases that there was not a contribution the occupational component from a general causation standpoint. (PX22 at 11)

Dr. Hogan also cited multiple scientific treatises which he relied upon and reviewed in forming his opinions. (PX22 at 12-17) Based upon these treatises he cited information that in heavily exposed workers, the effect of dust exposure may be greater than that of cigarette smoking alone. He further cited multiple studies that multiple exposure to dust, fumes, and gases have been established as risk factors for developing COPD. He further pointed a study that states that for workers who are cigarette smokers the doctors tend to ignore any other kind of exposure that's taking place and fail to look at the occupational history of the worker. Another study he cited shows that the average reduction in pulmonary levels associated with welding fumes is similar to that associated with smoking. He also cited a study that there's not a significant difference in exposures for welders and non-welders to the gases and nitrogen to which they are exposed in the work environment. He further pointed out that welding fume exposure levels are measured under the welding mask so they do not adequately reflect the exposure of a non-welder working in the area outside of the welding mask. He also cited studies that supported that these mixed exposures could exacerbate early COPD. (PX22 at 49)

As to scientific causation, Dr. Hogan testified:
"I have a reasonable degree of scientific certainty that his exposure at Vactor could have exacerbated, aggravated or accelerated his COPD. It is not a causation opinion – a medical causation opinion. It's a general causation opinion that someone similar in his position who had the same kind of exposures would have that kind of aggravation or acceleration, exacerbation taking place." (PX22 at 25)

Dr. Hogan testified that what was important from the hypothetical was that the employees, including Mr. Bruck, were experiencing an environment that was dusty, black smoke and airborne debris from sanding and grinding, paint particles and stainless steel particles that would enter their noses and mouths from grinding. It's consistent with what he read in the documents that he reviewed and consistent with the type of mixed exposure that the American Thoracic Society has been associated with an increased risk of airway disease. (PX22 at 25-26)

He further explained that if the distances in the hypothetical were to be a bit different at hearing, it would not change his opinions because the exposures that are described were consistent with what was taking place and that the literature shows that this type of exposures are associated with COPD. (PX22 at 26)

On cross-examination, Dr. Hogan explained that the welding fumes measured inside of the hood are almost always lower than what you would find outside of the hood. (PX22 at 28) He further testified that whether or not there were exhaust fans or make-up air units in the facility would not affect his opinions in the case of the mixed exposures that he testified to. (PX22 at 29) He further explained that there is a difference between general exhaust ventilation and local exhaust ventilation and that air changes per hour measured have to do with general air changes taking place and not what exposure may have gone through a particular worker's breathing zone. (PX22 at 30)

As to door openings, Dr. Hogan testified that it is difficult to determine one way or another how those effect exposure levels. He stated that some kind of air movement patterns can actually disturb ventilation systems so you can't say one way or another whether an open door would improve the air quality. (PX22 at 32)

Dr. Hogan testified that he did not take into consideration the part of the hypothetical wherein it was stated that there were no ceiling fans or ventilation systems. Rather, he assumed that they were present as per the report of Mr. Duffy. (PX22 at 32)

Dr. Hogan testified that there is scientific evidence that exposures in the workplace can cause bronchitis and emphysema. (PX22 at 43)

On February 5, 2013, three co-workers of Mr. Bruck testified as to the conditions of the work environment at Vactor Manufacturing. Richard Lotshaw testified that he worked at Vactor Manufacturing from 1989 through about 2000 as a painter. (PX23 at 4-5) He testified that he would have to walk through the subassembly department every day for the majority of the time that he worked for Respondent. He testified that the workers in the area did not wear any type of mask protection except for the welders. (PX23 at 6, 8) Mr. Lotshaw testified that they did not have any type of ventilation or air evacuation system in the subassembly area and that sometimes the overhead doors would be open or there would be small fans once in a while if it was really hot. (PX23 at 7)

On cross-examination Mr. Lotshaw testified that if there were overhead fans or ceiling exhaust fans in the subassembly area, he never noticed them. (PX23 at 10)

Gregg Spradling also testified via evidence deposition. (PX24) He testified that he has been working in the form shop since he first became employed with Vactor Manufacturing in 1996 and he continues to work there. (PX24 at 4-5) He was familiar with Mr. Bruck and aware that he worked in the area of assembly called subframes or subassembly. (PX24 at 5-6) His work in the form shop area was adjacent to the subassembly area and he would walk the subframe assembly area about two to three times. (PX24 at 6) Mr. Spradling testified that until about 7 years ago, the subassembly area was a congested area. (PX24 at 9) He explained that any fans that were present were in the paint shop on the ceiling or high on the walls. He further testified that when the doors were opened drafting occurs "where the air just shoots through there, and it pushes over spray, dust particulate off the floors, everywhere." He further explained that

at the time Petitioner worked in subassembly the outside surface as gravel and dirt not concrete as now so the forklift would bring in dirt from outside as well. (PX24 at 10)

Mr. Spradling further testified that in the 1990s when he left the plant, he would notice that the stuff would cover his skin and clothes. This would be true in the paint shop area, form shop area, heavy weld areas, and including the subassembly area. Mr. Spradling explained that in the subassembly area they were heavy into welding and did their own grinding. He further explained that the main aisleway would go through all rooms of the plant so that particulates and overspray reaches all parts of the building. (PX24 at 11-12) He testified that the use of masks in certain areas of the building was not part of the protocol until the last few years. (PX24 at 12)

Mr. Spradling said that overhead exhaust fans were not put into the room he works in until about ten or eleven years ago. (PX24 at 19) He testified that he has complained about the air quality and talked to the CEO about having health studies done in the plant because of his concern over the amount of co-workers with illnesses. (PX24 at 22)

George Sokol also testified regarding the condition of the plant. He worked at Vactor Manufacturing starting in 1992 for over 15 years. He was initially a welder but then worked in assembly including doing some welding in the assembly area. (PX25 at 4-5) He testified that he worked near Mr. Bruck for a few years while Mr. Bruck was building router pumps and that the area that Mr. Bruck worked in was basically a lot of stainless steel. He testified that there were at some point ventilation fans on the ceiling but that they did not work for years and that other than opening the doors he was not aware of any other ventilation. (PX25 at 8)

Mr. Sokol testified that he was welding booms and would have been within 30 feet of Mr. Bruck during the time that he was welding. He stated that the non-welders did not wear any type of protection. (PX25 at 9) He described the room that they worked in as filled with smoke including oil smoke from welding the booms, plasma smoke from cutting the stainless and the odor from the paint from the primer area. (PX25 at 10) There was also sanding and grinding done in the area where he worked with Mr. Bruck. (PX25 at 20)

David Duffy testified via evidence deposition on February 13, 2013. He testified that he is a board certified industrial hygienist. (p.5) Mr. Duffy testified that he visited the plant in 2010 and his knowledge regarding the conditions of the plant from 1993 to 2003 was from other workers and Daniel Simpson. (p.16) Duffy is a board certified industrial hygienist. He is licensed in the State of Illinois. He reviewed a number of documents, primarily the industrial hygiene reports, reviewed the specifications of ventilation systems, and examined the plant. The industrial hygiene reports were created by OSHA. They were also created by an independent consulting firm. He talked with people who had been in the plant from 1993 to 2003 to find out the overall layout of the plant. He knows that welding was done on the premises. He is familiar with welding processes, as he has been evaluating welding operations for 35 years. It is the primary

focus of his job, and he has evaluated exposures of literally hundreds of workers over this time frame. He reviewed a layout of the plant as it existed between 19993 and 2003. Between the main welding bay and the subassembly area, there was a wall that went from the floor that goes approximately up eight feet, and on top of that wall there is another eight feet of weld curtains. To the north of the subassembly area, there was a wall that went all the way floor to ceiling. Weld curtains are plastic curtains that are generally assigned as barriers to prevent arc welding from going to additional areas or a barrier to keep an area separate from another area. There was also dust and debris on horizontal surfaces and other surfaces in 1993 to 2003. He stated that wherever you have subassembly and welders, you are going to have sediment or settled dust, and that the presence of settled dust is not an indicator of exposure in the breathing zone. He further testified that when you have welders and grinders, you generate very dense particulate matter and that when you are grinding steel, it is very dense, and the particles are very large, they settle out and they settle very quickly. They are not available in the breathing zone to any certain extent, and they will settle out and settle on horizontal surfaces over time. The fact that at the end of the shift, someone's clothes were dirty or someone's skin was dirty would not be an indication of inhalation exposure. He stated that there are two types of ventilation systems, local exhaust ventilation and general exhaust ventilation. Local exhaust ventilation is relevant to a welder, and the local exhaust ventilation would consist of an exhaust duct and exhaust hood that when positioned near the welder would exhaust and capture welding fumes at the point of welding. General exhaust ventilation when welding fumes are generated will be used as those welding fumes will rise and they will dissipate in the upper areas of the facility. The general ventilation exhaust is designed to continually change air in the facility with outside air, which continually dilutes those contaminants and keeps them moving out. Between 1993 and 2003 in the subassembly area, there were three overhead ceiling exhaust fans and they were, from what he was told, operational from 1993 to 2003. These fans caused the air in that area to be exchanged 5.9 times per hour. So within an hour's time, the air was almost completely changed six times. There were also fans in the welding bay. The welding bay had three exhaust fans along the south wall, which was opposite to the subassembly area, and there were two makeup air units on the north end of the bay. These factors together caused an air exchange rate of just under nine air changes per hour. He reviewed the industrial hygiene surveys. Those surveys included TLVs and PELs. These are reference exposure limits for the data that is collected in the industrial hygiene report. TLV stands for threshold limit value and PEL is permissible exposure limit. When OSHA examines or conducts an exposure assessment, they are bound by law to a certain extent to use the PELs. The TLVs are more restrictive than the PELs. The welders were monitored for iron oxide, and the reason they were monitored for iron oxide is it the primary air contaminant associated with the welding process. The areas were monitored in the welder's breathing zone. Someone six feet away from the welder would not have an exposure level the same as outside the welder's hood. That is because the welding fumes are hot and welding takes place between 2,000° and 3,000°, so those hot fumes would rise quickly, go up through the welder's breathing zone, rise to the top, dissipate and follow the air currents. For those working within eight to ten feet of that vicinity, those fumes had already risen. The fumes do not go horizontal, and they do not settle. Because they are hot, they go up, and they follow the thermal properties. An

individual not a welder will not have an exposure equivalent to a welder. The fumes on their own rise and then the ceiling fans would cause them to rise faster and farther. Most of the welding at Vactor occurs on steel, and when you are welding steel, 90+% is iron, and therefore the main component of welding fumes when you are welding steel is iron oxide. After iron oxide, you have minor compounds such as manganese, copper and aluminum. His review of the records show the petitioner suffered from emphysema. COPD is a general category of respiratory diseases that are known to cause obstruction in the airways, and within that category of COPD, you have emphysema, bronchitis, asthma, restrictive airway disease, and there are other things that could simply be chronic shortness of breath. He is familiar with emphysema, and emphysema is a disease of the lower airways in what is termed the alveolar region, and emphysema is an obstructive lung disease. Emphysema is not a restrictive lung disease. It is a very well-known fact, well established in literature, that emphysema is caused by very few things, and the major cause of emphysema by far is cigarette smoking. The second cause is a genetic abnormality that a significant number of people in the population suffer from, and it is caused by a deficiency of the alpha antitrypsin which is a protein you need to basically maintain those alveolar regions. If you suffer from that, even if you are a non-smoker, you can develop emphysema. There is no indication in the literature that iron oxide in the absence of cigarette smoke will cause emphysema. No industrial hygienist is qualified to render an opinion regarding the aggravation of emphysema in an individual. He testified that industrial hygienists do not interpret pulmonary function tests that have been conducted on the individual. They are not medical doctors. It is completely outside the area of their expertise. This is strictly a medical question that would have to be answered by the examining doctor. He disagreed with Dr. Hogan's report that exposure may or might have accelerated or exacerbated Mr. Bruck's chronic obstructive pulmonary disease. He stated that he disagreed because first of all, Dr. Hogan did not indicate emphysema. This person does not have asthma. He does not have a restrictive airway disease. And he also feels strongly that a board certified industrial hygienist should not be making this statement. He does not believe iron oxide would cause or aggravate emphysema. He also does not believe that the dust and dirt that Mr. Bruck testified covering his clothing and skin could have caused or aggravated his emphysema. There is no indication that it was in his breathing zone. He has reviewed all the studies and literature, and iron oxide and manganese have not been associated with the development of emphysema. They have been associated with a disease called siderosis. Siderosis is not a condition that affects pulmonary function. Mr. Duffy did not list this type of work exposure as a cause of emphysema and when asked about whether it could have aggravated emphysema, he testified that he did not feel qualified as an industrial hygienist to make that type of causal opinion. (p.31-32)

Mr. Duffy testified on cross-examination that when he visited the plant in 2010 the subassembly area had changed since when Mr. Bruck was present so he was relying on Mr. Simpson's description of that area. He testified that the ventilation fans in subassembly were working at the time that he was present at the plant but that he could not testify as to other times. (p.37) He admitted that if the ventilation fans were not working in that particular area, there could be an impact on the welding fume levels in

that room. (p.38) It is possible that the workers could be exposed to a higher level of welding fumes. (p.39)

Daniel Simpson, facilities manager at Vactor Manufacturing, testified via evidence deposition on February 15, 2013. He testified to the areas of the plant where Mr. Bruck worked and stated that he would have been welding in the rodder pump area from 1993 to 2003 in three stations across from the area. (p.17) He admitted on cross-examination that there was a welding area that was open to the subassembly workers. (p.23) Mr. Simpson further admitted that there were times between 1993 and 2003 that there were reports of problems with the ventilation or fans not working but that he did not have any information at the time of the deposition upon which he could testify as to how often or how many repairs were made. (p.24)

Regarding a report of fiber counts in November 2002 in Mr. Bruck's area, Mr. Simpson testified as to the filters being overloaded with fibers that "they were tampered with." (p.26) When asked about how he knew that they were tampered with he testified that it was his guess that "they stuck a pile of dirt or dust and overloaded it." (p.26) That report recommended that the sampling be repeated due to those concerns but Mr. Simpson could not testify for sure if it was repeated or not and did not have a report available. (p.27) He further admitted that from 1993 through 2003, no workers in the subassembly area would wear any type of respiratory protection equipment except the welders. (p.28)

CONCLUSIONS OF LAW

In support of the Arbitrator's Decision as to C. WHETHER AN ACCIDENT OCCURRED WHICH AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT WITH RESPONDENT, the Arbitrator finds the following:

Petitioner and multiple co-workers testified to the dirty conditions and exposure in the subassembly area of the plant during his employment from 1993 through 2003 with Respondent. Petitioner testified that prior to his employment with Respondent he had no recollection of having any treatment for COPD. The record contains only one medical treatment record in April 1991 suggesting a diagnosis but a follow up x-ray order by Dr. Podzamsky revealed that his lung capacity and pulmonary condition at the time were normal.

Mr. Bruck testified that he was not aware of being diagnosed with COPD until after he had worked in the subassembly area and he had no significant breathing problems until he worked for Respondent. His breathing problems worsened and he sought medical emergency medical treatment in February 1999.

On March 19, 1999, Petitioner was officially diagnosed with COPD by Dr. Podzamsky.

The Arbitrator finds that Petitioner suffered accidental injuries which arose out of his employment with Respondent and culminated on March 19, 1999, the date he was officially diagnosed with COPD and underwent actual medical treatment for the respiratory condition. If the condition existed prior to this time, the record contains no convincing evidence of it given the lack of objective evidence of diagnostic films showing any pulmonary condition and given the lack of any medication or treatment prior to this time.

The Arbitrator further finds that the Petitioner and his co-workers credibly testified to the multiple exposures that Petitioner would have incurred while employed for 10 years in the subassembly areas of the plant.

Petitioner continued to work though restrictions were placed on him throughout the next few years. Finally, on May 7, 2003, Petitioner suffered significant trouble breathing which led to him being taken by ambulance from his workplace to the St. Mary's Hospital Emergency Room.

The Arbitrator finds that Petitioner suffered accidental injuries which arose out of and in the course of his employment with Respondent on May 7, 2003 when he could no longer handle working and suffered a severe episode of troubled breathing while attempting to perform his regular work duties. Dr. Podzamsky diagnosed him at that time with an exacerbation of his COPD while working.

In support of the Arbitrator's Decision as to E. WHETHER PETITIONER GAVE TIMELY NOTICE OF THE ACCIDENT TO RESPONDENT, the Arbitrator finds the following:

Petitioner testified that he complained multiple times about the quality of air to his foreman, Rick Pence, beginning as early as 1994 and multiple times thereafter. He testified that he was originally given a dust mask to wear the first few times he complained but that after that he felt like he was being retaliated against and put on dirtier jobs so he stopped asking for it.

Respondent did not offer the testimony of Rick Pence at hearing to rebut the testimony of Petitioner regarding notice. The only representative of Respondent who testified was Daniel Simpson, and he did not provide any testimony regarding knowledge or lack of knowledge of air complaints by Mr. Bruck.

The Arbitrator finds that based upon Petitioner's credible testimony and the lack of rebuttal evidence, it is reasonable for him to conclude that Respondent would have had timely notice of Petitioner's respiratory condition and difficulty with breathing in the workplace on or about March 19, 1999.

Further, Petitioner continued to work and there was no rebuttal testimony provided as to Petitioner's testimony that he had restrictions regarding overtime or weekend work.

On May 7, 2003, Mr. Bruck was taken ambulatory from his workplace to St. Mary's Hospital for emergency care and he testified that his foreman and the head foreman were the ones who were involved in calling the ambulance. Again, Respondent did not offer any testimony to the contrary.

Based on the record as a whole, the Arbitrator finds that Respondent had timely notice of the accident of May 7, 2003 given that he did not return to work following the emergency room trip after having difficulty breathing while performing his regular employment.

In support of the Arbitrator's Decision at to F. WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE ACCIDENT, the Arbitrator finds the following:

Petitioner and his co-workers all testified to a congested and smoky, dusty subassembly work area between 1993 and 2003. They further consistently testified that the ventilation in the area was lacking and that at times when the doors were open to the outside there would be a drafting that would blow the materials and fumes through the building areas. They testified that they would be covered in soot and dirt and grime. The co-workers all testified that the building had since changed significantly.

Petitioner offered the testimony of Dr. Eilers as well as Dr. Podzamsky both of who supported the work exposure as a causative factor in exacerbating Mr. Bruck's COPD condition.

Respondent offered the testimony of Dr. Cugell. However, Dr. Cugell had visited the building in 2010 and had never spoken to Petitioner. It is unclear from his report who he spoke to regarding the conditions prior to 2003 other than Daniel Simpson. He further testified that he had no direct knowledge of the subassembly condition at the time Mr. Bruck worked there. He admitted that welding fume exposure could aggravate COPD, but he did not think it was a factor for Mr. Bruck given his cigarette smoking.

Dr. Cugell also noted in his report that there was no mention in the medical treatment records of work exposure as being a factor. It is noteworthy, however, that in September 2003, Petitioner's treating pulmonary doctor at Peoria Pulmonary stated "he works as a manual laborer and is exposed to nonspecific dust and fumes." Further, Dr. Podzamsky, Petitioner's long time family physician and the Respondent's company physician, testified as to his knowledge of welding fumes and exposure and that he felt that Mr. Bruck's condition was exacerbated by his work exposure. It is clear that Dr. Cugell either ignored this evidence or was not aware of it.

Mr. Duffy could not testify one way or another as to whether the work exposure may have aggravated the COPD although he did not believe that the original exposure caused it.

Dr. Hogan testified at length as to his knowledge of this type of exposure and testified that from a scientific standpoint, there is literature that would support that this type of multiple exposure work environment would contribute to the exacerbation of COPD. This was based upon his 20 year experience of work exposure and air sampling as well as multiple scientific articles supporting this which were included in his testimony.

The Arbitrator recognizes that Petitioner was an admitted two pack per day smoker for many years leading up through 1999 and that all of the medical and scientific experts in this case have agreed that his smoking was a contributory cause in the development of his COPD. However, the Arbitrator finds that Petitioner has provided enough evidence that it is more likely than not that his work exposure over several years leading up to March 19, 1999 with his official diagnosis leading to actual medical treatment for the condition and restricted work as well as through May 7, 2003 when he ultimately could no longer breathe while performing his regular work duties were a contributory factor in the exacerbation and acceleration of his COPD and on that basis finds that there is a causal connection between Petitioner's accident as alleged herein and the injury he alleges as a result thereof.

In support of the Arbitrator's Decision as to G. THE AMOUNT OF PETITIONER'S EARNINGS, the Arbitrator finds the following:

The Petitioner did not provide any evidence at hearing contrary to the wage records provided by Respondent. Thus, the Arbitrator finds that the Petitioner's Average Weekly Wage is $601.89.

In support of the Arbitrator's Decision as to J. WHAT AMOUNT OF REASONABLE, RELATED, AND NECESSARY MEDICAL EXPENSES SHOULD BE AWARDED, the Arbitrator finds the following:

Petitioner's Exhibit #1 is a compilation of medical expenses related to the Petitioner's respiratory condition following his work exposure. Based upon the finding of liability, the Arbitrator finds that Respondent is liable for these expenses.

Dr. Robert Eilers testified that he is familiar with the reasonable and customary charges for the medical services that were provided prior to the fee schedule and that these charges were reasonable and customary for like medical services.

Based upon the greater weight of the evidence, the Arbitrator finds that Petitioner is entitled to a total of $334,495.96 less group adjustments of $14,822.66 leaving a total of $319,673.30 due and owed to Petitioner for his related medical expenses to date subject to the limitations of the medical fee schedule of Section 8.2 of the Act. Respondent shall not receive any Section 8(j) credit for group payments made as they were made through Petitioner's spouse's insurance carrier.

In support of the Arbitrator's Decision as to K. WHAT AMOUNT OF TEMPORARY TOTAL DISABILITY BENEFITS SHOULD BE AWARDED, the Arbitrator finds the following:

The Arbitrator finds that Petitioner was unable to return to employment as of May 7, 2003. Following that date, Petitioner was never released to return to any type of employment and his condition appeared to be permanent.

The Arbitrator finds that Petitioner is not entitled to temporary total disability since the evidence supports a finding of permanent total disability as of May 7, 2003. The Arbitrator finds that the short and long term disability benefits paid by the Respondent's group carrier through August 9, 2007 and totaling $17,981.36, as stipulated to at hearing, shall be credited against his award of permanent total disability.

In support of the Arbitrator's finding as to L. THE NATURE AND EXTENT OF THE INJURY, the Arbitrator finds the following:

Petitioner was unable to return to any type of employment following his May 7, 2003 trip to the emergency room for his respiratory condition. The medical treatment records show that he remained under active care and his condition progressively worsened.

Petitioner was granted Social Security Disability on October 31, 2003 with a finding that he became disabled on May 7, 2003.

Further, Dr. Podzamsky and Dr. Eilers testified that Petitioner's condition would continue to deteriorate and was permanent. Dr. Podzamsky provided him with a restriction slip in September 2003 supporting his permanent and total disability.

At hearing, Mr. Bruck was on oxygen 24/7 and required the use of a wheelchair on a regular basis particularly outside of his home.

Respondent provided no evidence at hearing that Mr. Bruck was medically capable of performing any type of employment.

Based upon the greater weight of the evidence, the Arbitrator finds that Petitioner has never been released medically to return to any type of employment since May 7, 2003 and that he is medically permanently and totally disabled. Thus, the Arbitrator finds that Petitioner is entitled to permanent total disability benefits at a rate of $401.26 commencing May 8, 2003.

As of the final date of hearing of May 9, 2013, the Petitioner is owed 522 1/7 weeks of benefits, or a total of $209,515.04 with Respondent to receive credit for group long and short term disability payments totaling $17,981.36, leaving a balance of $191,533.68 due and owed to Petitioner to date. Petitioner shall continue to be entitled to $401.26 per week for life pursuant to Section 8(f) of the Act.

In support of the Arbitrator's Decision as to M. WHAT AMOUNT OF PENALTIES AND FEES SHOULD BE AWARDED, the Arbitrator finds the following:

Although the Arbitrator finds that Petitioner met his burden of proving an acceleration of his disease caused by work exposure, the Arbitrator does not find evidence in the record that Respondent's actions in disputing the case were unreasonable or vexatious. Thus, the Arbitrator does not award penalties or attorney fees.

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

Terrence Doyle,
Petitioner,

vs.

NO: 10 WC 17413
14 IWCC 0501

State of Illinois DJJ IYC Joliet,
Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 4, 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 in the amount of $122,565.12 in temporary total disability benefits paid to or on behalf of the Petitioner on account of said accidental injury.

No bond or summons for State of Illinois cases.

DATED: AUG 0 4 2014

MB/jm

O: 6/5/14

43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
AMENDED

DOYLE, TERENCE
Employee/Petitioner

Case# **10WC017413**

14IWCC0501

STATE OF IL DJJ IYC JUSTICE
Employer/Respondent

On 10/4/2013, 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 0.04% 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:

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

1368 ASSISTANT ATTORNEY GENERAL
DAVID PAEK ESQ
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

OCT 4 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0501

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
AMENDED ARBITRATION DECISION

TERRENCE DOYLE
Employee/Petitioner

v.

STATE OF IL DJJ IYC JOLIET
Employer/Respondent

Case # 10 WC 17413

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, IL**, on **JULY 12, 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 **04/24/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$87,135.88**; the average weekly wage was **$1,675.69**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$122,565.12** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$122,565.12**.

Respondent is entitled to a credit of **$365.00** under Section 8(j) of the Act.

ORDER

Maintenance

Respondent shall pay Petitioner maintenance benefits of **$1,117.13**/week for **1 3/7** weeks, commencing **10/6/2012 through 10/15/2012**, as provided in Section 8(a) of the Act.

Temporary Partial Disability

Respondent shall pay Petitioner temporary partial disability benefits of **$1,117.13**/week for **127 6/7** weeks, commencing **4/25/2010 through 10/5/2012**, as provided in Section 8(a) of the Act.

Medical benefits

Respondent shall pay reasonable and necessary medical services of **$54,786.88**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of **$365.00** 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.

Permanent Partial Disability: Wage differential

Respondent shall pay Petitioner permanent partial disability benefits, commencing **10/16/2012**, of **$697.23**/week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

THIS AWARD SUPERCEDES ANY AWARD THAT HAS BEEN ISSUED BY THE WORKERS COMPENSATION COMMISSION.

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

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

#01 George J Andros
Signature of Arbitrator

9/26/13
Date

as Amended Award

OCT 4 - 2013

STATEMENT OF FACTS 10 WC 17413

In Support of the Arbitrator's Decision regarding "L" (Nature and Extent), the Arbitrator makes the following findings and conclusions:

This matter involves an 8(d)(1) wage differential claim where accident and causal connection have been stipulated (Arb. Ex. 1).

Petitioner, a 50 year old shift supervisor at IYC Joliet, responded to an inmate altercation and injured his right knee on April 24, 2010. He was treated by Dr. Bradley Dworsky at Hinsdale Orthopedics (Pet's. Exs. 3 -4a) from May 3, 2010 through April 4, 2013. He had surgery of the right knee October 12, 2010, consisting of a parapatellar retinacular release, and a chondroplasty of the medial and lateral facets of the patella, including the patellar trochlear groove and plicectomy of the medial plica of the right knee at Provena St. Joseph Medical Center (Pet's. Ex. 2). Following surgery, Petitioner underwent physical therapy at Newsome Physical Therapy Center (Pet's. Ex. 7) and injections by Dr. Dworsky. Dr. Dworsky's records show limited improvement through October 5, 2012. At that time, Dr. Dworksy noted that Petitioner would be considered at maximum medical improvement at a level less than his ability to return to work. Moreover, he would need continued Synvisc injections in the future given his history of chondromalacia, to return on an as needed basis (Pet's. Ex. 4, p. 50). The physical therapy records from Newsome (Pet's. Ex. 7), show limited improvement throughout extensive physical therapy, with the note of September 27, 2012 suggesting a return for strengthening, and the note of October 16, 2012, showing that therapy was stopped because of lack of approval for more physical therapy from the claims administrator . (Pet's. Ex. 7, p. 131). The last physical therapy narrative note, which was for treatment from November 2nd through November 29, 2011, more than a year after his surgery, showed that Petitioner continued to have problems with knee pain, difficulty with weight bearing activities involving knee flexion such as descending stairs or trying to squat, and walking. He noted that physical therapy only provided temporary relief, and his ability to progress with function and strengthening remained limited by anterolateral knee pain, and that his current limitations would not allow him to return to performing normal duties as a correctional officer (Pet's. Ex. 7, p. 42).

Petitioner's most recent medical treatment was when he received a Synvisc injection April 4, 2013. At that time Dr. Dworsky limited him to no inmate contact, no stairs, and no running (Pet's. Ex. 4a). Petitioner was also examined at Respondent's request pursuant to Section 12 by a Dr. Nikhil Verma of Midwest Orthopedics at Rush, who found the current diagnosis to be aggravation of pre-existing patella chondromalacia related to the injury of April 24, 2010, that injections would be required, and that as of that time Petitioner would not be capable of performing full duties. Dr. Verma did a supplemental report, (Resp. Ex. 1) where he recommended a functional capacity evaluation, but that based on the complaints at the time of the Section 12 exam, he opined that the restrictions of no stairs or running and no inmate contact appeared appropriate (Resp. Ex. 1 p. 2).

Petitioner testified that his job involved extensive standing, walking, and involvement in inmate altercations. All the medical evidence is to the effect that Petitioner can no longer perform those duties. He prematurely took his pension at a financial loss due to the injury.

Based upon the totality of the evidence , the Arbitrator finds Petitioner in the case at bar partially incapacitated from pursuing his usual and customary line of employment within the meaning of Section 8(d)1.

Accordingly, the Arbitrator finds as a matter of law the Petitioner is entitled to 2/3rds of the difference between the average amount which would he would have been able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident, and the average amount of what he is earning or is able to earn in some suitable employment or business after the accident.

Regarding the former, the parties stipulated that Petitioner would currently earn $7,652.00 per month or $1,765.85 per week in his usual and customary occupation (Arb.'s Ex. 1). This is further supported by Exhibit 10, where wages for a shift supervisor are within the same range. With regard to what Petitioner is currently earning, the Petitioner testified that he began looking for work in approximately May of 2012, interviewing for jobs in the $15.00 an hour range for 40 hours.

The Petitioner sought gainful employment in diligent fashion. He sought employment with the local State's Attorney interviewing for a job which to his knowledge was $15.00 to $20.00 an hour for 40 hours a week. He applied for full-time work. Instead he was offered a job for 8 hours a day, 3 days a week, or 24 hours a week total, but at a higher wage scale of $30.00 per hour.

The benefit of this situation to the employer was that benefits would not have to be paid, and those part-time positions were the only types being offered currently for the position, which was as an investigator. The testimony is supported by Petitioner's Exhibit 11 that he had started with the county on October 16, 2012, earning $30.00/hr. for 24 hours a week. He had already been there 9 months at the time of hearing, and there were only 2 additional days where he worked, one being an emergency and the other being to train someone else. Accordingly, the Arbitrator finds as material fact that Petitioner is currently earning $720.00/week.

Susan Entenberg, a Certified Vocational Counselor gave evidence both by report (Pet's. Ex. 8) and deposition (Pet's. Ex. 9). This is the only vocational evidence in the case. She opined that Petitioner had an earning capacity of $15.00 to $17.00/hour, in the areas of investigator, security, and armored car driver. She noted that direct placement was the first choice, although Petitioner was capable of further training (Pet's. Ex. 8, p. 4). Ms. Entenberg noted it more common that you see a lot of part-time jobs being offered, especially less than 30 hours a week, because then they are not paying for health insurance. They are saving in that respect, so they can pay more as part-time employment (Pet's. Ex. 9, p. 13).

When asked whether, having secured this job, it would not make sense for Petitioner to look for further work, and whether this would be an optimum job, Ms. Entenberg opined that this was a good job for him. Its right exactly the type of job she was recommending. It is within his level of expertise and skill, it's within his restrictions, and he is earning overall an appropriate wage (*Id.* pp. 14 – 15).

If the $720.00/a week he was making was spread over 40 hours, it would come out to $18.00/hour, which is very close to and slightly higher than the range Ms. Entenberg had recommended for job seeking, which was $15.00 to $17.00/hr. (*Id.* p. 10). Ms. Entenberg reaffirmed that she would base his earning capacity on the wage he is earning for the amount of hours that he is working a week, which comes out to $17.00 to $18.00/hour on a full-time basis, as even though the pay is $30.00/hour, they limit him to 24 hours a week (*Id.* @ 34).

Petitioner also testified to the jobs he looked for prior to accepting a job with the State's Attorney's office, and they were all in approximately the $15.00/hour range. The Arbitrator notes that the State has never had to pay a vocational counselor to assist Mr. Doyle in placement, and that the

maintenance awarded in this case is limited to 10 days, evidencing that Petitioner conducted a diligent and successful job search.

The actual amount that Petitioner is earning, which is one of the two alternatives, and the preferred alternative in Section 8(d)1, is $720.00/week. The other alternative, Petitioner's earning capacity based on the average of some suitable employment, is generally only used if current earnings are non-existent or inappropriate, and in this case all the evidence is that the job Petitioner sought on his own and accepted is both appropriate and optimum. Based on Petitioner's job search and the testimony of Ms. Entenberg, he could be expected to make, if able to secure a full-time job, $15.00 to $18.00/hour, and he already is earning the equivalent of that, although the job is only part-time.

This is not a case where Petitioner voluntarily took a part time job although full time was available. By Petitioner's testimony full time was not being offered to any investigator, and the Arbitrator finds Petitioner's testimony credible and the job to be suitable. This is simply a mutually beneficial situation where the employee works less hours and the employer pays higher because it does not have to pay benefits such as medical insurance. Where appropriate, the Commission has used a part-time job to calculate wage differential benefits. See *Rausch v. John Keno & Co.*, 09 IWCC 1013 and cases cited therein, also as to elements of proof.

Thus, the Arbitrator finds as material fact and as a matter of law Petitioner's earning capacity, the average he is able to earn in some suitable employment, the second alternative, also to be $720.00/week.

Accordingly, Petitioner is awarded from the Respondent at bar as a matter of law pursuant to Section 8(d)1 the sum of $697.23/week, representing 2/3rd of the difference between the stipulated amount of $1,765.85/week less $720.00/week, commencing October 16, 2012, which award shall be for the duration of the disability.

In Support of the Arbitrator's Decision regarding "K" (TTD and Maintenance), the Arbitrator makes the following findings and conclusions:

The parties stipulated and agreed that TTD was paid from April 25, 2010 through May 31, 2012 in the appropriate amount of $122,565.12 for 109 5/7ths weeks. An additional amount of TTD was claimed and agreed to from June 1, 2012, when Petitioner took a retirement pension, through October 5, 2012, when Petitioner was declared by Dr. Dworsky to be MMI, consistent with the *Interstate Scaffolding* case for an additional 18 1/7th weeks, or a total of 127 6/7ths weeks.

During this period Petitioner remained under active treatment, had extensive physical therapy, and as of the MMI date of October 5, 2012, he was still receiving shots. Limited improvement was noted up until that time.

Regarding maintenance, Petitioner actually secured employment which began October 16, 2012, so that the claimed period is only 10 days from October 6, 2012 through October 15, 2012, being 1 3/7 weeks.

Petitioner testified that he had been looking for work, and while his job search was limited it was of extremely short duration and successful. Petitioner is to be commended for securing excellent employment within a very short period of time, and the Arbitrator finds the period of maintenance to be most reasonable.

In conclusion, the Arbitrator awards as a matter of law temporary total disability of 127 6/7 weeks and maintenance of 1 3/7 weeks, with Respondent to have credit for the 109 5/7 weeks it paid.

In Support of the Arbitrator's Decision regarding "J" (Medical Expenses), the parties stipulated that the bills would be admitted into evidence and that Respondent could pay them directly to providers pursuant to the fee schedule or agreement.

The only unpaid bills appear to be for the emergency room physician at the time of the accident, for the pathologist at the time of knee surgery for Hinsdale Orthopedics who was the only treaters for the knee condition, including surgery, and for Newsome Physical Therapy, which was extensive.

Thus total bills are awarded as a matter of law the sum of $54,786.88 (See Arbitrator's Exhibit 2), after deducting $19,476.00 which Workers' Compensation paid towards the Newsome Physical Therapy bill.

Petitioner's group insurance paid $365.00 towards the Associated Pathologist bill for surgery, the total bill being $392.00, and Respondent shall have an 8(j) credit for that and hold Petitioner harmless with respect thereto. The Arbitrator notes that Respondent's Section 12 physician, Dr. Verma had states opposition or disagreement as to the reasonableness and necessity of the treatment Petitioner received. The Arbitrator finds as a matter of fact and law the treatment is reasonable and necessary.

STATE OF ILLINOIS)BEFORE THE ILLINOIS WORKERS' COMPENSATION
) SS COMMISSION
COUNTY OF COOK)

Tracy Howell,
Petitioner,

vs. NO. 09 WC 039531
14 IWCC 0578

State of Illinois/Menard Correctional Center,
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 Order of the Commission dated July 17, 2014, having been filed by Respondent. Upon consideration of said Petition, the Commission is of the Opinion that it should be granted.

The Commission finds that the original decision was issued with the case number 08 WC 039531 and the correct number is case number 09 WC 039531.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Order dated July 17, 2014 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 Order shall be issued simultaneously with this Order.

DATED: AUG 15 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/jm
43

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

Tracy Howell,
Petitioner,

vs.

NO: 09 WC 39531
14 IWCC0578

State of Illinois/Menard Correctional Center,
Respondent,

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of equal protection and permanency 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 finds that the original decision was issued with the case number 08 WC 039531 and the correct number is case number 09 WC 039531.

The Commission finds that there was no violation of Petitioner's rights pursuant to the Equal Protection Act. Furthermore, the Commission views this case differently than the Arbitrator and finds Petitioner permanently lost 20% of the use of each foot under Section 8(e) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $627.03 per week for a period of 66.8 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent loss of use of 20% of each foot.

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: AUG 15 2014

MB/jm
O: 5/28/14
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOWELL, TRACY
Employee/Petitioner

Case# **09WC039531**

14IWCC0578

STATE OF ILLINOIS/MENARD C C
Employer/Respondent

On 11/2/2012, 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:

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
KENTON J OWENS
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

NOV 2 2012

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)SS.

COUNTY OF WILLIAMSON)

14IWCC0578

- [ ] 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

TRACY HOWELL
Employee/Petitioner

v.

STATE OF ILLINOIS/MENARD C.C.
Employer/Respondent

Case # 09 WC 39531

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 **Gerald GRANADA**, Arbitrator of the Commission, in the city of **HERRIN**, on **August 14, 2012**. By stipulation, the parties agree:

On the date of accident, **08/17/09**, 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 $ **54,342.00** and the average weekly wage was $**1,045.04**

At the time of injury, Petitioner was **45** years of age, ***single*** with **0** dependent children.

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

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

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

14IWCC0578

ORDER

Respondent shall pay Petitioner the sum of $627.02/week for a further period of 33.4 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused **10% loss of use of right and left feet.**

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

10/29/12
Date

NOV - 2 2012

14IWCC0578

The Arbitrator finds the following facts:

The issue in dispute is nature and extent of injury. This case was previously tried pursuant to Section 19(b) and found to be compensable. Said decision was affirmed by the Commission. Petitioner is a 48 year old employee of the State of Illinois at the Menard Correctional Center. Petitioner testified that he worked as a correctional officer.

Petitioner was diagnosed with bilateral Achilles tendinosis. Petitioner underwent surgical release by Dr. John Krause on September 21, 2010 on the right Achilles tendon and November 30, 2010 on the left Achilles tendon.

Following the February 21, 2011 visit with Dr. Krause, Petitioner was released to return to work full duty with no restrictions. Petitioner completed physical therapy at Carbondale Memorial Hospital. At trial, Petitioner testified to having difficulty in his feet after work. Petitioner testified to having cramping and less mobility after work. Petitioner has changed job duties at work and is now the knit shop officer. Petitioner current job duties are easier on his feet than were the duties of correctional officer. Petitioner noted that the surgeries he underwent helped immensely.

Therefore, the Arbitrator concludes:

1. Respondent shall pay reasonable and necessary medical services if any as provided in Sections 8(a) and 8.2 of the Act.

2. As a result of his injury, Petitioner has sustained the 10% loss of use of each foot pursuant to Section 8(e). This is based on Petitioner's complaints corroborated by the medical 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 down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROGER MAY,

Petitioner,

vs.

NO: 07 WC 15818
14 IWCC 0602

GREENWOOD TOWNSHIP,

Respondent.

CORRECTED 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 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.

It is well established that the determination of the time for which a petitioner is temporarily totally disabled is a question of fact for the Commission to decide, and, unless that decision is against the manifest weight of the evidence, it will not be disturbed on review. *Lusietto v. Industrial Comm'n* (1988), 174 Ill. App. 3d 121, 528 N.E.2d 18. The period of temporary total disability encompasses the time from which the injury incapacitates the petitioner until such time as the petitioner has recovered as much as the character of the injury will permit, *i.e.*, until the condition has stabilized. *Rambert v. Industrial Comm'n* (1985), 133 Ill. App. 3d 895, 477 N.E.2d 1364. To show temporary total disability, the claimant must show not only that she did not work, but that she was also unable to work. *Rambert*, 133 Ill. App. 3d 895, 477 N.E.2d 1364.

The Commission finds that Roger May failed to prove that he is entitled to TTD from May 18, 2009 through July 19, 2009 and from August 12, 2009 through August 20, 2011. The evidence establishes that the Petitioner was able to perform his job duties as a Highway

Commissioner from the date of accident on April 15, 2006 through May 18, 2009, the date he voluntarily retired from his elected position. His testimony confirmed that no doctor ever informed him that he could not work as the Highway Commissioner or that he could not seek re-election due to his injury. T.59. & T.65. Further, no work restrictions were placed on the Petitioner at the time of his voluntary retirement on May 18, 2009. Dr. Matthew Ross, on July 17, 2008, indicated that Petitioner was fully capable of performing his job duties. T.59. & PX.8.

On July 20, 2009, Dr. Ross performed right cubital tunnel release on Petitioner. The Petitioner was taken off work by Dr. Ross and though he had already retired, he was correctly paid TTD from July 20, 2009 through August 12, 2009. Petitioner testified that he was released back to work with 10 pound restrictions. T.36.

The Commission notes that Petitioner did not offer into evidence any medical record outlining the parameters of the stated 10 pound restriction, or any medical record that indicated Petitioner had a 10 pound restriction following the cubital tunnel surgery and his discharge from care for that procedure. The only evidence regarding a 10 pound restriction is from Petitioner's testimony. Since there is no corroborative evidence, the Commission finds that the Petitioner's self-serving statement is not persuasive.

Petitioner offered no evidence that he presented his restriction (if any existed) to the Respondent or that the Respondent was unable to accommodate the restriction. Further, Mr. May offered no evidence that the restriction precluded him from performing his job duties as the Highway Commissioner. Additionally, Petitioner offered no evidence that he made any effort to seek employment and was denied employment because of his disability during the alleged period of temporary disability. The Petitioner offered no credible excuse for not looking for work within his alleged restriction during the period for which he seeks TTD. See *Lukasik v. Industrial Com. of Illinois*, 124 Ill. App. 3d 609, 465 N.E.2d 528, 1984 Ill. App. LEXIS 1871, 80 Ill. Dec. 416 (Ill. App. Ct. 1st Dist. 1984), which found no basis from the evidence to justify claimant's failure to seek any employment following his release for light work.

The Petitioner argues that he is entitled to TTD from May 18, 2009 through August 20, 2011 as his symptoms on August 20, 2011, the date he was taken off work by Dr. Lawrence Robbins, were the same as they were on May 18, 2009. His argument that this proves an inability to work during the entire period is not persuasive. The Petitioner provided the Commission with no guidance to support such an award. The Commission notes that the record is devoid of any doctor's note, as of May 18, 2009, or thereafter, that provided Petitioner with any work restrictions due to his work-related injury.

Based on the Petitioner's failure to look for work, his failure to provide documentation of any restriction of 10 pounds or otherwise, either to his employer or the Commission, his failure to inform Respondent of his alleged restriction and his failure to provide the Respondent an opportunity to accommodate his alleged restriction with light work, the Commission finds that Mr. May is not entitled to TTD from May 18, 2009 through July 19, 2009 and from August 12, 2009 through August 20, 2011.

With all of the above in mind, the Commission now considers the argument of the

Respondent relative to Petitioner's employment with May Sand and Gravel, Inc. Respondent has alleged that Petitioner was an active employee of May Sand and Gravel, Inc. It has suggested that the Commission reach this same conclusion based upon the location of the business and certain tax returns that were entered into the record. Additionally, Respondent has introduced a copy of an advertisement which listed Petitioner's name as a contact for the company. Both Petitioner and his wife, the majority owner and operator of the company, denied knowledge of the advertisement.

The Commission does not find the argument of the Respondent persuasive. Respondent's argument is based upon speculation and conjecture. Though the Commission is entitled to reach reasonable inferences, it cannot find that Petitioner was employed with May Sand and Gravel, Inc.

The Commission notes that the Respondent stipulated on the record that Mr. May is permanently and totally disabled as the result of his work-related accident. T.68. While the Commission may have a different view as to the extent of the disability, the Commission does not address this issue as the Commission is bound by the stipulation.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on September 30, 2013, is modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $871.78 per week for a period of 112-4/7 weeks, from July 20, 2009 through August 11, 2009 and from August 21, 2011 through September 23, 2013, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $871.78 per week for life, commencing September 24, 2013, as provided in Section 8(f) of the Act, because the injury caused the permanent and total disability of the Petitioner.

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

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: AUG 13 2014

MJB/tdm
052
O: 6/24/14

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MAY, ROGER J
Employee/Petitioner

Case# **07WC015818**

GREENWOOD TOWNSHIP
Employer/Respondent

14IWCC0602

On 10/28/2013, 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 0.07% 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:

0247 HANNIGAN & BOTHA LTD
RICHARD D HANNIGAN
505 E HAWLEY ST SUITE 204
MUNDELEIN, IL 60060

2389 GILDEA & COGHLAN
EDWARD A COGHLAN
901 W BURLINGTON SUITE 500
WESTERN SPRINGS, IL 60558

14IWCC0602

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Roger J. May
Employee/Petitioner

v.

Greenwood Township
Employer/Respondent

Case # **07** WC **15818**

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 **9/30/2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/15/2006**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$67,999.88**; the average weekly wage was **$1,307.69**.

On the date of accident, Petitioner was **66** 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 **$96,145.97** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$96,145.97**.

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 $871.78/week for 228 weeks commencing 5/18/2009 through 9/29/2013, as provided in Section 8(b) of the Act.

Respondent shall pay petitioner permanent total disability benefits of $871.78/week for life, commencing 9/30/2013 as provided in Section 8(f) of the Act.

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

Respondent shall pay medical expenses in the amount of $5,431.01 as outlined in petitioner's exhibit 18 Respondent shall be allowed a credit for any of those bills paid prior to September 30, 2013.

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

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

10/23/13
Date

OCT 28 2013

Roger J. May
Employee/Petitioner
v.
Greenwood Township
Employer/Respondent

Case # **07** WC **15818**

14IWCC0602

Findings of Fact and Law:

The parties have stipulated that the petitioner was injured on April 15, 2006. While descending a large snowplow on the outside ladder, the petitioner thought he had reached the bottom of the ladder and he released his hands from the ladder not knowing there was one more step. He free fell backwards onto the runner of the vehicle next to the snowplow. He struck his head on the back of the runner forcing his head and chin into his chest, cracking his teeth, fracturing the cervical spine, injuring the right arm and elbow. He was taken to Centegra were CT scan revealed a fracture of the facets at C6 (Px. 2). The petitioner has undergone extensive treatment from the date of the injury up through the date of hearing. The petitioner has worked light duty from the date of the accident through May 18, 2009. On July 17, 2008, there was a Section 12 evaluation with Dr. Matthew Ross. Among the many positive findings the doctor recommended a repeat EMG/NCV. The EMG/NCV was performed September 15, 2008 with numerous positive findings including a right ulnar neuropathy (Px. 8). On February 9, 2009, the petitioner announced to the Township board that he was not going to seek another term as a highway commissioner because of his work injury. In addition to the numerous treating physicians, the respondent tendered Dr. Ross as a treater. The petitioner saw him on June 24, 2009. Dr. Ross indicated that the petitioner would benefit from a right cubital tunnel release. That surgery was performed July 20, 2009. The petitioner was taken totally off work from thet date of surgery through August 12, 2009 when Dr. Ross gave him a 10 pound lifting restriction. The Respondent did not begin the payment of temporary total disability benefits until August 22, 2011. On September 3, 2009, Dr. Ross continued the petitioner on his restrictions and referred him back to the anesthesiologist for additional pain diagnostic work-up in an effort to locate and mask or ameliorate the neck pain.

Almost 2 years later the respondent had the petitioner evaluated by Dr. Robbins who is the pain doctor. Prior to that point in time he was referred to Dr. Dano. On March 8, 2010, his chief complaints to Dr. Dano were back pain, dizziness, ear congestion, eye pain, headaches, jaw clicking, jaw joint noises, jaw pain and limited mouth opening and muscle soreness, neck pain, ringing in the ears and shoulder pain. Dr. Dano indicated the petitioner suffered from jaw trauma due to the injury of April 15, 2006. On April 26, 2010 Dr. Dano recommended a mandible orthopedic repositioning device.

The respondent had the petitioner evaluated by Dr. Robbins on August 22, 2011. It should be noted that the petitioner's pain had not changed prior to being seen by Dr. Robbins. However, Dr. Robbins took him off of work on this date and never released him to return to work.

There is no dispute that the petitioner has been totally disabled from work as of August 22, 2011 when he saw Dr. Robbins. The dispute is whether the petitioner is entitled to temporary total disability benefits from May 18, 2009 through August 21, 2011.

Prior to May 18, 2009, the petitioner had been receiving epidural steroid injections in both the lumbar and cervical spine from Dr. Carobene. The petitioner obviously was not at maximum medical improvement on May 18, 2009. On June 24, 2009, Dr. Ross noted the ongoing epidural steroid injections for the cervical spine, the persistent pain in the right upper neck, head and sizzling or throbbing in the head, pain in the right upper back and scapula area, and numbness in the right hand. These are the same symptoms that Dr. Robbins noted on August 22, 2011 and what Dr. Robbins indicated precluded the petitioner from returning to any type of work. It is further noted that Dr. Ross took the petitioner totally off of work on July 20, 2009 when the petitioner had the right cubital tunnel release and did not release him to return to light duty work until August 12, 2009.

Dr. Robbins is currently treating the petitioner with trigger point injections which do, in fact, provide the petitioner with relief. On September 4, 2013, Dr. Robbins had the petitioner continued off work. This treatment is to alleviate the petitioner's occipital neuralgia.

Interstate Scaffolding v. Illinois Worker's Compensation Commission 236 Ill2d 132, 923 N.E.2d 266 (2010) indicates that a petitioner is entitled to temporary total disability benefits up until the point where he reaches maximum medical improvement. Based upon the treatment that the petitioner has had beginning May 18, 2009, it is the finding of the arbitrator that the petitioner had not reached maximum medical improvement and therefore it is the finding of the arbitrator that the petitioner is entitled to temporary and totally disabled from May 18, 2009 through the date of hearing of September 23, 2013.

It is the finding of the arbitrator that the petitioner's treatment has rendered by Dr. Robbins is necessary, reasonable and related to relieve the petitioner's condition of ill being.

It is the finding of the arbitrator that the petitioner has reached maximum medical improvement as of the date of September 30, 2013 and as of this date is permanently and totally disabled pursuant to Section 8(f) of the Act.

Respondent shall pay medical expenses in the amount of $5,431.01 as outlined in petitioner's exhibit 18. Respondent shall be allowed a credit for any of those bills paid prior to September 30, 2013.

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

Arbitrator Edward Lee

Date